Prostate Cancer Research

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Patient perspectives on overdiagnosis and overtreatment

October 2025

Contents

Please note, Johnson & Johnson provided funding which supported PCR to analyse patient and public perspectives of overdiagnosis and overtreatment of prostate cancer through this project but has had no input or involvement in the development or design of the report.

Introduction

Prostate cancer is now the most common cancer across all types in England. It usually has no symptoms until it has spread, and each year 12,000 men will be diagnosed too late for effective treatment. We know that it also does not affect all men equally, with Black men, men with a family history of prostate cancer, and men with certain genetic variants all at much greater risk of being diagnosed in their lifetimes.

Prostate cancer is the most common cancer without any national screening programme. It is now five years since the UK National Screening Committee (UK NSC)'s last review of prostate cancer screening in 2020. One of the principal arguments against screening for prostate cancer has always been the danger of 'overdiagnoses' and 'overtreatment' – whereby the harms incurred from the act of diagnosing and treating prostate cancer were considered greater than the benefits of screening for the disease.

But the modern prostate cancer pathway has substantially changed since 2020. Evidence shows that while the risks of harm have not been eliminated, they have been markedly reduced in recent years through advances in diagnostics, more accurate risk stratification, and wider use of active surveillance.[i]

Previous patient and public perspectives reveal a complex picture that includes fears about unnecessary treatment, loss of quality of life, and anxieties around screening. Given the improvements to the diagnostic pathway in recent years and to inform the latest UK NSC review, Prostate Cancer Research (PCR) wanted to gather up-to-date feedback on men's perspectives of prostate cancer diagnosis and treatment. In early 2024, we commissioned an external firm, Stack Data Strategy, to run a national poll of adult UK men. PCR also conducted in-person workshops to capture more in-depth qualitative insights.

Our findings in this report look at the emotional and practical complexities men face – from navigating uncertainty to managing the consequences of treatment. Listening to those experiences is essential to designing services that are not only clinically effective but also respectful, inclusive, and supportive.

[i] All-Party Parliamentary Group on Prostate Cancer. Reducing the risks: Overdiagnosis and overtreatment in today's prostate cancer pathway; 2025 appgprostatecancer.org.uk/news-and-updates/report-reducing-the-risks

Methodology

In 2024, PCR conducted a national poll and four in-depth workshops to explore how men understand and experience the risks and trade-offs associated with prostate cancer screening, diagnosis, and treatment.

We commissioned Stack Data Strategy, an independent on-line research data and analytics technology group, to run a poll asking men for their views on scenarios where they might be diagnosed with and potentially treated for prostate cancer. In March 2024, the poll collected responses from 725 adult men (18 years and over) across the UK.

- Demographically, most respondents were based in England (86%), white (75%) and educated to non-degree level (67%). Respondents came from across the socioeconomic spectrum, measured in terms of income and social grade. Participants were also evenly split in terms of age (using 10-year age bands from 18 to 75 years and over).

- The national poll asked three questions: about people's desire to want to know if they had slow-growing prostate cancer; their treatment preferences in the event they did; and whether they would use a free prostate cancer screening programme.

As participants were asked to imagine specific fictional scenarios, the poll did not ask about whether they had actually been diagnosed with prostate cancer.

During February-March 2024, PCR engaged an external social researcher to facilitate four in-depth qualitative workshops to supplement the poll findings, and better understand the barriers and facilitators to men engaging in a potential future prostate cancer screening programme. The workshops took place in Birmingham and Manchester.

- 49 men and women were recruited through social media and existing networks. Travel expenses were met, a payment offered and an information sheet shared with participants ahead of the workshops.

- Participants were split into groups: one focused on men with prostate cancer; another on men without prostate cancer; and one on women who have or had close experience of prostate cancer. Each workshop included participants from ethnic minority groups. One workshop focused exclusively on the experience of men with prostate cancer from ethnic minority groups. Across the workshops, men's age ranged from 46-79 and women from 32-74.

- The workshop discussions were structured around three themes: information needs, emotional responses to screening and diagnosis, and support required after diagnosis.

Methodology

Throughout this report, we highlight illustrative quotes and comments shared by participants during the workshops.

There are some notable limitations that should guide interpretation here.

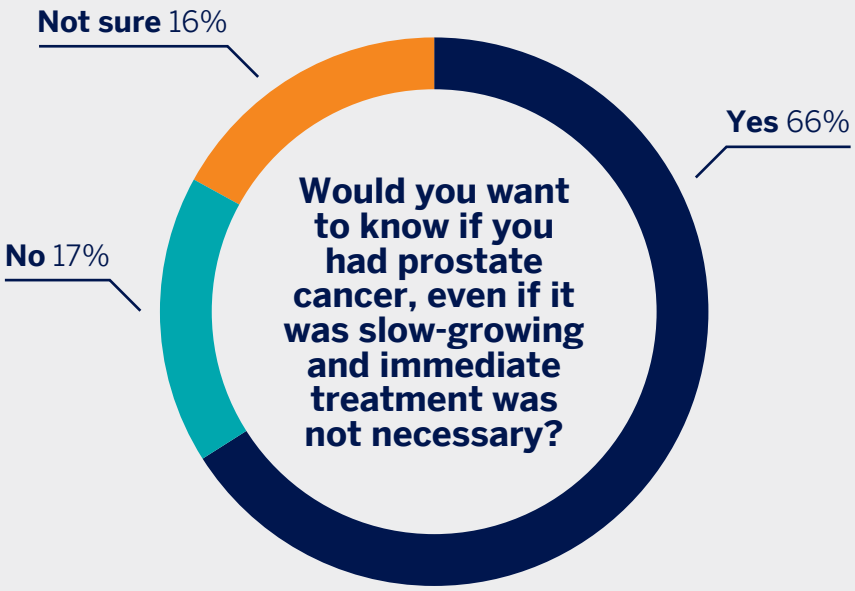
- First, our findings reveal a lack of knowledge to be a key barrier to prostate cancer screening and diagnosis. Participants expressed confusion over terminology (eg what 'slow growing' meant). They asked fundamental questions eg about the function of the prostate, how screening works, and what treatment options entailed. Given their clearly stated desire for better information to inform their decisions, results from the poll (about whether they would want to know if they had cancer, how they would approach it and whether they would participate in a screening programme) should be interpreted with caution.

- Additionally, the findings of this report look at the UK-wide picture. This is partly because sample sizes, in absolute terms, are too small to allow for meaningful country specific breakdowns. In some cases, we present data on regional variations, in the interest of highlighting potential areas for further research. But these specific insights should not be seen as conclusive.

National poll findings

Men would prefer to know, even if it was a low-risk cancer

Men taking part in the poll were asked whether they would want to know that they had prostate cancer, even if it was slow-growing and immediate treatment was not necessary. In this scenario, two-thirds of men (66%) said that they would like to know, with only 1 in 6 (17%) indicating they would prefer not to know, with little variation across UK nations.



However, there were some differences based on ethnicity. Non-white men were more likely to say they would not want to know, with 1 in 4 (24%) indicating this, compared to just 15% for White respondents.

The data also suggests people in deprivation may be less likely to want to know. For example, 70% of those in the highest income bracket (£48,000+ pa) said they would want to know, compared to 60% on the lowest income bracket (<£28,000 pa). Unemployed respondents were almost twice as likely to say they didn't want to know (29%), compared to those employed (17%).

National poll findings

Only a third of men would prefer immediate treatment for a low-risk cancer

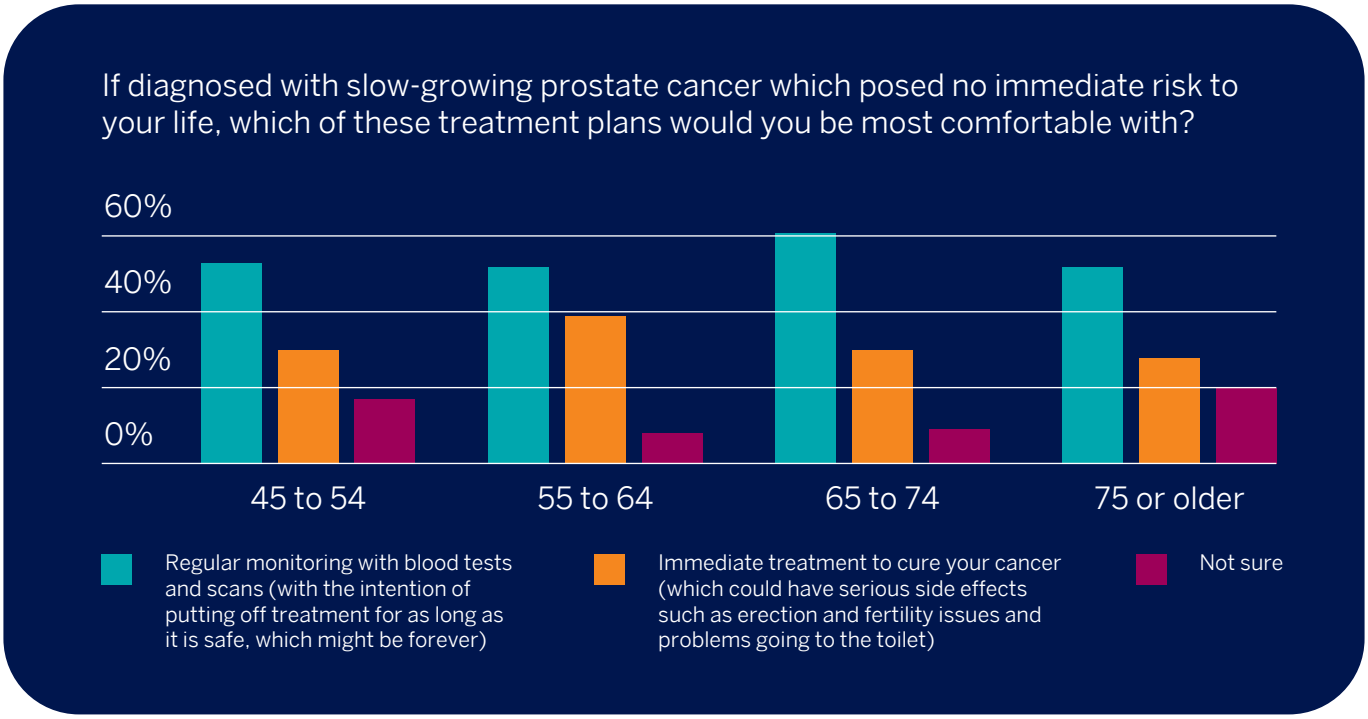
The poll also sought to gain insights into men's preferences around treatment and active surveillance for low-risk cancer. Participants were asked to imagine a scenario where they were diagnosed with slow-growing prostate cancer which posed no immediate risk to their life, before being asked to choose the treatment plan they would be most comfortable with from two options:

a. Regular monitoring with blood tests and scans (with the intention of putting off treatment for as long as it is safe, which might be forever), or

b. Immediate treatment to cure the cancer (which could have serious side effects such as erection and fertility issues, and problems going to the toilet)

Over half (53%) indicated they would prefer the active surveillance approach in this scenario, with one third (33%) instead opting for immediate treatment and 1 in 7 (14%) saying they were unsure.

Generally, responses suggest the older you get (from 18 to 75+), the more likely you are to choose monitoring as your course of action. When looking at the age groups that may form a future screening programme, active surveillance was most popular in the 65-74 age group, with around 3 in 5 (61%) choosing this compared to closer to half for those in the 45-54 and 55-64 age groups. However, 2 in 5 (39%) of the 55-64 age group suggested they would opt for immediate treatment – higher than any other age group over the age of 45.



A demographic profile emerged for which type of respondent would choose one treatment plan over the other in this scenario. You were more likely to choose monitoring over curative treatment, if you had lower income, were unemployed or a student, had less education and in a lower social grade.

National poll findings

Support for a national screening programme

The poll also sought to gauge how willing men would be to use a free national screening programme for prostate cancer if introduced. 71.6% of respondents said they would participate in a free national screening programme, with 14.2% suggesting they would not, and 14.2% unsure. These results were also reflected across all ethnic groups. Support was highest among older age groups, but lower among younger men and those with lower incomes or educational attainment. There were some important regional differences within countries. For example, in England, only 5% of men in the East of England said they would not use this programme, in contrast to a quarter of men (24%) in the West Midlands.

Workshop findings

Information needs and barriers to screening

Participants in the workshops identified a lack of clear, accessible and trusted information as a major barrier to screening. Many men had fundamental questions about what the prostate does, what screening involves, and how to interpret the results. Men often assumed that feeling healthy meant they had no reason to be tested.

Power dynamics in consultations and language barriers were also seen as impediments. Although GPs were seen as critical in maximising screening uptake, concerns were also expressed that GPs may lack knowledge or confidence to recommend screening, particularly for men under 60 or from ethnic minority backgrounds. This is backed by findings from a GP poll commissioned by Prostate Cancer Research in 2025, which found when asked to identify which groups of men were at the highest risk of prostate cancer just 38% of GPs correctly identified Black men, and only 53% correctly identified men with a close family history.

Participants proposed community-based solutions to provide intelligible, trusted, and culturally relevant information. Suggestions included mobile screening at football grounds or supermarkets, as well as outreach via barbershops and religious centres. Proactive outreach would also be important to better communicate with vulnerable and hard-to-reach groups.

The impact of diagnosis

"If you've got it, 'what's my life expectancy?' is the number one question"

Many participants across all four workshops described the psychological burden of diagnosis, regardless of whether the cancer was high or low risk, alongside several concerns that could discourage them from getting screened for prostate cancer:

- **Worries about treatment side effects,** including impacts on sex drive, energy, and quality of life, as well as how treatment might interact with existing health conditions.
- **Concerns about emotional, practical and financial implications,** such as the effects of a cancer diagnosis on their loved ones, work, income, and insurance.
- **Discomfort and stigma,** including embarrassment around physical or rectal exams, fear of a diagnosis, and concerns about how it might affect their identity – particularly for transgender women.
- **Cultural and religious barriers,** such as reluctance among some individuals to be examined by a doctor of a different gender, or worried of being discriminated against if part of an ethnic minority group.

Some men noted the cultural taboo of speaking openly about health, and the stigma associated with cancer more broadly. These concerns suggest the need for sensitive, culturally aware approaches when discussing prostate cancer screening.

Workshop findings

The importance of time and understanding

"You need time, it's an awful lot of information to take in."

Across all four workshops, participants felt that understanding treatment options played a key role in shaping attitudes toward screening. They highlighted the need for clear, accessible information and enough time to take in a diagnosis and what it means – not just for themselves, but also for their loved ones. Being able to fully understand the potential outcomes of different treatments was seen as essential for making informed decisions and seeking the right support.

Support needs at and after the point of diagnosis

"He doesn't know what he doesn't know; he needs someone to help him know the questions to ask"

Participants identified several issues that men commonly face after a prostate cancer diagnosis. While topics like life expectancy and quality of life had come up earlier, they became much more pressing once a diagnosis was received. Key concerns included:

- **Understanding the diagnosis,** including what "slow-growing" means and how it might affect life expectancy
- **Exploring treatment options,** their risks, and what active monitoring involves
- **Managing the personal impact,** such as effects on quality of life, emotional wellbeing, and relationships
- **Navigating practical challenges,** including financial concerns, available support (like disability benefits), and how to communicate effectively with healthcare professionals

Participants emphasised the need for clear, compassionate guidance to help men and their families through this stage. Targeted support should be considered for specific groups, such as men living alone who could be seen as more vulnerable, as well as for younger men whose family aspirations might be negatively impacted. Tailored psychological, emotional, and peer support were viewed as essential. Men wanted a range of options – from group discussions and peer mentors to one-on-one counselling. Community groups and culturally safe environments were seen as key enablers of trust.

Appendix

Table 1: Demographic profile of national poll participants

Variables	Classification	Percent (%)	Frequency (=725)
Nationality	England	86	625
	Scotland	8	55
	Wales	4	30
	Northern Ireland	2	16
Ethnicity	White	75	547
	Non-White	25	178
Social Grade	ABC1	58	418
	C2DE	42	307
Education	Degree	33	241
	Non-Degree	67	484
Employment	Employed	64	464
	Unemployed	10	74
	Retired	21	151
	Student	3.5	26
	Other	1.5	11
Income £ per annum	<21,000	24	174
	21-34,000	23	171
	34-55,000	25	180
	55-83,000	13	97
	83,000+	9	80

Appendix

Table 2: National poll question 1 respondent profiles and responses

Would you want to know if you had prostate cancer, even if it was slow-growing and immediate treatment was not necessary?

Variables	Classification	Yes	No	Not sure
Age	18-24 (n=79)	65%(n=51)	15% (n=12)	20% (n=16)
	25-34 (n=124)	55% (n=68)	29% (n=34)	16% (n=20)
	35-44 (n=120)	67% (n=80)	18% (n=22)	15% (n=18)
	45-54 (n=123)	64% (n=79)	19% (n=23)	17% (n=21)
	55-64 (n=118)	69% (n=82)	17% (n=20)	13% (n=16)
	65-74 (n=91)	81% (n=74)	5% (n=5)	13% (n=12)
	75+ (n=70)	68% (n=48)	12% (n=8)	20% (n=14)
Nationality	Scotland (n=55)	67% (n=36)	18% (n=10)	17% (n=9)
	Wales (n=30)	57% (n=17)	16% (n=4)	26% (n=9)
	Northern Ireland (n=16)	74% (n=12)	6% (n=1)	20% (n=3)
	England (n=625)	67% (n=419)	18% (n=112)	15% (n=94)
Regions	East of England (n=66)	78% (n=51)	9% (n=6)	13% (n=9)
	East Midlands (n=54)	56% (n=30)	21% (n=11)	23% (n=13)
	London (n=112)	69% (n=77)	20% (n=23)	10% (n=12)
	North East (n=35)	66% (n=23)	16% (n=5)	18% (n=7)
	North West (n=80)	70% (n=56)	16% (n=13)	14% (n=11)
	South East (n=95)	67% (n=63)	17% (n=16)	17% (n=16)
	South West (n=61)	65% (n=40)	17% (n=10)	18% (n=11)
	West Midlands (n=63)	53% (n=33)	31% (n=20)	16% (n=10)
	Yorkshire & Humber (n=60)	72% (n=43)	13% (n=8)	15% (n=9)
Ethnicity	White (n=547)	68% (n=372)	15% (n=82)	17% (n=93)
	Non-White (n=178)	62% (n=110)	24% (n=43)	14% (n=25)
Social Grade	ABC1 (n=418)	69% (n=288)	16% (n=67)	15% (n=63)
	C2DE (n=307)	63% (n=194)	20% (n=61)	17% (n=52)
Education	Degree (n=241)	66% (n=159)	19% (n=46)	15% (n=36)
	Non-degree (n=484)	67% (n=324)	17% (n=82)	17%(n=82)
Employment	Employed (n=464)	67% (n=311)	17% (n=81)	15% (n=72)
	Unemployed (n=74)	52% (n=38)	29% (n=21)	20% (n=15)
	Retired (n=151)	76% (n=114)	10% (n=15)	15% (n=22)
	Student (n=26)	61% (n=16)	20% (n=5)	19% (n=5)
	Other (n=11)	37% (n=4)	45% (n=5)	18% (n=2)
Income £ pa	<28,000 (n=260)	60% (n=156)	21% (n=56)	18% (n=48)
	28-48,000 (n=213)	72% (n=153)	12% (n=27)	15% (n=33)
	48,000+ (n=216)	70% (n=151)	19% (n=41)	11% (n=24)

Appendix

Table 3: National poll question 2 respondent profiles and responses

If there was a free prostate cancer screening programme, would you use it?

Variables	Classification	Yes	No	Not sure
Age	18-24 (n=79)	58% (n=44)	17% (n=14)	27% (n=21)
	25-34 (n=124)	70% (n=87)	18% (n=22)	12% (n=15)
	35-44 (n=120)	73% (n=87)	13% (n=16)	14% (n=17)
	45-54 (n=123)	69% (n=85)	18% (n=22)	13% (n=16)
	55-64 (n=118)	78% (n=92)	10% (n=12)	12% (n=14)
	65-74 (n=91)	80% (n=73)	11% (n=10)	9% (n=8)
	75+ (n=70)	73% (n=51)	8% (n=7)	18% (n=12)
Nationality	Scotland (n=55)	73% (n=40)	13% (n=7)	14% (n=8)
	Wales (n=30)	74% (n=22)	13% (n=4)	13% (n=4)
	Northern Ireland (n=16)	82% (n=13)	6% (n=1)	12% (n=2)
	England (n=625)	71% (n=444)	14% (n=88)	14% (n=88)
Regions	East of England (n=66)	80% (n=53)	5% (n=3)	15% (n=10)
	East Midlands (n=54)	63% (n=34)	19% (n=11)	17% (n=9)
	London (n=112)	74% (n=83)	11% (n=12)	15% (n=17)
	North East (n=35)	64% (n=23)	18% (n=6)	18% (n=6)
	North West (n=80)	77% (n=63)	12% (n=10)	11% (n=9)
	South East (n=95)	76% (n=72)	11% (n=11)	13% (n=12)
	South West (n=61)	64% (n=39)	21% (n=13)	16% (n=9)
	West Midlands (n=63)	59% (n=37)	24% (n=15)	17% (n=11)
	Yorkshire & Humber(n=60)	71% (n=42)	18% (n=11)	12% (n=7)
Ethnicity	White (n=547)	72% (n=394)	14% (n=77)	14% (n=77)
	Non-White (n=178)	70% (n=125)	16% (n=28)	14% (n=25)
Social Grade	ABC1 (n=418)	74% (n=310)	11% (n=48)	14% (n=60)
	C2DE (n=307)	68% (n=209)	18% (n=55)	14% (n=43)
Education	Degree (n=241)	75% (n=181)	11% (n=26)	14% (n=34)
	Non-degree (n=484)	70% (n=339)	16% (n=77)	14% (n=68)
Employment	Employed (n=464)	73% (n=340)	13% (n=61)	14% (n=63)
	Unemployed (n=74)	56% (n=42)	24% (n=17)	20% (n=15)
	Retired (n=151)	78% (n=119)	11% (n=17)	11% (n=17)
	Student (n=26)	53% (n=14)	16% (n=4)	31% (n=8)
	Other (n=11)	54% (n=6)	19% (n=2)	27% (n=3)
Income £ pa	<28,000 (n=260)	64% (n=166)	20% (n=52)	16% (n=42)
	28-48,000 (n=213)	78% (n=166)	10% (n=21)	12% (n=26)
	48,000+ (n=216)	77% (n=166)	12% (n=26)	11% (n=24)

Appendix

Table 4: National poll question 3 respondent profiles and responses

Imagine you were diagnosed with slow-growing prostate cancer which posed no immediate risk to your life, which of the following treatment plans would you be most comfortable with?

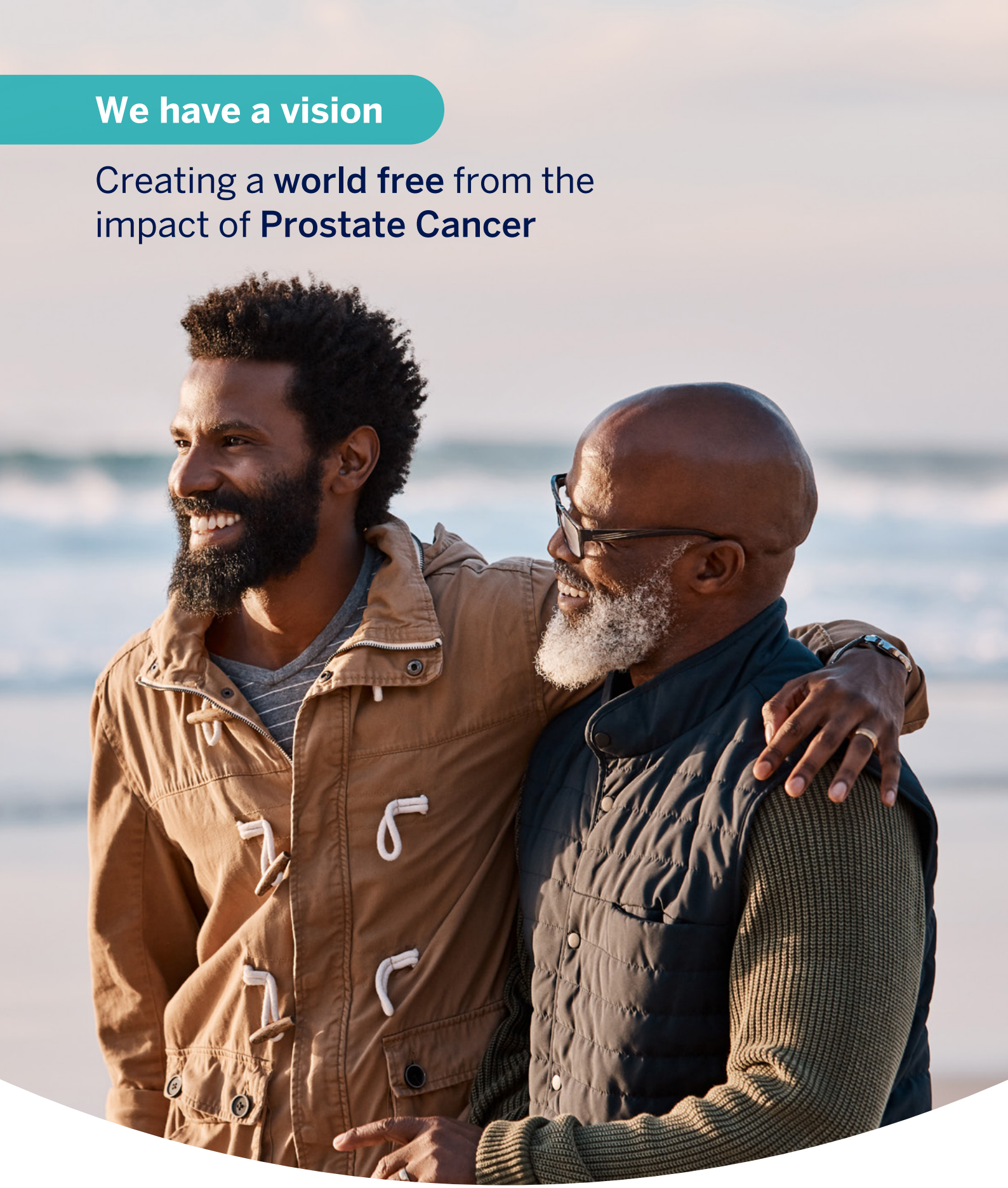
a. Regular monitoring with blood tests and scans (with the intention of putting off treatment for as long as it is safe, which might be forever)

b. Immediate treatment to cure your cancer (which could have serious side effects such as erection and fertility issues, and problems going to the toilet)

Variables	Classification	Yes	No	Not sure
Age	18-24 (n=44)	44% (n=19)	40% (n=18)	15% (n=7)
	25-34 (n=87)	55% (n=48)	29% (n=25)	16% (n=14)
	35-44 (n=87)	52% (n=45)	35% (n=31)	13% (n=11)
	45-54 (n=85)	53% (n=45)	30% (n=26)	17% (n=14)
	55-64 (n=91)	52% (n=48)	39% (n=36)	8% (n=7)
	65-74 (n=73)	61% (n=44)	30% (n=22)	9% (n=7)
	75+ (n=51)	52% (n=27)	28% (n=14)	20% (n=10)
Nationality	Scotland (n=40)	43% (n=17)	36% (n=14)	22% (n=9)
	Wales (n=22)	47% (n=10)	44% (n=7)	9% (n=5)
	Northern Ireland (n=13)	69% (n=9)	24% (n=3)	7% (n=1)
	England (n=444)	54% (n=240)	33% (n=147)	13% (n=57)
Regions	East of England (n=52)	57% (n=30)	27% (n=14)	16% (n=8)
	East Midlands (n=34)	41% (n=15)	40% (n=13)	19% (n=6)
	London (n=83)	59% (n=49)	28% (n=23)	13% (n=11)
	North East (n=23)	60% (n=14)	36% (n=8)	4% (n=3)
	North West (n=62)	59% (n=37)	27% (n=16)	14% (n=9)
	South East (n=72)	57% (n=41)	35% (n=26)	7% (n=5)
	South West (n=39)	50% (n=20)	37% (n=14)	14% (n=5)
	West Midlands (n=37)	51% (n=19)	26% (n=10)	24% (n=8)
	Yorkshire & Humber(n=42)	45% (n=19)	46% (n=20)	9% (n=3)
Ethnicity	White (n=393)	55% (n=216)	32% (n=126)	13% (n=51)
	Non-White (n=126)	49% (n=62)	37% (n=47)	14% (n=17)
Social Grade	ABC1 (n=310)	51% (n=158)	35% (n=109)	14% (n=43)
	C2DE (n=208)	57% (n=199)	30% (n=62)	13% (n=27)
Education	Degree (n=182)	49% (n=89)	38% (n=69)	14% (n=25)
	Non-degree (n=337)	56% (n=189)	31% (n=104)	13% (n=44)
Employment	Employed (n=340)	50% (n=170)	38% (n=129)	12% (n=41)
	Unemployed (n=41)	60% (n=25)	22% (n=9)	18% (n=7)
	Retired (n=118)	58% (n=69)	27% (n=32)	14% (n=17)
	Student (n=14)	78% (n=11)	7% (n=1)	15% (n=2)
	Other (n=6)	50% (n=3)	0%	50% (n=3)
Income £ pa	<28,000 (n=166)	60% (n=100)	28% (n=46)	12% (n=20)
	28-48,000 (n=167)	52% (n=87)	33% (n=55)	15% (n=25)
	48,000+ (n=167)	49% (n=82)	40% (n=67)	11% (n=18)

We have a vision

Creating a **world free** from the impact of **Prostate Cancer**



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