RADICAL PROSTATECTOMY AND WORK: MEN’S PERSPECTIVES

by

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Abstract

The objective of this study was to explore the connections between men’s experiences of work, prostate cancer and radical prostatectomy to develop a grounded theory that describes the processes used by participants to reformulate the worker identity. The research questions that guided the study were: 1. How does screening and diagnosis of prostate cancer affect men and their work? and 2. How are participants’ work-related experiences affected following radical prostatectomy? Digitally recorded, in-depth, individual interviews were conducted with 24 English speaking men who were working at the time of prostate cancer diagnosis and subsequently underwent radical prostatectomy. Constructivist grounded theory guided collection and analysis of the data. A masculinities framework highlighted the ways in which gender shaped participants’ experiences.

Findings suggest that work was central to participants’ masculine identities and was an activity that benefited men and their families. Related to this, finding prostate cancer emerged as a threat to most men’s health and work, and a stark reminder of their mortality. Choosing radical prostatectomy was viewed as necessary in treating the disease to ensure survival. In preparing the workplace for their absence due to surgery, men made sick leave arrangements with the aim of minimizing disruptions to workplace productivity.

The basic social process of Reformulating the Worker Identity after radical prostatectomy was developed. Results indicate that men reformulated worker identities to accommodate treatment side-effects and challenges for fully resuming work responsibilities. This process comprised two parts. First, recovering after radical prostatectomy allowed men to restore physical strength to resume daily activities through processes that included embodying the sick role, contesting side-effects, and conceding new realities wherein men drew on masculine ideals of resilience and responsibility for solving one’s problems, and by reconciling the changes surgery had imposed on their lives. Second, in re-negotiating work expectations, men adjusted work responsibilities to facilitate their return to work by assessing work capacity, re-balancing work and health, and re-setting work obligations, wherein men reevaluated the importance of work in relation to emergent health needs and lobbied for return to work accommodations needed to sustain ongoing recovery.
Lay Summary

This study explored the connections between men’s experiences of work, prostate cancer and radical prostatectomy. Individual interviews were conducted with 24 English speaking men who were working at the time of prostate cancer diagnosis and subsequently underwent radical prostatectomy. Work was found to be central to men’s masculine identities and was an activity that benefited them and their families. However, men viewed prostate cancer diagnosis as a threat to their health and work, and was a reminder of their mortality. In this context, participants chose radical prostatectomy as treatment to ensure survival. Men reformulated their worker identities as they recovered from radical prostatectomy, a processes wherein they recognized that some radical prostatectomy side-effects could limit their work capacity. As a result, men re-negotiated work expectations by adjusting their work responsibilities to facilitate their return to, and permanence at, work.
Preface

This study was conducted under the direction and supervision of Dr. John Oliffe, Dr. Joan Bottorff, and Dr. Joy Johnson. Dr. John Oliffe is a Professor in the School of Nursing at The University of British Columbia (Vancouver Campus). Dr. Joan Bottorff is a Professor in the School of Nursing at the University of British Columbia (Okanagan Campus). Dr. Joy Johnson is a Professor in the Faculty of Health Sciences at Simon Fraser University.

I was responsible for writing the research proposal, obtaining University of British Columbia Behavioural Research Ethics Board Approval (Project title: Radical prostatectomy and work: Men’s experiences, Certificate: H14-00559), recruitment, data collection, data analysis, and manuscript writing. Dr. John Oliffe, Dr. Joan Bottorff, and Dr. Joy Johnson provided guidance on research question construction and development, offered strategies for data collection and data analysis, and provided feedback throughout the manuscript-writing process.
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To my mother, for her unwavering encouragement and support over the years. I love you.
Chapter 1

Introduction to the study

Prostate cancer is the most commonly diagnosed male cancer in Canada. It is estimated that 21,300 new cases of prostate cancer were diagnosed in 2017, representing 21% of all new cancer diagnoses in Canadian men (Canadian Cancer Society [CCS], 2017a). In 2012, a substantial proportion of new cases were diagnosed in men of working age with 19% of new diagnoses occurring in males under the age of 59, and 40% of all diagnoses being made in men between the ages of 60 and 69 (Canadian Cancer Society’s Steering Committee on Cancer Statistics [CCSSCCS], 2012). Moreover, the number of men in the workforce diagnosed with prostate cancer is likely to increase due to two reasons. First, more than 1 in 6 workers are at least 55 or older, and employment rates of men over 55 are expected to continue to increase due to Canada’s ageing population (Carriere & Galarneau, 2011). Second, new cases of prostate cancer have been projected to increase substantially by 2021 as a result of the rapidly ageing population and the availability of the prostate specific antigen (PSA) test which is used in the diagnosis and monitoring of prostatic diseases (Quon, Loblaw, & Nam, 2011).

Early diagnosis and advances in prostate cancer treatment have also yielded significantly improved clinical outcomes. For example, prostate cancer related deaths decreased by 3.9% per year between 2001 and 2009, while five-year and ten-year relative survival ratios were 96% and 95% respectively (CCSACCS, 2013). These statistics suggest that: 1) a substantial number of men experience prostate cancer as a chronic illness; 2) more men will live with the risk of
prostate cancer recurrence; and 3) more men treated for prostate cancer are expected to work\(^{1}\) beyond 65 years of age.

**Prostate cancer treatment and work**

Treatment for prostate cancer comprises one or a combination of treatment modalities including: active surveillance, radical prostatectomy, radiotherapy and/or androgen deprivation therapy (Izawa et al., 2011). Choosing treatment often entails a complex process of evaluation that takes into consideration the stage of the cancer, treatment side-effects and patient preferences. Although prostate cancer treatment side-effects such as erectile dysfunction and urinary incontinence have long been highlighted as important issues in treatment decision making, the impact of treatment(s) on men’s work, work-related concerns, responsibilities and benefits (e.g., extended health insurance) may also influence treatment choices (Bradley, Neumark, Lou, Bednareck & Schenk, 2005). As such, men’s work situations can influence the treatment they choose and their experiences of prostate cancer. However, little is known about men’s experiences of prostate cancer, its treatment(s) and the connections to men’s work.

Research on prostate cancer underscores the importance of work as an avenue for expressing identity and social connection for many men (Chapple & Ziebland, 2002; Grunfeld, Drudge-Coates, Rixon, Eaton, & Cooper, 2013; Kelly, 2009). However, patients treated for prostate cancer can report a reduced ability to work which not only affects their identity and social connectedness, but also negatively impacts their income (Bradley et al., 2005; Grunfeld et al., 2013). In the Canadian context, patients with prostate cancer and their families can be burdened by the economic impact of prostate cancer and its treatment(s) (Longo, Fitch, Deber, 2013).

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&Williams, 2007). Besides bearing ‘out of pocket’ health-related expenses not covered under provincial health plans, many men must take extended leave from work during and after prostate cancer treatment(s) (Bradley et al., 2005). All of this occurs in the context of looming pension cuts in Canadian public-sector jobs (May, 2014).

**Exploring the connections between radical prostatectomy and work**

While there are various treatment modalities available for prostate cancer, many men choose radical prostatectomy as primary treatment for localized disease. The experiences of patients who choose radical prostatectomy as primary treatment for prostate cancer offers an important context to examine the connections between prostate cancer and work. Specifically, radical prostatectomy, as a surgical treatment, has sudden and dramatic effects on a patient’s ability to work. Indeed, patients who undergo radical prostatectomy can experience reduced ability to work for up to 12 months after surgery (Oberst, Bradley, Gardiner, Schenk, & Given, 2010). Reduced ability to work is concerning to patients with prostate cancer particularly when it leads to reduced income and/or changes in work-related benefits including the loss of extended health insurance (Bradley et al., 2005). Of particular concern is the dearth of understanding about the effects of potential work-related changes after prostate cancer treatment(s) on patients’ perceived well-being. My PhD study addresses these knowledge gaps by exploring the connections between prostate cancer and work from the perspectives of men who have undergone radical prostatectomy as primary treatment for prostate cancer.

**Problem statement, objective and research questions**

The effects of prostate cancer and its treatment on men’s ability to work are poorly understood (Macmillan Cancer Support, 2008), as are workplace supports to facilitate men’s
return to work (Nitkin, Parkinson, & Schultz, 2011; Steiner, Cavender, Main, & Bradley, 2004). Furthermore, although in some literature there is an acknowledgement of the potential impact of prostate cancer and radical prostatectomy on men’s relationships to work (Grunfeld et al., 2013; Longo, et al., 2007), little is known about these connections within the British Columbian context. The objective of this study was to explore the connections between men’s experiences of work, prostate cancer and radical prostatectomy to develop a grounded theory that describes the processes used by participants to reformulate their worker identity. The research questions that guided the study were:

1. How does screening and diagnosis of prostate cancer affect men and their work?
2. How are participants’ work-related experiences affected following radical prostatectomy?

Locating participants in this study

This study is based on the knowledge that participants are social agents actively engaged in choosing, deciding, planning and intervening to create the conditions in which they want to live their lives. Importantly, it is also acknowledged that participants and the researcher engaged in co-constructing knowledge and understandings of the phenomena under study. Throughout the study, I, as a researcher engaged participants in exploring their experiences of work, prostate cancer and radical prostatectomy in order to identify events, issues and gaps encountered during their transition from diagnosis, treatment, recovery, return to work, disability and/or retirement. Current study findings advance empirical understandings about men’s work, prostate cancer and radical prostatectomy, and provide insights to inform interventions aimed at assisting men’s return to work.
Reflexivity and locating myself in this study

Reflexivity is essential in qualitative research and refers to the process of critically reflecting on one’s role as a researcher. This requires a “conscious experiencing of the self as both enquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself” (Guba & Lincoln, 2005, p.210). This definition of reflexivity has two major implications, the first of which points to the relationship the researcher has with his/her self as a student of participants’ experiences. That is, through reflexivity, the researcher must understand that his/her perspectives evolve throughout the study and shape the way how participants are engaged, information is elicited, knowledge is understood and findings disseminated. The second implication points to the relationship the researcher has with his/her own understandings of the phenomena of interest, acknowledging that beliefs opinions and worldviews change informed by new insights gained through the processes of conducting the study. From the outset of this study, reflexivity began by identifying my own values and understandings that I brought to the scene, what I saw and how I saw work, prostate cancer and radical prostatectomy (Charmaz, 2006). This process involved critical introspection about my own experiences and how these informed my values and attitudes addressed in this study. Thus, reflexivity required that I look inwardly and commit to being aware of my intentions in each step of the study and required a transparent account about my predispositions so that readers of this dissertation can interpret and judge the applicability of the findings herein to their own particular contexts.

In reflecting on my perspectives, I recognize that this study is informed by my experiences as a medical-surgical nurse, and later emergency nurse in Winnipeg, Manitoba. My experience as a hospital-based nurse provided me with in-depth understandings about the range of ‘patient-centered’ services available for individuals in need of health care. However, I also
noticed that there were no men-specific health subspecialties while there were numerous health clinics and subspecialties in older adults’, women’s and children’s health. This realization led me to enquire about health issues faced by men, and to participate men’s health week events organized by the University of Manitoba, and by doing presentations on men’s health issues at community events. The positive feedback I received as a nurse engaged in promoting men’s health awareness fueled my desire to pursue post-graduate education in the form of a Master’s in Nursing with a focus on prostate cancer as a way of understanding men’s perceptions and practices around health. In order to complement the biomedical understandings offered through my Master’s education, and in an attempt to learn about men’s perspectives of prostate cancer, I participated extensively in prostate cancer support group meetings in Winnipeg. There, I encountered a gentleman who confided that he could “live with urinary incontinence and erectile dysfunction after radical prostatectomy but could not live without income”. This statement challenged how I saw prostate cancer and called my attention to seeing the disease as potentially affecting the lives of men and their families in ways that I had not anticipated or fully considered. I became increasingly interested in understanding how the disease and its treatment(s) were connected to men’s work.

**Significance**

Working men with prostate cancer need information about the consequences of radical prostatectomy to evaluate treatment options, make major life decisions, and adjust after treatment (Sidana et al., 2012). Attending to these challenges, clinicians must be able to provide comprehensive information about the effects of radical prostatectomy as primary treatment on various aspects of daily life including work. However, little is known about the connections between radical prostatectomy and work, and how the underlying processes can affect the daily
lives of men with prostate cancer. Exploring how radical prostatectomy, as primary treatment for prostate cancer, and work connect affords the opportunity to uncover important information about the needs of men with prostate cancer at different time-points across the illness continuum.

Dissertation structure

This dissertation has been organized into six chapters. Chapter 1 provided an introduction to the research topic addressed in this study, the purpose, rationale and a reflexive account of conducting this research. Following this introduction, I provide a review of the literature on work, prostate cancer and radical prostatectomy in Chapter 2 to set a contextual stage for the current study. In Chapter 3, I discuss the research design, my philosophical positioning, the methodology and methods, constructivist grounded theory, and the process of data collection and analysis. Chapter 4 addresses and contextualizes findings related to men’s work and their transition from diagnosis to treatment decision making. Chapters 5 provides a grounded theory of how men engage in Reformulating the Worker Identity after radical prostatectomy, describing the processes used by participants in returning to work. This dissertation concludes with Chapter 6, by discussing the study’s findings, strengths and limitations, clinical implications, recommendations for future research.
Chapter 2

Literature review

A literature review was conducted to inform this study and to identify knowledge gaps with a focus on radical prostatectomy and work. Although this review does not represent a systematic review of the literature on prostate cancer, it encompasses a broad, representative and relevant selection of the prostate cancer literature. Peer-reviewed journal articles and research reports based on Canadian populations are highlighted to ground understandings about prostate cancer within the Canadian context and the current study.

Incidence and mortality of prostate cancer

Historically, the lack of a screening test to rule out prostatic malignancies meant that prostate cancer was often diagnosed in advanced stages and, thus, was associated with poor prognosis. Research into detecting prostate cancer in its earlier stages resulted in the development of the PSA test, which was widely used by the 1990s in North America. This led to an increased number of early-stage prostate cancer diagnoses which, in addition to advances in treatment, improved survival rates for patients (Canadian Task Force on Preventive Health Care [CTFPHC], 2014).

The risk of being diagnosed with prostate cancer increases significantly by the fifth decade of life (CCS, 2017b). In the Canadian context, prostate cancer diagnoses have steadily increased over the past three decades and it is now estimated that 1 in 7 Canadian men will be diagnosed with prostate cancer (CCS, 2017a). Although new diagnoses of prostate cancer will continue to rise well beyond the next decade (Quon et al., 2011), current data shows that prostate cancer related deaths have declined since 2001 (CCSACCS, 2013) and it is expected that only 1
in 29 men diagnosed with prostate cancer will die from the disease (CCS, 2017a). The increased incidence of prostate cancer is largely attributed to population-based screening initiatives which have translated into earlier diagnosis and treatment (CTFPHC, 2014). However, there is controversy as to whether early diagnosis and treatment for prostate cancer improves life expectancy (CTFPHC, 2014). Inversely, it has been argued that treatment can, in fact, decrease quality of life (CTFPHC, 2014). The implications of prostate cancer treatment and its outcomes are poorly understood and particular attention must be paid to the effects of an increasing incidence of prostate cancer in an ageing male population and workforce.

**Screening and diagnosis of prostate cancer**

Current Canadian prostate cancer screening guidelines recommend the use of digital rectal examination (DRE) along with PSA testing to rule out abnormalities associated with increased risk of prostate cancer (Izawa et al, 2011). A DRE is performed by palpating the prostate for anomalies through the rectal wall and can be helpful in identifying prostatic swelling or masses. Although measuring PSA levels in blood can help identify changes to prostatic tissue due to inflammation, benign enlargement or cancer (CCS, 2017c), it is also known that normal PSA levels in men rise with age (CCS, 2017b). Therefore, despite the fact that neither DRE or PSA can definitively diagnose prostate cancer, they can help screen men for prostate cancer. Conclusive diagnosis of prostate cancer requires examination of prostatic tissue, which can be collected by way of a trans-rectal ultrasound biopsy (CCS, 2017d). This procedure requires that an ultrasound probe containing a tissue sampling needle be inserted into the patient’s rectum. Ultrasound imaging helps clinicians visualize the prostate through the rectal wall, where the needle pierces the prostate to extract tissue samples (CCS, 2017d). Inspection of prostatic tissue samples can confirm the presence of malignancy and allows for cancer grading.
Prostate cancer grading is done using the Gleason classification method. This method is used by pathologists to describe the characteristics of biopsied prostate tissue and serves to give an impression of how likely prostate cancer is to grow and spread beyond the prostatic capsule (CCS, 2017e). Using a scale from 1 to 5, the Gleason grading reflects the level of difference found in the biopsied sample from normal prostatic tissue. Accordingly, a Gleason grade of 1 is used to classify tissue that closely resembles normal prostatic cells and is considered to be in a slow growing stage. A tissue sample with a Gleason grade of 5 contains tumor cells that do not resemble normal prostatic cells and is regarded to be in an aggressive or fast growing stage. Given that biopsied tissue may contain more than one type of prostatic tumor grade, pathologists grade the two most abundant types of tumor tissues (British Columbia Cancer Agency [BCCA], 2014). The most abundant tumor tissue grade is known as the ‘primary pattern’ and the second most abundant tumor tissue grade is known as the ‘secondary pattern’ (BCCA, 2014). In order to help physicians and patients choose the best possible treatment, a Gleason score is used to give an overall measure of risk that the prostatic tumor may grow and/or metastasize. The Gleason score is calculated by adding the primary and secondary pattern grades which are included in the biopsy pathology report. In British Columbia, a Gleason score of 6 or below is considered a ‘low risk’ (slow growing) prostate cancer, while a Gleason score of 7 represents an ‘intermediate risk’ (neither slow nor fast growing) prostate cancer, and a Gleason score of 8 or more is considered a ‘high risk’ (fast growing) prostate cancer (BCCA, 2014). In the current study, participants’ Gleason scores provided important contextual information that helped understand men’s treatment decision making.
Radical prostatectomy as primary treatment for prostate cancer

Given the different treatment modalities available for prostate cancer, choosing a treatment depends on the stage of cancer and patient preferences. In most cases, a decision is made by evaluating potential treatment risks, side effects, age and quality of life associated with the treatment option being considered. Radical prostatectomy is recommended when the cancer is confined to the prostatic capsule, and for patients who are in good health and have a life expectancy exceeding 10 years (Izawa et al., 2011). This treatment entails surgically removing the entire prostate gland along with the seminal vesicles, and can be performed as either an open surgical procedure or laparoscopically with similar clinical outcomes in terms of survival and remission rates (Wirth, Psutka, Chapin, Wu, Wu, & Dahl, 2013).

Surgery to remove the prostate gland and seminal vesicles changes the physiology of the lower urinary tract and often results in urinary incontinence. This is because intra-operative damage to the nerves and striated muscle fibers in the bladder may weaken the bladder’s ability to form a tight seal around the bladder neck causing urinary leakage. The prevalence of urinary incontinence varies depending on the length of time since surgery and how incontinence is defined (Sacco et al., 2006). Some authors consider urinary continence as no urinary leak at all, whereas others characterize individuals with occasional leakage as being continent. With this caveat in mind, the literature reports a range of 0% to 87% urinary incontinence after radical prostatectomy (Alivizatos & Skolarikos, 2005). Despite the wide range of reported rates of urinary incontinence, there is consensus that younger men are more likely to regain urinary continence post-operatively compared to older men (Parsons, Evans, & Wright, 2009) and that the severity and prevalence of incontinence diminishes with time (Sacco et al., 2006). Studies investigating the natural history of urinary function following radical prostatectomy show that up to 93.4% of patients regain continence during the first 24 months after treatment (Sacco et al., 2006).
2006) and urinary control seems to be sustained well in the first two years post-surgery (Penson et al., 2005). Nevertheless, urinary incontinence can pose a serious inconvenience for working men treated with radical prostatectomy in a number of ways. For example, urinary incontinence may embarrass men whose work involves social interactions, and can be a concern to those who work for extended periods far from toilet facilities and/or work in physically demanding jobs invoking exertion induced incontinence. Not only can urinary incontinence interfere with work, it can also pose a health concern when the skin around the groin area is constantly exposed to urine, causing irritation and/or infection (Gray et al., 2012).

Erectile dysfunction is another potential side-effect of radical prostatectomy. Although the exact aetiology of erectile dysfunction after radical prostatectomy is unknown, it is believed that intra-operative damage to the vasculature and innervations to the penis account for impaired erections. Depending on intrinsic patient factors, surgical factors and reporting biases (Mulhall, Bivalacqua, & Becher, 2012), there is a significant variation in the reported rates of erectile dysfunction following radical prostatectomy, ranging from 30% to 87% (Alemozaffar et al., 2011; Burnett, 2005; Tal, Alphs, Krebs, Nelson, & Mulhall, 2009). However, despite the high prevalence of erectile dysfunction after radical prostatectomy, little is known about the connections between erectile dysfunction and prostate cancer patients’ relations to work.

A less well known, but potentially important consequence of radical prostatectomy on men’s work is lower abdominal hernias. The abdominal incision made to remove the prostate gland may weaken the lower abdominal wall and increase the risk for herniation over time. Studies examining the incidence of hernias after surgical treatment for prostate cancer report a 12%-25% higher incidence of inguinal hernias in men treated with open radical prostatectomy (Abe et al., 2007; Ichioka, Kohei, Yoshimura, Arai, & Terai, 2007; Stranne, Hugosson, & Lording, 2006; Two, Our, Yang, Cheng, Cheng, & Ho, 2005). There is also some evidence to
sugest that laparoscopic radical prostatectomy is associated with a similar incidence of post-surgical herniation as open surgery (12.4% vs. 10.1%, respectively) and this may also be associated with a higher risk of incisional hernia (adjusted HR 3.39, 95% CI 2.63-4.38, p<0.0001) (Carlson, Edie, Atoria, Elkin, & Eastham, 2013). The occurrence of lower abdominal hernias is a cause of concern to men because hernias can cause extreme pain during activity and may be particularly detrimental to men who work in physically demanding jobs (Hendry, Parson-Brown, & de Beaux, 2008). The risk of abdominal herniation, its potential impact on work and the potential for needing hernia repair surgery represents added considerations that working men should take into consideration when opting for radical prostatectomy.

**Secondary treatment after radical prostatectomy**

Secondary treatment after radical prostatectomy is recommended in the event of prostate cancer recurrence². Radiation therapy is advised in cases of prostate cancer recurrence with benefits to survival rates and quality of life (Thompson et al., 2013), particularly in patients under the age of 70 (Bolla et al., 2012). This treatment consists of delivering radiation energy to the prostatic region in order to destroy metastasized prostate cancer tissue, and treatment can be delivered through external beam radiotherapy, brachytherapy (implanting radioactive seeds in the prostate or prostatic region), or a combination of both. Side-effects of radiotherapy are related to the irritation caused by radiation to tissues adjacent to the prostatic area and include bladder outlet obstruction, dysuria, diarrhea, bloody stools and proctitis. Although symptoms occur most prominently during and shortly after radiotherapy, they can last well over three months (Thompson et al., 2013). Given the debilitating nature and duration of radiotherapy-

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² Prostate cancer recurrence is clinically defined as two consecutive PSA levels ≥ 0.3 µg/L (BCCA, 2015).
related side-effects, many patients report absenteeism from work for up to several months (Bradley, Oberst, & Schenk, 2006).

Another form of secondary treatment after radical prostatectomy is androgen deprivation therapy. This treatment option is recommended for treating advanced or metastatic prostate carcinomas, as adjuvant or neoadjuvant therapy with radical prostatectomy or radiotherapy, and helps to suppress prostatic tissue growth after therapy with curative intent. This form of treatment involves reducing the availability of androgens through the surgical removal of a patient’s testicles or by administering anti-androgenic agents. Although androgen deprivation therapy is effective in slowing the growth and spread of prostate cancer, it must also be noted that androgens are essential in a number of physiologic functions and their suppression during prostate cancer treatment may bring consequences that include loss of bone and lean mass density (Berruti et al., 2002), increased risk of bone fractures (Shahinian, Kuo, Freeman, & Goodwin, 2005), hot flushes (Iversen, Karup, van der Meulen, Tankó & Hutaniemi, 2011), arterial stiffness (Smith et al., 2001), new-onset diabetes mellitus (Smith, Lee, & Nathan, 2006), and cognitive decline (Cherrier, Aubin, & Higano, 2009). Despite the known side-effects, relationships between androgen deprivation therapy as secondary treatment and work are poorly understood.

Methods to diagnose and treat prostate cancer have progressed in the past three decades. Although much is known about the treatment consequences of radical prostatectomy, particularly erectile dysfunction, little is known about how surgical treatment alone or in combination with radiotherapy and/or androgen deprivation therapy can affect other aspects of patients’ lives such as work. In addition to understanding the clinical implications of prostate cancer, there is a pressing need to appreciate the scope and effects of treatment on the lives of patients.
Prostate cancer and chronic diseases

Men diagnosed and treated for prostate cancer may also be living with other chronic illnesses (Nanda, Chen, Moran, Braccioforte & D’Amico, 2013; Shikamov, Kocherginsky, Shalhav, & Eggener, 2012) and some of these comorbidities prove fatal (Briganti et al., 2013). For example, Shikamov and associates (2013) found in a retrospective study using data from 120,392 men who underwent radical prostatectomy between 1988 and 2003 that 30.6% died from non-prostate-cancer-related causes including cardiovascular diseases, whereas only 5.3% of the men died from prostate cancer in the same timeframe. Similarly, Eifler and colleagues (2012) conducted a study that examined data from 18,209 men who underwent radical prostatectomy between 1975 and 2009, finding that, of a total of 1,419 reported deaths, 379 were attributed to prostate cancer representing 2.1% of the population. Furthermore, there is also evidence to suggest that the recurrence of prostate cancer may be associated with lifestyle-related chronic diseases, independent of age at diagnosis and/or tumor stage (Basset et al., 2005). Basset et al. (2005) reviewed the data of 2,131 patients who underwent radical prostatectomy and were enrolled in the Cancer of the Prostate Urologic Research Endeavor (CaPSURE) to find that 251 (12%) developed recurrence at a median of 13 months (range 1 to 107). It was also found that there was a significant positive association between increasing body mass index (BMI) and disease recurrence ($P=0.028$). This was particularly salient in men who had a BMI of 35 or more who were 1.69 times more likely to experience recurrence relative to men with a BMI of 25 or less (95%, CI 1.01 to 2.84), suggesting that chronic health issues may continue to be a concern for men long after treatment for prostate cancer. Knowledge about the relationships between prostate cancer and chronic diseases provides context for patients and clinicians to intervene in reducing the impact of concomitant diseases and facilitate long term well-being. Thus, considering the impact of chronic diseases is important in foregrounding understandings of the
connections between men’s experiences of work, prostate cancer and radical prostatectomy in
the current study.

Overview of the research and care delivery in prostate cancer

Medical and psychosocial research constitutes much of the current body of knowledge on
prostate cancer. Medical research on prostate cancer has focused on diagnosis, treatment, side-
effects, and survival rates of specific clinical interventions, the results from which shape current
clinical practice. Characterizing medical literature is the use of clinical outcomes including
treatment side-effects and/or years of survival as measurable benchmarks reflecting
interventional success. Influenced by research in the social sciences, psychosocial research adds
knowledge by exploring the impact of prostate cancer on the lives of patients and their
significant others (Harden et al., 2013; Doherty, Bothwell, & Simmons, 2007; McCaughan, Prue,
McSorley, Northouse, Schafenacker, & Parahoo, 2013). The richness of evidence obtained
through psychosocial research has helped contextualize many of the issues faced by patients and
families affected by prostate cancer and contributed to clinical practice including treatment
decision making (Davison & Breckton, 2012) and in providing family support (Harden et al.,
2009; McCaughan et al., 2013).

Research steeped in disciplines such as physiotherapy, psychology and social sciences
have also highlighted the complex and multidimensional impact of prostate cancer. That said,
many Canadian patients with prostate cancer receive health care that is fragmented “because they
are delivered by multiple health providers, usually working independently, in multiple and
discreet settings” (Ravenscroft, 2005). Fragmentation of health services can curtail the
development of an overarching plan that takes into account the multiple health and work-related
needs of men with prostate cancer in an integrated, coherent way. For example, Skolarus and
associates (2012) conducted a study using data from 67,736 men diagnosed with prostate cancer and found that those who received fragmented health care spent more of their income on health-related services, were more likely to undergo redundant clinical interventions, and received care that was poorly coordinated resulting in poorer management of concomitant chronic illnesses. Given that many Canadian men with prostate cancer often receive health services from several health care providers, including family physicians and specialists, a study, such as the current research that explores men’s experiences with prostate cancer, must also consider the effects of multiple health care providers in men’s experiences from diagnosis, treatment decision making, treatment, recovery, return to work, medical leave and/or retirement.

In conclusion, understandings afforded by psychosocial research points to complexity in the prostate cancer experience and need for an integrated approach to delivering health services to maximize men’s well-being. However, delivery of an integrated health services may be curtailed by a model of health service delivery that does not have an overarching plan of treatment and follow-up creating gaps in the care men with prostate cancer receive. The current study recognized that participants can be burdened with making important health and treatment decisions without being fully informed about their implications and/or consequences, and explored how these experiences shaped their transition from diagnosis, treatment and recovery particularly as it relates to their ability to remain in the workforce.

**Men, work and retirement**

Since the elimination of a mandatory retirement age (McDonald & Donahue, 2011) many Canadian men work past age 65 (Sun Life Canadian Unretirement Index, 2015) or return to work after retirement (Schellenberg, Turcotte, & Ram, 2005). While the proportion of men aged
between 55 and 59 participating in the labour force\(^3\) has remained steady at about 80%, since 1976 there has been a steady increase in labour force participation for men aged 60-64 from 40% in 1976 to almost 70% in 2011 (MacEwen, 2012). Similarly, labour force participation rates for men aged 65-69 has doubled (7% to 18%) in the past decade (MacEwen, 2012). These statistics may reflect men’s concerns about projected financial uncertainties after retirement. Findings from a 2008 Statistics Canada survey of male workers over the age of 55 found that only 32% of respondents felt financially ready to retire, while 23% were retired due to layoff, closure or downsizing (Pignal, Arrowsmith, & Ness, 2008). Furthermore, most men’s income decreases substantially after retirement. According to a 2011 report by Statistics Canada, 55% of retired men belong to the lowest two income quintiles, compared with less than 24% of those who never retired (Park, 2011). Given that about 97% of all prostate cancer diagnoses in Canada occur in men over the age of 50 (Prostate Cancer Foundation, 2017a), these statistics provide context to why many men with prostate cancer aged 55+plan to remain in the workforce well past age 65. Therefore, there is a need to explore how financial uncertainties after retirement affect men’s perceptions about the importance of work and its connections with prostate cancer and radical prostatectomy.

**Prostate cancer and work**

To explore what was known about the connections between prostate cancer and work, an electronic search was done in January 2018 of research articles with the keywords: ‘prostate cancer’, ‘work’, and ‘occupation’. The search was conducted on publication databases that included CINAHL, Medline, and PsycINFO and yielded a total of 11,900 titles. Only original,
research study publications (qualitative, quantitative, and/or mixed methods) in English that included participants and/or databases of men who were diagnosed with prostate cancer were considered. Articles were included if they were about studies that: 1. investigated potential connections between work and/or occupation with the diagnosis of prostate cancer, 2. explored how the diagnosis of prostate cancer and/or its treatment(s) affected men’s work, 3. provided descriptions of how prostate cancer treatment(s) shaped participants’ self-concepts as workers and as men. After screening the abstracts of the most relevant titles, sixteen publications met all inclusion criteria and were reviewed. The publications were subjected to a global assessment (Table 1. Prostate cancer and work - Articles reviewed) that drew upon the McMaster University Quantitative Review Guidelines (Law et al., 1998) and the McMaster University Qualitative Review Guidelines Version 2 (Letts et al., 2007).

Of the publications reviewed, thirteen pertained to reports of quantitative research studies. The sample size of these studies ranged from 109 to 55,332 men and were conducted in the United States (6 studies), Canada (4 studies), China (1 study), Ireland (1 study), and the Netherlands (1 study). These study reports described data collection methods that included survey questionnaires and/or a combination of patient chart and/or database reviews. Five publications were of qualitative studies that described the impact of prostate cancer on men’s sexuality, masculine identity, daily lives, and work. Of these, three studies were conducted in the United Kingdom, while one published report was from a study done in Canada and one from the United States. While the sample size of qualitative studies reviewed ranged from 14 to 95 participants, reported results of these studies offer rich descriptions that complement findings offered by quantitative research studies. Importantly, qualitative study reports reviewed provided insights about the complex contexts and personal experiences men faced after their prostate cancer diagnosis.
Within the literature reviewed, three major themes prevailed. The first was concerned with the relationships between occupations and prostate cancer. Nine studies reported that some occupations were associated with higher incidence of prostatic malignancies such as farming and work in the armed forces (Sritharan et al., 2017), forestry and logging (Sauvé, Lavoué, & Parent, 2016), jobs involving pesticide use (Alavanja et al. 2003) and exposure to industrial chemicals and by-products (Sharma et al., 2016), electrical work (Aronson Siemiatycki, Dewar, Guerin, 1996), firefighting (Demers et al., 1994), metal and foundry work (Brown & Delzell, 2000), and healthcare (Hsing, McLaughlin, Zheng, Gao, & Blot, 1994; van der Gulden, Kolk, & Verbeek, 1995). It is important to note that although none of these studies proved a causal relationship between occupation and prostate cancer, the findings are valuable to health officials and clinicians planning screening interventions, and in identifying potential sub-populations at risk.

Four publications informed the second theme, which related to the financial impact of prostate cancer and the effects of treatment on men’s ability to work. In an Irish study that included 212 participants with prostate cancer, Sharp and Timmons (2016) found that 40.3% of the men experienced cancer-related financial stress. Furthermore, participants who were working at the time of prostate cancer diagnosis were more likely than retirees to experience financial stress (Sharp & Timmons, 2016). For Sharp and Timmons (2016), the financial obligations of working men (e.g., mortgage, family expenditures) and income reductions due to sick leave combine to exacerbate men’s sense of financial insecurity. Related to this, studies conducted in the United States suggest that prostate cancer treatment-related sequelae is associated with workplace-related adjustments to schedule and job-roles (Oberst, Bradley, Gardiner, Schenk, & Given, 2010) and/or absenteeism (Bradley, Oberst, & Schenk, 2006). For example, Bradley and colleagues (2005) compared a group of 267 patients diagnosed with prostate cancer (205 of whom had radical prostatectomy) with two control groups of 283 and 256 men without cancer,
finding that patients were at least 10% more likely than controls to be unemployed by the sixth month after diagnosis. This difference was no longer statistically significant by the 12th month following diagnosis, suggesting that most prostate cancer patients returned to work. However, of those who returned to work, 43% were unable to perform at their former capacity with many men forced to reduce work hours (Bradley, Neumark, Lou, Bednareck, & Schenk, 2005). In addition to the workplace-related changes required to remain employed, the researchers also found that more men with prostate cancer retired prematurely than controls by the sixth (6% vs. 1%, $P=.006$) and twelfth months (11% vs. 1%, $p<.001$) (Bradley et al., 2005). This may be due to the fact that men with prostate cancer were on average 7 years older (mean age: 55.5) than those in the control groups (Bradley et al., 2005). An additional confounder to these results may be the fact that, in the US, private health insurance can be costly and is often an employment benefit. It is probable that many patients treated for prostate cancer in the US chose to return to work in light of the employment-based health insurance benefits, which may contribute to substantial monetary savings to the patient. Conversely, it is also possible that a greater proportion of patients may choose to work fewer hours and/or retire prematurely in countries with comprehensive social safety nets and universal access to public health services such as Canada. Exploring the contextual realities around work, prostate cancer and radical prostatectomy in British Columbia is a first step towards gaining better understandings of the experiences Canadian men with prostate cancer face as they journey with the disease.

Five studies informed the third theme, which reported on the effects of prostate cancer on men’s identities and work responsibilities. Findings from three qualitative studies conducted in the United Kingdom (Chapple & Ziebland, 2002; Grunfeld et al., 2013; Kelly, 2009) indicate that men with prostate cancer often frame their identities in terms of their relationships to work. Engaging in work following prostate cancer treatment allowed men to maintain their identities as
valuable members of society by providing for their families and communities through their labour (Chapple & Ziebland, 2002; Grunfeld et al., 2013; Kelly, 2009). However, as previously discussed, prostate cancer treatment often leads to a reduction in work capacity. Reduced work capacity can affect prostate cancer patients’ identity, particularly within the family structure (Maliski et al., 2008). In a qualitative study involving 60 Latino and 18 African American men (of whom 67% and 46% had radical prostatectomy, respectively), Maliski et al. (2008) found that prostate cancer treatment can lead to shifts in men’s identities wherein they can no longer fulfill protector and provider responsibilities and become recipients of financial support. In exploring the impact of prostate cancer treatment on men’s identities, Kelly (2009) conducted a qualitative study involving 14 men from the United Kingdom and found that men attempted to maintain an “acceptable degree of biographical continuity” (p.154) by returning to work and/or engaging in work-related activities. Work and work-related experiences not only play an important role in the conceptualization of identity in men with prostate cancer, but also offer men a means with which to make sense of prostate cancer (Gray et al., 2002). In a study involving 18 participants with prostate cancer residing in Toronto, Gray et al. (2002) found that men framed interactions with their physicians as ‘doing business’ to objectively grasp the significance of diagnosis, explore treatment options and set recovery goals. For Gray et al. (2002), men’s identities as workers and their use of skills derived from solving complex problems at work were often harnessed by men to manage their prostate cancer.

In light of the publications reviewed here, two issues are key. The first is the fact that seven articles detailing employment issues after prostate cancer treatment were published prior to 2012. Therefore, many of the findings reported may not reflect the financial realities men face today. Second, although work-related changes have been associated with reduced income among men with prostate cancer (Longo et al., 2007), little is known about the effects of work-related
changes due to prostate cancer on patients’ identities as men and as workers. This crucial link is explored in the current study and findings presented herein offer important insights for Canadian policy makers, clinicians, patients, employers and families of men with prostate cancer.
Table 1. Prostate cancer and work - Articles reviewed

<table>
<thead>
<tr>
<th>Study</th>
<th>Aims/Objectives</th>
<th>Design/Methodology</th>
<th>Sample</th>
<th>Data collection</th>
<th>Conclusions and/or theoretical implications</th>
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</thead>
<tbody>
<tr>
<td>1. Alavanja et al. (2003) United States</td>
<td>Examine the relation between agricultural pesticides and prostate cancer incidence.</td>
<td>Quantitative, prospective, 7.2 yrs follow-up, comparison with general population database as control</td>
<td>55,332 men Licensed, private users and commercial applicators of restricted pesticides</td>
<td>Survey questionnaire Data base</td>
<td>Increased risk for prostate cancer in men who use pesticides. Contextual risk factors must also be taken into consideration to understand prostate cancer risk.</td>
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<td>2. Aronson et al. (1996) Canada</td>
<td>To provide evidence on the possible associations between cancer and exposure to occupational hazards.</td>
<td>Quantitative, retrospective, cross-sectional, comparison with general population database as control</td>
<td>3,730 men who were newly diagnosed with prostate cancer</td>
<td>Surveyor administered questionnaire Data base</td>
<td>Evidence supports the hypothesis that exposure to certain substances at work may increase prostate cancer risk.</td>
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<td>3. Bradley et al. (2005) United States</td>
<td>Investigate the influence of prostate cancer treatment on participants’ work activities.</td>
<td>Quantitative, prospective, comparison with two control groups of 283 and 265 men without prostate cancer</td>
<td>267 men 6 to 12 month post prostate cancer diagnosis</td>
<td>Survey Database</td>
<td>Prostate cancer diagnosis is associated with reduced employment and may affect finances.</td>
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<td>4. Bradley et al. (2006) United States</td>
<td>Examine the length of work absenteeism due to either breast or prostate cancer treatment.</td>
<td>Quantitative, prospective, 6-12 month follow-up</td>
<td>267 men who were employed at the time of prostate cancer diagnosis</td>
<td>Phone interviews</td>
<td>Employed men newly diagnosed with prostate cancer missed an average of 27 days from work.</td>
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<td>6. Chapple &amp; Ziebland (2002) United Kingdom</td>
<td>To explore the ways in which prostate cancer and its treatment affects men’s bodies, their roles and sense of masculinity.</td>
<td>Qualitative, retrospective, exploratory</td>
<td>52 men with suspected or confirmed prostate cancer</td>
<td>Face-to-face interviews</td>
<td>Masculine ideals framed as a barrier for men to seek medical help. Prostate cancer treatment side-effects, in particular ADT, affect how men fulfill their roles and interact with women, leading to a reduced sense of masculinity.</td>
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<tr>
<td>7. Demers et al. (1994) United States</td>
<td>Investigate whether exposure to fire smoke-related carcinogens increase the risk of cancer.</td>
<td>Quantitative, prospective, 16 yrs follow-up, comparison with police and general population database as control</td>
<td>2,447 men Firefighters</td>
<td>Survey questionnaire Database</td>
<td>Firefighters’ increased risk of prostate cancer may be partly explained by their exposure to known carcinogens.</td>
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<td>Study</td>
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<td>8. Gray, et al. (2002). Canada</td>
<td>Explore the linkages between masculinity and prostate cancer.</td>
<td>Qualitative, retrospective, “narrative approach” analysis, cross-sectional</td>
<td>18 men who were diagnosed with prostate cancer at least 1 year prior to recruitment.</td>
<td>Face-to-face interviews</td>
<td>Men re-negotiate their performances of masculinities after prostate cancer diagnosis. These re-negotiations occurred within the parameters of what was considered to be consistent with hegemonic masculinity. Re-negotiations of masculinities also gave rise to new expressions of masculinities.</td>
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<td>9. Grunfeld et al. (2013). United Kingdom</td>
<td>Investigate the meaning of work and describe the connections between masculinity and work after prostate cancer treatment.</td>
<td>Qualitative, retrospective, “framework” analysis, cross-sectional</td>
<td>91 men treated for prostate cancer. Of these, 41 men participated in a 12-month follow-up interview.</td>
<td>Face-to-face and/or phone interviews</td>
<td>Work is seen as an intricate part of men’s masculine identities. However, prostate cancer treatment side-effects may threaten men’s ability to work and, thus, affecting their self-perceived sense of masculinity. Urinary side-effects was found to have a profound effect on men’s decisions around return to work.</td>
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<td>10.</td>
<td>To investigate the relationship between the work environment and the risk of prostate cancer diagnosis.</td>
<td>Quantitative, retrospective, comparison with general population sample as control</td>
<td>109 men with prostate cancer</td>
<td>Self-administered questionnaire</td>
<td>Increased prostate cancer risk in farmers, metal and maintenance workers is likely due to exposure to chemicals associated with cancer.</td>
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<td>van der Gulden et al. (1995) The Netherlands</td>
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<td>11.</td>
<td>Evaluate the risk of prostate cancer in men of different occupations.</td>
<td>Quantitative, retrospective, comparison with general population database as control</td>
<td>264 men with prostate cancer</td>
<td>Cancer registry database, Census database, Interviews with prostate cancer patients and/or their next of kin</td>
<td>Elevated risk of prostate cancer (&quot;borderline significance&quot;) in white collar workers. However, prostate cancer is rare in China, and physical activity at the time of study was reported to be high in city where study was conducted. Risk of prostate cancer may be associated with sedentary lifestyle.</td>
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<td>Hsing et al. (1994) China</td>
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<td>12.</td>
<td>Kelly (2009)</td>
<td>Describe the ways in which men’s lives can change as a result of prostate cancer diagnosis.</td>
<td>Qualitative, longitudinal, ethnographic approach</td>
<td>14 men newly diagnosed with prostate cancer. Participants were followed-up for 18 months.</td>
<td>The risk of death posed by prostate cancer prompts men to re-examine their priorities in life. This causes shifts in how they view life, roles and work, often resulting in assigning greater importance to maintaining quality of life and nurturing relationships.</td>
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<td></td>
<td>United Kingdom</td>
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<td>Face-to-face interviews, in-clinic observations</td>
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<td>13.</td>
<td>Maliski et al. (2008)</td>
<td>Develop a descriptive model of how low-income Latino and African American men attribute meaning and adapt to prostate cancer treatment side-effects.</td>
<td>Qualitative, retrospective, grounded theory, cross-sectional</td>
<td>95 men treated for prostate cancer</td>
<td>Men try to renegotiate their masculine identity in the presence of prostate cancer treatment side-effects. In this process, the performance of work becomes an important and explicit aspect of their masculine worth.</td>
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<td></td>
<td>United States</td>
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<td>Face-to-face and/or phone interviews</td>
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<td>14. Oberst et al. (2010) United States</td>
<td>Describe work-related physical and cognitive disability estimates 12 and 18 months after diagnosis and treatment for breast and prostate cancer.</td>
<td>Quantitative, prospective, longitudinal</td>
<td>447 women newly diagnosed with breast cancer and 267 men who were employed at the time of prostate cancer diagnosis</td>
<td>Phone interviews</td>
<td>Many men experience reduced work capacity after returning to work. Financial need may represent a significant barrier to leaving the workforce.</td>
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<td>15. Sauvé et al. (2016) Canada</td>
<td>Explore the relationships between employment and prostate cancer risk.</td>
<td>Quantitative, prospective, population-based, case-control, comparison with general population sample as control</td>
<td>1,937 men diagnosed with prostate cancer</td>
<td>Face-to-face interviews, Clinical records</td>
<td>Exposure to chemicals and/or at work may increase prostate cancer risk.</td>
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<td>16. Sharma et al. (2016) Canada</td>
<td>Assess the rural occupational exposure, including farming, as a determinant of prostate cancer.</td>
<td>Quantitative, prospective, cohort study</td>
<td>2,938 men who were older than 45 years</td>
<td>Self-administered, mailed questionnaire, Rural Health Study database</td>
<td>Farming, work that involves pesticide/fungicide handling and use, were associated with increased prostate cancer risk.</td>
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<td>17. Sharp &amp; Timmons, (2016) Ireland</td>
<td>Investigate factors associated with cancer-related financial stress and strain in breast and prostate cancer survivors.</td>
<td>Quantitative, cross-sectional</td>
<td>486 women with breast cancer, 212 men with prostate cancer</td>
<td>Self-administered, mailed questionnaires</td>
<td>Cancer treatment results in greater financial stress, particularly on those who were working at the time of diagnosis.</td>
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<td>18. Sritharan et al. (2017) Canada</td>
<td>Examine prostate cancer occurrence by occupation, industry and duration of employment.</td>
<td>Quantitative, retrospective, cross-sectional, case-control, comparison with general population sample as control</td>
<td>1737 cases of men with prostate cancer and 1803 control cases.</td>
<td>Over-the-phone survey questionnaires</td>
<td>Occupations related to farming/agriculture management and armed forces are associated with a higher risk of prostate cancer diagnosis. The increased risk may be related to work-related exposure to carcinogens.</td>
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</tbody>
</table>
Financial burden of prostate cancer to patients

There is evidence to suggest that men with prostate cancer can experience financial burden regardless of their income level. In a study involving 282 Ontarians with breast, lung, colorectal and prostate cancer, Longo et al. (2006) found that at least 20% of the participants whose income ranged from less than $20,000 to over $80,000 perceived the financial burden of cancer and related treatments to be significant or unmanageable. One way of understanding the financial burden of prostate cancer to patients is by considering the direct costs (costs of services provided in clinical settings) and indirect costs (costs related to illness) that prostate cancer diagnosis, treatment and follow up can invoke on men and their families.

In Canada, the publicly funded and provincially administered health insurance system covers the direct costs of all medically necessary cancer care provided in hospitals and physicians’ offices, including diagnostic tests, treatments (e.g., radical prostatectomy) and follow-up care (Health Canada, 2016). However, patients with prostate cancer can incur substantial indirect costs related to their care. Expenses not covered under public health care insurance such as prescription medications (e.g., Viagra® for penile rehabilitation post radical prostatectomy) and transportation fees to medical appointments can amount to significant expenditures for many patients (Longo et al., 2007). In addition to both direct and indirect costs, patients with prostate cancer also incur expenses related to daily living such as housing and utility costs while being absent from work due to treatment or convalescence, heightening their financial burden.

There are legal and social benefit measures aimed at helping Canadians through financial burden incurred due to the diagnosis, treatment, and recovery from illness. In terms of lost wages due to work-absenteeism from prostate cancer treatment or convalescence, employed (including

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4 Defined here as a patient’s perception of financial strain or hardship resulting from cancer-related expenditures (Longo et al., 2006).
seasonally employed) and self-employed men may be eligible for partial income replacement through Employment Insurance Sickness Benefits (EISB) (Service Canada, 2017). As of January 2017, eligible individuals including men who underwent radical prostatectomy, can receive benefits of up to $543 per week for a maximum of 15 weeks. Despite the potential to serve as a financial lifeline, there are two important caveats men with prostate cancer must plan for when applying for EISB. The first is that the amounts paid through EISB are usually a fraction of the income generated through work. The second caveat is that there is an initial two-week waiting period after their application is approved in which applicants are not paid (Service Canada, 2017). Therefore, many men recovering from radical prostatectomy may not be able to fully replace their income and may have to use other sources of funding to pay for their expenses during absence from work.

In terms of job security during treatment and convalescence, the Canada Labour Code Provisions on Sick Leave protects all employees, including men diagnosed and treated for prostate cancer, against “dismissal, lay-off, suspension, demotion or discipline because of absence due to illness or injury” for up to 17 weeks (Government of Canada Labour Program, 2016). However, this is contingent on the employee having completed three consecutive months of employment with the same employer prior to the sick leave (Government of Canada Labour Program, 2016). Despite the limitations of both EISB and the Canada Labour Code Provisions on Sick Leave, the combination of both are important leverages that offer a safety net for many men as they recover from prostate cancer treatment.

In addition to universal coverage of the publicly funded and provincially administered health insurance, about 24 million Canadians have some form of private health insurance coverage (Canadian Life and Health Insurance Association [CLHIA], 2010) to reimburse many of the indirect costs associated with patients’ medical expenses. However, private health
insurance policies do not compensate patients’ loss of income due to illness or losses incurred by caregivers who take time off from work to assist patients. Therefore, the financial burden experienced by patients may also extend to their caregivers.

Disability insurance, unlike private health insurance, offers financial compensation when it is proven that the beneficiary is unable to carry out work-related duties due to illness and/or accident. About 9.4 million Canadians have disability insurance, most of whom are enrolled through group plans by their employers (CLHIA, 2015). Both private health and disability insurance policies are often part of a package of employment benefits. However, according to the Canadian Cancer Society (Nelson, 2010), workers who lose their jobs as a consequence of cancer face significant financial burden because they are vulnerable to losing all employer-sponsored insurance. Lack of private insurance is also a concern to working men with prostate cancer who are seasonally employed, work part-time or are self-employed, because they can be uncompensated for lost wages related to prostate cancer induced absences.

Overall, private health and disability insurance play important roles in availing prescription drugs and medical devices not covered under provincial health insurance plans (Longo et al., 2007) and in providing beneficiaries with income to help meet economic needs endured during prostate cancer convalescence (CLHIA, 2010). However, private insurance companies are for-profit organizations that improve their economic gain when the likelihood of paying an insurance claim is low. In this context, the likelihood of an insurance company paying out is decreased when individuals who are likely to make insurance claims are offered policies with exclusions or declined altogether. This translates into great difficulty for uninsured men with a diagnosis of prostate cancer to purchase private health and disability insurance policies because of their high risk of cancer recurrence.
Financial burden does not necessarily have an instantaneous effect on health (Blakely, Kennedy, Glass, & Kawachi, 2000). This is partly explained by the fact that financial burden can limit healthy choices and practices (e.g., balanced diet, taking time off from work to rest) for men with prostate cancer which, if sustained, can impact negatively on the long term health and well-being of patients. This implies that many health outcomes due to financial burden experienced by men with prostate cancer may not be emergent during or shortly after treatment. Thus, research about the effects of financial burden in men with prostate cancer must also recognize the potential for mid-term and heightened challenges long after treatment.

Masculinities, prostate cancer and radical prostatectomy

In the Canadian context, the Gender and Sex Based Analysis (GSBA) framework provides a method to understand the effects of gender on health (Health Canada, 2010). Within the GSBA framework, the concept of sex refers to the biological and physiological differences between males and females that affect how medications and/or treatments act in the body. The concept of gender refers to the range of socially constructed roles and behaviours that are expected of women and men which, by virtue of their performance (e.g., men minimizing health concerns), shape the health of individuals. Sex and gender are viewed in the GSBA framework as interacting with each other to influence the health of individuals whereby the physiological (sex) and the social (gender) are intertwined and contribute to differences and diversity in health risks, health services use, health system interaction and health outcomes (Health Canada, 2010).

In exploring the connections between gender and health, the masculinities framework has guided much of the psychosocial prostate cancer-related research (Chapple & Ziebland, 2002; Kelly, 2009; Maliski et al., 2008). Conceptually, Connell (2005) argued that masculinities serves as a frame with which to explain how men identify and position themselves in society. This
identification and positioning of individuals in society occurs in reference to idealized values associated with being a man, also known as hegemonic masculinities. In Western societies, idealized masculinities hinge on dominance, competitiveness, success and prowess which men strategically align with to position themselves favourably in their relationships with women and other men (Connell, 2005; Connell & Messerschmidt, 2005). As such, masculinities are conceptualized as a gender category that distinguishes men from women and plays a crucial role in men’s masculine identity⁵ (Connell, 2005). Given that ideals around masculinities are socially constructed and negotiated between the individual and society, there is acknowledgement that the practice of idealized notions of masculinities vary depending on the cultural and social contexts (Connell, 2005; Connell & Messerschmidt, 2005). Despite variation across contexts, idealized masculinities and masculine identities commonly embraced by men in Western societies include notions that emphasize sexual prowess, physical control and strength (de Visser & McDonnell, 2013), control over one’s emotions, and independence (Addis & Mahalik, 2003; Gill, Teese, & Sonn, 2014). However, men diagnosed with prostate cancer who undergo radical prostatectomy experience a range of side effects that can threaten their ability in adhering fully to socially established masculine ideals, impacting their perceived masculine identity (Hoyt, Stanton, Irwin, & Thomas, 2013; Maliski et al., 2008, Zaider et al., 2012).

**Embodiment of masculine ideals and work after radical prostatectomy**

Embodiment refers to the position that “thoughts, feelings and behaviors are grounded in sensory experiences and bodily states” (Meier, Schnall, Schwartz, & Bargh, 2012, p. 706). In this regard, bodies are disciplined to perform behaviours that are in line with the ideals and traditions

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⁵ Defined as a man’s subjective experience and expression of his own gender and gender roles (Broom, 2004; Maliski et al., 2008 ; Zaider, Manne, Nelson, Mulhall, & Kissane, 2012).
set by social environments (Butler, 1990, 1993; Foucault, 1978/1990; Longhurst, 2001); while at the same time, social environments reflect the “forms and interests of the bod(ies)” they are composed of (Grosz, 1998, p. 42). Writing about embodiment and the health of men, Watson (2000) argued that the body is the stage upon which gender, masculinities and behavior interact to produce the experience of health and illness.

It is widely recognized that the experience of prostate cancer and its treatment(s) is an embodied process (Arrington, 2003, 2008; Gannon, Guerrero-Blanco, Patel & Abel, 2010; Kelly, 2009; Oliffe, 2005, 2006). As a treatment, radical prostatectomy changes the physiology of the lower urinary tract resulting in side-effects (e.g., erectile dysfunction) known to challenge men’s ability to embody key masculine ideals around sexual prowess (Klaeson, Sandell, & Berterö, 2012) and physical control in the form of urinary incontinence (Higa, Moraes Lopes, & D’Ancona, 2013), impacting their self-perceived masculine identities (Kelly, 2009; Maliski et al., 2008). Responding to these challenges, qualitative research by Maliski et al. (2008) suggested that many men attempt to normalize erectile dysfunction and urinary incontinence as part of their cancer-related narratives and re-evaluate their beliefs around socially constructed masculine ideals allowing them to endorse and prioritize the ideals that are “most important to their own sense of being a man” (p. 1615). Indeed, in several studies, researchers have suggested that men who experience post-prostatectomy erectile dysfunction and urinary incontinence maintain their masculine identities by prioritizing the embodiment of various masculine ideals including the performance of work-related behaviours and roles⁶ (Bokhour, Powel, & Clark, 2007; Chapple & Zeibland, 2002; Kelly, 2009; Klaeson et al., 2012; Maliski et al., 2008). By being competitive, a hard-worker, professional and a breadwinner, many men are able to publicly adhere and fulfill

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⁶Defined herein as the “positions in the social structure to which behavioural expectations, including reciprocal rights and obligations are attached” (e.g., husband, worker, breadwinner) (Thoits, 2012).
masculine ideals that position them as productive men in their families and communities (Bokhour et al., 2007; Maliski et al., 2008). Although it is acknowledged herein that many men’s masculine identities are impacted by the side-effects of radical prostatectomy, key in this discussion is the recognition that the endorsement of masculine ideals is context dependent and that their embodiment is a dynamic process. The current study, by narrowing the focus to men’s work post-prostatectomy, affords important advancements to the aforementioned insights of masculinities and prostate cancer scholars.

**Literature review summary**

In summary, the current review of the literature highlighted four key issues:

1. Little is known about how best to facilitate the long-term well-being of Canadian men with prostate cancer in relation to their work.

2. In spite of publicly funded health care, the impact of direct and indirect costs and changes to paid work associated with prostate cancer on men and their families is not fully understood, particularly in the Canadian context.

3. Although work and income after treatment for prostate cancer are important concerns to patients and their families, these issues have received relatively little attention.

4. Men can endorse masculine ideals through their work. However, although work-related activities may provide an important opportunity for men to forge and/or sustain their masculine identity following radical prostatectomy induced side-effects, there is a dearth of knowledge regarding how this process occurs.
Chapter 3

Methodology and methods

Definitions

The current study drew on work by Crotty (2010) regarding epistemology, ontology, methodology and methods. Epistemology is the branch of philosophy concerned with understanding how we know what we know, by considering the history of knowledge as it relates to the nature, method, origin and limitations of knowledge development. Ontology is concerned with the assumptions made about the form and nature of knowledge, the study of ‘being’ and the nature of existence. Methodology refers to the planned set of steps and selected research tools that match the research objectives and are consistent with the epistemological and ontological principles that guide the study. Methods refer to the set of techniques and procedures used to gather and/or analyze data to address the research questions. I acknowledge that my views about what constitutes reality or knowledge about an issue informs my choice of methodology and methods. Therefore, epistemology, ontology, methodology and methods are interconnected whereby epistemology is defined by ontology, and the choice of methodology and methods are influenced by the epistemological and ontological positions taken up by me in the proposition of the research questions. With this emphasis, what follows is a discussion of the perspectives of knowledge that underpin the current study before describing grounded theory as a methodology for research and the processes involved in the recruitment of participants.

Perspectives of knowledge

Constructivism is the philosophical stance that views knowledge as neither discovered nor created, but constructed through individuals’ interactions with the environment and amongst
other individuals (Crotty, 2010). This stance recognizes that through education and socialization, systems of knowledge inform the ways people view the world. In other words, constructivism holds that worldviews are shaped by social structures including history, culture, and ethnicity. However, socially constructed knowledge is diverse. The meanings constructed by Group A for an event may differ to Group B. Similarly, individuals may have unique interpretations of the events unfolding around them, giving way to an array of personal interpretations of the same event (Crotty, 2010). Guba and Lincoln (2005) categorized constructivism as having a co-constructed, relativist\(^7\) ontology, and a value-mediated, transactional, subjectivist\(^8\) epistemology which can be explored through hermeneutical\(^9\) or dialectical methodologies.

Living with prostate cancer has been characterized as a process of adapting to the limitations imposed by the disease and the consequences of its treatment(s) (Kelly, 2009; Oliffe, 2009). This process occurs within a multitude of social environments that shape how men experience prostate cancer. Men are diagnosed with prostate cancer by physicians; supported by their spouses, families and friends; and continue to socialize with other individuals through community life. Information exchanged in these social interactions serves in constructing or co-producing knowledge that reflect the realities of social environments (Berger & Luckmann, 1966; Crotty, 2010). The literature reviewed suggests that patients interact in a historically and culturally shared system of symbols and structures (e.g., language, conceptions about cancer, work, financial obligations) that shape how they subjectively make sense of their own situation. Supported by this evidence, the findings produced by the current study are constructivist wherein participants and I co-constructed the data and results that flow from that work are influenced my

\(^7\) Defined as the philosophical position that values contained in thought, experience, evaluation and even aspects of reality are held relative to something else. For example, the sentence “Euthanasia is bad” can be true or false, depending on the values to which it is relative to.

\(^8\) Defined as the belief that reality is not absolute or universal, but is held conceptually by the consciousness of the perceiver.

\(^9\) Defined as a method of understanding and interpreting linguistic and non-linguistic communication.
knowledge, education and years of experience as a medical-surgical nurse. These experiences shaped my views about the biopsychosocial aspects of living with prostate cancer. Similarly, through my interactions with patients, teachers and peers, I co-constructed knowledge about cancer-related experiences while, at the same time, recognizing that I possess unique understandings and views. Therefore, throughout the current study, I have not sought the ultimate or one truth about the phenomena under study, but pursued knowledge from participants’ lived experiences.

**Methodology and methods: Grounded theory**

Grounded theory is a methodology that aims to find an underlying or latent pattern of behaviour (i.e., basic social process\(^\text{10}\) [BSP]) to explain social phenomena in a substantive area of research (Charmaz, 2006; Glaser, 1992). Therefore, grounded theory lends itself to the study of phenomena produced through individuals’ interactions with their environment, such as patients’ experiences of living with prostate cancer. The goal of using grounded theory methods is to understand the relationships amongst the concepts that give rise to the phenomena of interest and to inductively construct theories that may explain its occurrence (Charmaz, 2003; Glaser, 1992; Glaser & Strauss, 1967). The process can be summarized in six major steps: 1) Simultaneous collection and analysis of data, 2) Assigning codes to key information in the data, 3) Constant comparative methods to distill codes into concepts, concepts into categories, 4) Writing memos to help construct conceptual analyses, 5) Sampling to refine the researcher’s

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\(^{10}\) Defined by Glaser (2005) as a “core category” that has “two or more clear emergent stages”, and represents patterns of processes and change (p.1-2). For Glaser (2005), a core category sums up “the substance of what is going on in the data” (p.3), and is 1. related to other categories or variables in the theory, and 2. reoccurs frequently in the data.
emerging theoretical ideas, and 6) Integrating the theoretical framework to explain the phenomena of interest.

Three salient methods used in grounded theory research are constant comparative methods, theoretical sampling, and memo writing. Constant comparative methods refer to analyses that generate increasingly more abstract concepts and theories through processes that inductively compare data with data, data with category, and category with concept (Charmaz, 2006). Conducting constant comparative analysis may yield concepts and categories that are unclear and require further exploration. Theoretical sampling can help clarify and define the properties of emerging categories by specifically gathering data that is pertinent to the category until no new properties emerge (Charmaz, 2003). An important step to help advance analyses and develop ideas about codes and categories in grounded theory is memo writing. By writing memos, researchers can illustrate their thoughts, assess critically their own ideas about the research at hand and provide a tool for increasingly abstract thinking as new insights are articulated (Charmaz, 2006; Glaser & Strauss, 1967). Grounded theory has become a widely used methodology for sociological research (Glaser, 2002) and researchers have proposed modifications to suit specific research needs and philosophical stances (Charmaz, 2006). Within the current study, I used constructivist grounded theory, the details of which follow.

**Constructivist grounded theory**

Proposed by Charmaz (2003) in the 1990s, constructivist grounded theory assumes a relativist ontology and a subjectivist epistemology (Mills, Bonner, & Francis, 2006), whereby: a) data are co-constructed through the interaction between the observer and the observed, the researcher and participant; b) interview data are reconstructions of experience in narrative form; c) data analysis is an interactive process between the researcher and the data; and d) the products
of constructivist grounded theory research are renderings, interpretations of reality and cannot claim objective depiction of it. These assumptions had important implications in the current study. First, it presupposes that the BSP is a byproduct of the researcher’s participation in and through analysis of data that was mutually constructed between the researcher and participants. Therefore, I did not espouse that the BSP emerged from the data nor do the findings provide a reality. Rather, I acknowledge the BSP represents my understanding of reality as guided by the analysis of co-constructed data. Second, researchers using constructivist grounded theory work with the data to define conditional statements to interpret how participants construct their particular experiential realities (Charmaz, 2003; 2006). This was achieved, partly, by incorporating participants’ voices in rendering their lived experiences throughout analysis in the current study. The acknowledgement of the importance of these conditional, contextual statements provided me with insights to the realities perceived by participants. Therefore, I focused on implicit and explicit meanings within the data in order to understand participants’ stories. Third, constructivist grounded theory acknowledges the importance of the particular, lived experience in the construction of the BSP and reflects this by enabling participants’ perspectives to be visible in the report so that the reader constructs the findings and is given the opportunity to make connections between the findings and the data from which they were derived (Charmaz, 2003). Fourth, considering participants’ contextual experiences in data analysis acknowledges that the phenomena under study does not occur in isolation and adds rich descriptions of circumstantial variations in the occurrence of the phenomena of interest (Charmaz, 2003; 2006). Fifth, I cannot claim a position of neutrality in the collection and analyses of the data. Disciplinary and personal predispositions shaped how I saw, organized and understood experiences, which invariably affected the way how the study was conducted. Instead, I provided the most accurate account recognizing my philosophical, professional and
experiential perspectives and their shifts across this study. Charmaz (2003; 2006) suggested the use of sensitizing concepts to help clarify, structure, and organize data analysis to counter researchers’ professional and personal biases which may arbitrarily influence their research.

**Sensitizing concepts**

First used by Blumer (1954), the term “sensitizing concepts” refers to concepts that serve as general points of reference and provide broad directions to explore phenomena. As such, “(s)ensitizing concepts draw attention to important features of social interaction and provide guidelines for research in specific settings” (Bowen, 2006, p. 3). Although sensitizing concepts can be identified and used overtly in research, they can also be embedded in how researchers see the world (Bowen, 2006). Researchers often start their study with assumptions that are thought to underpin, shape and/or be connected to the phenomena of interest. The notion of using sensitizing concepts in constructivist grounded theory refers to the application of concepts thought to be connected to the processes of interest in the study and help orient and sensitize the researcher to ask certain kinds of questions about the topic being studied (Charmaz, 2006). In this sense, I sought to pay attention to men’s daily lived realities and the choices they had in making health-related decisions, and to ask questions about the processes informing men’s experiences of prostate cancer, treatment and work. A description on how the masculinities framework and the complexities in treatment decision making were used as sensitizing concepts is provided.

**Masculinities framework.** In the context of men’s health research and clinical practice, Lohan (2007) acknowledged the importance of men’s daily lived realities as key determinants of health. It is acknowledged herein the exploration of men’s experiences with prostate cancer needs to
recognize the importance of masculine ideals that privilege expressions of strength, power, independence and emotional control, whilst acknowledging the plurality of masculinities (Wenger & Oliffe, 2014). Furthermore, Wenger and Oliffe (2014) argued that prostate cancer research needs to be foregrounded on socially constructed gender processes of health, recognizing that men are exposed to various gender norms across time and contexts through the intersections of gender, ethnicity and social class. Throughout this study, recognition was given to the real-life complexities faced by men with prostate cancer and particular attention was paid to men’s decision making around prostate cancer treatment and return to work after radical prostatectomy.

**Complexities in treatment decision making.** In exploring the experiences of men diagnosed and treated for prostate cancer, it was acknowledged throughout the current study that participants were social agents actively engaged in choosing, deciding, planning and intervening to create the conditions in which they lived their lives. In order to be sensitive to men’s agency in making decisions around prostate cancer, treatment and work, I drew on the work by Bird and Rieker (2008) who argued that the processes involved in health decision making are shaped by the choices available to individuals at the family and work level, community level, and social policy level. Family and work are seen by Bird and Rieker (2008) as providing individuals with two social environments that significantly shape men’s decisions around health. Through their roles as family members and workers, men generate choices as they interact in their family and work environments on a day-to-day basis. Decisions made taking into consideration family and work environments are seen by Bird and Rieker (2008) as intertwined because family and work-related demands often overlap. For example, the decision of a man with prostate cancer to work past age 65 may be underpinned by his family’s financial needs. In order to better understand the effect of
work on men’s trajectories with prostate cancer, I highlighted connections between work and family to contextualize those connections after radical prostatectomy.

The choices at the community level refer to the options available to men through their local realities (Bird & Rieker, 2008), such as availability of physicians and medical infrastructure, which shape men’s health decision making. The effects of choices generated at the community level directly impacted men’s decision making around prostate cancer by availing the resources needed for their diagnosis and treatment. As a result, a man’s decision to have radical prostatectomy was not only a function of what he considered to be the best option for him, but also of what was available to him in terms of the resources at the community level. In the current study I explored the impact of local resources (e.g., how limits for health service delivery resulted in the postponement of some men’s radical prostatectomy) to further contextualize participants’ experiences of returning to work after radical prostatectomy.

Social policies refer to government provisions aimed at benefiting the population (Bird & Rieker, 2008). As such, social policies reflect the political views of “policy makers who (…) maintain or change a country’s social policy and welfare agenda” (Bird & Rieker, 2008, p. 79). For example, the British Columbia Medical Service Plan (MSP) is primarily intended as a safety net to provide all British Columbians with access to medical health services. However, despite choices garnered by social policies that aim to benefit the population as a whole, the significance and impact of the policies can vary in their effect on individuals. For instance, the MSP may be of greater importance to men with the least financial resources in receiving provincially covered treatments for prostate cancer (e.g., surgery, radiation and androgen deprivation therapy) than high income earners who can afford optimal medical care even in the absence of MSP.

Sensitizing concepts were used throughout data analysis in understanding complex interactions. Consequently, by using sensitizing concepts I was reminded that data derived from
interviews also contained implicit contexts, meanings and interpretations that lay beyond its literal significance. This translated in the concomitant exploration of conceptualizations around masculinities, prostate cancer, work, and the economic and financial realities that participants faced as they navigated through return to work.

**In-depth, semi-structured interviews**

Interviews are guided conversations around a specific topic and are a useful data-gathering method in grounded theory research (Charmaz, 2006). Interviews allow exploration of a particular topic through the elicitation of participants’ interpretation of their experiences. Interviewers can elicit well-thought out and reflexive answers by conducting in-depth interviews that ask participants to describe their experiences and perceptions about a topic of interest. In-depth interviews require that interviewers listen, observe and encourage participants to respond to open-ended, non-judgmental questions while paying attention to nuanced or implied meanings given by participants. Charmaz (2006) suggested that researchers conducting in-depth interviews should be interested in what is being said by participants and want to know more, even information that may be considered intimate. Therefore, I used prompt questions such as: “Please tell me more about that” to elicit information from participants on topics that I had little understanding of to obtain descriptions about the experience.

In addition to eliciting vast amounts of rich data from participants, I also wanted to make sure that a specific set of topics were covered during each individual interview. This was achieved by conducting in-depth, semi-structured interviews wherein I prepared in advance a list of topics or questions to be discussed during each participant interview (Appendix 1 Interview guide). Knowing that I would likely obtain information pertinent to the enquiry by bringing prepared questions to the interview, I also focused on encouraging participants to respond in
their own words and giving as much detail as they wished to understand their experiences around work, prostate cancer and radical prostatectomy.

Sample, rationale, entry and recruitment

In qualitative studies, sampling does not aim to represent the population. Instead, the focus of sampling is to ensure that individuals with the most relevant experiences about the phenomena under study are invited to take part in constructing the data. Therefore, the characteristics of participants sought needed to meet inclusion criteria, recognizing that these criteria might change over time, and as data were collected and analyzed (Charmaz, 2006).

Initially, a sample of men who met the following criteria were recruited:

1. Working at the time of prostate cancer diagnosis, regardless of occupation, current work status or concurrent illnesses.
   
   **Rationale:** Men who were working at the time of diagnosis provide important insights about the connections between prostate cancer and work.

2. Undergone radical prostatectomy as primary treatment for prostate cancer within the past 36 months, regardless of subsequent or current secondary treatments(s).
   
   **Rationale:** Radical prostatectomy has been identified as an important cause for work absenteeism and work-related changes in men for up to 18 months after surgery (Bradley et al., 2005; Oberst et al., 2010; Sultan, Slova, Theil, & Lepor, 2006). The insights of men who had radical prostatectomy up to 36 months prior to the interview helped understand the immediate and long-term implications of surgery on men’s work.
3. Men of any ethnicity living in the Greater Vancouver Area who were able to read and speak in English.

**Rationale:** Acknowledging the diverse ethnic groups in Vancouver, it was necessary to standardize the language used in the consenting process of this study. The consenting process, consent forms and demographics information questionnaire documents were in English.

The sample size was not determined in advance. Instead, sampling and/or the recruitment of participants from whom to collect data continued until rich, substantial and relevant data for developing categories was achieved (i.e., saturation) (Charmaz, 2006; Corbin & Strauss, 2008; Glaser, 1992; Glaser & Strauss, 1967). The point at which no new information was gained to develop categories was reached by the 18th interview. However, the data that informed the construction of categories was based on a relatively homogeneous sample of men - most of whom were in their mid fifties to mid sixties, married/living in common law, and Caucasian. Related to this, Glaser and Strauss (1967, p. 61) stated:

> As he (the researcher) sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated. He goes out of his way to look for groups that stretch diversity of data as far as possible, just to make certain that saturation is based on the widest possible range of data on the category.

Recognizing that the categories developed could be strengthened by including data that described perspectives from a more diverse sample, six additional men (who were in their early fifties or late sixties, single and/or never married, and of diverse ethnic backgrounds) were interviewed.
While the additional data served to contrast perspectives amongst participants and contexts, no new theoretical insights were obtained from its analysis.

Prior to sampling, I gained entry into a community of men and women affected by prostate cancer through a number of prostate cancer support groups in the Greater Vancouver. Identifying myself as a PhD student interested on men’s experiences with prostate cancer to the leaders and members of prostate cancer support groups, I attended fund-raising activities and numerous monthly support group meetings. My role in support group activities was to learn about prostate cancer as it is experienced by men. I was also invited to conduct presentations about preliminary findings of my research at group meetings, participate in prostate cancer support group organized webinars and engaged in discussions about prostate cancer-related topics with group leaders and members alike. Through these interactions, several prostate cancer support group leaders and group members learned about my study which they affirmed explored an important aspect of life with prostate cancer, and assisted me with recruitment.

Recruitment took place at prostate cancer support groups within the Greater Vancouver (Burnaby, Richmond, Surrey and Vancouver) and at the Prostate Cancer Supportive Program at the Vancouver Prostate Centre. Prostate cancer support groups are non-profit organizations that provide information and support to men diagnosed with prostate cancer, their families and the public through monthly meetings (Yu Ko et al., 2016). Meetings provide a forum where attendees could feel at ease to ask questions and share their personal experiences with prostate cancer. Given the participatory and self-disclosing nature of these meetings, many of the attendees were comfortable sharing personal stories about prostate cancer and disclosed information regarding their personal life such as work and their experiences with radical prostatectomy. Recruitment of participants commenced in late April of 2014, after the University of British Columbia Research Ethics Board approved the study. Recruitment occurred in three
simultaneous stages. The first was through my own participation at monthly support group meetings held in Burnaby, Richmond, Surrey and Vancouver, where I briefly introduced and explained the purpose of my study to attendees. At the same time, a pocket-sized recruitment advert (Appendix 2: Pocket sized recruitment card) outlining the purpose, methods and inclusion criteria, and containing my contact information was given to all attendees at the meetings. Interested individuals were encouraged to contact me by telephone or email. The second stage of recruitment consisted on placing a full-sized recruitment advert (Appendix 3: Full size recruitment advert) on support groups’ websites and newsletters. The advert was an open invitation to men who were employed at the time of diagnosis and had radical prostatectomy to participate in the study. Recruitment activities at the Prostate Cancer Supportive Care Program (Appendix 4: VCH Research Institute certificate of approval) was done through the program manager, who on behalf of the PCSC Director: 1) distributed pocket-sized and/or full sized recruitment adverts to men who met inclusion criteria, and 2) asked men who met inclusion criteria if they would like to be contacted by me to participate in the study. The program manager obtained the names and contact information of those who agreed to be contacted and sent the information electronically via secure network email to me.

Throughout the recruitment process, I answered and addressed any questions and/or concerns raised by individuals enquiring about the study. Individuals interested in participating were, with their permission, screened for inclusion criteria by asking the following questions: 1) Were you working at the time of prostate cancer diagnosis? 2) Did you have radical prostatectomy as primary treatment within the past 36 months and, 3) Can you read and speak in English? Inclusion criteria were met if individuals answered yes to the three questions and these men were invited to participate in the current study.
Prospective participants were asked to take part in the study by attending in person to complete an in-depth, semi-structured individual interview. Interviews took place at least one week after participant screening, in a mutually agreed location that was private, quiet, and comfortable. Interview locations included the UBC School of Nursing research offices, participants’ homes, and in men’s workplaces. On the day of the interview I: 1) greeted and answered any questions or concerns brought forth by the prospective participant, 2) reviewed the University of British Columbia Research Ethics Board approved study consent form (Appendix 5: Consent form) and answered any questions or concerns participants had about the study, and 3) started individual semi-structured interviews once participants consented to participating in the study by signing and completing consent forms and demographics questionnaires (Appendix 6: Demographic survey), respectively.

Data collection and analysis

The audio-recorded interviews were conducted between April 2014 and January 2016 and lasted approximately 90 minutes. At the beginning of each interview, I reassured participants they could stop participation at any time. Without exception, participants disclosed being open to talking about their experiences with prostate cancer and no one refused to answer any of the questions I asked.

I noticed signs of emotional distress during three interview sessions. In all three instances, participants were distressed when answering questions about their families’ perceptions about prostate cancer. Despite offering to stop the interviews, participants requested that the interview continue. Interruptions occurred in a number of interviews; however they were
related to telephone calls participants received, persons canvassing at the door, and washroom-breaks. Several participants offered to participate in further interviews in the event I needed further information. Only one participant was interviewed twice.

In order to contextualize participants’ biographical details, I started each interview by asking broad questions including “Tell me about yourself” and “Tell me about your work”. I found that answers to these questions allowed participants to start the interview with confidence, and by talking about themselves. I was able to gain a broad understanding of each participant’s particular realities. Through this interactive engagement, I adapted successive questions from the semi-structured interview guide to follow-up with participants’ answers, while paying attention to their mood and level of comfort in continuing with the interview. I was able to formulate questions that were relevant to the participants’ experiences while limiting my own tendency to interrupt. As an interviewer, I initially found every single response participants gave to contain important information that I wanted to explore further. As a result, I posed questions that were not in the semi-structured interview guide but were related to participants’ answers about their experiences with prostate cancer, and through this process, my understandings broadened. This also allowed me to adapt, change, and add questions to the interview guide with the intention of exploring topics raised by previous participants in subsequent interviews.

Engaging participants through interviews helped establish rapport. This rapport also meant that they had their own questions for me and, in some instances, participants asked questions about my family, career goals and future plans. Although I was very pleased to share, I was also aware that the purpose of interviews was to collect data from participants. Therefore, I briefly answered every question participants had for me and turned the focus back to the participants. I explained that my focus was on their stories, but was happy to chat more generally once the interview had ended. In one instance, a participant invited me to his garage and showed
me his newly acquired sports car as I was leaving his home. This gesture added to my understanding about his interview and the details were recorded in my post-interview notes as an event along with my interpretations: “…very humbling to see how generous men can be when one listens to them and builds rapport”.

Interviews that took place at participants’ workplaces provided insights to diverse behaviours. In all six instances, participants either came out to greet me at the workplace lobby or I was led by an assistant to the office where participants awaited. The brief interactions participants had with their co-workers were handled matter-of-factly, in a professional manner that reflected their workplace roles and cultures. Given that the participants I interviewed at their workplaces held positions of power (i.e., managers, directors), the interactions I saw with their co-workers were clearly hierarchical in nature. Based on these observations, I anticipated participants to answer interview questions in a matter-of-factly fashion with little, if any, descriptions of their experiences of prostate cancer. However, in the interviews, participants showed a vast range of emotions through their tone of voice and gestures, giving ample detail about their innermost emotions and opinions about radical prostatectomy and work.

Demographic information was collected from each participant through a survey questionnaire and served to provide an aggregate description of the sample. Qualitative data was collected through individual audio-recorded in-depth, semi-structured interviews that explored personal experiences regarding: 1) work experiences before prostate cancer diagnosis, 2) experiences around work and prostate cancer diagnosis, 3) decision to undergo radical prostatectomy as primary treatment, and 4) work-related experiences following radical prostatectomy. Digitally recorded interviews were transcribed verbatim; however, identifiable information such as names, workplaces and physicians’ names were removed to ensure participants’ anonymity. I transcribed the first 6 interviews (they were accuracy checked by a
research assistant) and I accuracy checked interviews 7 through 25 which were transcribed by a research assistant. Transcripts were uploaded to a Nvivo™ compatible computer along with relevant notes and memos pertaining to the analysis of data. The data were then electronically tagged to maintain a marker of origin to aid subsequent analyses. Digital transcripts and all other digital documents related to the study are stored in a password protected computer at the UBC Men’s Health Research (MHR) Program. Hard copies of transcripts, notes and all other documents related to the study are stored in a locked cabinet at MHR.

Data analysis began with data collection and continued throughout the research process. During the initial period of data collection and analysis, interviews yielded data of interest that pointed to areas for further exploration. Therefore, changes and/or adjustments to the questions within the semi-structured interview guide were made throughout the data collection phase as a reflection of the diverse experiences men encountered with prostate cancer.

Following transcription, I read each transcript and its accompanying post-interview notes or memos to gain an overall sense of the essential features of the data without committing to formally coding the data. This allowed me to better understand the transcript data as an entire unit of knowledge. A further reading of the transcripts was conducted listening to the accompanying recording to facilitate annotations about the actual interview. Such notations were intended to add richness to the data by reminding myself about the events and impressions not captured during transcription including ambiance and/or tone of voice.

During initial coding gerunds were used to code words, lines and/or segments in the data. Gerunds (verbs ending in “ing”) were used to extensively preserve actions within the data to focus analysis on events rather than making theoretical interpretations of the data. Assigning codes to the data facilitated making constant comparisons, which is an essential method in conducting research based on the constructivist grounded theory methodology (Charmaz, 2006).
While keeping the research questions as the focus of analysis, many interpretations were made about the data by asking: 1) why did the event occur? 2) what did the event mean to the participant?, and 3) how does the event relate to the data? This often led to assigning more than one code to the same section of transcribed data. For example, when participants told their employers and co-workers about their diagnosis of prostate cancer, the text was labeled ‘openness’ as well as ‘co-worker relationship’. At times, codes were assigned to a participant’s entire response and at other times shorter excerpts were assigned codes. Comments and queries about codes were documented in memos throughout the analytical process.

Making constant comparisons involved: a) comparing participants’ perspectives, views and/or experiences, b) comparing incident with incident, c) comparing data with category, and d) comparing category with other categories (Charmaz, 2003). As comparisons progressed, initial codes were constantly compared to other codes, many of which were merged under a higher order label, marking the start of categorical development (Charmaz 2003, 2006). Figure 1 titled: “Codes grouped and raised to the category of ‘preparing the workplace for their absence’” provides an overview of how concepts were grouped together. As an example, the codes ‘telling at work’ and ‘delegating tasks’ became part of a higher order category labeled ‘preparing the workplace for their absence’.

‘Telling at work’ was apparent in the following excerpt:

“I told them basically I have prostate cancer and I'll need surgery, and I'll probably be gone for a couple of months…” (Julio)

The following excerpt from Alejandro’s interview was coded ‘delegating work’:

“…it was hard for my team members because they, had to pick up a lot of work that I do”
The properties and dimensions of labels assigned to the data became apparent by comparing codes. Properties were the characteristics of a category and dimensions represented “the location of a property along a continuum” (Strauss & Corbin, 1998, p. 117). The properties and dimension of the category ‘preparing the workplace for their absence’ were identified and indicated the extent of activities required to maintain workplace production during participants’ absence.

Figure 1. Codes grouped and raised to the category of ‘preparing the workplace for their absence’

As the coding of words, lines, segments and incidents gained momentum by the fourth transcript being analyzed, coding became more selective and conceptual in nature. At this stage, and consistent with constructivist grounded theory methodology, I employed focused coding as a coding technique to help advance data analysis. Focused coding is characterized by the use of the most significant and/or frequently used codes (or focused codes) during initial coding as a heuristic to synthesize and explain larger segments of data (Charmaz, 2006). In this study, focused coding facilitated comparisons between larger pieces of data such as entire transcripts in order to understand participants’ perspectives and generated analytical leads that: 1) helped identify new processes, 2) yielded new understandings about previously coded data, and 3) prompted exploration of topics that had been glossed over. These analytical leads, and my ideas about them pointed to areas to explore during subsequent data collection. Consider the following
field notes from the second interview in this study. The participant, Alberto, was a Program Director in the Federal Government at the time of his prostate cancer diagnosis:

I asked him: How would budgetary cuts affect the work you were doing? He responded: ‘You know, like it’s-it’s clear and I didn’t have an appetite for going through the adjustment and change that were involved with the cutting back. I have been through those cycles, and uh, you go through them and it has a constructive element to it, but you don’t want to go through it. I didn’t really have the fire in my belly to do that’.

Despite his passion he felt for his work, I also sensed his fatigue from the years he’d dedicated to his department. Maybe he was looking for a reason to retire or maybe it was the fact that the stress of departmental restructuring, in conjunction with prostate cancer, were too much for him to bear. In any case, his answer to my question gave me a sense of him slowing down the pace to a level that was both physically and emotionally more bearable, now, as a man treated for prostate cancer. Acknowledging that he ‘did not have the fire in his belly’ was an admission of lack of desire, if not a lack of physical stamina, to continue working under the new circumstances.

Insights gained from the interview with Alberto led me to ask others about similar circumstances and eventually develop the code ‘changing pace’ to label data that described instances where participants reported either increased or decreased intensity in their output at work. The code ‘changing pace’ also called my attention to view participants’ interactions with work differently. Not only did participants’ views and relationships with work change over time, but there were also changes in the way they responded to events both at and outside of work.
This prompted me to compare the views men held about their work before the diagnosis of prostate cancer against their views of work after treatment. Through this process, I distilled how work could become less or more of a focus for men following radical prostatectomy for prostate cancer.

Sensitizing concepts around masculinities, men’s lived realities and the choices men had in health-related decisions were applied throughout the analytic process to highlight the effects of family, work, community and social policies on process of decision making around prostate cancer, its treatment and work. This was done by paying close attention to individual transcripts to recognize descriptions about the particular social environments to which participants belonged, and by exploring participants’ interpretations about how their social environments (e.g., co-workers, community) shaped experiences of prostate cancer.

By constantly comparing the data, I gained an understanding of the processes described in the data. Such understandings were written in memos to help articulate and refine ideas during analysis, assist in classifying incidents of phenomena, and document insights gained from making comparisons. This allowed me to define concepts, summarize key ideas, and identify gaps in the data and emerging issues that require further exploration. By writing memos, I produced a record of how findings were derived, enhancing transparency of the analytic process. As this study moved forward, the content of memos gradually shifted from being descriptive in providing an account of analysis, to documenting theoretical understandings of the data. Likewise, the volume and theoretical richness of memos increased and their content was sorted to help me make sense of them. This required that memos about antecedents, contextual factors, actions, and resulting outcomes that influence key concepts and categories be identified and depicted visually through diagrams to explain how they were connected. At the same time, comparisons between categories were conducted to identify similarities, differences, and
relationships amongst them in order to further define and distinguish the categories produced. In this respect, in Chapter 4, I described men’s experiences around work, prostate cancer screening, diagnosis and their decision to have radical prostatectomy as a background to contextualizing the grounded theory focused on returning to work post prostatectomy (detailed in Chapter 5). In Chapter 5, I organized the findings around processes to provide an explanation and theory of about how men reformulated their worker identity within the context of returning to work post-prostatectomy.

**Rigour**

Lincoln and Guba (2000) argued that rigour in qualitative research cannot be ascertained using positivist notions of validity, but rather on a criterion of trustworthiness. Trustworthiness in qualitative studies refers to the extent to which findings reflect the meanings and experiences described by participants (Lietz, Langer, & Furman, 2006) and is shaped by: credibility, transferability, dependability and conformability (Lincoln & Guba, 2000). Credibility refers to a study’s ability to convey an accurate description or interpretation of experiences that people who share the same experience would recognize (Thomas & Magilvy, 2011). In order to increase credibility I: 1) sampled for participants who experienced the phenomena under study, 2) used open-ended and probative questions during interviews so that participants could discuss at length their own stories and give rich, thick descriptions of experiences, 3) reviewed the data looking for similarities within and across the participants, and 4) ensured that the experiences of participants were represented by using their own words and descriptions throughout the findings and discussion sections of this dissertation.
Transferability denotes the applicability and/or ability to transfer findings from one context to another. Whether research findings can be transferrable or not is determined by the users of research findings, and not by the researchers themselves (Speziale & Carpenter, 2007). I used two strategies to help users evaluate whether study findings are transferrable to their particular situations. First, I provided dense descriptions about the sample from which data were derived and reported about the policy (e.g., MSP, EISB), economic and geographic backdrop of the study to inform the usefulness of research findings in other contexts. Second, I identified and reported similarities and differences in elements of the constructed theoretical model across different contexts and noted the range of conditions under which processes can occur to help users assess the applicability of the research findings to practice.

Dependability refers to the degree to which the research process is auditable and it is strengthened when the analytic process is consistent between researchers and stable over time (Thomas & Magilvy, 2011). One way of increasing the dependability of the study findings is by establishing clear procedures for research and reflecting on the positions that the researcher took throughout their implementation (Gasson, 2003). In order to achieve this, I engaged in a continuous process of reflection throughout the study to help recognize my biases and kept a detailed reflective journal and field notes to aid in this process. Thomas and Magilvy (2011) also suggested that dependability can be facilitated when steps are taken to facilitate other researchers’ ability to follow the decision-making trail are implemented by the researcher. Other strategies used to strengthen this study’s dependability included: 1) providing the rationale for and justifying research-related decisions, and 2) inviting my dissertation committee to review the analytic logic employed during data analysis as a way of identifying potential oversight in the research process.
Confirmability is concerned with the extent to which the results of a study can be corroborated by others and is directly influenced by the credibility, transferability, and dependability of the research (Thomas & Magilvy, 2011). Hall and Callery (2001) suggested incorporating reflexivity throughout the research process to increase the credibility, transferability, dependability and confirmability of grounded theory research. By being reflexive, I examined my own influence in the research process by maintaining an honest and critical view about my interactions with participants, the data and my personal motivations and goals about this study to “…come clean about (my) predispositions so that readers can adjust proffered interpretations in appropriate ways” (Hall & Callery, 2001, p. 263). In order to increase the confirmability of study results, I maintained an extensive audit trail through writing memos to help illustrate the thought processes that led to the conclusions. The Nvivo™ software was used to help organize and keep a log of important decisions made throughout this study.

**Ethics**

Ethics review and approval from the University of British Columbia was obtained before data collection for the study. Prior to this, I completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE) on October 28th 2013. The knowledge gained through the course helped me plan and articulate an ethically sound study. Ethical standards were maintained around participant recruitment, confidentiality, and obtaining informed consent. Participant pseudonyms were assigned by me and chosen from common names used in Spanish-speaking countries. This measure was aimed at further ensuring the men’s anonymity. Data was stored in password protected files. Only Dr.
John Oliffe and I have access to the data, memos and hardware (e.g., recorder, storing media) related to the study.

**Meeting the participants**

The goal of recruiting participants for this study was to obtain quality data that would help me develop a grounded theory. Therefore, the focus of recruitment was not to assemble a large number of participants but on inviting men who were willing to give rich information about their experiences of prostate cancer, radical prostatectomy and work. At the start of each one-on-one interview, I invited participants to introduce themselves and to describe what work meant to them. This helped me understand their social situations and offered a window into their biographies which was important in contextualizing the data.

The following section offers brief participant biographies to help describe men’s social and personal locations. These descriptions were not used to compare men, but to understand how contextual realities anchor the way men experience work, prostate cancer and radical prostatectomy. Each man’s biographical account reflected a singular perspective which helped me understand how, in addition to social policies, family, work and community environments shaped men’s experiences of prostate cancer.

In the biographies that follow, participants’ names have been replaced with pseudonyms while the names of organizations and places have also been changed to ensure participants’ confidentiality. It will be apparent that most participants were diagnosed with prostate cancer within the past six years and underwent radical prostatectomy within 3 years prior to interview. While most of the men received radical prostatectomy as the only treatment for prostate cancer,
three received adjuvant treatments following surgery and considered their prostate cancer in remission.

There was variation in the ethnic background of participants (n=24) that included men who self-identified as Caucasian (n=14), Asian (n=5), South Asian (n=2), Aboriginal (n=1), Caribbean (n=1) and Latin American (n=1) (Table 2. Sample demographics). Participants’ ages ranged from 44 to 75 with a mean age of 62.3. Twenty men were married, whereas 3 reported being single/never married and 1 participant disclosed being divorced. It must be noted that one participant was interviewed while on sick leave and interviewed again one year after he returned to work. Given this caveat, at the time of the one-on-one interview, 13 men were engaged in full-time employment, 9 were working part-time, 1 was on sick leave, and 2 were retired. Most participants (n=20) had either college and/or university education while 12 men earned between $60,000 and over $100,000 at the time of interview.

1. **Oscar.** Fifty-three-year old Oscar was a father of three adult children who was diagnosed with prostate cancer in January 2013. Oscar described his diagnosis of prostate cancer as the result of luck and insistence. He recounted how in 2009 an imaging technologist discovered an enlarged prostate during a preoperative ultrasound test for hernia repair surgery. Although the enlarged prostate was not accompanied by any symptoms, Oscar’s family physician monitored his PSA over three years, recording an increase from 3.0 µ/L to 4.0 µ/L by the end of 2012 (normal PSA range for men aged 50 to 59 is 0.0 µ/L to 3.5 µ/L [CCS, 2015]). Despite his family physician’s explanations that a PSA rise of 1.0 µ/L over three years was not a cause for concern, Oscar insisted on a referral to an urologist for assessment. Oscar commented that the urologist wondered “*why he had to see him*” given that his slow PSA rise was not clinically significant. However, Oscar was
undeterred in finding the reason for his PSA rise, eventually having a prostate biopsy leading to his diagnosis of cancer.

Oscar described himself as a proactive person and, despite suggestions from his family physician and urologist that active surveillance was a suitable option for his prostate cancer, he proudly observed that he was “not that kind of person” and had to “take (prostate cancer) out and throw it out in the garbage”. In terms of his work, Oscar was considering selling his cleaning company at the time of his diagnosis and indeed sold it by the time he had radical prostatectomy, in June 2013. He described owning a business as extremely stressful and did not seek work for close to one year after surgery. Although physically capable of working, Oscar decided to rest and looked after his ailing mother daily during his year recovering from radical prostatectomy.

2. **Alberto.** Alberto was 64-years-old at the time of the interview and had just retired from a career spanning over 30 years with the Federal Government. As the Department Director, he was diagnosed with prostate cancer in August of 2011 and underwent radical prostatectomy two months later. Alberto took less than one month of sick leave and returned to work after surgery. He remained at work for nine months after surgery and retired due to budget reductions at his workplace. In describing his decision to retire, Alberto said that it was “easy” because he was “at the age of retirement” and understood that one of his junior co-workers was at risk of being laid off had he not retired. Alberto saw his occupation as a defining element of his identity and has enrolled in a number of volunteer activities since retiring to remain active in the community.
3. **Julio.** Fifty-one-year-old, Julio was married and had no children. Diagnosed with prostate cancer in January 2013 he had a radical prostatectomy in May of the same year. Unfortunately, he had a series of post-surgical complications that required two hospitalizations and a prolonged recovery period of six months. Julio returned to work part-time as a mechanical engineer four months after surgery and considered himself “lucky” because he had a very “understanding” employer. However, two months after returning to work, Julio was told that the prostate cancer had returned. He subsequently underwent androgen deprivation therapy followed by external beam radiation therapy with the intent of cure. Julio was very thankful that his employer kept his job with the company during his prolonged treatment-and-recovery-related absence. Julio was also promoted to a less physically demanding position and was given a raise in wages upon his return to work, which he saw as an overt gesture of support from his employers.

4. **José.** Sixty-five-year-old José suffered from multiple debilitating chronic diseases including recurrent kidney stones and lower back problems. He was diagnosed with prostate cancer in 2011 and had radical prostatectomy in February 2012, at age 63. Unfortunately, he developed a series of post-surgical infections that required hospitalizations and intravenous antibiotic treatments at home that lasted nine months. José was unable to return to work as an auditor for the federal government because the consequences of surgery compounded his chronic conditions, making him physically “unfit” for work. In order to make ends meet, José applied for long-term disability insurance benefits which he described as an “ordeal”. He officially began receiving retirement benefits in 2014, at age 65. In describing his work environment, José said it was very stressful and that his chronic diseases had him regularly take time off, which did
not bode well with his supervisors. Despite this, he emphasized how his hard working nature led him to work even harder for his team during acute episodes of his chronic diseases. He explained that his strong will to work was derived from a very difficult childhood in which he had to rely on himself to survive.

5. **Javier.** Sixty-eight-year-old Javier was a married father of two and a grandfather to five young children. For over three decades, Javier worked for a local utilities company before choosing early retirement in his late 50s. Javier became a self-employed carpenter since retirement and was working on a number of carpentry projects at the time of prostate cancer diagnosis, in March 2013. He praised his family physician’s diligence in referring him to an urologist for a prostatic biopsy when his PSA level rose to “0.1% over the norm”. Biopsy results detected a “small and slow-growing tumour” that justified his urologist’s recommendation to “monitor” its progression as opposed to pursuing active treatment. Javier’s PSA rose over the following year leading to a second prostate biopsy. Biopsy results suggested the tumour “became very aggressive” and was urged to have radical prostatectomy “right away”. “Being told to have surgery right away” was a source of stress not only for him but also for his family because “everyone was fearful” of the threat prostate cancer. Javier had radical prostatectomy within four weeks of his second biopsy and was relieved to have removed his prostate cancer despite experiencing fatigue and urinary incontinence since surgery.

6. **Enrique.** Enrique was the oldest participant at age 75, who at the time of the interview held a position as an academic at a university. He was diagnosed with prostate cancer in August 2013 and had radical prostatectomy in October 2013. Enrique described his work
as a “joy” and “passion”, and considered himself “fortunate” to be able to work in a field he liked. Having been diagnosed with bowel cancer six years earlier, he felt that the chances of having a second type of cancer were extremely low prior to his prostate cancer diagnosis. Indeed, Enrique recounted his shock and disbelief to learn that he had prostate cancer. He also noted his co-workers and wife were more encouraging and emotionally supportive of him during his bowel cancer treatment period than during the treatment period for prostate cancer. A reason why Enrique felt less support during his prostate cancer treatment was because both his wife and co-workers perceived prostate cancer as being less life-threatening than bowel cancer.

### 7. Jorge

At age 61, Jorge was working full-time running his own property inspection business and as an instructor at a local community college. Married with two adult sons, Jorge had radical prostatectomy in January 2013 and returned to work six weeks after surgery. Jorge emphasized “work first, then family” because the former allowed him and his family to “survive”. Although work occupied a central place in his life, Jorge conceded that he would retire immediately if his PSA levels rose, and dedicate his time to enjoy life with his wife and family.

### 8. Carlos

Carlos was 56, married with two adult children at the time of interview. As a clergyman, Carlos led Sunday masses and was a director in the religious organization he worked at. Given the size of the congregation he headed, Carlos classified his job as one of heightened stress and responsibility. However, Carlos saw his work as a “calling” and a “service” from which he derived great personal satisfaction and spiritual fulfillment. At the same time, he reported his workplace had a large pool of human resources that
temporarily replaced Carlos’ ten month absence due to his prostate cancer, diagnosed in May 2013. Despite his great devotion to the clergy, Carlos recognized that maintaining his health was above his work obligations and was considering to work less and/or in a less demanding job.

9. **Ricardo.** An environmental consultant, Ricardo was a 56-year-old divorced father of one teenage daughter. Having undergone radical prostatectomy in February 2013, Ricardo felt fortunate to work at a company with a generous work-sponsored disability insurance plan that provided income during his six month sick leave. Ricardo emphasized the importance of family members, and was thankful for the support he received from his fiancée and his ex-wife throughout his prostate cancer journey, which he believed helped him overcome the disease.

10. **Fernando.** Aged 66, Fernando was single and worked as a tour bus driver. At the time of the interview, Fernando wore bilateral back-slab-wrist-casts due to recurring, work-related tendonitis. Given the physical nature of his work, Fernando suffered a number of injuries including a ruptured hernia in August 2012 which required surgical repair. A PSA test was conducted during routine blood tests prior to his hernia repair surgery. The PSA results were elevated, which lead to a biopsy and diagnosis of prostate cancer in October of 2012 and underwent radical prostatectomy in December of the same year. At the time of the interview, Fernando was very concerned about money because he was not financially prepared for retirement, and felt his employer wanted to make him redundant due to his multiple health issues.
11. **Omar**. At age 56, the married father of two had been working as a dentist for almost three decades. Omar was diagnosed with prostate cancer in March 2014, had radical prostatectomy five months later and returned to work by the sixth week after surgery. Due to work-related cervical and lower back injuries which need surgical treatment, Omar decided that it was in his best interest to work part-time and was in the process of reducing his weekly work hours. Omar described himself as being proactive in terms of maintaining good health and stressed he learned about prostate cancer from medical journals and from reputable websites before making the decision to have radical prostatectomy.

12. **Alejandro**. A 67-year-old married man, Alejandro worked part-time as a software engineer. In terms of his prostatic health, Alejandro had a history of benign prostatic hyperplasia (BPH) from which he suffered urinary frequency and nocturia. After years of monitoring elevating PSA levels, Alejandro had a biopsy that confirmed prostate cancer. He decided to have radical prostatectomy in June 2013, which according to him would improve his BPH-related urinary symptoms by removing the prostate. Alejandro returned to work by the sixth week after surgery and worked from home for the first month. When describing his family’s reactions about his return to work after treatment, Alejandro said: “they expected me to return to work”.

13. **Diego**. Fifty eight-year-old Diego had three adult children and was married to his second wife at the time of the interview. As a full-time, self-employed automobile wholesaler, Diego recounted that the business demanded a lot of hard work, but was also financially rewarding. He explained that he co-owned the business with his wife and that it was run
by both of them. Because the business could not be run by his wife alone, it was closed during Diego’s surgery and recovery. Diego returned to work two weeks after radical prostatectomy (performed in May 2014) to help get the business back on track and minimize disruption to his clients.

14. Francisco. At 62 years of age, Francisco considered himself a “relatively successful” realtor with 24 years of experience of working in the local property market. As a long time endurance athlete, Francisco never had major health issues boasting that his blood pressure and pulse were “lower than many of (his) family physician’s 20-year-old patients”. Despite his fitness, he was diagnosed with prostate cancer and a Gleason score of 10 (considered ‘high risk’ in terms of its potential to metastasize beyond the prostatic capsule [BCCA, 2014]). Given the perceived risk of the cancer, Francisco was enrolled in a clinical study where he underwent androgen deprivation therapy and chemo therapy in March 2014, prior to radical prostatectomy in August of the same year. He saw his physical fitness as a major reason why he tolerated treatment side effects well. The married father of two adult sons “did not let prostate cancer stop” him and was training to run a local half-marathon two weeks after the interview.

15. Augusto. Augusto was a 67-year-old married father of two adult sons immigrated to Canada 15 years ago. Having worked for over 30 years at a financial institution prior to relocating to Vancouver, Augusto worked full-time at a construction-materials factory. Augusto was diagnosed with prostate cancer in May 2013, and underwent radical prostatectomy in August of the same year. After surgery, he experienced a number of side effects including urinary retention that required urethral dilation. He suffered from
“severe” urinary incontinence since dilation and underwent surgery to improve his continence in January of 2015. In terms of his employment, Augusto was thankful his employers gave him a less physically demanding workload post-radical prostatectomy, but was concerned that his employers would lay him off given his age and his medical history. Having taken a second mortgage to refinance his house, the fear of being laid off added to Augusto’s financial concerns.

16. Félix. Aged 66, Félix was a married father of one adult daughter. Although he worked in a “dream job” for over 30 years as an airline pilot, Félix also confided that the job was physically demanding due to the long hours, constant time zone changes, and prolonged time away from home. By his mid 50’s, Félix found it increasingly difficult to pilot trans-Pacific flights due to benign prostate hyperplasia-related urinary frequency. Félix had to step out of the cockpit constantly to void which, in addition to the security measures in entering and exiting the cockpit, he saw as an inconvenience to perform his duties as a pilot. By his late 50’s, Félix voluntarily requested to pilot shorter, regional flights to reduce the number of times he had to step out of the cockpit per flight. He eventually left the airline industry in 2013 and continued to work part-time as a motorcycle-riding instructor. In terms of his prostate cancer, Félix was diagnosed with the disease in January 2014 which had a diagnostic Gleason score of 6 (considered ‘low risk’ [BCCA, 2014]). Félix chose to have radical prostatectomy in February 2014 despite suggestions from two urologists and a radiation oncologist to actively monitor prostate cancer and postpone surgery. He did not regret having radical prostatectomy and felt redeemed in his decision when the post-surgical pathology report found a ‘high-grade tumor’ (raising his Gleason score to 8) that was not found during biopsy.
17. **Oscar.** Oscar, a 54-years-old man who had been previously interviewed in the current study. Having come across him at local support group meeting almost one year after his participation, Oscar shared that he was very happy for having returned to work after radical prostatectomy. This intrigued me, as he confided during the first interview that he had sold his business and was “tired of chasing the almighty buck”. I wanted to explore the reasons why Oscar returned to work and, above all, why he enjoyed his current job. The second interview with Oscar occurred exactly one year after he started working as a building manager for low-income families. Oscar explained his job kept him “occupied” while at the same time it was not as demanding or time-consuming as owning a business, which allowed him to spend with his family. Importantly, he enjoyed his work because of the social interaction it afforded him. As he put it: “I go around telling little old ladies (tenants) how beautiful they look. And they love it!” It was obvious that work was important to Oscar not only because it afforded him a means to contribute financially to his family, but was valued because of the opportunities it gave him to engage socially with other individuals.

18. **Martín.** Martín was a 69-year-old career oriented man who, after more than three decades working in the oil industry, was offered a retirement package at age 65. Although Martín accepted to leave his employer, Martín did not retire and started his own company doing contractual work for businesses in the oil and energy sectors. The married father of one adult daughter recalled viewing work as the most important activity throughout much of his adult life because it provided him with “a means to survive and a sense of purpose”. However, “seeing (his) parents’ health decline” and his wife’s “battle with
“cancer” over 15 years ago led him to prioritize health in his daily life and has since become vegetarian while training as an endurance runner. Given the lack of symptoms and his health conscious practices, Martín recounted feeling shocked upon receiving his prostate cancer diagnosis in 2010. Given the low Gleason scores of his first biopsy, Martín was recommended active surveillance of his prostate cancer, and to defer curative treatment to avoid side-effects. A subsequent prostatic biopsy in early 2014 showed cancer progression that led Martín to opt for radical prostatectomy in June 2014. Martín expressed satisfaction with the surgical outcomes and reported minimal side-effects, which allowed him to return to work.

19. César. César was a 62-year-old married father of five children who worked a full-time job and a part-time job at the time of the interview. Though both jobs were in the courier business, César had a long history of working in the food industry mainly in restaurant businesses. As an Asian immigrant, he first arrived in Vancouver almost four decades ago, César recalled humble beginnings working as a “car wash assistant” and as a “busboy” at a Greek restaurant. With time, and hard work, César was promoted to restaurant manager, a title he held at various restaurants. Through wise financial management, César and his second wife saved enough money to open what he proudly recalled was “the largest (ethnic) restaurant in Vancouver” and owned four homes in the city. Key to César’s success was hard work and his desire to be “the first and the best” at everything he did. Investment decisions led him to sell most of his assets and find work as a courier. César recognized that work-related stresses and his work ethic led to his diagnosis of diabetes, cardiovascular disease and prostate cancer.
In terms of his prostate cancer diagnosis, César was diagnosed with the disease in December 2013 and had radical prostatectomy in July 2014.

20. Camilo. Sixty-four-year old Camilo worked for almost 40 years as a photographer in British Columbia. Single and without children, Camilo considered himself as a “healthy and fit vegetarian” who was “satisfied” in life despite the diagnosis of prostate cancer. When talking about his prostate cancer, Camilo explained that his diagnosis was almost a fortuitous event because he suffered nocturia for almost three years before telling his family physician who then began monitoring his PSA levels. Documenting a steep rise in his PSA levels over the following two years, his family physician referred Camilo an urologist who eventually diagnosed prostate cancer in June 2015.

As the only son to Japanese immigrants and youngest of seven siblings, Camilo confided that he was “spoiled” during his childhood and had distanced himself from his family during part of his adult life. However, he was thankful to his sisters for taking care of him after his radical prostatectomy in July 2015, and for offering financial assistance during his time off work. Camilo attributed his speedy recovery to his sisters’ care and returned to work by the fifth week after radical prostatectomy.

21. Manuel. Forty-four-year-old Manuel was a South Asian immigrant and a married father of two children. As a franchise owner of four restaurants, Manuel described himself as a hard worker that strove to provide the best service possible to his clients and was “on top of everything” managing his business. In 2014, Manuel developed shoulder pain that led him to seek medical treatment. Despite his young age and lack of urinary symptoms, Manuel’s physician ordered a PSA test that yielded abnormally high antigen levels.
Follow-up PSA tests and a biopsy resulted in the diagnosis of “aggressive” prostate cancer in April 2015. Manuel explained that the diagnosis of prostate cancer had a “tremendous” impact on his ability to focus at work and explained: “I still can’t comprehend why I have cancer. I’m young, eat well and exercise an hour a day”. Manuel had radical prostatectomy in May 2015 and has since suffered from urinary incontinence; a side effect that severely affected his work-performance and social life. Despite the changes prostate cancer brought to his life, Manuel did not regret undergoing radical prostatectomy and was thankful to his family physician for having the foresight to test his PSA levels when “it was starting to rise”.

22. Juan. Aged 70, Juan was a married father of three adult children. Born in India, Juan described himself as a strong-willed person who endured adversity during his military career in his home country. Juan immigrated to Canada in 1965 and worked as a plumber, electrician and welder for the oil industry in Alberta. Despite being a smoker for over 40 years and having worked with asbestos without protective equipment, Juan denied having chronic diseases and boasted good physical strength and fitness that allowed him to climb up to 200 feet to install oil drilling rig bevels. In terms of his prostate cancer, Juan was diagnosed with the disease sometime in 2010 and underwent radical prostatectomy in 2014. Juan considers himself fortunate because he has regained urinary continence and is able to hold urine for long periods of time. However, he also suffered from erectile dysfunction and was considering penile erection-implants at the time of interview.

23. Luis. Luis was 67-year-old software programmer who considered himself as “a quiet person” who preferred to “stay at home rather than to socialize”. The married father of
two sons was an avid long distance runner who used to “hike the Grouse Grind (mountain trail) in half the time it takes the average hiker”. A nature lover, Luis had long preferred to work for companies involved in the monitoring and protection of the environment. In this context, Luis framed his commitment to “work for as long as possible” as his duty and personal contribution to help “preserve the nature and beauty of BC”. In terms of his health, Luis shared that he held a very “healthy and active lifestyle”, and rarely consumed meat other than the “occasional chicken pizza on weekends”. As someone with no known risk factors, Luis was surprised to be diagnosed with prostate cancer in September 2014. Despite having had “successful” radical prostatectomy one month after his diagnosis, Luis experienced post-surgical urinary incontinence which led him to request his employers for permission to work from home. For Luis, working from home was essential in allowing him to manage his incontinence privately and in facilitating his return to work.

24. Aged 65, Pedro was an architect and architecture firm owner whose business benefited from the growth in the real estate market in Vancouver. As a divorced father of two adult children, Pedro was planning to run his business with his daughter, who was studying architecture at university. However, Pedro had no intention of retiring, instead seeing continued work as necessary to generate income needed to support his son, who was recovering from an episode of acute mental illness. In terms of his prostate cancer, Pedro was diagnosed with the disease in 2000 and chose active surveillance to monitor his cancer until February 2015 when he underwent radical prostatectomy due to increasing PSA and tumor growth. Although Pedro shared his satisfaction to have recovered quickly
from surgery, he continued to be concerned about his son’s health and future, emphasizing that his roles as a parent and caregiver were not over.

25. Humberto. Humberto was a 61-year-old owner of a food processing company. As a married father of one adult daughter, Humberto described his occupation as “a dream job” that he tried to manage responsibly not only for his own personal financial gain, but for the benefit of all employees. In this context, Humberto established a comprehensive extended health insurance program for the workers and encouraged a fair and respectful work culture, which he thought were the reasons behind the low attrition rate of his workers.

Diagnosed with prostate cancer in December 2014, Humberto had radical prostatectomy in March 2015. Despite an uneventful recovery, Humberto experienced a rise in PSA three months after his surgery and was suggested to consider radiation therapy and/or androgen deprivation therapy. For Humberto, news that the prostate cancer was not totally removed during surgery were catalysts for him to re-evaluate his priorities in life and to consider selling his business.
Table 2. Sample demographics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Race / Ethnicity</th>
<th>Age</th>
<th>Marital status</th>
<th>Employment Status</th>
<th>Occupation</th>
<th>Yearly income</th>
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<tr>
<td>1. Oscar</td>
<td>White</td>
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<td>Medical leave</td>
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<td>2. Alberto</td>
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<td>3. Julio</td>
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<td>Retired</td>
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<td>12. Alejandro</td>
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<td>Marital status</td>
<td>Employment Status</td>
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<td>Software programmer</td>
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<td>White</td>
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<td>Humberto</td>
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</tbody>
</table>

*Second interview. First interview occurred in 2014, while the participant was recovering from surgery. The second interview occurred in 2015, after the participant found employment in a different occupation.
Chapter 4

Findings

This chapter provides context to the grounded theory presented in Chapter 5 and is organized in two parts. Part One (Figure 2. Part One - The significance of work in men’s lives) describes the significance of work in men’s lives prior to prostate cancer to contextualize the findings that follow. In Part Two, research question one, “How does screening and diagnosis of prostate cancer affect men and their work?” is addressed detailing how receiving a diagnosis of prostate cancer and making treatment decisions can be linked to men’s work.

Part One
The significance of work in men’s lives

1. Benefits of work
2. Health impacting work
3. Work impacting health

Figure 2. Part One - The significance of work in men’s lives.

Part One

The significance of work in men’s lives

The men saw work as a way to generate the income needed to sustain their material needs and fulfill obligations to provide for their families. This perspective prevailed regardless of participant income, family composition, type of work and social status. Indeed, without
exception, all participants shared the view that work allowed them to be self-sufficient and independent, attributes that resonated with masculine ideals of strength and autonomy. As Oscar, a 56-year-old business owner stated:

*If you wanna have nice things, and be able to educate your kids and put a roof over their heads and food on the table and clothes and stuff, you gotta run a million miles an hour chasing the buck. You, and everybody does. It’s a million miles an hour running for the dollar.*

Many men signaled their buy-in into masculine ideals of leadership and provider roles, linking their work to honouring their commitment to ensuring family wellbeing. It was also evident that purchasing power that resulted from participants’ work in many ways determined their potential for success in their roles as protectors and providers. That said, participants engaged in work that was often times stressful and demanding. As José, a 65-year-old auditor for the Federal Government explained:

*My work was very demanding, the workload was heavy. The nature of the work was complex and very technical and the individuals that you have to deal with are very adverse to what you are doing, so it makes the overall situation difficult to deal with.*

José’s excerpt exemplifies how the tasks he carried out as an auditor could draw resentment from the persons whom he audited, making it difficult for him to perform work-related tasks let alone connect socially to others through work. Similarly, other men recounted how ostracism at work, by virtue of hierarchical report lines and/or specific job duties, added to their workplace stress. Evident also in the context of work-related stress were men’s perceptions...
that they were constantly and increasingly expected to produce more without proportional increases in time and resources. This led many participants to work overtime both at the workplace and at home to meet employer and/or clients’ expectations. Although participants were clear that work allowed them to sustain their families, it was also acknowledged that work-related demands for increased productivity reduced their participation in family life and leisure activities. For example, Jorge, a 61-year-old self-employed home inspector and college instructor explained why he prioritized work over family life:

Work is first, then family. Every morning, I have to go out and work. Even when I’m at home, I would devote most of my time to work doing reports, and would leave family activities for later because nobody will force me to participate in them. But, because people pay me to do work, they expect me to have a report for them in the morning or they will be on my case and that’s why work will always be a first priority.

It was clear that most participants saw work as transactional where their time and labour was remunerated financially by employers and/or clients who had expectations about the work quality and timely delivery of services. It was also apparent that, whilst the income was beneficial to men’s families, it led to men’s absences from family life; a position justified by men’s focus on ensuring sufficient income was derived to support their families. Thus, many men constructed their identities as workers around ideals of hard work and productivity; values that were necessary to portray themselves as aligning to dominant social expectations that place men as breadwinners and guardians.
1. Benefits of work

Despite the work-related stresses men experienced, participants also identified aspects of work that they benefited significantly from. Men whose occupations required them to apply their skills and expertise to industries and issues that they found interesting valued the opportunities to engage, learn and advance in their careers. Through their work, many men felt fulfilled in knowing that their skills, knowledge and dedication contributed to workplace productivity and/or client satisfaction. Furthermore, the level of satisfaction and engagement participants had with work was connected to the amount and type of benefits they derived from the workplace. Good working relations with employers and co-workers, as well as positive team spirit were seen as strong incentives that facilitated productivity. Ricardo, a 56-year-old environmental consultant suggested:

*You look forward to coming to work. We work on probably 15 to 20 different projects at a time, so there’s always something new. It’s an employee owned company, so the more senior of us own more share, so the harder people work the better off everybody is, so it’s – keeps it going.*

By coupling incentives with productivity, men’s commitment to the workplace was recognized and rewarded financially which, in turn, increased their work-output and loyalty to co-workers and the company. Aside from the economic benefits, work also provided many participants with opportunities to contribute to their communities. As Fernando, a 66-year-old tour bus driver said, work enabled him to be “*a productive member of society through (the) services (he provided) and taxes*” he paid. In this sense, work offered Fernando, and many other participants, a position and platform to positively impact society.
It was evident from participants’ narratives that there were both tangible and indirect benefits of work. Tangible benefits ranged from access to resources at work such as equipment for personal use to extended health insurance plans that complemented British Columbia’s Medical Services Plan (MSP) coverage. Some participants attributed their ascending social status and privilege to tangible benefits of work. For example, 66-year-old Félix recalled his experience as an airline pilot, “I am truly fortunate my job allowed me and my family to see the world. Not many people can say that about their jobs!” Similarly, Francisco, a 64-year-old realtor shared:

*I was a banker for 18 years and then I became a realtor. I’ve been a realtor for the last 24 years now; and between my wife and I, we feel we are sort of set up for our retirement years in comfort.*

Indirect benefits of work were those that included personal and professional growth through work experiences and opportunities for socialization with work-colleagues. Diego, a 58-year-old automobile wholesaler said, “over the years, my business competitors became friends and there’s a group of us that meet regularly”. Furthermore, some participants were able to confide their work-related frustrations, anxieties and fears with individuals who had first-hand experiences of their workplace challenges. As Camilo, a 64-year-old free-lance photographer, explained, “we know the problems the other faces, and understand the frustrations at work”. In essence, befriended work-colleagues became a source of support for participants affording respite to families whom the men did not want to burden with work-related problems.
2. Health impacting work

Though there was some variation among participants’ conceptualization of health, most men shared Martín's, a 69-year-old self-employed contractor in the oil industry, definition of health as “a physical and mental state (of being) that affects people’s ability to do the things they want”. Furthermore, participants constructed the concept of health as a function of age, where increasing age was associated with poorer health leading to decreased ability to perform work activities. This conceptualization implied that health and age pre-determined the type, length of time and degree of effort individuals could exert to perform work. In this context, participants saw health as an antecedent of work, where the absence of illness facilitated men’s engagement in work. As Martín explained: “I run long-distance and consider myself fit and healthy. I can pretty much do anything I could 10-20 years ago. That’s why I work”. Conversely, a few participants with chronic illness reported that their ability to work was shaped by the intensity of symptoms they experienced. José, a 65-year-old auditor for the Canadian Government recalled:

I have chronic kidney stones and back pain, and the pain was simply unbearable at times for me to work full days. But I did my best not to let these symptoms get in the way of my work. I showed up (to work) and worked until I couldn’t take it anymore. I had discussed this (health issues) with my employer. But he just didn’t care much about me or my health.

Reduced ability to work due to chronic illnesses was a cause of stress for some participants. However, despite their efforts to work while ill, a few men noted the indifference that employers had towards their health and wellbeing. This negatively impacted participants’ relationships with their employers, as Fernando, a 66-year-old tour bus driver who suffered from work-related chronic wrist tendonitis, explained:
I worked as hard and much as I could, but they (employers) are only focused on profits. It didn’t matter the sacrifices I made for them over the years. We’re just replaceable parts of the money making machine. And I know they (employers) want me replaced.

This excerpt illustrates how employers’ expectations around maintaining productivity levels fueled resentment for some men who experienced sub-optimal health. Although it was acknowledged by participants that their employers’ role was to improve productivity at their workplaces, some men with chronic illnesses felt that they were not treated as workers who contributed to the success of their respective department/company. Augusto, a 67-year-old factory worker who suffered from benign prostate hyperplasia before his prostate cancer diagnosis explained:

I’d been to the bathroom probably 6-7 times by lunch time. My manager thought I was being lazy, and didn’t believe I really had to go. So there were a few times he followed me into the bathroom to make sure I was really urinating and not just killing time. Everybody at work knew I was going to the bathroom frequently because it is a small company. What’s worse, some of my co-workers made fun of me because of this. But what could I do? All I could do was to hold the urge for as long as possible before going to the bathroom.

Augusto’s experience details a side of the workplace wherein surveillance and supervision can constitute policing with which co-workers can readily participate. The excerpt also concedes Augusto’s decreased productivity and inability to contest the marginalization he experienced due to health problems. Despite having a medically diagnosed condition, Augusto felt inhibited to
disclose the health-related reasons of his frequent bathroom visits for fear of further ridicule or, worse still, losing his job. Other participants, though in less explicit examples, shared concerns that confiding with employers or co-workers about an illness could provide evidence of weakness and raise questions about their ability to work.

3. Work impacting health

Work-related strain contributed to many participants’ perceived decline in health status. In connecting physically demanding work and declining health, Fernando, a 66-year-old tour bus driver, explained that he suffered from work-related injuries which included chronic bilateral wrist tendonitis from lifting passengers’ luggage, in addition to experiencing a ruptured abdominal hernia from exertion at work. On the other hand, jobs that required little physical effort such as office or desk work were also noted to impact the mental and social health of some men. José, a 63-year-old who worked as an auditor for the Federal Government at the time of his prostate cancer diagnosis, explained that work-related demands made him feel “constantly drained” and “stressed out”, symptoms that often ignited “a short fuse” and impacted negatively on his relationships with family and friends.

Participants also recognized that there was a need for them to maximize their income by exerting themselves for extended periods, often times without sufficient rest. The resultant fatigue was seen by Oscar, a 56-year-old father of four and business owner, as a reason for his diagnosis of prostate cancer:

*I truly believe, I truly, 100% believe that it was the stress and the million miles an hour that got me where I am. So, I dunno, I just think that, people go too fast, it just makes them sick, whether it’s prostate cancer or whatever people get these days.*
As exemplified by Oscar, many participants felt that sustained exertion and stress at work led to health problems. Despite this, many men felt they could not work less or decrease work-productivity for fear being sidelined as an unproductive worker. José, a 65-year-old man who worked at a desk job as an auditor, explained how he remained a reliable and productive worker while experiencing acute symptoms of recurring kidney stones:

*I never used my (health) condition not to work. I was the opposite, I worked even harder. But it was vicious cycle because the harder I worked, the worse I felt.*

It was clear that exertion to maintain productivity during acute illness had a negative effect on José’s health. When asked why he exerted himself during illness, José replied, “*because that’s who I am. I rather be doing something than to sit at home and ask: ‘Why me?’*” José’s response hinted at two important reasons why some men chose to work despite experiencing illness. The first reason related to men’s efforts to uphold masculine ideals around productivity. Most participants viewed productivity through work as an important component of their identities as workers and men because it confirmed their value and worth in society. The second reason was related to the way some men coped with illness. As suggested in José’s excerpt, work-activities helped him cope with illness and demonstrated his strong adherence to masculine ideals about hard work regardless of the circumstances. A final reason elicited by José had to do with the availability of accumulated paid sick leave days. As he later explained, “*I used up all my paid sick leave and wasn’t getting paid for the days I didn’t work*”, suggesting the need to secure income was a strong incentive to work through episodes of illness.
In summary, most participants portrayed themselves as hard workers by constructing narratives that highlighted personal sacrifice and significant contributions to their workplaces’ productivity and success. In these narratives, men also gave examples of instances where they did not take adequate rest, but instead worked through a variety of challenges, which served to further substantiate their claims of dedication to work. As middle age and older men, most participants conceded that their most productive work years were behind them. However, depending on their health, the degree to which they identified as working men and/or the retirement resources they had accumulated, participants varied in their aspirations and plans to sustain a working life.

**Part Two**

**How does screening and diagnosis of prostate cancer affect men and their work?**

In this section, the findings focus on describing the reasons men underwent prostate specific antigen testing, which eventually led to biopsy and diagnosis of prostate cancer; while detailing how they responded to these tests and the implications these had on men’s treatment decision making and work (Figure 3. Part Two - How does screening and diagnosis of prostate cancer affect men and their work?).


**Part Two**

**How does screening and diagnosis of prostate cancer affect men and their work?**

1. **Screening for prostate cancer: The PSA test**
   - Normal PSA results - It’s only temporary
   - Abnormal PSA results - Something is wrong

2. **Finding prostate cancer**
   - Reacting to the diagnosis
   - What’s important in life

3. **Evaluating treatment options**
   - Working as a team (with physicians)
   - Considering radiation therapy
   - Choosing radical prostatectomy

4. **Considering whether or not to disclose prostate cancer at work**

5. **Delegating work tasks**

6. **Delays in undergoing surgery**

7. **Working until the day before surgery**

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Figure 3. Part Two - How does screening and diagnosis of prostate cancer affect men and their work?

1. **Screening for prostate cancer: The PSA test**

   Other than knowing that it was a ‘prostate test’ and that it could be associated with a diagnosis of prostate cancer, most participants reported knowing little about PSA at the time of testing. This was attributed to the short time available for family physicians to give detailed explanations about the PSA, and resultant lack of time for men to formulate questions during
medical appointments. Despite their limited understandings about PSA testing, participants thought undergoing the test was a prudent and responsible way of monitoring their health. Some participants had their first PSA test performed due to medical reasons (e.g., urinary symptoms, family history of prostate cancer). As such, these men were aware that they had some chance of having an abnormal PSA level and experienced anxiety as they awaited results. Diego, a 58-year-old automobile wholesaler who had his PSA tested upon learning of his brother’s prostate cancer diagnosis, explained, “I was afraid it would show an abnormal result. But at the same time I knew I had to wait for the results and hoped for the best”.

Indeed, most participants were asymptomatic and had their first PSA test for one of the following three reasons. The first and most commonly cited reason was related to the men’s age. For example, Carlos, a 56-year-old clergyman recounted:

\[
I \text{ was at the doctor’s for my annual checkup and by the end of the}\n\text{appointment he said: ‘You’re 50 now. So, why don’t we check your blood}\n\text{and add PSA?’ I figured I was having blood tests done anyway, so I had it}\n\text{(PSA) tested as well.}\n\]

Carlos’ story also exemplified many men’s experiences wherein the recommendation to undergo PSA testing occurred during a medical consultation for an unrelated health problem or general checkup. In this context, discussion about the advantages and disadvantages of PSA testing were not discussed during the meeting and exploration of men’s preferences about prostate cancer screening were often neglected. Also present in Carlos’ excerpt was an understanding that the PSA test could be performed with other, routine blood tests. In this sense, PSA testing was framed by most men as a quick and convenient test that could help them gain a more comprehensive perspective about their health status.
Second, PSA testing was part of mandatory health screening programs in some occupations. Félix, a 66-year-old retired airline pilot explained:

(Airline company) invests a lot of money on its pilots and it’s a huge loss to the company if a pilot quits for health reasons. So every two years, they send you to the doctor and do a complete medical assessment that includes PSA.

Exemplified in Carlos and Félix’ stories was how, in the absence of urologic symptoms, PSA testing was often understood as a simple blood test. As such, the implications of abnormal results were not fully discussed and/or explored.

The third reason for PSA testing was related to the eligibility to purchase health and life insurance policies. For example, Jorge, a 61-year-old business owner of a home inspecting company and college instructor recounted, “I went to get life insurance, and as a requirement they tested my PSA”. Regardless of the reason for testing, some participants who were asymptomatic experienced anxiety as they awaited results. This was exemplified by Francisco, a 62-year-old realtor, who commented:

The reason you get tested is because you don’t know if you have cancer or not and you want to find out. So there is always a nagging feeling that they will find cancer.

The experience of anxiety was often related to men's perception that prostate cancer posed a threat to their lives, work, and ability to provide for their families. Although the level of anxiety experienced varied across participants, none of the men reported disclosing their PSA-related concerns to work-colleagues. Enrique, a 75-year-old university academic, explained:
I didn’t tell my colleagues about it because it is personal information and I didn’t feel like they needed to know.

For most men, not disclosing health information and health-related concerns were crucial in maintaining perceptions of being fit to work, a strategy they felt essential in maintaining their position as productive workers. Furthermore, most men were asymptomatic at the time of their first PSA test and perceived the test as routine. Ricardo, a 56-year-old environmental consultant who reported having a “very good relationship” with his work-colleagues recounted, “I didn’t think it was worth mentioning (about the PSA test) because I didn’t think it was worth burdening them with my problems”. The pattern of clinical interventions and implications of PSA testing was determined by test results and are detailed in the following sections.

Normal PSA results - *It’s only temporary*. Many participants whose first PSA test results were within normal range felt relieved to know that there was no reason to suspect prostate-related disease. Unfortunately, these participants eventually experienced a rise in their PSA levels, leading to increased concerns about the potential risk of having prostate cancer. This was a reason why some participants including Javier, a 68-year-old self-employed carpenter, “seriously learned” about the implications of rising PSA values by visiting “reputable” health-related websites and reading “scientific” articles about prostate cancer. Concurrently, participants did not expect that their work would be immediately affected by rising PSA levels. Alberto, a 64-year-old department director at the Federal Government, recalled:

*I thought of preparing them (co-workers) in the event I was diagnosed with prostate cancer and away for treatment. But that was a distant possibility at the time. So I didn’t think too much about it.*
Abnormal PSA results - Something is wrong. Although many participants knew that PSA levels increased with age, most recalled being somewhat surprised at their abnormal results. As Fernando, a 66-year-old tour bus driver explained, “I didn’t have any symptoms. It just caught me off guard”. Continued increases and/or abrupt changes in PSA levels resulted in family physicians referring participants to specialists for clinical follow-up. Carlos, a 56-year-old clergyman explained:

My first PSA was 1.8. But two years later it was up to 4.1. That alarmed my family doctor. He said: ‘It’s better to monitor it on a regular basis’. So, during that year I tested twice more and the results were 4.8 and 4.7. That’s when my family doctor referred me to the urologist.

Despite knowing that the PSA was not a diagnostic test for prostate cancer, most participants were concerned about the possibility of having the disease. Responding to these concerns many men felt obligated to learn about the disease and to be prepared in the event of its diagnosis. This led most participants to seek information about prostate cancer, often on the internet. Information obtained online played an important role in helping men understand prostate-related diseases, serving well in what Alberto, a 64-year-old department director at the Federal Government, called “asking informed questions” during medical appointments.

Through their research, participants became increasingly aware that rising PSA levels signaled something was wrong in their bodies which needed to be identified and corrected. Though some participants suspected they had prostate cancer given their rising PSA, most men felt it was important not to jump to conclusions before a biopsy was performed. As Alejandro, a
67-year-old software engineer, described, “I sort of thought it could be prostate cancer, but couldn’t call it that because it hadn’t been diagnosed yet”.

Despite suspicions about having prostate cancer, participants also realized that the lack of a definitive diagnosis provided a strong reason to focus on maintaining their normal day-to-day lives. As Martín, a 69-year-old self-employed contractor in the oil industry, described:

*I wasn't diagnosed yet and I didn’t have symptoms. There was nothing holding me back from work. So I kept working as usual because that’s what I thought I should be doing.*

2. Finding prostate cancer

To confirm the presence of prostate cancer, men were scheduled to undergo a prostate biopsy. Men explained that they had no trouble in requesting/scheduling a day off from work to have the procedure. Men’s narratives also suggested that their workplace cultures respected the privacy of individuals, particularly around health issues. In this sense, participants did not tell their employers, co-workers and/or clients about their prostate biopsy or potential for prostate cancer diagnosis. Alejandro, a 67-year-old software engineer explained:

*My team knew I was off to see the doctor, but they didn’t ask what it was for. It wasn’t because they didn’t care. It was because they knew I would tell them if they needed to know.*

In addition to privacy issues, some participants thought that there was no purpose in sharing their health-related concerns with co-workers. Enrique, a 75-year-old university academic, explained that his work-colleagues “would not be able to help” and did not feel he should “trouble them with personal problems”. Enrique’s assertions highlighted two important
issues. The first was related to his adherence to masculine ideals of strength and toughness, which translated into his reluctance to share his health-related worries. The second issue was related to Enrique’s concerns that his productivity and competency at the workplace could be challenged if his health-related concerns were known to others. This was particularly true for men who worked in highly competitive occupations. Francisco, a 62-year-old realtor explained:

*My clients would’ve thought I was unable to work for their best interests.*
*Some competitors would’ve capitalized on this and spread rumours that my days in the business were numbered.*

Central to Enrique and Francisco’s concern for others knowing about their potential to have prostate cancer was the competitiveness within their workplace. Herein prostate cancer was equated with weakness and an inability to compete at work. Although participants were concerned about the potential implications of prostate cancer while at work, such thoughts did not prevent them from being productive.

Participants also knew that the prostate biopsy could yield false negative results. Because of this, some participants described the prostate biopsy procedure as an attempt to find cancer amid knowing that there was no certainty that it would be located. This was a reason why some men and their treating physicians were skeptical about negative biopsy results, particularly when PSA values were rising. Jorge, a 61-year-old home inspector and college instructor, recounted how his urologist’s suspicions about prostate cancer led him to undergo two biopsies:

*I had my first biopsy in January 2012. They took six samples and didn’t find anything. The doctor said: ‘That’s impossible. They probably didn’t aim at the right place. Let’s do it again in six months’. Six months later, they took eight samples. Two of them had cancer.*
Waiting for biopsy results forced many men to acknowledge that potential changes to their lives laid ahead. Although the specifics of such changes were unknown to participants, some took proactive approaches in preparing for life with prostate cancer. Sixty-four-year-old photographer, Camilo, recounted how the fear of having prostate cancer prompted him to consult a lawyer and “draft a will to set things up in case (he) was unable to do so later”. For Camilo, as well as many other men, masculine ideals around responsibility and commitment towards one’s family translated into interventions aimed at pre-empting uncertainty and protecting their families against adversity. In this regard, participants also rationalized the importance of proactively searching for prostate cancer through biopsies because they thought it afforded them the possibility of treating the disease, hopefully in its early stages.

**Reacting to the diagnosis.** Although most participants reported experiencing anxiety, uncertainty and shock after diagnosis, the degree of such feelings varied across participants. For example, Omar, a 56-year-old dentist recounted:

*I don’t think I eat excessive amounts of red meat. Since I turned 40, I gave up on drinking cow’s milk. I drink soy. I’ve been taking ‘Men over 40’ supplements. I’m of Italian heritage and get lycopenes everywhere. I take fish oil supplements, we eat cold water fish. I eat unsalted raw nuts. You name it, I was doing it all. So I was both shocked and chagrined because I shouldn’t be the one getting this!*

Omar’s excerpt reflected many participants’ shock at their diagnosis of prostate cancer. The majority of participants reported being healthy and without prostatic symptoms. However, the diagnosis of prostate cancer brought into question those embodied experiences. Narratives
suggested the stage or aggressiveness of tumor(s) at biopsy was a factor in determining the degree of concern men had about their diagnosis. For example, Carlos, a 56-year-old clergyman, recalled how his physician’s comments suggesting that the prostate cancer “was in its early stages” and that it “was curable” offered him solace in accepting the diagnosis with the caveat that something could be swiftly done to rectify the problem. In contrast, men diagnosed with prostate cancer that was considered aggressive experienced significant anxiety. Fernando, a 66-year-old tour bus driver who had a Gleason score of 9, reported being worried about the aggressiveness of his prostate cancer and feared it had spread beyond the prostatic capsule:

*I got really frustrated and I was scared. So I said: ‘You know what? Let me just have the damn thing taken out!’.*

Although most participants were told by their urologists that their prostate cancer was not an imminent risk to their lives, men saw the disease as a significant threat to their health that needed to be eradicated as quickly as possible. Amid the sense of urgency in neutralizing the cancer, men also described not knowing how best to deal with the disease, particularly as many reported having little experience in making treatment decisions. Though most men knew there were different treatment options for their prostate cancer, some described feeling overwhelmed at the vast amount of information presented to them by their urologists during medical appointments, while others reported significant anxiety around choosing the ‘right’ and ‘best’ treatment(s). Like many men, Jorge, a 61-year-old home inspector and college instructor, highlighted the tension he felt knowing that he eventually had to make a treatment decision while lacking a “real understanding” about the pros and cons “of the treatments being offered”. The tension men felt around choosing a treatment option was heightened by the fact that most participants understood treatment side-effects could impact their ability to work. In exemplifying
this view, Carlos, a 56-year-old clergyman, explained that his “life changed” from the time of diagnosis because his “work and retirement plans were subject to change without notice”.

Implied in this statement was Carlos’ recognition that prostate cancer could alter his future in unanticipated and undesired ways, impacting not only his personal health, but also affecting his family’s wellbeing. Though participants recognized some anxiety and uncertainty were part of their daily lives, most men also underscored that the diagnosis of prostate cancer exacerbated such feelings. Juan, a 70-year-old welder in the oil industry bluntly shared:

You don’t know if this summer will be your last, or if you will get to see your grandchildren graduate from high school. You simply don’t know what’s going to happen next”.

In light of the diagnosis of prostate cancer and the uncertainties it brought them, some men emphasized a profound sense of change in how they perceived themselves as individuals, workers and as providers for their families. The following section focuses on how the diagnosis of prostate cancer had transformative effects on some men as workers and as breadwinners.

What’s important in life. Most participants described the diagnosis of prostate cancer as a sudden reminder of their own mortality, which triggered a re-evaluation of what was most important to them. Through this process, most participants prioritized improving their quality of life as they reflected on decades of hard work. Oscar, a 56-year-old business owner shared:

I was running a million miles an hour chasing this all mighty buck and all of a sudden I saw the finish line and thought: ‘Wait a minute, I kinda wasted my life chasing the buck and I didn’t really slow down to enjoy life with my family?’ So, I’m just gonna falter back, I backed off the throttle,
In the aftermath of prostate cancer diagnosis, Oscar, and many men, began to view work as an activity that competed with, and had often won out over spending time with family. In this regard, participants reflected that they had structured their lives around work and lamented missing important family-milestones such as birthday celebrations and participating in their children’s after-school activities. Although men understood that the income generated through work provided for the material wellbeing of family members, they were also aware that the fulfillment of work obligations did not necessarily optimize their relationships with their families. In this context, most men expressed desires to reconnect with families in meaningful ways, by prioritizing spending time and sharing experiences with them. Carlos, a 56-year-old clergyman who devoted a significant portion of his time at home working, exemplified how some men learned to limit work after a prostate cancer diagnosis:

*I get a lot of calls from people who are in distress and in desperate need of help and I have to attend those calls regardless of where I am or what I am doing (...) But I learned to protect my family time and prioritize it a bit more. Now I rely more to other pastors and church staff, so their workloads increased.*

Increasing the time they spent with family members meant that participants had to become selective with when and which work-related tasks they did after work hours. This resulted in a reduction of overtime-work which was justified as men exchanged work for family life.

The diagnosis of prostate cancer also disrupted many participants’ ability to sustain masculine ideals of toughness, strength and self-reliance. As they redefined priorities, many
participants conceded experiencing fear and vulnerability in coming to terms with prostate cancer. Under these circumstances, many men saw communication with family members as an important tool to help them face the uncertainties posed by the disease and its treatment(s). Javier, a 68-year-old carpenter, shared how his resolve and stoicism gave way to the sentimentality he felt, and the strong desire he had for being with his family:

*The diagnosis drew us closer. We say what we feel. Like, I got all teary when my son looked at me and said: ‘Dad, you gotta stick around’. I still get choked up every time I think about it.*

Similarly, many participants noticed how other men in their families began to express emotions, concern and care. Francisco, a 62-year-old realtor who was enrolled in a clinical trial prior to his radical prostatectomy, explained how his son doted on him:

*My son insisted on driving me to my (clinical trial) treatment and wanted to cover me with a blanket and put a touque on me. It was just beautiful, I mean, that was a side of him I hadn’t seen before. He’s become a great support to me.*

As noted in many men’s narratives, these shifts in masculine practices were socially constructed wherein the sons of Javier and Francisco opted out of ideals about stoicism and self-reliance. Instead, other masculine values were brought to the fore at a time of challenge eliciting support and the desire to help another man, thereby overriding masculine restraints in how men typically establish emotional and physical connections. Overall, men conceded that increased connectedness with family members provided significant benefit. Francisco, a 62-year-old realtor, noticed his sons were more “attentive” to his needs and “wanted to do the chores”
usually performed by him, while Oscar’s (53-year-old business owner) wife and children searched online for prostate cancer-related information to support his treatment decision making. Furthermore, many men detailed the important roles their spouses played. Javier, a 68-year-old self-employed carpenter, described how his wife was an “extra pair of eyes and ears” during medical appointments and positioned her as a “core player in (his) prostate cancer team”. It is important to note that despite the important assistance family members offered participants, many men also recalled declining the help offered. Again, Javier, who described his wife as a “very caring” person, explained, “I didn’t want her to worry too much and I told her that I could manage on my own”. Evidenced was how masculine ideals of protecting family members and autonomy underpinned Javier’s recognition that assistance was not always necessary or desirable in his management of prostate cancer.

Men who did not have a significant other or spouse lacked the close and intimate support offered by a partner, but expressed gratitude for the support they received from family members and close friends. Camilo, a 64-year-old photographer, explained that despite his sisters’ poor health, “they were always there, ready to help (him) and offer comfort when (he) needed it most”. In this, he accepted that the lack of a significant other with whom to share his “darkest moments” was a “down side of being single”; however, he also recognized becoming closer to his siblings as a valuable experience that helped him “get through” his journey with prostate cancer.

These stories give evidence to the range of reasons why and how participants reprioritized what was important to them. Recognizing the importance of family relations as they faced prostate cancer, most men downgraded the centrality of work in their lives while many made the effort to limit work and its related activities from interfering with family life. As participants rekindled family ties, men also detailed how prostate cancer became a shared
problem amongst family members and, as such, mobilized loved ones to assist them with day-to-day activities. Fortunately, all participants reported receiving support from their family members upon disclosure of their diagnosis which they positioned as reflecting positive family bonds.

3. Considering treatment options

Aware that there were a number of treatments available, participants embarked in a process of evaluating and choosing the treatment option that offered the best chances of cure. Most participants characterized this process of choosing radical prostatectomy as one wherein they had to, as 75-year-old university academic Enrique put it, “remain as objective as possible”. For many men, objectiveness in deciding which treatment option was best for them implied considering the pros and cons of different treatments based strictly on a technical evaluation of facts. For example, José, a 65-year-old auditor for the Federal Government, shared:

*You naturally want to treat cancer right away. But I had to fight the urgency of having to come up with a decision. I didn’t want my emotions to make decisions for me and I had to base my decisions on facts. I began to study the information my specialist gave me, explored alternatives and read up on what others had to say about surgery and radiation therapy (...) Basically, I looked for leads and followed the evidence, just like I did at work.*

Highlighted in José’s story, and many men’s narratives, was how the most effective and efficient way of making decisions around treatments was by employing problem-solving strategies similar to those used at work. For most men, these strategies afforded them ways to manage their prostate cancer and consider treatment-related issues. Although all participants underwent surgery as primary treatment for prostate cancer, most participants made the decision to have
radical prostatectomy after having consulted with their physicians and thoughtfully considering an array of treatment options.

**Working as a team with physicians.** The men’s narratives described being part of a ‘prostate cancer team’ whose goal was to successfully treat the disease. In this sense, participants’ masculine ideals of independence and self-reliance gave way to collaboration and consultation through their interactions with physicians. As advisors, physicians were highly respected and, in a few cases, privileged within the patient-physician dyad. For example, Camilo, a 64-year-old photographer, forfeited exploring radiation therapy after consulting “the head of the urology department” who “advised that it was best to have radical prostatectomy”. Positioning his urologist as an experienced leader, Camilo was confident that the medical recommendations he received would be validated by other specialists who “would’ve recommended the same thing anyway”, thus refuting the need to formally explore other treatment options. Others felt that their decision to accept medical recommendations did not rest exclusively on their physicians’ authority, but on well-substantiated explanations that helped them understand why a specific treatment was recommended. In this sense, Manuel, a 44-year-old franchise owner of four restaurants, described that it was his urologist’s use of clear and logical explanations about his particular condition that “convinced (him) radical prostatectomy was the best treatment to have”. However, despite knowing that their physicians made recommendations in the men’s best interests, most participants emphasized that consultation with their specialists did not erode their autonomy in choosing the treatment they felt was best for them. As Alejandro, a 67-year-old software engineer shared:
My urologist explained the benefits of radical prostatectomy and tried to convince me to have surgery. But I knew that I could see a radiation oncologist or ask for a second opinion because, in the end, I was the one deciding which treatment to have.

As decision makers, most men felt responsible for knowing as much as possible about the treatments offered to them. In this sense, many participants strategically consulted specialists to learn about the treatment options available to them. Furthermore, participants expected their physicians to convey all the information they needed to make treatment-related decisions. César, a 63-year-old courier whose first language was Chinese highlighted how his physicians’ willingness to “explain things at length using simple terms and examples” allowed him to confidently understand the treatments he could receive.

A few participants noted insufficient time during medical consultations prevented them from fully taking advantage of their physicians’ expertise, creating gaps in their understandings about their prostate cancer. Although these participants were able to ask their physicians for further information and clarification in subsequent medical appointments, some men including Augusto, a 67-year-old factory worker, thought that they could have been “spared the uncertainty of not knowing or misunderstanding something” had their physicians “spent 10 more minutes explaining things in the first place”. In these examples, participants experienced their physicians as hurried and somewhat lack luster in making sure men understood all of the information they needed to make treatment decisions.

Threaded within these stories were many participants’ sense of independence and critical evaluation of physicians’ recommendations which were key in making informed treatment decisions. It is also important to note that working as a team characterized most participants’
relationships with their physicians throughout their prostate cancer treatment, described in the following sections.

**Considering radiation therapy.** Many participants consulted a radiation oncologist and learned that radiation therapy (in either external beam radiotherapy or brachytherapy) had comparable five-year survival rates as radical prostatectomy and had clear benefits over surgery in terms of preserving urinary continence and erectile function for a number of years after treatment. Participants also learned that recovery-time after radiation therapy was shorter than that of radical prostatectomy; an important benefit many men considered as they explored the implications of treatment on their ability to work. Jorge, a 61-year-old home inspector, explained:

*I was inclined to have brachytherapy because the recovery time was shorter and there would be no big wound, so I could crawl, climb the ladder and do some lifting. But with surgery, I was expected to rest for about three months before I could fully get back to work. That's too long to be without income.*

Jorge’s initial preference for brachytherapy was based on his understanding that it had a short recovery time compared to radical prostatectomy, allowing him to return to work sooner. However, despite the benefits of brachytherapy, Jorge became concerned about its effectiveness in eradicating prostate cancer because he felt there were “too many uncertainties”. Most salient among them was Jorge’s concern that “there was no way of knowing if the cancer had spread inside the body or if all the cancer tissue was properly irradiated”. Similarly, many men who considered external beam radiation therapy were concerned about the precision of delivering
radiation to the prostate gland, a process best described by César, a 63-year-old courier, as “aiming (radiation) at a guesstimated location in the body”. Some participants felt the lack of precision in irradiating prostate cancer, along with the perceived benefits of radical prostatectomy (described in the following section), rendered radiation therapy an inferior treatment option.

Choosing radical prostatectomy. In consulting their urologist, most participants perceived that radical prostatectomy could best thwart prostate cancer progression and metastases. Oscar, a 53-year-old business owner, explained:

_The cancer (would) be taken out and thrown into the garbage. And as long as none of the (cancer) cells escaped the prostate, you’re cured. That’s it._

_End of story._

Participants also learned that radical prostatectomy allowed pathologists to examine the entire resected prostate under a microscope to identify tumour(s) size, stage and prostatic capsule integrity as a way to determine potential cancer spread beyond the gland. This was a key benefit of surgery for Alejandro, a 67-year-old software engineer, who shared:

_You know what type of cancer you are dealing with and you can tell if the cancer escaped the prostate. If it did, you would follow-up immediately with further treatment. You wouldn’t be able to know that with radiation therapy._

Importantly, some men felt that post-surgical biopsy results offered information that could help them strategically plan their lives. Carlos, a 56-year-old clergyman, recounted how
knowing his cancer was organ-confined gave him some confidence to make work and vacation-related plans:

They took it all out. That’s a good sign because I know I’ve got some years left in me to live disease-free. So, I will be able to work for a few more years and I’m planning next year’s vacation and I’m not worrying too much about the cancer. At least for now.

Also important was participants’ understanding that undergoing radical prostatectomy did not forego further treatment(s) if required. This was a crucial benefit offered by radical prostatectomy as urologists explained that surgery after radiation therapy was extremely difficult and not advisable for treating prostate cancer recurrence.

Aside from evaluating the benefits of radical prostatectomy, participants also considered the risks of surgery. Most commonly cited risks participants discussed with their urologists were intra-operative bleeding and damage to tissues surrounding the prostate. Diego, a 58-year-old automobile wholesaler, cautioned, “there’s always a danger that something could go wrong during surgery. You simply don’t know what could happen”. However, it was clear that participants’ decisions around treatment were derived from having framed prostate cancer as a threat to their lives. In this context, men saw the consequences of surgery, with its promise to eradicate prostate cancer, as a preferable alternative to what they thought was certain death from untreated disease. Javier, a 68-year-old carpenter explained:

I knew there were risks, and that I might not come out alive from surgery.

But, the chances of that happening were slim compared to the certainty that the cancer would spread and lead to a slow, painful death.
Although participants were aware of the genitourinary side-effects of radical prostatectomy, their severity and effect on men’s work were often downplayed. Augusto, a 67-year-old factory worker, was reassured by his urologist that urinary incontinence would “decrease over time” and that he could “resume work once the (surgical) wound healed”. Convinced that the experience of post-surgical consequences would be temporary and manageable, participants did not consider the impact of radical prostatectomy on their work. In fact, most participants equated radical prostatectomy with an opportunity to extend life expectancy and increase their productive work years. As Manuel, a 44-year-old franchise owner, explained:

_I have a mortgage and a family. What are they gonna do without me? I thought, and still think, prostatectomy was the best option I had to keep me alive and working. I was worried about the incontinence and not having sex and all of that. But, I’ve got other things to worry about and my family came first._

As exemplified in Manuel’s story, many men strongly asserted forgoing masculine ideals around sexual prowess and control of the body; while at the same time justifying their treatment decision as a way to increase their chances of survival and ability to provide for family.

As evidenced in these stories, participants showed confidence in their understandings about the implications of surgery and strategically prioritized radical prostatectomy in their treatment plans to eradicate prostate cancer while reserving radiation therapy to treat potential cancer recurrence. In doing this, participants attempted to maximize the effectiveness of each treatment option in controlling prostate cancer and extending life as a means of protecting and providing for their families.
4. Considering whether or not to disclose prostate cancer at work

The diagnosis of prostate cancer and its treatment posed unique challenges in participants’ relationships with work as it called for disclosure of a health issue many men considered private. Regardless of their seniority and/or position at work, most participants notified their employers and/or human resources department about their prostate cancer diagnosis as they requested treatment-related sick leave amid initiating the pertinent work-sponsored entitlements. As Ricardo, a 56-year-old environmental consultant, recounted:

*I told my bosses I had cancer because they had to know why and for how long I was going to be away for. Then I had to tell the HR person because she was responsible for the insurance paperwork.*

Although most men disclosed the reasons for their sick leave, some men limited the information they shared with work-colleagues. Omar, a 61-year-old dentist, explained:

*I told the staff I was having surgery, but didn’t tell them what for. (Prostate cancer) is a pretty personal thing and if the staff knew, it could be broadcast very quickly to my patients. So there’s gonna be a couple thousand (people) that know I have prostate cancer. And I thought: ‘Well, what about my privacy?’*

Similarly, a few self-employed participants felt it was necessary to conceal their diagnosis for fear it could hurt their business. In this sense Martín, a 69-year-old contractor for the oil industry, recounted, “I didn’t tell any of my clients because they’d think I wouldn’t be able to do the job and I would lose business”. Others, including Camilo, a 64-year-old free-lance photographer, was guarded, “I only told the customers I knew I could trust”. Evidenced in the men’s stories
was a range of considerations they gave to the potential benefits and consequences of prostate cancer disclosure to their work and, by extension their income. It must be noted that most men who disclosed having prostate cancer tried to downplay its potential impact on work. For example, Francisco, a 62-year old realtor whose diagnosis of prostate cancer “shook (him) to the core”, tried to reassure his work-colleagues that “everything would be fine” and that he “would be back to work in no time” after treatment. Exemplified in Francisco, and many other men’s, stories was how they tried to minimize their concerns about prostate cancer in an attempt to reassure others that the disease would not affect their desire to return to work and productivity, qualities central to their identities as men and workers.

5. Delegating work tasks

In delegating work tasks, participants who disclosed their sick leave plans transferred their work-responsibilities to co-workers. Although most men expressed confidence in their work-colleagues’ expertise as key in the successful delegation of tasks, some participants worried that their sick leave could negatively impact the projects they oversaw, and were concerned that their colleagues would struggle to cope with the increased workload. Julio, a 51-year-old engineer, noticed how the impending sick leave fueled his employers’ concerns about maintaining adequate staffing levels to sustain productivity, which led his boss to “hire someone to do (his) job”. Realizing his employers’ need for qualified staff while he was on sick leave, and bound by the responsibility he felt towards maintaining workplace productivity, Julio did his “best to train the new co-worker” on the tasks to be performed during his absence. In this example, Julio’s loyalty towards his work-colleagues precluded any perceived threat that his employment and position within the company would be compromised:
“I knew (new co-worker) could replace me at work, but my bosses were good to me and I wanted to reciprocate”.

Julio’s eagerness to help his new co-worker may have also been strategic in demonstrating his ‘fit’ and ‘value’ as an important team player within his workplace, attributes which could have positioned him favourably in returning to work after surgery.

6. Delays in undergoing surgery

Two participants reported experiencing significant delays in undergoing radical prostatectomy. Omar, a 56-year-old dentist who wanted to undergo surgery “as soon as possible” was told by his urologist that, due to scheduling issues, surgery would take place almost five months after his diagnosis. Similarly, Jorge, a 61-year-old home inspector recounted:

My surgery was cancelled three times. The first time, I was rescheduled to have surgery two months later. Then it was cancelled again and rescheduled for a month later. And then it was cancelled for a third time, but this time, they said they didn’t know how long I had to wait. Obviously, my family and I were concerned.

Evident in Omar and Jorge’s stories was the view that delays in undergoing radical prostatectomy could undermine the effectiveness of what they thought was the best treatment available to cure their prostate cancer. However, despite their concerns, both participants also recognized that medical resources were limited and stoically awaited for surgery because, as Omar put it, “I wasn’t the only one on a waiting list”.

Delays in undergoing surgery also affected Jorge’s work-schedule resulting in lost income. As a business owner, Jorge referred clients to competitors as soon as he was scheduled
for surgery. However, postponements of the surgery led to lost business as he was unable to recall clients he had referred to competitors. This added to the frustration experienced by Jorge because the income lost during the waiting period was “unexpected and not (his) fault”. Furthermore, Jorge emphasized how the cancelations also affected his ability to deliver services within agreed time-frames which seriously challenged his ability to maintain his business reputation, potentially impacting his ability to provide for his family.

7. Working until the day before surgery

Most participants reported working until the day before surgery and detailed four reasons for doing so. First, prostate cancer and radical prostatectomy were sources of worry for most men, many of whom felt that they coped better by engaging in work. Alberto, a 64-year-old department director at the Federal Government explained:

*I didn’t find it particularly constructive to sit around doing nothing and thinking about the surgery and what was gonna happen. It was far better to keep my mind occupied. I just felt better at work because that was a normal thing for me to do.*

For many men, including Alberto, engaging in work until the day before surgery not only provided them with routine, but also offered them a distraction from constant preoccupation with prostate cancer.

Second, by working until the day before their surgery, some participants attempted to demonstrate that their prostate cancer did not impact their ability or desire to work. Augusto, a 67-year-old factory worker, explained:
I’m older than most of my co-workers and I’m sure some of them would like to see me gone. But I need this job, so I worked harder so they (employers) would notice and welcome me back after surgery.

Evident in Augusto’s excerpt was how concerns about job security also led him to contest dominant social constructions that prescribe older ill men as relatively less productive.

Third, participants were aware that their time off work due to surgery translated into greater workloads for their co-workers and inconvenienced their employers, business partners and/or clients. One strategy used to minimize the repercussions of their time away from work was to work until the day before their surgery. Alejandro, a 67-year-old software engineer, recalled feeling “responsible in contributing to the team effort, so (he) worked to the last day doing as much as possible to help reduce (his co-workers’) load”.

The fourth reason for working until the day before surgery had to do with participants’ financial needs. Participants who experienced financial concerns reported a heightened need to generate income. For example, Camilo, a 63-year-old free-lance photographer, shared:

I don’t have any employee benefits. No sick leave, nothing. So, there is not much of a safety net for me. That’s why I worked, because I had to be self-sufficient.

As evidenced in the above excerpts, men’s descriptions of their reasons to work until the day before surgery rested on the benefits afforded by their work-activities. Although work during this period allowed participants to cope with uncertainty, contribute to their workplace, and generate income, the stories also referenced social expectations about work, responsibility and productivity.
Chapter Summary

Chapter 4 provided insights about the complexities and contexts that shaped participants' relationships to work and decisions around screening, diagnosis, and choosing radical prostatectomy. Although it was clear to participants that prostate cancer affected their individual health, men recognized that the implications of the disease also had a direct impact on their work and ability to provide for their families. Faced with the prospect of treating prostate cancer amidst the performance of worker and breadwinner roles, participants sought to identify what was most important to them in life.

Prioritizing treatment as a way of extending life, most participants sought and meticulously evaluated the information presented to them about the treatment options available. In this regard, although physicians’ opinions around treatment were highly regarded, most participants emphasized their autonomy in critically evaluating clinical information and in making informed treatment decisions. In preparing the workplace for their treatment-related absence from work, most participants planned with employers, co-workers and/or clients interventions that would help maintain productivity during their surgery-related sick leave. Through the delegation of work-tasks and working until the day before surgery, participants demonstrated their fit at the workplace, and loyalty towards their work-colleagues. These findings are important in foregrounding the grounded theory of Reformulating the Worker Identity presented in the following chapter.
Chapter 5

How are participants’ work-related experiences affected following radical prostatectomy?

Chapter 5 presents the findings addressing research question two: “How are participants’ work-related experiences affected following radical prostatectomy?” This research question is answered in describing the processes underpinning the grounded theory Reformulating the Worker Identity.

Reformulating the Worker Identity

As discussed in Chapter Four, most participants described themselves as being healthy prior to surgery. However, radical prostatectomy resulted in a period of convalescence and side-effects ranging from fatigue to urinary symptoms that included frequency, urgency and incontinence. The physiological changes that resulted from surgery undermined participants’ work capacity and challenged the men’s potential to return to work disrupting their sense of purpose and routine and ability to provide for family. Within this context, participants detailed processes toward Reformulating the Worker Identity(Figure 4.Reformulating the Worker Identity), which is the basic social process\(^{11}\) in the grounded theory presented here. As a basic social process, Reformulating the Worker Identity refers to the men gauging and adjusting work-related roles, relationships and career plans based on changes brought about by prostate cancer and radical prostatectomy. Embedded were men’s post-surgical efforts and concessions in

\(^{11}\)Defined by Glaser (2005) as a “core category” that has “two or more clear emergent stages” (p.1-2).
reformulating work and career-related goals. As Oscar, a 53-year-old man who sold his business prior to surgery, explained there were deep connections between prostate cancer, radical prostatectomy and his work aspirations:

* Surgery makes you see things differently. You are the same person up here (points at his head), but the body has changed. Up here, (points at head) you wanna do the things you did, but your body says: ‘Nope. You can’t’. So, you work around that. You prioritize doing the things you can do and look for a happy medium. That’s why I’m working as a building manager now. I’m not a boss and I don’t go about telling others what to do. I’m an employee because I can’t put up the effort and energy to run a business. But I can do minor stuff like fixing lights, taps and drains; so that’s what I do. I’m still working and active; that’s what matters. Things aren’t what they used to be, but you make it work for you.

By Reformulating the Worker Identity, Oscar, and other participants, acknowledged changes to their bodies but remained committed to working and contributing to society and their families’ wellbeing.

Underpinning Reformulating the Worker Identity were an array of processes which began during the immediate post-operative recovery period wherein men’s concerns emerged about being unable to fully recover their physical strength, stamina and function. Doubts about their post-surgical physical capabilities, in turn, led most men to contemplate potential changes to their work. Thus, Reformulating the Worker Identity is detailed in two parts: 1. Recovering after radical prostatectomy, and; 2. Re-negotiating work expectations.
Figure 4. Reformulating the Worker Identity.
Recovering after radical prostatectomy

Recovering after radical prostatectomy refers to the processes men engaged to recover from surgical removal of the prostate gland wherein they focused on re-gaining the physical strength and function to resume daily activities, including returning to work. Participants detailed three underpinning processes in recovering after radical prostatectomy: 1. Embodying the sick role, 2. Contesting side-effects, and, 3. Conceding new realities.

1. Embodying the sick role

Overall, the men emphasized that post-surgical recovery typically began by embodying the sick role during convalescence. Most participants detailed that surgery-related convalescence was a period of unavoidable absence from their usual roles at home and at work. For example, Camilo, a 64-year-old photographer, explained how post-operatively the focus was on nurturing his body back to health:

I was pretty beat up from surgery and I couldn’t do anything on my own during the first couple of weeks. So I just had to rest and let the body heal.

In describing this period, participants acknowledged being in a state of heightened vulnerability for post-surgical complications (e.g., infections), and as a trade-off, many of the roles they had performed at home were relinquished. Javier, a 68-year-old self-employed carpenter who was the gardener at home, recounted how his wife became responsible for that domestic work to ensure that he did not “over exert” to the detriment of his post-surgical recovery. Javier also described limited autonomy during this period wherein his wife’s support...
early on in his recovery focused on reminding him about what he could safely do, “there were things she told me not to do without her help, like moving stuff around or getting out of bed”. Although Javier acknowledged that being ‘sick’ implied weakness and dependency on others, he also emphasized that these deficits were imposed on him in the short term by the surgery and, therefore, did not reflect who he ‘really’ was.

Central to embodying the sick role were participants’ efforts at maintaining their masculine worth. This was achieved in part by framing their sick role as strategic to ensure healing. Jorge, a 61-year-old home inspector, explained that rest, and dependence on his wife were not signs of weakness, but rather strategies necessary to achieve optimal recovery and facilitate his eventual return to work. Building on this, Alejandro, a 67-year-old software engineer, linked the sick role to his masculine worth by framing convalescence as a “test” of his “strength” in managing yet another challenging situation in his life. Central to many participants’ sick role experiences was adherence to values of determination and resilience in weathering acute post-surgery pain and immobility. As José, a 65-year-old auditor for the Federal Government who suffered from multiple chronic illnesses, shared:

> It wasn’t good. I developed infections and I was in and out of hospital. But I didn’t give up. I kept telling myself: ‘I can’t let it win’.

Embodying the sick role also allowed men to begin to trade some masculine ideals wherein they conceded their need for help amid claims that these practices benefited their family. In this sense, most men, including Carlos, a 56-year-old clergyman, defended his need to temporarily embrace ‘un-masculine’ practices such as “asking for help” and “doing things slowly” in a bid to reduce recovery-related complications that might “cause others to worry”.
Herein, Carlos, and many other participants conceded falling short of some masculine ideals including autonomy and self-reliance; while, at the same time suggesting their conservative approach to recovery was also influenced by a desire to protect others from worrying about them.

As participants recovered from surgery, they began to tolerate mild physical activities such as ambulating unassisted and/or helping with light-duty house chores. Men gradually distanced themselves from the dependence associated with the sick role. César, a 63-year-old courier recalled that by the second week after surgery:

I was feeling better and I was able to do some (light) chores... like, loading the washing machine and doing the dishes. But I didn’t wanna push my luck either (with more demanding chores), because the wounds were still tender. But I was definitely not waiting for things to be served and handed to me.

Despite improving physical health César’s wound discomfort reminded him that his recovery was on-going. Within this context, César had learned to “respect the healing process” and focused on improving his physical health “one step at a time”. Indeed, most participants detailed how the sick role faded gradually as their physical capabilities and independence returned. Thus, men saw this distancing from the sick role as an important step toward evaluating their potential for returning to work. For example, Félix, a 66-year-old motorcycle riding instructor who took one month’s sick leave, explained that in the third and fourth weeks post-surgery he “declined help whenever possible” as a way of re-establishing some of his pre-surgical roles.
2. Contesting side-effects

As recovery progressed and the pain and immobility reduced, most participants gauged potentially longer term side-effects in evaluating next steps toward a return to work. Central to this were men’s efforts at contesting side-effects, a process in which participants evaluated and tried to reduce the impact of side-effects on their daily lives and worked toward more fully re-establishing pre-surgical routines. Contesting side-effects was strengthened by men’s resolve to recover the attributes and qualities they deemed essential to re-establishing their identities as men and workers. Men’s narratives around contesting side-effects primarily centered on addressing their fatigue and urinary incontinence.

Participants’ stories around fatigue focused on how this side-effect of surgery prevented them from fulfilling some obligations at home and fueled concerns about returning to work. As Oscar, a 53-year-old business owner, explained, “a lot of times I wouldn’t finish what I started because I’d be exhausted”. Some men also described how fatigue interfered with their family roles. Manuel, a 44-year-old franchise owner and father of two who experienced fatigue, explained, “you stop spending time with your children. So they find other things to do, and they do them without you”. Evident in these examples was how fatigue affected men’s daily routines and had the potential of distancing them from their family and delaying their return to work, side effects that participants sought to contest.

Although participants were determined to overcome their fatigue, the path to recovering physical strength was an arduous one for many men. For example, Ricardo, a 56-year-old environmental consultant who worked out at a gym at least three times a week prior to surgery, explained:
*I wanted to exercise (to regain strength). But my problem was that it was hard to get started, it was hard to get motivated and when I got motivated, my body wouldn’t agree with me. So I’d stop soon after I got warmed up. I had to force myself. It was like fighting against myself, you know? I was in that vicious cycle for weeks before I noticed it got any better.*

Before his surgery, Ricardo also had an active social life and was used to managing a busy work schedule. However, post-radical prostatectomy, he was forced to stay at home and forgo many of the activities he had previously enjoyed. Dissatisfied with the fatigue, Ricardo persisted in challenging his body to regain physical fitness and improve his energy levels. Similarly, many men worked hard to overcome their fatigue by pushing themselves to regain their pre-operative energy levels and activities regardless of how they felt.

In contesting side-effects many participants slowly saw improvement and, crucially, began to demonstrate competence in performing some of the roles they had played prior to surgery. Javier, a 68-year-old self-employed carpenter, described how contesting fatigue was central to proving to his family that he was fit to retake his obligations at home and his role as a grandfather:

*I didn’t have any strength at all. I couldn’t do anything on my own and that’s why my family, particularly my wife, were very protective of me. They didn’t want me to do anything, and made sure I had everything at hand. But I kept trying to do stuff around the house and once I was strong enough to pick up my grandson, I convinced them (family) that I would be able to babysit him. That was a big sign that things were starting to return to normal.*
Fatigue and physical weakness were reasons why Javier’s family limited his home and family duties. Restricted in what he could do at home, and feeling ‘left out’ from interacting with his grandchild, Javier focused on contesting the fatigue in gradually reclaiming the activities that were central to his domestic roles. For Javier, and many participants, fatigue was a surgical side-effect that decreased men’s autonomy and undermined their ability to position themselves as capable of helping others. In this regard, men’s efforts and performativity in contesting fatigue and working to regain their pre-operative energy levels were driven by masculine ideals around optimizing productivity, and protecting and providing for others. Linked to these performances were narratives suggesting resilience and toughness in laying claim to their identities as men who were willing to work at their recovery as a means to actively contribute in domestic and paid work arenas.

*Contesting side-effects* was also described as a key process in many participants’ stories around their recovery of urinary continence. Men’s urinary incontinence was associated with a loss of bodily control and poor hygiene, characteristics that were potentially shaming and undermined their ability to return to work. For example, Alejandro, a 67-year-old software engineer, predicted that urinary incontinence was a surgical side-effect that could give rise to discrimination in the workplace because, “*people think you are dirty and smell. So they try to avoid you*”. Furthermore, some participants described social attitudes that linked urinary incontinence with weakness and physical disability, conditions men feared would elicit the pity of others. Manuel, a 44-year-old franchise owner of four restaurants, shared, “*some people think incontinence is like the worst thing that could happen... and feel sorry for you*”. Not wanting to be pitied or perceived as dirty and/or helpless were strong motivators in men avoiding some social situations and addressing their urinary incontinence. For many men, staying at home afforded the privacy needed to contest their urinary incontinence. However, some men felt
isolated in their quest to overcome urinary incontinence. Julio, a 51-year-old mechanical engineer explained:


_incontinence can make you feel lonely because you stop seeing people...
But I’d rather be lonely than to have people talk about my incontinence. I can always meet and do stuff with them again once I regain control of my bladder._

For most men, including Julio, the purpose of reducing social interactions was to avoid any embarrassment or shaming from the visibility of urinary incontinence as they privately contested that loss of control. In this sense, self-isolation was strategic for many men in dealing with their urinary incontinence but it also limited significantly the potential for returning to work.

Pelvic floor exercises were the main strategy used by participants in contesting urinary incontinence. However, there was variation in terms of the frequency and length of time men did the exercises. Men who were able to control their urinary incontinence and urgency shortly after the removal of their urinary catheter did pelvic floor exercises sporadically stopping altogether once they felt they had good control. For example, Jorge, a 61-year-old self-employed home inspector who described having “minor leakage” two weeks after his urinary catheter was removed, shared, “I did them (pelvic floor exercises) for a few days, but I stopped because I had pretty good continence”. However, men who experienced longer term urinary incontinence following urinary catheter removal performed pelvic floor exercises more frequently. Oscar, a 53-year-old business owner who “couldn’t squeeze tight enough to stop the urine” recalled doing pelvic floor exercises “all the time” to overcome his incontinence.

Although most men noticed improvements in urinary control after a few months post-surgery, a few participants experienced longer term incontinence issues. Men who did not have
improvements in the first few months post-surgery became increasingly concerned that their incontinence might be permanent. Manuel, a 44-year-old franchise owner who had been doing pelvic floor exercises for four months shared:

My doctor said that I have up to one year to regain bladder control. But I also read that most people regain continence in the first few months after surgery. I’m scared because I don’t have any control at all!

Believing that the chances of regaining urinary control decrease significantly after the first year post-surgery led Manuel to step up interventions to address his urinary incontinence, “I’m going to see the (pelvic floor) physiotherapist. Hopefully, that will help”. Concern turned into desperation as the window for regaining continence closed. Augusto, a 67-year-old factory worker who had urinary incontinence almost two years after his surgery, recalled:

It isn’t easy to deal with this, you know? I did the exercises and did everything the (pelvic floor) therapist told me to do. But still, nothing worked. I’m depressed. I’m more reclusive, it is inconvenient to deal with and I spend $50 a month on diapers. That’s more than $600 a year!

Manuel and Augusto’s prolonged urinary incontinence was burdensome and had implications for returning to work and the nature of the work they could complete. Augusto, who also experienced a post-prostatectomy wound infection shared, “I don’t want more surgeries. But I am running out of options. That’s why I’m thinking about sling surgery”.

Although some participants had longer term challenges in contesting side-effects, most men noted improvements post-surgery. For example, Oscar, a 53-year-old business owner, explained that improved physical endurance and urinary control gave him “confidence to leave
home and meet with friends”, which he described as key in regaining a sense “of freedom” that 
“boosted (him) emotionally and psychologically”. Some participants attributed improvements in 
mood and energy levels to their strict adherence to medical recommendations around recovering 
overall fitness, eating healthy and getting sufficient rest. José, a 65-year-old auditor for the 
Federal Government, attributed improvements in the reduction of his side-effects to his 
determination in contesting them:

The side-effects don’t bother me much now because I did everything the 
doctors told me to do. But my goal is to make them disappear. I haven’t 
given up yet.

For many men, including José, contesting side-effects was a long-term process that involved 
strictly following medical recommendations and disciplined self-management. In this sense, 
many men took professional advice in attempting to effectively restore physical function.

In summary, radical prostatectomy led to changes in how men functioned socially and at 
home, which in turn had implications for their return to work. This led men to actively contest 
side-effects of fatigue and urinary incontinence. Drawing on masculine ideals of resilience and 
responsibility for solving one’s problems, men were determined to re-establish pre-surgical 
levels of function in returning to work.

3. Conceding new realities

Despite their best efforts, many men realized that some surgery induced changes might 
not be fully reversed. When this happened, participants became resigned to the idea of having to 
live with some changes, most of which had implications for their daily activities, family relations 
and work performance. In these cases, men engaged in conceding new realities wherein they
worked toward adjusting to the longer term impacts of prostate cancer and surgical side-effects on their lives. Although conceeding new realities implied an acceptance of some limitations, participants refuted the idea that they had given up trying to re-establish previous routines and/or the activities they enjoyed. Instead, many men described creating opportunities to pursue their interests and sought alternate ways to live life to the fullest. For example, Luis, a 67-year-old software programmer and avid hiker, recounted how he “enjoyed the challenge of hiking the Grouse Grind (a mountain climb) in half the time it takes the average hiker” but recognized that his “body (couldn’t) take that kind of abuse” post-surgery. He conceded that “going at a slower pace and appreciating the scenery” were equally enjoyable and satisfied his “need to be physically active and feel challenged”. In accepting these changes, Luis acknowledged that aspects of previous ways of being were no longer central to his recreation and masculine identity. Instead of giving up on hiking, Luis purposefully practiced and continued to enjoy the activity, albeit with some changes.

In conceeding new realities, many participants accepted the consequences of surgery and continued to look for ways to reduce the impact of side-effects on their daily lives. For example, Manuel, a 44-year-old franchise owner who “love(d) the outdoors”, explained that post-surgical urinary incontinence was a reason he avoided lengthy outings with his family. Having conceded that urinary incontinence was emerging as a longer term issue, Manuel felt compelled to “come up with new activities to do with (his) children indoors” as a way of spending quality time with them. Playing board games and doing crafts at home replaced outdoor activities as he adapted to the limitations urinary incontinence invoked. Although Manuel missed outdoor activities with his family, there were other priorities he was able to satisfy as a father, “seeing them (children) grow is really important to me. I’m really lucky to be part of that”.
Some participants described how family members were impacted by their prostate cancer and surgery, and conceded new realities. Carlos, a 56-year-old clergyman, shared how his children (both in their early 20’s) “understood that things would be different”. Also noted by Carlos was his children’s recognition that they were central to alleviating the burden radical prostatectomy had imposed on the family, “they realized that they had to be more independent and help out more at home”. As Carlos’ children became responsible for many of the chores he had previously done at home, he described that his children grew closer because they “communicate more and are more supportive of each other”. In conceding new realities, and in adapting to the circumstances that resulted from prostate cancer and radical prostatectomy, Carlos shared that he felt “proud” of his children because “they matured a lot” since his surgery.

Participants also became increasingly aware that their post-surgical bodies might not be able to tolerate some of the physical demands required for work. César, a 63-year-old courier who described himself as a “very competitive person”, was concerned about not being able to deliver as many parcels as he did prior to surgery. Although he had previously thought about the potential impact of surgery on his work, it was amid conceding new realities that César worried about “not measuring up” to his co-workers. While the inability to fully meet work demands was perceived as a threat to most participants, many men framed the expected reductions in work capacity and productivity as outcomes preferable to prostate cancer induced mortality. For some men, conceding new realities served as a catalyst that empowered them to think differently about work. For example, Julio, a 51-year-old mechanical engineer, explained that he often had to “move heavy equipment in the shop” as part of his work duties. However, post-surgical restrictions on lifting led Julio to consider opportunities to “work in other areas of the company”.
and be exposed to different aspects of the industry”, a concession that he suggested could lead to “growth and be relevant in the business”.

Conceding new realities did not mean that men were satisfied with living with the consequences of radical prostatectomy or that they had given up in their efforts to recover presurgical levels of energy and physical function. Instead, most participants sought to move on with life by reconciling the changes prostate cancer and radical prostatectomy imposed on their lives. Central in this process was men’s resolve to reframe life within these constraints. Rather than deficits, the men tended to focus on what they might best offer in the context of work. In line with strength-based models of masculinity and men’s health, participants strategized and planned their return to work amid being ever mindful that their work performance would be tempered in the short, and perhaps, longer term. Key in the men’s decisions around work arrangements was their prostate cancer diagnosis and recovery from surgery in assessing and communicating to employers and/or clients how and what they could reasonably contribute.

Re-negotiating work expectations

Anticipating a return to work, men were concerned that their post-surgical work-limitations would prevent them from fully satisfying work responsibilities and/or meeting work expectations. Luis, a 67-year-old software programmer explained:

I needed to be really close to the bathroom because I couldn’t control the urge to urinate and the washroom at work is too far for me to get there in time. So, ideally, it was best for me to work from home because the bathroom is just 2 steps away. But I knew my boss wanted me to work at
Luis’ excerpt exemplified how post-surgical side-effects could impose work limitations and a disjuncture between participants’ work preferences and employers’ work expectations (and in many men’s contexts the expectations of clients and co-workers). In this sense, *re-negotiating work expectations* referred to the processes wherein participants, on their own or in consultation with their employers, clients and/or co-workers assessed and re-negotiated work tasks and responsibilities to facilitate their return to work. For most participants, the process of *re-negotiating work expectations* began prior to their actual return to work. In this context, *conceding new realities* (as previously described) had heightened men’s sensitivities for the need to connect with employers, clients and/or co-workers to begin negotiating the specificities of their return to work. Indeed, ever present were participants’ descriptions about communicating with employers, clients and co-workers within the context of *re-negotiating work expectations*, an overarching process underpinned by: 1) Assessing work capacity, 2) Re-balancing work and health, and 3) Re-setting work obligations.

**1. Assessing work capacity**

*Assessing work capacity* began prior to the men’s return to work and was a process in which participants itemized the work tasks that they could and could not do post-surgery. The purpose of these assessments was to inform work-related decisions, wherein men prioritized their safety at work as a strategy for ensuring ongoing recovery and gradually resuming full-work responsibilities. Javier, a 68-year-old self-employed carpenter who built wooden frames and furniture, recalled:
I kept thinking how I was going to manage the work once I got back (to work) because I knew things were going to be different. I was concerned with lifting heavy objects because of the (surgical) wound. So I couldn’t do that until it healed completely. But I also felt dizzy at times. That ruled out anything that required (climbing) the ladder or reaching high-up unless there was someone to help me.

Exemplified was how consequences of surgery including limitations on physical exertion and reduced strength could impact work capacity. Within this context Javier and many other men returned to work knowing that they would not be able to take up all the pre-surgical duties of their job. Although participants assessed their work capacity, communication about the outcomes and potential changes to their work varied. For example, self-employed men often times had the autonomy to make adjustments independently and continue to assess their potential for a full return to work. Jorge, a 61-year-old self-employed home inspector who described his job as one that required some physical exertion, explained:

I couldn’t use the ladder because the wound still felt a bit tender. Basically, I couldn’t do the larger properties because I hadn’t recovered enough for that. I didn’t want to turn down clients, but I had to limit the inspections because I didn’t want to be overwhelmed and do a sloppy job.

Jorge’s narrative confirmed two important issues. First, he assessed his work capacity conservatively with the understanding that working beyond his physical capabilities might risk injury, and by extension his ability to eventually fully return to work. Similarly, many participants positioned work and their recovery from radical prostatectomy as occurring simultaneously wherein, ideally their work capacity would increase over time. Second, although
Jorge and many self-employed men lamented having to turn down some business, this was typically framed as an honorable choice to produce only quality work. In this sense, doing a good job was prioritized over work volume as an important step in providing quality and value to clients, and in preserving the participants’ reputation as good workers.

Among employees, more formal report lines existed for communicating their work capacity. For example, 51-year-old Julio, a mechanical engineer who designed, built and tested custom-made equipment, recounted:

*I called my boss to let him know that I couldn’t lift anything heavy which meant that I couldn’t work in the shop for the first couple of months.*

As seen in Julio’s example, communication with employers was key to sharing the results of their assessments and negotiating return to work arrangements. Within this context, most participants disclosed potential reductions in their work capacity so that, as Luis, a 67-year-old employee at a software company, put it, “*(co-workers) know what to expect from you*”. Also evident in many participants’ narratives were alignments to ideals that honored teamwork and accountability at work. Indeed, many employees, regardless of their rank and/or roles in the workplace, were concerned that changes to their work capacity could increase the workload for others. As Humberto, a 61-year-old owner of a food processing factory, shared, “*there are times when you can’t meet their (co-workers’) expectations and you get a bit concerned*”. The inability to match pre-surgical work rates led many men, including Humberto, to assess their capacity for working in different duties and/or responsibilities to help sustain or increase the overall workplace productivity. Ricardo, a 56-year-old environmental consultant, explained that he searched for alternative ways to contribute in light of his reduced concentration levels because:
I didn’t think I could do the technical stuff as well as I used to and I didn’t want to take it easy when everybody else was working hard. So I pondered about doing some marketing instead.

Evident in Luis, Humberto and Ricardo’s excerpts was an awareness of the connectedness and impact of their work performance on others. Hence, although competitiveness is often linked to men’s work and work cultures, exemplified here was how work adjustments for the benefit of co-workers and/or clients were made by many participants as an honorable masculine ideal around work ethic and team ethos. As Humberto later added, “you have to look for ways of making yourself useful because people depend on you to do their work”.

Although most participants shared that assessing work capacity was instrumental in setting return to work expectations, some men detailed that they had overestimated their work capacity. This became evident once men returned to work, wherein their recovering bodies were subjected to the strains and demands of the workplace. As Omar, a 56-year-old self-employed dentist who was “ready to work” by the end of his sick leave, explained:

I knew it would take me some time to adjust, but I didn’t expect it to be that tough. The incontinence, the (surgical) wound and the strain on my body made it very difficult to work. I wondered if I should’ve reduced my hours even further because it felt like it was too much.

For Omar, and most participants, the full impact of prostate cancer and radical prostatectomy on their work capacity was not fully known until they returned to work. In this context, many participants underscored the importance of continued assessments in making adjustments to ensure the viability of their return to work.
For the most part, gradual improvements in physical strength and endurance were accompanied by participants’ increased confidence to resume more work responsibilities. As a result, the focus of the men’s assessments of work capacity shifted from informing work-related decisions aimed at ensuring safety to increasing their productivity and range of duties. Manuel, a 44-year-old franchise owner of four restaurants who “could only work for a few hours a day” upon returning to work, explained, “I wanted to get used to the pace and go from there. So I only cleaned and stocked service counters for the first three weeks”. However, dissatisfied with what he considered were modest contributions, Manuel constantly assessed his capacity for resuming more work responsibilities. He looked for opportunities to add tasks that “didn’t require a lot of strength” to support his staff. By the fourth week after his return to work, Manuel felt his stamina returning and increased his work hours and, while still on light duties, “I started working eight or more hours a day and did some minor repairs, ordered supplies and helped where I could”. Exemplified in Manuel’s story was how resuming his pre-surgery work duties occurred gradually over time. Related to this, many men framed their improving work capabilities as markers of their recovery. Carlos, a 56-year-old clergyman explained that by his tenth month back at work, “I’m doing everything I used to do at work. That’s a huge improvement because I could barely walk after surgery”. Evident was how the ability to restore daily routines and obligations was positioned as an important milestone in participants’ recovery. Furthermore, although many men continued to experience side-effects at work, they underscored the importance of resuming work as a way of restoring their ‘normal’ life.

In summary, assessing work capacity allowed men to make adjustments at work aimed at facilitating a full return to work or relinquishing some aspects of work. In this process, some men detailed that the centrality of work in their lives shaped the adjustments they were willing to make as they returned to work. In this context, men’s assessments of their work capacity took
into account the physical changes and changed priorities in judging what they thought could be realistically achieved with their return to work.

2. Re-balancing work and health

Rebalancing work and health was a process in which men thoughtfully and purposefully reframed their views and perceptions around work. Carlos, a 56-year-old clergyman whose role demanded long work hours, shared that he had often dismissed symptoms and worked through discomfort before his prostate cancer diagnosis because, “I’m only in my fifties and I never thought anything serious could happen to me”. However, after his prostate cancer diagnosis and treatment, Carlos was more conservative in his views and actions about his health. Moreover, the fear of prostate cancer recurrence and/or the diagnosis of another potentially life-threatening condition were highlighted wherein Carlos prioritized his health and was on the lookout for other illnesses:

We never listen to our bodies. I learned the hard way. Now, I take half a day off to see the doctor, even if it is for a minor thing.

Evidenced in Carlos’ story was how he re-balanced work and health to reflect the increasing importance he gave to safeguarding his wellbeing in the context of life with prostate cancer. In this process, an altered relationship with work emerged where Carlos became less selfless despite his work being anchored to discourses about helping others. For Carlos, and many men, discomfort, aches and pains became reasons for limiting or suspending work and seeking medical assistance. Masculine ideals prescribing ‘real’ men as those who disregard their own safety and/or health were countered by many participants. Instead, recognition of one’s mortality
led many men to prioritize self-health promoting practices over work commitments. This signaled a philosophical shift for many men wherein they put themselves ahead of their work commitments.

That said, many men also felt responsible to earn income as a way of satisfying obligations at home. For example, Omar, a 56-year-old dentist, shared:

*I developed carpal tunnel and chronic neck pain from work. I wanted to slow down a bit, reduce my hours (at work) and help maintain my quality of life. But my youngest son is still in high school. That’s why I can’t retire yet.*

Omar’s example highlighted how fulfillment of masculine roles as a protector and provider for his family underpinned his return to, and commitment for staying at work. Also underscored in this example were the complexities and tensions in re-balancing work and health. In this sense, multiple contextual factors shaped how participants re-balanced work and health priorities. As Alberto, a 64-year-old departmental director at the Federal Government, explained:

*(My wife and I) live comfortably and don’t have any major expenses. I thought about this for a long time and felt that I should retire if the conditions (at work) were right. Instead, I could spend more time with my family or be doing things I enjoy.*

Two important insights can be drawn from Omar and Alberto’s stories. The first was how participants’ re-balancing work and health priorities considered a number of potentially competing interests such as earning income, spending time with family and pursuing personal interests. Indeed, many men explicitly prioritized recovering fully from surgery, maintaining
their health and/or improving their quality of life over pursuing career growth and/or financial gain as central to living a fulfilling life. Second, clear in many men’s stories was how the level of perceived financial need determined their desire in returning to work. In this sense, participants who reported having few financial concerns actively sought to work under less demanding conditions and/or considered working less. Again, Omar, a 56-year-old dentist and father of two, explained, “I wanted to reduce my practice by one day a week because it wouldn’t affect our living standards”. For Omar, the financial benefits of working full-time were not worth the additional stress and physical exhaustion of a full-time work schedule, particularly after a prostate cancer diagnosis and radical prostatectomy.

The narratives of participants experiencing financial challenges were, by contrast, characterized by needing to work as long as possible; ideally under conditions that did not threaten their ongoing recovery and/or health. For example, Manuel, a 44-year-old franchise owner of four restaurants and father of two, explained:

Honesty, I wasn’t ready (to work). But I have a family, a mortgage and people to pay. Plus, my managers were barely making it through on their own. I just had to come back (to work). But I told the staff that I couldn’t do any of the physical stuff and that I was going to work a few hours a day.

Concerns about debt and financial losses were strong reasons for Manuel’s return to work. Also evident in Manuel’s narrative was how he adhered to normative masculine ideals highlighting his breadwinner role in returning to work amid his ongoing recovery.

A few participants detailed that the health needs of family members were also thoughtfully considered as they re-balanced work and health needs. For example, Pedro, a 65-
year-old architecture company owner and single father of a 25-year-old son who experienced an acute episode of mental illness, explained:

> My son needed a lot of help and I spent a lot of time with him. He’s better now, but I still have to do a lot for him. So, I have to balance between work and caring for him as well.

Similarly, Julio, a 51-year-old mechanical engineer whose wife required weekly treatments for a chronic illness, shared:

> My wife had a relapse when I was about to return to work. So, I had to take time off and bring her to the clinic once a week. She was very weak and I looked after her. That was tough because I had to juggle my health issues, hers, and work.

Highlighted in these men’s excerpts was how re-balancing work and health needs was also influenced by commitments outside of their own health. Within this process, participants framed their provider and caregiver roles as central considerations in re-balancing work and health. In this regard, the men’s stories also underscored the relational nature of gender, whereby most men responded to re-balancing work and health needs explicitly considering their role in optimizing the health outcomes of family and themselves.

The diagnosis of prostate cancer and the potential risk it posed to participants’ lives was a catalyst for some men to move towards retirement. For example, Francisco, a 62-year-old realtor who teamed up with a rookie colleague, explained:

> I don’t want to work forever. I’m not one of those people. I want to enjoy life. There are things that I’d like to do while I’m still able. In the
meantime, I want to make sure that my partner (rookie colleague) learns the tricks of the trade because I don’t want him to make the mistakes I made. Eventually I have to retire and give way for the younger realtors. I’d have no problems in retiring soon.

Francisco’s excerpt reflected many men’s philosophies, highlighting two issues. First, retirement was framed by some participants as autonomously deciding their tenure and when they would leave the workforce. In this context, retiring on one’s own terms was framed as a strength-based decision. Second, men’s commitment to mentoring other workers enabled some participants to give back to the workplace, with this generosity being signaled as a prized masculine value. Indeed, many men hoped to leave a lasting legacy at their workplaces through such activities.

Although most participants returned to work after radical prostatectomy, José, a 65-year-old auditor who had worked for the Federal Government retired after surgery. In retirement, he found balance and time to manage a number of chronic illnesses, conceding, “I just couldn’t work”. In this context, José framed his retirement positively highlighting his focus on more fully connecting with his wife:

*It’s not fair that the only time my wife gets to spend with me is when I’m sick and she has to look after me. I decided to retire because I had to focus on getting better and let my bosses hire someone right away.*

Evident in José’s account was a shift away from work in conceding his capacity and will to work had ended. For José, the focus was on his health, and connections with family. In this sense, prostate cancer and an array of co-morbidities likely hastened by his decision to retire.

To summarize, in *re-balancing work and health*, participants adjusted their work practices to accommodate their health needs and optimize relations with others - most often
family. Titrating work capacity with health and potentially competing priorities, some men moved toward (and into) retirement while others steadfastly aligned to workmen ideals in garnering continuous commitment to a graduated return to fulltime work.

3. Re-setting work obligations

Re-setting work obligations referred to the process wherein participants arranged and implemented (alone or in negotiation with their employers, clients and/or co-workers) the work accommodations they thought were necessary to return to work and sustain their ongoing recovery. Work hierarchies, and the power\textsuperscript{12} associated with them, were important factors influencing these work arrangements. For example, participants who were company executives (e.g., CEOs, company owners, directors) emphasized that they had the power to set work obligations in managing a graduated return to work. Humberto, a 61-year-old owner of a food processing company, shared, “I just told my directors that I was coming back and that they would still be responsible for much of my workload”. Similarly, Manuel, a 44-year-old franchise owner of four restaurants told his site managers that, “I would only work a few hours a day and leave because I couldn’t do more”. Evident in these examples was how some men could delegate duties to subordinates within their leadership roles. However, to efficiently making these changes, Carlos, a 56-year-oldclergyman, shared, “I asked my staff to tell me what to do because I didn’t know exactly what was going on”. Evident was how, despite having a leadership role, Carlos, as well as some other men, worked within their limitations to optimize outcomes at work.

Managers’ power to assign specific work duties was also evident. Julio, a 51-year-old mechanical engineer and manager who oversaw the design, testing and manufacture of custom-

\textsuperscript{12} Defined here as “one’s ability, or perceived ability to influence others” (Ragins & Winkel, 2011) and/or one’s work environment.
made equipment, shared that working in a company that had multiple specialized departments afforded an array of work roles which he could take up on returning to work. In this sense, Julio, who was unable to do the physically demanding tasks of his job post-surgery, explained:

*I couldn’t work in the (machining) shop. Luckily, the owner was looking to expand the business, but the person doing the marketing already had his plate full. I knew that several of my previous clients could refer new business to us, so I told the owner I could do some marketing and help out that way. That’s how I began to learn about promoting our company and incorporated marketing into my job description.*

Julio’s story highlighted two important issues. First, by aligning with his company’s business priorities, Julio strategically and opportunistically negotiated work obligations to accommodate his physical limitations. Second, the willingness to learn new tasks was key for helping Julio, and many other men, to find roles and responsibilities that facilitated their return to work. In this sense, readiness to lobby for and/or accept different work responsibilities was powerful in allowing some managers to strategically arrange accommodations for men’s graduated return to work.

Among non-managerial workers (i.e., participants who did not supervise other employees and whose work involved manual labour and/or constant physical exertion), a myriad of negotiations emerged in *re-setting work obligations*. Despite having the skills to effectively do their job, most of these men’s narratives were characterized by concerns about being perceived by their work-colleagues as letting the team down and/or not measuring up at work. As Augusto, a 67-year-old factory worker who was advised not to lift heavy objects by his surgeon, explained:
I didn’t want to tell anybody that I had to take it easy at work because my co-workers are younger and I don’t have a lot of seniority, which means that I cannot get them to do things for me unless my manager tells them to. And I don’t want my co-workers to be doing things for me because they will think that I can’t do my job.

Augusto’s account revealed his lack of power and heightened vulnerability in the workplace. Although Augusto communicated to his supervisor his limitations, he steadfastly concealed the discomfort an infected surgical wound caused him because, “I didn’t want my co-workers to think I needed special treatment”. As an older worker, Augusto was concerned that being seen as weak would fuel resentment from his co-workers. Indeed, a few men in similar situations were hesitant to request or under-requested return to work accommodations for fear of being perceived as a burden. Fernando, a 66-year-old tour bus driver who experienced post-surgical pelvic pain and was unable to drive long distances, shared:

I didn’t want to ask for a lot of concessions, because there are other guys that can do my job. I didn’t want to make it hard for them (employers) to keep me around [...] I told them (employers) I was willing to drive the shorter circuits in the smaller vehicles. I even settled with helping with small bags.

Exemplified in Augusto and Fernando’s stories were their alignment to masculine ideals around productivity and strategies for protecting one’s job and livelihood. Contrasted in these accounts were how some men without power at work could be challenged to negotiate accommodations and comfortably stay at work. However, for many men, particularly non-managerial workers,
their reduced work productivity and need for work accommodations were only temporary, a
position that was informed by their emergent recovery, as Fernando later added, “I’m confident
I’ll be back to where I was because I’m getting better”.

Self-employed participants comprised business owners who worked on their own (e.g.,
without co-workers and/or employees). Most of these men feared that their work limitations
would ultimately threaten the viability of their business. As Martín, a 69-year-old self-employed
contractor for the oil industry, explained:

_I’m lucky that I don’t have to report to anybody. But, also, I don’t have
anyone to help me. That’s why I have to be careful choosing the jobs I will
take and I have to be clear in telling my clients about what I can do and
when to have things done by. Then it is up to them to decide whether or not
they want to work with me._

Evidenced was Martín’s power to take ‘easier’ jobs. As Javier, a 68-year-old self-employed
carpenter who experienced lightheadedness, urinary incontinence and was unable to lift heavy
objects, explained, “you do what you’re good at and stick to that”. In line with company
executives, managers, and non-managerial worker sub-groups, self-employed men constantly
evaluated the limits of their labour and re-set work obligations in ways that allowed them to
gradually increase and/or resume full work obligations. In this regard, some self-employed men
recognized that improvements in their work capacity were provisional. Jorge, a 61-year-old
home inspector, explained:

_I was feeling stronger by the fifth or sixth week (after returning to work)
and I thought I could start inspecting larger properties. But I didn’t tell my
clients and decided to wait until I was totally certain that I could handle_
the work, because I didn’t want to set myself up for something I couldn’t do.

Exemplified in Jorge’s story was a cautious and prudent approach to re-setting work obligations, likely reflecting some philosophical (as well physical) shifts in his relationship to work.

In summary, participants’ efforts and success at re-setting work obligations were shaped by hierarchies - and the power wielded in their relationships with others at work, their readiness and willingness to adapt and accept ‘new’ work responsibilities, and resourcefulness in brokering a graduated return to work. Although diverse in how men re-set work obligations, it was evident that participants aligned with, and emphasized, masculine ideals of productivity and hard work in their ongoing commitment to fully resume work. In this regard, despite their post-prostatectomy limitations, most participants sought to position themselves as men who contributed to the workplace team effort by increasingly taking greater work responsibilities.

Chapter Summary

As seen in the above stories, Reformulating the Worker Identity began in the aftermath of radical prostatectomy wherein participants recognized their vulnerability throughout post-surgical convalescence and the need for assistance with activities of daily living (e.g., making meals, maintaining hygiene). However, the post-surgical convalescence period was also marked by the men’s adherence to masculine ideals in framing their reliance on others as temporary and the result of undergoing potentially life-saving surgery. Indeed, most men viewed and accepted such assistance as responsible and essential to optimize their recovery. While many men
experienced improvements in physical strength, urinary continence and stamina, most participants recognized that some radical prostatectomy side-effects could become long-term and/or permanent challenges.

Recognizing that surgical side-effects would impact their work capacity, many men conceded to adjusting their roles and responsibilities at work after radical prostatectomy. The ‘letting go’ of some previous work practices allowed many participants to take less regimented views of work. For other men, there were tensions around the job insecurity that accompanied such changes. Although medical advice prescribed the range of work tasks men could perform, it is also important to note that contexts including family needs and/or workplace characteristics (e.g., opportunities to perform different roles) impacted men’s ability to balance work and health, and find alternate ways to contribute.
Chapter 6
Discussion

Although previous studies have explored how masculinities are linked to men’s work (Batnitzky, McDowell, Dyer, & 2009; Bloksgaard, 2011; Saucedo & Morales, 2010) and men’s gendered experiences of prostate cancer (Gannon et al., 2010; Oliffe, 2005, 2006, 2009; Zaider et al., 2012), the current study findings address significant knowledge gaps by shedding light on the connections between masculinities, work and prostate cancer in the specific context of men who have undergone radical prostatectomy. Using a masculinities frame, the implications of the findings are discussed including their potential for informing interventions.

To foreground the discussion of the current study findings, an overview of Connell’s (2005) social constructionist masculinities framework is briefly re-visited. Masculinities comprise ideals and cultural norms regarding men’s behaviours, including those related to health and illness (Connell, 2005). In response to these masculine ideals, an array of performativities and practices emerge as context specific and relational (Connell, 2005). Within the masculinities and men’s health literature, masculine ideals have typically comprised characteristics including stoicism, self-reliance, and competitiveness along with power discourses wherein hegemonic masculinities are positioned atop masculine hierarchies dominating and wielding power over others (Connell & Messerschmidt, 2005). That said, men’s alignment to idealized masculinities are context dependent and subject to change. For example, while some men align with masculine ideals of stoicism and competitiveness at work (Rademacher & Kelly, 2016; Saucedo & Morales, 2010; Warren, 2016), they can also reconfigure masculine practices to show care and gentleness as they fulfill parenting and partner roles at home (Eerola & Mykkänen, 2013; Wall, 2014; Wall, Aboim, & Marinho, 2007). Related to the current study, men’s alignments to masculine ideals
and work emerged as deeply context-bound to prostate cancer and radical prostatectomy, events that provide direction in developing interventions for working men undergoing and recovering from treatment.

The significance of work in men’s lives

The study findings highlight the complex and diverse influences that work can have for men both before and following a diagnosis of prostate cancer and expand on current understandings of the significance of work in men’s lives proposed by others (Dahl et al., 2014; Grunfeld et al., 2013). In this regard, Elizur (1984; 1991) and Lyons, Higgins and Duxbury (2009) suggested that the value of work be explored by considering its outcomes in three distinctive domains. The first domain had to do with the instrumental outcomes of doing work such as pay, employer-sponsored benefits and the workplace resources men accessed. The second domain pertained to the affective outcomes of work and referred to the social relationships that are constructed between individuals and work-colleagues. The third domain was related to cognitive outcomes, including the psychological effects of work including a sense of achievement, responsibility and independence (Elizur, 1984; 1991; Lyons et al. 2009). The current study findings revealed participants’ work as significant in these three domains. For example, men’s accounts linking work with financial security, social status and connectedness, and a sense of personal growth and purpose confirmed the centrality of instrumental, affective and cognitive outcomes in their working lives. Furthermore, extending on Elizur (1984, 1991) and Lyons et al. (2009) findings, the current study results suggest that the connections between the instrumental, affective and cognitive outcomes of work were underpinned by masculine ideals wherein many men self-identified as experts and leaders in their respective jobs and industries, and were remunerated accordingly for their work proficiencies. In these contexts,
many participants’ masculine identities were tied to successful careers, accumulation of wealth, and recognition that they had successfully fulfilled provider roles for their families. These results are in line with Fideler’s (2014) findings that men over 60 often continue to work because they find fulfillment and meaning in using their abilities, skills and training in productive ways. At the same time it is noteworthy that some participants in the current study also acknowledged that work-related stressors threatened their health, a finding that supports previous research linking work to some men’s poor health outcomes (Demerouti, Bakker, Geurts, & Taris, 2009; van Hoof, Geurts, Kompier, & Taris, 2007). Indeed, for some men, the benefits of work were overshadowed by the negative consequences employment had on their wellbeing. In this sense, reduced work capacity due to illness was a significant burden for a few participants who, in order to sustain their employment, exerted themselves, potentially further depleting and perhaps jeopardizing their health. Similar results were detailed by Oliffe et al. (2013) who found that work-related stressors among some older Canadian men who experienced depression triggered and/or exacerbated depressive symptoms. Given the potential for work to challenge and/or benefit men’s health, the connections to masculinities should be understood as diverse, context dependent and subject to change. Indeed, the men in the current study aligned to varying degrees of masculine and work ideals in the absence of prostate cancer. For some men, their desire to work and ability to reap the benefits associated with work were somewhat fragile due to pre-existing illnesses and were exacerbated by the diagnosis of prostate cancer. In contrast, some participants’ successful careers offered strong masculine identity markers. These differences are important because they signal the plurality of masculinities in regards to men’s alignments to work and career ideals – ahead of being diagnosed with prostate cancer. Also evident was the centrality of work as a signifier of masculinity wherein its value as masculine capital was known well to all participants – regardless of their specific situation.
As Korpi (2001), Mitchell and Bates (2011), and Schur (2003) previously noted, illness-related reductions in work capacity can pose significant limitations in terms of keeping a job and/or securing career advancement. For some men in the current study, illness and injury-related reductions in productivity heightened their job insecurity and potentially threatened masculine ideals that were tied to worker identities and family provider roles. Indeed, a few men noted that the highly competitive nature of their jobs fueled distrust amongst co-workers and challenged their ability to maintain their masculine identities and hierarchical positions at work. Also evidenced in the current study was how financial needs, health and work-related demands were intertwined to shape participants’ linkages and commitment to work. Related to this, some men were subordinate to employers, directors and/or managers with reduced bargaining power to make illness-related work accommodations while others were relatively autonomous by virtue of being self-employed and/or in managerial positions. Indeed, the men’s pre-prostate cancer linkages to work and their alignments to work-related masculine ideals were tied to hierarchical work arrangements. Importantly, this study is amongst the first to demonstrate how men’s pre-prostate cancer linkages to work and their alignments to work-related masculine ideals provide rich contexts from which to ground and understand men’s prostate cancer and return to work experiences post radical prostatectomy.

**Masculinities and the impact of prostate cancer screening and diagnosis on men’s work**

In order to appreciate how screening and diagnosis of prostate cancer affected men and their work, the current study considered how gender and identity (Lohan, 2007; McVittie & Willock, 2006) shaped the contexts in which participants’ PSA testing took place. Related to this, Springer and Mouzon (2011) found in a study involving preventive practices among older men that, in seeking health services, men negotiate between conflicting masculine ideals of self-
reliance and invincibility versus taking responsibility for their own health. Springer and Mouzon (2011) also stressed that the decision to seek health services is further complicated when men are asymptomatic because they do not have an obvious or compelling reason to request and/or follow medical advice. The current study explored men’s experiences of PSA testing, and the findings support and extend Springer and Mauzon’s (2011) conclusions. Although men described their relative good health using terms associated with idealized physical characteristics synonyms with being “strong” and “fit”, many men visited their physicians regularly as part of their yearly health checkups. For these participants, scheduled medical visits were justified in recognition of their advancing age and increased susceptibility to illness or as a requirement of their employment. In this context, and despite most participants’ lack of urinary symptoms, the men accepted their physicians’ recommendations to undergo PSA testing to screen for prostate cancer as a routine and wise practice to detect disease in its early stages. That said, most men indicated that they had poor understandings about the implications of abnormal PSA test results. Participants often attributed their lack of understanding about the PSA test to the little information they received from their physician about prostate cancer screening and its positioning as being “just a blood test”. Similarly, Chapple, Ziebland, Hewitson and McPherson (2008) found that few men fully understood the implications of PSA testing because consultations with physicians are often rushed, limiting men’s ability to enquire about the advantages/disadvantages of the PSA test. Despite their lack of knowledge about the potential consequences of testing PSA levels, current study participants retrospectively described the PSA test in positive, action-oriented terms positioning it as key to making an early diagnosis of their prostate cancer. In linking these practices to masculinities and men’s health help-seeking, akin to the review findings by Galdas, Cheater and Marshall (2005), most men in the current study were strongly influenced by health care providers’ recommendations. As Oliffe (2009) pointed out
PSA screening attracts much debate – but the vast majority of men are unaware of those controversies or the potential implications of agreeing to have PSA testing.

In relation to work, the men framed their desire for privacy by pointing to the inconclusiveness of an elevated PSA and the lack of relevance to the work context as the primary reasons for not discussing the test with work-colleagues. Similarly, participants who experienced chronic illness were also reticent to disclose details to work-colleagues or clients. Hearn’s (1992) public and private masculinities frame provides a useful perspective for interpreting these practices, wherein health and potential health threats are often compartmentalized by men as private issues, separate from public work performances. In this sense, participants did not discuss their health concerns at work, and by extension they avoided being seen as vulnerable or weak while privately recognizing the possibility of being diagnosed with prostate cancer. Internalizing problems and denying vulnerabilities have long been described as masculine ideals which men align to in order to portray strength, self-reliance and emotional control (Connell, 2005; Connell & Messerschmidt, 2005). Moreover, men’s competiveness has been touted as preventing them from revealing weakness (Möller-Leimkühler, 2002; O’Brien, Hunt, & Hart, 2005), particularly within the work environment (Verdonk, Seesing, & de Rijk, 2010). Within these contexts, most participants embodied masculine ideals in working as they usually did, rationalizing that disclosure of having a PSA test could unnecessarily expose potential vulnerabilities and perhaps cause undue panic to co-workers, employers and/or clients.

Findings around the diagnosis of prostate cancer also provided important insights to the challenges it posed to participants’ roles as workers and providers. Previous research has suggested that men try to adjust to the physical, psychological and social consequences that arise from being diagnosed with prostate cancer while attempting to preserve a sense of their masculine self (Gray et al., 2002; Grunfeld et al., 2013; Kelly, 2009). Extending previous
research, the current study findings indicated that being diagnosed with prostate cancer served as a catalyst for many participants to re-evaluate what was most important to them in life. Indeed, in light of their prostate cancer diagnosis, work, which had been central to many men’s masculine identities, was de-prioritized amid efforts to optimize their health and strengthen family relations. Within these changes, emergent were some men’s re-evaluations of career, finances and retirement plans. For example, participants who were financially secure contemplated working less and/or retiring earlier than they had originally planned due to their fears that prostate cancer might shorten their life or erode their current quality of life. Certainly, the diagnosis of prostate cancer prompted and hastened such considerations for many men wherein self-care and quality time with family were linked to masculine ideals including rationality, and problem solving focused on fighting their prostate cancer, amid optimizing self-health and family protector roles. These results align with Jonsson, Aus and Berterö’s (2009) findings suggesting that the diagnosis of prostate cancer is a powerful reminder of men’s fragility and limited control over life. In this sense, Jonsson et al. (2009) argued, uncertainty and thoughts about mortality triggered a process of psychosocial adaptation wherein men re-configured their ideals about existence, life goals, and roles and relationships with others. Thus, despite being depicted as a disease that is unlikely to cause death in most men (CTFPHC, 2014; Government of British Columbia, 2017a), the diagnosis of prostate cancer was a major event that significantly re-shaped the current study participants’ life-priorities, and relationships to work and family.

Of course, the ease of such transitions varied amongst participants. For example, men who had financial challenges and/or unmet career goals tended to link their efforts to optimizing their health and overcoming prostate cancer as a means to ensuring their capacity for and return to work. For these men, financial needs and work-related obligations provided an important contextual backdrop that shaped how they viewed themselves as men and made decisions around
their prostate cancer treatment. In this regard, Fidelers’s (2010) assertion that men view generating income as central to their identity was evident in some participants. Indeed, it might be reasonably argued that these participants, by virtue of having fewer financial resources, focused on eradicating prostate cancer to resume their worker roles rather than reconfiguring their linkages to family and work. These varying alignments to masculine ideals are important considerations, especially in light of the increasing number of Canadian men expecting, and in many cases, needing to work past age 65 (MacEwen, 2012; Sun Life Canadian Unretirement Index, 2015).

**Considerations around treatment decision making**

Robertson’s (2006) work on masculinities and men’s health practices offers a useful frame to interpret the reasons why participants in the current study decided on radical prostatectomy. According to Robertson (2006), life-course events such as becoming a father and/or being responsible for the welfare of others changes the way men think about health and health-related practices. These changes are underpinned by two key moral elements. The first, Robertson (2006) argued, is “rule based” wherein men frame making health-conscious decisions as a duty and/or responsibility to others. The second is related to the positive outcomes of doing health; that is, men are driven to make healthy choices by their desire to enjoy life free of illness (Robertson, 2006). In the current study, although participants were primarily driven to treat prostate cancer to avoid death, many men also rationalized treatment as doing the ‘right’ thing for the benefit of others. Many participants linked their longevity to family benefits and positioned their commitment to treatment – and by extension ‘beating’ prostate cancer - as a masculine virtue deeply tied to breadwinner and protector roles. In this sense, the potential impact of treatment side effects on men’s erectile function and urinary continence were
dismissed in triaging a commitment to curative treatment. Building on Robertson’s (2006) second point, it was also evident that participants, by choosing radical prostatectomy, hoped that their prostate cancer could be eradicated quickly, and with that clean bill of health they could resume life and work.

Having to choose a prostate cancer treatment enabled many participants to position themselves as active agents in the treatment decision-making processes. In this regard, Greenhaus and Powell (2006) previously asserted that skills, values and knowledge gained through work are often used by individuals to frame, assess and plan interventions to solve problems encountered outside of the workplace. Similarly, many participants in the current study relied on familiar, work-related strategies (e.g., examining options, planning interventions) to systematically determine the treatment option that best suited them. Likewise, interactions with health care providers were often described in professional terms (e.g., focused on solving problems, succinct and limited to exchanging facts), wherein participants thoughtfully considered physicians’ expert knowledge and recommendations in making their treatment decisions. These current study results confirm findings by Oliffe and Thorne (2007) while expanding on the work of Gray et al. (2002) who reported that work-related experiences shaped how men managed prostate cancer. Specifically, Gray et al. (2002) explained that men apply administrative and supervisory skills used at work to make treatment-related decisions (e.g., evaluating the benefits of specific treatments, switching health care providers, deciding on the purchase of health services). Similarly, some participants in the current study requested second opinions and consulted with different specialists, while others connected with other men who had been treated for prostate cancer to learn about and evaluate potential prostate cancer treatments. Despite the changes to work over the last 15 years in Canada (Ontario Ministry of Labour, 2016; Policy Horizons Canada, 2016), the current study results are similar to Gray’s et al. (2002)
findings in that many men who experience prostate cancer actively and effectively use work-
related skills to: 1) engage health care providers, 2) find and evaluate information about prostate
cancer, and 3) plan health-related interventions.

The current study findings around choosing radical prostatectomy should be also
understood in the context of the participants’ diagnosis of organ-confined prostate cancer, a
pathology that is typically treated either through radical prostatectomy or radiation therapy.
While most men knew that neither treatment was superior in curing prostate cancer, they
understood that prostate cancer recurrence was possible and gave preference to the treatment
option that offered, in their opinion, the greatest chances of being prostate cancer free. In this
regard, two primary reasons drove men’s preference for radical prostatectomy. The first reason
related to the men’s preference for physically removing the cancer-containing prostate gland. For
most men, removing prostate cancer from their bodies was viewed as essential to achieve cure,
avoid metastases and/or prostate cancer recurrence. This finding confirms previous studies’
reports that physical removal of prostate cancer was an important factor in men’s decision to
undergo radical prostatectomy (Anandadas et al., 2010; Sidana et al., 2012) with Hall, Boyd,
Lippert and Theodorescu (2003) suggesting that the certainty of having removed prostate cancer
from the body likely offers additional psychological benefits to men. In line with these findings,
most participants in the current study drew on the aforementioned beliefs in deciding on radical
prostatectomy. The second reason had to do with the options available for treating prostate
cancer recurrence post-prostatectomy. Currently, while radiation therapy is often recommended
to treat prostate cancer recurrence after radical prostatectomy, radical prostatectomy after
radiation therapy is complicated and rarely recommended (Kirby, 2014; Prostate Cancer
Foundation, 2017b). In this regard, despite being less invasive and having fewer immediate side-
effects than radical prostatectomy, most men were influenced by the idea of reserving radiation
therapy to treat a potential recurrence of prostate cancer. Threaded throughout the findings around choosing radical prostatectomy were participants’ alignment to masculine ideals of rationality and decisiveness. Thus, despite some men’s sense of urgency to be treated to reduce their vulnerability to prostate cancer spread, most participants’ accounts offered rich descriptions of rationally considering input to treatment decision processes. Indeed, many participants framed their decision to choose radical prostatectomy as being the product of significant research, exhaustively considering the various treatment options and their potential impact on health, work and income. Noticeably absent from the men’s accounts were details about the emotions that accompanied making such decisions. While debate on the role and significance of emotions on masculinities suggests that men are increasingly willing to talk about emotions (de Boise & Hearn, 2017; Elliott, 2016), the current study findings indicated alignments to more traditional masculine ideals of stoicism and emotional restraint. Although participants’ narratives were retrospective and provided after undergoing radical prostatectomy, clearly evident was the emphasis they placed on showing rationality and decisiveness in their treatment decision making. In this respect, central to the men’s accounts about deciding on radical prostatectomy was their orientation to take action by treating – and ideally eradicating – prostate cancer.

Many participants considered radical prostatectomy as a treatment that could extend their lives and increase their working years, which was central to their ability to continue to provide for their families. However, the narratives highlighted marked differences in how participants made sick leave arrangements for radical prostatectomy that has not previously been described in the Canadian context. For instance, self-employed men, by virtue of having no direct report line to a manager, often chose to avoid self-disclosures about their impending radical prostatectomy with clients. Instead, these participants re-scheduled clients without making reference to having prostate cancer. Central to self-employed men’s decision for this was their fear of losing clients
who might equate prostate cancer as limiting their ability and/or reliability to provide labour. These results support Stergiou-Kita, Pritlove and Kirsh’s (2016) findings suggesting that working men diagnosed with a range of different cancers are often perceived by their employers as less capable of doing work. However, current study participants who were employees and/or who had to request sick leave through a human resources department, often recounted having to disclose their diagnosis of prostate cancer as a justification for their extended absence and claims for workplace-sponsored insurance benefits. Of course, within this context, the men’s direct report line may not have been fully aware of some men’s prostate cancer specifically. The rights to privacy in this regard likely limited discussions about and planning for some participants’ return to work.

In summary, the men in the current study showed diversity in their alignments to masculine ideals wherein some participants acknowledged prostate cancer related vulnerabilities while others reported decisiveness in choosing radical prostatectomy to treat their prostate cancer. It is fair to say that work concerns did not feature prominently in the treatment decision making of the current study participants. Indeed, the primary concern for the men was to treat the prostate cancer. This finding is reminiscent of men’s willingness to prioritize prostate cancer treatment above potential treatment side effects including erectile dysfunction and urinary incontinence (Oliffe, 2005). Such prioritization about treatment is also entirely reasonable in the context of work; however few men anticipated significant issues round returning to work post radical prostatectomy.
In foregrounding participants’ linkages to work and the events leading up to radical prostatectomy, an array of interconnections with masculinities were evident in setting the scene for the grounded theory findings reported in Chapter 5. Specifically, evidenced was a plurality of masculinities across the men’s interviews. For example, although work was linked to men’s masculine identities making available provider and protector roles, the masculine capital yielded from the men’s work varied as did the extent to which participants were invested in their jobs and careers. However, shared across the men’s accounts was a desire to work – driven by factors ranging from a love of their job to financial necessity. For some participants, their claim on work had been eroded to some extent by pre-existing illness, and in this regard a prostate cancer diagnosis added to their ill health and the challenges in sustaining work activities. For other ‘healthy’ men, the diagnosis of prostate cancer and a commitment to treating it with radical prostatectomy interrupted their work, while for many participants this also marked a re-evaluation of what was most important in their lives – typically a focus on health and family amid easing their commitment to work and/or career.

The grounded theory, Reformulating the Worker Identity(Figure 4.Reformulating the Worker Identity, re-introduced in the following page) is an important new contribution to the field of masculinities in relation to men’s experiences of prostate cancer. The theory is supported by the data collected in this study, and extends previous research to fill key knowledge gaps. The findings offered also serve as basis to inform psychosocial prostate cancer services and employers as a means to supporting men with the work transitions that permeate the post radical prostatectomy period.
Reformulating the Worker Identity

Recovering after radical prostatectomy
- Embodying the sick role
- Contesting side-effects
- Conceding new realities

Re-negotiating work expectations
- Assessing work capacity
- Re-balancing work and health
- Re-setting work obligations

Figure 4. Reformulating the Worker Identity
As a starting point, the basic social process of *Reformulating the Worker Identity* describes men’s experiences in the period after radical prostatectomy and the processes detailed by the men about recovering from radical prostatectomy and re-negotiating work expectations. It was evident that while a prostate cancer diagnosis and treatment decision drew men’s attention away from work, the period following surgery was characterized by a strong focus on returning to work. This finding is important because it suggests that work related concerns emerge almost entirely in the aftermath of radical prostatectomy.

Most men had expected to return to work within a month or two of their surgery, and assumed that they would resume their pre-treatment duties. However, without exception, participants learnt soon after their surgery that their relationship to work – and by extension their worker identity - had changed significantly. Central to *Reformulating the Worker Identity* in this regard was participants’ recognition that their bodies and views about work had changed in ways that they had not anticipated. As middle aged and older men, these changes brought into question the men’s capacity and resolve for not only recovering from the surgery but also returning fully to work. While these findings are supported by previous research suggesting that men’s responses to prostate cancer diagnosis and treatment often involve an altered sense of self (Cayless, Furhat, Illingworth, Hubbard, & Kearney, 2010; Gannon et al., 2010; Maliski et al., 2008), the current study adds and expands on previous understandings about identity changes post-prostatectomy. The current study results provide valuable insights to how men’s worker identities are shaped by the implications of prostate cancer diagnosis and radical prostatectomy on health, income earning capacity, family wellbeing, and work-related plans. Furthermore, while previous research has explained how masculine identities are re-conceptualized after prostate cancer treatment(s) (Bokhour et al., 2007; Cayless et al., 2010; Gannon et al., 2010; Kelly, 2009, Maliski et al., 2008), the current study findings provide important descriptions
about the saliency of work post-prostatectomy and its intricate connections with men’s identities. In this regard, Reformulating the Worker Identity was found to facilitate men’s efforts at restoring what they perceived to be their ‘rightful’ roles and relationships at home, workplace and community.

Recovering after radical prostatectomy

Recovering after radical prostatectomy included three processes men engaged to recover from surgery wherein they focused on re-gaining the physical strength and stamina to resume their daily activities, including returning to work: 1. Embodying the sick role; 2. Contesting side-effects, and; 3. Conceding new realities.

Embodying the sick role

Much of the masculinities and men’s health literature asserts that illness, disease and visible disability invoke weakness on the men who embody such deficits, marginalizing and subordinating them within masculine hierarchies (Emslie & Hunt, 2009; O’Brien, Hart, & Hunt, 2007; O’Brien et al., 2005; Solimeo, 2011). Rebuttal to being seen as weak, however, tends to draw on masculine ideals that require men to show resilience and self-reliance toward overcoming such ‘health’ challenges (Emslie & Hunt, 2009; McVittie & Willock, 2006; Oliffe, Galdas, Han, & Kelly, 2013). In the current study this played out through men’s embodiment of the sick role wherein they situated their need to rely on others as temporary and connected to the physical side effects of their surgery. While Fergus (2011) and Petry et al. (2004) reported that men depend greatly on their caregivers during the early stages of post-prostatectomy recovery,
the current study highlighted the transient nature of these arrangements along with participants’ justifications that their need to rest was directed by health care professionals and integral to allowing men the time they needed for their bodies to heal. In this context, men rejected suggestions of disability and/or deficit, and maintained a resolve to fully recover their independence. Recognizing their post-surgical vulnerabilities, participants highlighted the crucial support roles caregivers played in aiding their recovery process. These results echo findings by Queenan, Feldman-Stewart, Brundage and Groome (2010) who reported that tangible help with daily tasks as well as the provision of emotional support during recovery from prostate cancer treatment improved men’s health-related quality of life. Building on this, the current study findings also reveal spouses as protective and guiding, and in some cases leading the men’s efforts for ensuring their recovery.

**Contesting side-effects**

As the sick role diminished with post-surgical improvements, the men’s reliance on others dissipated. Milne, Spiers and Moore (2008) asserted that men’s desire to regain control over their daily lives was crucial toward reclaiming a sense of their masculine-self after radical prostatectomy. In the current study, participants similarly sought to regain control, by gradually declining assistance whenever possible and increasingly resuming their pre-surgical domestic responsibilities (e.g., doing the dishes). While much of the media idealizes men’s fight against prostate cancer as action oriented (Halpin, Phillips & Oliffe, 2009), within the specific context of the period immediate post radical prostatectomy, participants were also aware of their limitations and avoided over-exertion to diminish the potential for pain and injury in fostering their full recovery from surgery. Yet, clearly, tensions arose wherein men grappled with rest and its
implications for dependence versus embodying the masculine ideals of actively working toward
their recovery and return to work.

From the gradual resumption of domestic work grew men’s efforts to contest emergent
post radical prostatectomy side effects. As Iyigun, Ayhan and Tastan (2011), Milne et al. (2008)
and O’Shaughnessy and Law (2009) reported, men are often unprepared and/or overwhelmed by
the experience of radical prostatectomy and its side-effects. Although participants in the current
study positioned their experience of radical prostatectomy side-effects as somewhat expected
surgical outcomes, the men were also concerned about the severity of the changes and the
potential that side-effects would become long-term issues that could negatively impact their
ability to fulfill family and work responsibilities. Within this context, participants engaged in
contesting side-effects, a process wherein men focused their efforts on reducing the severity and
impact of two side-effects - fatigue and urinary incontinence. While the side effect of fatigue has
been described in men receiving androgen deprivation therapy (Bourke et al., 2012; Grunfeld,
Halliday, Martin, & Drudge-Coates, 2012; Joly et al., 2006; Keogh & Patel, 2014; Oliffe, 2006;
Wright-St Clair, Malcolm, & Keogh, 2014), little is known about the impact of men’s fatigue
post-prostatectomy (Köhler et al., 2014; Langston, Armes, Levy, & Ream, 2013). The current
study findings suggest participants’ post-prostatectomy fatigue is a significant barrier to men’s
ability to engage in domestic activities, potentially impacting their return to work. However,
overcoming fatigue drew significant effort from the participants. As Connell (2005) suggested,
masculinities are enacted wherein gender is actively and contextually practiced. In this regard,
fatigue threatened the men’s work capacity, and was, for many participants, an unexpected
challenge. In response, the men highlighted their commitment to actively working toward
overcoming their fatigue and reduced activity. Related to this, Hodge, Itty, Cadogan, Martinez
and Pham (2016) found that men who experience cancer-related fatigue fear being stigmatized as
being lazy and reliant on others for their daily necessities. In countering fatigue-related stigma, Hodge et al. (2016) reported that many men, regardless of the primary cancer site, were often compelled to boost energy levels through various strategies that included taking dietary supplements, self-motivation and physical exercise. In the context of prostate cancer, exercise has been found to decrease fatigue, and improve mental and social wellbeing in men treated with androgen deprivation therapy for prostate cancer (Cormie, et al., 2015a). Related to this, Ricciardelli, Clow and White (2010) contended that exercise serves as a conduit to attaining masculine ideals of physical fitness, strength and muscularity in men. Similarly, Cormie, Turner, Kaczmarek, Drake and Chambers (2015b), suggested that engaging in physical exercise was a masculine value especially appealing to the health promotion efforts of men who have prostate cancer. In line with the aforementioned work, the current study also found that many men attributed a reduction in their fatigue levels to increasing their physical exercise. Linked to this, were men’s efforts to put mind over matter in willing themselves to exercise as a means to counter fatigue. Akin to Robertson (2006), who suggested that men often engage in health promoting practices for the benefit of others, especially family, participants in the current study suggested that they worked through their fatigue with physical exercise as a means to regaining energy and strength to help others in the domestic sphere by being less dependent. Building on the work of Cormie et al. (2015b), masculine values around being physically active and affording service to others were potent drivers of men’s efforts to overcome fatigue along with men’s aspirations for returning to work.

Also of significant concern to many men was the side effect of urinary incontinence post prostatectomy. Urinary incontinence is experienced by many men as embarrassing with strong linkages to poor hygiene, lack of self-control, incompetence, helplessness and ageing (Elstad, Taubenberger, Botelho, & Tennstedt, 2010; Mitteness & Barker, 1995; Molinuevo & Batista-
Miranda, 2012). Previous research reported that prostatectomy-induced urinary incontinence challenges men’s ability to demonstrate control over their bodies and threatened their self-concepts as adult men (Chapple & Ziebland, 2002; Iyigun, Ayhan, & Tastan, 2011). In the current study, participants’ accounts pointed to urinary incontinence as a major cause of embarrassment and shame after surgery. Specifically, participants feared any involuntary leakage of urine in public would be visible and associated with disability. As a strategy, participants tended to avoid social activities and preferred to stoically manage their urinary incontinence privately. In terms of work, little is understood about connections between radical prostatectomy-induced urinary incontinence, masculinities and men’s efforts for returning to work. However, the current study findings suggest that participants viewed urinary incontinence and the stigma associated with it as major threats to their return to work. While much of the research regarding prostatectomy side-effects and masculinities has focused on sexual dysfunction (Gannon et al., 2010; Hedestig et al., 2005; Kelly, 2009; Nelson, Scardino, Eastham, & Mulhall, 2013; O’Brien et al., 2011; Oliffe, 2005, 2009; O’Shaugnessy & Laws, 2009), it was clear urinary incontinence was a significant concern and barrier to returning to work. Implicit in many participants’ accounts was how bladder control was intricately connected with socially constructed views on professionalism and work competence. Indeed, many men noted that regaining bladder control was crucial to maintaining relationships with co-workers and/or clients as well as retaking a full workload. Kelly’s (2009) argument that recovery of physical function after prostate cancer treatment is central in men’s ability to re-align with conventional standards of masculinities resonated to some extent with the current study findings around the men contesting urinary incontinence. In this regard, participants who regained bladder control reported that they were much relieved and confident of returning to work. Those with persistent urinary incontinence, however, gauged negatively their potential to return fully, or to sustain work.
In summary, radical prostatectomy resulted in side effects that shaped how men functioned in their day-to-day lives and planned their return to work. The current study findings suggest that, prompted by radical prostatectomy-related fatigue and/or urinary incontinence, men drew from an array of masculine ideals to counter their fatigue while privately dealing with, and where necessary concealing, any sign of urinary incontinence. Evident here is the importance of discussing fatigue and urinary incontinence as significant issues after radical prostatectomy, which in turn can delay and threaten men’s return to work. As Brenner, Brenner and Horowitz (2009) and White, Keller and Horrigan (2003) suggested, telling patients about side effect prevalence percentages as a means to claiming informed consent does not provide enough context, especially in light of the fact that many men automatically anticipate being in the unaffected cohort – or diminish the significance of such issues in triaging the removal of their prostate gland in eradicating the prostate cancer. The connectedness and potential effects of fatigue and urinary incontinence for men’s work capacity were also unexpected and/or underestimated by most participants.

Conceding new realities

Radical prostatectomy not only changed men’s bodies, its side-effects also restricted what they could and could not do on a daily basis; thus, affecting their personal, social and professional lives. Related to this, Bokhour et al. (2007), Hedestig et al. (2005) and Kelly (2009) argued that an important aspect of life after radical prostatectomy is to accept the consequences of prostate cancer and surgery. Hedestig et al. (2005) contended that such acceptance occurs via three strategies. The first, Hedestig et al. (2005) explained, required that men “live in the present” by acknowledging their current life circumstances as men who were diagnosed with prostate cancer and underwent radical prostatectomy. The second strategy included framing
radical prostatectomy as necessary to achieve cure. The third strategy required that men pursue
the things and/or activities that would improve their quality of life. In the current study,
participants acknowledged that their lives were changed by radical prostatectomy. Specifically,
many participants understood that their lives were now shaped by concerns around prostate
cancer and recognized that some prostatectomy-related changes could become permanent.
Consequently, the men feared that their quality of life might not be fully restored. Yet, despite
experiencing surgical side-effects and the lifestyle changes that resulted from them, participants
refuted any decisional regret about undergoing radical prostatectomy. Furthermore, the men were
convinced that their chances of achieving cure and prolonging life were optimized by the
surgery. Within this context, participants conceded new realities wherein they accepted the idea
of having to adjust to the longer term consequences of prostate cancer and surgical side-effects.
However, *conceding new realities* also entailed acknowledging that strategies were needed to
regain and/or improve quality of life post-prostatectomy. For some men, this meant engaging in
new activities to strengthen family relations (e.g., spending more time with family) while, for
others, it involved finding new ways of appreciating and/or enjoying life (e.g., pursuing hobbies).

With regards to work, Grunfeld et al. (2013) found that the side-effects of prostate cancer
treatment (with either or a combination of surgery, radiotherapy, androgen deprivation therapy
and/or chemotherapy) resulted in men’s lost confidence about their ability to return to their
former work-roles. Results from the current study expand Grunfeld’s et al. (2013) findings by
providing details on how *conceding new realities* after radical prostatectomy shaped men’s views
and decisions around returning to work. Although surgical side-effects were accepted as trade-
offs much preferred to mortality, current study participants also acknowledged that side-effects
represented significant challenges on their work and income generating capacity. In this regard,
concerns about sustaining pre-surgical levels of productivity drove men’s efforts to creatively
and strategically think of different ways to increase their competitive edge in the workplace. For many participants, this meant negotiating or making adjustments to how, as well as what, work was to be done.

In terms of masculinities, Zaider et al. (2012) contended that prostate cancer and its treatment side-effects often leads to the disruption of men’s masculine identities. Recognizing that masculinities are constantly practiced and much contested (Connell, 2005), Gannon et al. (2010) argued that men draw from alternate valued ideals around masculinities such as restraint and stoicism to re-construct their masculine identities after radical prostatectomy. In the current study, participants’ accounts suggested conceding new realities, while privately dealing with those changes – especially in the context of returning to work. Included was the retaking of some responsibilities and roles that they had before surgery. Similarly, Bokhour et al. (2007) and Walsh and Hegarty (2010) found that, although concessions to new realities were made due to post-prostatectomy side-effects, men reaffirmed their masculine identity by restoring pre-surgical responsibilities and relationships. In the specific context of work, this might be understood as a desire to return to work to re-establish purpose and routine as well as monetary earnings. While this enterprise might be aligned to masculine ideals and financial gain, most men revealed a concerted effort based on their need to reclaim familiar territories and routines amid all the changes that had occurred with a prostate cancer diagnosis and radical prostatectomy.

Re-negotiating work expectations

Participants renegotiated work expectations directly with employers or by themselves in making a graduated return to work. Although previous research by Bradley et al. (2005, 2006)
and Dahl et al. (2014) provide important insights on the prevalence of employment and return to work after prostate cancer treatment, little is known about the processes involved in re-negotiating work expectations after radical prostatectomy. The current study findings highlighted three processes underpinning re-negotiating work expectations; 1) Assessing work capacity, 2) Re-balancing work and health needs, and 3) Re-setting work obligations.

**Assessing work capacity**

Previous research by Bradley et al. (2005, 2006), Dahl et al. (2014) and Grunfeld et al. (2013) have found that radical prostatectomy significantly impacts and/or reduces men’s work capacity. Similarly, current study participants recounted that their experience of radical prostatectomy side-effects affected not only their ability to do day-to-day activities, but also restricted their capacity to work. In this regard, participants engaged in processes for assessing their work capacity wherein work tasks were itemized in terms of what the men could and could not do upon returning to work. These assessments were essential to making work flow decisions and requesting workplace accommodations to ensure participants’ productivity and ongoing recovery. One important factor that shaped men’s assessments of work capacity was related to who they reported to at work. For example, self-employed participants, by virtue of being their own boss, were fairly autonomous in reducing their workloads and were, therefore, able to work conservatively and gradually retake a full workload as a means to avoiding overexertion and injury. In contrast, men who were employees were often concerned that their employers and co-workers might label them unproductive in requesting or informally relying on such accommodations. Recognizing that their reduced work capacity might burden others, some participants looked to contribute in alternative ways in line with their reduced capabilities while clearly wanting to support their co-workers’ productivity. In this context, although
competitiveness is often positioned by men as a valued ideal in the workplace and in society (Verdonk et al., 2010), many participants in the current study chose to support their co-workers’ productivity and framed these contributions as fulfilling noble and altruistic masculine ideals. In this sense, some men suggested that teamwork was a masculine value to which they could contribute at work even with their diminished capacity. Related to this, Bradley et al. (2005) argued men’s decision to return to work may also depend on whether or not there are opportunities for men to work in less demanding activities. Similarly, the current study participants’ uptake of less rigorous or full time work depended on the job opportunities available and on their employers’ willingness to offer work accommodations. For most employees, communication with employers ahead of their return to work was necessary to pre-empt potential work limitations, jointly identifying and negotiating alternate work responsibilities, and to initiate return to work arrangements. Besides sharing their expected work capacities upon returning to work, participants often emphasized in these communications that their tolerance to physical activities would likely improve and that they expected to recover full work capacity. The men’s willingness to concede their reduced work capacity while expressing their readiness to return to work offered an interesting juxtaposition in terms of masculine ideals. For example, participants who were employees disclosed their needs for special consideration amid offering assurances that these accommodations would be short-term. Vulnerability in this respect was countered with assertions that they would regain their previous work capacity. These results somewhat align with Grunfeld’s et al. (2013) findings suggesting that some men refute health concerns and treatment side-effects with work-colleagues. In this context, the men in the current study focused on their graduated return to work and likelihood they would increase their workload over time as their recovery was fully realized.
Although previous research suggests that men treated for prostate cancer tend to work fewer hours than individuals who do not have cancer (Bradley, Neumark, Luo, & Schenk, 2007; Dahl et al., 2014), Grunfeld et al. (2013) contended that prostate cancer survivors seek opportunities to increase their workload as they continue to recover post-prostatectomy. Similarly, the current study found that men actively sought ways to increase their workload. Key to these efforts were men’s ongoing assessments of work capacity after their return to work, which facilitated re-adjustments and re-arrangements of work responsibilities to match their increasing work capacity. In this regard, although many participants recounted difficulties in fully restoring their worker identities due to the experience of side-effects, the men also shared that ongoing assessments of work capacity allowed them to reconstruct their worker identities as dedicated to fully recovering their work capacity. This was important for participants as they sought to move past prostate cancer and radical prostatectomy and return to a pre-surgical way of life, which included retaking breadwinner roles.

Current study findings suggest that social interactions in the workplace are an intricate part of men’s work. In this sense, the public nature of men’s performances of work draws appraisals and critique from others. Clients, co-workers, subordinates and bosses maintain and express, to varying degrees, evaluations of men’s workplace efforts. In the context of the current study, employees sought concessions for workplace accommodations by pre-empting their diminished work capacity with their bosses. Permeating this process were masculine ideals about being forthright and honest about their need for accommodations. Although often signalled prior to returning to work, requests for accommodations were also ongoing once the men returned to work. For some men, their jobs afforded flexibility and autonomy in this respect. However, it is important to note that some men, including some who ‘worked for themselves’, concealed their
hardships in this regard, and to varying degrees felt compelled to privately address their challenges and evaluate the feasibility of realizing and/or sustaining their full return to work.

Re-balancing work and health

The significance of radical prostatectomy and the impact of its side-effects on participants’ lives provided strong reasons for men to reconsider the importance of their relationships with work. Dolan (2011) contended that notions about, and the relationships between masculinities, work and health are context dependent and, therefore, constantly changing. Related to this, there is a vast body of research suggesting that the experience of prostate cancer diagnosis and its treatment side-effects often change men’s masculine identities and invoke a re-evaluation of life-and-health related goals (Gannon et al., 2010; Kelly, 2009; O’Brien et al., 2007; Wall & Kristjanson, 2005; Walsh & Hegarty, 2010). However, little is known about the impact of prostate cancer and its treatment consequences on men’s work-related decisions (Grunfeld et al., 2013). With regards to the current study, prostate cancer and radical prostatectomy side-effects challenged participants’ masculine identities and sparked the re-balancing of work and health priorities in their lives. While previous research across various cancer populations suggested that the diagnosis of cancer alters how individuals view and value work (Fantoni et al., 2010; Lilliehorn, Hamberg, Kero, & Salander, 2013; Main, Nowels, Cavender, Etschmaier, & Steiner, 2005), Wells et al. (2013) found that the importance of work tends to diminish in relation to family and personal pursuits after cancer treatment. Similarly, current study participants engaged in a process of re-balancing work and health wherein, recognizing their vulnerability to illness - and potentially prostate cancer recurrence or death, many men explicitly prioritized improving health and enhancing quality of life over career advancement and/or financial gain. These results suggest participants did not reject work as an
important activity in their lives. Instead, most men emphasized their need to be well and able to work without forgoing their health. Also evidenced were differences between subgroups of men. For instance, while many men could live comfortably working less and/or independently of having to work, some participants framed work and the masculine ideals surrounding it as being important post-prostatectomy - particularly when they believed that their family relied on the men’s ability to continue to labour. However, despite differences in the purchase participants had on work, notions of self-preservation emerged as being central in the men’s lives post-prostatectomy and prompted them to prioritize their health over work responsibilities. These results are important in helping contextualize Bradley’s et al. (2005, 2006) and Dahl’s et al. (2015) survey study findings indicating that men often reduce work hours and/or change occupations after prostate cancer treatment.

Current study findings around re-balancing work and health highlighted participants’ pressures toward setting realistic goals around work and how this served as a foundation from which men re-delineated their career plans after radical prostatectomy. These findings add to previous research suggesting that making work-related decisions after prostate cancer and treatment is a complex process that takes into consideration various issues central to men’s lives (Bradley et al., 2005; Dahl et al., 2014; Grunfeld et al., 2013). For example, Bradley et al. (2005) and Dahl et al. (2014) concluded that financial need is a fundamental factor that influences men’s views about work after prostate cancer treatment, and is associated with their return to work. On the other hand, Grunfeld et al. (2013) contended that thoughts about prostate cancer mortality can trigger men to change their work behaviours, often leading to a reduction of working hours and pursue a more leisurely lifestyle. For current study participants, financial status along with health and family contexts were intricately connected and shaped men’s decisions about work after radical prostatectomy. In this regard, participants who disclosed having few or no financial
concerns tended to play down the importance of work and income-earning in their lives. For these men, work was perceived as an activity that often competed directly with their efforts at preserving health and improving wellbeing. Thus framed, many participants considered that a potential reduction of work activities (i.e., working fewer hours) was necessary to enhance their quality of life and strengthen family bonds. In contrast, the narratives of participants who experienced financial hardship were characterized by descriptions of the importance of returning to work, meeting financial responsibilities, and providing for their families. However, similar to the wealthier participants, men who experienced monetary worries were keenly aware of the detrimental consequences of excessive and/or demanding work on their physical and mental health opting, where possible, to labour under conditions that did not threaten their ongoing recovery.

Implicit in many men’s narratives was their alignment with masculine ideals of autonomy and self-determination in re-balancing work and health. In this context, although health-conscious practices are socially constructed to be unmasculine behaviours (Connell, 2005), the current study participants framed their increased attention to maintaining and enhancing health as a deliberate decision to preserve their capacity to protect and provide for their families. Indeed, prioritizing health was viewed by many men as reflecting their wisdom and autonomy, and was underpinned by a sense of responsibility towards themselves and others.

Re-setting work obligations

Although most men had returned to work by the sixth week post-prostatectomy, they also acknowledged that ongoing residual side-effects (e.g., urinary incontinence, surgical wound tenderness) somewhat limited their work performance. In this regard, most participants justified their need to re-set work obligations prior to retaking work responsibilities. However, little is
known about the ways in which men recovering from radical prostatectomy re-set work obligations. What is known, is that self-employed cancer patients are more likely to obtain the work accommodations that they need post-cancer treatment than individuals who are employees (Torp, Syse, Paraponaris, & Gudbergsson, 2017). Related to this, Bunderson and Reagans (2011) and Magee and Galinsky (2008) found that hierarchy at work, and the power associated with it, often determined how individuals requested and whether or not they obtained work-related resources in the workplace. Likewise, evidenced in the current study was how the social structure and the men’s hierarchical relationships at work were understood to be part of the workplace culture. In this regard, participants’ hierarchical positions at work were found to be a factor that shaped men’s work accommodations. For example, whereas company executives shared that they had the authority and autonomy to re-set their work obligations as they saw fit, some non-managerial workers explained how their subordinate status and lack of seniority at work underpinned their sense of disadvantage in negotiating workplace accommodations. Similar results were reported by Baldridge and Swift (2013) who found that workers with disabilities and little work seniority often declined to request accommodations out of concerns of being perceived as unwilling to work hard. Taken together, these results suggest that men who occupy the lower ranks within hierarchical workplace structures may be a sub-population at risk of not obtaining the work accommodations that they need to sustain their ongoing recovery.

Baldridge and Swift (2013) found that individuals negotiating return to work accommodations after sick leave often refrain from providing detailed information about their health problems and resulting limitations on work capacity for complex reasons that emerge from the convergence of gender, age and disabilities. The current study findings detail how participants’ social location as older men and breadwinners experiencing urinary side-effects combined to generate unique tensions around their decisions about disclosing the reasons for
their reduced work capacity to work-colleagues. For example, although the men felt responsible to reveal the ways in which the consequences of radical prostatectomy affected their work performance (e.g., sharing how surgical wound tenderness limited their ability to lift or move heavy objects at work), most participants abstained from providing information about side-effects that they thought would negatively impact their ability to meet professional standards and masculine work ideals (e.g., disclosing how urinary incontinence was a cause of distraction at work). Furthermore, in the context of re-setting work obligations, it was also found that men held strong and direct linkages between radical prostatectomy side-effects and illness, disability and unproductiveness. In this respect, the men’s reluctance to fully disclose surgical side-effects reflected their alignment with masculine ideals around work such as showing physical strength, resiliency and desire to work hard. Accordingly, men were inhibited in disclosing their vulnerabilities amid fears that they could be outcast as sick workers and/or as unprofessional. These findings support previous research suggesting that workers treated for prostate cancer often conceal details about their illness and the experience of treatment side-effects for fear of being discriminated against by their work-colleagues (Grunfeld et al., 2013). For most participants in the current study, concealment of deficits were often accompanied with efforts at shifting attention away from their work limitations. In this respect, the men emphasized how their work expertise and post-surgical contributions would benefit workplace interests and productivity. This was evidenced in many men’s narratives highlighting how their post-prostatectomy work capacity was compatible with business priorities and goals, and by offering to do alternate work tasks that were less demanding yet valued in the workplace as the men levered optimal return to work accommodations.

Evident throughout the participants’ narratives was the centrality of retaking work responsibilities to the men’s restoration of breadwinner masculine roles. Related to this, re-
setting work obligations was an ongoing process that allowed men to retake work activities by re-adjusting work accommodations and/or responsibilities to match their physical strength and work performance post-prostatectomy. In this sense, men viewed the resumption of work activities as being connected with the re-establishment of obligations and relationships that were interrupted by radical prostatectomy. These results confirm findings by Iyigun et al. (2011) and Milne et al. (2008) that men often frame the consequences of radical prostatectomy (e.g., not being able to participate in work and social activities due to urinary incontinence) as conditions that are incongruent with their self-concepts and affect how they view themselves as men. Bokhour et al. (2007) previously found that men treated for prostate cancer focus on managing side-effects and engaging in pre-surgical responsibilities as a way of resuming their identities as men. In the current study, participants’ efforts at restoring their masculine and worker identities were not limited to restoring full work activities, but also focused on aligning themselves with masculine ideals of stoicism and industriousness post-prostatectomy. These results support previous research findings suggesting that men returning to work after prostate cancer treatment want to be perceived as workers who contribute to workplace productivity (Grunfeld et al., 2013). Importantly, and extending Grunfeld’s et al. (2013) research results, the current study also found that re-setting work obligations afforded participants with opportunities to restore their work-colleagues’ and/or clients’ confidence in the men’s work capacity. In this regard, establishing working conditions that enabled men to gradually increase productivity and reduce their reliance on others allowed participants to demonstrate that they were capable of safely meeting and/or exceeding work expectations amid their ongoing recovery. This finding is significant because it suggests that re-setting work obligations can greatly influence the success in men’s resumption of work activities after radical prostatectomy, and represents a key moment wherein health care providers’ interventions can support men’s return to work.
Study strengths and limitations

A major strength of the current study was the rich diverse data which included perspectives from men who worked in a broad range of occupations. The men’s stories were also anchored in the Canadian work context and current financial environment. In this regard, the findings were considered amid increasing concerns around job security (Canadian Labour Congress, 2014), ageing populations and workforces (Statistics Canada, 2017), and changing landscapes wherein workers are increasingly expected to work for longer (Sun Life Canadian Unretirement Index, 2015). The study findings in this regard also highlighted the ways in which the men’s age and work hierarchies shaped their return to work post-prostatectomy.

The current study has several limitations. First, all study participants were from the Greater Vancouver Area and the experiences that they shared around work and health care services are specific to the British Columbian context. As health service delivery and legislation around employment may vary across Canada, the findings presented herein may not be applicable to other provinces. Second, participants were recruited from various prostate cancer support groups in Vancouver and the Vancouver Prostate Centre. Related to this, men’s decision to participate in the current study may have been influenced by their relationships with other prostate cancer support group members and/or staff at the Vancouver Prostate Centre. Similarly, while participants shared that they wanted to help others and to contribute to better understanding prostate cancer-related experiences, it is also possible that their positions as support group members and/or patients attending the Vancouver Prostate Centre may have shaped their responses. In this regard, participants may have wanted to be perceived in a positive way by providing narratives that aligned with socially desirable values and/or ideals. Third, although there was diversity in the occupational fields and income levels among men in the
current sample, many participants worked in office environments and reported having financial security. Therefore, it might also be conceded that the findings reported here are not representative of the full diversity of men who undergo radical prostatectomy but, instead, afford preliminary insights to connections between socioeconomic status, prostate cancer and men’s return to work after radical prostatectomy.

Clinical implications

Clinicians must be aware that support for acquiring, interpreting, and integrating information are essential to ensuring men are genuinely informed about all the potential side-effects of their prostate cancer treatment decisions (Orom, Biddle, Underwood, Nelson, & Homish, 2016). In this regard, the interconnections between fatigue, urinary incontinence and return to work after radical prostatectomy should be explicitly discussed in detail with men considering radical prostatectomy. Gaining insights into men’s work contexts is necessary to preempt potential return to work accommodations and/or needs post-prostatectomy. Related to this, it is also important to underscore that the side-effects of radical prostatectomy may last longer than anticipated and to highlight the importance of making graduated return to work plans. Although most participants in the current study were able to negotiate favourable return to work accommodations with their bosses and/or work-colleagues, some Canadian employers likely require assistance from health care providers to make appropriate duties available to workers resuming work (Stergiou-Kita et al., 2016). Clinicians and/or occupational therapists may act as intermediaries by thoroughly assessing men’s work capacity and a range of work roles and/or tasks available in the workplace based on professional evaluations of men’s capabilities and
work contexts. Furthermore, clinicians’ ongoing assessments of post-prostatectomy work capacity should be ongoing to inform adjustments in men’s work tasks and/or roles to safely maximize their productivity and recovery.

In making return to work plans, clinicians, patients and employers must recognize that post-prostatectomy fatigue poses a work-safety risk for many men and their co-workers. In this regard, clinicians can play a key role in brokering men’s return to work accommodations aimed at preventing fatigue-related accidents and/or injuries. Clinicians can provide written return to work recommendations to support men’s graduated return to work negotiations focused on reducing monotonous and repetitive work, distractions and multi-tasking (Maheu, Cashman, Johson, & Parkinson, 2017), and offering periods of rest within the work-shift and facilities in the workplace where men can rest (Work Safe, 2017a). Similarly, with regards to urinary incontinence, clinicians can support men returning to work post-prostatectomy by formally recommending that they be assigned space where men can store urinary incontinence supplies and clothing, hourly five-minute washroom breaks and/or relocate their work station to a position that is close to the lavatory (Depend, 2017).

While erectile dysfunction dominates discussions around radical prostatectomy side-effects (Mulhall, Bella, Briganti, McCullough, & Brock, 2010; Nelson et al., 2015; Nelson et al., 2013), the current study findings highlight the need for clinicians and patients to recognize that work, family life and retirement are important issues for many men after radical prostatectomy. Indeed, the doing of work, as a masculine ideal synonymous with successful older men, must be understood as key to men’s identities. Therefore, in acknowledging that radical prostatectomy may profoundly affect men’s work, clinicians and patients must also plan for post-prostatectomy interventions that include post-surgical rehabilitation to help men resume and adjust their work routines in sustainable ways.
Workplace recommendations

The current study findings suggest that participants viewed returning to work as a key signifier of their post-prostatectomy recovery. By returning to work, men aimed to restore previous routines and income. Related to this, several return to work guidelines have emerged within the British Columbian context (Government of British Columbia, 2017b; Work Safe BC, 2017b, 2017c, 2017d). However, although the guidelines may help workers and employers map the steps toward returning to work, they do not address two important issues. First, current British Columbian return to work guidelines do not discuss the complex interpersonal issues that arise in the process of re-setting work obligations. For example, offering return to work accommodations may increase some co-workers’ workloads who, in turn, may be dissatisfied with and/or resent such work arrangements. Therefore, although some men may prefer not to involve work-colleagues when negotiating work accommodations, it is important to recognize that co-workers are key to constructively planning and facilitating workplace accommodations that protect the returning worker, as well as the other workers.

Second, current British Columbian return to work guidelines underscore the importance of open communication between workers and their employers in pre-empting and addressing issues that may arise after returning to work. However, many participants in the current study noted that disclosure of their work limitations was hindered by concerns around work competitiveness and fears of being discriminated against. Therefore, employers, managers, and/or company executives must reassure men that their privacy will be maintained amid providing equal opportunities (e.g., promotions, work-related training) to ensure their rights as workers are respected as per current legal regulations (Canadian Human Rights Act, 1985, s 7; Canadian Human Rights Commission, 2007).
Lastly, the current study findings suggest that many men who return to work after radical prostatectomy make gradual gains and improvements in their work capacity. It is, therefore, critical that work accommodations be re-adjusted to facilitate men’s graduated return to work. To achieve this, ongoing monitoring and assessment of work accommodations are warranted to optimize men’s potential for fully recovering work capacity. In this respect, men and their employers should agree and set periodic (e.g., bi-weekly, monthly) evaluations of the appropriateness of work accommodations to inform proper adjustments in work tasks and/or responsibilities with a focus on ensuring the safety and wellbeing of men returning to work (Work Safe BC, 2017c).

**Future research**

While the masculinities framework (Connell, 2005) has been used previously to explore the impact of prostate cancer treatment(s) on men’s masculine identities (Cayless et al., 2010; Kelly, 2009; Maliski et al., 2008; Oliffe, 2005; 2009), few studies connected masculinities to radical prostatectomy and men’s work. Use of the masculinities framework in the current study provided focus to understanding the interplay between gender, socioeconomic status, work, illness and radical prostatectomy-induced challenges. Indeed, the application of the masculinities framework proved to be valuable in distilling the connections between work and radical prostatectomy that inform recommendations for interventions towards addressing various issues faced by many working men who undergo radical prostatectomy. In this regard, current study findings could and should be used in conjunction with the masculinities framework to inform
future studies examining men’s illness and work-related experiences in other types of cancer, illnesses and their treatments.

Although the side-effects of radical prostatectomy challenge many men’s ability to meet some ideals of masculinity (Gannon et al., 2010), current study findings also suggest that return to work is central in men’s efforts at restoring their pre-surgical roles and identities as men and workers. Given the high five-year survival rate for men with prostate cancer (CCS, 2017a) and the increasing number of men who choose to work longer (Sun Life Canadian Unretirement Index, 2015), it is important to guide men who decide to return to work after prostate cancer treatment. Thus, future studies exploring men’s return to work, and how work shapes their roles, responsibilities and identities post-prostatectomy should be conducted to inform interventions that help men maintain work and, eventually, transition to a fulfilling retirement.

Grunfeld, Low and Cooper (2010) found that employers held more negative views about the impact of urological, breast, gynecological, and head and neck cancer on work capacity than cancer patients returning to work. Similarly, current study results suggest that discrepancies about what constitutes the ‘right’ workload and/or working conditions may be emergent and fluid, hindering men and their employers’ ability to set realistic return to work goals. Future research should investigate factors shaping employee and employers’ perspectives and negotiations throughout the return to work process as a means to tailoring industry specific interventions aimed at helping men successfully return to work.

Urinary incontinence was a significant side-effect of radical prostatectomy that affected participants’ self-concepts and shaped their return to work plans. Although urinary incontinence is a recognized barrier to men’s return to work and ability to perform work tasks (Grunfeld et al., 2013), the current study also found that concealment was a focus for managing the visibility of urinary incontinence in the workplace. While confirming previous research (Grunfeld et al.,
2013), little is known about other urinary-symptom management strategies (e.g., reducing fluid intake, medications) in the context of work post-prostatectomy. Research in these areas are needed to understand the ways in which men can be supported as they manage urinary incontinence throughout their return to work.

**Conclusion**

Work was found to be essential in sustaining participants’ masculine identities. Through their contributions at work, the men generated income, found opportunities to socialize, and applied their knowledge and expertise for the benefit of others. That said, the current study affirmed connections between work, prostate cancer and radical prostatectomy that challenged many participants to continue to fulfill their roles and responsibilities as men and as workers. Ever present in *Reformulating the Worker Identity*, men re-considered what was important to them regarding work, family and health. Affirmed were diverse masculinities amid strong gendered patterns anchoring men’s work as an important and familiar foundation. The current grounded theory, in this regard, provides insights and explanations of a complex phenomena intricately intertwined with masculinities and shaped by shifting contexts. As such, afforded by this work is important affirmation of men’s challenges as well as much needed guidance for health care providers, employers and policymakers to guide men’s return to work post-prostatectomy.
References


Orom, H., Biddle, C., Underwood, W., Nelson, C.J., & Homish, L. (2016). What is a “Good” treatment decision? Decisional control, knowledge, treatment decision making, and


Wells, M., Williams, B., Firnigl, D., Lang, H., Coyle, J., Kroll, T. ... MacGillivray, S. (2013). Supporting work-related goals rather than return to work after cancer: A systematic


Appendix 1: Interview guide

General Questions

1) Please tell me about your work.

   Probe questions:
   a. How many jobs have you had in the past?
   b. What is your work history?
   c. What was work like before prostate cancer?
   d. Tell me about the work you were doing before prostate cancer.
   e. Tell me what work meant for you before prostate cancer.

2) Tell me a bit more about your prostate cancer.

   Probe questions:
   a. Tell me about your life before prostate cancer.
   b. What does prostate cancer mean to you?
   c. Tell me how prostate cancer got in your life.
   d. How does prostate cancer play out in your life?

3) Who did you tell about your prostate cancer at work?

   Probe questions:
   a. Why did you tell/not tell about your prostate cancer at work?
   b. What were the considerations in telling/not telling your boss, co-workers and/or clients about your prostate cancer?
   c. How did telling/not telling about prostate cancer at work affect how you work?
4) Thinking back to the time of treatment, how did considerations about work impact your decision to treat prostate cancer?

Probe questions:
   a. What was it about your work that influenced your decision to treat prostate cancer?
   b. As you were considering treatment for prostate cancer, what were some of your priorities as you planned ahead in terms of your work?
   c. What were some of the work-related considerations that came into play when you decided to treat prostate cancer?
   d. How did your boss, co-workers, workload, and/or employment benefits influence your treatment decision making?

5) Tell me about the work-related issues that worry/worried you after diagnosis of prostate cancer.

Probe questions:
   a. What are/were your biggest concerns about work after prostate cancer diagnosis?
   b. Since your diagnosis of prostate cancer, what work-related issues worry you?
   c. What are/were some of partner’s or family’s expressed concerns about work after prostate cancer?
      i. Did they tell you to work less/more/retire?
   d. How did your partner and/or family adjust to your work-related worries after prostate cancer?
i. Are there changes in your/household/family’s financial situation?

6) Tell me how treatment with radical prostatectomy affected your work.

Probe questions:

a. Tell me about the considerations that informed your decision to return (or not) to work.
   i. Tell me about the obstacles you faced in returning to work.
   ii. Tell me about the things that encouraged you to return to work.

b. (If currently working) How are things different now from the time before your diagnosis?

c. How did recovery from surgery affect your work?
   i. Were you in pain?
   ii. Did you have urinary symptoms?

d. How did radical prostatectomy/and subsequent treatment(s) change the ways you work?
   i. How did radical prostatectomy/and subsequent treatment(s) impact your ability to work?

e. How did radical prostatectomy affect your relationships with work?
   i. How did prostate cancer and its treatment(s) change your relationships with your boss, co-workers and/or clients?

f. (If currently not working) What are the issues that would make you want to return to work?
   i. Tell me about the reasons you would want to return to work.
   ii. Tell me about the reasons you would not return to work.
7) What was it like to return (or not) to work after radical prostatectomy?

Probe questions:

a. How did returning (or not) to work affect you?

b. How did you adapt to returning (or not) to work?

c. Who did your return (or not) to work affect the most at work? Why?

d. Who did your return (or not) to work affect the most at home? Why?

8) What work-related recommendations do you have for employers of, and working men considering radical prostatectomy?

Probe questions:

a. What do you suggest working men considering radical prostatectomy should consider before undergoing radical prostatectomy?

   i. What are some of the work-related issues that men should be aware of prior to undergoing radical prostatectomy?

b. What do you suggest employers and co-workers should consider to support men who are about to undergo radical prostatectomy?

c. (If already received secondary treatment for prostate cancer) What are some of the long term work-related considerations men have to think of after radical prostatectomy?
Appendix 2: Pocket sized recruitment card

Diagnosed with Prostate Cancer?

Wellam Yu Ko, a PhD student at the UBC School of Nursing, is conducting a series of interviews to discuss the issues faced by men who were working at the time of prostate cancer diagnosis and who subsequently had radical prostatectomy.

### Who can participate in this study?
- Men who were **working at the time of prostate cancer diagnosis** regardless of current work status.
- Men who **had radical prostatectomy** within the past 36 months.
- Men of any ethnicity who are **able to read and speak in English**.

### What will happen if I participate in the study?
- You will take part in a one-on-one interview about your experiences with work, radical prostatectomy and prostate cancer (approx. 60 to 90 minutes in duration).
- You will be reimbursed for parking expenses.
  
  Your participation in this study is **voluntary** and **confidential**.

For further information please contact: Wellam Yu Ko at [contact information removed]
Appendix 3: Full size recruitment advert

Diagnosed with prostate cancer?

Did you know?
- In Canada, prostate cancer is the most common malignancy in men.
- Many working men are diagnosed with prostate cancer.
- Men’s work can be affected by radical prostatectomy.

Wellam Yu Ko, a PhD student at the UBC School of Nursing, is conducting a series of interviews to discuss the issues faced by men who were working at the time of prostate cancer diagnosis and who subsequently had radical prostatectomy.

Who can participate in this study?
- Men who were working at the time of prostate cancer diagnosis regardless of current work status.
- Men who had radical prostatectomy to treat prostate cancer.
- Men of any ethnicity who are able to read and speak in English.

What will happen if I participate in the study?
- You will take part in a one-on-one interview (60 to 90 minutes in duration).
- Interview questions will focus on your experiences with work, radical prostatectomy and prostate cancer.
- You will be reimbursed for parking expenses.

Your participation in this study is voluntary and confidential.

For further information please contact: Wellam Yu Ko at (contact information removed)
Appendix 4: VCH Research Institute certificate of approval

October 9, 2014

Dr. John Oliffe
UBC School of Nursing
302 – 6190 Agronomy Road
Vancouver, B.C.
V6T 1Z3

Vancouver Coastal Health Authority Research Study # V14.00559

FINAL CERTIFICATE OF APPROVAL

TITLE: Radical prostatectomy and work: Men’s perspectives

SPONSOR: Unfunded

This is to inform you that your project has been approved and can start immediately. Approval has been granted until April 7, 2015 based on the following:

1. UBC Behavioural Research Ethics Board Certificate of Approval # H14-00559
2. Vancouver Coastal Health approval

Yours sincerely,

[Signature]

W. Robert McMaster, D. Phil.
Vice President Research, Vancouver Coastal Health
Executive Director, Vancouver Coastal Health Research Institute

Partnership in research between the Vancouver Coastal Health Authority and the University of British Columbia.
Appendix 5: Consent form

Radical Prostatectomy and Work: Men’s perspectives

Principal Investigator:
Dr. John Oliffe, School of Nursing, University of British Columbia, (contact information removed)

Co-Investigators:
- Dr. Joan Bottorff, School of Nursing, University of British Columbia (O), (contact information removed)
- Dr. Joy Johnson, School of Nursing, University of British Columbia, (contact information removed)
- Mr. Wellem F. Yu Ko, PhD Student, School of Nursing, University of British Columbia, (contact information removed)

Are there any conflicts of interests?
No actual or potential conflicts of interests have been identified in the conduction of this study.

Why are we doing this study? Why should you take part in this study?
It was estimated that 23,600 men were diagnosed with prostate cancer in 2013, many of whom were working at the time of diagnosis. In spite of the importance of work to men with prostate cancer and their families, little is known about the connections between prostate cancer, work and radical prostatectomy. The purpose of this study is to understand how work informed your decision to have radical prostatectomy for treating cancer, and how its side-effects affected your work. The findings of this study will be used to help inform and promote the health of men who experience prostate cancer. You are being asked to voluntarily participate in this study because you were working when diagnosed with prostate cancer and treated with radical prostatectomy.

What happens if you say “Yes, I want to be in the study”?
If you say “Yes”, this is how the study will proceed:
1. We will ask you to complete a Demographical Survey (about 5 minutes).
2. You will be asked to participate in a one-on-one, audio-recorded interview that will be approximately 1 to 1.5 hours (60-90 minutes) long. Interview
questions will be about: a) how your work informed your decision to have radical prostatectomy, b) your work-related experiences following radical prostatectomy, and c) the work-related recommendations you would give men considering radical prostatectomy. Audio recordings will be transcribed word-by-word for data analysis. Interview transcripts will be reviewed and compared to identify important ideas about the connections between prostate cancer, radical prostatectomy and work. Findings of the study will be used to enhance the well-being of men who experience prostate cancer and the families affected by it.

**Study results**
The results of this study will be reported in a doctoral dissertation and may also be published in journal articles and books. Study results will also be shared amongst participants that took part in the study, Prostate Cancer Support Groups in the Greater Vancouver Area, and the British Columbia Cancer Agency.

**Is there any way being in this study could be bad for you?**
We do not think there is anything in this study that could harm you or be bad for you. Some of the questions asked during the interview may seem sensitive or personal. You do not have to answer any question if you do not want to. Please let the interviewer and/or Wellam F. Yu Ko know if you have any concerns.

**What are the benefits of participating?**
We do not think taking part in this study will help you. However, in the future, others may benefit from what we learn in this study.

**How will your privacy be maintained?**
Your name will not be associated with the digitally recorded interviews of typed transcripts. Digital files will be password-protected and hardcopy documents will be identified only by code and kept in a locked filing cabinet. Only research staff associated with this project will have access to the data. You will not be identified in any reports of this research.

**Will you be paid for taking part in this research study?**
We will not pay you for the time you take to be in this study. However, we will reimburse your parking expenses.
Who can you contact if you have questions about the study?
If you have any questions or concerns about what we are asking of you, please contact:

- Dr. John Oliffe at (contact information removed);
- Dr. Joan Bottorff at (contact information removed);
- Dr. Joy Johnson at (contact information removed);
- Welling F. Yu Ko at (contact information removed).

Who can you contact if you have complaints or concerns about the study?
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Consent
Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative consequence on you. By signing on this form, you agree to participate in this study and acknowledge receiving a copy of this consent form for your own records.

________________________________________________________________________
Participant ’s Signature                Date

________________________________________________________________________
Participant ’s Name (print)
Would you like to receive a brief summary of the study findings?

- No
- Yes - If yes, please provide a postal or email address

[Blank lines]
Demographic Information Questionnaire

Please circle and/or write the answer that best applies to you.

1. Age______

2. Marital Status:
   a) Single/Never married
   b) Married/Common law
   c) Divorced/Separated
   d) Widowed
   e) Other (specify):______________________________

3. Highest level of education:
   a) Less than high school
   b) High school
   c) Community/Technical College
   d) University
   e) Other (specify):______________________________
4. **At the time of prostate cancer diagnosis, what was your yearly income?**
   a) Less than $20,000
   b) Between $20,000 - $40,000
   c) Between $40,000 - $60,000
   d) Between $60,000 - $80,000
   e) Between $80,000 - $100,000
   f) Over $100,000

5. **Currently, what is your yearly income?**
   a) Less than $20,000
   b) Between $20,000 - $40,000
   c) Between $40,000 - $60,000
   d) Between $60,000 - $80,000
   e) Between $80,000 - $100,000
   f) Over $100,000
6. Number of jobs held at the time of prostate cancer diagnosis:
   a) 1
   b) 2
   c) 3
   d) Other (specify): ______________

7. Employment status at the time of prostate cancer diagnosis (you can choose more than one option from the list):
   a) Full-time
   b) Part-time
   c) Permanent
   d) Temporary
   e) Seasonal
   f) Casual
8. **Type of employer(s) you worked for at the time of prostate cancer diagnosis:**
   
g) Public sector  
h) Private sector  
i) Self employed  
j) Other (specify): ______________________

9. **Amount of time taken off work due to radical prostatectomy:**
   
a) Less than 1 month  
b) Between 1 and 3 months  
c) Between 3 and 6 months  
d) Between 6 and 9 months  
e) Between 9 and 12 months  
f) More than 12 months  
g) Other (specify): __________________________
10. **Amount of time taken off work due to other treatments (other than radical prostatectomy) for prostate cancer:**
   
   a) Less than 1 month
   
   b) Between 1 and 3 months
   
   c) Between 3 and 6 months
   
   d) Between 6 and 9 months
   
   e) Between 9 and 12 months
   
   f) More than 12 months
   
   g) **Not applicable**, did not have other treatment(s) for prostate cancer
   
   h) Other (specify): ___________________________

11. **Current employment status:**
   
   a) Full-time
   
   b) Part-time
   
   c) Disability/Medical leave
   
   d) Semi-retirement
   
   e) Retired
   
   f) Unemployed
12. If you are currently employed, please choose your current employment status:

a) Permanent
b) Temporary
c) Seasonal
d) Other (specify): ___________________________
e) Not applicable

13. If you are currently employed, please choose the type of employer(s) you currently work for:

a) Public sector
b) Private sector
c) Self employed
d) Other (specify): ___________________________
e) Not applicable
14. If you are currently not working, how many months did you work after radical prostatectomy?

a) Less than 1 month
b) Between 1 and 3 months
c) Between 3 and 6 months
d) Between 6 and 9 months
e) Between 9 and 12 months
f) More than 12 months
g) Other (specify): ___________________________

15. Who was the main wage-earner in your household at the time of your prostate cancer diagnosis?

a) I was the main wage-earner
b) Spouse/partner/significant other
c) Other (specify): ___________________________
16. Who is the main wage-earner in your household now?
   a) I am the main wage-earner
   b) Spouse/partner/significant other
   c) Other (specify): _________________________

17. Please enumerate from 1 to 5 the following according to their level of concern to you (1 for most concern; 5 for least concern):
   a) _____ Clothing
   b) _____ Food
   c) _____ Housing
   d) _____ Medical expenses
   e) _____ Other (please specify): _________________________
18. Have you been diagnosed with any of the following? (You can choose more than one option from the list):

   a) Diabetes
   b) Cardiovascular disease
   c) Kidney disease
   d) Lung disease
   e) Musculoskeletal disease
   f) Other (specify):_______________________

19. Ethnic Background:

   a) Aboriginal
   b) Asian
   c) African descent
   d) Caucasian
   e) Latin American
   f) Middle Eastern
   g) Other (specify):_______________________________
20. Date of prostate cancer diagnosis (month/year): _______ / _______

21. Date of radical prostatectomy (month/year): _______ / _______

22. Other treatments for prostate cancer:
   a) Radiation therapy (month/year) _______ / _______
   b) Hormone therapy (year started): __________
   c) Chemotherapy (year): __________

Other (specify):________________________ Year:_________