EVOLUTION OF FAMILY VISITATION
IN THE POST-ANESTHETIC RECOVERY ROOM

by

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ABSTRACT

The Post-Anesthetic Recovery Room, commonly known as the recovery room is a specialized and designated unit where a patient recovers from a surgical procedure and the effects of anesthesia. Historically, the recovery room has been a closed and restricted unit to the family members of surgical patients. Over the past 20 years, a growing body of nursing research has emerged supporting the inclusion of family visitation in the immediate post-operative period. Still, the issue of family visitation in the adult recovery room remains an unresolved and controversial issue among nurses and other health care professionals. To further explore this issue, a study on the history of family visitation in the recovery room was conducted. The primary sources consisted of an extensive literature review of published books and journal articles on recovery room care from the 1940s to the 1960s and oral history interviews. Nine recovery room nurses who practiced in the 1960s-1980s were interviewed. The findings revealed that the issues of space, privacy and safety were grounds for restricting family visitation during this time period. However, the findings also revealed that the reasons why family visitation was restricted back in the 1950s no longer holds the same merit in present-day recovery rooms. The face of the immediate post-operative patient has changed in the last 50 years, and as a result, a re-evaluation of this dated policy and practice is in need.
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CO-AUTHORSHIP STATEMENT

As first author, I identified and designed the research study. I performed the research and data analysis. I wrote 100% of the manuscript that was published. My thesis supervisor, the second author, guided with developing the manuscript into a publishable paper.
CHAPTER ONE: INTRODUCTION

Background

The Post-Anesthetic Recovery Room, commonly known as the recovery room is a specialized and designated unit where a patient recovers from a surgical procedure and the effects of anesthesia. Historically, the recovery room has been a closed and restricted unit to the family members of surgical patients. Only doctors, nurses, and authorized hospital personnel have access to this area. Over the past 20 years, a growing body of nursing research has emerged supporting the inclusion of family visitation in the immediate post-operative period. Still, the issue of family visitation in the adult recovery room remains an unresolved and controversial issue among nurses and other health care professionals.

Problem Statement

Despite a growing body of evidence-based research over the past 20 years supporting the positive effects of family visitation in the immediate post-operative period for patients and family members, a "No Visitors" hospital policy continues to be practiced in acute care recovery rooms. In the spring of 2005, I personally contacted 13 Vancouver Lower Mainland hospitals in British Columbia (BC) spanning from the North Shore to the Fraser Valley to inquire if a hospital policy for family visitation in their recovery rooms existed. All 13 hospitals had a "No Visitors" policy in their recovery rooms; however, 1 out of the 13 hospitals occasionally allowed for open family visitation but did not have a formal policy set in place and did not have any future plans to institute such a policy. The general consensus regarding the other 12 hospitals was that family visitation should be completely restricted unless the patient had undergone a cesarean
section, was mentally challenged, needed an interpreter, was critically-ill, was an overnight client, or was a child; however this practice varied from hospital to hospital and from nurse to nurse. Interestingly, these circumstances did not guarantee the family member entry into the recovery room and gaining entry depended solely on the primary nurse’s discretion. Therefore, to further investigate this issue, I decided to conduct a study on the history of family visitation, to explore the context of restrictions on family visitation in the recovery room, now known as the Post-Anesthetic Care Unit, and examine the historical influences that had shaped this practice. In this thesis, I present the results of this inquiry.

Literature Search

In order to gain a better understanding of the context and background of my question, I first conducted a literature search. I used the following electronic databases: CINAHL, PubMed, Web of Science, and Academic Search Premier. The following key terms were used: family visitation, post-anesthetic recovery room, post-anesthetic care unit. A number of qualitative and quantitative studies were found, dating back to the mid 1980s. The studies focused primarily on the outcome of family visitation. The findings revealed family visitation in the recovery room was beneficial for the immediate post-operative patients, their family members, and in some cases, for the nurses. With the findings demonstrating the benefits of family visitation, the question of “why” family visitation continues to be restricted emerged.

Since the studies revealed the positive outcomes and benefits of family visitation, I felt it was necessary to understand the continued resistance of family visitation in the recovery room from a historical perspective. Family visitation in the recovery room has
been a restricted practice dating back to when recovery rooms were first formally
developed in the 1940s and 1950s. Examining why family visitation has been a restricted
practice from the beginning of the recovery rooms existence will allow for a deeper
understanding as to why this issue remains unresolved.

Therefore, in addition to examining the current research literature on family
visitation, I also examined the historical literature on recovery room care. Although we
have a growing historical literature on the history of hospitals and nursing more broadly,
very little is written on the history of the recovery room. Several works provide a
foundation to gain an understanding of the changes and developments in general hospitals
and the nursing profession, especially with regard to specialized nursing practice in the
second half of the twentieth century. Within the nursing profession, Fairman & Lynaugh
Keeling (2004) discussed the expansion of nurses roles in coronary care units in the
Her work was particularly helpful for my study because of its focus on space, which also
became a central analytic concept in my analysis of the recovery room. Toman (2003)
examined nurses roles and responsibilities in the area of blood work and transfusion from
1942-1990. More broadly, Mitchinson (2002) explored the history of childbirth in
Canada from 1900-1950, which was relevant to my study since I found that the recovery
phase of women from a cesarean section provided a key context for change in family
visitation in the late seventies. The acceptance of fathers into the recovery room
following a cesarean section influenced the norms around restricted access for families.
McPherson (2003) provided an in-depth analysis of Canadian nursing history up until the
1960s. She, however, does not focus on specialized areas of nursing. All these studies have major significance in understanding the history of nursing from a historical perspective. In my study, I build upon these works, exploring post-anesthetic care as an area of specialized nursing that has received little scholarly analysis.

Research Questions

In order to understand why the issue of family visitation remains unresolved and controversial, the following research questions were posed for analysis:

1. Why has family visitation been historically restricted in the adult recovery room?
2. What are the barriers that have historically impeded the acceptance of family members in the adult recovery room?

A historical approach allowed for an examination of this deeply rooted practice, bringing upon new knowledge and understanding to this phenomenon.

In the second chapter, I present a review of the historical and evidence-based literature on family visitation in the recovery room. In the third chapter, the research design and methods are outlined. In the fourth chapter, I present the findings of my inquiry, which was based on written primary sources, as well as, oral history interviews with nurses from three large hospitals in the Vancouver Lower Mainland area of BC. All the nurses had long standing careers in post-anesthetic care nursing. In the fifth chapter, I present a discussion of the findings and a conclusion.
CHAPTER TWO: LITERATURE REVIEW

Two sets of literature reviews will be outlined in this chapter. The first section will be on the historical literature dating back to the 1940s to the 1960s. The historical literature is a critical piece in this research study, as the literature provides insight on how family members were perceived during this time period. Subsequently, in the second section, the literature review will transition to the evidence-based literature. The evidence-based literature revealed the changes in thinking towards the restriction of family visitation in the recovery room. The studies focused specifically on the outcomes of family visitation in the immediate post-operative phase.

Review of the Historical Literature on Family Visitation

Family Visitation in the 1940s-1960s

To place the issue of family visitation in context, I will discuss the emergence of the recovery room itself and then review the few primary written sources I found on the history of the recovery room. These were mainly books and manuals about the design and planning of recovery rooms, primarily written by physicians, and one handbook about recovery room nursing, first published in 1967. I also found some published journal articles from the 1940s onwards.

Although the concept of a recovery room dates back to the early 1800s, the wide-spread establishment of recovery rooms began in the 1940s due to World War II (Zuck, 1995). According to Adams and Theodore (2002), “It was not until the coming of the post-World War II hospitals that modernist design in the exterior image of the hospital was used to promote the modern hospital” (p. 203). Because of the changes

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emerging in health care, the way hospitals were built, viewed, and utilized were under examination. Hospitals began to restructure their built environments to meet the growing and complex demands of patient care.

With an increase in surgical procedures being performed during this time, specialized recovery room units were needed for patients requiring complex care. As an early text on the recovery room indicated: “Many [recovery room] patients [went] back in four hours; the majority of abdominal cases stay[ed] overnight or twenty-four to forty-eight hours maximum ... [and] thoracic surgery cases stay[ed] about four days or until the drain tubes [were] ... removed” (Adriani & Parmley, 1958, p. 11). To address these emerging post-operative patient needs, new spaces were created. Prior to the establishment of recovery rooms, post-operative patients were cared for on the wards, which contributed to a number of post-operative complications resulting in death. A shortage of nurses also influenced the development of recovery rooms, as “fewer nurses could provide a safer level of nursing care for more postoperative patients in a recovery area” (Barone, Pablo, & Barone, 2003, p. 238). The reasons for the inception of recovery rooms were “inadequate nursing care coupled with respiratory obstruction in the postoperative period” (Ruth, Haugen, & Grove, 1947, p. 882). As of the late 1940s, the establishment of recovery rooms gained increasing attention in the medical literature.

A few books about recovery room care were published in the 1950s and 1960s. The majority of the content focused on how to create and implement a post-anesthetic recovery room. Published articles were also found on recovery room care dating back to the late 1940s to the 1960s, some of them published by nurses. For the most part, these articles evaluated the success and future improvements needed in their existing recovery
rooms. Although the focus of these books and articles were primarily on the structural aspects of planning, developing, and evaluating the requirements for recovery rooms, the issue of family visitation in the recovery room was a topic of discussion in these documents dating back to the late 1940s.

One article commented on the anxiety experienced by waiting family members:

Another minor objection is that relatives are sometimes apprehensive because the patients are kept upstairs for such long periods. For the first few months we advised the patients about the recovery room when we made our pre-operative visits. Notices were also sent to all floors requesting nurses to reassure the relatives and ask them to remain in the waiting rooms, and we have had very few disturbed families as a result (Noble, 1948, p. 289).

In this quotation, the family members' emotional state is acknowledged and a solution is found to alleviate their stress. It appears, based on previous experiences with family members, physicians, and nurses were taking active measures to alleviate their stresses and anxieties. As one physician stated:

One of the main problems that had to be met within the introduction of this new department was that of the anxious family and friends of the surgical patient. At no time are they allowed in the post-anesthesia room, so the floor nurses assume the responsibility of informing them where the patient is and why. If the patient is going to remain in the post-anesthesia room for any length of time, the nurse in charge of the department keeps the floor nurses informed about the general condition of the patient. In most cases, the visitors have accepted the reassurance of floor nurses (Kerns, 1949, p. 375).
Other 1940s and 1950s physicians and nurses reiterated the same sentiments in keeping the family members informed of the patient’s progress regardless of the length of stay in the recovery room (Charbon & Livingstone, 1949; Leon, 1952; McQuillen, 1948; Oschner, 1951; Schafer & Galbraith, 1952).

However, not all physicians and nurses embraced or accepted the same kind of thinking or practice. A 1950s book documented a symposium held on the establishment of the recovery room. It included a discussion amongst physicians regarding visitors in the recovery room. Specifically, physicians were asked “Should visitors be allowed in the recovery room?” (Adriani & Parmley, 1958, p. 85). The following are the responses of the physicians.

Physician 1:

No visitors are permitted in the recovery room. There was only one exception in over ten years to this rule, and that was in an instance where an adult expired in the recovery room after a strangulated scrotal hernia was reduced under local anesthesia. The patient had been in frank decompensation for two days (p. 85).

Physician 2:

No, visitors are not permitted in the recovery room (p. 86).

Physician 3:

We have very strict rules which excludes visitors from the recovery ward except after 7:00 p.m. (for patients who stay over-night) or for emergency purposes. If some one of the immediate family, parent, wife or only relative has not been able to see the patient before operation and shows up later in the recovery ward waiting room they are permitted to enter, to see the patient for one minute as a
matter of assurance, and they are excluded until 7:00 p.m. or until the patient has returned to his own ward (p. 86).

Clearly, all three physicians had varying opinions concerning visitors in the recovery room. The initial answer of "No" appears to be the common response. However, it was not a firm "No". There were extenuating circumstances that waived this rule. Death was a justified reason for allowing visitors in the recovery room, as it was a time for the family to grieve and say "good-bye" to their loved one.

Interestingly, another reason for allowing visitors in the recovery room was when a family member had no opportunity to see their loved one before surgery. This circumstance was quite remarkable as the emotional needs of the family seemed to be taken into consideration. A stark contrast from the traditional rule of no visitors.

Continuing from the first question about visitors, a subsequent question was posed: "Should close relatives be allowed to visit in the recovery room?" (Adriani & Parmley, 1958, p. 86).

No one should be admitted to the recovery room at any time. Should the patient's condition be extremely critical, then only, may close relatives be admitted for a short period (p. 86).

This response was also found in another recovery room manual. Storch (as cited in Beal, 1956) stated "Visitors are allowed only if the patient has been placed on critical care or serious list" (p. 5). In the following chapter, Jones (as cited in Beal, 1956) reiterated the same opinion: "Visitors should not be allowed in the recovery room unless the patient is critically ill" (p. 16). She further added, "It is important that the staff
maintain liaison with the family which will allay apprehension while the patient is still in
the recovery room” (p. 16).

Clearly there were exceptions to the “No Visitors” rule from the onset. As I found
in other recovery room books and articles on family visitation, and in my oral history
interviews, family was permitted to visit if the patient was in a critical care state
(Masters, 1949; Sadove & Cross, 1956). The reason being that when a patient was in a
critical care state, the length of stay was typically prolonged from a couple hours, to an
overnight stay, or even to a few days given the gravity of the patient’s condition. This
particular practice still seems to be quite common in present day recovery room nursing
practices.

What is intriguing about Jones’ response is her concern for the emotional needs of
the family members, as this kind of concern is scarcely documented in the 1950s-1960s
recovery room care literature. Similar to Physician 3, she expressed an understanding of
the stresses related to surgery from the perspective of the family. Both acted as advocates
for the patient and the family.

On the other hand, not all physicians and nurses expressed the same kind of
understanding and empathy on behalf of the patient’s family. Betschman (1967), a
recovery room head nurse wrote a handbook on recovery room nursing. She noted:

The problem not every hospital seems to have solved is to satisfy the impatience
of waiting relatives who continue to harass staff member even when they have
been warned that the patient will be detained for some hours after the operation
(p. 3).
This is a powerful statement as it vividly describes how she viewed the family member. Based on her choice of words, family members were perceived as demanding and difficult. However, the family members so called “impatience” may be attributed to anxiety and stress regarding the outcome of the patient’s surgical success and prognosis.

In a follow-up sentence, Betschman added “Unless the patient is in extremis visitors are usually barred from postanesthesia rooms” (p. 3). In extremis means at the point of death (Taber’s Cyclopedic Medical Dictionary, 1989). The impending death of a patient continued to be the determining factor in permitting visitors to reconnect with their loved one. Betschman also added, “It helps ... if the family gets frequent bulletins on the patient’s condition” (p. 3). It appears as though Betschman agreed with the need to keep the family updated on the patient’s condition during times of critical events in an attempt to alleviate concern and apprehension. She further supported this belief under the duties for registered nurses. She wrote, “Nurses should be mindful of the psychological aspect of the patients and their families before, during, and after surgery, and should strive to help and give reassurance wherever possible” (p. 8). This is a stark contrast from her earlier viewpoint on the role the family played in the recovery phase of being impatient and bothersome to the hospital staff.

In another recovery room manual, Belinkoff (1967) also supported a no visitors rule with a specific exception. He stated:

Visitors are not permitted in the recovery room at any time, with the exception of the immediate family if the patient is in extremis. In this circumstance, the patient is isolated by curtains and may be seen for a very short time by the immediate family or by the clergy if death appears imminent (p. 13).
Belinkoff, as well as the other authors, have supported the concept of allowing family to visit when the patient is in a critical state (Oschner, 1951; Sadove, Kretchmer, Wyant, Gittelson & Puestow, 1951). Despite the varied practices concerning family visitation, it is clear that the inclusion or exclusion of family members was an important topic during the development of post-anesthetic recovery rooms.

Review of the Evidence-Based Literature on Family Visitation

Family Visitation in the 1980s

The topic of family visitation in the adult recovery room surfaced in the mid-1980s in academic and non-academic nursing journals. During this time, similar issues concerning family presence in other specialized areas also began to emerge. For example, family presence during resuscitation and family visitation in the pediatric recovery room were gaining increased attention from the nursing and medical community (Doyle, Burney, Maino, Keefe, & Rhee, 1987; Junge, 1987).

Cappiello (1984), an obstetrics nursing instructor from the US, was the first nurse to publicly question why families were “off limits” in the adult recovery room (p. 15). Cappiello criticized the claim made by health care professionals that family members may become upset at the sight of their loved one. She refuted this claim by comparing the recovery room to the intensive care unit where patients who are acutely-ill and connected to restrictive and invasive equipment welcome family members at the bedside. She further described an all too common scenario where a patient has experienced a delayed resolution of a spinal anesthetic, which has caused an extended length of stay in the recovery room. This created anxiety for the family members waiting to reconnect their
loved one. Cappiello raised the necessity of this separation and requested nurses to challenge this practice.

Soon after the publication of Cappiello’s article, follow-up letters from recovery room nurses responded unfavorably to the mere thought of including family members in the adult recovery room. Sapp (1984) expressed concern over family members being disturbed by the sounds and sights of the recovery room and the limited space of the environment; therefore “adding to the nurses’ problem” and workload (p. 7). Burden (1984) felt that “an open-door policy as standard protocol” would create an unmanageable working atmosphere for nurses and would add stress to recovering patients (p. 7).

Vogelsang (1986) recognized that no formal research study had evaluated the effects of family visitation in the adult recovery room. Vogelsang was the first researcher to conduct a study on nurses’ assumptions about patients perceived needs in the recovery room, and the effects of family visitation on reducing patient anxiety in the recovery room. Based upon her findings, she concluded that nurses’ preconceived ideas were not supported by nursing research and that family visitation in the adult recovery room has positive effects on alleviating patient stress and anxiety.

The following year, Vogelsang was investigating “the relationship between nursing interventions and levels of anxiety in surgical patients” (Vogelsang, 1987b, p. 25). The primary nursing intervention of her study was the effects of family visitation compared to no family visitation on the adult surgical patient’s anxiety scores. Vogelsang measured the anxiety levels of 60 surgical adult patients prior to and after their surgical experience. These findings supported the hypothesis that surgical patients who received
family visitation in the immediate post-operative period had significantly decreased patient anxiety scores compared to patients who did not receive family visitation.

Within that same year, Vogelsang conducted another study measuring the anxiety levels of female surgical patients (Vogelsang, 1987a). Vogelsang’s rationale for focusing on female patients was that during the development of the State-Trait Anxiety Inventory, an instrument used to measure state and trait anxiety levels, “women were found to be more emotionally labile than men in their reaction to either stressful or relaxed conditions” (p. 231). Vogelsang used family visitation as the primary nursing intervention to determine the effects of family visitation on patients’ post-anxiety scores. Vogelsang found that female patients benefited from family visitation in the recovery room reflected by their lower anxiety scores post-operatively.

By the end of the 1980s, nurses working in adult recovery rooms began to share their own personal experiences of being the family member waiting to reunite with their loved one. Fields (1989) described how her nurse-centered attitude towards family visitation in the adult recovery room dramatically changed when she was given permission to visit her acutely-ill father in the recovery room. Fields stated, “my personal experience forced me to reconsider the traditional [recovery room] visiting policy of my unit” (p. 85). Fields was influential in the creation of a liaison nurse and changes to her institution’s “No Visitors” policy. The role of the liaison nurse was to keep the families members updated on their loved one’s condition and to arrange recovery room visits. Fields’ article was of particular interest because a copy of her institution’s newly implemented policies on the duties of the liaison nurse and recovery room visitation was included in the article.
Family Visitation in the 1990s

As family visitation programs in adult recovery rooms slowly began to develop, research studies were focusing on the outcomes of these visitation programs. Noonan et al. (1991) sought to evaluate family visitation from the family member’s perspective. Noonan et al. found that 89% of the patients and 96% of family members felt that family visitation was beneficial. Cormier, Pickett, and Gallagher (1992) assessed the perceived needs of family members during the immediate post-operative period and found that nurses’ perceptions of family members needs compared to family members perceived needs greatly differed. Nurses ranked family visitation seventh in importance out of a list of ten needs, whereas family members ranked family visitation as second.

Within that same year, Poole (1992) published a summary of completed family visitation studies involving various critical care areas: coronary care units, intensive care units, pediatric recovery rooms, and adult recovery rooms. Poole thoroughly outlined the findings of all the studies and confirmed that regardless of the setting, family visitation has positive effects and benefits for both the patient and family members. A year later, Poole (1993) conducted a modified replication of Vogelsang’s 1987b study to validate her findings. Poole found a considerable decline in anxiety scores for the group who received visitors in the recovery room, which were consistent with Vogelsang’s earlier findings.

Tuller et al. (1997) reiterated that “most families of adult postoperative patients continue to be excluded from [recovery rooms]” (p. 402). Tuller et al. found that nurses’ and physicians’ strong personal opinions impeded the creation of family visitation programs. Tuller et al. piloted a family visitation program in their recovery room and
evaluated the outcomes of the program through patients’, family members’, and nurses’ responses. The results revealed that only 64% of patients remembered the visits, yet 76% of patients felt family visitation was helpful to them, and 85% of patients thought family visitation was helpful to their visitors. On the other hand, 94% of family members stated they benefited from the visit. From the nurses’ perspective, 71% observed that family visitation had more than one benefit to the patient, 35% described an improved mental state for patients, and 35% felt family visitation was beneficial to the family members.

**Family Visitation in the 21st Century**

In an opinion piece, Sullivan (2001) discussed the controversial nature of family visitation for adult patients. Sullivan contended that “nurses would buy into a visitor program if adequate support systems were in place to effectively manage the program” (p. 29). Sullivan recommended that expectations of the patient, family members, physicians, and nurses must be adequately defined well before the establishment of a visitation program. She stressed that nurses are responsible to evaluate and incorporate research findings into their practices.

In addition to Sullivan’s recommendations, Ninger (2003) proposed guidelines on how to establish a visitation program in the adult recovery room. Ninger advised: “establish a policy; set guidelines for visitation; ensure privacy of patients; educate patients and families; [and to] test the program” (p. 21). Education of staff and families became a major focus and was deemed necessary for successful program initiation as this was a missing component in earlier studies.

Smykowski and Rodriguez (2003) stated that family visitation continues to be an unresolved issue in adult recovery rooms nation-wide due to privacy concerns, space, and
high patient acuity and turnover. Smykowski and Rodriguez developed and implemented a visitation program in their adult recovery room which reflected the recommendations made by Sullivan (2001) and Ninger (2003). The nurses involved in the program claimed that an open visiting policy was ultimately rewarding and satisfying because they witnessed the positive impact visitation had on the recovery room experience of patients and families.

The American Society of PeriAnesthesia Nurses (ASPN) publicly announced a position statement in favor of family visitation in the spring of 2003 in response to the emerging body of evidence supporting the benefits of family visitation in adult recovery rooms. ASPAN is a professional, specialty nursing organization representing nurses in all areas of ambulatory surgery, pre-anesthesia and post-anesthesia care (American Society of PeriAnesthesia Nurses, 2006). ASPAN stated “it is the position of the ASPAN that visitation in the Phase I level of care is supported and that perianesthesia nurses develop guidelines within their own practice settings to incorporate this into their practice” (Position section, para 1). Phase I level of care is the provision of post-anesthesia nursing care in the immediate post-operative period (ASPN, 2006). This was a revolutionary event in the world of post-anesthetic care nursing.

Summary

Family visitation in the recovery room has been an issue since the emergence of the recovery room in the late 1940s. Family visitation has been a restricted practice from the very beginning, only allowing family members access if the patient was in a critical state or near death. Over the decades, evidence-based literature challenging the restrictive practices of family visitation has emerged. The findings reveal that family visitation has
positive outcomes for the post-operative patient and the family member, as well as, the nurse. Despite the evidence-literature supporting family visitation, it continues to be restricted. In the next chapter, I will outline how I used a historical research approach to further examine the history of restricted access for families in the recovery room.
CHAPTER THREE: RESEARCH DESIGN AND METHODS

Research Design

Historical research is “undertaken to answer questions about causes, effects, or trends relating to past events that may shed light on present behaviors or practices” (Polit & Beck, 2004, p. 256). D’Antontio (2005) asserted that the past informs the present and an exploration of the past shapes our professional culture. To gain greater insight and understanding as to why family visitation has been historically restricted in the adult recovery room, a historical analysis was conducted to explore how and why this nursing practice has remained unchanged.

Elements of the Design

Historical research uses various sources for examining the past such as academic and non-academic journals, government and administrative records, books, newspapers, letters, and reports (Hewitt, 1997; Polit & Beck, 2004; Streubert-Speziale & Carpenter, 2007). For this study, the most relevant primary sources consisted of an extensive literature review of published books and journal articles on recovery room care from the 1940s to the 1960s. I also searched for relevant documents at the College of Registered Nurses of BC (CRNbc) in their archival department. Archival material on family visitation was very limited. However, the first guidelines on recovery room nursing in BC were published by the Registered Nurses Association of BC, now known as CRNbc, in February 1979. These guidelines were later revised in November 1986. Upon further investigation, no revisions were made after 1986. Contained within these archival documents was a small section discussing the need to develop unit policies for a number of areas, and visitation in the recovery room was identified as an area for policy
development. Actual policies, however, were not included. I also explored existing public archives in Vancouver. Due to the limited amount of relevant archival documents within the Vancouver City archives and hospital archives, I conducted oral history interviews with recovery room nurses to learn first hand about the early development of recovery rooms in selected hospitals in the Lower Mainland, as well as, about their experience with family visitation.

Oral History

Oral history is a powerful tool to unearth the meaning of past events and experiences from an individual who possesses first hand knowledge. Furthermore, oral history is both an analytical framework and methodology (Boschma, Scaia, Bonifacio, & Roberts, 2008). Biedermann (2001) claimed that "a significant advantage of oral history is that the testimony may help explore written documents, provide clarification of the written evidence, explain underlying assumptions and motives, and provide missing evidence that may complete the picture of the event" (p. 62). Biedermann explained that oral history has the advantage over historical documents in that the interviewers are able to interpret events that would not be possible with documents alone.

Interview Sample

The sample consisted of nine registered nurses who possessed first-hand knowledge and experience from working in an adult post-anesthetic recovery room during the 1960s-1980s. This time period was chosen because the issue of family visitation arose in the mid-1980s. Furthermore, nurses who worked in the adult recovery room prior to the mid-1980s had knowledge and experience that proved to be useful in informing and identifying why family visitation historically had been restricted. The
sample was purposefully chosen from nurses who were employed in the following tertiary hospitals in the Lower Mainland: Royal Columbian Hospital (RCH), St. Paul’s Hospital (SPH), and Vancouver General Hospital (VGH). These three hospitals were chosen as they embodied a rich and diverse history due to their long-standing and central role in the delivery health care in the Lower Mainland.

The sample represented five recovery room nurses from SPH, three recovery room nurses from RCH, and one recovery room nurse from VGH. The recovery room nurses were all female and ranged in age from 53-68 years old. These registered nurses were either retired or still practicing. I sampled staff nurses, nurse educators, nurse managers, and nurse administrators. My experience as a recovery room staff nurse informed the purposeful sampling of nurse educators, nurse managers, and nurse administrators since they all possessed an extensive background as a recovery room staff nurse prior to engaging in education, managerial, or administrative positions. Research participants had to consent to openly share their personal experiences, accounts, and memories with the researcher and sign an informed consent form. Research participants were excluded from the study if they did not meet the above inclusion criteria. Ethical approval for the study was obtained from the Behavioral Research Ethics Board (BREB) of the University of British Columbia (UBC). A copy of the certificate of approval as well as the consent form are included in Appendix A and B respectively.

**Sampling Method and Technique**

In qualitative research, individuals are selected to participate based on their personal and professional experience with the issue being studied (Streubert-Speziale & Carpenter, 2007). This process is inherent in historical research and is known as
purposeful sampling. Purposeful sampling is a form of non-probability sampling where
the researcher is able to hand pick those individuals who would be most representative
and informative (Polit & Beck, 2004). Purposeful sampling was the primary sampling
method for this research study based on the inclusion criteria. In addition, a purposeful
sampling technique called “snowballing” was applied. “Snowballing uses one informant
to find another” (Streubert-Speziale & Carpenter, 2007, p. 30).

Through connections from my professional network and with help from the
British Columbia Nursing History Group, I found primary contact individuals for each of
the three hospitals. Through the assistance of the primary contact individuals, potential
participants were identified and informed of the research study. The primary contacts
distributed a flyer outlining the purpose and requirements of the research study. These
flyers were also posted in the three worksites. Individuals who expressed an interest in
the study were asked for their permission to release their names and contact information
to the researcher. Once the researcher made contact with the individual, the participant
was invited to take part in the study by an “invitation to participate letter”. The
snowballing technique was implemented once the initial participants were selected and
contacted for an interview. Regardless if a participant agreed or declined to be
interviewed, the individual was asked whether he or she would be willing to assist in the
recruitment of additional participants.

Sampling Bias

Sampling bias was accounted for by selecting study participants from three
different tertiary hospitals. Both positive and negative thoughts and beliefs about family
visitation were sought for from the study participants to ensure representativeness of the
data. Regardless of the study participants’ personal and professional position on family visitation, all data was included in the study. Research participants were not paid for participating in the study. The sample was recruited over a six month period.

Methods of Data Collection

Books and Articles from the 1940s to the 1960s

The books and articles which served as primary sources were located via a library search using the terms: recovery room, recovery room care, and post-anesthetic recovery room. This search generated quite a large number of relevant books that pre-dated empirical studies conducted on family visitation as of the 1980s. They mainly covered the time period from the 1940s until the 1960s and were a significant source for this study. The articles were located using the reference list from the books, and I later used the reference list of these articles to further identify other published sources.

Oral History Interviews

Oral history interviews were another important source of primary evidence. An invitation to participate letter was mailed to either the participant’s home or work address. In addition to the invitation to participate letter, the consent form was also enclosed. Providing the consent form prior to the interview allowed the participant a sufficient amount of time to review the consent form and raise any questions or concerns prior to the interview date. The participant was contacted one week after the mailing date to ensure that the forms were received, to address any questions or concerns regarding the research project, and to schedule an interview date and time.

The oral history interviews were conducted face-to-face at a mutual location decided and agreed upon by the participant and researcher i.e. the participant’s residence
or participant’s workplace. Oral history interviews were tape-recorded to ensure verbatim responses of the participants. One interview was required and lasted from forty-five minutes to one and a half hours.

The start of the interview consisted of broad, open-ended questions that focused on the health care professional’s experience of working in the recovery room. A set of interview questions were developed. The questions were broad and open, and focused on understanding the experiences and viewpoints of nurses. I developed questions that would help explore the reasons why family visitation was restricted from the perspective of the nurse. I felt it was necessary to understand their attitudes and beliefs surrounding this issue. The initial questions began with the participant’s educational background and work history, and then questions related to post-anesthetic nursing care were asked, which lead into questions regarding family involvement in the post-operative phase.

In the interview, the participant determined the direction of the interview and the information they felt comfortable in disclosing. When the participant moved away from the topic, the participant was re-directed back by rephrasing the initial question. Participants were told that they could refuse to answer any question(s) at any time during the interview. Every effort was made to keep the participants’ personal information private and confidential, unless the participant agreed to have their names identified. Confidential information was not collected via email and was only available to the researcher and researcher’s thesis supervisor. Participants were given a choice not to have their name identified; however participants were made aware that there was a slight chance readers could recognize their identity through the information that they have
shared; therefore anonymity was not guaranteed. This was stated within the consent form (See Appendix B).

Upon completion of the interview, the tape was sent for immediate transcription to a transcriptionist affiliated with the UBC School of Nursing. Interview tapes, transcripts, and field notes were kept and stored in a secured area. Field notes were utilized to reflect upon key points, observations, or highlights during the interview. Moreover, the field notes allowed for contemplation of personal and professional biases. Within the consent form, participants agreed to have their tapes and transcripts deposited to an archive, such as the university archives after five years from the completion of the study.

Data Analysis

Data gathering and analysis occurred simultaneously. A framework was developed as a way to organize the data. Hamilton (1993) stated, “In historical inquiry the researcher must have some kind of framework by which to analyze the findings” (p. 47). Hamilton described that a historian’s lens must be established in order to frame the study, develop questions, and to conduct the analysis. As a result, a thematic analysis was applied based on the meaning of the text and as a means to organize the data. According to Daly, Kellehear, and Gliksman (as cited in Fereday & Muir-Cochrane, 2006), “thematic analysis is a search for themes that emerge as being important to the description of the phenomenon” (p. 3). Oral histories were analyzed by careful line by line reading and re-reading of the transcripts.

With a historical approach, the researcher “would begin with the data collection, sift through the information, analyse and then theorize about the relationships and
silences that emerge” (Yuginovich, 2000, p. 71). I applied various lenses to analyze the phenomenon of interest. Persistent issues of space and privacy resounded throughout the literature. Therefore a spacial lens drawing from architectural history and a privacy lens drawing from medical and nursing history were integrated into the thematic framework (Drain & Shipley, 1979; Fairman & Lynaugh, 1998; Kingsley, 1988). Direct quotations from the participants’ oral history interviews were used throughout the analysis and during the writing of the findings to ensure that the participants’ voices were heard and represented within the study.

**Issues of Rigour and Data Quality during Analysis**

According to Tobin and Begley (2004), “rigour is the means by which we show integrity and competence: it is about ethics and politics, regardless of the paradigm” (p. 390). Rigour is a crucial component within all qualitative methodologies which must be addressed. There are slight variations on how to assess and evaluate the rigour of the data; however the framework developed by Guba and Lincoln (1985) appears to be the most widely used and accepted framework (Koch, 1994; Tobin & Begley, 2004). Guba and Lincoln (as cited in Emden & Sandelowski, 1998) evaluates rigour through: credibility, transferability, dependability, and confirmability.

In this study, credibility was assessed by clearly documenting and reporting the perspectives of the participants’ regardless of their biases. Transcripts were reviewed by the researcher to ensure accurate transcription by listening to the interview tapes against the transcripts. Transferability was accounted for through the use of purposeful sampling. Purposeful sampling was achieved in this study by sampling recovery room nurses with a long standing career in post-anesthetic care from three tertiary hospitals in the Lower
Mainland, which allowed for a range of information collected. Dependability and confirmability was attained through an audit trail. The researcher's logs and field notes clearly outlined and documented the steps taken and the decisions made during the entire research study. Furthermore, reflexivity is a central component in the audit trail, which was incorporated in this study (Tobin & Begley, 2004). Reflexivity is the "critical reflection about one's own biases, preferences, and preconceptions" and was documented in the researcher's journal on an ongoing basis throughout the duration of the study. (Polit & Beck, 2004, p. 730).

Ethical Considerations

According to the Tri-Council Policy Statement, the type of research that was conducted was considered "minimal risk". As outlined above, ethical approval was obtained from the UBC BREB. Consent forms were provided to the participants prior to scheduling and conducting the interviews. During the interview, participants were given the choice to refuse to answer any question(s) and to end the interview at any time. All participants agreed to have their names identified; however nurses are referred to by their first and last initials throughout the thesis. The interview tapes and transcripts were stored in a locked drawer in a secured area in the researcher's home.
CHAPTER FOUR: FINDINGS

In this chapter, I describe the major findings, which are subdivided by major themes. The findings arose during the literature review of the historical books and articles on recovery rooms and in the oral history interviews. A constant comparison between the documents and the oral history interviews was performed to establish accuracy and validity of the findings. The concept of space, privacy, safety and financial costs were major themes that arose from the historical books and articles and the oral history interviews. Furthermore, the gradual acceptance of family visitation for particular patient groups is discussed.

Space: The Built Environment

As I began to further explore the early designs of recovery rooms and the new recovery room blue prints dated in the 1950s and 1960s, I noticed that a reoccurring theme began to unravel. The concept of space resounded throughout the literature and in the oral history interviews, and seemed worth exploring as one explanatory context to the restriction of family visitation in the recovery room. More broadly, according to Andrews and Poland (as cited in Andrews, 2005) the concept of space is gaining increased attention in the areas of nursing and other health care disciplines. There has been a shift in understanding how these health care spaces have shaped and influenced a particular culture of thinking. “Places are conceptualized not just as sites where “observations” are located, but as more complex cultural and symbolic phenomenon constructed through relationships between people and their settings” (Andrews, 2005, p. 56).

The physical space of the environment has meaning beyond the four walls. A space is not viewed just in terms of how it is built, but the way it was built. What is the
purpose of this space? What does it represent? What does it symbolize? And how a space is created determines how the space will be utilized, but mostly importantly interpreted and understood. How individuals interact and share a space, in this case the recovery room, will affect their own personal and professional views and beliefs about the space. “Nurses have important roles in the making of their environments and, at the same time, their environments making nursing” (Andrews, 2005, p. 144). This view is applicable to understanding the space of the recovery room. Recovery room nurses have made a significant contribution in terms of how they, as well as, other health care professionals, and the public perceive the role of the recovery room.

The explanatory framework of space in the recovery room is of major significance to the analysis of family visitation. The architecture of the recovery room has meaning beyond its physical appearance. “Architecture symbolizes the activity or the institution and tells us something about its importance within a culture” (Kingsley, 1988, p. 63). The examination of the architecture of the built space of the recovery room provides a valuable explanation as to how this space was valued by health care professionals in terms of its role in the health care system. Furthermore, such an examination also reveals how this space informed and influenced recovery room nurses’ practice in the care of the post-operative patient. The spatial context shaped nurses’ views as to how families did not fit into the recovery room.

Creating Space for Recovery Rooms

As the demand for establishing recovery rooms in hospitals increased, and the necessity to revamp outdated make-shift recovery rooms grew, pressure was placed on physicians and hospital administrators to address the rising popularity and growing
requirements of the recovery room. In the books and journal articles on recovery room care from the late forties through the sixties, the authors, who were primarily physicians, commented frequently on the challenges of creating space for recovery rooms. One physician stated, “Sufficient space should be provided so that [stretchers] can be moved into and out of position conveniently without bumping into other stretchers or equipment” (Belinkoff, 1967, p. 24). It was apparent that the layout of the recovery had to be carefully planned in order to utilize the little space available. The recovery room space needed to be functional and practical in operation for both hospital staff and equipment. According to Belinkoff (1967), “There are basically two types of recovery rooms: (1) Those in new buildings, where they were planned as an integral part of the building .... (2) Those in hospitals with an existing plant that is not being changed or enlarged and recognize the need for a recovery room, but must incorporate it into finished structure, with existing walls, some of which cannot be moved” (p. 17).

Prior to designating a specific area for a recovery room within the hospital, make-shift recovery rooms were created from storage areas, wards, or any available space that could be developed (Masters, 1949; Booth, 1951). Interestingly, in 1944, the New York hospital’s original recovery room was established in a vacant operating room; although “small in size and limited [in] capacity ... the recovery room was a success” (Storch, 1956, p. 3). Physicians and hospital administrators were undoubtedly resourceful and creative in their ways to develop recovery rooms from the limited resources available.

Recovery Room Popularity

The reason for the recovery room’s rise in popularity was attributed to the number
of advantages this space had to offer. Fewer nurses were required to care for immediate postoperative patients as patients were segregated in one room, as opposed to being dispersed throughout the surgical ward in any vacant bed available (Conboy, 1947; Dunn & Shupp, 1943; Hudenburg, 1948; Lundy & Gage, 1944; Masters, 1949). This in itself had a number of advantages: ward patients were not disturbed by the sights and sounds of postoperative patients emerging from anesthesia. For example, in the 1950s and 1960s nausea and vomiting were common occurrences and side effects of general anesthesia (Dunn & Shupp, 1943; Zuck, 1995). Ward nurses could focus primarily on caring for ward patients, instead of shifting back and forth from ward patient to post-operative patient, thereby decreasing the stress and work expenditure of the ward nurse.

Furthermore, based on the hospital setting, it appears that some ward head nurses may have separated immediate post-operative patients from the general ward patients in an attempt to conserve the nursing workload. Dunn and Shupp (1943) stated, “The subsequent moving and shifting of ward patients to group anesthesia patients is eliminated. The head nurse spends less time planning and rearranging the time schedule to make provisions for the return of the patient under anesthesia” (p. 280). The nursing care required for an immediate post-operative patient and a surgical ward patient greatly differed. The nursing skills and knowledge base required to care for these two different types of patients on the same ward would have impacted the nurse’s ability to provide safe and competent care. For example, an immediate post-operative patient would require constant observation and monitoring, specifically in the first 15 minutes. During this time of surveillance, the nurse would be detained; therefore unable or limited in her ability to attend to other patients if needed. This type of efficiency was also of central importance
in another area of speciality nursing that was emerging from the concept of the recovery room, intensive care nursing. Fairman & Lynaugh (1998) described that intensive care units were “built upon the similar principles” of the recovery room (p. 13).

Another advantage of establishing a recovery room was the ability to centralize emergency and non-emergency medical equipment in one space, which resulted in an elimination of reduplication (Anonymous, 1951; Booth, 1951; Conboy, 1947; Davies & Hunter, 1952; Dolezal, 1949; Honey, 1950; Leigh, 1949; Lowenthal & Russell, 1951; McIntosh, 1953; Weissmiller, 1950). Lowenthal and Russell (1951) stated, “For instance, one resuscitator serves the recovery room adequately” (p. 472). Prior to the creation of the recovery room, the scenario may have been that more than one resuscitator and other types of equipment and possibly specialized life saving medications, which were specifically used in the immediate post-operative period, were purchased and readily available for every ward. By consolidating these items in this exclusive space equated to great savings for the hospital budget. This economic savings would have obviously appealed to physicians and hospital administrators since these funds could be allocated and invested in other areas of health care. In a survey conducted in 1949, Lowenthal and Russell declared that “one hospital showed a gross income from the recovery room of $8000.00, a net income after deducting salaries, of $5000.00” (p. 472). This was a significant amount of hospital income and one that could not be ignored.

Constructing the recovery room space in the vicinity of the operating room was advantageous for hospital personnel. Anesthesiologists, surgeons, and nurses were concentrated in one general area. The primary purpose of situating the recovery room so closely to the operating room was if an emergency situation arose with a post-operative
patient, the anesthesiologist was easily accessible (Sanders, Graff, Aikins, & Cooling, 1949; Wanro, 1949). The recovery room nurse could either page or call the anesthesiologist via the intercom system which connected the recovery room to the operating room theatre, or inform the anesthesiologist in person if adequate hospital personnel could attend to the absence of the nurse during this time. The latter circumstance may have been more frequent in a smaller, community-based hospital setting versus a larger, tertiary hospital setting because the distance between the recovery room and the operating theatre was shorter in the community-based hospital as there were only three to four operating rooms in service. The larger, tertiary hospitals may have had seven to ten operating rooms, which would take more time to locate the anesthesiologist.

The location of the recovery room made it convenient for the surgeon to assess the condition of the patient since the recovery room was adjacent to the operating room theatres. They could easily check on the progress of their patient in between surgeries without having to venture out to the wards. For example, if the surgeon wanted to know the patient’s urine output, all he would be required to do is walk over to the recovery room. This system was quite efficient in the eyes of the surgeons, as they did not have to leave their surgical domain (Dunn & Shupp, 1943; Leigh, 1949; MacEachern, 1950; Weissmiller, 1950). Prior to the recovery room being built, surgeons would have had to journey out to the wards and locate their patients, and it appears that the patients may have been scattered throughout the ward due to bed availability. By having the patients nearby would decrease the amount of traveling time to and from the operating room theatre and ward. As a result, the layout of the recovery room was redesigned to
incorporate the need to increase the efficiency and visibility to provide and maintain constant observation of the post-operative patient.

**Layout of the Recovery Room**

The majority of the layouts of the recovery room in the mid to late 1940s and early 1950s, which was viewed and later labelled as traditional in appearance, mimicked the look of a four bed ward (Noble, 1948; Jones, 1956; Belinkoff, 1967). This appears to have been the most common layout, since these rooms were already established. Little work was needed to improve the function of these rooms and could be occupied quite easily.

This type of design had two major design flaws: poor visibility to observe patients and a limited number of patients could be admitted into the recovery room (see Figure 1).

![Figure 1. Traditional Recovery Room.](image)


Poor visibility was attributed to patients being observed in different rooms. Upon reviewing a variety of recovery room sketches during this time period, it appears as
though up to three to four separate rooms, with a capacity of four patients per room were used to monitor immediate post-operative patients (Jones, 1956). With a staff of two or three graduate staff nurses for each shift, this would have been a demanding and draining patient assignment. The nurse would not be able to observe all of the patients at once. Rather, the nurse would have to move from room to room assess her patients, meaning some patients would be left unattended for a period of time.

This type of scenario would have posed a number of concerns. The safety of the patient was greatly compromised because the majority of the patients admitted to the recovery room had received a general anesthetic during surgery. The number of life-threatening complications associated with a general anesthetic was enormous. Respiratory depression, respiratory obstruction, respiratory distress, asphyxia, and aspiration were only a few complications linked to general anesthesia (McMahon & Fife, 1945). The nurse responsible for the patients would need to closely monitor for these complications and would have to have the knowledge and skill to respond quickly and appropriately. Continual movement from room to room would have negatively impacted the nurse's ability to provide "constant careful observation" (Jones, 1956, p. 8).

The earlier recovery room designs revealed that the number of patients admitted into the recovery room ranged from four to sixteen patients. This was dependent on the hospital space available and the type of surgical procedures being offered within the facility. Although the majority of the recovery rooms were four bed wards, some recovery rooms were formed from semi-private rooms, known as two bed rooms and from private rooms, known as a single bed room. A private room was necessary for
post-operative patients requiring isolation or privacy. Isolation was mandatory for cases where a patient might have been a carrier of tuberculosis and was at high risk for infecting other patients or health care personnel. Issues of privacy were of concern for cases in which a post-operative patient was critically-ill or was dying. During these circumstances, the patient would be cared for in this private space so that the family of the patient would be able to visit during this distressing time (Carnaban, 1949). This space also allowed the patient to be free and away from the constant activity and noise that was common in the recovery room. There was a constant turnaround of patients in the recovery room. Patients were being admitted and discharged routinely. However, this private space was not available in every recovery room. The cost of constructing a private room may have not been feasible and the matter of identifying a vacant space in the hospital had always been an ongoing issue and debate.

Reconstructing the Recovery Room

In the early 1950s and 1960s, according to the various books and journal articles from that period, a process of restructuring of the recovery room took place, and the architectural layout of the recovery room drastically changed in order to address the two major design flaws. Physicians identified the need to improve the visibility and efficiency of the department. This new design concept was considered “modern” during this time as the space was being reconfigured to a contemporary look. The modern recovery room was redesigned by physicians and architects to be an open concept room (see Figure 2).
Visibility was markedly improved by removing or scaling back pre-existing walls or pillars that were not foundational supports, and repositioning the nurses' station in a central location where patients could be easily observed from a distance.

A dramatic increase in patient capacity was achieved through this new design. There was approximately double the patient occupancy compared to the traditional recovery room. Although there was additional bed space, the amount of space between some of the hospital beds drastically decreased. This latter change had important implications for the utilization of the space as there was now less room between the stretchers. Only one nurse would be able to navigate in that particular space. This lack of space significantly impacted how the restriction of family visitation was shaped.

In the traditional recovery room, the amount of space between the hospital beds was five to five and a half feet. Now in the modern recovery room, the amount of space between the hospital beds was four to four and a half feet. One to one and a half feet of bed space was lost with the restructuring; which would have made the spaces between the
hospital beds tight and cramped. It appears that one of the reasons for decreasing the allotment of space between the beds was that the traditional hospital beds were being replaced with sleeker and skinnier stretchers designated specifically for the recovery room, which took up less room (Sadove & Cross, 1956).

However, this change from hospital beds to stretchers was not adopted nationwide. The reason for not switching to stretchers was not clear from the textbook literature I studied. The cost of purchasing the stretchers may have been a factor. Furthermore, physicians or nurses may have viewed hospital beds safer, since the patient would only have to be transferred once upon completion of the surgery. With the introduction of the stretchers, the patient would need to be moved twice, from the operating table to the recovery room stretcher and from the stretcher to the hospital bed. This may have been perceived as disruptive and excessive to the recovery of the patient.

Although the amount of space between the beds was narrower, the ultimate goals of improving visibility and occupancy were achieved. In addition, efficiency of the department greatly increased. In the traditional recovery room as previously discussed, each bed had its own set of privacy curtains, but now in the modern recovery room, only two beds were designated with curtains. Reasons for removing the curtains was, according to one 1950s physician “Curtains are a bother and seldom if ever needed” (Adriani & Parmley, 1958, p. 13). The removal of the curtains influenced the reason to restrict family visitation in the recovery as the lack of patient privacy was at risk.

**Issues of Space**

The issue of space was not only discussed in the contemporary articles and academic textbooks, but was frequently commented on during the oral history interviews.
Nurses raised the matter of space in number of contexts throughout the interviews. One nurse supported the point made in the historical articles and academic textbooks that make-shift recovery rooms were created from available space. Nurse F.M. from SPH stated, “And [the recovery room] was sort of shaped in an L shape, I mean it was sort of an add-on. St. Paul’s in the old building was kind of just ... put together” (Oral History Interview #2, p. 16). She further stated “... our recovery room at St. Paul’s when I first went ... was a Mickey mouse situation. We could put ... maybe sixteen ... oh no, we had isolation, so it was maybe seventeen or eighteen people we could put in there” (p. 16).

From her description, recovery rooms were created, and hastily put together into existing spaces, which were never intended for that purpose. There was little thought or consideration given to recovery room organization.

Nurse F.M. later stated:

Oh this [recovery room] was a stupid set up, this was absolutely stupid, but you see St. Paul’s was never built originally to have a recovery room. I mean it’s an old building. This is a 1928 building so ... this would be a ward at one time. This was never ever intended to be what it was (p. 20).

Nurse F.M. was extremely frank and truthful of her opinion about the physical layout of the St. Paul’s recovery room and again supported the fact that recovery rooms were not defined units within the hospital structure. From her statement, it seems that the hospital compensated for the lack of hospital space by converting ward rooms into a recovery room. In doing so, this conversion constituted difficulties and challenges, and may have not been a conducive environment for providing nursing care.
Nurse F.M.'s experience at SPH did not differ from Nurse L.M.'s experience at VGH. Nurse L.M. described the Heather recovery room at VGH as a "huge barn and the patients were just lined up down the side and down the middle, no suction, no oxygen beside them" (Oral History Interview #7, p. 4). Later, she further added:

I didn't work in the new recovery room at VGH only [in] the old Heather and the Centennial recovery rooms and they were like huge barns. Just on a little ledge on the back you had your tray with your swabs and your mouthwash, your glycerin, your mouth sticks and things which you used and there were oxygen outlets and suction on the walls but it wasn't necessary that all patients went on oxygen at the very beginning, this is going back ... '68, '69, '70 (p. 6).

Nurse L.M.'s description of the recovery room provides the interviewer with a powerful image of the working conditions and environment the nurses worked in. Her comparison of the two recovery rooms to a "huge barn" is quite interesting. Through her description, it appears as though the recovery rooms were open and relatively large spaces and patient stretchers were organized in a manner similar to the spacial construction of a barnyard where animals are laying side by side. A designated slot for each patient. Minimal equipment was available at each bedside. Although oxygen and suction outlets were available, it appears as if it was not utilized frequently.

Spatial Organization

The spatial organization of the recovery room posed a major concern for nurses in regards to family visitation. In the oral history interviews, nurses frequently commented on the lack of space as one of the reasons for restricting family visitation. One Nurse S.F. from SPH stated:
It’s a factor of space … I would say that is the biggest thing because … there’s no more than this amount of space … about four feet between the beds … the nurse is between the beds and … he or she is trying to do charting and has equipment there and so there just really isn’t that much space (Oral History Interview #5, p. 9).

She further added:

For some inexplicable reason, hospitals … don’t spend a lot of money on curtains … there [are] a lot of things that you do for a patient just in any setting requires privacy (p. 9).

Nurse S.C. from SPH described the recovery room as “one big open room with beds, you know bumped up against one with just curtains to protect them” (Oral History Interview #3, p. 6). And Nurse J.V. from SPH stated “the excuse has always been or the rationale has been that its physical surroundings … aren’t conducive to having family members … usually PARs are … a big open room with patients beside one another” (Oral History Interview #4, p. 7). Clearly, the lack of space and lack of privacy was on the minds of the nurses when they thought about the reasons why family members did not fit in easily. Nurse D.L. from RCH described the 1950 Royal Columbian recovery room as “one small room, beds were shuffled around as patients entered, the rest of the beds got moved around the room … we could barely get between beds so it was just a jam packed room full of patients” (Oral History Interview #8, p. 2). Nurse L.M. from VGH had the same experience, “there was very little space, I mean the beds were quite close together, there was no privacy” (Oral History Interview #6, p. 18).
The recovery room nurses' concern for the limited amount of physical space in the recovery room was of major significance, and one that clearly cannot be ignored or overlooked. In Figure 3, a picture of a 1950s recovery room underscores the observations of the nurses.

![Figure 3. Space Constraints in a 1950s Recovery Room.](image)


The photograph clearly gives a general idea of the physical layout of how the recovery room was organized. This picture supports nurse F.M.'s earlier comments that the stretchers are lined up against the wall. Interestingly, the patient's head is facing towards the center of the room. The primary reason for positioning the patient stretchers in this manner was for efficiency. According to McQuillen (1948), "This saves many unnecessary steps as the nurse walks from one patient to another" (p.22). However, not all physicians and nurses agreed with this practice. Nurses found it difficult to observe
the patients from a distance as only the tops of the patients’ heads could be viewed. This presented a major safety concern. If a patient had vomited or aspirated, there was a possibility that the nurse might not be aware, which could have resulted in a serious or life threatening situation to the patient’s condition (Dunn & Shupp, 1943). Furthermore, observation of the patient’s skin color, specifically facial color is a key post-operative nursing assessment.

Referring back to the photograph, there were a number of spatial issues. To the right of the stretcher, it was apparent that there was less than four feet between the stretchers. The majority of physicians in the 1950s-1960s determined that four feet between the beds was sufficient. According to one physician, this amount of space “was adequate for both personnel and equipment of all types, which may be brought into use” (Beal, 1956, p. 4).

Although four feet between the stretchers appeared to have been an agreed upon space for many physicians, some physicians thought otherwise. One physician thought three to four feet between the beds was adequate as he preferred to use hospital beds than stretchers because “[he] didn’t like them” (Adriani & Parmley, 1958, p. 12). Adriani and Parmley (1958) stated, “Generally 50sq. ft. (a space 6 X 8 ft) is ample” to the allotment per bed (p. 12). A bed space of four feet would be relatively minimal and tight, thereby supporting the nurses’ claims in the oral history interviews that there was no room for anybody else but the health care professionals. In the photograph, there were vital pieces of equipment that were mandatory in the care of the immediate post-operative patient, a suction apparatus and a blood pressure device. The portable suction apparatus was quite bulky and occupied the majority of the space between the stretchers, and the
portable manual blood pressure cuff was placed off to the side as there was no room for it. No equipment would be able to be placed on the left hand side of the patient as it would obstruct the doorway entrance and pose a safety hazard.

Figure 4 (Adriani & Parmley, 1958, p. 89) appeared to be a seven bed recovery unit.

![Figure 4](image_url)

**Figure 4. 1950s Recovery Room.**


It is clear from the background of this picture, that little space was provided among the beds and there were no privacy curtains. This particular recovery room’s set-up was different from the earlier photograph. Here, there were oxygen and suction outlets piped in from the wall, however not all bed spaces had this convenience. In the foreground of the picture, the recovery room nurse was using a portable suction apparatus, similar to the one in the previous photograph. Again, the picture shows a large and bulky suction unit that would occupy a fair amount of space. There were manual blood pressure cuff devices installed on the wall at each bedside, which suggests that physicians and nurses were
attempting to scale back on the size of the equipment as a way to reduce the amount of equipment on the floor space.

Privacy Issues

In the two photographs, there is a lack of privacy curtains. Concerns of privacy were also mentioned by the nurses in the oral history interviews as a reason for restricting family visitation. The lack of privacy and confidentiality would be severely compromised in a recovery room area like the one in these photographs. Nurse D.L. from RCH confirmed that they did not have curtains in their recovery room, “We had a little portable screen” (Oral History #8, p. 16). At VGH, Nurse L.M. stated that there were “some curtains ... some areas didn’t ... because curtains ... as they go back against the wall ... you didn’t really have a wall, and there would be patients lined up down the middle of the recovery room” (Oral History #7, p. 21). With the recovery room being an open space, maintaining privacy and confidentiality would have been an issue with regards to family visitation, particularly if patients were cared for in the middle room as it would have been difficult to partition patients off with a screen or with curtains.

Safety and Financial Cost

Upon further analysis of some of the historical documents, it appears that the values and beliefs surrounding the space of the recovery room were grounded in the notion of being “life saving and economical” (Lowenthal & Russell, 1950, p. 470). The recovery room was a space meant to “prevent morbidity and death during the postanesthesia period” (Lowenthal & Russell, 1950, p. 470). The recovery room was a space that represented safety, as patients were cared for by specially trained nurses who
were “carefully instructed by the anesthesiology staff” and life saving equipment was at hand (Lowenthal & Russell, p. 471).

From the historical data, it became clear that the recovery room embodied a place of safety. This was the sole purpose of the recovery room, to recover the immediate post-operative patient in a safe environment (Anonymous, 1950; Anonymous, 1951; Griffith, 1950; Honey, 1950; Leigh, 1949; McNearney, 1951; Newcombe, 1970). Patients returning from the operating room were in great danger of a number of post-operative complications (Sadove, Kretchmer, Wyant, Gittelson, & Puestow, 1951). Close and constant observation and assessment of the patient was the central role of the recovery room nurse. During the establishment of recovery rooms in the 1950s, the majority of patient cases were anesthetized with a general anesthetic. General anesthesia is comprised of potent anesthetic gases, paralyzing agents, and analgesics—a powerful, and at times lethal, combination of drugs. These patients would arrive in the recovery room heavily sedated and often times unconscious and not breathing—a stressful and critical time for the recovery room nurse. The nurse’s attention would be solely on closely observing the patient for any signs of airway obstruction, monitoring vital signs and assessing the surgical site for any signs of bleeding or haemorrhaging—an extremely challenging task. During these situations, the nurse-patient ratio would immediately be one-to-one nursing, and fellow nursing colleagues would absorb this nurse’s patient assignment and workload in addition to their already busy patient assignment and workload.

Moreover, during the 1950s time period, the use of cardiac monitors and pulse oximetry was not yet available. Nurse B.E. from RCH stated:
In '79 ... the space was hugely limited. We didn’t have monitors at every beside.
I mean we started out with like five pulse oximeters [then] every bedside had
pulse oximetry. I mean that became standard of practice as things evolved, pulse
oximetry was the norm, everybody has pulse oximetry, it wasn’t originally ... I
came back from maternity leave in ’86 and all of sudden we had pulse oximetry
(Oral History Interview # 6, p. 34-35).

Nurse D.L., also from RCH confirmed the use of pulse oximeters and cardiac monitors.
“We started using oximeters when we moved to the 1976 ... we only had a couple and
they were little portable things ... in 1976 we got monitoring equipment” (Oral History
Interview # 8, p. 16).

The introduction of new technology in the mid 1970’s demonstrated changes in
patient care. Nurse L.M. from VGH commented on this change. Referring to surgeries
being performed on patients:

The major change from being very general, to being very specific and then, of
course, all the equipment changed and then we, we didn’t have, well occasionally
we had a patient on a Byrd respirator in the recovery room, but mostly if they
needed long term ventilation, they went down to the ICU. And we didn’t have any
of the fancy monitoring systems. We’d have maybe one cardiac monitor and then,
of course, we got into oximetry, and as the equipment increased and the
sophistication for care we were providing increased and it became standard to
have oximetry. So ... patients went on oxygen when they first came in (Oral
History Interview #7, p. 5).
According to Nurse L.M., the reason for placing the patient on oxygen was “some of those anesthetic agents were pretty depressing … So the standard of care really changed enormously over time” (p. 5).

The use of pulse oximetry appeared to have revolutionized the way patients were cared for in the immediate post-operative period. Nurse L.M. disclosed:

[That the introduction of pulse oximetry was not until the] late seventies but then it was a rare thing, they were big bulky machines and it was relatively rare, it wasn’t until very recent years we’ve had this lovely little pulse oximeter that are little portable things. They were fairly heavy substantial units and we didn’t have a lot of space (Oral History Interview # 7, p. 6).

Again the notion of the lack of space is revealed within this statement. As the acuity and complexity of patients increased over the decades and the development and implementation of new technologies were being introduced, the need for space to house the latest equipment was needed. Nurse B.E. discussed how the RCH recovery room had to adjust and cope with the new technology. She stated:

... we outgrew our electrical, we outgrew our oxygen outlets. We had to close down the whole recovery room and totally renovate our oxygen supplies about ’83, no, ’92, 3, because we didn’t have enough. We didn’t meet code anymore .... We had to have a whole electrical upgrade. We totally maxed out our electrical supply as technology, we now have electric beds, we have electric pumps, we have electric everything, we didn’t have enough electrical supplies, so I mean the physical plant outgrew the technology as we developed more and more technology so it was a real evolution, so we were constantly upgrading and
From the stories of the nurses, it is quite evident that the duties of the recovery room nurse drastically changed over the years. Surgical procedures, anesthetics, technology, and the types of patients greatly affected the nursing care provided to immediate post-operative patients. It would seem that with the advancement in technology and in anesthesia that the nursing duties of the recovery room nurse would have been eased compared to previous decades. However, based on the oral history interviews, nurses had to contend with a number of issues. The unfamiliarity of the new equipment added another dimension to the care. Time and orientation was needed to incorporate this technology into everyday practice.

In the oral histories, the words of the nurses indicated how they understood the space as it symbolized safety. Nurse J.S. stated, “Safety is absolutely paramount in the recovery room because these patients, they rely on you for safety and the observation and I don’t care how good a nurse you are, you can’t observe ten patients at a time” (Oral History Interview #1, p. 5). Safety was and still is paramount in the recovery room. Safety was not only important for the patient, but it extended to the patient’s family as well. Recovery room nurses were concerned how the family would react when allowed in the recovery room. Nurses were afraid that the family would respond negatively to the sights and sounds of the recovery room. Nurse S.C. from SPH stated, “I remember one situation were a husband just fainted or fell on the floor and ... you had to look after him” (Oral History Interview #3, p. 8). Nurses spoke about this kind of situation as adding to the nurse’s workload, thereby creating safety issues for the post-operative patients,
recovery room nurses, and department. The construction of the recovery room influenced why the presence of families did not fit into this unit. Maintaining a safe space for the patient was of primary importance and the inclusion of families would have jeopardized this practice.

 Exceptions to “No Visitation”

 Although family visitation has been a restricted practice, concessions have been made for particular patient groups to waive this policy. There has been a gradual acceptance over the decades to allow family members into the recovery room for certain surgical cases or for specific patients. In the next section, I discuss some changes in family visitation practice that gradually took place.

 Cesarean Sections

 Although family visitation has been a restricted practice in post-anesthetic recovery rooms from the onset, there has been a gradual change over the decades within this particular practice. By the 1970s, for example, the medical community changed its attitude on the acceptance of fathers in the recovery room in the face of increasing cultural pressure on the role fathers played in the birthing process. Up until then, women’s choices regarding their birth plans was controlled by the medical model, focusing on technology and procedures rather than on the mother’s and father’s emotional and physical needs (Mathews & Zadak, 1991). Fathers were not seen as playing a significant role during the birthing process and were therefore excluded; however, this changed in the 1970s. During this time, fathers began to be included in the birthing process, not just for vaginal births, but also for cesarean sections (Leavitt, 2003). Fathers and mothers wanted to share this special and joyous occasion of child birth
together. Although it was a long and daunting process to change the policy to allow fathers in the birthing room, the policy did eventually change and the medical community slowly adapted this new way of thinking into their practice (Leavitt, 2003). This change also impacted family visitation in the recovery room since it was the place where women recovered from a cesarean section.

In the oral history interviews, the majority of nurses recalled having reacted favourably to allowing partners or fathers into the recovery room when the mother had a cesarean section. Nurse J.S. stated:

... now they might have the occasional one but again like a [c-]section, you’d use your head and especially a lot of sections now are done under an epidural or something, so the mum is perfectly wide awake, it’s a wonderful experience, you want to share it with your husband ... (Oral History #1, p. 19).

Within her comment, Nurse J.S. revealed a number of interesting thoughts. She acknowledged the fact that the majority of cesarean sections are performed under an epidural, which allowed the mother to be fully conscious during the operation. This example demonstrates the changes that have occurred over the decades in terms of administration of anesthetics. The use of anesthetics has changed (Perrott, 2008). Prior to the introduction of epidural and spinal anesthetics, general anesthetics were used where the mother would be unconscious during the operation. In this circumstance, the father would likely not be present for the birth. Nowadays, the use of general anesthetics for cesarean sections would be very rare and only administered for emergency situations (Tsen, Pitner, & Camann, 1998).
Nurse J.S. also commented on the wonderful experience the birthing process was and that it should be shared with the husband. Here, her own values and beliefs surrounding the birth of a child are revealed, reflecting a larger cultural change in society. She viewed it as an important time in the mother’s and father’s life and one where they should be together, not separated.

Nurse B.E. had similar observations about the relationship of mothers and fathers experiencing cesarean section:

The other group of patients that was an interesting group of patients was fathers and mums having c-sections because the mums, most of them were awake having epidurals and they would see them in the OR and then the father would go with the baby to the nursery and once the mum was settled in the recovery room they wanted to come over and celebrate … and see them and make sure they’re okay and stay with them and which we would let them in. Once they were … okay … we would encourage a short visit and then go back to the baby because the mum was wide awake, unless the mother was really anxious and really grabbed on and needed that support of the husband, but often the mum was too wide awake and the dad was too lookey looey, [laughter] … and so you had to really assess each situation and a lot of it was individual situation. It wasn’t carte blanche depending on what was going on that day (Oral History # 6, p. 20).

Nurse B.E. provided a brief description of the events that occurred during and after a cesarean section. Her description reveals a picture of the degree of separation that all three parties, the mother, the father and the newborn baby endured after a cesarean section. While the mother was in the recovery room, the father and baby were in the
nursery, an area far away from the recovery room. Once the mother was stable and settled in the recovery room, the father was admitted into the recovery room to be reunited with his wife to share the joyous occasion; however, the newborn baby was left in the nursery. Recovery room nurses appeared to have taken an accepting approach for the mother and father to reconnect by encouraging the father to visit the mother and then go back to the nursery to be with the baby, which reflected the changing cultural beliefs about a father’s presence at childbirth.

This belief and value was reiterated in the other oral history interviews. Nurse D.L. stated, “Cesarean section, very important that the father is there or the husband is there or the support person” (Oral History #8, p. 10). And Nurse J.V. stated, “C-section fathers, it was just also an understanding that they would come in to be with their wife” (Oral History #4, p. 9). As we can see, the changes that occurred in the 1970s drastically influenced the way nurses’ perceived fathers. Their attitudes shifted from excluding the father to ensuring the father was present for the mother. This practice appeared to have become a norm in the care of the cesarean mother.

Nurses’ empathy for mothers who required a cesarean section was profound. Nurses expressed concern for the mother and father who had to endure a cesarean section as this type of surgery was typically performed on an emergent basis. Nurse D.L. mentioned after the taped-interview ended that mothers and fathers were not usually prepared for a cesarean section because they expected the birth to be vaginal. She said, “I don’t think they would even think of a c-section if the pregnancy has been normal” (Nurse D.L., personal communication, October 21, 2006). When a cesarean section was necessary, it was because either the safety of the mother’s or baby’s life was at risk. This
was a stressful time for the mother and father as the scheduling of a cesarean section was extremely quick, with very little time for the mother and father to absorb the gravity of the situation. Under these circumstances, recovery room nurses may have felt compelled to reunite the mother and father as quickly as possible in order for them to bond as a family, a psychological insight that increasingly gained ground as birthing practices changed (Bowlby, 1969).

**Pediatric Patients**

As fathers were being reunited with the mother after a cesarean section, parents of pediatric patients were welcomed into the recovery room as well. In the 1970s, a social movement had erupted where parents were demanding to be with their hospitalized child. Prior to this movement, parents were segregated or had limited contact with their child during hospitalization. Parents began to question the validity and possible detrimental psychological effects this separation caused their child (Junge, 1997). The concept of family-centered care flourished. "Family-centered care emerged as an important concept in health care [in] the second half of the 20th century, at a time of increasing awareness of the importance of meeting the psychosocial and developmental needs of children and of the role of families in promoting the health and well-being of their children" (American Academy of Pediatrics, 2003). Put simply, family centered care focused on the needs of the child and parents. The child and the parents were placed at the center of the care and were increasingly considered to be part of the interdisciplinary health care team. Parents are involved as little or as much as they feel comfortable with surrounding for example, the decision-making process in the child’s care. (American Academy of Pediatrics, 2003).
With the formal adoption of a family-centered care approach in hospitals, parents were increasingly able to visit and see their child without restrictions in the post-anesthetic recovery room. Recovery room nurses spoke of welcoming parents into the unit. Nurse D.L. stated, “Pediatric patients, we welcome the parents, please come in and sit with your child, and the child, ninety percent of the time will calm down” (Oral History #2, p. 10). Nurse C.R. and some of her colleagues shared the same beliefs: “Only in critical situations or exceptions like a child or a c-section should we have visitors” (Oral History #9, p. 16). The acceptance of parents in the recovery room demonstrated a shift in practice. Parents were seen as an extension of the child; therefore reuniting them when they could was in the best interest of the child and parents.

Nurse L.M. described her observation of how children and parents responded once they were reunited:

Totally variable, I mean it depends so much on well the kid to begin with. You’ve got the spectrum there right, it depends on the parent. Some of them are just … they couldn’t pick up the kids, the kids had chest tubes in or they were on the … Herrington rods … and stuff … but usually the parents were pretty well prepared by the surgeon. If the surgeon knew that they were coming or by the nurses … and you had some [parents] who were absolutely fabulous, cool and able to focus in on their little one and others who came in and all they could do was look around at everything. They were just totally overwhelmed so, you can’t generalize. Yeah, the most important, critical thing is that they, that any parent coming in … is really aware of the situation and aware of their limitations. If they’re asked to leave, then they need to leave. We used to have incidents, I don’t
know how many incidents there are now but we used to have the odd arrest or bleed or somebody who was waking up ... really distressed, and so there were other elements that people needed to know there may be an occasion when if you’re coming in. We’ll need to ask you to leave and that means leave not hang around. [Laughter] ... I think maybe now ... I know that they have more individual cubicles and things that there’s more privacy, if maybe it’s easier to accommodate (Oral History #7, p. 20).

Nurse L.M. described situations where the reaction of the children when seeing their parents after surgery varied, as all children were unique and distinct individuals and respond to situations differently. It was a stressful and emotional time as the child was in a foreign environment being cared for by unfamiliar faces. Furthermore, as Nurse L.M. illustrated, the child was confined and restricted due to tubes and rods. The types of procedures that she described were extremely painful for the child and quite distressing for the parents to see. Parents were unable to hold or cradle their child making it difficult for the parents to console their child.

Nurse L.M raised an issue of some parents being distracted by the recovery room environment. This might have been due to the equipment and technology that were used in the unit. The sights and sounds in the recovery room can be very overwhelming and sometimes upsetting and disturbing. As a result, the parents needed to be prepared beforehand by what they were going to see. Nurse L.M. mentioned that the surgeon would prepare the parents before entering the recovery room so the parents were not shocked by the child’s condition. It was also an opportunity for the surgeon to explain the limitations or expectations of the parents while in the recovery room. Parents needed to
understand their role while in the recovery room and the type of behaviour that was expected. Nurse L.M. explained that parents needed to understand that if they were asked to leave the recovery room, it was because a serious or critical event was unfolding and having the parents there could potentially compromise care. It is apparent from the interview that nurses felt that limitations were needed to be set for the parents from the onset, as there were circumstances where a parent might think it would be fine to “hang” or wander around the recovery room. This was not an acceptable behaviour because this could upset other patients or parents in the recovery room.

Other Exceptions to Family Visitation

Since the 1970s, broader cultural changes have also shaped family visitation. For example for patients who could not communicate in English, an interpreter, which usually was a family member, would be allowed to visit the patient in the recovery room and help with translation. Nurses welcomed a family member to be present in these situations. Having the family member available to translate also enhanced the level of care for the patient as the nurse was able to promptly assess and determine what kind of care the patient needs.

Another circumstance where the family member would be granted access into the recovery room was if the patient was mentally challenged (Nurse D.L., personal communication, October 21, 2006; Nurse S.C., personal communication, August 4, 2006). Usually these patients required a level care where one to one nursing might be necessary. In these cases, it would be extremely beneficial to have a family member or caregiver at the bedside to assist with the assessments and nursing care. For example, if the patient received a general anesthetic during surgery, the mental status of the patient
would be further impaired post-operatively, but to what degree? Having the family member or caregiver would be a beneficial asset as they could provide information on the general mental state of the patient prior to the surgery, which in turn would aid the recovery room nurse in the assessment of the patient’s postoperative recovery status.

Summary

The oral history interview participants explained that space, privacy, and safety were reasons for restricting family visitation in the recovery room. All three of these reasons are intertwined with one another. Due to the open and limited recovery room space, there were inherent risks for jeopardizing patient privacy and safety. The recovery room nurses role was to protect the patient and maintain a safe recovery environment. However, over the decades, there has been a shift in attitude regarding the degree of involvement family members had in the post-operative phase. Initially, fathers were off limits to reunite with the mother after a cesarean section and parents were not allowed to reconnect with their child after surgery. With the advent of family-centered care, the belief system to segregate patients and families changed. Health care providers witnessed and acknowledged the psychological benefits family visitation had on patients and their family. The focus of care from a medical model to a holistic approach greatly impacted the subtle changes in the delivery of post-anesthetic care.
CHAPTER FIVE: DISCUSSION

When I began this project, my primary focus and goal was to understand why family visitation was restricted in the post-anesthetic recovery room. As a practicing recovery room nurse, I could not understand why we continued to restrict visitors in the unit despite the current research studies that supported family visitation in the post-anesthetic recovery room. Although a number of methodological approaches could have been implemented to answer this question, I felt that a historical analysis was the methodological approach that would be best suited to answer this question.

My reason for choosing this particular approach was that I felt it was crucial to understand from a historical perspective why family visitation was restricted from the time recovery rooms began to flourish in the health care system, as there were no research studies about family visitation in the post-anesthetic recovery room that focused on this period. What were the reasons for such restrictions? Why did surgeons, anesthesiologists, and recovery room nurses feel compelled to segregate families from their loved ones in this area? Furthermore, I felt that it was necessary to explore and understand the perspectives of recovery room nurses from the 1960s-1980s as they practiced during a time when visitation was so strongly opposed, and were also part of the progress that emerged in the 1970s as a result of families requesting to be part of the patient’s recovery phase.

In this study, I have outlined and described the reasons why family visitation has been historically restricted in the recovery room. In this discussion, I will also shed light on the barriers that have historically impeded the acceptance of family members in the adult recovery room. Prior to this research study, the majority of research studies
conducted on family visitation had largely focused on the benefits of family visitation for the patient and family members. The impact of family visitation from the perspective of recovery room nurses had been neglected.

**Reconfiguration of Space**

All of the recovery room nurses in the oral history interviews spoke about the issue of space as one of primary reasons why family visitation was restricted in the recovery room. When reviewing the “modern” recovery room blueprint in the 1950s (See Figure 2), it is clear that the physical environment did not allow for more than one nurse, at most two nurses, to be at the bedside. The nurse had to be continuously there—between the stretchers—to continuously monitor and provide care. The space was specifically meant for “recovery” of the patient. This was the fundamental principle of recovery room care. The patient was the focus, not the family.

During the oral history interviews, I had asked the nurses to draw the layout of their respective recovery rooms in order to get a clear mental image as to how these spaces were set-up. What I found so fascinating was the fact that all of these recovery room nurses distinctly remembered the layouts of their recovery rooms, for example, the SPH recovery room nurses even described what “wall” a particular patient group would occupy. They all described in detail how the space was utilized and functioned.

From examining their drawings, one can see that the recovery room space was indeed cramped and in some cases relatively small. Although one may think by looking at the drawings that these spaces would be large given that they were open rooms, they were in fact not. And it is quite clear that visitors were not meant to be in these spaces, only nurses and patients. Since recovery rooms were created and carved out from existing
spaces in the 1950s, the space initially allotted for these areas were already at a disadvantage as it did not allow for future growth of the unit.

With technological advancements by the late 1970s and 1980s, new equipment was being introduced but there was either little or no space for the equipment. The nurses spoke to the size of the machines and how it consumed the small space they were already working in. This in turn added another dimension of complexity into their practice to an already challenging work environment.

Whereas space might serve as an explanation as to why family visitation remained restricted, my findings also revealed that safety of the patients was another primary reason for the restriction. In some regards, the concepts of space and safety went hand in hand in the way recovery room care was shaped and delivered.

Safety for the Patient

Again, in all the oral history interviews, the recovery room nurses spoke of safety of the patients as they thought about why families were not allowed into the recovery room. The safe recovery of the patient from anesthesia and the surgical procedure were the driving principles in the care of post-operative patients. There was a level of specialized care that was expected and needed from the recovery room nurse.

The type of care that was required for post-operative patients in the 1950s through to the 1970s had drastically changed compared to present day. In the 1950s and 1960s, recovery room nurses did not have the sophisticated equipment and technology that is being currently used in post-anesthetic recovery rooms. The use of monitoring equipment such as, cardiac monitors to monitor the patient’s blood pressure and heart rate, and the use of pulse oximetry to monitor oxygen saturation were not available to recovery room
nurses in that time period. Some of the recovery room nurses explained that they had to manually monitor patient’s blood pressures via portable blood pressure cuffs. A daunting and labour intensive task, as the monitoring of patient’s vital signs depended on the level of consciousness of the patient. Heart rates were also assessed manually by the recovery room nurse via a stethoscope or by palpating for the patient’s radial pulse. At this time, pulse oximetry had not been invented (Severinghaus & Honda, 1987). Rather recovery room nurses assessed the patient’s oxygen status by observing the rate and depth of the respirations via a stethoscope, as well as, the color of the patient.

What made these conditions unique compared to that of the general wards was that the level of acuity was heightened in the recovery room. A distinct and specialized body of knowledge was required in the post-anesthetic recovery room. In addition, a set of highly specialized skills were also vital. The patients admitted into the recovery room had just undergone major surgery and had received a general or spinal anesthetic. The nurses spoke about receiving patients who were still unconscious and not breathing when admitted into the recovery room, requiring one to one nursing care. This was a critical period. Safety of the patient was of utmost importance as recovery room nurses had to observe and assess that the patient was safely emerging from the effects of anesthesia and the surgical procedure. From their stories, the recovery room nurses had to be quick and efficient as it was a life-threatening time.

What is also important to note is that the staffing levels during this time period was relatively inadequate for the level of observation and care that was required for this unit. Based on the 1950s literature, the nurse-patient ratio during a day shift was 1:5, an evening shift it was 1:7 and on a night shift it was 1:6 (Adriani & Parmley, 1958). The
present day recovery room nurse-patient ratio is 1:2—a drastic difference. From the oral history interviews, it appeared that the staffing varied depending of the number of operating rooms running on a specified day and the type of surgical procedures being performed that day. The nurses mentioned that the staffing was scattered throughout the day, having the most concentration of nurses on during the middle of the day.

Based on this information, the recovery room nurse’s responsibilities were extremely demanding both physically and emotionally. Constant observations and assessments were critical in ensuring that the patient recovered safely. Having family members present would have impacted that level of specialized care as family members may interfere with the recovery room nurse’s observations and assessments.

Protecting the Patient

In the oral history interviews, recovery room nurses expressed concern about maintaining privacy and confidentiality for the patients. The reason for their concern was that the recovery room was an open room with only curtains separating one patient from another, or there were no curtains at all. If visitors were present in the recovery room, they could likely overhear private and personal information about another patient. For example, when a patient was admitted into the recovery room, the anesthesiologist provided a detailed report of the patient’s past and present medical history, in addition to the type of anesthetic administered and surgical procedure performed. This was private and confidential information that should only be shared between health care professionals. However, if family members were present, this could possibly breech privacy and confidentiality laws.
Nurses also spoke about family members possibly wandering around in the department which could upset other recovery room patients. They mentioned that the patients were in plain sight to the visitors as the curtains are typically open and not drawn. Curtains were usually drawn if the patient was going to be exposed due to an assessment or if a procedure was to be carried out. Curtains were also drawn when a visitor was present; however it blocked the visibility of other recovery room patients, therefore causing a possible safety issue for the nurse. In combination, these reasons seemed to outweigh the potentially favourable psychological effect visiting family members likely had on the well-being and recovery of the patient, an insight that gradually gained ground in the latter half of the 20th century. These circumstances for restricting family visitation were grounded in maintaining optimal safety for the patient.

Gradual Changes in Practice

Although the recovery room has been a restricted unit, concessions have been made for particular patient groups. Recovery room nurses accepted the important roles fathers had for the cesarean section mother and parents after their child’s surgery. The acceptance was gradual but successful. The movement of family-centered care played a pivotal role in the changes to family visitation. Physicians’ and nurses’ changing attitudes which eventually became supportive of keeping the family structure together and united have made a significant impact on how the family unit is viewed. Moreover, the surgical procedures, as well as, the size and availability of monitoring equipment, and anesthetic practices have also changed. Yet, despite this changing context, which has influenced for some change, nurses continue to be influenced by traditional ways they were socialized into their role.
Training of Recovery Room Nurses

The training of recovery room nurses in the 1940s through to 2000 has been largely based on an apprenticeship model, beginning nurses learning from experienced nurses (du Boulay & Medway, 1999). Initially, anaesthesiologists were the ones teaching and training the nurses about recovery room care (Beal & Eckenhoff, 1969; Masters, 1949; Sanders, Graff, Aikins, & Cooling, 1949). Over time, this responsibility was eventually taken over by recovery room nurses as they gained increased knowledge, skills, and experience. In doing so, new graduate nurses were trained by senior recovery room nurses or the head nurse of the department. This kind of training still continues today, firmly rooted in the way nurses continue to be prepared for specialty nursing practice.

The primary focus of recovery room care has always been on the ABCs, Airway, Breathing and Circulation, a physiological and medically grounded criterion. These concepts are central to the care of the immediate post-operative patient. Just as these concepts have been ingrained from the time of the conception of the recovery room, so has been the attitude towards family visitation. From the 1940s-1960s books and articles, to the oral history interviews, family visitation from the outset has been restricted. Because of this way of thinking and practice, it has continued to be passed on throughout the decades to new generations of recovery room nurses.

The nursing care required for a post-operative patient has drastically changed from the 1950s. The basics remain the same, but the type of anaesthesia used now is far more superior compared to the 1950s anaesthetics, the surgeries being performed are far less invasive with decreased complications, and the recovery phase is considerably
shorter. The reasons for restricting and excluding family members back in the earlier decades made sense due to the complexity and critical state of the patient as well as the literal spaces between the beds. The type of nursing care required during that time was extremely labour intensive and complicated as they did not have the type of equipment and sophisticated technology that present-day recovery rooms now use. For example, nowadays, recovery room nurses have the luxury to monitor patients from afar as they are connected to cardiac monitors that continuously monitor their vital signs. However, despite the advancements in patients’ status, surgical techniques, and technology, the belief of restricting family visitation still remains. Present-day recovery room nurses continue to restrict family visitation based on the 1950s rationale, but those reasons are dated and seem no longer valid. The nurses’ stories also indicate that their active involvement in such change seems important, as is the need for families to be heard.

Whose space is it and what are the values driving its construction and symbolic meaning? Present-day recovery room nurses need to incorporate evidence-based literature into their practice regarding family visitation, as there is a growing body of knowledge that supports the inclusion of family visitation in the immediate post-operative period. Times have changed and so does the practice of restricting family visitation.

Implications and Recommendations for Practice

The issue of space is a strong and valid argument for the restrictions placed on family visitation and one that needs further investigation. From the time recovery rooms were created and developed, space has been on the minds of physicians and nurses. The physical space constraints are evident in past and present recovery rooms based on the 1950s blueprints, to the drawings of the oral history interview participants of their
respective recovery rooms. Many of the present day recovery rooms appear to be outdated. For example, Nurse S.C. from SPH stated “this recovery room was designed in 1970 and it opened in 1984, so it was kind of outdated by the time it opened” (Oral History #3, p. 10). The architectural design and configuration of the recovery room units needs further revamping. Making space for family visitation should be one of the priorities when designing a recovery room.

The issue of maintaining patient privacy and confidentiality was a major concern for recovery room nurses given the open concept design of the recovery room. This is a valid issue and one that needs to be further addressed. The creation and development of a recovery room guidelines pamphlet for patients and family members may assist with solving this issue. The pamphlet should address the roles and expectations of family members when in the recovery room. For example, one guideline could be: Family members are expected to remain at the patient’s bedside during the visit and are not permitted to wander around the department. A further explanation of this guideline can include the importance of maintaining patient privacy and confidentiality for all recovery room patients during the visit. Another approach to maintain patient privacy and confidentiality is to ask visiting family members to leave when a patient admission is expected to arrive into the recovery room. This could be another guideline in the pamphlet: During patient admissions, family members are not to be present in the recovery room in order to maintain patient privacy and confidentiality. The development of a recovery room pamphlet is to provide information and guidelines for the family members. Some family members may not know what to expect when they enter the recovery room or what is expected of them as a visitor. Setting guidelines and boundaries
for family members may help ease the tension of family visitation (Smykowski & Rodriguez, 2003).

Limitations of the Study

Given that I am a practicing recovery room nurse, I have an intimate connection with this subject. I have experienced being both the nurse restricting family members and have been the family member being told “No, you aren’t allowed in” to the recovery room. I had to consider my own personal and professional biases as to how I was going to approach this research study. After each interview, I would reflect on what was said and shared during the interview, noting what may be a prejudiced or an unfair judgement. This aided in maintaining an open mind and neutral stance during the interviews and during the analysis. Furthermore, during the interviews, I would check my own understanding of the participant’s story by asking additional questions as a form of member checking.

Some of the participants knew I was a practicing recovery room nurse. This may have possibly influenced their answers during the interview, particularly the questions surrounding family visitation. For example, some of the participants may have assumed that I was in support of family visitation; thereby telling me that they were also in support of family visitation. I was conscious of this when I had started the oral history interviews, and decided not to inform them of where and what department I worked in until the end of the interview, unless they asked me during the introduction, then I would reveal my area of nursing practice.

In addition, no Canadian research studies have been conducted on this topic and there were little written documentation and sources available. This is quite interesting due
to the amount of controversy that this issue has generated for over 20 years in US hospitals. In addition, comparison of family visitation practices to other regional areas and hospitals in Canada may be important.

Conclusion

The issue of family visitation continues to be a controversial and unresolved topic. Through a historical analysis, a deeper understanding of the issue was revealed. The reasons why family visitation was restricted back in the 1950s no longer holds the same merit in present-day recovery rooms. The face of the immediate post-operative patient has changed in the last 50 years, beginning with, the types of anaesthetics being administered, the way surgical techniques are being performed, and the variety of equipment that is currently accessible. Present-day recovery room nurses need to recognize and re-evaluate their practice and attitudes towards family visitation. The research supports the inclusion of family members in the immediate post-operative period. There have been various strides over the decades which have begun to change the attitude towards family visitation. The acceptance of fathers into the recovery room after a cesarean section and parents after their child’s surgery are two examples of this change. The insight that family members play a beneficial role in the recovery of the post-operative patient is gradually gaining ground, changing the norms that constrain family visitation.
References


members’ perceived needs during postanesthesia care unit visits. *Journal of Post Anesthesia Nursing, 7*(6), 387-391.


Oral History Interview #1 with J.S. by author, July 31, 2006

Oral History Interview #2 with F.M by author, August 7, 2006

Oral History Interview #3 with S.C. by author, August 4, 2006

Oral History Interview #4 with J.V. by author, August 30, 2006

Oral History Interview #5 with S.F. by author, September 6, 2006

Oral History Interview #6 with B.E. by author, September 19, 2006

Oral History Interview #7 with L.M. by author, October 4, 2006


*Hospitals, 26*, 68-77.


Vogelsang, J. (1986). Nurses’ assumptions about patients’ perceived needs in the PACU. *Critical Care Nurse, 6*(6), 44-54.


Wanro, N.W. (1949). The recovery room has much to recommend it. *Modern Hospital, 73*(11), 65.


Certificate of Approval

The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approved on behalf of the Behavioural Research Ethics Board by one of the following:
Dr. Peter Sudhoff, Chair,
Dr. Susan Rowicy, Associate Chair
Dr. Jim Rupert, Associate Chair
Dr. Arminee Kazanjian, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.
Consent Form
Evolution of Family Visitation in the Post-Anesthetic Recovery Room

Principal Investigator: Dr. Geertje Boschma, Associate Professor, School of Nursing
Co-Investigator: Nerrisa Bonifacio, RN, BSN, MSN student, School of Nursing

Purpose:
The purpose of this study is to explore the evolution of family visitation in the Post-Anesthetic Recovery Room in Lower Mainland hospitals from the 1960s to the 1980s. I am particularly interested to learn about your experiences of working in the Post-Anesthetic Recovery Room and any involvement and interactions you may have had with families of recovering patients. I am also interested in the influence of hospital administrators and nursing managers on the creation of recovery room policies and the impact of these polices on nursing practice.

Study Procedures:
The information you share with the researcher may be used in this research study. There is a possibility that the information will be published. The researcher might request two interviews with you for one hour, but no more than one and a half hours each. The researcher will tape record the interviews. The information from the tape recording will be typed. The interview can be conducted at a location of your choice.

The information you will share will assist in understanding how policies were created and why particular policies have remained unchanged. The study is for a Master's thesis. The study has no direct benefit to you; however, you may enjoy sharing valuable information and contributing to historical knowledge.

There is a small risk that you may feel uncomfortable when sharing personal memories. You may change the topic, stop the interview, or decline to answer any question at any time during the interview. If you become exceedingly uncomfortable, the researcher will stop the interview. There are no other expected risks or discomforts associated with this interview.
Confidentiality:
Your personal information (address and phone number) will be kept private. It will be available only to the researcher. Confidential information will not be collected via email.

You will be given credit for any information used in the study. You may choose not to have your name identified. However, there is a slight chance readers may recognize your identity through the information that you have shared; therefore anonymity is not guaranteed.

The information you share is of historical value. It may be used by future researchers interested in this topic, with appropriate ethical approval. It will be stored in a secure, locked location for five years upon completion of the study. After the five years, information you have provided will be sent to the archives i.e. UBC Archives.

Remuneration/Compensation:
You will not be paid for participating in the research. If you have to pay for parking expenses for attending the interview you will be compensated for the cost.

Contact for information about the study:
If you have any questions or require further information with respect to this study, you may contact Nerrisa Bonifacio at XXX-XXX-XXXX or Dr. Geertje Boschma at 604 822 7457.

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604 822 8598.

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time.

(1) Do you agree to have your name identified in the study?
   Yes ___ No ___

(2) If you answered No, do you understand that every effort will be made to keep your information confidential but that anonymity might not be guaranteed entirely?
   Yes ___ No ___

(3) Do you agree to have your information kept available for future historical research of Dr. Boschma, in which the interviews will be used in the same way, but for a broader project? For example, the history of Post-Anesthetic Recovery Room care in Western Canada.
   Yes ___ No ___
(4) Do you agree to have your interview tapes and transcripts forwarded to an archive upon completion of the project after five years?  
Yes ___ No ___

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

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<th>Printed Name of Subject</th>
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If you would like to receive a copy of the final report of this study please provide your mailing address below: