

Academic Paper

Peer Coaching During Treatment Decision Making with Men Newly Diagnosed with Prostate Cancer

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Abstract

One in six men born in the UK after 1960 will be diagnosed with prostate cancer and must make a difficult choice from a wide range of treatment options with possible negative life-changing consequences on their sexual, urinary and bowel functions. This study examines the lived experience of men who received peer coaching during their treatment decision-making after a prostate cancer diagnosis, and seeks to enable the future development of such peer coaching. A qualitative Interpretive Phenomenological Analysis (IPA) approach was used and three themes emerged from the data: Beginnings, where the journey starts; No longer alone, finding a companion on the journey; A 'good' decision and beyond. This study provides a greater understanding about the experiences of men who have received peer support during their treatment decision-making and will help the development of beneficial and accessible peer coaching schemes across the UK.

Keywords

peer coaching, treatment decision making, peer support, prostate cancer, patient decision aid,

Article history

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Introduction

Annual data for 2018 showed that 48,487 men were diagnosed and 11,855 died from prostate cancer in the UK (Prostate cancer statistics, 2021). Men are given their diagnosis in a 21-minute (average) consultation and under the current policy of shared / informed decision-making, they then attend consultations lasting an average 13.5 minutes during which they choose their treatment pathway (Sartor, 2008). The choice is made from a complex and increasing range of options that, depending on the stage of cancer progression, will typically include one or more of Active Surveillance, Surgery, Radiotherapy, High Intensity Focused Ultrasound (HIFU), Brachytherapy and Hormone Treatment. All have curative intent with comparable success rates for early stage diagnoses. However, treatment has the potential for life-altering side effects that include urinary, bowel and sexual dysfunction amongst others (Wagland et al, 2019). This can lead to a reduction in

the quality of life, decision regret (Christie et al., 2015), depression and suicide (Guo et al., 2018) and these primary treatments aimed at cure are not always successful, with 15-30% of men seeing a recurrence of the cancer within 10 years (Knowledge, 2021).

The benefits of patients taking an active role in their health care choices are well established (Coulter & Ellins, 2007). However, men diagnosed with prostate cancer struggle with this shared decision-making process (Wagland et al., 2019). Furthermore, prostate cancer has a long history of over and under diagnosis as well as over and under treatment (McCaffery et al., 2019). There is a wide acceptance (Coulter & Ellins, 2007) of the need for interventions or decision aids to support men in their role of shared decision-maker. Peer coaching is one intervention that is not widely used and is not a well-researched topic.

The aims of this study are to advance the understanding of the experience of men who receive peer coaching during their treatment decision-making and to critically explore the relevant literature to then inform the launch of new schemes in Prostate Cancer Support Groups across the UK. The definitions in Table 1 are used to define four of the key areas being studied. For coaching and peer coaching I have prepared composite definitions from various research papers in the literature review.

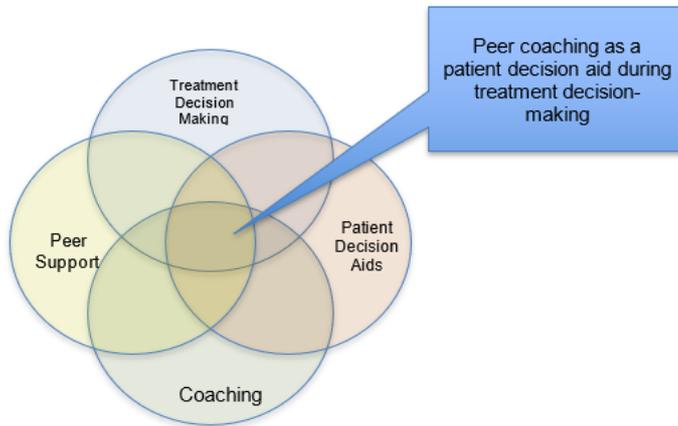
Table 1: Definitions

Term	Definition
Treatment Decision-making (TDM)	The process where the patient understands their own diagnosis and the treatment options they have (including doing nothing), the potential consequences including benefits, side effects and risks, and their likelihood. These are then discussed with their medical team to arrive at a shared and informed treatment decision. (Ryan & Cunningham, 2014).
Patient Decision Aid (PDA)	Tools designed to help people participate in decision-making about health care options. They provide information on the options and help patients clarify and communicate the personal value they associate with different features of the options. Patient decision aids do not advise people to choose one option over another, nor are they meant to replace practitioner consultation. Instead, they prepare patients to make informed, values-based decisions with their practitioner' (International Patient Decision Aids Standards (IPDAS) Collaboration, 2021).
Peer Support	Assistance given by an individual who is considered equal and may include emotional, informational and affirmational support (Dennis, 2003).
Coaching	Non-directive support to others with their information seeking activities, their information understanding and the facilitation of the treatment decision-making process.
Peer Coaching	A subset of peer support, where coaching is provided by an individual who is considered equal

Literature Review

There were no direct results found for research on peer coaching during treatment decision-making by men diagnosed with prostate cancer so the search topic was deconstructed into four areas to build a picture of the overlapping area, as shown in Figure 1.

Figure 1. Search areas of focus



The relevance of gender

Wenger and Oliffe (2014) recognise that there is a gendered response to seeking medical help and men attempt to manage their cancer through control, strength and masculine stoicism. Hoey et al. (2008), with their systematic review of cancer peer support programs covering 44 research papers of which 30 were for breast cancer, concluded that the findings for one cancer type were not suitable for generalising over other cancer. Hoey and colleagues (2008) along with a literature review by Macvean and colleagues (2008) all concluded that in any case there was scant rigorous evidence demonstrating either the effectiveness or benefits of peer support. A further review of research on peer support published between 2007 and 2014 by Meyer and colleagues (2015) found it continued to be an understudied topic. This study aims to address this.

Defining coaching

Although the word 'coaching' was widely used in the literature, I found that only in some papers was there a clear definition (Ilic et al., 2018; O'Connor et al., 2008; Alders et al., 2017; Stacey et al., 2013) with a common theme of non-directive facilitation and provision of information in preparation for a medical consultation. In other papers there is an intervention that carried a strong resemblance to coaching but had different labels including: Counselling (Sartor, 2008) Decision Navigation (Hacking et al., 2014), Training and Practice (Mishel et al., 2009) and Nurse Navigation (Thera et al., 2018). The primary role of the coaches included researchers (Brown et al., 1999; Hacking et al., 2014) and nurses (Mishel et al., 2009; Thera et al., 2018). There was very little reference to either the coaching qualifications, the frequency, duration or nature of the encounter with several sources (Ilic et al., 2018; O'Connor et al., 2008; Stacey et al., 2013) specifying it as being undertaken by trained individuals but with little detail on what that training involved.

Coaching outcomes and topics

In a study about the implementation of patient decision aids in urology a nurse's comments are reported: 'at the end of the day, any decision is a good decision' (Wirmann et al., 2006, p.28). However, a later large US quantitative study on prostate cancer treatment decision-making offers that a 'good' decision is one that is 'informed and consistent with patients' preferences and values' (Orom et al., 2016, p.714). It measured this from the patients' perspective by determining the level of their associated knowledge at the time of decision-making and then comparing it with their quality of life six months after treatment and this showed a positive correlation between their quality of life and the level of their knowledge. However, it also showed that increased levels of knowledge increase the level of decision difficulty.

Reviewing the related literature on coaching for treatment decision-making consistently shows the aim of the coaching intervention is to develop an informed and engaged patient who is prepared for the medical consultations (Ilic et al., 2018; O'Connor et al., 2008; Alders et al., 2017; Stacey et al., 2013). This common aim of increasing the knowledge of the patient (Thera et al., 2018) also has the benefit of dispelling misconceptions and anecdotal evidence (Denberg et al., 2006). This is not only knowledge of the treatments available but also knowledge of the associated risks and side effects (Stacey et al., 2013). In particular, experiential knowledge provision was seen as a key and valued element of peer support (Macvean et al., 2008; Hoey et al., 2008; Kandasamy et al., 2018) that can offer more information than a booklet or website.

To help cancer patients make a decision, they need the capability of identifying and verbalising any questions they have about their treatment options and to express what is most important to them in terms of values, e.g. continence, sexual potency or perhaps the requirement to keep working during treatment. In the literature, frequent coaching topics to enable this capability are communication skills and confidence building. Coaching starts with the self-identification of the patients' values and short-term goals and a general preparation for the medical consultations (Hacking et al., 2014; Mishel et al., 2009; Stacey et al., 2012; Alders et al., 2017; Alders et al., 2019; Sartor, 2008; O'Connor, 2008; Brown et al., 1999).

What is missing from the definition of a 'good' decision by Orom and colleagues (2016) is the reality that the decision may be one the patient later regrets, which can then lead to depression (Erim et al., 2019) and suicide (Guo et al., 2018). Connolly and Reb (2005) identify three possible types of decision regret in the context of cancer related decisions: outcome regret, e.g. a regret that the cancer recurred after treatment, option regret, e.g. they regret the treatment chosen and finally process regret e.g. regretting making a hasty, poorly-informed treatment decision.

A systemic review of regret in prostate cancer patients shows that decision-making aids were effective at reducing likelihood of regret (Christie et al., 2015). Process regret can be measured at the time of decision-making and this is done in one paper (Mishel et al., 2009). Connolly and Reb (2005) also suggest further research into anticipated regret where for example anticipation of process regret may improve the decision-making process.

An early attempt to measure the efficacy of coaching to help prostate cancer patients during their treatment decision-making was a small quantitative study (n=60) of a range of cancer patients (Brown et al., 1999). This study was conducted before the widespread policy of shared decision-making and patient participation was only measured by the number of questions asked by the patient in the consultation. It showed that the use of a question prompt sheet significantly increased question asking, as did coaching, when compared with no prompt sheet or no coaching (Brown et al., 1999). This concluded that a prompt sheet was sufficient to raise the level of question asking - a very blunt measure of patient participation in a medical consultation.

Some ten years later a new quantitative study, a randomised clinical trial with prostate cancer patients, involved a range of measures for success based on the Uncertainty of Illness Theory. This theory recognises that a prostate cancer diagnosis is characterised by uncertainty and the coaching intervention is aimed at managing the uncertainty associated with the treatment choices through the acquisition of knowledge along with supporting communication skills. The study demonstrated that the coaching intervention did prepare patients with improved knowledge and communication skills (Mishel et al., 2009). This paper also identified decision regret as a measure of success in decision-making and timed the survey to the point on the treatment pathway when side-effects would have presented.

Two Systematic Reviews of coaching, one for a range of medical issues and one focussed only on cancer, both concluded that there was evidence - albeit limited - to suggest that coaching, when compared with simple Patient Decision Aids (literature, question prompts, videos etc.) was effective. However, more studies were needed to identify which patients would benefit the most

(Alders et al., 2017). Stacey and colleagues (2012) emphasised the theoretical evidence that justified the use of coaching, namely that improvements in decision-making will occur if there is support in the decision-making process that includes having discussions with others and support to improve communication skills.

Qualitative research papers showed an increased richness on desired outcomes and efficacy of the coaching and uncovers what patients are looking for from coaching, whereas the quantitative studies were looking more from the medical providers' perspective; how can the patients be better prepared for these short consultation sessions? Themes in the qualitative studies included increasing knowledge and communication support, as seen in the quantitative studies, but additionally: reassurance in light of their anxiety; dealing with the patients practical concerns and their discouraging narratives (Thera et al., 2018); addressing uncertainty; fear and a desire for rapid treatment (Denberg et al., 2006); providing emotional support (Thom et al., 2016).

Methodology

Interpretative Phenomenological Analysis (IPA) was chosen as the most appropriate approach for this study. IPA is an approach for 'applied' psychology that was experiential and qualitative (Smith et al., 2009) and has been widely adopted as a research method in health psychology (Brocki & Weardon, 2006) where researchers explore participants' sense-making in relation to significant events (Miller et al., 2018).

Research participants

Contact with leaders of UK Support Groups that operate a Buddy Scheme yielded four participants. This led to the sample being homogeneous: they had all received peer coaching and were part of a peer support group, through the sampling route suggested by Smith and Osborn (2015). Coincidentally, not by design, they all had wives or partners and were of a similar age group. Anonymity of the participants was assured in the participation information sheet and only limited demographic information can be reported and this is included in Table 2.

Table 2: The participants

Participant pseudonym	Age range	Employment status	Marital status
Alan	(60-65)	Retired	Married
Bob	(65-69)	Retired	Married
Chris	(55-59)	Working	Married
Don	(55-59)	Working	Partner

Data collection and analysis

A semi-structured interview with each of the research participants was the chosen method for gathering the data as identified by Reid and colleagues (2005) as the preferred method for IPA. The interviews were conducted using Zoom videoconferencing at a time to suit the participants and lasted between 33 and 53 minutes. Participants took the calls in their own homes where they could feel safe, familiar, comfortable and quiet (Smith et al., 2009). The schedule of questions covered diagnosis, treatment decision-making, and the peer-coaching experience. I transcribed the interviews and then followed the process outlined by Smith and colleagues (2009) with the additional practice of watching the recorded Zoom interview video.

The first transcript was read and re-read, supplemented with watching the related video recording again. This enabled familiarisation with the transcript and ensuring its accuracy and completeness. The transcripts were formatted into a three-column landscape table with the text in the centre column and printed out. During the reading I underlined in pencil any text that resonated with me.

These were the words that I recalled as being the most significant when I heard them, words that caught my attention that made me think “Aha” and that captured the essence of what was being said. Then, line-by-line, I made comments in the right-hand column using different coloured inks. These were firstly descriptive comments, then linguistic comments and finally conceptual comments.

The hard work of the double hermeneutic then began in earnest as I tried to make sense of the participant making sense of the peer coaching (Smith & Osborn, 2015). I identified emergent themes in the left-hand column. I then moved on to the next transcript. Once the transcripts had been analysed individually I searched for connections across the emerging themes for each transcript and identified the super-ordinate themes. I did this by writing the emergent themes on coloured cards – a different colour for each participant – and grouping them into higher level themes. After I completed this for each transcript I assembled all of the individual emergent themes to identify the common superordinate themes for the set of transcripts from all participants and could quickly see any commonality. This enabled me to merge some of the higher-level themes identified for each participant.

Findings

Three superordinate themes were identified each with three emergent themes as shown in Table 3 below.

Table 3: Superordinate and Emergent Themes

Superordinate Theme	Beginnings, where the journey starts	No longer alone, finding a companion on the journey	A ‘good’ decision and beyond
Emergent Themes	Antecedents	Buddying up	The best decision for me in the circumstances
	The diagnosis and its immediate impact	Knowledge gained	Bonus features – the emotional boosters
	Taking back control and going in search of knowledge	Enablers and club rules	Reciprocity

The themes copy the framework metaphor of a journey as used by the participants themselves and are in the chronological order of those journeys.

Theme 1 – Beginnings, where the journey starts

The participants’ stories all started before the diagnosis, with the diagnosis itself being less of an event but a process that had a significant emotional impact. Their initial responses were to take control of their new situation by going in search of knowledge.

Antecedents

The participants wanted me to know that they had a prior personal history that they brought to this episode of their lives; they had prior life experience that they wanted me to know about; they had personal circumstances and lifestyles. They had a self-image, values and goals. For example, Alan poignantly evoked his gender when describing his previous self: “I was 60 when I was diagnosed, a fit hill-walking male”. There was a strong relationship between their prior working background and how they felt equipped, or otherwise, to deal with their situation. Don described his frustration dealing with the uncertainty in the information provided:

I came from an engineering background...things are: they either work or they don’t work, they are right or wrong...none of these horrible shades of grey

Chris voiced the importance to him of getting to be known as an individual and his frustration at being treated impersonally:

What I feel difficult to deal with...one or two consultants.. is that they don't even look at you. They look at your diagnosis, they look at the screen and they then prescribe what is required.. and, you know, without touching you, without knowing anything apart from the screen..

The diagnosis and its immediate impact

All participants described the immediate emotional impact of hearing their diagnosis, which was followed up moments later with an explanation of what options they had for treatment. Alan described it variously as 'feeling quite numbed' and 'dissociated really from where I was'. Bob described how 'everything goes sort of blurry' and 'how much I actually took in...I'm not sure'. Chris described it as 'surreal' and as 'shellshock'. They variously described how the diagnosis was not limited to a single event but was an unfolding story to first determine if there was cancer present, then how aggressive it was and then if it had spread through their body. This unfolding story as described by Chris was full of "tricks and turns" subject to delays, false positives and false negatives, a period of time he called being in "the valley of death".

The diagnosis was a watershed moment for the participants. Alan said:

it is like a knife-edge, you know your life before.... your life afterwards, and you do change your image of yourself from that point

Taking back control and going in search of knowledge

After the initial impact of the diagnosis and faced with making a treatment decision, the participants described how they used the information they were given and also started their own research. This became a consuming activity. Alan described how he went on-line and "plunged myself into the information, made sure I got good sources". The participants refer to being provided with "information" about options at the time of diagnosis, but also talk about how they look for "knowledge", "facts", they want to achieve "understanding". In addition they want to know about "reputations" and they set about their research using the internet, bringing them into contact with local support groups and other men previously diagnosed with prostate cancer.

Theme 2 – No longer alone, finding a companion on the journey

This quest for knowledge led the participants to work with a 'buddy'. Emergent themes were how this link-up came about, what knowledge was gained from their 'buddy' and what the enablers were for the relationship.

Buddying up

All the participants said that their experience of peer coaching had been a positive one with Bob, Chris and Don all saying how suddenly they realised that, as Bob put it: "you are no longer alone". Alan said: "It was valuable – I didn't seek it though"

Bob said that the bundle of information he received from the hospital on diagnosis included a leaflet for a local support group. He sent them an email as he said: "At that point I wasn't really in the mood for speaking to people". Nevertheless, he was promptly contacted by phone and what transpired was: "A very important phone call for me."

Chris contacted a support group quite quickly and was matched with a one-to-one buddy who had a similar diagnosis, but as his own diagnosis was refined following more tests Chris started working on a one-to-one basis with someone else who had a more comparable diagnosis. Don also

proactively sought out one-to-one support and matched himself with someone of a similar age and had similar interests who had gone down the same treatment route as Don's initial preference.

Knowledge gained

The participants' premise for speaking to strangers on a one-to-one basis was to build their 'actual' knowledge. Alan already had a strong initial preference for his treatment choice and his one-to-one Buddy provided him with detail in layman's terms based on his personal experience. This was an 'honest' account of what the treatment involved, the side effects and consequences if there was cancer recurrence. Alan said: "I thought that I could ask him anything, and I did."

Bob described the value of hearing about the 'actual' lived experience versus the theoretical information provided:

Hearing the first-hand experience of someone who's gone through it helps you to sort of ... kind of visualise where you're going to be, and how you would cope with the stress of the situations that he was describing going on afterwards. It just makes it a little bit more practical and tangible, I suppose, rather than reading the percentages from the literature, and so on.

Enablers and club rules

The participants all found themselves opening up very quickly to their Buddies. A theme of enabling behaviour and unspoken rules emerged from the interviews. Buddy behaviours that were candid, open and honest with 'no holds barred' (Don) seemed to give permission to the participants to open up themselves. Don who said that he was normally a very private person said:

It made me feel that I could ...there were no reasons why I shouldn't ask these questions

The importance of having someone who listened to them was identified as of prime importance for Bob:

I think it's just in the first instance just really having someone who is prepared to listen

As Alan succinctly put it: "You just want somebody to ..to listen." A bond had been formed through the shared experience of the diagnosis but also a shared destiny, as Don described in a conversation he had with his Buddy, Tom:

Tom said that we're in forever.. you know, we are ..we are we are together you know... as long as we are alive

This strongly contrasted with how Alan described some of the clumsy encounters he had with friends and acquaintances when he was first diagnosed:

You could see in their faces that they, they have this feeling of regret or horror or whatever

The availability of one-to-one support was an enabler, particularly for Bob who reported that his hospital allocated a Key Worker who wasn't available to him so he never got to speak with her.

Theme 3 – Reaching a 'good' decision and beyond

This theme shows how the decision was made as well as some of the additional benefits that peer coaching provided.

The best decision for me in the circumstances

Both Bob and Don described pivotal moments in their one-to-one sessions that helped them arrive at a final decision. Bob described how in his first phone call his Buddy helped him reframe his approach. Instead of looking at all the treatments and their side effects, which was starting to overwhelm him, his Buddy prompted him to look at what outcome he wanted from the treatments and to work back from that. Don says despite Active Surveillance being a pathway option, he had initially decided to go straight to the immediate option of having surgery with all the consequences. However, he was challenged by his Buddy who had previously had surgery:

If you're going down that route you have to be sure it's what you want to do

This caused him to pause for thought, change his mind and to pursue the Active Surveillance route which would then monitor the situation through regular blood tests and he would only have surgery when it became absolutely necessary, enabling him to live a side effect free life until then, which could be years away.

Participants remarked on the temporal nature of their decision. Bob said that what he found out about the hospital's reputation and the different side effects from the different treatments were the important pieces of information and described his decision as:

It's really a, sort of, I think, a reasonably balanced decision based on what had been investigated and learnt.... we could find out at the time.

Alan said that in his prior professional life he was used to decision-making in the context of uncertainty and stressed the importance of the process you followed:

So, I was aware that there is no err.... ideal solution, given the information I had you just have to identify the factors which are most important to you and go with that err....in the knowledge that, you know, in hindsight, you may make the wrong decision, but you try to minimise that.

Bonus features – the emotional boosters

The participants gained more than information and decision support from their Buddies. Chris described his Buddy as: "Very positive he always gives you some positive energy". Anxiety about the chosen treatment itself was not unusual and speaking to someone who had experienced the treatment helped with that as reported by Alan when speaking about surgery with his Buddy:

He played it down quite a bit and that, and that reassured me because I'd been ramped up in terms of my anxiety at that point

Reciprocity

The experience of peer coaching led the participants to make themselves available as a Buddy to other men and two were already doing so. There was something about their experience that made them want to help other men on the same journey.

Discussion

Beginnings

Using the Journey as a metaphor for a cancer story is an often-used patient metaphor along with the violence or war-like metaphor and there has been a recent attempt by the NHS to move away from violence metaphors (Semino et al., 2017).

I presumed, as did the previously reviewed literature, that Day One for treatment decision-making was when the diagnosis and options were presented at the diagnosis consultation. However listening to the participants' pre-diagnosis life story revealed insights into their pre-existing hopes and fears, coping mechanisms and support networks (Doka, 1993) which could be useful later in any coaching sessions, as well as helping to build rapport and establish them as unique individuals. Chris, in particular, experienced a lack of personal connection and a poor rapport with his consultant that contrasted significantly with the rapport he developed with his Buddies. Establishing rapport is recognised as a required skill for coaches (Rogers, 2016).

Wallace and Storms (2007, p.186) identified a model for the support needs of men with prostate cancer. It shows the first stage of the patient prostate cancer experience as the 'taking in' of the diagnosis that is characterised by an 'emotional roller coaster ride and disengagement from society' and the next stage as the 'taking on' that is characterised by information-seeking and treatment decision-making. The findings supported the literature with all participants going through these two stages.

The literature review focussed on information-seeking as part of a treatment decision strategy. Going in search of knowledge is also an approach coping strategy deployed by men with a prostate cancer diagnosis, which does have positive benefits. It is worth noting that has been found to be different to strategies used by women with a breast cancer diagnosis (Lashbrook et al., 2018 and Spendelov et al., 2018) who look for more different activities.

No longer alone

Continuing with the Journey metaphor, the empowering scenario of the patient having a travelling companion who is a fellow patient has been observed as a common phenomenon (Semino et al., 2017). What 'being alone' meant to the participants was not explored.

Matching was an important and valued characteristic of the participants' dyads. Participants displayed a preference for matching with similarities such as age or grade or stage of prostate cancer. Bob talked about his feelings of guilt when talking with men who had a worse diagnosis and Alan talked about how he was unhappy when his Buddy expressed his relief that his own diagnosis wasn't as bad as Alan's. Chris was much happier working with men his own age and Don took great comfort from working with someone whose diagnosis was comparable to his. In a study of health coaches, Thom et al. (2016) observed that shared characteristics, such as language, culture and life experience helped develop trust.

The participants valued the benefit of hearing about lived experience from their peer coaches; this enabled them to learn first-hand about a treatment itself and potential treatment side effects. This access was identified as a facilitator that helps men make their treatment decision and prepare them for side effects (Wagland et al., 2019). Also, in support of their treatment decision, participants sought and learned about specific hospital and individual medical practitioner reputations as part of what was identified as 'Medical Administrative Information' in a systematic review and qualitative meta-synthesis of 29 studies on the use of information in prostate cancer treatment decision-making (Kandasamy et al., 2017).

Opening up to relative strangers about your fears and anxieties and being able to ask them about subjects that previously you might have thought taboo and off-limits, subjects such as impact on sexual relations, continence, and even fear of death all require a sense of safety. That was created for the participants by the confidentiality of a one-to-one setting and the disclosure by the peer-coach about their circumstances that quickly created an environment of trust. Bozer and Jones (2018) in their systematic literature review of coaching effectiveness show that trust in the coach is key for the coachee to show vulnerable behaviours, such as sharing sensitive information. Therefore, peer coaches need to be prepared to lead by role modelling their own vulnerability, by

talking about their own situation but only as an icebreaker to enable the coachees to open up in turn.

The participants valued being listened to by their peer coaches. The importance of listening to the coaching process is recognised (Cox, 2013). In a phenomenological study, Hill (2016) shows the positive link between listening, rapport building and acknowledging the coachees story, which were also themes that were seen within this study.

A subtle theme that ran through all four participant experiences was the availability of the peer coach: they were there when they were needed. This was also seen with health coaches in Thom and colleagues (2016) and is especially important in that short window of treatment decision-making, which drives a demanding sense of urgency in men who are newly diagnosed.

The ‘good’ decision and beyond

Telling their coachees about their actual experiences provided them with information that could help them with their decision-making. The literature also points to the need for men to make a decision that is consistent with their own values and preferences (Hacking et al., 2014). Different men will have differing values and preferences and these need to be discovered as part of the decision-making process.

In Bob’s case his coach did challenge him to think more about what he wanted versus what the immediate treatment option offered. In Don’s case the coach challenged him to be ‘sure’ before he made a final decision. These challenges were made in a high support context and according to the participants were pivotal to their decision-making. Blakey and Day (2012) argue that working in this quadrant of the support/ challenge matrix will get the best results.

The participants were all too well aware that they were not making a perfect decision. There is still too much uncertainty about the likelihood and impact of side effects and potential recurrence of the cancer. In the Uncertainty of Illness Theory (Mishel et al., 2009) discusses how the gathering of information helps reduce uncertainty but then the last stage of the theory is learning to cope with uncertainty and articulating this in the safe space of a coaching session may help. This may go beyond the scope of how peer coaching is experienced during decision-making, but it is worth noting from the literature review on coping strategies by Lashbrook and colleagues (2018) that men with prostate cancer follow the information seeking route as a coping strategy and women with breast cancer follow different coping strategies.

Wilson and colleagues (2014) studied posttraumatic growth after prostate cancer and noted 53-95% of cancer survivors self report some personal growth. His study also identified the positive impact of peer support on posttraumatic growth. Men who sought out peer support were not only taking an adaptive coping approach but also were exposed to positive role models for posttraumatic growth. This was seen with all the participants who all wished to be Buddies to others in the future.

What was missing?

Peer coaching helped men communicate with their medical professionals (Alders et al, 2017; Alders et al., 2019). This study’s participants were all confident, articulate and displayed high levels of self-efficacy so it was probably not surprising that they did not mention using peer coaching to help them communicate actively with medical professionals and actively take part in the shared decision-making process. The presence of self-efficacy in particular has been identified as a predictor of success in coaching (Bozer & Jones, 2018) and all the participants reported on their belief that they could handle the decision-making process, comparing it to their professional

experience. Further research with participants with lower self-efficacy would highlight whether or not they needed more peer-coaching support for their communication in medical consultations.

All four participants had, in their minds, broadly positive experiences with their peer coaching and offered very little negative information. The one negative comment about the peer coaching received related to a breach of confidence following discussions outside of the coaching dyad that the peer coach had with his wife, which was relayed to the coachee's wife in turn. This had led to some upset and is a reminder that peer coaches do need to be trained in the basic ethics of coaching and this example supports the literature on the importance of agreeing the rules on confidentiality (Iordanou et al., 2017) and sticking to them.

Conclusions

Findings from research interviews

All of the participants described their cancer story as a 'journey'. The participant's experiences all sat within their individual context of antecedents that they wanted to share which included their personal situation and work history. They described their diagnosis as an imprecise and uncertain process that had an emotional impact following which they were quickly required to make a decision about their treatment.

The participants were not all actively seeking a buddy or peer coach to help with their decision-making but were all seeking information to 'take on' the cancer challenge (Wallace & Storms, 2007). This is a common coping strategy for men as opposed to women (Lashbrook et al., 2018). Whilst seeking information from someone who had previously been diagnosed, their peer coach, they discovered that they were no longer alone on their journey. It was important to the participants that their peer coach was a similar person to themselves and someone with a similar diagnosis who had been on their preferred treatment pathway who could then provide a first-hand account.

Participants actively sought information about their peer coach's lived experience of the treatments and side effects. They also wanted information about the reputations of institutions and treatment teams. In some cases, they used to help make a decision or to validate their initial preference. This information helped calm anxieties and reduce uncertainties.

The coaching relationships were characterised by trust, and coaches who listened and were available when needed providing energy and reassurance and allowed the peer coaches to challenge the thinking of men with their decision-making approach. The participants all had positive experiences of peer coaching and made treatment decisions that they did not later regret.

Implications – conclusions drawn from the findings

Peer coaching can be a valuable tool for men with their decision-making. Men, by nature, seek information and avoid support. Peer coaching can offer needed information and may therefore attract more interest if offered as an information source rather than a support mechanism.

The peer coach's role is to be a non-directive companion for the patient's information seeking activities, their decision-making process and preparation for the medical consultations. Coaching best practices of listening, confidentiality, rapport building, suspending judgement, and challenging are valid in this context.

The requirement for a good match between the peer coach and their coachee requires a wide range of peer coaches to be available. Understanding what a 'good' decision is means that a

decision, once made, can be tested to verify that it is a 'good' decision and the decision process itself will not be the subject of future regret.

Limitations and Opportunities for Future Research

Black men, by ethnicity, are three times more at risk from prostate cancer, and more likely to present with an aggressive disease, than white men. However for many reasons they are underrepresented in prostate cancer research studies (Toms et al., 2016). None of the participants in this study were black and this is a limitation on this study. The participant sampling was of men who had all successfully received peer coaching and may therefore be subject to participant bias. This does not tell us much about any unsuccessful peer coaching or unsuccessful treatment decision-making.

This study covers a subject that has not received much research attention so there much scope for further research that includes:

- The role of the partner in peer coaching.
- Peer coaching for black men.
- Peer coaching for men with low levels of self-efficacy.

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