

‘Solitary struggle’ Getting back to normal

Surgical patients lived experiences that are managing their recovery period at home after a short hospital stay, without anticipatory guidance or assistance from health-care givers.

The Vancouver School of Doing Phenomenology provided the guidance of the methodology of phenomenological research approach in the study.

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Declaration

‘This dissertation is submitted to the RCN Institute in part fulfilment of the MSc in Nursing and has been conducted and presented solely by myself. I have not made use of other people’s work (published or otherwise) and presented it here without acknowledging the source of all such work’.

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Abstract

Today's trend is to have the surgical patient return to the comfort of his or her home, rather than remaining in hospital for nursing and medical care. Thus they are at home in their own environment when recovering from surgery. This is also seen as highly cost-effective and convenient for the patient. It is therefore very important to understand how these patients cope in their recovery period, in order to improve the care and preparation of other patients for recovery at home without any assistance from the health-care system. Better understanding and further knowledge in this field helps nurses to bridge the gap between hospital nursing care and home- or self-care.

The purpose of the study is to learn how Icelandic individuals experienced their recovery at home without the guidance or assistance of health-care givers after surgical procedures and less than 48 hours' stay at a surgical unit.

The co-researchers numbered fourteen, from three different hospitals. They ranged in age from 28 to 73 years, both male and female. They had different operations. However, the common factor was that they all stayed less than 48 hours in the surgical units.

The phenomenological perspective within the paradigm of qualitative research was chosen to achieve the purpose of the study and in-depth dialogues were used with the dialogue partners. The guidance of the methodology of the Vancouver School of Doing Phenomenology, which is a unique blend of description, interpretation, explication and construction, was utilized in analysing the data.

The over-riding theme '*solitary struggle – getting back to normal*' was constructed together with four sub-themes from the data, '*the solitary struggle*,' '*the sense of insecurity*,' '*communication or lack of communication*' and '*recovery – toward the usual self*'. The findings are described using quotations from the co-researchers.

The findings revealed that the co-researchers were determined to manage on their own in their convalescence. Information leaflets addressed the operation period very well, but they were not deemed to contain guidance on dealing with daily life after returning home, which led to a sense of insecurity. The short stay at the unit meant that there was little scope for bonding with staff. Therefore co-researchers preferred to consult others than the surgical unit if they required guidance later on. The co-researchers were in agreement that it took time to recover from the surgery. However, most of them had unrealistic expectations of being more active shortly after returning home, as the short hospital stay led them to believe that the operation was more minor than it actually was. Revision of discharge instructions is recommended as a result of the study: the instructions would be individualised and printed out prior to discharge for each patient. Limitations are addressed, as well as implications for nursing practice, education and nursing research, and further studies.

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Chapter I

Introduction

1.1. Experience of surgical procedure, recovery at home

The purpose of the study is to learn how individuals manage during their convalescence after surgical procedure, having stayed less than 48 hours in the care of health providers. Over the last decade surgery services have changed greatly in Iceland. Increasing numbers of surgical procedures previously only performed on in-patients are now undertaken as short-stay cases. Patients undergoing surgical procedure are today discharged from hospital earlier than they would have been several years ago. Today's trend is to have the surgical patient return to the comfort of his or her home, rather than remaining in hospital for nursing and medical care. Thus they are at home in their own environment when recovering from their surgery. This is also seen as highly cost-effective and convenient for the patient (Macdonald and Bodzak, 1999).

New treatments, such as laparoscopic procedures, have led to a reduction in the time patients stay in hospitals, and because of this short time there patients often have unrealistic expectations of a quick recovery. Some studies have been done outside Iceland regarding the experience of patients from the time they are discharged from the hospital to the time when they see the doctor again in the office. However, little is known about the experience of Icelandic patients. Therefore the experience of Icelandic patients recovering at home after surgical procedure and a short hospital stay will be the focus of this study.

There have been several studies that look into whether the patients are satisfied with a short hospital stay. There are also studies that address the issue of whether the patients meet the discharge criteria before being discharged from hospital, together with studies that ask questions about pain management, bleeding, nausea, fever, voiding and oral intake etc., in the postoperative period (e.g. Beatty *et al.*, 1997; Kleinpell, 1997; Tong, *et al.*, 1997; Coslow and Eddy, 1998; Mackintosh and Bowles, 1998; Hession, 1998; Macdonald and Bodzak, 1999). These studies do not answer the questions of how the patients cope with this period, and how their experience is interpreted and understood by health-care givers.

Furthermore, I have only come across a few studies in Iceland that look into issues similar to this one. One nursing study explored satisfaction with care received by patients undergoing ambulatory surgery (Sigurðardóttir, 1996). In one study for a BSc-degree in nursing, patients stayed five days or less in the hospital, and in another BSc-degree nursing study patients stayed at least five days in the hospital; both studies addressed pain control (Kristjánsdóttir and Úlfarsdóttir, 1995; Guðmundsdóttir *et al.*, 1992). Other research projects focus on pain and pain management in general after surgery. Therefore I find it most appropriate to study this theme here in Iceland, not least because of the changes which surgery services have undergone during recent years. Nurses like myself need to understand how patients manage their recovery period, and how they abandon their illness condition, in order to be able to facilitate other patients in this process (Baker, 1989).

My own experience is that the patients do not expect to be very unwell and helpless in this period. It tells me that these individuals are unprepared for this process. Their expectation is sometimes that short-stay surgery means one, or at most, a few days' recovery. This area of nursing is not explored enough, and there is a need for nursing research to focus on the lived experience described from the perspective of the patients themselves (Rose, 1990). In this sector new technologies are also expanding. Furthermore, hospitals are focussing on costs, and there is pressure to increase the number of surgery cases that allow patients to leave soon after the actual surgery. It is therefore crucial to increase new knowledge in this field, so that health-care givers will be able to provide better nursing or counsel to the patients.

1.2. The purpose of the study

What is the experience of Icelandic individuals of managing their recovery at home without the guidance or assistance of health-care givers after surgical procedures and less than 48 hours stay at a surgical unit?

1.3. Research question

The dialogue questions were e.g.:

Can you tell me how you experienced your recovery time after your surgery?

How has your recovery been going after you left the hospital?

With the aim to:

Better understand the experience of the participants.

Become more experienced myself in this field of nursing and hopefully add to the body of knowledge in nursing in general.

1.4. Definition of concepts

Experience is practical acquaintance with any matter. Experience is to gain practical knowledge by trial or observation.

Convalescence or **Recovery** is to win back something such as health, or to regain a former state after medical procedure such as surgery. The WHO definition of **Health** is 'a state of well-being' a positive goal that can be achieved by personal advances (Fridlund and Hildingh, 2000).

1.5. Values of the researcher

I have been working as a perioperative nurse for over 20 years, and perioperative-nursing care has changed rapidly in recent years in Iceland. My working experience has been exclusively in hospitals, and therefore my knowledge is bound to the hospital environment and not to the home of our patients. Due to my own experience I, like some other hospital nurses, have little knowledge of how patients staying at home in their recovery period, without any assistance from health personnel, manage their daily lives. My interest is to gain knowledge as to how those patients cope with this period in their lives. Therefore I decided to conduct this qualitative study, using phenomenology, with the aim of listening to the description of individuals coping with their convalescence in their own environment.

I am aware that I have my own preconceptions about this theme. I have in this study striven to lay aside my assumptions and listen to the participants with an open mind. That means to call into question my former knowledge and assumptions, and not to take for

granted my own knowledge in this field (Crotty, 1998). That also means to let the words of the participants speak for themselves. As Husserl writes (1929/1981 p.73), the true significance of the phenomenological method is the ‘bracketing’ (Einklammerung) of one’s own knowledge, which does not mean the rejection of all knowledge. Rather, naïve or dogmatic knowledge is to be set aside, to allow new and even genuine knowledge to develop from the informants in the study. From my point of view it is important to improve and add new knowledge in this field of nursing, for the benefit of other patients in the future.

1.6. Significance of the study

It is very important to understand how these patients cope in their recovery period, in order to improve the care and preparations for other patients for recovery at home without any assistance from the health care system. Better understanding and further knowledge in this field helps nurses to bridge the gap between hospital nursing care and home care. Therefore it is important for health professionals who focus on caring, communication and interaction to understand individuals’ experience in their convalescence (Holloway and Wheeler, 1996). In this study I will allow the co-researchers themselves to describe their own experience, in order to learn what could be done better or learn from them how nurses can prepare other patients to cope with this period. Knowledge from this study can also be of benefit to nursing in general, both administratively and for nursing training.

1.7. Methodology

The basis of the study design is phenomenology with an interpretive and descriptive approach, with systematic explanation of human experience and perspectives in mind (Halldórsdóttir, 2000). Phenomenological enquiry is the approach that helps to recognise and examine the lived experience, that which is ordinary or commonplace in everyday living. Often we do not take experiences into account, or even notice them, and they may even be taken for granted (Crotty, 1998; Holloway and Wheeler, 1996). Human experience of health and illness is one of the nurse’s concerns. To capture and study the lived experience of individuals, without making prior assumptions about the reality of

those experiences, provides a foundation for phenomenological research (Holloway and Wheeler, 1996). The study focuses on how individuals experience their recovery period at home after surgical procedure and a shorter stay than 48 hours in a hospital environment. This research approach is chosen in the study because it involves the background that nurses have towards holistic care, and it provides a better understanding of health and illness experienced by individuals in their own environment (Hall, 2000). Dialogues are taken with each co-researcher and they are transcribed verbatim. The dialogues are analysed according to the Vancouver School of Doing Phenomenology (Halldórsdóttir, 2000).

1.8. Limitations

Several factors have influenced this study that may have limited the result.

1. The study sample is a small purposive sample, 14 individuals, who did not all have the same surgery. Therefore, the needs of the patients differed.
2. The selection of the participants in the study was handled by charge nurses on the wards where the patients had been admitted. The possibility is that convenient or ‘good’ patients were selected.
3. All but one of the dialogues took place in the home of the co-researcher. To invite a stranger into one’s home can be very demanding, not least when the purpose is to share experience that may have been difficult or painful. One dialogue took place in a dining room of a health-resort hotel (where patients from the rural regions of the country can recover before travelling home). There was some noise from other people, that may have interfered with how the co-researcher communicated.
4. The communicative skill of the researcher is also a great influencing factor where data-gathering relies on how the questions are asked and how the conversation flows in the dialogue.

1.9. Summary

In this chapter the background for the study subject has been introduced. It has been my great concern how individuals manage in their convalescence at home, with or without their family members. The lack of guidance or support from health-care givers can make this time more difficult or prolonged than necessary. Therefore I believe it is of great importance for nursing to study how these individuals are coping after surgical procedure and a short stay in the hospital environment. This study will hopefully add to the body of nursing knowledge how to prepare future patients to manage in their convalescence.

Chapter 2

Review of the literature

2.1. Introduction

This chapter will address the current state of research on recovery or convalescence at home without assistance of health-care providers after surgery procedure and a short stay at the surgical facilities. There has, however, been a debate on the place of the literature review (Holloway and Wheeler, 1996) and also on the purpose and timing of the literature review, that vary in qualitative studies according to Burns and Grove (1999). From the early days of phenomenological studies the researcher has been advised to collect and analyse the data prior to the literature review, so that the information gained from the literature will not influence the objectivity of the research. However, I agree with Sandelowski (1994), who warns researchers to avoid the folly of reinventing the wheel, and the research question may already have been answered. This is opposite to the approach in the grounded theory methodological approach, where it is recommended that the preliminary literature review should be minimal, according to Burns and Grove (1999).

In my opinion a systematic search of the literature is necessary to determine the questions that remain unanswered about the topic in the study and to become familiar with current knowledge. That is consistent with the purpose of the literature review, i.e. to compare and combine the findings from the study with the literature, in order to determine current knowledge of the phenomenon. It is also worth mentioning that the researcher's mind is not a '*tabula rasa*' and one should avoid starting out without any notion of what has already been researched. Also in the Vancouver School the researcher is advised to be well informed about the phenomenon under study in order to become free from narrow-minded preconceptions in his or her own mind (Halldórsdóttir, 2000). I choose to rank the issues in the literature review from the most commonly addressed to the least addressed issues in studies on recovery after surgical procedure.

There were some difficulties in evaluating the studies, because the researchers addressed the issues using different methodologies and methods. None of the researchers use the same research questions or approach the participants in the studies in the same manner.

Therefore the review can only be a presentation of several studies that examine, each in its own way, convalescence or recovery at home without assistance from health-care providers after surgical procedure, and the studies are presented as such. Nevertheless it is well known that feedback and information gained from patients provide nurses with a wealth of information about the ways patients experience and manage recovery after discharge (Beatty *et al.*, 1997).

The literature search was mainly conducted through the use of computerised databases such as Journals@Ovid full text, Cinahl (1982-2001), Medline (1990-2001), Proquest.com, PsychLit, PsycINFO (1984-2001) and BNIplus databases. The following list gives some examples of the keywords used: postoperative/nursing care, postoperative pain, after care, recovery, convalescence, fatigue, postoperatively/recovery, ambulatory care, short stay, follow-up, readmissions and experience of surgical procedure/nursing care. I also reviewed publications of several journals such as *Journal of PeriAnesthesia Nursing*, *AORN*, *Journal of Advanced Nursing*, and *Anesthesia & Analgesia* 1995 to 2001.

2.2. Postoperative pain

The severity of pain is difficult to assess since pain is a personal experience. It can therefore be a challenge to all nurses in postoperative care where the goal of pain management is to achieve and maintain safe analgesia by the patients (Kneeder and Dodge, 1994). Thus the all-too-common complaint of inadequate management of postoperative pain experienced by the patient is a matter of concern for nurses and doctors (Roberge and McEwen, 1998).

Many studies and articles have been published addressing this issue, especially due to the change from in-patient to out-patient settings. In reviewing 97 studies on peri-operative care, Leinonen and Leino-Kilpi (1999) found out that the majority of the studies dealt with postoperative and recovery adaptation and pain. Their conclusion was that, although postoperative pain has been well examined, such research should be continued because researchers still find treatment of pain to be inadequate. They also indicate that the postoperative pain may begin in the operating or recovery room where it casts its 'shadow over the entire post-operative pain experience' (p.135).

Nurses have great impact on how patients are informed and educated prior to discharge, and studies that are based on their experiences are therefore important. In one surgical institution, nurses concerned that patients might suffer unnecessary pain after surgical procedure and a short stay in hospital, contributed to the design of a questionnaire used in the study conducted by Oberle *et al.* (1994), in which they interviewed 294 patients on their fourth day postoperatively. The findings indicated that the patients expected to have pain postoperatively, but that the intensity and duration of the pain came as surprise both to the patients and the researchers. Up to 25% of patients in one surgical category suffered severe pain on their second postoperative day, and in another surgical category the number of patients who experienced severe pain increased from 11.8% on the second to 14.7% on the third postoperative day (score 4 or higher on 5-point scale).

It is important to acquire information from individuals who are managing in their own convalescence at home after surgical procedures, in order to be able to provide more accurate instructions to those who undergo such surgical procedures in the future. Cason *et al.* (1996) conducted a study with the purpose of evaluating and describing the recovery period; 53 patients, interviewed five times postoperatively, described their experiences. In this study, 81-85% of the patients reported having intense pain on day zero and day one and 51% of the patients still had pain on the seventh postoperative day. In other studies conducted by Fitzpatrick *et al.* (1998), 40 patients were questioned, and in the case of Swan *et al.* (1998) the sample was 100 patients. From both studies the authors conclude that postoperative pain emerged as a problem in the study sample. One-fifth of the patients had severe pain on the seventh postoperative day in the former study, while in the latter one, symptom distress remained but declined gradually and persisted until the 7th post-op day (hernia procedures). Only 22% of patients were back at work on day 7 in the study by Swan *et al.* (1998).

The patient's attitude and expectations have a great impact how he/she feels or experiences postoperative pain, and how it affects his/her daily living. In order to reflect on this matter Kristjánsdóttir and Úlfarsdóttir (1995) distributed to 29 patients postoperatively a questionnaire containing questions about their expectations, attitudes and experiences on pain and pain management postoperatively and a short hospital stay. In their response it emerged that most of them were suffering pain when they left the

hospital, and 25% of the patients had ongoing pain on the 8-10th day, or had experienced continuous pain since they left the hospital. They also indicated that the severity of the pain had a great influence on their daily life and activities (ADLs). This corresponds to the study by Lupien *et al.* (2000) of 48 individuals, which indicated that postoperative pain or myalgia has great impact on the completion of ADLs. It is a matter for concern, as Carr and Thomas (1997) maintain, that most of the patients underestimated the severity of the pain they would experience postoperatively. In a phenomenological study by Thatcher (1996), six individuals indicated that they required better pain control, at least for the first few days. Kleinbeck and Hoffart (1994) point out in their study that the information the patients received was inadequate for the postoperative care. This agrees with the view stated by Bostrom *et al.* (1996), who say that patients need further information and guidance regarding pain management in order to be able to manage their care regarding recovery. Sjöström *et al.* (2000) discuss also in their paper that it would be advisable to teach nurses and physicians different strategies for pain assessment in order to improve pain management post-surgery.

Follow-up after surgery gives extensive information on the well-being of the patients and is often used in a study projects. However, in studies where patients are telephoned on the day following their surgery, the answers about pain management are somewhat diverse. Hawkshaw's (1994) sample size was 1,008 patients of whom 700 (or 69%) reported pain where the pain score ranged from 37.0% (369) mild pain to 11.4% (115) severe pain. Only 6.1% (61) patients reported postoperative problems, such as lack of sleep due to pain. In the Kleinpell (1997) study of 485 individuals, 45% (218) of the patients admitted suffering from pain, but on the other hand only 96 (44.4%) of these said that the analgesic had relieved them of most of the pain. It is also worth mentioning that Tong *et al.* (1997) postulate that the postoperative symptoms such as pain could be a predictor of dissatisfaction with care. This corresponds with Boström *et al.* (1997), who indicate in their research a correlation between patients' satisfaction with nursing care and pain relief. Which brings me to the conclusion of the study by Chung and Mezei (1999), who claim that the greatest and most important challenge is still to manage pain postoperatively. Here they all agree with Beatty *et al.* (1997), who came to the conclusion that pain management following the patient's discharge from hospital needs

further evaluation. Furthermore it needs to be recognised that the patient's perspective plays an important role in the planning and evaluation of pain management (Coll *et al.*, 1999).

2.3. Postoperative nausea and vomiting

Since the early days of surgery and anaesthesia a common and distressing postoperative complaint has been nausea and vomiting (abbreviated PONV). Many studies have therefore dealt with this problem. Its incidence seems, however, to be declining through improved anaesthetic techniques and newer anti-emetic drugs (Marshall and Chung, 1999). Studying patients' experience with nausea and vomiting following surgical procedure and a short hospital stay, Carroll *et al.* (1995) completed a follow-up telephone interview 24 hours after discharge with 193 (91.5%) of the enrolled participants. More than 35% of the participants experienced PONV and these were more likely to report impairment in performing their daily activities than other patients in the study. The researcher recommended more detailed instructions to prevent PONV, because the patients are no longer under direct supervision from health-care providers during their recovery period. It is also important to mention that these patients did not experience these difficulties until several hours after discharge. This aspect is not mentioned in other studies I have seen. Nausea was reported by 27% of the study sample (53 patients) in the previously-mentioned study of postoperative experience by Cason *et al.* (1996) and 7% experienced vomiting on the first day. For 17% patients the nausea persisted throughout the initial seven-day postoperative period. In the Thatcher's study (1996), half the sample group (three patients) experienced nausea and vomiting. They found it distressing, but expected. In a small-scale telephone survey conducted by Fitzpatrick *et al.* (1998), 30 surgical patients were asked about their experience of pain, nausea and vomiting, wound-healing and fatigue during the seven days following discharge. They found that 40% of the respondents experienced PONV but only on the actual day of surgery, and none of the sample group reported emesis following discharge. The researchers stress however, the importance of identifying patients at risk of PONV, because of the way it impairs the patients' daily routine and appetite.

2.4. Readmissions and wound concerns

In the literature it is estimated that wound infections should be lower for patients spending less time in the hospital environment than for in-patients, because the risk of cross-infection is minimized (Holmes and Readman, 1994). In their study of 97 patients after day-case surgery, the infection rate was 4% in comparison of 7.3% for in-patients. It can therefore be advantageous for the patient to leave the hospital environment as soon as possible after surgical procedure and recover at home in his/her own environment. In the study of Fitzpatrick *et al.* (1998) just over 23% (seven patients) reported wound problems such as bleeding or oozing for a shorter period. This is comparable with the study conducted by Burke *et al.* (1997) in which most of the patients, i.e. 84%, had no difficulties with their wounds or drainage care. The sample group consisted of 52 women who were interviewed twice: 24-72 hours and 7-10 days post-discharge. This indicates that up to 20% of surgical patients may have some concerns about their wounds. However, Holmes and Readman (1994) point out that assessment of wound problems needs to be followed up for at least one month postoperatively in order to establish accurate information.

Causes for readmission are one of the indicators that can give some information about surgical complications. Twersky *et al.* (1997) studied the frequency of return hospital visits after surgery discharge over a 12-month period, with the attempt to identify some of the factors causing them, so as to improve patient education and safety. Of the 6,243 cases in the study, 187 return hospital visits were reported (i.e. 3%) to the same health care facility, within 30 days after surgery. Of these 65% were connected to treatment in surgery, of which bleeding was the most common reason for all hospital returns (41.5%). Thirty-five percent of the return visits or readmissions were not related to previous surgery. Gold *et al.* (1989) made a study of the causes for 100 readmissions: in 18 cases this was due to excessive bleeding, in 18 due to pain and in 17 due to vomiting. This is consistent with Marshall and Chung (1999), who state that the most common causes for readmissions are surgical factors such as bleeding, and the unanticipated hospital admission rate varies from 0.2% to 1.42% (Chung, 1995; Osborne and Rudkin, 1993; Fortier *et al.*, 1998). However, contacts with GPs or emergency rooms within 30 days postoperatively vary from 3 to 12% (Marshall and

Chung, 1999). It is not uncommon to see readmission rates such as 3%, as mentioned before by Twersky *et al.* (1997), and in a study by Bostrom *et al.* (1996) of 1,413 patients, readmission within 30 days post-discharge was 3%. This variance may be due to different research methods. It is also worth considering whether early discharges put an extra burden on emergency rooms or GPs in the district services (Twersky *et al.*, 1997).

2.5. Fatigue

Getting back to normal is a usual part of the recovery period. Postoperative fatigue syndrome is a well-known phenomenon and can have long-term implications. The causes of postoperative fatigue are not clearly known, although many studies have been conducted in an attempt to explain it better (Petersson *et al.*, 1994). According to Oberle *et al.* (1994), fatigue came as the most surprising and troublesome symptom to the patients in the study, in which 297 participated. Many of the patients indicated that they had not expected the duration and the degree of fatigue they experienced. Although in a study by Cason *et al.* (1996) the fatigue gradually abated as expected and their patients rated fatigue similarly to other studies, the patients tended to resume normal activities more slowly than reported in other studies. In this study only 52% had returned to normal activities by the 7th postoperative day, while in the study by Brown *et al.* (1993) 83% had resumed their normal activities on the 7th day postoperatively. Different methodology and sample and data collection methods may illuminate this deviation. In the study by Fitzpatrick *et al.* (1998) most of the patients experienced postoperative fatigue, although they had sufficient support from their family at home. All these researchers, Oberle *et al.* (1994), Cason *et al.* (1996), and Fitzpatrick *et al.* (1998), agree unanimously on the importance of adequate and accurate information on the expected duration of recovery and the importance of teaching patients how to cope with fatigue and pain. This is in harmony with the study findings of Hawkshaw (1994) who indicates that patients needed more information about the duration and the degree of disability that surgery may impose on them. This leads to the conclusion that the patients require appropriate guidelines by which to

gauge their progress through the postoperative period. Good guidance may have an impact upon the patient's feeling of fatigue, and improve recovery.

2.6. Family and social support

When patients are discharged early from health institutions it can be very desirable that family members be at hand to assist the patient at home if needed. Their presence can provide support and security for the patient. In a review by Coll *et al.* (1999), it is maintained that when patients are discharged following a short stay after surgery, without continuity of care from health-care personnel, this leads to an automatic transfer of care to family members and friends. This is in keeping with the view of the participants in Thatcher's study (1996), who felt reliant on their family members and that they had to take considerable responsibility both in the care and role function, causing the patient to feel guilty. She also indicates the importance of support for self-confidence, both for patients and for carers, who play an important role in the recuperation period. It should also be mentioned that community or district nursing service is not always available for the patient in the home. However, in another study the issue is raised that the provision of home-care nurses may outweigh the savings from discharging patients earlier (Marshall and Chung, 1999). Voepel-Lewis and Malviya (1997) also stress the importance of educating family members, as well as the patient, preoperatively to improve the patient's preparation for surgery and decrease the psychological stress experienced post-surgery.

It may nevertheless be questionable whether cost savings in the health care system rely mostly on the family members to provide the nursing needed in the postoperative period. In the study conducted by Burke *et al.* (1997) a complicated education program is presented in the study about wound and drainage management for the family members. However, problems occurred postoperatively when the preoperative trained caregiver was later replaced by another, and also when the caregivers could not attend the training sessions preoperatively and all the teaching was given postoperatively under more stressful circumstances.

2.7. Education and contacts with health professionals

The importance of preoperative education has been well documented (Brumfield *et al.*, 1996). Preoperative education decreases anxiety and stress before the operation, and this helps reduce the likelihood of postoperative complications. The appropriate kind of education can reduce postoperative pain when advice on proper use of pain medicament and rest is given beforehand (Burke *et al.*, 1997). Standardised teaching handouts are the most commonly used information leaflets in surgical departments. Brumfield *et al.* (1996) point out, however, that such a package may not be effective, since it may not meet the individual's need for education, and that nurses must be sensitive to the possibility that the patient may not understand the information in the leaflet or that they may not see it as relevant to him/her personally if it deals with the subject in general terms (Bostrom *et al.*, 1996). Not all patients remember afterwards having received information leaflets, and some may be unsure if they received any, as mentioned both in the studies of Lewin and Razis (1995) and Heseltine and Edlington (1998). This is in harmony with the review from Marshall and Chung, (1999) who in their findings indicate that patients tend to forget or ignore instructions, or even not to read the leaflets until late in their convalescence (Kleinbeck and Hoffart, 1994). It is therefore important to include both written material and verbal instruction in preoperative education (Burke *et al.*, 1997). Marshall and Chung (1999) stress furthermore that instructional video presentations may be of some help, but written instructions must continue to be recommended. However, health personnel must avoid incomplete, over-complicated or jargon-loaded instructions about aftercare, because such information could lead to doubts for the patients or his carers; also they should not assume that the patients already have sufficient knowledge of the degree and duration of the recovery period (Hawkshaw, 1994). Sigurðardóttir (1996) also stresses that health professionals that participate in the patient's operational process must make an effort to coordinate their pre- and postoperative education to ensure and enhance the quality and continuity of care postoperatively.

Recovery plans and clinical-care guidelines have been designed in several hospitals, and one is presented in each of the articles of Bumgarner and Evans, (1999) and Lewis *et al.* (2000) (Appendix VII fig.2). These plans and guidelines provide vital information for the

patients and their caregivers. They are easy to read, and have pictures or images that can facilitate the patients' understanding and recollection of the verbal instructions.

Kleinpell (1997) points out that follow-up telephone contacts can provide further information and guidance, and are an important factor in the care of patients staying only for a short time in the care of health personnel. In Hawkshaw's study (1994), a project measuring the success or failure of services provided, he telephoned patients the day after surgery; many patients experienced the questions as a part of their care, and one patient commented 'it is nice to know that someone is looking after us' (p. 350), and they had further questions about their recuperation time. This is consistent with the study of Bostrom *et al.* (1996) that over 90% of the patients had questions and concerns about their recovery. They were studying whether follow-up telephone calls to patients after discharge make a difference to the patients' satisfaction with the health care provided. In short, there was no difference in satisfaction with care between the three groups in the study, whether they received telephone calls after discharge or not. It has to be pointed out that the response rate in the study was only 37%, and the fact that the researchers interpreted this as 63% of the patients included in a satisfaction survey poses a question: were these patients unsatisfied or did they choose not to participate in order to avoid taking a stand in the study? As in the qualitative satisfaction study of Boström *et al.* (1997), all the patients expressed their worries that their answers might influence their continued care, and the researchers ask themselves if the patients were reluctant to criticise the staff because they were dependent on them.

Bostrom *et al.* (1996) also indicated that some patients needed immediate readmission or had to call their physician as a result of a follow-up by telephone. This stresses the importance of follow-up contact for the patients post-surgery, and further evaluation for nurses on how to reach out to those patients that are in most need of further education and assistance at home. Brenner (2000) also points out the need for nurses to 'think outside the box' (p.17), in order to be able to reduce postoperative complications and provide patients with the appropriate information on an individual basis, since premature discharge may not only cause development of complications, readmission and medical concerns for the patient him- or herself, but can also impose an additional burden on carers and other family members (Fitzpatrick *et al.*, 1998). It is worth making the point

that, while patients may have been discharged from the hospital, they have not fully recovered until they have returned to their preoperative state (Marshall and Chung, 1999).

2.8. Patients' lived experience

Issues regarding pain, fatigue, and PONV have frequently been asked statistically. I came across only a small number of studies that explore the lived experience of the patient him-/or herself. Thatcher's phenomenological study (1996) explored the experiences of six participants after discharge. She interviewed patients at home two to four days postoperatively. Similarly to other studies, such as the one by Cason *et al.* (1996), the physical problems such as pain were the most distressing category, closely followed by nausea and vomiting. Communication with, and information received from, hospital staff was inadequate. The staff used medical jargon that was unclear to the participants. The participants in this study had trouble remembering discharge instructions, and the carers wished that they had been present when the discharge planning was discussed. Kleinbeck and Hoffart (1994) interviewed 19 patients twice by telephone during the first postoperative week. The patients defined recovery as getting back to the same physical stage as before the surgery. The theme 'toward the usual self' emerged in the study (p.397). This is in harmony with Baker's (1989) study where the participants (25) defined the postoperative recovery trajectory as a process of returning to normal. The participants in Kleinbeck and Hoffart's (1994) study managed their symptoms on trial-and-error basis, which leads one to think that the instructions were not adequate for their individual needs. Apparently they did not read the instructions until late in their recovery.

How patients experience the period before the surgical procedure is an important aspect; the patient's well-being and sense of security at this time can have an impact on the recovery period. Costa (2001) interviewed 16 patients one week postoperatively about their perception and view of the peri-operative experience. The first theme was 'fear': the patients were afraid of death caused by anaesthesia. The second theme described was 'knowing': the patients felt that they did not know enough about the surgery and the whole experience, about what to expect before,

during and after surgery. Another theme was “to be known”, i.e. the health care team recognized them as individuals, which is consistent with one of the topics of patients’ concerns mentioned by Koch (1994b). The last theme was ‘presence’: someone was there for them the whole time, e.g. a nurse or a family member.

Quality is an important topic in the health care system. The focus has been on improving services. Otte (1996) conducted a qualitative study exploring eight patients’ perspectives and experience. The study focused on how to improve health professionals’ knowledge and understanding, in order to improve the quality of day-case surgery. Four theoretical themes emerged 1) ‘The importance of planning’: the patients were dissatisfied with having to wait a long time for surgery. They thought that discharge planning was not well organized. 2) ‘Fear of the unknown’ emerged in this study, as in the study by Costa (2001); the patients themselves felt unprepared for the whole process and not adequately informed. The information in the booklet was not individualised and contained too much general information. 3) ‘Improving the service’: the patients felt that the doctors lacked time, which caused a breakdown in communication between patients and health-care staff. 4) ‘The value of day case surgery’: the patients preferred a short stay, because it minimized disruption of their personal lives. In Otte’s (1996) study the patients unanimously agreed that they had been inadequately prepared for the operations, and there had been a lack of continuity in care during the short stay in the hospital facilities. The patients found themselves unprepared for increased involvement in their own care.

2.9. Summary

Recovery at home after a surgical procedure is an experience that is unique for each individual. However, many studies have been conducted to explore how patients manage with different questions and aims in this period. Traditionally the focus has been on preoperative education, pain, PONV, wound-healing and fatigue. To summarise these findings, it can be concluded that in some cases preoperative education was seen as inadequate: too often patients experienced more pain than expected. Their postoperative fatigue lasted longer than predicted. There seems to be a tendency towards unrealistic expectations of rapid recovery, as a consequence of a short hospital stay. The patients’ self-care is sometimes on a trial-and-error basis and they must rely on their family

members or friends for assistance. The responsibility for aftercare has been transferred from health-care staff to the patients themselves and their families. The shift from in-patient to out-patient surgery, where the patient is sometimes evaluated as a consumer, calls for changes in the nurse-patient relationship. It is therefore important to explore the recovery experience from the patients' point of view. The education process may require updating and changing to a more individual basis, because standardized teaching may be too generalized for patients to be able to apply the information to their own situation.

Chapter 3

Methodology

3.1. Introduction

In this chapter the paradigm underpinning the study will be declared. I will explain the rationale for my choice of methodology and methods in the study, discuss the method of selecting participants, and explain the data collection. Method for analysing the data will also be explained.

3.2. Methodology

The philosophical paradigm underpinning the study is interpretive/constructivist, where the reality is seen as subjective and essentially circumstantial. The topic is to be studied in its natural appearance, where truth and knowledge is created or the meaning of the world studied, and the researcher must interpret it with the aim of deepening his/her understanding of that world (Burns and Grove, 1997; Crotty, 1998). The approach in qualitative research is guided by the paradigm that knowledge is seen from the individual's point of view. What is believed to be truth by one individual may not be the truth according to another individual. The individual is always influenced by his/her own cultural circumstances (Clarifying theory for practice Study Guide, p.19). This paradigm is concerned with the human world such as feelings, thoughts, values, emotions and purposes, in other words 'human science'.

Studies are commonly distinguished in two main approaches, natural (quantitative) science (naturwissenschaften) and human (qualitative) science (geisteswissenschaften) (van Manen, 1990). Wilhelm Dilthey (1833-1911) had characterised this difference, maintaining that each required different attitudes and approaches in which they are rooted (Crotty, 1998; van Manen, 1990). Husserl, one of the founders of phenomenological philosophy, borrowed Dilthey's expression and its intentions about human science (Ricoeur, 1967). Natural science studies 'objects of nature,' 'the way that object behave,' and uses methods such as quantitative measurements and analysis, controlled experiment, observation and mathematics to explain natural phenomena, but human life must be understood (van Manen, 1990). Colaizzi (1975) encourages nurses to

encounter the patient for the purpose of mutually illuminating their experience, which in turn opens up the possibility of each sharing his/her world with the other. This is only possible within the dimension of human science.

As Burnard (1995) points out, it is not a question of one method replacing others, but simply a matter of a method offering another perspective. The gain, however, in my opinion, which I share with many others, might consist in helping us to understand more fully the human condition. One of the differences between quantitative and qualitative research approaches is the close connection between the researcher and the participants in qualitative research (Burns and Grove, 1997). In human sciences questions are asked and language is used as a tool that enables the individuals to express their experiences in meaningful way to the researchers (Crotty, 1998).

I am aware, as Ray (1994) states, that my world-view and my experience as a nurse is the influencing factor in my choice of methodological perspective and how the study was to be accomplished. How the patients' cope, recover, and express their experience from their surgical procedure is to some extent well-researched in other countries. In Iceland, however, the person-centred view of these patients has not been explored, at least not to my knowledge.

3.3. My choice

The choice between two different research approaches, quantitative or qualitative, lies with the research question that I am seeking to answer. Questionnaires with quantitative approach on pain, vomiting etc., and satisfaction surveys, have been conducted to measure such factors as satisfaction with service provided or the convenience of recovery at home, for instance. With the aim of adding valuable information on patients' recovery, I decided to conduct this study, in light of the research question, within qualitative methodology with a phenomenological perspective.

The principle of quantitative research methodologies is to produce a 'hard' science that is formal, rigorous, objective and uses systematic processes to create knowledge or information about the research subject (Burns and Grove, 1997; *ibid*, 1999). Researchers are required to keep very much in mind the distinction between subjective, unverifiable knowledge and objective, empirically verifiable knowledge (Crotty, 1998). This method

is useful in testing theories; examining relationships among variables using the right instrument or tool for measurement, and conducting statistical analyses of the research findings (Burns and Grove, 1997).

On the other hand, the principle in qualitative research methodologies is more to produce a ‘soft’ science with an artistic, philosophical approach, where the focus is consistent with the person-centred and holistic philosophical perspective of nursing (Burns and Grove, 1997; *ibid*, 1999; Holloway and Wheeler, 1996). Qualitative research is conducted to explore and describe the unique, dynamic, and holistic nature of human beings, in order to promote understanding of it. The philosophical base is in that context interpretive, humanistic or naturalistic, and is concerned with understanding the meaning of social interactions of the participants (Burns and Grove, 1997). One has to bear in mind that the term “qualitative” is an umbrella covering a variety of research traditions (Koch and Harrington, 1998) with different approaches such as phenomenology, grounded theory, ethnographic, and historical research (Burns and Grove, 1999).

My choice was the phenomenological research approach, whose aim is to capture and describe the lived experience as expressed by the study participants. In phenomenological methodology the participants are supposed to answer the research questions because they are the only reliable source of information of the lived experiences in question (Burns and Grove, 1999). Phenomenology invites the participants to interpret their experiences for the researcher, who interprets them by analysing the data (Crotty, 1998). Therefore in phenomenological research the connection between the researcher and the participants is close, based on mutual trust. This is the opposite to the nature of quantitative research, where distance is needed.

My intention was to understand how individuals manage in their convalescence after surgical procedure having stayed less than 48 hours in the care of health providers. From my point of view it was necessary to have the opportunity to establish a close connection with the co-researchers, in order to learn from them how they had been coping in their convalescence. This approach would not have been possible in quantitative research. Therefore, I chose the phenomenological perspective within the paradigm of qualitative research to achieve the purpose of the study.

3.4. The philosophy of phenomenology

The birth of phenomenological philosophy as a methodology has largely been attributed to the work of Husserl (1859-1938) as a school of thought (Omery, 1983). Husserl clarifies phenomenology as a way of true science, where ‘phenomenological philosophy regards itself in its whole method as a pure outcome of methodological intentions’, which allows the problems to be taken in hand and completed and ‘this path is endless’ (Husserl, 1927/1981 p.35).

As Spiegelberg (1984) points out, not only does phenomenology show enormous differences in its appearance, but it has also served as a tool for extremely divergent enterprises. Therefore I will only refer to the methodology itself. The goal of phenomenology as a methodology is to describe fully the lived experience by the participants in a study with the aim of enlarging and deepening the range of that immediate experience (Hall, 2000) which is commonly taken for granted. It requires empathetic understanding; the researcher must try to examine the situations, events and actions from the participants’ of view and not impose his/her own perspective (Holloway and Wheeler, 1996).

The focus of phenomenological inquiry is what participants experience in regard to the phenomenon in question, and how they interpret their experience. It is believed that lived experience gives meaning to each participant’s perception of the particular phenomenon in question. It is assumed that human existence is meaningful and interesting because of the participant’s consciousness of existence (Polit and Hungler, 1997). The researcher should approach the participants within the whole of their life context, not as individual entities who exist in a vacuum (Holloway and Wheeler, 1996).

Standards of objectivity and subjectivity need to be re-conceived in a phenomenological study. Meaning and significance are found in the personal relation that is established with the object of the research. Whereas objectivity means that the researcher remains true to the object, subjectivity means that the researcher needs to be insightful and discerning, in order to be able to show or disclose the subject in its richness and depth. The researcher has to avoid the danger of becoming carried away or captivated by preconceptions (van Manen, 1990).

One of the fundamental enterprises in phenomenological research is the suppression of the researcher's preconceived ideas about the phenomenon being studied, in order to hear something new and take in what the co-researcher is saying (Halldórsdóttir, 2000). In other words 'bracketing' (Einklammerung), which does not lie in the rejection of all transcendent knowledge and objects of knowledge, but in the rejection of all naively dogmatic knowledge (Husserl, 1929/1981 p.73) or calling in question what is taken for granted, in order to embrace, and learn to see and hear, what is in front of the researcher (Crotty, 1998).

How the researcher decides to approach the research question depends upon the chosen phenomenological philosophy (school of thought), i.e. the actual method, the 'doing' of phenomenology: whether it is eidetic (of essence), descriptive, interpretive, constructivist-structured or with combined structure (Holloway and Wheeler, 1996). Husserl's phenomenology is primarily eidetic structure and focuses on description. Heidegger (1889-1976), a German philosopher, developed Husserl's ideas further, to the interpretation of phenomena (Heideggerian hermeneutics) where the focus is on 'being in the world' of human existence. This research approach is a search for the fullness of living (van Manen, 1990).

I choose the guidance of the methodology of the Vancouver School of Doing Phenomenology, which is a unique blend of description, interpretation, explication and construction, where the aim is to understand the experience of participants in the study in order to coach them or guide them and others better through a transition in life (Halldórsdóttir, 2000).

3.5. Sampling

According to Polit and Hungler (1997) phenomenological studies typically involve a small number of study participants. This has a profound effect on the quality of the research, the sample and quality of information obtained in the study. The sample size in qualitative researches has to be both appropriate and adequate. The method of sampling fits the aim of the study if it is appropriate and is helpful in understanding the research problem. The strategy of sampling is adequate if the information is relevant and the

quality of the data is sufficient (Holloway and Wheeler, 1996). In this study I choose to use the purposeful sample as recommended in the Vancouver school.

Purposeful sampling is selection of participants that is criterion-based. The sample is selected according to certain criteria. The sample shares experience of the research topic. Individuals are sought who have undergone experience on which the researcher wants to gain information. There must be harmony between the sample and the aim of the study. It is important that informants be willing to share their experiences and response to the situation with the researcher (Halldórsdóttir, 2000, Holloway and Wheeler, 1996). The participants must share the same experience in this study: they must have had convalescences at home after surgical procedure, without assistance or guidance from health-care givers.

According to Sandelowski (1995) it is important that the sample include variation in race, class, gender or other background or person-related characteristics. In order to avoid homogenous or geographical biases, three different hospitals in three different towns were approached for selection of participants in the study. The criterion for the sample was patients that underwent surgical procedure, and the length of stay in hospital was less than 48 hours. No gender or age criterion was applied, although minors were excluded for ethical reasons. Race or language issues are of little concern in Iceland since we are a very homogeneous nation.

3.6. Data collection

Observation, interviewing and examination of written text are the most common data-collection methods used in qualitative researches. Of these, interviewing is most used in data gathering. The format of the interview is mostly open-ended, and the sequence of questions is not fixed (Burns and Grove, 1999). The researcher may choose between interview, dialogue or conversation to approach the participant of one's choice. The approach format depends largely upon the researcher's capability to obtain necessary information for the study, and to maintain well-being and a non-distressing atmosphere during the interview, both for the participant and the researcher.

I used dialogues, because the research participants are seen as dialogue partners and co-researchers. This enables the researcher to develop relationships with the

participants and share with them their meaningful lived experiences. The dialogic nature of the study is also central to constructivist thinking, where both the participants and the researcher are aware of each other's knowledge of their own world (Halldórsdóttir, 2000). The intention to elicit information from the participant that is almost entirely one-sided makes it necessary to guide the dialogue towards the experience journey of the participant, to explore his/her perceptions, feelings and thoughts (Holloway and Wheeler, 1996).

3.7. Method for analysing data

Data analysis in qualitative research occurs concurrently with data collection, rather than sequentially as in quantitative research (Burns and Grove, 1999). Data are collected from the first interview, where ideas begin to develop and become more and more focused and specific as the process develops (Holloway and Wheeler, 1996). The analysis occurs in three stages: description, analysis and interpretation. In the description stage, the researcher needs to become familiar with the data. The second, analysis, goes beyond description, using methods to transform the data where the emphasis is on identifying themes and patterns from the data. However, during interpretation, the researcher articulates his or her interpretation of what is going on. Understanding and explanation are the main focus and go beyond what can be stated with certainty (Burns and Grove, 1999).

3.8. Summary

My choice was the phenomenological research approach with the aim to capture and describe the lived experiences as expressed by the study participants. As mentioned before, I choose the guidance of the methodology of the Vancouver School of Doing Phenomenology, where the actual methodology also embraces the description of analysis and interpretation. The aim is to understand the experience of participants, in order to learn from them and contribute to the greater social good (Halldórsdóttir, 2000). As recommended in the Vancouver school I used purposeful sampling.

Chapter 4

Data collection and analysis

4.1. Introduction

In this chapter I will explain the procedure of the data collection and analysis following the steps of the Vancouver School of Doing Phenomenology (Halldórsdóttir, 2000). The selection of the participants/co-researchers and their characteristics are explained. Ethical considerations are discussed, as well as the validity and reliability of the study.

4.2. Selection of dialogue partners

One nurse in each hospital selected dialogue partners. If they matched the criteria, she both told them about the study and gave them a letter of introduction from me (appendix III). If the patients were willing to participate, she gave them another letter containing a more detailed explanation of the study (appendix IV). She also gave them an informed consent form (appendix V), which they either signed and handed over immediately, or gave to me the first time we met. The nurses provided me with the names and telephone numbers of these patients, so that I could call them. I contacted the patients at home in order to arrange a convenient date, time and location for the individual interviews.

Most of the dialogues took place at the co-researchers' homes in the period from the 7th to the 14th day after the operation. One dialogue took place in the dining room of a health resort hotel. I had slight reservations about that dialogue because of the other people in the dining room; however the individual turned out to be a person who had an interesting story and was also interested in the study.

Of the 17 patients who agreed to participate, 14 completed the study. I was not able to reach two of them in spite of several attempts and one was re-admitted into the hospital on the third postoperative day. The participants came from three different hospitals; six from one, and four from each of two other hospitals. The participants in the study were of different ages, both male and female. They had had different operations but most of them had undergone laparoscopic procedures: cholecystectomies, tubal ligation or other female laparoscopic procedures. Shoulder

operations were also performed on three of the participants. Ages ranged from 28 to 73 years (mean 55.4, see appendix V table 1).

4.3. The identity of the dialogue partners

Iceland has a very small population, and I had to be very careful not to describe the co-researchers in too much detail, in order to protect their anonymity. Each co-researcher was therefore assigned a pseudonym to ensure his/her anonymity, as promised in the informed consent letter. Eleven were married, one widowed and two divorced. Three of the participants were retired. All the others were working either outside their home or at home.

4.4. Ethical considerations

Before I began the research process I asked for permission to conduct the research in the hospitals where dialogue partners were selected. Consent was obtained from the National Bioethics Committee at the Ministry of Health (appendix I, answer appendix II). The letter to prospective dialogue partners was prepared and sent with the research proposal as well as a letter of introduction. In this letter I asked for fully-informed consent from the expected dialogue partners in my study (appendixes III, IV, V). I indicated how I was going to conduct the study and collect the data, which was to be tape-recorded. Furthermore, I stated that I would destroy the data after completing the study. The dialogue partners were informed that they could withdraw from the study at any time. It was also clearly stated that the dialogue partners were to remain anonymous, so that the fact that the names had been changed would not come as a surprise to them afterwards.

In this phenomenological study I conducted in-depth dialogues with the dialogue partners about their definition of lived experience in the recovery phase. This is a complex topic, and I had to be careful in managing the dialogues in a manner that did not distress the dialogue partners. In every study, researchers need to assure the dialogue partners of anonymity and confidentiality. Therefore, as I mentioned before, the dialogue partners were assigned pseudonyms; I choose names that are known in

the English language, such as James, Anna, David, Martha, Maria, Thomas, Susan, Ruth, Jim, Robert, John, Elisabeth, Laura, and Margaret.

In studies where researchers use dialogues, they may affect the informants so that they not only provide the information asked for, but also reveal their experiences and thoughts. This can awaken hidden feelings, which can make the dialogue partners vulnerable. As a researcher I had to be aware of this possibility and not rush through the interview, leaving the informant in a state of distress. However, I did not experience this in any way. Not only as a researcher did I gain knowledge from the informants, they in turn may have found a patient listener for their feelings and thoughts. This means that reciprocity may exist and patients welcome the opportunity to talk with someone about their experience and find it beneficial (Holloway and Wheeler, 1996).

In my case I had the impression that the co-researchers in this study welcomed this opportunity, and found it beneficial to be able to ask questions about their recovery. The kindness and helpfulness I received from the co-researchers astonished me at the beginning. The dialogues influenced me and I became thrilled of this opportunity that had been given to me. Their positive criticism was most helpful. I enjoyed the time spent with them and I admire them and they taught me a lot.

4.5. Bracketing

I cannot deny that I have my own knowledge about the phenomenon in question. As mentioned above, it is important in phenomenological studies for the researcher to identify and hold in abeyance his/her preconceived beliefs and opinions about the phenomenon in the study (Polit and Hungler, 1997). That is: not to allow one's beliefs and assumptions to influence or shape the data collection or the analytical process (Crotty, 1996). Therefore, in order to 'bracket' my own preconceptions I wrote down what I knew or believed I knew about the phenomenon, and examined this before I began the research process, and kept a reflective journal throughout the study (Halldórsdóttir, 2000; Holloway and Wheeler, 1996). The aim was to prevent my knowledge interfering with the data and, furthermore, to allow the data to speak for themselves in their purest form (Polit and Hungler, 1997).

4.6. Participating in a dialogue (data collection)

The most common form of data collection in phenomenological studies is the interview (Holloway and Wheeler, 1996). I used focused or semi-structured dialogues as a dialogue guide (appendix VI), to explore the lived experience of the co-researchers. According to Holloway and Wheeler (1996) the advantages of a semi-structured or focused dialogue guide is that it ensures that similar types of data are collected from all the co-researchers.

All but one dialogue was face-to-face in the home of the co-researchers. They were tape-recorded, and varied from 25 to 90 minutes in length. However, the time spent with the co-researchers was sometimes considerably longer, both preliminary to the interview, and afterwards in small talk. It came as a surprise to me how freely the co-researchers talked in the presence of the tape recorder. I had in advance assumed that it could be an obstacle.

The co-researchers were encouraged to recount their experience as a journey, which they had taken, and I allowed the co-researchers to lead the dialogue. Along the journey I would ask questions occasionally, to narrow the focus, or to go backwards in time in order to get a clearer understanding and to reflect and to validate. Although I was interested in how the patients cope with their recovery after the surgery I realised when I wrote down my own pre-suppositions about the phenomena in question, that it would be easier for the co-researchers to talk about their experience how everything had gone from the beginning when they came to the hospital, and not just after they had left. Thereby 'listening to the voices' of the co-researchers (Koch *et al.*, 1995 p.185).

Most of the co-researchers, however, began their stories by telling me why they had needed the operation. It was also interesting for me as a nurse to listen to how the co-researchers compared this event with any previous experience of surgery, that is to say if they had such experience. They compared this recent surgery with earlier and sometimes sorrowful and difficult surgical experiences in their lives. Yet they told me they did not know why they were telling me all this, because I was not asking about their past experiences. 'It all comes back to me when I'm talking to you. I just do not know why' one lady said. The distance and difference between the researcher and the

co-researchers is acknowledged; one tells the story and the other tries to understand and ‘the dance of the dialogue begins’ (Halldórsdóttir, 2000, p.61).

4.7. Sharpened awareness of words (data analysis)

When I began to collect the data I followed Burnard’s (1995) advice of making sense of it. He states that it always involves some reduction of the text. However, following the Vancouver School of Doing Phenomenology:

a) *I taped and transcribed each dialogue verbatim and I read and reread the dialogue to get the sense of it before I compared them in any way.*

- As Halldórsdóttir (2000) writes so beautifully, the step of ‘living with the data’ is to listen carefully and read the transcripts attentively (p.62).

I also followed the most useful advice of Burnard (1995) and Koch (1998) to view the dialogue transcripts as narratives of stories, in order to gain different or new understanding. In that way I was able to explore a range of meanings in what was offered to me in the form of the stories (Burnard, 1995). This gave a potential richness of data and insight into the lived experiences that could have been lost by more inflexible approaches (Carr and Thomas, 1997).

The following steps of the Vancouver School of Doing Phenomenology are summarized here (Halldórsdóttir, 2000):

b) *Beginning consideration of essences (coding).*

This step involves first *identifying key statements* of the participants that have a special bearing on the phenomenon under study, as one would do in reading an important text to be analysed. Secondly it involves *identifying themes of key statements and coding the themes*, giving them names and writing them down in the margins of the transcript of each dialogue. The researcher asks again and again ‘*What is the essence of what this co-researcher is saying?*’ (Halldórsdóttir, 2000, p.63).

c) *Construction of the essential structure of the phenomenon for each case, (case construction)*

This step involves taking all the different themes that have been constructed in each case, grouping them and constructing *the essential structure of the phenomenon for each dialogue partner - each case* (Halldórsdóttir, 2000, p.63). This is constructing the picture in the researcher's own mind, and is similar to steps 4 and 5 in Spiegelberg's (1984) description of the phenomenological steps. He writes 'that the exploration of the phenomena is not only in the sense of *what* appears, but also in the *way* in which things appear' (p.703) and 'how the illustration of the structure of the experience gradually takes shape in the researcher's mind' (p.706). It is, however, 'important to be true to the lived experience of that individual. It *requires the use of the researcher's abstract thought processes, particularly reasoning, intuition and introspection*'. As Halldórsdóttir (2000) emphasizes this step requires the researcher's attentiveness and the cyclic process of silence, reflection, identification, selection, interpretation, construction and verification (p.64).

d) *Verifying the single case construction with the co-researcher or verifying the essential structure of the phenomenon or phenomena with the participants.*

It is important that the researcher verifies the case construction with the co-researcher. However, it can be very problematical or even impossible to return with the transcripts to the co-researchers, and it is questionable whether the participants can identify their contribution after the data analysis, and after their statements have been subsumed under many different themes (Koch and Harrington, 1998).

e) *Constructing the essential structure of the phenomenon from all the cases, (metasynthesis of all the different case constructions)*

This step involves comparing the different dialogues in order to find the "common threads," as well as the differences, in the dialogues, in order to construct the overriding theme as well as the essential structure of the phenomenon. It is an attempt to mediate the unfamiliar (e.g. the lived experience of the recovery process) into understanding, so that those who do not know the phenomenon from personal experience, but have to help

those who have undergone such an experience, may gain a better appreciation of how it is actually to live through it, and thereby become more able to help (Halldórsdóttir, 2000, p.65).

f) Comparing the essential structure of the phenomenon with the data

When the essential structure of the phenomenon has been identified, it is compared with the transcripts in order to see whether it fits the actual data.

g) Identifying the over-riding theme, which describes the phenomenon, (interpreting the meaning of the phenomenon).

This step answers the question: What is the meaning of the phenomenon under study? Finding and identifying the over-riding theme is a process that requires abstract thought from the researcher and can take considerable time, which should not be underestimated. This can be compared with artistic thinking, because the over-riding theme should tell the reader in a nutshell the meaning of the phenomenon, from the point of view of those who have lived it (Halldórsdóttir, 2000, p.66).

Data analysis within phenomenology is challenging and can sometimes be difficult. I found myself sometimes going round in circles. However, the steps of the Vancouver School show the way. They are clear and very helpful in analysing the data.

4.8. Validity or trustworthiness

Evaluation of validity or trustworthiness is not the same for quantitative and qualitative studies, and it also varies between qualitative studies themselves. As Sandelowski (1986) states, the term “qualitative” is an umbrella for different research approaches, each with its own rules concerning aims, evidence and verification. Koch and Harrington (1998) maintain that in order to establish rigour in a study it must be well characterized, so that readers will be able to read and understand the world of the participants and the researcher’s text, and decide for themselves whether the text is believable or trustworthy. Such clarifications of the study process will establish the trustworthiness of the study (Koch, 1996) and the process trail in the study has to be in

connection with openness and the conscientious faithfulness of the researcher to the chosen philosophical perspective (Burns and Grove, 1999).

Within the Vancouver School, validity is seen in connection with the skills, know-how and rigour of the researcher him/herself; where he/she is seen in a sense as the research tool (Halldórsdóttir, 2000). It is therefore of great importance that each researcher recognise the enthusiasm that has to be put into the whole process. While collecting and analysing the data I tried to prioritise this work and not let other work or my household interfere with my thinking. The data collection itself was not problematic. However, the analytical process was more difficult because how long time I needed to finish it. Then I compared the identified structure with the original data to see if it matched, which it did. And when I called on two of the co-researchers in the study to consult them about whether I had captured their experience - as Koch (1994a) points out - as a way to establish the validity of the study, I was relieved to find out that their experience fitted with my description in the study. I also collected new data – following the advice given by Burns and Grove (1997) to avoid fallacy late in the study – in order to compare with the findings that I had come to, and found that these agreed with my findings.

Keeping a reflective diary throughout the study is generally considered advisable in qualitative studies (Lincon and Guba, 1985), and I followed this advice, trying to write down everything that came into my mind during the research period and lay aside my preconceived conceptions that I had about patients' experiences when recovering at home after surgical procedure and a short stay in hospital. I was well aware that my own knowledge might affect the process: the nature of questions I put forward in the dialogues, and also the way I listened to the answers the participants might give. I found that the diary kept me on track, and helped me not to lose sight of the signposts on the way.

4.9. Summary

Fourteen participants took part in the study. Not all of them had the same kind of surgical procedure. However, they all had the common experience of being at home during their convalescence and staying less than 48 hours in the hospital environment in the care of health-care professionals. Data was collected and analysed according to the Vancouver School of Doing Phenomenology in order to construct the essential structure of the phenomenon under study. The over-riding themes were '*solitary struggle*' '*getting back to normal*' and four main subthemes evolved in the study, see table 2.

Table 2: General theme and main themes which have evolved:

General theme: Solitary struggle Getting back to normal			
The objective of each individual was to become as he/she was before, or even to feel better, as the aim of the surgery was to improve the condition.			
Major theme	Major theme	Major theme	Major theme
The solitary struggle	The sense of insecurity	Communication or lack of communication	‘Recovery – toward the usual self’
The individuals were determined to manage on their own, and did not want to be dependent on others. They did not seek help or advice, except in exceptional cases. The time was characterised as a period of waiting to ‘be better.’ Family members were not active participants. Their concern could lead to paradox of the ill person waiting on the well. Women were more likely than men not to be able to defend themselves against their immediate environment. Experience or lack of it was a real influence on how the day passed. Expectations were high of being able to do things as usual. Definition of illness was unclear in most cases.	Many individuals did not realise what to expect when they came home. Most found the preparation for the actual surgery and anaesthesia very good, which meant they did not fear the procedure. Information leaflets were generally given to them before surgery. They were not deemed to contain guidance on dealing with daily life after returning home. It was left to the patients themselves to proceed by trial and error, but they feared damaging the outcome of the surgery.	Communications with health-care workers were very important to the individuals. But the short stay at the unit meant that there was little scope for bonding with staff. This meant that, if they required guidance later they preferred to consult some other person whom they knew, rather than contacting the surgical unit. Hence they consulted their GPs or health-care workers in their family for guidance and help.	The individuals were in agreement that it took time to recover from the surgery, but they had not expected to be as unwell as proved to be the case. Pain management was haphazard; patients proceeded by trial and error without consulting their GP. Some experienced nausea and dizziness. They did not always receive satisfactory help when they contacted the surgical units. The short hospital stay led to patients thinking that the operation was more minor than it was. They had unrealistic expectations of being able to be active shortly after returning home.

Chapter 5

Presentation of study findings

5.1. Introduction

The purpose of the study was to explore the experience of surgical patients who are managing their recovery period at home after a short hospital stay, without guidance or assistance from health-care givers. In this chapter the research findings will be presented. Every co-researcher in the study will have a voice, where the data from each dialogue have been interpreted into themes that shape the final framework. Halldórsdóttir (2000) reminds us that co-researchers' own words should be used in the writing as much as possible. The research questions focussed on the main issue, e.g. can you tell me how you experienced your recovery time after your surgery? How has your recovery been going after you left the hospital? Further questions developed as the dialogue continued, and I also had a dialogue guide (appendix IV) for each dialogue, to ensure that similar information was obtained from each co-researcher. The findings are divided into four themes, where the overriding theme of each co-researcher, however, is *getting back to normal* as quickly as possible, or to the prior condition as before the surgery or even better. Firstly, to my surprise, is how '*alone*' the co-researchers in the study were during their convalescence. Issues regarding relatives and former experience are addressed. Secondly is '*the sense of insecurity*' which can be felt when the participants did not know what to expect, and the fear of affecting the outcome of the operation. This is a consequence of the pre- or postoperative '*education or lack of education*' which reflects insecurity, such as fear, and insufficient pain relief. They did not seek assistance, but learned by trial and error what they were able to do. Thirdly is '*communication or lack of communication*' with health-care personnel. The participants were not able to develop the necessary relationship with others during the short time spent within the hospital environment, and did not seek further guidance there. The fourth is '*recovery - toward the usual self*,' that sometimes took longer than expected. The quotations in this chapter are presented with the pseudonyms that were assigned to each co-researcher as mentioned before.

5.2. The solitary struggle

The factor which I found the most surprising was how *alone* many of the co-researchers were as they dealt with the period immediately after their return home. The routine of the home was not disrupted, the spouse went to work as usual, and so on. The person who had undergone surgery was home alone. Some of the co-researchers wanted to manage on their own, and did not want to be dependent on others. They did not ask for assistance, not even from their spouse if applicable. Other specifically refused assistance from relatives, especially if that meant they could not be at home, for instance in the case of widows and widowers. They said they preferred to be at home, as that was what they were used to, and they wanted to see if they could manage. A few had, however, made back-up arrangements, for instance to contact a neighbour if necessary. Most of the co-researchers had tried to make preparations for their return home as far as possible:

'I was alone a lot, especially at night. My relatives would ring and call in to check up on me. I found it rather psychologically wearing for a time. I would have got my strength back better if I'd stayed in hospital for longer. '

Ruth (p.3)

If problems arose, the co-researchers did not always seek advice, but opted to wait and see whether the problem resolved itself. It was also interesting to hear co-researchers remark, "if other people can do it, I must be able to" and "the hospitals are short of funding, and are cutting back. So you have to do your bit. It's so expensive, they have to use all possible resources."

The co-researchers took one day at a time, making few demands. Most of those who had had a general anaesthetic slept a lot for the first two days. Remarks such as "I slept and slept" and "I tried just to lie and rest," were not uncommon. This period was often characterised by vague waiting and "drifting."

'I was a bit lonely, rather lost, for a time. I didn't know how to make myself comfortable. I hadn't the extra energy to ask for help, and I didn't even know what to ask for.' Susan (p.1)

5.2.1. The family – concern and support

Family members were more-or-less outside the process. The co-researchers were at home, ill, or not ill, depending upon one's definition. Family members were not active participants; they received information only from the patient him/herself, and hence coloured by their own interpretation of their illness or wellness. As one co-researcher said:

'These laparoscope's procedures are made to sound so minor. I was sometimes annoyed to find things were taking so long. I had to explain to my family that I wasn't able to do everything.'

Laura (p.3-4)

The concern of some family members was displayed in various forms, such as repeated telephone calls and even visits. One of the co-researchers commented: 'I didn't have a moment's peace. They were always ringing to find out how I was.' Some co-researchers received visits; the visitors' concern could become a burden on the person who had just undergone surgery. Women, rather than men, found themselves in the situation of not being able to defend themselves from their immediate environment.

'I got very tired and fatigued after visits. I made coffee and so on. You automatically do your usual tasks, you don't know how to be ill at home.'

Laura (p.1)

5.2.2. The knowledgeable and the non-knowing

Several of the co-researchers had prior experience of some kind of surgery, and this gave them an advantage over those who had no experience.

'The operations I have had have all gone well, and I've always recovered quickly from the anaesthesia. You just take it easy. I prepared my home. I'd done all the tasks I usually do, like laundry and so on, so I didn't have to do anything but cook meals'

Annie (p.4)

For those who had no prior experience, each day was in many ways different from the one before, with new discoveries and experiences. There was a strong expectation of being able to everything as before, preferably as soon as possible.

'I would have liked to have prepared myself, maybe to know more about what was going to happen. Maybe to have some carer, to replace the nurses, to protect you from invisible attacks like visits.'

Susan (p.6)

Many of the co-researchers had planned to do some small task at home, and were quite surprised not to have the energy for such a small thing. They remarked about themselves that they were a bit feeble, not to be able to do more. The definition of being ill, or not ill, was unclear. They felt that they were mentally quite well, but they had very little physical energy, and this surprised them. Some felt that they were home just to recover fully, not really “ill.”

5.3. 'The sense of insecurity'

Co-researchers expressed a certain degree of insecurity regarding the process. They remarked, for instance, that they had not really understood what was being said, and this led to insecurity, so that they had to depend wholly on the staff, and subsequently on themselves, once they were home. The experience of loneliness also appears.

'One is lonely, in the never-ending wait for the next thing, consultations with various people and tests – it makes a big difference how friendly everyone is.'

Susan (p.1)

'I didn't understand everything that was said. I thought, oh, that will come.'

Jim (p.1)

Some of the co-researchers mentioned a long wait for surgery on the actual day of surgery. The order of surgery was sometimes changed, due to reasons beyond the hospital's control. The co-researchers appreciated knowing the reason for the delay, which meant a longer period of waiting and of fear of the unknown. Those who experienced the wait in this manner were also in agreement that the preparatory drugs had certainly not worked - that they were simply given routinely.

Most of the co-researchers felt that the surgery was less traumatic than the general anaesthetic – for which they experienced more apprehension. Some, however, said frankly that they had been very apprehensive about the operation, and others said the same about the anaesthesia. This apprehension was both concerned with fear of the unknown, and also with the results of the operation: *‘was anything else wrong?’* The surgery could also be risky due to the danger of infection, and the co-researchers were on their guard against any such symptoms. There was also fear of not waking up from the anaesthetic, or suffering some after-effects. One of the co-researchers said: ‘They’re my respiratory organs,’ and another said:

‘It made a big difference to me to talk to the anaesthetist. He said there would be a doctor with me all the time, and he wouldn’t leave me.

Sabrina (p.3)

5.3.1 Anticipatory preparation – ‘Education or lack of education’

Preparation for surgery varied, from almost none to excellent and informative, from all parties such as nurses, midwives and physicians.

Some co-researchers spoke of having little preparation, neither time to prepare themselves nor their home, and this exacerbated their negative feelings. The surgery in these cases was at short notice, but in most cases sufficient time was available. By the same token, when a patient’s first visit to the facility was for the surgery itself, there was little time for preparation by staff. Co-researchers were unhappy with this, and they experienced more stress.

‘I had little chance to prepare my home or myself. It would have been better to have more time’

Ruth (p.2)

Most felt that they had only received information from the actual surgeon, and also from speaking to the anaesthetist, who explained his/her part in the procedure. Nurses and other staff were not those members of staff who were generally regarded as providing information, except in exceptional cases. Those co-researchers who felt they had

received detailed information on what was to be done, i.e. in the surgery itself, had much to say about this. It made an important difference to them, and enhanced their sense of security.

'It was all explained to me precisely, by most of the people there, what would be done, and I thought that was excellent. I also received an information leaflet.' Susan (p.1)

'The anaesthetist explained to me what was happening. It was just his view. I was given some papers before and after.' James (p.1)

Leaflets were always given to the patients, and these were seen more as information leaflets than educational ones. Co-researchers were invited to ask questions if they did not understand something in the leaflets. The co-researchers placed more emphasis on what the physicians said than on the content of the leaflets. One co-researcher remarked that information to patients needed to be so *'diplomatic.'* Another expressed a similar view, and said that staff ought to be trained in telling patients things that they might already know. Some found it patronising, but such information must be given for the safety of the patient. It cannot be assumed that other people know what is obvious to a health worker.

5.3.2. Anticipatory guidance – 'Education or lack of education'

When it came to information regarding their own role, and the next stage, the co-researchers felt that their discharge from hospital was far less organised. One co-researcher said: *'they said absolutely nothing.'* But most had met with a physician and nurses before leaving. Co-researchers mentioned not having received any real guidance, simply information on their return appointment.

'You don't take anything home, you're left hanging.' Maria (p.1)

'There was no guidance on what to do when I got home. I took a rest in the afternoon, because I was so tired. But I didn't receive any advice.' Laura (p.2)

The co-researchers who went home shortly after surgery mentioned how emotionally fragile they had been. Some felt that staff were waiting for them to go. When asked if they felt well enough to go, they had answered in the affirmative, as arranged, but one co-researcher said that when she said *‘Oh, yes, I can go home...’*

*‘...I really meant **no, no**, because I was nauseous and dizzy and I didn’t feel well enough, but I didn’t like to make a fuss, one is so fragile.’*

Susan (p.3)

These individuals felt that they would have been permitted to stay for longer if they had asked. But they still felt they ought to go home, like other patients. Those who felt unwell also felt insecure once they were home. They felt they had been discharged too soon, although they had survived.

‘When I got home I felt so insecure and lacking in confidence. I would have liked to stay another night or two.’

Ruth (p.2)

Others were quite content, not feeling that they had been under any pressure to go home. It was up to them, and they said ‘I can relax better at home’ or ‘I sleep much better at home.’ A difference was discernible between those patients who stayed one night in the facility, and those who went home the same day. Those who went home the same day were generally more fragile, but there were exceptions:

‘I could have stayed another night, but I said no thank you. But in retrospect I can see, and I thought sometimes, that it might have been more sensible.’

Sabrina (p.2)

Co-researchers also recounted the discharge entailing a different kind of stress for themselves. They had received so much information from physicians and nurses that they simply could not absorb it all.

‘You don’t take it all in, because suddenly the actual site of the surgery is the main issue. You don’t remember what they said when you left, so when you get home you start thinking about it... what did they say, again...’

Maria (p.6)

Information before and after surgery was not always linked to what would happen after the patient went home. The co-researchers appear to have paid attention to what was to be done, but they did not appear to have taken as much notice with regard to what would follow, and how they would feel after surgery, or they did not receive this information. They did not know whether they needed information on what was normal or abnormal after they went home. Thus they asked no questions. This would simply be a matter of waiting and seeing. They were to get in touch if anything was wrong, but the definition of when that might be was unclear. Co-researchers tended to wait and see if they were uncertain.

'I was asked if I needed painkillers. I said no, because I didn't know if I'd have pain. I thought it would be up to me.'

Maria (p.2)

Information leaflets were not necessarily read, or were sometimes left behind, so they were of no use at home. It also emerged that the leaflets were read only before surgery, and not consulted later once the patient was back home. The co-researchers were in agreement that the leaflets contained useful information on what was to be done, i.e. the surgery or anaesthesia, but little on what followed. The co-researchers did not remember the leaflets recommending rest or painkillers after coming home.

The journey home went well in most cases, although nausea, dizziness and pain were experienced during the car journey by those who went home on the day of surgery, or the following day. Others said that it had been all right – they had just been driven gently. The distance home was a factor; longer car journeys meant more discomfort.

5.3.3. Insecurity

A noticeable factor was the way that co-researchers minimised their experience, speaking almost apologetically of themselves. They did not understand what was happening – after all, it was such a minor procedure. They were not always prepared for what they experienced. They did not know what to do if something went wrong, and did not know how to make themselves comfortable.

'I was always trying to find some position where I would feel better. Maybe there was no such position, that's quite probable.' James (p.4)

'I was always thinking whether it was supposed to be like this. I would have like to ask someone. I suppose I should have rung them.' Ruth (p.3)

'I was always thinking, should it be like this, or why do I feel so bad? But one doesn't necessarily want to call the doctor, that's the thing – I'd rather ring someone who's had this kind of surgery before, preferably someone I know.' Maria (p.7)

Co-researchers were rather uncertain about what they should and should not do. All the co-researchers said that they did not want to do any damage; all movements and actions were based on the principle of not damaging the outcome of the surgery. Those who had undergone abdominal laparoscopy spoke of feeling unusual movements inside, like bloating. They feared that sudden movements might do damage, and hence hardly moved at all. Those who had undergone orthopaedic surgery wanted above all to be well, and thus naturally took no risks.

'I didn't want to be moving around. I didn't want to do any damage and have that on my conscience.' Elisabeth (p.3)

The period of time after retuning home was marked by a sense of insecurity; information provided by staff and in leaflets appeared not to affect this feeling. This period was thus a time of waiting and seeing - being patient, and not damaging the doctor's work.

5.3.4. Trial and error

All the co-researchers found out by trial and error what they could do, but far too many of them felt they had not received any “real advice” on what they should do, and what they were allowed to do. It should be pointed out, however, that those who underwent orthopaedic surgery had received detailed instructions on how much they were

permitted to, and should, move at the actual surgical site. It was primarily with regard to practical things, those tasks that everybody has to perform, like looking after oneself, that guidance was either not absorbed or not given. Remarks such as “I wasn’t told anything’ and ‘I just went on by trial and error’ were common. Also ‘I didn’t know whether I ought to take a shower, so I just washed the old-fashioned way’ (remark eight days after surgery).

Many of the co-researchers described proceeding by trial and error with their daily activities, e.g. finding out whether their pain worsened or they tired quickly. Then they would stop, or wait until they felt more capable to doing the task. But when asked if they had requested help from family, they overwhelmingly answered ‘*no, one tried to manage on one’s own. It wasn’t that important.*’

5.4. ‘Communication or lack of communication’

Communications with health-care staff are important in the view of the co-researchers. It was clear from the dialogues that the staff were all pleasant and friendly. The patient was pleasantly received, and everybody was friendly, but staff were very busy. In general, they felt that health-care facilities were typified by a heavy workload, but that the staff gave themselves time to smile, and that this made all the difference.

One co-researcher suggested that one specific person ought to be responsible for receiving and taking care of each patient, so the patient would have his/her own professional member of staff – that it was so confusing to be dealing with so many different people.

Co-researchers were of the view that, in the case of such a short hospital stay, there was no opportunity to bond with the staff. The patient was in contact with so many different people, and generally staff in different departments. The co-researchers were not even able to learn the names or titles of the people they had met. It was important to them, however, that all the staff were so pleasant.

‘It’s a pity, of course, that you don’t have the opportunity to form a bond with the staff, because you don’t remember, and don’t know what to ask, when you stay for such a short

time. All communications are important, and more important the more serious the condition.'

James (p.4)

'You feel fond of the staff – they're all so kind... then that's it... it's over, that's what the communications were like.'

Martha (p.2)

5.4.1. Seeking advice and support

Some co-researchers had felt insecure, and a few of them had called the facility where they underwent the surgery for further information; they experienced changes which made them feel uneasy, and wanted to know what to do. They felt that the answers they received were not always clear enough, and they tended to attribute this to the person answering the query not being familiar with their case. They felt it made a difference if they knew the person personally, or connected them with the surgery. Some also sought advice, not from the surgical facility, but from their own GP.

'One didn't receive any real advice. I went to my GP on my own initiative after a week, to check if everything was all right.'

Jim (p.2)

'I went to my GP, to find out if I should do something'

Margaret (p.2)

'I didn't want to disturb them. I just called my GP, because he knows me. He gave me some different painkillers.'

Annie (p.3)

'I rang for advice, because I was bleeding from the wound. They told me what to do, but I later had to get members of the family to help me with it.'

Maria (p.1)

Co-researchers also consulted members of the family for information and advice, especially if a relative was in the health service. Advice from family and friends was both good and bad: some was useful, while others told alarming stories of similar cases, or old wives' tales, which only increased the patient's insecurity. Under these circumstances, the co-researchers had to assess for themselves the information they received, and then try to make decisions based on this.

5.5. 'Recovery – toward the usual self'

All the co-researchers regarded this period as an inevitable waiting period before they would feel as well as usual, and preferably even better, since this was the purpose of the surgery, to cure a disease or improve a condition. Co-researchers were generally in agreement that it was good to be at home, but as one of them remarked '*it's good, but a bit misleading, being at home to recuperate.*' This is the matter of being ill or not. To them, this was just a minor procedure, nothing to make a fuss over, as they would recover in a few days. But they intended to follow the physician's instructions by staying at home, yet they intended to make good use of the time. It transpired that it was necessary to stay at home, and sometimes more difficult than they had foreseen. The co-researchers spoke of it as a certain life experience – so much happened in such a short time.

5.5.1. Pain and pain management

Painkillers were usually given with instructions to take them as required. Co-researchers said they were to decide for themselves. A few said that they had been given a free hand. All the co-researchers experienced pain after returning home. Most felt that pain and discomfort were the same. They experienced pain if they moved or stretched in some way.

The majority took painkillers after returning home, either following instructions or by trying to find their own way. One was against painkillers, and tried to rest for much of the time and move only carefully. One co-researcher had to take painkillers on the way home, due to discomfort. Another said that the car journey had been so difficult that all she could think of was getting to bed. She could not hang up her coat or put her shoes away. One co-researcher said that the first evening and night after returning home had been appalling. He experienced considerable pain, and could not find any position in which he could rest. The painkillers did not suffice to dull the pain. It was quite difficult.

'It would have been better to lie in a bed with a 45° slant, like the hospital bed. But you can't complain. There are others worse off than me.' James (p.5)

Contacting the surgical facility, or seeking other assistance, due to pain was not regarded as necessary, except by a few, who consulted their GPs in preference. The co-researchers were asked if they had phoned the surgical facility for advice or other drugs:

'No. It would have been all right, but I preferred to call my GP.' Sabrina (p.3)

'I called, but I got better advice from a medical professional in my family. I was exhausted after the first week; - I think it was mostly due to pain and lack of sleep' Maria (p.2)

One co-researcher said she had been kept going by painkillers for the first few days, after which things improved. Yet another co-researcher had to change over to another painkiller, as she felt they made him/her unwell. She took painkillers three times a day for three days due to considerable pain, then reduced the dose gradually. After a week she was taking no painkillers.

'The pain stopped me. I was taken aback when I felt pain when I did certain things. At one stage I was in constant pain.' Laura (p.2)

One co-researcher started to experiment upon herself, changing the way she used painkillers. She attributed the discomfort she experienced partly to her unaccustomed use of painkillers.

'I stopped taking the medication that I'd been given, and tried some stronger painkillers that were in the house.' Ruth (p.2)

Co-researchers were discouraged by needing to seek help or advice, feeling that they could not cope on their own, and were dependent upon others. Thus it was difficult for them not to know what to expect; and finding out for themselves what was happening at any time was an experience in itself.

With regard to use of painkillers and side-effects, the co-researchers received no information or advice, except for those who consulted their GPS due to discomfort. Others went on from day to day by trial and error. Most had stopped using painkillers a week to ten days after surgery.

5.5.2. Postoperative nausea and vomiting (PONV)

Nausea and dizziness were problem for four co-researchers, all of whom had undergone general anaesthetic for the surgery. Only one co-researcher was prescribed medication for nausea and vomiting. Others lay down, took painkillers, and tried to drink water, in order to feel better.

The nausea increased during the day. Eating made me feel bad – I tried to eat as little as possible. Annie (p.1)

The nausea exacerbated the discomfort of these co-researchers, and they were all in agreement that the knowledge that they were staying home for the next few days was a crucial help. One of them remarked:

‘My main comfort was knowing that I had the next few days off to rest.’ Susan (p.5)

‘I got scared when I started to feel faint. I talked to a doctor to get some advice.’ Ruth (p.1)

In two cases the nausea and dizziness had ceased after two days, but the others continued to experience them for up to two weeks. The co-researchers agreed that feeling this way was difficult; they felt tired, lacked appetite, and felt helpless.

5.5.3. Fatigue

The co-researchers often spoke of an undefined fatigue or weakness, which they felt persisted for a long time. They sought some explanation of this fatigue, which they considered a consequence of the surgery, and also of having been tired before that.

'I was very tired before I had the surgery, and for the next few days I did nothing but sleep. Then I would rest several times during the day for the first week after surgery, if I felt tired.'

Elisabeth (p.1)

'I found I got very tired on the actual day of surgery – it wasn't so bad after that – I tried not to overdo'

Jim (p.3)

'I was terribly tired after the journey home – felt I would never get over it. Then I had to rest in the afternoons – I was exhausted by then. But after a week I felt well.'

Annie (p.2)

Co-researchers placed varying interpretations on the fatigue they experienced: some saw it as a problem, others as a natural consequence of surgery. As one co-researcher said:

'I'd realised that people are often tired after surgery, and have to get over it. So I tried to be well rested before I had the surgery.'

David (p.2)

5.5.4 Sleep and rest

Several co-researchers mentioned sleeping for much of the first two days after surgery. Their ability to sleep at night was largely contingent on the pain they experienced, and being able to find a comfortable position, especially for the first few nights. Some had little sleep due to pain for the first few nights at home, or found they woke frequently and tried to find a more comfortable position.

'I got up several times during the night, and tried to sleep in a chair, but that was no good. Then I took some pillows and blankets so I could raise my head, and then I managed to get some sleep'.

James (p.6)

'The first few nights were difficult because of the pain – I didn't sleep for long – I was always wandering around. My temperature was weird – I felt alternately hot and cold. I was tired out by the time I managed to get some proper sleep.'

Maria (p.3)

'I usually sleep with my head raised, so it was all right. But I woke up several times, and carefully changed my position.'

Thomas (p.1)

'It took me a long time to get to sleep the first evening. Eventually I took a sleeping pill I had, so I could get to sleep.' Annie (p.2)

One co-researcher found it strange to find herself waking up in the middle of the night, wide awake, over and over again – to be tired during the day and yet not to be able to sleep properly at night. Co-researchers made some use of sleeping pills in order to sleep. As one said: 'you feel so bad if you can't sleep. That's when you really start to feel tired.'

5.5.5. Exercise and diet

Most of the co-researchers moved around only at home for the first week, 'pottered around indoors' as one of them said. During the second week after surgery they started to go out. If they went shopping, they took someone with them to carry the bags. The co-researchers said they were very tired after the first times they went out. They rested on their return home. The co-researchers gradually started to exercise more, especially in the second week after surgery. They were aware of the importance of exercise in regaining their prior strength. Only one was back at work on the eighth day after surgery.

The co-researchers' diets varied considerably, reflecting the varying nature of their surgery. Most of those who had undergone some kind of abdominal orthopaedic surgery were more careful. They ate foods they knew would do no harm; one of these co-researchers, however, said he had 'changed nothing – I just ate what was available.' Several co-researchers were able to eat whatever they liked.

5.5.6. Insecurity concerning the follow-up

In the case of the majority of the co-researchers, follow-up consisted to attending an appointment with the surgeon or GP after a certain time. They were also told to contact the facility or the surgeon if there was anything wrong. This instruction was not always accompanied by a further definition of what that might mean. The exceptions were mainly concerned with follow-up regarding surgical wounds. The co-researchers were

told to make contact if there were problems with the wound, such as heat, reddening or fluid in the wound. They were given instruction sheets on the subject.

Only those individuals who experienced considerable problems made contact with the surgical facility, and they did not always receive the answers they needed. The co-researchers felt that the nurses they spoke with were not always equipped to answer their questions, and the co-researchers were then referred to a physician.

'The surgical wounds bled quite a lot, so I got in touch with them for information, but it was up to me to deal with the problem. It was good to have a health professional in the family to help me. I couldn't do it myself.' Maria (p.1)

A few of the co-researchers had to wait for the results of tests on specimens taken during surgery. They found this difficult – in fact the hardest part of the process. They were in a state of uncertainty, living in fear that they might have some serious condition.

'It was terrible having to wait so long, I would never have thought it. Do they have to keep you waiting so long? Can't they give you the result at once? I thought a lot about other women who had to wait. You've got no-one to discuss it with. No-one has any answers. It was terrible. I couldn't listen to the radio or anything – I just waited. I didn't start to feel any better until I'd got the results.' Ruth (p.4)

The surgical facilities did not contact the co-researchers on their own initiative. The co-researchers were asked whether, if it were routine to ring the patient within 72 hours of discharge, they would appreciate this or feel it made any difference. They were in agreement that this would have made them feel more secure.

'I think it would have been good, if someone had rung to check up. Then you wouldn't have the feeling of being thrown out, and they didn't care how you were doing. Admittedly they said I should ring if anything was wrong – that gave me a certain feeling of security.'

John (p.1)

'I'm sure I'd have appreciated it if someone had rung to check up on me.' Sabrina (p.3)

‘Yes, I think so. Then I would probably have found it easier to ask for advice.’ Maria (p.4)

Co-researchers saw the short stay in hospital, and the lack of opportunity to form a personal bond with staff, as a hindrance to contacting the surgical facility, and hence they tended to consult their GPs in preference.

5.5.7. Getting back to normal (relinquishing the sick role)

A number of co-researchers expected to be quite well during their stay at home. Some of them were aware that the process would take some time. Most mentioned having planned to do things, and finding that they could not. They had planned visits, and even some small tasks to be done at home. They planned to use the time to do things for which they never had time. It was noticeable that co-researchers tended to try to do something to pass the time it was so alluring.

They found that there was no energy; also that they generally felt quite unwell at the beginning, experiencing pain, restricted movement, nausea and other side-effects of surgery. These were all limiting factors on what they could do, for which not all co-researchers had been prepared.

‘I couldn’t move much for the first week. I have plenty of patience. One must not expect too much.’

Thomas (p.2-3)

All the co-researchers were in agreement that it took time to regain their former strength – more time, in fact, than most had expected. Remarks such as ‘you’ve got to give your body time’ or ‘I’ve had surgery before, so I know it takes time’ were made. Few co-researchers spoke of ‘illness,’ but rather of the time it took to recover.

5.6. Summary

The experience of patients, who are at home coping with their convalescence, and how they feel, is unique to each individual. Yet there were certain common factors which developed when the co-researchers were asked how they felt during this time. Primarily, they expressed determination to manage alone and not to be reliant on others. The family or others close to the patient received information only from the patient him/herself, and were thus not aware of whether help was needed. The co-researchers did as much as possible themselves, and felt that they were expected to do so.

The period of recovery entailed a certain sense of insecurity, but prior experience or lack of experience was a major factor here. They did not know whether they could be more comfortable. Their preparation and information consisted largely of extensive information about the actual procedure and anaesthesia. Co-researchers were also very content with the information they received, which was excellent in the vast majority of cases – although it did not cover the post-surgery phase equally well.

Nurses were not regarded as providing information regarding the patient's self-care – physicians were seen in this role. It should also be mentioned that co-researchers had not absorbed information given when they were discharged – both due to stress after surgery, and also co-researchers felt that they had not been given any real advice on their daily activities. This led to a feeling of insecurity; these individuals proceeded by trial and error, dealing with their daily lives, but always fearing to damage the outcome of the surgery.

Chapter 6

Discussion of findings, implications, recommendations and conclusion

6.1. Introduction

The purpose of this study was to explore how individuals cope with convalescence at home after surgery, after staying only 48 hours or less at the surgical unit, and without expecting guidance or assistance from health-care staff. The scope of the study was circumscribed by the duration and circumstances of my period of study. It was also necessary to take into account seasonal variations at such surgical units, and when it would be possible to find potential co-researchers. The findings of the study cannot be generalised to apply to society in general.

6.2. The solitary struggle

It may sound strange to talk of the ‘solitary struggle’ of those who are at home after surgery. But my dialogues with the co-researchers made this point clearly. Several of them especially mentioned feeling alone, and lonely. They were generally at home alone, and were the only people in the household who were unwell. Thus they were in a special position vis-à-vis the other members of the household. They wanted to do their best not to be dependent on others, deal with whatever came up, and solve their own problems.

I found no study that specifically supported this conclusion, but Thatcher (1996) and Coll *et al.* (1999) discuss in their studies the transfer of responsibility for post-surgical care to the individuals themselves, so that they are responsible for their own care. Otte (1996) also considers the cultural change that has resulted from short stays in hospital, i.e. the change from the paternalistic traditional structure of inpatient care to one of increased patient empowerment. This supports the finding that patients are at home during their convalescence after surgery, without care from health-care staff. The reduction of the time spent in hospital has led to shorter waiting-lists for surgery and to savings in health spending; but I agree with the point made in the study of Swan, *et al.* (1998) that costs may simply be transferred from the health system to the home.

6.2.1 The family - concern and support

The findings of the study indicate that other members of the family are rather passive with regard to the illness of the person who is at home. It was clear in my study, as in those of Costa (2001) and Thatcher (1996), that family members receive no information on back-up from health-care staff. Only the person undergoing surgery meets the health professionals. Responsibilities in the home were also clearly divided; the women worried about domestic tasks and tried to do these as best they could, while men were less concerned. This point is also made in a review article by Coll *et al.* (1999), that the home and children are the woman's responsibility. Doyle (1999) points out the importance of providing information to family, no less than to the patient him/herself, as it is necessary that they participate in the care of the patient. Dunn (1998) maintains, and I agree with him, that nurses could play a key role in preparing and supporting the patient and his/her family through the process.

6.2.2. The knowledgeable and the non-knowing

Naturally enough, those individuals who had prior experience of surgery were better prepared for the process than those who had no such experience. But in the majority of cases, the co-researchers expected to be able to do far more than was in fact the case. This is consistent with Thatcher (1996); her subjects had assumed that they would be back to normal much sooner than was the case. They felt guilty vis-à-vis the home and family; by the same token, my co-researchers felt they were rather feeble for not being able to do more. Costa's study (2001) reveals that the patients did not know what to expect after surgery, nor what was expected of them.

6.3. The sense of insecurity

My study reveals a certain sense of insecurity with regard to the process. The co-researchers felt insecure on arrival at the surgical unit, and the staff spoke professional jargon, so that the patients did not fully understand. While other studies do not specifically address the issue of insecurity, Thatcher's study (1996) reveals that patients did not understand the staff's professional jargon, and that this led to uncertainty. Doyle

(1999) also stresses the importance of patients understanding the information they are given, as this makes them feel more secure.

My study reveals that co-researchers found the wait for surgery a hard and uncomfortable time. They felt it was unnecessary to be called in early in the morning, when they did not go into surgery until the afternoon. This point is also made in Heseltine and Edlington's study (1998), where the participants felt it was important to try to reduce the waiting period. As in Otte's study (1996), the patients did not believe that they had been called in at the right time, and this led to confusion and discontent. Tong *et al.* (1997) point out that this discontentment felt by patients is more often than not a result of inadequate explanation and communication – that the patient is not kept properly informed by the staff. Hence I feel it is important that patients receive accurate information on the surgery schedule on the day of surgery, in order to reduce their feeling of uncertainty.

My co-researchers were expressive of their feelings of relief that the local or general anaesthesia had gone well, as this was what they had feared most. It was of great significance to them to meet the anaesthetist before the procedure, and be reassured that he/she would not leave them during the surgery. This is consistent with the studies of Costa (2001) and Scott *et al.* (1999), who concluded that patients' fears were concentrated on the general anaesthetic, as this meant they would not be in control. Fear of death emerges clearly in both studies.

6.3.1. Anticipatory preparation – 'Education or lack of education'

My study reveals that the co-researchers experienced variable preparation for surgery. This is largely attributable to the fact that they underwent surgery at three different units, whose practices varied. They were called in for surgery at differing times before the procedure, from two to three days before surgery to the same day. The co-researchers also expressed differing views on this. While it is not my conclusion that the patients who were called in on the day of surgery were worse or less-fully prepared, the individuals themselves felt that this was the case.

The majority of the co-researchers in the study were women, and it was important to them to be able to prepare the home before they underwent the surgery. Responsibility

for the home appeared to be theirs; I also wonder whether women find it difficult to hand over this responsibility to others when incapacitated by illness.

The co-researchers were of the opinion that the principal information on the surgery process had been provided by physicians and not nurses. The study of Oberle *et al.* (1994) finds the same. My co-researchers were generally very content with the information they had received from physicians. Only exceptionally did they mention nurses as providing information. Fox (1998) points out in her paper that it is not enough to hand the patient an information sheet when the surgeon gives him or her information. This information must be reiterated and followed up. This is consistent with my study. Co-researchers were given information leaflets to read, usually by a nurse, and they were urged to ask questions if anything was unclear. The co-researchers commented on this, feeling that health-care staff should beware of assuming that patients knew and understood as much as they did themselves. It was difficult for them to ask about things, if they did not know that the information was lacking. The information must be presented ‘diplomatically’ as one co-researcher put it.

6.3.2. Anticipatory guidance– ‘Education or lack of education’

The results indicated that the discharge of co-researchers had been rather disorganised. They mentioned both that no real guidance had been given, and at the same time that some quantity of information had been given verbally. Henderson and Zernike (2001) write that patients have difficulty absorbing information when they are discharged, as the circumstances typically involve haste and lack of time. I reach the same conclusion; I am in agreement with Otte (1996) who points out in her study that discharges are not well organised. My findings indicate that discharge does not have the same formalised status as admission, and that health facilities ought to consider whether this should be changed, in view of the brief duration of many patients’ stays in hospital.

The co-researchers were generally in agreement that they had been under considerable stress when discharged. At this point the operation – the surgical wound(s) - had become the main issue. It is worth giving thought to their state of mind when they speak of feeling fragile under those circumstances. They did not absorb information, and did not remember what had been said; this is consistent with Thatcher (1996). She mentions

that family members would, for this reason, have wished to have the opportunity to be present when the patient was discharged.

Marshall and Chung (1999) also discuss the problem of patients tending to forget information given verbally. They write, in fact, that patients sometimes ignore their instructions completely. I do not agree with this interpretation, and I feel that the stressful circumstances of discharge are the crucial factor here. As my co-researchers said, they were not in any state to absorb information under those circumstances. They were reluctant to ask practical questions, as they had no idea what to expect once they were home. Oberle *et al.* (1994) also mention how little time patients have to ask questions under these circumstances.

Little has been written about the nature of the information patients would like to receive on discharge (Henderson and Zernike, 2001), and this would be worth considering in the future. As my study reveals, the information leaflets given to patients do not address the post-operative phase, although they are very informative on the surgical process itself. Co-researchers said that there was no mention of rest, painkillers, etc. Leaflets were also not necessarily read at all, as in the findings of Kleinbeck and Hoffart (1994), or might be left behind at the surgical unit, and were hence of no use once the patient was at home. This was also the finding of Heseltine and Edlington (1998). It is also important to have in mind, as Bostrom *et al.* (1996) point out, that the patients may not be able to apply the information in the leaflets to their own case, because the leaflets give information that is too generalised.

6.3.3. Insecurity

The co-researchers felt insecure about making themselves comfortable. They were very anxious about the possibility of damaging the outcome of the surgery. This worry is also mentioned in the work of other researchers, such as Thatcher (1996), Kleinbeck and Hoffart, (1994) and Doyle (1999), who describes in addition the fear experienced by the patient when the pain is more than he/she had anticipated. But it should be mentioned that those who had undergone orthopaedic surgery were more anxious than other patients. They were also given more precise instructions by their physicians on what they should and should not do.

6.3.4. Trial and error

The findings indicate that several of the co-researchers felt they had not received any real guidance on what they should and could do in their everyday activities, and that they resolved this by a process of trial and error. This worked reasonably well, as also emerges in the work of Thatcher (1996) and Kleinbeck and Hoffart (1994). The worst aspect of this was forgetting ‘what one did yesterday,’ and so co-researchers had to carry on day after day by trial and error. I feel that there is a real lack of instruction by nurses on how the patients should approach day-to-day activities.

6.4. ‘Communication or lack of communication’

The findings indicated that it was not possible to bond with staff due to the shortness of the hospital stay, and the workload of the staff. Costa (2001) points out that nurses and patients have a very brief time for communication, which may thus become minimal on both sides. Carr and Thomas (1997) also point out that when staff are so busy, patients are reluctant to take their time.

When patients spend a very brief time in hospital, there is very little scope for forming personal bonds with staff. The co-researchers had difficulty in identifying the different professions involved in their care, let alone remembering any names. This is consistent with the findings of Coll *et al.* (1999), Costa (2001), Henderson and Zernike (2001), Otte (1996) and Thatcher (1996), who mention the limited time available for communication between nurses and patients – also the importance of improving and coordinating such communications, so that they can take place pleasantly and securely, because there is so little spare time for communication with patients.

6.4.1. Seeking advice and support

The findings of the study indicated that co-researchers preferred to consult their GP, or other health professionals they knew, rather than contacting the surgical unit for further guidance or help. Some of them, however (three), sought advice from the surgical unit. These, along with four others, consulted also or only their GP or a health professional in the family. They comprise half of the co-researchers. They sought assistance mainly due

to pain and the condition of the wound. Other studies have reached similar conclusions, such as that of Fitzpatrick *et al.* (1998), in which 57% of the participants consulted a physician. Twersky *et al.* (1997) make the point that it is matter for concern that short-stay surgery may be leading to a considerable burden on GPs and hospital emergency units, although the latter did not arise in my study.

6.5. 'Recovery – toward the usual self'

The findings of the study reveal that the co-researchers saw their convalescence as a waiting period until they regained their prior strength, or better. Fox (1998) defines recovery as being capable of doing the same as prior to the operation. The co-researchers were generally in agreement that it was good to be at home, although some would have preferred to stay another day or two in hospital, as they felt more unwell than they had foreseen. And the process had gone quite well and without major problems, at least by the time when the dialogues took place. Other studies have reached the same conclusion, that the majority of patients wish to be at home if the process goes well, but want to have the option of staying in hospital for longer if problems arise (Otte, 1996; Hawksaw, 1994 and Oberle *et al.*, 1994).

6.5.1. Pain and pain management

My study reveals that all the co-researchers experienced pain after returning home. My findings indicate that the information provided at the surgical units was haphazard, Oberle *et al.* (1994) reached the same conclusion. The co-researchers in my study were supposed to manage their own use of pain medication. It also revealed that the leaflets given to patients did not discuss pain medication. This meant that those who had no experience of surgery started out taking painkillers by trial and error, while those who had prior experience were better prepared.

Pain and pain management is the best-studied aspect of short-stay surgery. Studies reveal that pain medication is often inadequate, and also that pain is worse than the patient expected (Oberle *et al.*, 1994). It is pointed out that more detailed instructions should be given regarding pain management (Leinonen and Leino-Kipli, 1999; Cason *et al.*, 1996). Brown *et al.* (1993) state, however, that the advent of laparoscopy techniques

has reduced patients' need for pain medication, and that painkillers are only needed for a few days, which is a great improvement on what went before.

6.5.2. Postoperative nausea and vomiting (PONV)

My study, like others, reveals that the incidence of discomfort due to nausea and vomiting has gradually decreased by comparison with older studies, due to advances in anaesthesia (Marshall and Chung, 1999). Four individuals in my study experienced such symptoms, however, and this had a considerable impact upon their ability to perform day-to-day activities. Other researchers make the same point, such as Carroll *et al.* (1995), and Marshall and Chung (1999), who were in agreement that patients found these symptoms very distressing (Marley, 1996).

6.5.3. Fatigue

The experience of fatigue developed clearly in my study; co-researchers were somewhat surprised to have so little energy, for so long. They had expected to be able to do far more than was in fact the case. I feel that there was a real lack of information to them on how they could expect to feel, which is nothing new after surgery and anaesthesia (Petersson *et al.*, 1994). This finding is in accord with other studies. The work of Cason *et al.* (1996) and Fitzpatrick *et al.* (1998) reveals that participants were surprised at the degree of fatigue they experienced, and how many days it persisted, and that this had a real impact on their day-to-day activity.

6.5.4. Sleep and rest

The question of sleep relates closely to the fatigue experienced, and is also connected with the anaesthesia. Three co-researchers had inadequate pain management, and could not make themselves comfortable, and had difficulty sleeping for their first few nights at home. Most of the other co-researchers were able to sleep. Some used sleeping pills, as was their habit. My study also revealed that those co-researchers who did not rest during the day for the first few days had more difficulty sleeping at night. This may indicate that they had become over-tired, or that their use of pain medication was incorrect. Doyle (1999) points out that rest is crucial in dealing with pain.

6.5.5. Exercise and diet

Exercise was very limited for the first week in the majority of cases; the co-researchers moved around only indoors (except one). They started taking more exercise as soon as the pain and other discomfort decreased. During the second week, all went out for one reason or another. Only one co-researcher had gone back to work, which was not physically demanding, on the eighth day after surgery. This is a slightly better result than emerges from Cason *et al.* (1996) where only 51% of the patients had regained normal mobility on day seven, while in Swan *et al.* (1998) 22% of patients were back at work on day seven, after similar surgery. The age distribution and number of participants in the studies may affect the findings. Bisgaard *et al.* (2001) carried out a study in which two days of postoperative convalescence were recommended for those in work which was not physically demanding, and with regard to leisure activities, while one week's postoperative convalescence was recommended for those in more demanding work, following laparoscopic cholecystectomy. The conclusion of the study was that most of the patients required six to ten days to regain their former strength, which is consistent with the findings of my study. I feel it is not reasonable to expect patients to return to work until at least a week to ten days, after comparable surgery.

6.5.6. Insecurity concerning the follow-up

Follow-up appointments with physicians were intended primarily for removing stitches and a check-up, after a week to ten days, and some of the co-researchers felt insecure about the period until the follow-up appointment. They were, however, generally advised to contact the surgical unit if anything came up. As mentioned above, they tended to consult their GP or a member of the family in preference. It was disappointing to observe that those who sought advice at the surgical unit did not always receive sufficient help.

They felt that they lacked a personal link with some specific member of staff. This is consistent with the findings of Henderson and Zernike (2001) and Otte (1996), that one of the patients' major complaints was lack of continuity in the staff dealing with them.

They formed no personal bonds, and hence it was difficult to seek advice from the unit, or ask the right questions.

In my study I asked the co-researchers whether they thought it would be desirable for the surgical unit to contact them on its own initiative to check on how they were, as is the practice in some other countries. Their answers were consistent with Hawkshaw's finding (1994), that they would have appreciated this, and felt that the staff were not indifferent to them. Once they had been at home for a while, they would also know what information they lacked. Henderson and Zernike (2001) suggest that the same nurse who took care of the patient during the process of surgery should contact him/her afterwards, as he/she would be best informed about the patient in question. They point out that it makes a difference to the patient to deal with the same nurse, and I am entirely in agreement with them.

6.5.7. Getting back to normal (relinquishing the sick role)

The conclusion of the study was that it takes time to regain one's former strength; all the co-researchers agreed that it took time, and that this must be allowed for. They had, however, hoped that the process would be less lengthy than it proved to be in practice. This is in accord with the findings of Coll *et al.* (1999) and Thatcher (1996), where rapid recovery had been expected since the patients had stayed only briefly in hospital. I feel that the idea of 'being at home' raises false hopes of being able to do various tasks, which proved in fact to be beyond the co-researchers' powers, causing them some disappointment. These individuals generally felt more comfortable in their own home environment, which may, directly and indirectly, prove an encouragement to activity. Fox (1998), Doyle (1999) and Dunn (1998) for instance feel that this offers an opportunity for nurses, and that their responsibility is great in preparing the patient well for the time it takes to return to normal. I am entirely in agreement with them.

6.6. Conclusion

The principal conclusion of this study is that I believe our patients are too isolated in dealing with their recuperation after surgery. I feel that it could be a consequence of inadequate preparation by nurses. It seems to me that nurses do not have enough time to fulfil their task of providing information and instruction, due to their heavy workload. This is, however, not universally true; at least two of my co-researchers said that nurses had sat down with them and gone through the surgery process with them. I felt that close relatives should be able to participate in the preparation, and in the provision of information at discharge, and that this opportunity was lacking.

I feel that here in Iceland we have not yet adjusted to the fact that post-operative care of patients has largely been transferred to the home, to the patient him/herself and the family. The findings also indicate that provision of information on pain, care of the wound, rest and exercise, is haphazard.

The co-researchers appeared not to have any higher expectations, and I feel that this was because they were not aware that a better service could have been provided. They make allowances for the health-care service, and assume that it is due to funding cutbacks that they are sent home early. I believe that this is also because they know no better.

Today, in general, people are expected to take more responsibility for their own care and health. Technological progress has also led to surgical procedures being far less invasive than in the past. Thus patients today generally feel better after surgery than a few years ago, and hence do not require such intensive nursing care.

All my co-researchers said they were happy with the service they received at the surgical units, but nurses did not play a noticeable role there. In my view nursing can make a crucial difference to the patient in regaining his/her health after surgery. Hence it is important that we adapt to changed circumstances, and reorganise ourselves the service we provide, among other things to take account of this category of patients.

6.7. Limitations and strengths of the study

The principal strength of the study is the frankness of the co-researchers – the way they shared their experiences with me in a very positive manner. They entirely understood my feeling for the necessity of adding to knowledge in nursing on how patients deal with convalescence at home after surgery. Another strength of the study in my view is the research approach, i.e. to speak directly with the individuals who have the experience. Each individual recounts his/her experience and how he/she felt. This phenomenological approach is very demanding, and also similar to nursing itself – taking a holistic view of, and with, the individual.

Limiting factors, on the other hand, are how I interpret and process this information – how I work with the data to produce a conclusion, without losing the individuals in some diverse cluster. In addition, the researcher (I) must succeed with working with the co-researchers. Another limiting factor is my ability to elicit information without causing negative reactions or lack of trust. The choice of participants can be a limiting factor; for instance in the case of this group one may consider whether the patients chosen are only ‘good’ patients, or only ‘difficult’ ones.

I believe it may be counted as a strength in this study that the co-researchers took such a positive view, wishing to make a contribution, so that other patients dealing with the same situation in the future might be better prepared for it.

6.8. Implications for nursing practice

The study revealed certain factors, which I feel, could be significant in nursing.

- Those individuals who share their experience with nurses add considerable knowledge to nursing, which will prove helpful to other patients, and to nurses in their work.
- It is important that patients participate in their care in a positive way, with the support of nurses. It is thus important that the patients’ views be known, and that they be offered the opportunity to express their wishes with regard to their care.

- Nurses are, and have been, in a key role in coordinating all the different elements relating to the patient in the surgical process. Nurses should be more visible to the patient in their work. I believe this provides the patient with the sense of security he/she needs.
- It is important to review the discharge of patients. The most important factors regarding post-operative care should be reiterated at this time. Instructions in pictorial form should be prepared specifically for each patient, in his/her name, explaining the main factors in post-operative care (my recommendations see appendix VIII fig. 2).
- Closer collaboration is needed between health-care facilities and the home nursing service, so that the home nurses will be better equipped to nurse patients recuperating at home after surgery.

6.9. Implications for nursing education

In my view, the findings of the study reveal a need for additional training of nursing students and nurses on care and instruction of short-stay surgical patients. This also applies to day-surgery patients. I examined the syllabus of the University of Iceland Department of Nursing, and I could see no mention of teaching with regard to care of day-surgery patients. This may not be correct, as the syllabus is not detailed. If it is indeed so, that there is no specific teaching with regard to these patients, it is important that such tuition be introduced in the near future. Teaching materials and books have been published on the subject, and many studies have been published, so that abundant material is available to improve knowledge of this field of nursing. It is important that nurses be familiar with the problems and solutions involved in recuperation at home after surgery.

6.10. Implications for nursing research and further studies

While this study was in progress, it transpired that various other factors regarding this category of patients also deserved scrutiny. I make no judgement on whether any particular research subject may be more important than another.

- A study of nurses' knowledge and attitudes with regard to these patients, and what kind of instruction nurses feel is necessary when short-stay surgical patients are discharged.
- A quantitative study dealing with the same issues as I dealt with in my study.
- A study of the views of the families of surgical patients recuperating at home.
- A study of readmissions of patients to surgical units after surgery and a stay of not more than 24-48 hours in hospital. Including whether recuperation of patients at home after short-stay surgery causes a corresponding burden on GPs and hospital emergency units, and if so, how much. Such study should be classified by the nature of the surgery, in order to ascertain whether one type of procedure is especially implicated.

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Appendix I

Application for the National Bioethics Committee

Nr. umsóknar: 00-124-51	Móttékin:	Afgreidd:
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Umsókn til Vísindasiðanefndar

1. HEITI RANNSÓKNAR. Beðið er um fullt heiti rannsóknir, íslenskt eða erlent eftir atvikum.

Reynsla einstaklings í afturbata (heima) eftir skurðaðgerð, með minna en 48 klst. dvöl á stofnun

2. TILGANGUR RANNSÓKNAR OG LÝSING Í HNOTSKURN. Útdráttur úr rannsókninni, þ.m.t. markmið, þátttakendur, framkvæmd, vísindalegt gildi og ávinningur

Markmið þessarar rannsóknar er að kynna reynslu og líðan þeirra sjúklinga sem hafa nýverið gengið í gegnum þá reynslu að fara í skurðaðgerð en dvelja skemur en 48 klst á stofnun. Á undanförmum árum hafa orðið miklar framfarir og breytingar er varða skurðsjúklinga, dvöl þeirra á sjúkrahúsi hefur styst til muna og umönnun þeirra færst frá hjúkrunarfólki til aðstandenda og/eða þeir þurfa á minni umönnun en áður var vegna breyttra aðferða við skurðaðgerðir. Því leikur mér sem skurðhjúkrunarfræðingi hugur á að kynna betur þessum reynsluheim sjúklinganna í þeim tilgangi að auka við þekkingu í hjúkrunarfræði. Einnig til að bæta þá þjónustu sem veitt er þessum einstaklingum. Leitað er til þriggja stofnana til að nálgast þátttakendur. Verður leitað til 12-14 einstaklinga og þeim boðin þátttaka. Höfð verða viðtöl við þá sem yrðu hljóðrituð, gögnin greind og flokkuð samkv. Vancouver skólanum í fyrirbærafræði. Vísindalegt gildi og ávinningur er aukið þekking rannsakanda á reynslu og líðan þessara einstaklinga auk þess sem vænst er að rannsóknin auki við þekkingu í hjúkrunarfræði.

3. ÁBYRGÐARMADUR RANNSÓKNAR. Rannsakendur skulu tilnefna einn ábyrgðarmann úr sínum hópi sem annast samskipti við Vísindasiðanefnd og sem ber jafnframt faglega ábyrgð á framkvæmd rannsóknarinnar.

Nafn:	Dr. Sigríður Halldórsdóttir	Kennitala:	Staða: prófessor Háskólanum á Akureyri
Vinnustaður:	Háskólinn á Akureyri	V-Sími: 463 0911 beinn sími 463 0900 skiptiborð	Fax: 463 0999 pósthólf 224, 602 Akureyri
Heimilisfang	Steinahlíð 8a 603 Akureyri	H-Sími: 462 7676	Netfang: sigridur@unak.is

4. AÐRIR UMSÆKJENDUR. Tilgreina þarf nöfn og vinnustaði allra rannsækenda, þ.e. annarra en ábyrgðarmanns.

Nafn:	Erlín Óskarsdóttir	Vinnustaður:	Heilbrigðisstofnun Selfoss	Staða:	skurðhjúkrunarfræðingur
Nafn:		Vinnustaður:		Staða:	
Nafn:		Vinnustaður:		Staða:	
Nafn:		Vinnustaður:		Staða:	

5. AÐRIR SAMSTARFSADILAR (þ.m.t. fjármögnunar- og styrktaraðilar). Hér skal t.d. greina frá þeim stofnunum og fyrirtækjum, innlendum eða erlendum, sem að rannsókninni koma hafi slíkar upplýsingar ekki þegar komið fram í liðum 2 og 3.

6. VERKASKIPTING SAMSTARFSADILA. Hér skal greina frá því hvaða aðilar hafa umsjón með einstökum verkþáttum rannsóknarinnar. Ef rannsakendur njóta styrkja eða annarra fjármögnunar vegna rannsóknarinnar þurfa einnig að koma fram upplýsingar um tengsl fjármögnunaraðila við rannsakendur.

Erlín Óskarsdóttir er skurðhjúkrunarfræðingur og er rannsóknin hluti af meistaraðunámi hennar sem er samvinnuverkefni Háskólans á Akureyri og Royal College of Nursing/ Manchester háskóla. Ekki hefur verið sótt um styrki vegna rannsóknarinnar enn sem komið er, en athugað verður að sækja um styrk í B-hluta Vísindasjóðs Félags íslenskra hjúkrunarfræðinga seinna á árinu.

7. ÞÁTTTAKENDUR. Tilgreinið fjölda þátttakenda svo og hvernig og á hvaða forsendum úrtakið verður valið.

Leitað er til þriggja sjúkrastofnana er framkvæma skurðaðgerðir af þessum toga, Heilbrigðisstofnunar Selfoss, St. Jósefsspítala í Hafnarfirði og Sjúkrahússins á Akranesi, vegna vals á þátttakendum, bæði til að auka fjölbreytni og að ekki sé hægt að rekja niðurstöðurnar til einstaklinga eða sjúkrastofnana. Óskað er eftir að fá að eiga viðtöl við 4-5 einstaklinga á hverjum stað eða samtals 12 - 14 einstaklinga sem uppfylla þau skilyrði að vera sjúklingar sem gengist hafa undir skurðaðgerð á sjúkrastofnun en dvelja skemur en 48 klst. á stofnunni. Viðmiðunin er að sambærilegar eða eins aðgerðir hafi áður (f. nokkrum árum) krafist innlagnar eða sjúklingarnir ekki útskrifaðir frá stofnun fyrr en eftir nokkra daga vegna skurðaðgerðarinnar. Svo sem kviðslitsaðgerðir, gallkögunaðgerðir, æðahútaaðgerðir (saphenous æða stripping), bæklunaraðgerðir o.fl. aðgerðir.

8. ÁVINNINGUR/ÁHÆTTA. Tilgreinið í hverju ávinningur jafnt sem áhætta þátttakenda í rannsókninni verður helst fólgin.

Ekki er talinn vera neinn ávinningur fyrir þátttakendur að taka þátt í rannsókninni, né heldur áhætta.

9. ÖFLUN UPPLÝSTS SAMÞYKKIS. Tilgreinið hvernig upplýst samþykki þátttakenda verður aflað, þ.m.t. hvaða aðili muni leita til þeirra eftir slíku samþykki. Athugið að ef alla á upplýsinga eða sýna frá börnum þarf samþykki frá foreldri eða forráðamanni. Afrit af upplýsingum og samþykkisblöðum skulu fylgja umsókninni.

Þeim sem samþykkja að taka þátt í rannsókninni verður afhent kynningarskjal þar sem þeim er gerð grein fyrir tilgangi rannsóknar, framkvæmd og birtingu rannsóknarinnar. Þar er ítrekað við væntanlegan þátttakanda að hann geti dregið sig út úr rannsókninni hvenær sem er, óski hann þess. Fullum trúnaði er heitið af hálfu rannsakanda.

10. RANNSÓKNARGÖGN. Hvers konar gögnum (persónuupplýsingum, lífssýnum o.s.frv.) er fyrirhugað að safna vegna rannsóknarinnar? Hvaða aðilar munu hafa aðgang að þeim gögnum? Hvaða öryggisráðstafanir verða gerðar? Hver hefur umráðarétt yfir gögnunum að rannsókn lokinni? Hvernig verður trúnaður við þátttakendur varðveittur?

Ætlunin er að hafa viðtöl við einstaklingana sem verða hljóðrituð. Gögnin verða geymd í læstri hirslu á heimili rannsakanda á meðan rannsókn stendur, enginn annar mun hafa aðgang að gögnunum. Þeim verður eytt að rannsókn lokinni. Við úrvinnslu á gögnum verður öllum nöfnum breytt svo og heiti á stofnunum. Leitað er til þriggja stofnana til að tryggja megi að ekki eigi að vera hægt að rekja einstakling til ákveðinnar stofnunar. Tryggt verður að enginn komist í gögn á vinnslustigi og að ekki verði hægt að rekja upplýsingar til þátttakenda. Rannsakandi ritir nafn sitt á sama skjal og þátttakandi er hann staðfestir upplýst samþykki. Rannsakandi heitir þar með undirskrift sinni fullum trúnaði frá sinni hálfu. Þátttakandi heldur eftir einu eintaki og rannsakandi öðru.

11. SIÐFERÐILEG ÁLITAMÁL. Hér skal greina frá helstu álitamálum af siðferðilegum toga sem rannsóknina varða.

Þar sem ætlunin er að hafa viðtöl við einstaklinga um líðan þeirra og reynsluheim verður að gæta þess að viðtölin valdi ekki streitu hjá þátttakendum. Viðtölin fara fram eftir vali þátttakanda þ.e. á heimili hans/hennar, á heimili rannsakanda eða í fundarherbergi á viðkomandi sjúkrastofnun. Þess verður að gæta að truflun á meðan viðtali stendur sé í lágmarki og traust ríki á milli þátttakanda og rannsakanda.

Til þess að tryggja fulla persónuleynd verða þátttakendur númeraðir 1, 2, 3... og viðtölin a, b, og c... Þannig að fyrsta viðtöl við þátttakanda verður merkt 1a annað viðtöl 1b. Sjúkrastofnanirnar verða einnig númeraðar A, B, og C, þannig að fyrsta viðtöl á sjúkrastofnun A verður merkt A1, annað viðtöl í sömu stofnun A2, annað viðtöl við fyrsta þátttakanda í sjúkrastofnun A merkt A1b, annað viðtöl við þátttakanda tvö verður merkt A2b og svo framvegis.

Í lokafrágangi rannsóknarskýrslunnar verður sjúkrastofnunum svo og einstaklingunum gefin nöfn sem ekki geta tengst þeim á nokkurn hátt til að skýrslan verði aðgengileg til aflestrar. Þess yrði gætt að ekki væri hægt að staðfæra sjúkrastofnanirnar hvorki í þéttbýli eða landsbyggð né heldur draga ályktanir af tilbúnum nöfnum sjúkrastofnana um hvaða stofnanir sé að ræða.

12. VÍSINDALEGT GILDI. Gerið stuttlega grein fyrir þeim vísindalega ávinningi sem rannsóknin mun hafa í för með sér.

Tilgangur rannsóknarinnar er að auka þekkingu og skilning hjúkrunarfræðinga og annarra umönnunaraðila á reynslu þeirra einstaklinga er gangast undir skurðaðgerð en dvelja skemur en 48 klst. á stofnum. Markmiðið er að bæta þá þjónustu sem veitt er þessum einstaklingum.

13. FRÆÐIGRUNNUR RANNSÓKNAR. Lýsa skal fræðilegri þekkingu á rannsóknasviðinu og öðrum bakgrunni rannsóknarinnar, þ.m.t. helstu niðurstöðum eldri rannsókna. Taka skal sérstaklega fram hvaða reynsla er af viðkomandi aðferðum og/eða meðferð í fyrri rannsóknum. Þessum lið má skila á sérblaði eða vísa í ítarlegri rannsóknaráætlun sem þá skal fylgja umsókn.

Sjá meðfylgjandi rannsóknaráætlun (Research proposal). Þar kemur fram fræðileg þekking á rannsóknarsviðinu og annar bakgrunnur rannsóknarinnar, þ.m.t. helstu niðurstöður fyrri rannsókna.

Sjá einnig meðfylgjandi lýsingu á rannsóknaraðferðinni (Vancouver skólanum).

14. RANNSÓKNARAÐFERÐIR. Gera skal grein fyrir aðferðafræði rannsóknarinnar. Taka skal fram hvort ætlunin sé að afla upplýsinga annars staðar en frá þátttakendum sjálfum. Ef ætlunin er að notast við upplýsingar úr sjúkraskrá eða sýni úr lífssýnabanka þurfa afrit af tilskyldum leyfum að fylgja umsókninni. Koma þarf fram til hvers er ætlast af þátttakendum, s.s. hvers konar rannsóknir verði gerðar á þeim, hversu oft þeir munu koma í eftirlit eða mat og hvers konar sýni verða tekin. Þessum lið má skila á sérblaði ef þörf krefur.

Gögnum verður safnað með viðtölum við þátttakendur sem verða hjóðrituð. Upptökurnar verða varðveittar í læstri hirslu á heimili rannsakanda á meðan gagnavinnsla á sér stað en verður eytt að rannsókn lokinni. Eitt megin viðtal verður haft við hvern þátttakanda u.þ.b. 1 til 1½ klst. Um það bil einni til tveimur vikum síðar þegar rannsakandi hefur unnið úr gögnumum er úrvinnsla hans borin undir þátttakendur til að kanna hvort þeir hafi sama skilning á niðurstöðunni og rannsakandinn til að auka nákvæmnina í rannsókninni. Ekki er þörf á að fá aðgang í nein sjúkragögn stofnunar, einungis verður aflað upplýsinga með viðtölum við þátttakendur sjálfa.

15. ÚRVINNSLA GAGNA. Tilgreinið hvers konar úrvinnsla (t.d. tölfraeðleg) verður gerð og hvort stuðst hefur verið við "power analysis" eða aðrar hliðstæðar aðferðir við undibúning rannsókna.

Viðtölin verða vélrituð, greind og krufin til mergjar til að finna meginatriðin í lýsingum þátttakenda. Niðurstöður eru settar fram í greiningarlíkani sem er síðan notað til að flokka og kynna niðurstöður.

16. RANNSÓKNARTÍMABIL. Tilgreinið hvenær áætlað er að rannsókn hefjist og hvenær henni muni ljúka.

Áætlað er að byrja að taka viðtöl um leið og leyfi fæst til þessarar rannsóknar. Lokaskil á rannsóknarskýrslunni er 05. 10. 2001 til leiðbeinanda.

17. NIÐURSTÖÐUR RANNSÓKNAR. Gerið grein fyrir fyrirhugaðri nýtingu og/eða birtingu / kynningu á niðurstöðum rannsóknarinnar

Um meistaragráðuritgerð í hjúkrunarfræði er að ræða. Sem slík verður ritgerðin aðgengileg að námi loknu. Kynning á niðurstöðum er fyrirhuguð á vettvangi hjúkrunarfræðinga og væntanlega einnig á sjúkrastofnunum. Rannsóknin kann einnig að verða kynnt í alþjóðlegu tímariti skurðhjúkrunarfræðinga.

18. FLUTNINGUR GAGNA. Ef fyrirhugað er að flytja gögn rannsóknarinnar (t.d. lífssýni eða persónuupplýsingar) úr landi verður að tilgreina í hvaða tilgangi og formi það verði gert, svo og til hvaða stofnunar og lands gögnin verði flutt. Jafnframt ber að tilgreina hver á viðkomandi stofnun hafi umráðarétt yfir gögnunum og/eða beri ábyrgð á þeim.

Ekki er gert ráð fyrir að nein gögn verði afhent til þriðja aðila af neinu tagi.

19. VARÐVEISLA OG EYÐING GAGNA. Hvar verða rannsóknargögnin varðveitt? Hvenær og hvernig verður þeim eytt?

Rannsóknargögnin verða geymd á heimili rannsakanda á meðan á úrvinnslu gagna stendur að Eystri Hellum 801 Selfoss. Gögnunum verður eytt þegar rannsókn lýkur.

20. SAMNÝTING GAGNA. Tilgreinið hvort fyrirhugað sé að samkeyra upplýsingar rannsóknarinnar við aðrar skrár eða samnýta upplýsingar og/eða sýni við aðrar rannsóknir. Ef svo er, greinið þá frá hetti viðkomandi rannsóknar og ábyrgðarmanni.

Gögnin verða ekki samkeyrð með neinum öðrum skráum

21. EFTIRLIT OG TRYGGINGAR. Hver mun annast eftirlit með heilsu og líðan þátttakenda og hvernig verður því háttað? Með hvaða hætti og hjá hvaða aðila eru þátttakendur tryggðir gagnvart hugsanlegum skaða?

Ekki er gert ráð fyrir að þátttakendurnir geti orðið fyrir heilsutjóni að neinu leiti. Einungis er um viðtöl að ræða sem þátttakendum er boðið að taka þátt í af fúsum og frjálsum vilja. Þeir geta sagt sig úr rannsókninni hvenær sem er.

22. GREIÐSLUR VEGNA ÞÁTTTÖKU. Tilgreinið hvort greitt verði fyrir þátttöku í rannsókninni og þá jafnframt hvers eðlis og hversu háar þær greiðslur verði.

Þátttaka einstaklinga verður þeim að kostnaðarlausu. Um sjálfboðaliða þátttöku er að ræða.

23. AÐRAR UMSÓKNIR EÐA LEYFL. Afrit af leyfi stjórnar lífssýnasafns vegna notkunar lífssýna; leyfi yfirlæknis vegna aðgangs að sjúkraskrá og/eða leyfi stofnunar fyrir framkvæmd rannsóknarinnar skulu fylgja með umsókn. Hafi umsóknin áður hlotið samþykki Stóráðs landlæknis eða stofnanasiðanefndar skal afrit þess leyfis einnig fylgja.

JÁ ___ NEI ___ Tölvunefnd, dags. _____ JÁ ___ NEI ___ Önnur siðanefnd, hver: -

JÁ ___ NEI ___ Lyfjaefirlit ríkisins, dags. _____ JÁ ___ NEI ___ Lífssýnasafn, hvaða: _____

JÁ ___ NEI ___ Geislavarnir ríkisins, dags. _____ JÁ ___ NEI ___ Skráarhaldari, hvaða: _____

JÁ X NEI ___ Stofnun, hvaða: ?) Umsókn um leyfi til læknaáða hlutaðeigandi sjúkrastofnana.
Svar frá læknaáði Heilbrigðisstofnunar Selfoss.

24. FYLGISKJÖL MEÐ UMSÓKN. Starfságrip/ritaskrá ábyrgðarmanns, svo og upplýsinga- og samþykkisblöð vegna þátttöku í rannsókninni skulu ávallt fylgja umsókn til Vísindasiðanefndar. ÖLL FYLGISKJÖL SKULU SEND Í ÞRÍRITI.

<input checked="" type="checkbox"/> Starfsferilsskrá ábyrgðarmanns	<input checked="" type="checkbox"/> Nákvæmari rannsóknarlýsing(ar) 'Vancouver skólinn'
<input checked="" type="checkbox"/> Kynningarblað/-blöð	<input type="checkbox"/> Spurningalistar, fjöldi <input type="text"/>
<input checked="" type="checkbox"/> Upplýsingablað/-blöð	<input type="checkbox"/> "Case Report Form"
<input checked="" type="checkbox"/> Samþykkisblað/-blöð	<input type="checkbox"/> Afrit af leyfum
<input checked="" type="checkbox"/> Önnur fylgiskjöl (hver: <input type="text"/>)	Rannsóknaráætlun unnin sem hluta af námi umsækjanda. Bréf til hjúkrunarforstjóra hlutaðeigandi sjúkrastofnana.

25. ATHUGASEMDIR UMSÆKJENDA. Hér er hægt að koma á framfæri athugasemdum eða skýringum sem ekki komust fyrir annars staðar í umsókninni.

Aflað verður skriflegs samþykkis þeirra lækna sem hafa haft þátttakendur til meðferðar áður en rannsókn verður kynnt væntanlegum þátttakendum.

VERÐI EINHVERJAR BREYTINGAR Á RANNSÓKNARÁÆTLUNINNI BER ÁBYRGÐARMANNI AÐ TILKYNNNA ÞÆR ÁN TAFAR TIL VÍSINDASIÐANEFNDAR.

Staður:

Dagsetning:

Undirskrift ábyrgðarmanns:
f.h. Sigríðar Halldórsdóttur

Eyþín Hellur

22.11.2000

Eyþín Halldórsdóttur

Vinsamlegast sendið umsókn í ellefu eintökum en fylgiskjöl í þríriti.
Umsókn sendist: Vísindasiðanefnd, Laugavegi 103, 105 Reykjavík.

Æskilegt er að umsóknin fylgi einnig á rafrænu formi, annað hvort á disklingi eða verði send með tölvupósti á netfangið: thorvardur.arnason@vsn.stjr.is.

Appendix II

Approval from the National Bioethics Committee

Sigríður Halldórsdóttir, prófessor
Háskólinn á Akureyri
Þingvallastræti 23
600 Akureyri

Tilvísun: 00-124-S3

Reykjavík, 5. apríl 2001.

Varðar: "Reynsla einstaklings í afturbata eftir skurðaðgerð, með minna en 48. klst. dvöl á stofnun" – Leyfi yfirlækna.

Vísindasiðanefnd staðfestir hér með móttöku leyfa frá yfirlæknunum Jóni B. Stefánssyni (dags. 26.03.2001) og Sveini M. Sveinssyni (dags. 15.03.2001) þess efnis að nemandi þinn, Erlín Óskarsdóttir, megi bjóða skjólstæðingum Heilbrigðisstofnunar Selfoss þátttöku í ofangreindri rannsókn, en rannsóknin hafði verið endanlega samþykkt af Vísindasiðanefnd að fengnum leyfum frá læknum þátttakenda hennar, sbr. bréf nefndarinnar dags. 20.03.2001.

Vísindasiðanefnd gerir ekki frekari athugasemdir við framkvæmd ofangreindar rannsóknar.

Virðingarfyllst, f.h. Vísindasiðanefndar,



Þorvarður Árnason, framkvæmdastjóri

Afrit: Erlín Óskarsdóttir, deildarstjóri. Heilbrigðisstofnun Selfoss, Skurðeild, 801 Selfoss.

Heild 11/04'01 80

An introduction to the study

A letter of introduction to the individuals, possibly participating in the study.

Getting back to normal. A phenomenological study

My name is Erlín Óskarsdóttir and I am a **surgical nurse** at Heilbrigðisstofnun Selfoss. I work in the hospital's surgical unit and my field of interest is the condition of the patients following surgery.

I am starting on a study, which is a part of my master's degree in nursing (my final thesis) at the Universities of Akureyri and Manchester. The title of the study is: 'getting back to normal'. The questions I seek to answer in the study are: What is the experience and feelings of patients following surgery? How do they tackle daily routines during their recuperation?

The National Bioethics Committee at the Ministry of Health has accepted the study.

As you have recently experienced surgery, I would be interested to learn about your experience and I would be very grateful if you would agree to participate in the study. The study is based on a qualitative approach and will be conducted through interviews, which will be recorded on tape. All information provided by you is confidential and all recordings of our interviews will be stored in a safe place while being processed. All recordings will be destroyed on completion the study. Basically a one-hour conversation is planned. All personal traits will be erased before the information will be finally processed. You can withdraw from the study at any time.

Should you be interested in further information my private phone number is 486 3397, my mobile phone number is 862 2897 and my e-mail is erlin@simnet.is. I will contact you within three weeks following the surgery at the latest to check whether you are interested in participating in the aforementioned study.

With kind regards

Erlín Óskarsdóttir
surgical nurse
Eystri Hellur
801 Selfoss

Private phone	486 3397	Mobile phone	862 2897
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An introduction for the participants in the study:

Getting back to normal
A phenomenological study

Dear participant,

Thank you for taking part in the study: 'Getting back to normal'. With this information letter I want to inform you more fully about the study and its aims. I also want to explain to you in more detail how the interview will be conducted and what to expect.

The study

The aim of this study is to gain insight into the experience and condition of patients who have recently experienced recuperation following surgery and have stayed less than 48 hours in an institution. How do they feel? How do they manage to tackle everyday routines? No studies have been conducted in Iceland using a phenomenological approach in order to gain information about the experience of individuals who have undergone surgery, at least not to my knowledge.

A phenomenological approach aims to look at the personal experience of the individuals in order to throw a clearer light on the experience being researched. This kind of approach calls for mutual trust between us in order to enable you to tell me about your experience. By looking into how individuals deal with this period from their point of view, it is easier to accommodate their needs. The changes in the length of patients' stay in hospitals have become common practice in Iceland and it is important that nurses get to know this period: what is positive and what could be improved. Increasing the knowledge of the matter will possibly make it easier to accommodate the needs and wishes of the individuals who undergo operations, based on the experience of those who previously have experienced it.

The interviews

It is important that the interview is conducted in a relaxed atmosphere where the risk of interruption is minimal. In order to reach this aim, it is also important that both parties feel at ease. I can visit you or provide a room for the meeting in my home. Should you have any special wishes or suggestions I will take them into consideration. I have made arrangements for one interview. Which will take about an hour (might take longer) during which you will tell me about your experience. In the interview we will go through the period from the surgery until the day of the interview: How have you been feeling? What went well and what did not go as planned, or was difficult for you? Was this period like you expected and were prepared for? I want to get to know this period as well as possible and will therefore urge you to describe your experience in as much detail as possible.

It is important that you are aware of the fact that you don't need to answer any other questions than the ones you are willing to answer. The interview, as already stated in the letter of introduction, will be recorded in order to facilitate all the processing following the interview. The recordings will be stored under lock and key, so no third party can access them. They will be destroyed on the completion of the study.

I would like to stress that if you wish, you can withdraw yourself from the study at any time and then all your information will be destroyed. I pledge absolute confidentiality before, during and after the study. The findings of the study will contain no characteristic traits of the participants. Participants will also be given new names so it will be impossible to trace any information to them.

My wish is that our cooperation will be possible and I would be very grateful for all the trouble you will undertake due to it.

Kind regards

Erlín Óskarsdóttir surgical nurse

Eystri Hellur

801 Selfoss

Home phone 486 3397

Mobile phone 862 2897

Email erlin@simnet.is

Informed consent

The title of the study: Getting back to normal
a phenomenological study

Researcher: Erlín Óskarsdóttir
surgical nurse studying for her master's
degree at the University in Akureyri
(distance learning in connection with the
University of Manchester)
Home phone 486 3397
Mobile phone 862 2897
Email: erlin@simnet.is

The aim of the study: is to increase the understanding and knowledge of nurses and other care personnel of the experience of patients who undergo a surgery but stay for less than 48 hours in a hospital. How do these individuals tackle their period of recuperation? What promotes on one hand a positive experience and a negative experience on the other. The goal is to improve the service provided.

How the study is carried out: The individual is interviewed for an hour during which the participant describes his/hers experience of having undergone a surgery followed by a short stay in hospital. The interviews are recorded; the recordings are locked away in order to ensure that no one not connected to the study can have access to them. The researcher guarantees complete confidentiality concerning the information revealed during the interviews. The interviewed individuals can refuse to answer questions and withdraw themselves from the study at any time. On completion of the study the researcher will destroy the recordings.

Publication of the study: As this is a part of a master's degree study, the final report as such will be made accessible. In that report all quotations from the answers of the individuals will be presented in such fashion that all personal traits will be erased. Furthermore, the individuals will be given new names so the information cannot be traced back to them. The participant will not be reimbursed in any way; however, their participation will possibly serve to improve the service provided in future, that is if the findings will indicate that improvements are necessary.

**I undersigned Mrs./MS _____
hereby declare that I am willing to take part in this study.**

I hereby permit the interviews and allow them to be recorded. I understand that the recordings will be destroyed on the completion of this study. I am aware that the findings of this study will be published and therefore made accessible to others. I understand that all my personal features will be erased and my name as well as the names of others mentioned in the recording will not appear in the study. I am aware that I can refuse to answer certain questions and I am fully authorized to withdraw myself from the study at any point.

I have had the opportunity to ask the questions I wanted to ask and my questions have been answered to my satisfaction.

The participant

The researcher promises absolute confidentiality and vouches for that with her signature.

The researcher

Dialogue guide:

1. Can you tell me how you experienced your recovery time after your surgery?
2. How has your recovery been going after you left the hospital?
3. If you have experienced; pain, nausea, vomiting, and fatigue, how have you managed?
4. Did you receive information leaflets during your stay at the surgical unit was it helpful?
5. Did you contact the surgical unit for advice or assistance in your recovery period?
6. From whom did you seek advice if needed?
7. How have you been sleeping after you came home?
8. Would you appreciate if it were routine to ring the patient within 72 hours of discharge, or feel it made any difference?
9. Can you give other patients advice if they were in similar situation?

Overview of sample







Participant	Gender	Age	Surgical procedure	marital status
1.	Male	65-69	Shoulder operation	married
2.	Female	50-55	Breast construction	married
3.	Female	65-69	Laparoscopic Cholecystectomy	widow /living alone
4.	Male	70-74	Shoulder operation	married
5.	Female	40-44	Laparotomy /minitomy	married
6.	Female	60-65	Laparoscopic Cholecystectomy	married
7.	Female	50-55	Laparoscopic Cholecystectomy	divorced/living with her youngsters
8.	Male	70-75	Shoulder operation	married
9.	Female	45-49	Laparoscopic tubal lig	married
10.	Female	45-49	Laparoscopic Cholecystectomy	married
11.	Male	25-29	Pilonidal cyst and sinus operation	married
12.	Male	50-55	Laparoscopic Cholecystectomy	married
13.	Female	45-49	Laparoscopic Cholecystectomy	married
14.	Female	70-75	Laparoscopic Cholecystectomy	divorced /living alone

Age ranged from 28 to 73 with the mean age of 55.4 years.

Four of the patients had nerve blockade anaesthesia and ten had general anaesthesia.

Of the (17) patients who agreed to participate (14) completed the study, two were not able to reach after several attempts and one was remitted in the hospital.






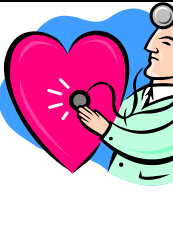
YOUR GALLBLADDER OPERATION (Laparoscopic Cholecystectomy)

	THE DAY BEFORE YOUR OPERATION	THE DAY OF YOUR OPERATION	ONE SIX DAYS AFTER YOUR OPERATION	ONE WEEK AFTER YOUR OPERATION	TWO WEEKS AFTER YOUR OPERATION
 People You Will Meet	<ul style="list-style-type: none"> Nurse X-ray & laboratory workers Anesthesia Nurse 	<ul style="list-style-type: none"> Nurses Technicians Doctors 	<ul style="list-style-type: none"> Nurses Doctors 	<ul style="list-style-type: none"> Keep your appointment with your doctor. 	<ul style="list-style-type: none"> Keep your appointment with your doctor.
 Your Treatments	<ul style="list-style-type: none"> Blood work X-ray 	<ul style="list-style-type: none"> Blood pressure Temperature A tube (IV) will be put in your hand or arm. A shot may be given to help you relax. Your doctor may let you go home in the evening, if you are able. 	<ul style="list-style-type: none"> You may go home the day after your operation if you are able to eat and drink and if your pain is less. 	<ul style="list-style-type: none"> Blood pressure Temperature Your stitches or staples may be removed by the doctor or nurse. 	<ul style="list-style-type: none"> Your doctor will look at your incisions, check your temperature and blood pressure.
 Your Diet	<ul style="list-style-type: none"> Do not eat or drink after midnight. 	<ul style="list-style-type: none"> No food or drink until after your operation. 	<ul style="list-style-type: none"> Eat light, low-fat meals. Drink a lot of fluids Eat normal meals after the 1st day as you can. 	<ul style="list-style-type: none"> Normal food and drink. If any foods cause constipation or diarrhea, do not eat them. 	<ul style="list-style-type: none"> Normal food and drink.
 Your Activity	<ul style="list-style-type: none"> Go to bed early the night before your operation. 	<ul style="list-style-type: none"> Cough and take deep breaths after your operation. You may get up and walk to the bathroom with help 2 to 3 hours after you wake up. 	<ul style="list-style-type: none"> Rest a lot. Do not lift anything over 5 pounds. Do not drive. Walk as much as you are able. 	<ul style="list-style-type: none"> Rest for short periods during the day. You may be able to drive. Walking is good for you. Your doctor may let you go back to work, if you do not have to lift. 	<ul style="list-style-type: none"> Rest when you are tired. Your doctor may let you go back to work.
 How to Care For Your Incisions		<ul style="list-style-type: none"> Big bandaids will be over your incisions. You may take medicines for pain. 	<ul style="list-style-type: none"> Take your bandaids off the 2nd day after your operation. You can take a shower on the 2nd day. You may need to take your pain medicine. 	<ul style="list-style-type: none"> You may still need medicine for pain. Keep your incisions clean and dry. You can cover your incisions with bandaids if you want. 	<ul style="list-style-type: none"> Your incisions should be healed. There may be some soreness.
 Who to Call For Any Questions or Concerns You Have	<ul style="list-style-type: none"> Call the Day Surgery Center at (704) 326-3898 or your doctor. 	<ul style="list-style-type: none"> Ask your doctor or nurse. 	<ul style="list-style-type: none"> A nurse from the hospital will call you the day after you go home. You can ask questions then or call your doctor. 	<ul style="list-style-type: none"> Call your doctor for any concerns or if you have a fever (100° or more) or chills. There is fluid or drainage from your incisions. There is more pain or redness at an incision. 	<ul style="list-style-type: none"> Call your doctor if you have any questions or if you are having any problems.

Appendix VIII, Figure 1, p.16.

Bungartner, S.D. and Evans M.L. (1999) Clinical care map for laparoscopic cholecystectomy patient, *Journal of PeriAnesthesia Nursing*, 14(1) pp.12-16

Patient's name:
Surgical procedure:
Date of procedure:

	<p>Be prepared to stay at home for the first two weeks or as long as your surgeon has advised you.</p> <p>However, when planning when to return to work you should also take account of the nature of your work.</p>
	<p>You will probably need painkillers 2-3 times a day for the first three days, which can then be tapered off. If the painkillers recommended to you are not satisfactory, you should contact your surgeon or GP, depending on your discharge instructions.</p>
	<p>The surgical wounds should heal in one week. You can shower 2-3 days after the surgery, if not otherwise instructed at discharge. Usually you may change dressings as required, if the surgeon has not advised otherwise. Sutures are most commonly removed after 5-7 days, if they do not dissolve by themselves. Contact the surgical unit, surgeon or your GP and if your body temperature rises, or if you have unexplained heat, redness, oozing or bleeding in the surgical wound.</p>
	<p>You are advised to move around regularly. Breathing exercises as well as physical exercise can prevent complications from surgical procedures. Light walking exercises will do you good. Then progressively increase your exercise. Rest regularly, but take care not to disrupt your nighttime sleep.</p> <p>If you have had an orthopaedic procedure it is important that you exercise as your surgeon has advised.</p>
	<p>Be prepared to eat light food for the first day or two. Then you should be able to eat ordinary food. It is important to drink 2-3 extra glasses of water a day, for the first few days after the operation.</p>
	<p>Keep your appointment with your surgeon or GP as advised.</p> <p>Date: _____ Time: _____</p> <p>If any questions arise please do not hesitate to contact the surgical unit.</p>

Our best wishes in your convalescence

The page may be changed for each patient personally prior to discharge according to his/her operation.