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## The significant unmet needs of cancer patients: probing psychosocial concerns

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**Abstract** ‘Significant unmet needs’ are those needs that patients identify as both important *and* unsatisfied. In this article we ask whether the overall needs of cancer patients are actually being met. We believe that the range of unmet need, and the kinds of patients who are more likely to claim unmet need, should be carefully identified. The needs responses of a series of 295 cancer patients in a cross-sectional survey were analysed. The majority expressed the opinion that information and good relationships with health care professionals were important, and few expressed dissatisfaction with these aspects of need. Similarly, needs items about support from family and friends were largely rated as important and satisfied. For a sizeable minority of patients, items of significant unmet need cluster around aspects of managing daily life, emotions, and social identity. The distri-

bution of significant unmet needs is not random but is more likely to be experienced by patients who are younger, have a long-standing illness or disability, do not own/have use of a car, and/or have no religious faith. Furthermore, significant unmet needs relate to patients’ ability to talk freely to a carer about the cancer, the degree to which the cancer interferes with social activities, and whether financial difficulties are experienced. Most of the significant unmet need is beyond the remit of services primarily designed for the treatment of disease. We consider whether multidisciplinary cancer teams can be expected to deal with all aspects of the cancer experience.

**Keywords** Cancer · Patients · Psychosocial needs · Health services

### Introduction

The importance of psychosocial factors in the cancer journey has been stressed in UK government policy since the Calman–Hine Report [7]. The NHS Cancer Plan [8] has highlighted the need to streamline cancer services ‘around the needs of the patient’ [8, p. 6] and to provide ‘the right professional support and care as well as the best treatments’ [8, p. 5]. These laudable aims can hardly be challenged. However, the real question is whether the overall needs of cancer patients are actually being met [3]. We believe that the range of unmet need,

and the kinds of patients who are more likely to claim unmet need, should be carefully identified. However, the task of doing something about the shortfall may be a little more complicated than most have appreciated. Recommendations in the literature are commonly limited to the requirement that health care professionals have good communication skills and that patients have easy access to relevant information. It is difficult to develop appropriate psychosocial support services without understanding much more about what might make it easier to live with the knowledge and social consequences of having this illness.

Whilst much has been written about psychological morbidity, notably anxiety and depression, in patients with cancer, there is less published work on the needs underlying psychological morbidity [3, 17]. Unresolved concerns at an early stage in the cancer journey are known to have an impact on later poor psychological adjustment [22, 30]. Unmet need across the cancer trajectory was addressed specifically by Houts et al. [14], who found more unmet practical needs in the terminal phase, and more emotional and spiritual needs around the time of diagnosis. Guadagnioni and Mor [12] studied patients who were undergoing chemotherapy and found unmet need in 27% of their sample. Poorer health status was linked with higher levels of need in a study of patients with advanced cancer, whilst unmet need was primarily associated with the social support network [20]. More recently, a large study in Australia found that patients' perceived needs were highest in the psychological, health system and information, physical, and daily living domains and lowest in the domains of patient care and support and sexuality, and that subgroups of patients had differing needs [27].

In this paper we ask what kind of psychosocial needs may remain unmet amongst cancer patients, and whether there are particular groups within the population of cancer patients who are more likely to experience unmet need. Our aim is to identify particular needs that may be under-addressed in health services.

## Patients and methods

### Study

Our exploration of unmet need among cancer patients is part of a larger NHS-funded research project on the psychosocial needs of cancer patients and their main carers, which took place in the North West of England [21, 28]<sup>1</sup>.

### Unmet need

Defining unmet need is crucial, for different definitions may produce different results. Our definition is a fairly stringent one. A 'significant need' is defined here as a need that is deemed to be important or very important by the patient; it becomes a 'significant unmet need' if it is also perceived as not satisfied. Hence, the focus on 'significant unmet need' helps to exclude minor concerns that are not satisfied. While ideally one would like patients to be totally satisfied, the focus on those needs deemed important by the patient seems appropriate.

<sup>1</sup> The full title of this multidisciplinary study is 'How can cancer services best meet the psychosocial needs of patients and their main carers? A study of user experience of cancer services with particular reference to psychosocial need'. It was funded through the Institute for Health Research at Lancaster University by the NHS Executive North West, Research and Development Directorate, UK, 1997–2000

### Subject selection

A consecutive series of patients receiving services in three health authority areas in the North West of England was recruited with the assistance of 21 participating consultants and their staff over a period of 1 year. The services were broadly similar in the three study areas and typical of most districts across the United Kingdom. They included specialist surgical and nonsurgical oncologists, specialist nurses, community support services and palliative care teams. To obtain a cross section of patients four tumour types were selected for study, to reflect the range of cancers and outcomes: breast, colorectal, lymphoma and lung. Similarly, patients were recruited within 1 month from one of four 'critical moments' in their cancer journey: diagnosis, end of first treatment, first recurrence, the move from active treatment to palliative care.

One thousand eligible patients aged over 18 years were referred to the study for receipt of a postal questionnaire pack. Some bias in patient recruitment was identified: some clinicians filtered out patients who they felt were too unwell, or too distressed or confused to be selected. There was also some random exclusion of eligible patients when clinic workloads were particularly heavy. Nevertheless, despite these limitations, this study approached a representative cross section of adult cancer patients with specified tumour types at different critical moments.

### Survey instrument

The patient questionnaire booklet was a wide-ranging self-completion instrument. The main focus of this paper is the response to the section, 'What makes it easier to live with your current illness? (over the past few weeks)'. This section comprised a 48-item psychosocial needs inventory<sup>2</sup>. The 48 needs items are listed in Table 2. Each need item had two five-point scales assessing the *importance* of the need item and the level of *satisfaction* of the need. The criterion of a 'significant unmet need' was that the patient considered the need item to be either very important or important *and* the level of satisfaction of this need item was given as 'not at all satisfied' or 'not very satisfied'. There was also scope for a respondent to tick a box for 'does not apply to me' for each need statement. If a patient indicated that the need item did not apply to them, or there was a missing response, then the need was considered to be unimportant for that patient.

### Qualitative interviews

In-depth guided interviews with a purposively selected sub-sample of 47 surveyed patients were conducted. The aim of the interviews was to obtain accounts of cancer experiences together with reflections on what did or could 'make it easier' to live with the illness. Interview transcripts were thematically analysed with the assistance of the NUD\*IST qualitative analysis programme [23]. We use extracts from the interview data in the following presentation of findings to throw light on the statistical data concerning significant unmet need.

### Explanatory variables

A number of variables were used in the statistical analysis to identify patients likely to have significant unmet needs. We distinguish between two types of variable: those with which patients enter the

<sup>2</sup> This section of the questionnaire was developed from eight individual in-depth interviews and five focus groups ( $n=30$ ) with patients and informal carers. With permission, we also drew on comparable 'needs' research with cancer patients and informal carers reported by a team of North American researchers [13, 32]

cancer journey ('people' variables) and those that relate more specifically to their 'cancer journey' ('patient' variables).

The people variables used are patients' age, gender, whether they are owner-occupiers of their dwelling and whether they own or have use of a car/van (established indicators of socio-economic status), whether they live alone, whether they have a religious faith, whether they have caring responsibilities and whether they have a long-standing illness or disability. The variables that more closely relate to respondents' roles as patients are: the nature of their tumour; the critical moment in the disease trajectory; their global health<sup>3</sup> status; whether they can talk freely to the main carer about the illness; whether they have been offered support services; and whether their physical condition interferes with their social, or family, or financial circumstances. As the global health variable gives a measure of overall health, this variable subsumes long-standing illness and disability, which is therefore omitted from any analysis that includes global health.

## Results

### Sample characteristics

The number of questionnaires returned was 402, for a response rate of 40%, varying by tumour type: lymphoma 58% ( $n=36$ ); breast 55% ( $n=183$ ); colorectal 33% ( $n=121$ ); and lung 26% ( $n=62$ ), and by critical moment: diagnosis 50% ( $n=222$ ); end of first treatment 47% ( $n=75$ ); first recurrence 62% ( $n=44$ ); move from active treatment to palliative care 19% ( $n=61$ ). Whilst 40% might appear to be a low response rate for a social survey, it has to be remembered that these patients were grappling with serious diseases and the size of the questionnaire pack was too burdensome for some. Ethical considerations demanded that we did not place pressure to respond on those who received our questionnaire pack. It is perhaps not surprising that the response rate for a self-completion questionnaire was particularly low for patients in receipt of palliative care only, and for this group it was agreed not to pursue the idea of a follow-up letter for nonresponders. If this last group of patients is excluded from the calculation then the overall patient response rate rises to 51%. An examination of the limited data we have on nonrespondents (age, gender, geographical location, tumour type and moment) suggests that those who *did* respond were more likely to be: younger, female, living in a semi-rural area, with breast cancer or a lymphoma, and not in a palliative-care-only phase of the cancer.

Of the 402 returned questionnaires, 22 had entirely blank responses to the 48 need items, and these patients were immediately excluded from the analysis. Subsequently, any patients with missing values of the explanatory variables used in the analysis were also excluded. Thus, the final dataset used in this paper involved 295 cases, 34% of whom were male; 44% were under

<sup>3</sup> 'Global health' is derived from a combined morbidity and quality of life score from the EORTC-C30 quality of life scale [1] in another section of the questionnaire

**Table 1** Number of unmet needs

No. of significant unmet needs	No. of patients	Percentage of total patient sample
Nil	183	62.0
1	37	12.5
2	17	5.8
3–9	45	15.3
10+	13	4.4
Total	295	100.0

60 years of age; 14% lived alone; 82% stated they had a religious faith; 82% were owner-occupiers; and 84% owned/had the use of a car. Only 9% had caring responsibilities for others, while 38% had an existing long-standing illness or disability as well as the cancer.

A comparatively low response rate produces a challenge to a strong claim of representativeness. One would suspect that those with unmet need may be more likely to use an opportunity to express their concerns, although, alternatively such persons may be less willing, or able (owing to ill health), to co-operate. In such circumstances, caution must be attached to numbers and percentages, but the level of response rate does not seriously undermine the ideas being developed in this paper.

### How many significant unmet needs?

Table 1 shows that approaching two-thirds (62%) of cancer patients surveyed indicated that they had no significant unmet needs. It is heartening to find that in the majority of cases important needs were being appropriately recognised and satisfied, although this outcome partly reflects the stringent application of the criterion, based on our operational definition, of significant unmet need. In contrast, approaching 1 in 5 patients (18%) identified either 1 or 2 significant unmet needs; a further 15% identified between 3 and 9 unmet needs, while a residual 4% indicated 10 or more unmet needs (in fact, 4 patients identified over 20 unmet needs). Clearly there is a considerable range in terms of patients experiencing significant unmet need.

### What are the significant needs and the significant unmet needs?

Not unexpectedly, there was a considerable range in terms of which needs items listed on the psychosocial needs inventory were regarded as important or very important. As Table 2 shows, the top-ranked item – 'Confidence in the health professionals I meet' – was so categorised by 94% of the patients – while the lowest ranked item – 'Help with child care' – was identified as important by just 7% of patients. This difference high-

**Table 2** Significant need and unmet need (ranked by percentage rating item as important or very important) ( $n=295$ )

Need item	Those rating item as important or very important		Those with significant unmet need for item	
	No.	%	No.	% <sup>a</sup>
Confidence in health professionals I meet	277	94	6	2
Health professionals who have time to discuss issues with me	272	92	9	3
Health professionals who treat me with respect	269	91	3	1
Easy and quick access to doctors	269	91	16	6
Support from family	268	91	3	1
Honest information	267	91	11	4
Information given sensitively	263	89	11	4
Information about treatment plans	262	89	13	5
Information about what to expect	261	88	18	7
Health professionals who listen to me	261	88	6	2
Support from friends	258	87	3	1
Easy and quick access to health professionals other than doctors	254	86	9	4
Information about medication and side effects	248	84	11	4
Advice on what services and help are available	239	81	13	5
Support from care professionals	233	79	10	4
Hope for the future	214	73	19	9
Someone to talk to	210	71	10	5
Access to other sources of information	209	71	13	6
Opportunities to participate in choices around treatment	198	67	21	11
Help in maintaining independence in the face of illness	179	61	15	8
Support from neighbours	169	57	2	1
Help with any fears	166	56	16	10
Help in dealing with the unpredictability of the future	160	54	20	13
Help in maintaining a sense of control in my life	160	54	18	11
Support in dealing with changes in my body or the way I look	154	52	15	10
Help with any distressing symptoms	149	51	11	7
Time for myself	143	48	7	5
Help with finding a sense of purpose and meaning	140	47	10	7
Help with transport	135	46	12	9
Help with any sad feelings	130	44	18	14
Help in dealing with any tiredness	122	41	14	11
Help in dealing with feelings of others	119	40	15	13
Advice about food and diet	112	38	21	19
Support in dealing with any changes in the way other see me	110	37	11	10
Opportunities for personal prayer	107	36	4	4
Help with any loneliness	105	36	12	11
Support in dealing with any changes in my sense of who I am	104	35	9	9
Support from people of my faith	102	35	4	4
Opportunities for meeting others who are in a similar situation	100	34	15	15
Help with housework	93	32	10	11
Help with getting out and about socially	93	32	6	6
Help with any anger	85	29	16	19
Help with financial matters	63	21	22	35
Help in filling out forms	58	20	14	24
Support from a spiritual advisor	54	18	1	2
Help with any feelings of guilt	53	18	5	9
Help in considering my sexual needs	41	14	5	12
Help with child care	21	7	2	10

<sup>a</sup> Percentage of those who rated the item as important or very important

lights an important point. As patients, almost all people want the best from the health professionals (e.g. 'Confidence in the health professionals I meet'; 'Health professionals who have time to discuss issues with me'; 'Health professionals who treat me with respect' etc.) but many of the other needs will reflect patients' current social circumstances. For example, given the age distribution in this sample of cancer patients, relatively few

will have caring responsibilities for a child. In brief, while there may be personality differences between patients (i.e. some people may be more easily dissatisfied than others), this paper largely focuses on the relevance of *social* context (i.e., some social contexts produce a wider range of needs than others).

The next question to consider is whether these important needs are met satisfactorily. The last two columns of



**Table 3** Significant need and unmet need – top 18 items (ranked by percentage with significant unmet need) ( $n=295$ )

Need item	Those rating item as important or very important		Those with significant unmet need for item	
	No.	%	No.	% <sup>a</sup>
Help with financial matters	63	21	22	35
Help in filling out forms	58	20	14	24
Help with any anger	85	29	16	19
Advice about food and diet	112	38	21	19
Opportunities for meeting others who are in a similar situation	100	34	15	15
Help with any sad feelings	130	44	18	14
Help in dealing with feelings of others	119	40	15	13
Help in dealing with the unpredictability of the future	160	54	20	13
Help in considering my sexual needs	41	14	5	12
Help in dealing with any tiredness	122	41	14	11
Help with any loneliness	105	36	12	11
Help in maintaining a sense of control in my life	160	54	18	11
Help with housework	93	32	10	11
Opportunities to participate in choices around treatment	198	67	21	11
Support in dealing with any changes in the way other see me	110	37	11	10
Support in dealing with changes in my body or the way I look	154	52	15	10
Help with any fears	166	56	16	10
Help with child care	21	7	2	10

<sup>a</sup>Percentage of those who rated the item as important or very important

Table 2 highlight two complementary points. The more ‘universal’ needs are generally being met, while there tends to be a much higher proportion of significant unmet need in relation to some important needs identified by a minority of patients. In broad terms, therefore, it seems that most of the ‘health care’ needs are being met, while some needs that might be termed ‘social and emotional’ are much more likely to be unsatisfied.

This outcome becomes clearer in Table 3, where significant unmet need is ranked. It focuses on all the items that were rated as significant unmet needs by at least 1 in 10 of those reporting need for them. For example, while only 63 patients regarded ‘Help with financial matters’ as important or very important, over one-third (35%) felt that their need in this area had not been met satisfactorily. In fact, it is notable that when ordered by percentage of significant unmet need, the items emerging with the highest rankings are very different from those in Table 2, where the ranked order relates to the proportions rating the item as important or very important.

We suggest that the need items that represent real difficulty for some patients, identified in Table 3, can be broadly divided into three main themes – managing daily life, managing emotions, and dealing with changes in social identity. The exception is the item ‘Opportunities to participate in choices around treatment’, which two-thirds (67%) of the sample identified as important and which was seen as a significant unmet need by over 1 in 10 of these patients. This item goes against the broad trend of satisfaction of need items that directly involve health care personnel in the conventional sense. We consider the implications of this outcome in the ‘Discussion’ section.

### *Managing daily life*

Everybody has a daily life to manage but for some – even without the impact of the cancer experience – this is more difficult than for others. For cancer patients, financial matters come top of the list in Table 3; it is the item with the highest proportion of unmet need (35%) among those who identify it as important. Other matters to do with managing daily life, such as filling in forms, managing diet, tiredness, housework and child care, also rate highly as significant unmet needs.

The interview data suggested that the item ‘filling in forms’ was mostly associated with claims for social security payments:

And the financial side of it, I am getting stressed out every day because they have pushed me around from pillar to post – “fill a form in here”, “fill that form in”, another set of forms come with the answer, asking me these questions. That has been my biggest problem. [Man (age 50) recently diagnosed with lung cancer]

This man goes on to say that he has been unable to afford repairs on his car. The lack of finance had a knock-on effect, making him a ‘prisoner’ in his home and undermining his will to live:

When the car was up and running I just got in and went, and did it myself, and that is the biggest problem I have at the moment. I’ve sort of become a prisoner and it’s getting to me. I’m thinking, well, if I can’t go out and do this, and do some of the things I used to be able to... I sit many a time in the evening and think why the hell should I bother? I might as well just sit here and let it happen.

It was notable that many patients interviewed had received help from health care professionals, usually specialist nurses or GPs, when applying for financial support, but the process was often complicated and slow:

But 12 weeks! Surely it doesn't take 12 weeks. Even the [consultant radiologist] wrote a letter to them. [The specialist nurse] wrote from the hospice. So they've had the information from the experts, so there's no reason for them to be holding back really. [Woman (age 49) at the end of first treatment for breast cancer]

This extract shows how the ultimate meeting of a social need is often out of the hands of health professionals. Interestingly, a few of the interviewees who were experiencing financial hardship expressed the opinion that this aspect of living with cancer was almost worse than the disease itself:

I'm very happy with the medical side of it. I'm quite happy with the treatment, well more than happy with the treatment. I'm happy that I'm going to be OK, and I shall be carrying on, apart from having the bag on beside me for the rest of me life. But the main worries I've had have purely and simply been the financial help that I need to get me through until I'm on my feet again and I can get back to work. [Man (age 54) at the end of first treatment for colorectal cancer]

### *Managing emotions and self-identity*

Becoming a cancer patient heralds emotional upheaval and the need to re-negotiate identity [4, 19]. Need items to do with emotional response and changes to self-identity constituted significant unmet needs for a small but important proportion of patients. For example, almost 1 in 5 (19%) of those who rated 'help with any anger' as important perceived little support. The interview data suggested that anger was mostly associated with instances of perceived poor clinical care, especially late diagnosis, and with loss of independence and control. It was notable that when strong emotion was discussed it was often hedged around with observations about normative expectations [24] and the desire to be positive and protect the feelings of others:

It's difficult, but you've got to look on the bright side of things. I mean if you let yourself get down, you're only making yourself miserable, which makes everybody round you miserable, and nobody has a life at all. [Woman (age 61) with recurrence of breast cancer]

Strong feelings were described in interviews as intermittent, or occurring at particular points, and/or in relation to other life circumstances. If emotions need more managing at some times than at others, and if people are wary of expressing their emotions too forcefully for the

sake of others, it is likely that levels of unmet emotional need may be higher than reported.

One woman who was having emotional difficulties associated with the responses of her mother and husband described how help from health care professionals had played a crucial supportive role:

Through [the time I was in hospital] I had a lot of counselling from some of the nurses. I really had gone down to the lowest level I think I'd been. I was physically and mentally exhausted, apart from having everything else happen you know, and it was the support that I got from the nurses there, they were great and they listened. [Woman (age 50) with recurrent breast cancer]

Some patients found talking to other cancer patients of assistance in meeting emotional and identity-sustaining needs. For example:

She was so full of life and energy and fun, and this was somebody who'd been through this and survived. That was really, really sustaining, to know that you can come out of this with a sense of humour and you can actually still be there so many months later, so that helped tremendously. [Woman (age 49) at the end of first treatment for breast cancer]

'Opportunities for meeting others in a similar situation' was a significant unmet need for 15% of those who rated this as important. While many interviewees were wary of formal support groups there was much talk of contact with other cancer patients. This was reported as helpful for various reasons, such as modelling new identity through meeting 'survivors', for picking up information and 'tips', for feeling less 'different', or it just being good to talk to someone who'd gone through the same experience.

Which patients are likely to have significant unmet needs?

Is there scope for identifying groups of patients who are likely to have difficulties that will not be met? More pertinently, which types of variables seem to be particularly helpful in this quest? Can we tell which types of persons are more likely to have significant unmet need by focusing on people variables (that is, those attributes held by people entering the 'cancer journey') or 'illness' variables (that is, those variables aggravated by, or which come into play as a result, of the illness). If the differences are people variables, then there is scope for recognising from the outset those persons who are likely to be candidates for having significant unmet needs unless something is done. In contrast, if the differences are identified by the illness variables, then one must await the outcome of the illness before beginning to recognise the candidates who are more likely to have significant

unmet needs in the course of their cancer journey. The analysis suggests that both sets of variables are relevant.

Logistic analysis was used to test the relationship between patients with and without significant unmet needs and a range of explanatory variables: firstly using the eight people variables, and then adding the eight illness variables (and replacing long-standing illness/disability with global health). As backward elimination and forward selection procedures yielded different results, the best model was found by using the Akaike information criterion [18]. Patients entering the cancer journey with any of the following of the eight people variables were statistically more likely to have at least one significant unmet need: being younger; having a long-standing illness or disability; not owning/having use of a car; not having a faith. In other words, patients with these pre-illness characteristics were at greater risk of experiencing significant unmet need.

When the eight variables representing the illness are incorporated into the model, in addition to the people variables, the four previously significant variables (apart from long-standing illness/disability, which is now replaced by global health status) are retained, but a further three are added: not being able to talk freely to the main carer about the cancer; having social activities interfered with by the illness; and having financial difficulties.

Interest usually centres on *significant* variables, but importance should also be attached to the finding that certain variables are *not* significant. Of the people variables, patients' gender, and whether or not they are owner-occupiers, live alone, or have caring responsibilities were all *not* significant, while among the illness variables this was true for tumour type, cancer interfering with family life, and whether support services had been offered by health professionals. The possibilities for explaining a lack of significance will be at least two-fold – either the nonsignificant variables are correlated and thus subsumed under significant variable(s) or, alternatively, they are not indicators for distinguishing those with significant unmet needs. Some variables, for example health status, which is significant, are associated with critical moment, which was found not to be significant. Although patients in poorer health are more likely to have unmet needs, there seems little doubt that for patients who are socially or economically disadvantaged in some way there is a much greater likelihood of there being significant unmet need during their cancer journey.

## Discussion

Focusing on the significant unmet needs of cancer patients in relation to their psychosocial concerns fits in with recent policy initiatives to streamline cancer services 'around the needs of the patient' [8]. This paper contributes to the assessment of how far this occurs. We also

want to consider how feasible a completely favourable outcome in satisfying needs is, given that so many significant unmet needs are 'social' in character.

Using a fairly stringent criterion to determine a significant unmet need, it was quite remarkable that nearly two-thirds (62%) of patients had no such needs in terms of the 48 needs items presented, a proportion that mirrors that of 'satisfied patients' found in most traditional patient satisfaction surveys [26]. Between 71% and 94% of the patients surveyed expressed the importance of good relationships with health care professionals and of obtaining information, but few expressed dissatisfaction with these aspects of need. Apart from one item (opportunities to participate in choices around treatment), levels of significant unmet need in these areas were low (2–6%). This reflects well on health care professionals who, in the great majority of cases in this study, were treating patients with the respect, courtesy and concern that they expected. The exception – the fact that 11% of patients who wanted opportunities to participate in choices around treatment felt that this need had not been satisfied – probably illustrates where there is still some range of opinion and practice within the medical profession [5]. Similarly, items about support from family and friends produced rates of high importance (87–91%) and low unmet need (1%). Whatever the personal cost to family and friends in responding to need, there rarely seems a significant shortfall on their part from the patients' perspective.

As revealed in Table 3, the items of significant unmet need cluster around aspects of the management of daily life, emotions, and social identity, rather than around more clinical experiences and needs. This suggests that cancer services are less responsive to nonclinical aspects of the cancer experience that cause significant difficulty for patients in particular circumstances.

Importantly, our analysis did not identify tumour type or critical moment as markers for significant unmet need. This suggests that help from health care professionals is not located unevenly as far as clinical characteristics are concerned. We did find, however, that some of the significant unmet needs are associated with patients' socio-economic circumstances (car ownership/use, financial status) and other features of their social lives: age; ability to talk freely to a main carer; the presence or absence of a faith; and whether the illness interferes with social activities. These findings suggest three things. First, another dimension of documented cancer health inequality [2, 10] is that there are higher levels of significant unmet need amongst those who are relatively socially and economically disadvantaged. Second, those with higher levels of social support and social capital [6, 11, 16, 31], through participation in Church activities for example, are less likely to have significant unmet needs. Third, our findings may also reflect differential levels of expectation among patients, although disentangling pa-

tient expectations is complex [26, 29]. For example, younger patients, being more used to a 'therapy culture' [15], may have higher expectations of services and of the lay people around them, and thus be more likely to be disappointed than older people. Whatever the full explanation for the differential distribution of significant unmet needs, is it helpful to cancer service providers to know which specific groups of patients have higher levels of such needs?

This question relates to how much cancer services, which are primarily designed to treat disease, should be involved in addressing the kinds of unmet social, emotional and identity needs highlighted in this study. There are certainly examples of good practice in attending to some of these needs in our study areas. For example, help with financial need (and concomitant form-filling) is often given by specialist palliative services, specialist nurses, attached social workers and GPs; emotional help is being given through NHS-linked counselling and charitable support organisations. We know that nation-wide coverage in the latter is variable [25]. While befriending schemes and support groups have become more widespread in cancer care over recent years [9], our findings suggest that there is still scope for doing more in this area. Other studies have shown that the presence of, and confidence in, a support network are related to lower expressed need [12, 20]. The importance of managing emotion so as not to alienate others may be particularly important, and sources of help outside the lay circle may be especially helpful. Of course, some aspects of significant

unmet need relate to problems that arise in the interstices of various care systems, and it is currently not the responsibility of health care professionals to become directly involved in arranging home care assistance or child care, for example. Should things be otherwise?

We suggest that cancer services could go further than they currently do. It is increasingly recognised that the management of cancer should be provided by multidisciplinary teams (MDTs) and that the constitution of these teams should reflect the full range of needs experienced by cancer patients from diagnosis to cure or terminal care [7, 8]. Based on the findings in this study, we would argue that MDTs should include social workers, counsellors and spiritual advisors as well as the current standard of relevant medical nursing specialties and the palliative care team. At the very least, health care professionals should network with these other care providers, and the needs of each new patient with cancer should be assessed with such a network in mind. The specialist medical and nursing teams are uniquely placed to identify the full range of psychosocial needs of their patients and, in doing so, to access appropriate support that could have an important effect on the cancer experience. Meeting the full range of psychosocial need is likely to contribute significantly to the well-being of cancer patients and thus to reduce rates of cancer-related psychological morbidity.

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