PATIENTS’ EXPERIENCES OF PARTICIPATING IN AN ENHANCED RECOVERY AFTER COLORECTAL SURGERY (ERACS) PROGRAM

by

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ABSTRACT

Enhanced Recovery After Surgery (ERAS), previously called fast-track, originated in 1999 in Denmark and is gaining ever-increasing acceptance throughout North America. ERAS attempts to minimize the body’s stress response and organ dysfunction while enhancing recovery by decreasing complications and increasing feelings of wellbeing after major surgery. Patients are guided along regimented recovery periods in which they become active and engaged participants throughout all stages. The local health authority has adopted and adapted ERAS as a new surgical incentive called “Enhanced Recovery After Colorectal Surgery” (ERACS). Evidence from a large body of quantitative research has demonstrated the medical benefits of ERAS for patients, but there is limited qualitative research to understand the patient experience with no Canadian studies to date.

The purpose of this qualitative study was to gain an understanding of the experiences of patients with colorectal cancer participating in this newly implemented ERACS program. The study used the narrative inquiry work of Holloway and Freshwater, plus Clandinin and Connelly. Five men and two women participated in a structured storied interview that documented the peri-operative phases of their ERACS journeys. From these interviews, Emden’s core story creation process was used to mold stories into surgical narratives using sjuzet, or organization by use of sequence and temporality.

The participants’ ERACS experiences included constant motion in context to three compounding disruptions: life, time and surgical, all coming with multiple themes and sub-themes. In life disruption, they faced vulnerability as their nil to mild body clues were diagnosed with colorectal cancer. In time disruption, they reflected on their past, present and future along with a sense of changing speeds of time. In surgical disruption, they entered the hospital for surgical intervention and relayed their passage through to discharge. Their journeys were driven
forward by motion and clock time, compliance, resilience, post-traumatic growth, plus the concept of non-care emerged. This study adds to the limited qualitative knowledge base and has implications for research, practice, and education. By seeking out rich experiential stories, we can listen, learn and understand to help build safe surgical programs for the benefit and care of all future ERACS patients.
PREFACE

This study was granted ethics approval by a harmonized review between the University of British Columbia – Okanagan (UBC-O) and the Interior Health Authority (IHA), #H11-03489. As per UBC Okanagan Research Ethic Board guidelines, Dr. Kathy Rush was designated as the Principal Investigator, and Shannon Desilets was the UBC-O graduate student who completed this project for graduate requirements as per the UBC-O Master of Nursing Program. Shannon Desilets engaged in data collection with thesis committee guidance, while data analysis was a collaborative effort between herself and her thesis committee, consisting of:

1. Dr. Kathy Rush, UBC-O Associate Professor of Nursing, Committee Chair.
2. Dr. Dixon Sookraj, UBC-O Associate Professor of Social Work
3. Dr. Penny Cash, University of Victoria, Faculty of Human & Social Development
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ACKNOWLEDGEMENTS

Like the saying goes, “it takes a village to raise a child”; so to can it be said, “it takes a team to create a thesis”. This was not a solo journey, but one that needed many to agree to join me in order to make this a reality. Much expertise, time, energy and patience was required from others as I sought answers to my one research question that ultimately became this finished work.

There are so many to thank:

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DEDICATION

This is dedicated to all of those whose lives and selves were changed in a brief moment of time when your body clues were labeled with a disease, and you heard the three spoken words of “YOU HAVE CANCER”.

To the seven ERACS patients who stepped forward and told their stories of surgical experience,

THANK YOU!

Be proud... this is your work of knowledge and art!
CHAPTER ONE: INTRODUCTION

According to the Canadian Cancer Society (CCS), colorectal cancer is the third most commonly diagnosed cancer amongst Canadians (retrieved June 21, 2013). It is the second leading cause of death from cancer in men and the third in women. Statistics obtained from the CCS reveal, “in 2013 an estimated 23,900 Canadians will be diagnosed with colorectal cancer and 9,200 will die of it”. Of this number, an estimated 13,200 men will be diagnosed (1 in 13) and 5,000 will die (1 in 29), and an estimated 10,600 women will be diagnosed (1 in 15) and 4,200 will die (1 in 31). On an average day, 65 Canadians will be diagnosed with colorectal cancer and 25 deaths from it will occur.

Historically, colorectal cancer surgery focused on cure at all costs with little regard for a patient’s holistic self and surgical experience (Sideris et al., 2005). Kehlet and Wilmore (2008) states “surgical training has traditionally been based on the guild system” (p. 189) whereby surgeons pass on their preferred techniques and care practices to residents in training. These traditional surgical methods, sometimes referred to as “sacred cows”, have hindered changes to current practices. Due to shifts to evidence-based practice, there is new attention to the creation of clinical protocols. Previously, my organization had no written surgical pathways to guide colorectal surgery, but this has changed with the implementation of the “enhanced recovery after colorectal surgery” (ERACS) program resulting in our surgical culture and practices changing from traditional methods into an evidence-based surgical model.

There is a large body of quantitative research supporting the medical and objective benefits of an “enhanced recovery after surgery” (ERAS) program (Chalabi et al., 2010). This evidence-based surgical care plan attempts to minimize the body’s stress response and organ dysfunction while it optimizes surgical recovery and personal wellness (Wilmore & Kehlet, 2001). An ERAS program has been well documented to:
(a) accelerate recovery, (b) hasten return of organ function, (c) decrease morbidity and mortality, (d) decrease rates of complications, and (e) decrease length of stay (Carli, Baldini & Stein, 2009; Eskicioglu, Forbes, Aarts, Okrainee & McLeod, 2009; Kehlet & Wilmore, 2008). By using the enhanced surgical approach, the traditional length of hospital stay for colorectal surgery has been reduced from six to ten days to four or less (Carli et al., 2009; Eskicioglu et al., 2009).

An enhanced surgical program has many components, with the four main ones cited in the literature including: (1) optimal pain control; (2) use of carbohydrate loading prior to surgery; (3) early enteral [oral] nutrition; and (4) early mobilization (Wilmore & Kehlet, 2001). In total, my organization has 25 components that form the ERACS clinical path, all contributing to an individual’s overall surgical outcome. The components encompass the pre-, intra- and post-operative surgical phases (see Appendix A). Gustafsson et al.’s (2011) study outlines the positive correlation between ERAS component adherence and successful patient outcomes. Patients on our ERACS program receive a series of tools and documents that include:

1. ERACS Pre-Operative Instruction Sheet (see Appendix B).
2. ERACS Patient and Family Information Booklet (see Appendix C).
3. ERACS Post-Operative Order Set (see Appendix D).
4. ERACS Discharge Booklet (see Appendix E).

Research related to ERAS has been primarily quantitative with an emphasis on the medical story of enhanced recovery. Despite literature demonstrating positive objective ERAS outcomes (Teeuwen et al, 2010), limited attention has been given to the patients’ stories and their experiences with this strict and regimented surgical program (Norlyk & Harder, 2009).

Only two qualitative studies were found that described patients’ experiences of an ERAS program. Firstly, Norlyk and Harder (2009) engaged in a phenomenological study with sixteen Danish patients, aged 55-77, who were placed on a well-established ERAS program. Although
patients wanted to comply and regain health, they found program participation to be a challenge as power tensions were present. Secondly, Aasa, Hovback and Bertero (2013) performed a qualitative interpretive study with twelve Swedish patients, aged 46-73, to understand the impact of pre-operative ERAS information sessions on active participation. Patients experienced a disconnection between their information sessions and their hospitalization experiences. The authors stated the need for patient participation, but also for ERAS role responsibility of both nurse and patient. The current study builds on these two qualitative studies (Norlyk & Harder, 2009; Aasa et al., 2013) by including Canadian participants in a newly developed enhanced recovery program whose stories of ERACS experience span the entire peri-operative period.

**Purpose of Research and Question**

The purpose of this qualitative research was to gain understandings and meanings of the experiences of patients with colorectal cancer participating in this newly implemented ERACS program. Through narrative inquiry, the participants’ stories were told and analyzed in order to answer the research question "what do patients with colorectal cancer experience as they travel through an ERACS program?"

**Clarification of Abbreviations**

To clarify, two similar abbreviations are used throughout this study - **ERAS** and **ERACS**. The first, ERAS, stands for enhanced recovery after surgery, and is also known as the fast-track method. The second, ERACS, stands for enhanced recovery after colorectal surgery, and is the specific name that my organization has given to our program.

**Upcoming Chapters**

From this introductory Chapter One, the reader is moved through four additional chapters. Chapter Two offers the findings from a literature review of qualitative studies related to patients’ experiences of both the traditional and enhanced recovery surgical approaches. It concludes with
a discussion of similarities and differences between them. Chapter Three presents the qualitative method of narrative inquiry (NI), both as it was planned for use, and how it was modified as the needs of the study unfolded. A discussion regarding the terms stories and narratives occurs. Chapter Four reveals phases, themes and sub-themes that emerged from the analysis of the participants’ interviews, subsequent stories and surgical narratives. Chapter Five explores the concepts that paralleled the participants’ narrative documentary as they travelled along the ERACS pathway. This chapter concludes with reflection upon the study, plus addresses the limitations and recommendations for research, practice and education.
CHAPTER TWO: LITERATURE REVIEW

Due to a scarcity of qualitative studies that explore patient experience with ERAS, I opted to review the literature related to patients’ traditional surgical experiences from being diagnosed with colorectal cancer to undergoing surgery for it. The literature review begins with traditional colorectal surgical experience, and then moves into the ERAS experience. The similarities and differences between the findings from these two surgical approaches are discussed.

TRADITIONAL COLORECTAL SURGERY LITERATURE REVIEW

A recurring pattern in the literature regarding cancer and various stages of its’ journey is the need to regain control of, and normalcy in, one’s life (Simpson & Whyte, 2005). The theme of “normal” becomes present in each phase of the journey, from hearing the actual diagnosis, to starting radiation or chemotherapy, preparing for surgery, or accepting final outcomes. There is an ongoing need to regain a sense of normal, despite the changes that happen to one’s body and self. Qualitative research has captured patients’ experiences with traditional colorectal surgery, moving from a taken-for-granted normal, to a disrupted normal, into a new sense of normal.

Three electronic databases were utilized for searching qualitative studies that addressed the traditional surgical experience. These included PubMed and CINAHL combined with MedLine. Four key terms were used: colorectal, surgery, experience, and qualitative. English was the only stipulated limit. This search produced 12 articles in PubMed and 24 in CINAHL with MedLine. Of the 12 PubMed articles, seven were relevant in featuring experiences with colorectal cancer from diagnosis to treatments and surgical recoveries. The seven articles were listed in the other databases. Seven themes were then synthesized across the studies, including: chaos and loss of control; communication and information; personal and social attitudes; support of others; health care providers and environment; control and coping; and new normal. These are explained.
Chaos and Loss of Control

Before cancer, people were their normal selves and living normal lives. They began to have subtle clues that something was wrong, such as changes in bowel habits or abdominal discomfort. Many assumed that these symptoms were a result of an inconvenient and temporary problem, like hemorrhoids, and many did not immediately seek medical attention (Broughton, Bailey & Linney, 2004). This delay in medical help may have been due to symptom denial.

When symptoms persisted, they saw their doctors and the battery of medical tests began. Negative emotions, like uncertainty and anxiety, surfaced as they waited to find out what was wrong (Mizuno, Kakuta, Ono, Kato & Inoue, 2007). Frank (1991) states, “as soon as the body forces the question [of what is wrong with me] upon the mind, the medical profession answers by naming a disease” (p. 8). The theme of chaos and loss of control commenced with diagnosis.

With all aspects of cancer, people can experience many intense and negative emotions, like shock, fear, anxiety, disbelief, uncertainty, vulnerability and numbness (Taylor, Richardson & Cowley, 2009; Wilson & Fletcher, 2002). As physical bodies underwent a battery of invasive tests, disassociation occurred in some as a coping mechanism, and this was described as the self taking second place to the body, or as being a “stranger-in-the-body” (Taylor et al.; Wilson & Fletcher). There were statements made about handing their bodies over to the health care experts that potentiated the feelings of loss of body and control (Broughton et al., 2004; Taylor et al.).

Loss of control and emerging vulnerability were strong themes that continued post-surgery. This was often associated with unpredictable and erratic bowel patterns, plus the fear of incontinence that hindered a feeling of “normal” (Desnoo & Faithfull, 2006; Mizuno et al., 2007). Patients experienced many post-operative side effects, including fatigue, gastrointestinal symptoms, urinary problems and sexual dysfunction (Taylor et al., 2009). People feared a
reoccurrence of cancer, along with what the future in general would hold for them (Mizuno et al.).

**Communication and Information**

As they attempted to understand the diagnosis, people needed effective communication and information. Patients wanted clear, honest and thorough explanations, plus the expectations about their conditions (Broughton et al., 2004). They needed unhurried and understandable communication with time to absorb what was being said (McCahill & Hamel-Bissell, 2009). Information needed to be delivered at their level, not at the medical professionals level. One person commended a doctor for drawing what he was saying in order for the patient to gain understanding (McCahill & Hamel-Bissell). Two studies stated the positive impact of clinical nurse specialists (CNS), as these nurses gave continuity of care and time, plus they provided effective communication and information for their patients (Broughton et al.; Desnoo & Faithfull, 2006).

Negative comments made in the studies related back to the lack of public knowledge and awareness of colorectal cancer as this may have contributed to the delay in medical attention (Broughton et al., 2004). One participant was disappointed with information that he found on the Internet (McCahill & Hamel-Bissell, 2009). There was also a lack of discharge information when they were released from hospital. Some participants stated discharge information would have been beneficial to know what to expect during the next phase of recovery at home (Broughton et al.).

**Personal and Other Attitudes**

Attitudes towards self and from others were found to be important within this literature review. Personal and positive attitudes that surfaced were described as strength, courage and perseverance as they engaged in their battles with cancer (McCahill & Hamel-Bissell, 2009).
Many positive attitudes continued when treatment ended, and they felt they had done their part, had reached a significant milestone, and had a sense of achievement (Simpson & Whyte, 2006). Negative attitudes stemmed mainly from social taboos that prevented discussion of bowel habits and movements (Broughton et al., 2004). After colorectal surgery, bowels can be unpredictable and erratic, leading to incontinence issues. In addition, some people required stomas that led to further psychological and social issues (Simpson & Whyte). People became reluctant to discuss bowel function and tended to suffer in silence, plus they avoided potentially embarrassing social situations (Broughton et al., 2004; Desnoo & Faithfull, 2006). This led to increased feelings of isolation and further avoidance of social interactions (Desnoo & Faithfull). Negative social ideals and attitudes hindered motion towards a new sense of normal.

**Support of Others**

People needed the support of their family and friends, especially at the time of diagnosis (Broughton et al., 2004; Simpson & Whyte, 2006). Others were considered positive when they provided support, encouragement, hope and perseverance (McCahill & Hamel-Bissell, 2009). Some were considered negative if they were anxious or fussed over them too much (Mizuno et al., 2007). Many appreciated the support from their family and friends, and just knowing that they were a phone call away provided comfort (Simpson & Whyte).

**Health Care Providers and Environment**

The health care providers were considered the experts who knew best, and thus, some patients allowed them to take control and make decisions (Simpson & Whyte, 2006). Studies showed that people had trust and confidence in the staff, and this was enhanced by effective communication, clear information and sharing of same, continuity of care, and efficient and perceived expertise of the staff (Broughton et al., 2004; McCahill & Hamel-Bissell. 2009;
Simpson & Whyte). Patients wanted to be heard and have others listen to them, plus they appreciated the time, care and concern afforded to them (Broughton et al.).

On the negative, McCahill and Hamel-Bissell (2009) found some patients had concerns with lack of communication and expertise of staff members, inadequate staffing levels and of care received. Another commented on fear and anxiety regarding invasive tests, surgery and delays if these occurred (Broughton et al., 2004). Plus, some felt that they were handing their bodies over in surrender to the health care experts (Taylor et al., 2009).

The lack of continuity of care, or constant change of staff members, became concern to some. One patient stated it was like having many strangers in your home (Simpson & Whyte, 2006). Some patients benefited from the constant care of a CNS (Broughton et al., 2004); however, these nurses were not employed in every institution. When discharged, some had apprehension and anxiety about going home (Simpson & Whyte), and others felt that better discharge information was required (Broughton et al.).

**Control and Coping**

As people recovered from surgery, they started to respond emotionally, not just physically. At this time, they began to reconnect and accept their “new” bodies (Taylor et al., 2009). Time was required for acceptance because they had to learn to trust their physical bodies once again. Often there was a need to incorporate adaptive coping mechanisms into their new normal, like incontinence pads or stoma appliances (Desnoo & Faithfull, 2006; Simpson & Whyte, 2006). These coping mechanisms allowed them to begin truly living again. Once control was restored and relationships renewed with their physical bodies, acceptance began (Taylor et al.).

As patients reflected on their cancer experience, many became grateful for it (Mizuno et al., 2007). It allowed them to review different areas of their lives, like parenting or work, and make necessary and positive changes (Simpson & Whyte, 2006). They had better appreciation for life
and started to live one day at a time, be present in the moment, and look forward, not backwards (McCahill & Hamel-Bissell, 2009; Simpson & Whyte). They accepted the cancer experience for what it was, plus what it had given them. They started to live life again. They understood there was a risk of reoccurrence, but began to accept where they were in the living present (Simpson & Whyte).

**New Normal**

As people regained control over their cancer situation and took back their physical bodies, they transitioned into their new normal. They felt trust in their “body” and its’ capabilities again (Taylor et al., 2009). They felt they had recovered their lives as normal routines and activities of daily living resumed (McCahill & Hamel-Bissell, 2009; Mizuno et al., 2007). The physical body was no longer in the foreground, and simply became a part of who they were. In one study, an individual described the body as becoming “autonomous, harmonious and fully functioning” (Taylor et al.). Qualitative literature regarding traditional colorectal cancer shows disruption and transition as current normal changes, and then a new normal becomes accepted. Now, what does the qualitative ERAS literature reveal?

**ERAS LITERATURE REVIEW**

To access qualitative ERAS literature, the same three electronic databases were used: PubMed, CINAHL combined with MedLine. Key terms of fast track, surgery and experience yielded 50 articles with many cardiac in nature. By adding the fragment colo*, the number of articles decreased to 13, with one being of significance. This was Norlyk and Harder’s (2009) phenomenological study. The other articles were quantitative in nature, and looked at empirical data such as decreased rates of complications and lengths of stay, or program implementation. Surgeon and anesthetist perspectives on the program and specific practices regarding bowel preparation and antibiotic usage were also reviewed. These studies did not explore the patient
experience of an ERAS program. A second qualitative study was located just prior to study conclusion, and was by Aasa, Hovback and Bertero (2013). The findings from these two qualitative ERAS studies are reviewed.

**Norlyk and Harder**

Norlyk and Harder (2009) conducted a descriptive phenomenological study based on the lived experiences of 16 hospitalized Danish patients (gender not specified) who met inclusion criteria of: (a) had a colonic resection; (b) were on the fast-track [ERAS] program; and (c) were capable of answering the questions. These authors commented on the lack of qualitative studies available. Five key themes that emerged from their study were: facing vulnerability; responsible participation; compliance – defiance relationships; professional support; and feeling safe.

In the first theme, “facing vulnerability”, negative emotions of fear, anxiety and vulnerability in relation to cancer diagnosis and its’ treatment and surgery surfaced. On the positive, people understood the program structure and this gave them an increased sense of security and control. They became committed and cooperated in order to live up to program expectations that stated predetermined daily goals.

In the second theme, “responsible participation”, people knew the expectations placed on them by both the health care professionals and themselves. They wanted to comply with their patient role, and they became “good patients”. Being aware of potential surgical complications motivated their participation, but at times instilled fear (i.e. prevent clot formation). The authors noted that the ERAS program created a “high degree of personal responsibility and a low degree of influence” (Norlyk & Harder, 2009, p. 174). People felt responsible to follow the program as set out by the medical world, but they did not feel they possessed any power to change it.

In the third theme, “compliance – defiance relationship”, comments of disembodiment were expressed. Participants stated they had a loss of control both of their situation, and of their
physical bodies. After surgery, they did not trust their bodies or its’ capabilities, but pushed through this fear in order to meet expectations. They encountered conflict when their own self-assessment mismatched that of the health care team.

In the fourth theme, “getting professional support”, health care professionals had both positive and negative impacts on the patients. Positively, they enjoyed hearing any affirming feedback regarding forward progress and achievement of goals. Negatively, they disliked the authoritarian mannerism that some health care professionals assumed. Some did not feel they could engage in meaningful conversation with the care providers, and therefore, they felt they suffered in silence.

In the fifth theme, “feeling safe”, patients began to trust their bodies’ physical capabilities in managing the ERAS program, plus trusted the health care professionals. They felt safe when they had experienced and competent staff members caring for them. Conflict was encountered when their own self-assessment did not match that of the health care providers when it came to discharge dates. Negative feelings arose when some of them felt forgotten, when they felt they did not regain full control of their bodies prior to discharge, or when staff members appeared to lack knowledge.

Norlyk and Harder (2009) acknowledge the primary focus of fast-track as being a medical perspective, with a lack of patient experience. This study begins to fill this identified knowledge gap. A second study with an interpretive design was located and provided further understanding of the ERAS experience, and is by Aasa, Hovback and Bertero (2013).

**Aasa, Hovback and Bertero**

Aasa et al. (2013) used an interpretive design to guide their research, with the purpose to “identify and describe patients’ experiences of a preoperative information session with a nurse, as part of the [ERAS] concept, and its impact on patient participation in their own care” (p. 1). The
sample size was twelve (nine male and three female) participants, with two inclusion criteria of: (a) they were dealt with in accordance with the ERAS concept; and (b) understood and spoke Swedish. From this study, five themes emerged: being seen; security; trust; responsibility; and participation.

In the first theme, “being seen”, patients felt acknowledged in the pre-operative information session. They had an opportunity to ask questions and gain information. It occurred one week prior to admission, so they had time to process and absorb it. Once in hospital, their sense of acknowledgement waivered, and some felt that they were not listened to, or given appropriate information. Some also stated there was a lack of discharge information given.

The second theme, “security”, became forth. Participants felt well informed and prepared for surgery because they were pre-educated and knew the expectations, including what lay ahead and length of stay. Their sense of security increased when a family member attended the meeting and they were able to review the material together at a later time. The sense of security decreased when discrepancies occurred between written and verbal information, such as when to expect bowel movements to start after surgery, or how much to lift.

The third theme, “trust”, provided increased calmness as participants felt less frightened and threatened by their upcoming admissions to hospital. The information sessions provided confidence, competence and trust in both the staff and surgical instructions. Higher levels of confidence and trust related to a decreased sense of loss of control.

The fourth theme, “responsibility”, showed engaged participants before, during and after hospitalization. Participants knew they were also responsible for “good results”, and they had to remain active during recovery. They were not passive in the recovery processes, achieving both program and personal goals. With guidelines on paper, this helped remind them of what needed to be done. Some participants felt a discrepancy between the information session and hospital
staff that seemed disconnected from the program. Some thought nursing staff had the greatest responsibility of patient care, and should oversee patient activity on the program. Some stated this did not happen, and therefore, they took over responsibility for it.

The fifth theme, “participation” was present in the active participants. Pre-surgery, they were able to use a syringe to deliver medication; post-surgery, they filled out menu and activity forms. Some did not, as they stated the nurses never asked if the forms were being followed or filled out. Many took the initiative in the recovery process, like getting out of bed on their own.

**Critical Issues from ERAS Literature Review**

With only two qualitative studies identified that addressed the patient experience with ERAS, a knowledge gap and limited understanding of many aspects of this experience was evident. Enhanced recovery is a well-established, accepted surgical program in European health care systems since the 1990’s. However, the combined sample size of these two studies was only 28 European participants. Despite the authenticity of the findings, they provided only a glimpse of the overall ERAS experience for the European patients on well-established programs. North American studies, in which newly developed programs are just beginning to emerge, have been strikingly absent. Learning more from ERACS patient stories and having their voices heard within these contexts is important to strengthen new programs and the care they provide.

The two reviewed studies focused on the surgical period only, and concluded with discharge home. In regards to recovery time, ERAS has a shorter length of hospital stay when compared to traditional colorectal surgical methods. Yet, this is not full recovery time needed after major surgery, with much recovery being done at home. There is limited study of how ERAS patients and their families manage beyond hospitalization and into their home recovery periods.
ERAS is an evidence-based medical model that involves many pre-determined decisions, such as length of stay and activity time. The medical model takes precedence in the hospital setting as it constructs the ERAS program and dictates compliancy from and responsibility of the patients. This power hierarchy may limit the patient’s decision-making power during recovery from major surgery. To date, research has not addressed power dynamics occurring within the hospital context as part of the ERAS program, and the influence of societal expectations and norms on patient experiences. There is need to explore the ERAS concept in relation to a variety of factors, including hierarchal power and control relationships, along with various stakeholders’ perspectives, especially those of nurses and patients.

Evidence to date suggests that nurses disengage and exercise authoritative mannerisms over patients on the ERAS program, often leaving vulnerable patients to carry greater responsibility to manage the program and achieve outcomes than the health care professionals. The ERAS concept must be one of shared responsibility, and onus should not be placed solely on the patient to manage this intense surgical program. This calls for research studies that examine the health care professionals, in particular nurses, and their experiences of working with both an ERAS program and the patients on it. There is still much to be learnt from all aspects and lens of the ERAS concept.

**Similarities Between Traditional and ERAS Surgical Approaches**

Several similarities were observed between patient experiences in traditional and ERAS colorectal surgical approaches. First, people were facing vulnerability and change, with many negative feelings experienced, like shock, fear and anxiety. Their body clues, once considered temporary or inconvenient nuisances, were named with a disease and these could no longer be ignored. The diagnosis was upon them and this caused chaos and loss of control to begin. They were no longer their taken-for-granted “normal” self.
Second, they were reliant on the health care system and professionals within it. Many made comments about a disassociation with their physical bodies, as they handed their physical bodies over to the experts, thus intensifying their sense of loss of control. In regards to the health care professionals, both positive and negative comments were made. Positively, they all appreciated competent staff that provided support, explanations and information. Negatively, some felt they suffered in silence if they were not listened to, or when staff lacked communication, or appeared to lack knowledge and expertise.

Third, people needed time to reconnect with their physical bodies and lives. They had to begin to trust their body and its’ capabilities again. After surgery, the body can be unpredictable and lead to embarrassing situations, such as incontinence. They began to regain normal life and daily activities, but they had been changed. Upon reflection of their experiences, positive benefits were realized, despite negative life disruptions. They began to appreciate life and live again in the moment. They did not dwell on the disruption, making positive change to enhance life and living.

**How the ERAS Approach Differs**

Although many similarities were identified, the biggest difference amongst the traditional and ERAS colorectal surgical approaches stemmed from patient preparation and education prior to admission for surgery. The ERAS patients benefited from pre-operative education that provided many recovery advantages. First, all participants faced vulnerability, but the ERAS group stated they felt more secure and maintained a better sense of control because they were well informed and prepared for surgery. They felt acknowledged during their pre-surgical visit, being given enough time to process the information. They understood the ERAS program and its structure, plus they knew what was expected of them. They maintained a higher sense of control than the traditional group.
Second, with knowing expectations, they took responsibility and became actively engaged in their recovery processes. With pre-education, they knew the expectations from both the health care members and of themselves. Not only did they want to meet program goals, but their own personal goals as well. They took initiative to maintain activity and aid in their own recovery. They did have some concerns when hospital staff seemed to be disengaged in the program, or when discrepancies occurred between written and verbal information. Yet, overall the ERAS group showed benefit due to proper preparation and education. This led to increased sense of responsibility, active engagement and participation through all phases of the surgical journey.

**Current Study Relevance**

With only two qualitative articles found during this study, a skewed knowledge base is realized between quantitative and qualitative ERAS data. The inception of the ERAS concept dates back to 1999 (Abraham & AlBayati, 2011) with vast numbers of quantitative studies showing beneficial medical and objective outcomes that can be achieved (Wilmore & Kehlet, 2001). Empirically, the most often cited benefits are reduced complication rates and shortened length of hospital stay (Basse et al., 2000; Teeuwen et al., 2010; Zargar-Shostari et al., 2008). In the past decade, there has been an overwhelming medical acceptance of the ERAS concept (Scatizzi et al., 2010), this being true within my organization. We have recently adopted and adapted the ERAS concept for our colorectal surgical patients under medical management and supervision.

Although positive medical benefits encourage an ERAS program, there is little known about patient experience with such a program. Frank (1991) conveys “doing to the body is only part of what needs to be done for the person” (p. 8). With this new program and practice within my organization, we have an ethical responsibility to listen and learn from the patients who have
experienced it. The relevance of this research study is enhanced by the lack of qualitative studies and sparse knowledge base found on the patient ERAS experience.
CHAPTER THREE: METHODOLOGY

Qualitative research is not objective or number laden (Mayan, 2009). It brings researchers out of the lab and into the natural setting in order to explore participants’ lived experiences and perspectives (van Manen, 2002). It is a “naturalistic, interpretive and inductive process” (Mayan, p. 11). Qualitative researchers claim that research cannot be neutral because they enter into the studies with preconceived notions, values and beliefs of the phenomenon that is to be explored (Creswell, 2007). This type of research can be described as emergent and flexible in its design. Qualitative researchers confess to being biased as they expose their worldly positioning, and the authenticity of the findings is supported by the transparency of the researcher’s exposed position (Mayan).

My Researcher and Nursing Position

As a novice researcher, I asked one question that sparked this study. I realized there would not be a single answer or truth claim, and therefore, it could not be found within the quantitative world, or from a positivism approach. Quantitative research has objective realities and facts that are observable and can be tested again in order to be established as rigid law (Crossan, 2003). Positivism truth is of “examination and observation of external reality... speculation and assumptions are discarded” (p. 52). It does not “provide a means to examine human beings and their behaviors in an in-depth way” (p. 51). Thus, I needed to find my answers in the qualitative world with a post-positivism view on research that takes account of the lived experiences of others.

My research question inquired about the nature of the ERACS experience, and an appropriate qualitative method was needed that could access this. Qualitative research looks at the stories behind the numbers (Mayan, 2009); and de Sales (2006) relays a patient’s story has life and power to it. With the use of storytelling and narrative inquiry, an understanding of the
ERACS experience could be captured. This enabled a view of reality that was constructed by research participants that allowed for multiple truth claims, different realities, plus a flexible design to support the documentation of their experiences.

As a surgical nurse, I did not realize the extent of the knowledge gap related to patients’ experiences with an enhanced recovery program. I was naïve to the importance of, and lack of, this type of knowledge as I focused my energies into making the ERACS program a reality within my organization. I had been introduced to the ERAS surgical pathway during a nursing conference in a neighboring health authority. I was enthralled with the work that they were doing and I thought it provided patients with safe and fast surgical recoveries. I wondered why we were not doing it in my region.

I brought back the ERAS information with me and started on the change process over three years ago. To date, we have had 139 patients move through our ERACS program since it started in December of 2011 (D. Dunton, personal communication, June 17, 2013). We have had many successes and failures in this program, and continue to revise it. However, as a surgical nurse, I found myself in a position of tension while the ERACS program materialized. Despite the fact I was an advocate for the program, I still wondered about the standardization of medicine and nursing care in relation to the patients’ individualized experiences with this type of program. Could these three components be integrated to produce a strong ERACS program that is based on evidence? Did the potential medical benefits outweigh the individual patient’s interest, and as a surgical nurse, could I be OK with this? Would holistic care be sacrificed for medical outcomes? What would our patients think, feel and experience in this new ERACS program?

As a nurse, I agree with change and evidence-based practice, along with the revisions it brings to our surgical care practices. Yet, I did not want to participate in cookie-cutter medicine
that spilt over into nursing and hindered care. Muller-Smith (1999) pondered the loss of caring in the nursing profession as she stated:

In the midst of chaos and change in health care, much of the visible and tangible demonstration of caring is getting lost or, at best, relegated to the bottom of the list of tasks and activities that nurses provide to their patients” (p. 91).

Would the ERACS program encourage the loss of caring even further?

In addition, I feel empirics are once again overshadowing the aesthetic ways of knowing and being. In her revered article, Carper (1978) identified four fundamental ways of knowing in nursing: (a) empirics, or science; (b) esthetics, or art; (c) aspect of personal knowledge; and (d) ethics, or moral knowledge (p. 14). Each has value, and contributes to the overall knowledge base of being a nurse. Yet, I believe that due to societal and historical hierarchies, some forms of research and knowledge, like quantitative and empirics, are given more merit and credibility than others, like qualitative and aesthetics. However, I strongly believe there is much to be learned from an aesthetic approach and hearing the experiential stories of others. By acknowledging aesthetics, we can listen and learn from multiple perspectives and realities of the medical, nursing and patient ERACS worlds. Then, we could continue to build and improve our ERACS program. By use of aesthetics, story telling and narrative creation, I gained an enriched understanding of the ERACS experience. For clarity, I feel it is important to distinguish between the two terms of story and narrative before delving into the research methodology of narrative inquiry.

**STORY VERSUS NARRATIVE**

Throughout the literature, there is debate that exists between the terms story and narrative. Some use story and narrative interchangeably, while others see them as being different. I agree with authors like Frank (2000) and Wiltshire (1995) who determine the two to be dissimilar, as I explain below.
Story

Within all communication forms, whether spoken words or written texts, stories exist. People tell stories to relay meaning in all aspects of their personal and professional lives. Stories are told to “inform, instruct, entertain, empower, exonerate or cathart, amongst other things” (Smith, 2000, as cited in Holloway & Freshwater, 2007, p. 8). Sandelowski (1991) suggests as human beings we have an impulse to not only tell stories, but to listen to them (Emden, 1998a). Stories become verbal or written representations of life events that have a sense of temporality, or a link amongst the past, present and future (Holloway & Freshwater, 2007). Bailey and Tilley (2002) contend “individuals make sense of their world most effectively by telling stories” (p. 575).

A story has a beginning, middle and end, and it is able to “capture a complete idea” (Creswell, 2007, p. 235). Stories are formulated after the event, and thus, are interpretive and representative of what has occurred, often containing “selected components in order to convey the [intended] meaning” (Bailey & Tilley, 2002, p. 575). Stories are influenced by the past and help formulate the future, with many influential factors such as social, political, cultural, racial, gendered and economical stances (Moen, 2006).

Stories are interpretive, and may have different meanings for those who tell them and for those who receive them. A story is an informal communication tool that is used in our everyday world to relay our personal experiences and meanings to others. A story is “informal, provisional and exploratory” (Wiltshire, 1995, p. 81). So, how do narratives differ from stories?

Narrative

Although narratives also tell stories of experience to relay meaning, there are some key differences. Narratives are “premeditated, organized, more formal and have a structure that is
their own” (Wiltshire, 1995, p. 78). They are purposefully constructed, organized and derived from the informal stories that we tell in our daily lives.

Wiltshire (1995) explains that narratives differ from stories since they possess abstract (reflective) thought, intellectual commitment and energy, plus meditation upon social, ethical, power and voice issues. Narratives possess richer, more useful data. Thus, narratives are “consciously formulated, premeditated and [are] coherent accounts of experiences” (p. 81). As Frank (2000) states, “people do not tell narratives, they tell stories” (p. 354). For this thesis, my definition of stories and narratives are as follows:

**Stories** are informal words of our everyday lives that allow us to make sense of our immediate worlds, and we relay these meanings to others who may or may not interpret them differently.

**Narratives** are the premeditated and formal written creations that come from the informal stories of others that are used in research to gain understanding and meaning of the lived experiences of the phenomenon being studied.

Within the qualitative research realm, the methodology of narrative inquiry utilizes stories of lived experiences as data. I was attracted to narrative inquiry as it allowed me to listen to and use the stories of others who wanted to share their ERACS experiences. From this sharing, my own wonder could be awakened. This leads to the realization of multiple truths, meanings and understandings of the studied phenomenon, or that of the ERACS experience. Narrative inquiry became the obvious choice of methodology as the stories of patients that could be used to create narratives were actively sought out.

**NARRATIVE INQUIRY**

Cresswell (2007) states “those undertaking qualitative studies have a baffling number of choices of approaches... [with] several classifications or typologies” (p. 6). Although there are many choices “the focus on all qualitative research needs to be understanding the phenomenon
being explored” (p. 3). This has historical stance in the philosophy of phenomenology used by theorists such as Husserl (Dowling, 2007). Husserl “regarded experience as the fundamental source of knowledge” (p. 132). For this study, I intended to use narrative inquiry since it was a personal fit with me as researcher, because I wanted to gain knowledge by understanding lived ERACS experiences of others “as expressed in [their] lived and told stories” (Cresswell, p. 54).

**The Methodology**

Narrative inquiry is a qualitative research methodology that has prompted controversy and debate due to various approaches with “no single clear and precise approach to be found (Hardy, Gregory & Ramjeet, 2009, p. 7). The general premise of NI is “how stories and storytelling make meaning of our lives” (p. 49). Some state it is both an art and a science that requires a flexible and creative process of utilizing stories as data (Holloway & Freshwater, 2007). It involves stories that are lived and told, then art to relive and retell them (Clandinin & Connelly, 2000). Echoed by Mayan (2009), “the end result [of NI] is a story of participants’ stories” (p. 50). According to Connelly and Clandinin (1990), we “humans are storytelling organisms who individually and socially lead storied lives… [and] the study of narrative, therefore, is the study of the ways humans experience the world” (p. 2). As Moen (2006) relays, “storytelling is a natural way of recounting experience, a practical solution to a fundamental problem in life, creating reasonable order out of experience” (p. 2).

Three basic principles of narrative inquiry are: (a) researchers help organize people’s experiences of the world into narratives; (b) the stories told are dependent on many factors, such as temporality, context, values and recipients; and (c) stories contain multiple voices and interpretations (Moen, 2006). For clarification, the influencing factors of temporality and context are defined. Holloway and Freshwater (2007) refer to temporality as the linked sequence between a story’s beginning, middle and end, or the past, present and future. Clandinin and Connelly
(2000) state temporality does not simply look at the “here and now, but with life as it is experienced on a continuum” (p. 19). Context is a constant presence in relation to time, space and people, along with the influences and interactions between them (Clandinin & Connelly).

As with any research, the researcher must be transparent in how the study was conducted and unfolded to support its findings. This study’s research components of: sample; recruitment; data collection; data analysis; authenticity; and research ethics are discussed in relation to the chosen methodology of narrative inquiry.

**Sample**

A sample was required before data collection could begin. In narrative inquiry, there are various types of sampling that can be used, such as a single case study, homogenous (same) or heterogeneous (varying) sampling (Holloway & Freshwater, 2007). The study’s sample was homogenous as I recruited people with two similar characteristics: (1) colorectal cancer, and (2) had an ERACS experience. To achieve this, I employed criterion-based sampling, meaning inclusion and exclusion criteria were used to facilitate the recruitment of participants who were “similar to each other with certain characteristics for the purpose of the study” (p. 72). I wanted to gain understanding of the lived ERACS experiences from patients who had colorectal cancer, so a purposeful sample was used to recruit participants who could best provide information about this phenomenon (Mayan, 2009). The sample was comprised of ERACS patients with colorectal cancer from a single hospital.

Participants were included if they met the following criteria: English speaking; were greater than 19 years of age; had colorectal cancer; were post-operative; had an open surgical procedure with midline incision; had participated in the ERACS program; wanted to share their ERACS story and experience; and agreed to have the interview audio recorded. Patients were excluded
when: they were non-English speaking; less than 19 years of age; had a diagnosis other than colorectal cancer; or had a laparoscopic surgical procedure.

Qualitative research favors smaller sample sizes, and Cresswell (2007) relays that narrative inquiry is “best for capturing the detailed stories or life experiences of a single life or the lives of a small number of individuals” (p. 55). Smaller sample sizes are congruent with narrative inquiry since “depth rather than breadth in data collection is sought” (Holloway & Freshwater, 2007, p. 70). However, there is “no fixed sample size number... the size depends on the phenomenon or group under study and the rationale of the research” (p. 71). For this study, I sought a sample with a minimum of six to a maximum of ten participants.

**Recruitment Process**

Geographical location was taken into account with recruitment limited to a specified region. The city and town names are withheld for confidentiality purposes. If I had not been successful in obtaining an appropriate sample size from this region, participants outside this stipulated area would have been considered. All participation had to be recruited voluntarily without any coercion.

As the nursing lead on this program, I had an ongoing list of all ERACS patients and their surgical procedures. I did not make contact with any ERACS patients when they were in hospital. In order to avoid coercion at a time when they were vulnerable and recovering from surgery, recruitment was postponed until after they had been discharged home. After discharge, I mailed recruitment packages to 24 eligible participants who met the inclusion criteria. From this number, seven agreed to participate. Another of the invited participants wrote a letter to discuss her experience, but focused on stoma teaching and care, not on her actual ERACS experience. The recruitment packages contained three documents that included:

1. ERACS Recruitment Flyer (see Appendix F).
2. ERACS Letter of Consent (see Appendix G).

3. ERACS Demographic Information Form (See Appendix H).

Potential participants were asked to respond approximately two weeks after receipt of the recruitment materials to schedule interviews that ideally were within four weeks of their actual discharge dates. They were not excluded if acceptance of the invite came after the requested two-week time frame. Plus, many people had been discharged home before ethics approval was obtained for this study; therefore, they were invited to participate despite being beyond this time frame.

All seven interested participants contacted me directly by telephone. I answered any questions that they had about the study and then scheduled a mutually convenient time for the interview. Implied consent was given upon acceptance of both study’s invite and interview; with formal consent obtained by completing the Letter of Consent immediately prior to commencing the interview and data collection.

Recruitment led to a sample size of seven, and included one patient outside the stipulated inclusion criteria. He had diverticulitis, not colorectal cancer, and had been sent a recruitment package in error. He called to set-up an interview date and stated he “had plenty to say and needed a longer interview because it was about time someone wanted to listen to the patients”. His story provided further insights into the ERACS program, and this prompted the decision to include it in the study’s findings. From the 24 recruitment packages, the seven who responded were all included in the study, and no one was turned away based on diagnosis.

**Data Collection**

With narrative inquiry, there are different ways to look at data collection. Clandinin and Connelly (2000) classify data as “field notes” because it is a creation by researcher and participant within the narrative inquiry field. This field has been referred to as “the midst”, or
area where both parties’ stories intersect, containing time, place, personal and social aspects (Clandinin & Connelly). The authors list various sources as “field notes”, and a non-comprehensive list includes: stories, journal and autobiographical writing, letters, field notes, conversations, photographs, life experience and research interview. Field research is composed from these sources of field texts.

Holloway and Freshwater (2007) do not refer to data as “field notes”, but also contend that the main source of NI data comes from “oral stories of the participants gained in interaction with the researcher” (p. 75). They convey that data comes from spoken, written and visual text, never through observation of the participant. They state that the “tell me your story...” approach is ineffective, and stories need to be drawn by use of the narrative interview. The stories can be: (a) spontaneous (although rarely ever captured); (b) elicited (with critical incidents); or (c) asked for. The most common method is asking for stories. They state a NI researcher has the research agenda to hear the participants’ stories of experience while accessing their thoughts and feelings.

**Interview process.** While drawing forth stories, a narrative interview approach can be used that “centers on the flow of talk from the participants” (Holloway & Freshwater, 2007, p. 76). Some questions are required, but the number is restricted in order to prevent frequent researcher and participant interaction. The researcher talks minimally to allow participants to spontaneously tell their stories. For this study, a semi-structured interview guideline was used (see Appendix I).

With narrative interview, I wanted to use a limited number of questions that would prompt and cue the spontaneity of each story’s emergence, but this did not happen. I got a sense that the participants waited for my questions and cues in order to tell me what I wanted to hear and know. This was most likely the fault of my novice researcher and interviewer skill set. Each participant was interviewed once, with the sessions ranging from one to almost four hours in length. They
were face-to-face with six being held in a hospital meeting room, and one at the residence of a participant who needed to accommodate her family member. This interview was the longest in length of almost four hours as her family member had interest in the process, often interrupting the interview session with her own line of questions for me.

Upon reflection of the interview sessions, it became obvious that they were guided by both the ERACS program and guidebook. The first interview began with “tell me your story” and the original semi-structured interview guide, but the participant wanted additional structure to guide him through the telling of his story. He admitted to being a man of very few words, answering succinctly, briefly and matter-of-factly. It was hard to draw forth his story of experience, or any free-flow dialogue, thoughts or feelings. To help him tell his story, I drew a diagram of the peri-operative ERACS journey (see Appendix K) and we then moved through each phase together. At times, he would spontaneously go off tangent and speak of his life interests. I did not stop him and just allowed him to share. This is what intrigued me as a researcher and surgical nurse - the participant as a person, not simply as a patient.

As a consequence, the narrative interview was modified to a structured storied interview to take each participant along a specific ERACS journey with three distinct phases, pre-, intra- and post-operative, all of which were used to capture the ERACS experience. This constrained their stories from flowing freely. However, this was helpful in the construction of narratives that had similar structure for analysis purposes.

In addition to the interviews, there were other forms of NI data present, such as personal medical documents (i.e. pathology reports) and pictures. Some of the participants came armed with a file folder that contained important papers that depicted their story of experience. These had pathology reports stating positive or negative lymph nodes or pictures of tumors from their colonoscopies. Most came with their ERACS guidebooks in tact, although they appeared worn
and well used. These were important items to them, helping to create and validate their stories and ERACS experiences. They referred to their documents in order to help recall events, such as dates, or data like number of affected lymph nodes. I did not take any copies of these documents or use any for the creation of the narratives. The only data collected and used were the seven digital recordings of the structured storied interviews that were transcribed verbatim. Once an interview session was complete, data analysis began.

**Data Analysis**

A hired transcriptionist, who signed a confidentiality agreement, transcribed the seven structured storied interviews verbatim. These were reviewed and analyzed for the process of creating formal narratives. Emden (1998b) employs a process called “core story creation” whereby the researcher “reduces full length stories into shorter stories to aid the narrative analysis” (p. 35). A series of steps can be followed to create a core story, by reducing an extensive semi-structured interview into a succinct, but complete narrative. The steps are:

1. Read and re-read the full interview to understand content.
2. Delete all interviewer questions and comments.
3. Delete all words or sentences that distract from key ideas.
4. Read remaining text for sense.
5. Repeat steps three and four - keep all key ideas and remove all extraneous content.
6. Identify themes.
7. Move fragments to create complete stories.
8. Member check the completed core story with the subject (Emden, 1998b, p. 35).

Just as there is no one “absolute” way to conduct narrative inquiry, there is no “right” way to analyze the data. Holloway and Freshwater (2007) convey there is an empathetic stance taken by the researcher and participant that allows for both objective and subjective aspects to come
forth with data engagement. Personally, I view this as a relationship triangle between the three elements of researcher, participant and data, along with a constant motion, or ebb and flow that occurred between them. With narrative inquiry, there is strong premise on researcher interpretation and reflexivity that can be flexible or rigid in its design (Holloway & Freshwater).

Narrative inquiry does not claim to produce single truth, but multiple truths as findings are not only participant dependent, but also researcher and reader reliant. Van Manen (2002) echoes this by stating that with qualitative inquiry “no interpretation is ever complete, no explication of meaning is ever final, no insight is beyond challenge” (p. 237). Phenomenological writing is embedded in narrative inquiry. Van Manen describes phenomenological writing as consisting of: seeking, or finding the space to write; entering, which reflects moving into the lives of the other; traversing, in which the writer becomes absorbed into the other’s experience; drawing, where one’s own sense of wonder becomes heightened; gazing, where questions are posed about the experience; and touching, that evokes empathy. This writing process is elaborated on within the findings section, being integral to the unfolding of the findings.

It should be noted that phenomenological writing “does not present the reader with a conclusive argument or with a determinate set of ideas, essences or insights” (Van Manen, 2002, p. 238). Rather, it is the researcher who makes the reader a writer by re-writing the text with every reading. From this, it must be noted that as researcher, I am responsible for my personal interpretation of the narratives, but I do realize that others may see things in the same way that I do, or they may not. And this is fine, as I am not making statements of absolute truths and laws, but feel I have gained an understanding of the ERACS experience. We all have our own context, beliefs, values and interpretations of data and text. This is what makes the reader the writer, and continues to awaken wonder to further the inquiry of the phenomenon.
From the relationship triangle of participants, data, and myself, I used the notions of sequence and temporality to create formal narratives of similar structures. I used the peri-operative time span of the ERACS journey to gain starting and ending points for each narrative, recognizing this as “sjuzet”, or the “way chronological raw materials of a story are organized” (Holloway & Freshwater, 2007, p. 82). I read and re-viewed all transcribed interviews multiple times, and then wrote the subsequent formal narratives with the same start and end points that featured the physical presence of home. The start was the moment the participants left their homes, with or without body clues, to endure medical tests and gain their diagnoses. From here, I moved the participants through the pre-, intra- and post-operative phases of the ERACS program, with end point reached when they were discharged home. The sequencing and temporality began with diagnosis as they reflected on the past, the surgical intervention and hospital stay as the present, and the discharge home to “normal”, but changed, life as implied future. This structure showed motion in a linear, but circular, pattern as all journeys began and ended at home. For confidentiality reasons, a decision was made to not include the surgical narratives within this thesis. However, a collective narrative has been created from the seven (Appendix J).

To support authenticity, all narratives contained the spoken words of the participants. Fillers and links were added to create sequence, plus their thoughts were organized to show motion and temporality. I stayed true to the essence of their spoken words by trying to relay it in the written texts. For example, if they used slang terms, this was not corrected because how they spoke was part of whom they are as people.

These were preliminary narratives that were mailed to each participant for review. They emailed with any discrepancies that required changes. I then revised their narratives and sent an email back to acknowledge these changes were made. If I did not hear from them, I assumed that they were content with their narratives. In total, I heard back from three participants. One stated
he was happy with his narrative with no changes needed, while two requested minor adjustments, such as the number of lymph nodes that had come back positive. By use of participant checking, authenticity of the study was supported.

**Coding**

Once the participants approved their narratives, or I had to assume approval, the coding process began. I did not start with interview sequence, but with the shortest one to avoid being overwhelmed with my first attempt at coding. Before I began, I listened to the taped interview and simultaneously reviewed the typed transcript to ensure accuracy, thus helping to support authenticity. During this process, I made side notes of words of interest, such as no symptoms and shock, to help with the upcoming coding. Once I was satisfied with transcription accuracy, the coding process commenced.

I had a pre-conceived notion that the participants stepped onto and off of an ERACS path. It was like they were moving along a path of stepping-stones. There was a temporal sense to this, and it was the entirety of their journeys and experiences that I wanted to capture. Coding was done line by line by line with my own words eliminated. As I read each spoken line of the written text, wonder awakened and I began to see and hear the emerging themes. I highlighted key words and made notations of these alongside the transcript, and even doodled to try to visualize and capture themes, ideas and organizational patterns. I organized common ideas into the emerging themes along the stepping-stones of the ERACS path.

I created a word document for each theme as it came forth, with ten general themes surfacing by the end of the first coded interview. This was only a preliminary theme schematic, and it underwent multiple changes as I read and coded the remaining six transcribed interviews. Once all lines from all interviews were reviewed and entered onto the word documents, they were printed and I stepped away from them to pause. I needed time to let this enormous amount of
information sit before I started to immerse myself in the data again. I then began to read and revise... read and revise. Continuous movement occurred within and amongst these documents while I added, subtracted and moved the lines. Many themes and their sub-themes were renamed, removed, combined with others, or pulled apart into newly named ones. This revision process was repeated multiple times. Themes were constructed, deconstructed and then re-constructed, de-constructed before finalized.

Suddenly, three general phases of disruption were realized, and this prompted further revisions to the themes and subthemes. I was completely absorbed in the coding process and thought about it day and night, and probably even during my sleep. Freshwater (1998), cited in Freshwater and Holloway (2007), was quoted as saying “the research question and the data becomes part of the researcher’s life in both waking and sleeping moments”, and an incubation period is necessary for analysis and interpretation to occur (p. 81).

Revisions to the coding schematic even occurred during the final write-up phase of this study. In the end, after many enlightening moments, there were three major phases of disruption, with associated themes and sub-themes, formed from the spoken words and written texts of the participants. The overall schematic was finalized as:

1. Phase I : Life Disruption with five themes.
2. Phase II : Time Disruption with four themes.
3. Phase III : Surgical Disruption with five themes, two with sub-themes.

This gave understanding to myself as researcher, surgical nurse and reader of what the participants experienced on the ERACS program.

**Authenticity**

With qualitative research and narrative inquiry, it is hard to prove “rigor” as the study findings cannot be rigorously tested over and over again to obtain the same results as with
quantitative inquiry (Mayan, 2009). Narrative inquiry is interpretive and reflexive, with the findings produced from the reciprocal relationships between the researcher, participant and data that has been collected. The term authenticity, not rigor or validity, should be used with NI, and be evident on both the levels of participant and researcher (Freshwater & Holloway, 2007).

A trust exists that the participant is telling the truth, but often memories can fade, become distant and details muddled (Freshwater & Holloway, 2007). This happened within this study especially when participants had lengthy time periods between discharge and interview. They made suggestion to this many times during the interviews, with comments such as “I cannot remember” or “I think so”. To support authenticity, participant checking occurred as they were asked to review their preliminary narratives. All requests for changes were made when received, and an assumption of approval made if they did not respond back. These were their experiences transformed into narratives, and I wanted to ensure they were accurately portrayed.

On a researcher’s level regarding authenticity, I had to look at my own reflexivity. I knew I was an integral part of all aspects of this study, including the interpretation of findings, through my own biases, beliefs and relationships with both the participants and data. My wonder was awakened as I had prolonged engagement with the data. In particular to my nursing perspective, I was moved by their stories and empathetic emotions took over. I felt participants endured solitary suffering and elements of non-care, and this was not acceptable to me on any level, but especially as a nurse. To ensure authenticity, I clearly stated that these interpretations came from me, as researcher, and not from the participants. As researcher, I showed transparency to support the study’s authenticity.

In qualitative research, authenticity can be achieved by many strategies that include: researcher responsiveness; methodological adherence; sampling; collecting and analyzing data concurrently; thinking theoretically; prolonged engagement; participant checking; researcher
From my researcher perspective, I think authenticity has been achieved. I had researcher responsiveness, and the best example of this is removing initial ideas that were later found to be poorly supported or questionable. I was willing to be creative and flexible, and work in and with the data. With help from my thesis committee, all intent was to stay true to narrative inquiry, yet this was challenging both as a graduate student and a novice researcher. If any methodological errors are present, they were unintentional, such as with the interview process. Sample size of seven was appropriate for narrative inquiry, and I collected rich, detailed data that accurately portrayed their experiences. Data collection and analysis occurred simultaneously that allowed movement between these two areas. This aided time management while progressing this work forward. The study incorporated literature on the ERAS subject, along with the theoretical works of van Manen, Frank and many authors, to help support the study’s discussion. Without doubt, there was prolonged engagement with data and it became a constant and consuming part of my life. Participant checking occurred and was discussed. I did keep a small research journal that focused on my own reactions to certain segments of interviews once completed. Through reflection and wonder, the notions of aloneness and solitary suffering appeared to me, and these were incorporated from my personal perspective. In regards to audit trail, I have been transparent in all aspects of this study, from my reasons and intentions for conducting it, to the decisions I had to make along the way to reach conclusion. Authenticity has been achieved with research ethics being respected and upheld along the way.

**RESEARCH ETHICS**

Ethics, or the “right and wrong” ideals of society are relevant to medicine, nursing and research. In research, ethics is defined as “a system of moral values that is concerned with the degree to which research procedures adhere to the professional, legal and social obligations to
study participants” (Polit & Hungler, 1997, p. 456). The ethical principles of autonomy, non-maleficence, beneficence, and justice were respected and upheld in this study.

**Autonomy**

Autonomy is the ethical principle of free choice. All participants were invited to participate according to their own free will, and were never coerced (Holloway & Wheeler, 1995). In addition, to being the researcher, I was an insider as I was a paid employee of the hospital, was on the ERACS working committee and cared for the vascular patients on the surgical ward that housed the ERACS patients. I did not provide direct nursing care to any ERACS patient, but I did monitor adherence to the ERACS components. This was disclosed in the Letter of Consent.

Participants were made aware of all potential benefits and risks (Ramcharan & Cutcliffe, 2001), and these were outlined in the Letter of Consent. Informed consent was obtained after the participants were discharged from hospital. This timing was used to minimize the risk of coercion from power hierarchies or greater patient vulnerability from the influences of medications, such as anesthetics or narcotics that could have impaired judgment. Participants were aware that they could withdraw at any time from the study without consequence. This did not become an issue as no consented participant asked to withdraw.

**Non-Maleficence**

Non-malificence is the ethical principle to do no harm. It is unethical to do research that will cause blatant harm, yet there are potential negative side effects that can result from any study. Within this study, negative emotions (i.e. anxiety, stress or fear) could have surfaced as participants relived their experiences through storytelling. Reid (2009) states, “it is morally wrong to interview a research participant and then leave them in emotional distress without adequate support or safeguards” (p. 31). Although negative emotions were present in the interview sessions, they were manageable. The participants spoke of shock and loss, but always
turned it into hope. It was my intention for participants to engage in positive healing while they shared stories to benefit themselves and others.

**Beneficence**

Beneficence is the ethical principle to do “good”, or the obligation to provide positive outcomes (Ramcharan & Cutcliffe, 2001). In this study, I gained understandings of answers to the research question “what do patients with colorectal cancer experience as they travel through an ERACS program?” This built on the limited qualitative knowledge base that currently exists. As well, through storytelling, the participants may have engaged in personal healing by sharing their experiential stories that contained life disruption and challenges. Though assumed negative, they found positive such as post-traumatic growth that hopefully they realized. From the stories came narratives that can help build the ERACS program for the benefit of future patients.

**Justice**

Justice is the ethical principle to fair treatment and privacy (Reid, 2009). As per the consent form, confidentiality was maintained by removing personal names and identifiers from all study material. The participants were given a reference number, from 1 through 7, based on interview schedule. No names or identifiers were used. All data will continue to be protected, with the participants’ information being respected and handled as if it were my own.

In summary, quantitative methods cannot be utilized for all research questions pondered; and therefore, qualitative methods must be recognized and accepted for their unique contributions. Mayan (2009) stated there are times when we need to look beyond the numbers to see the people and hear their stories to answer such questions. It is amazing how much knowledge our fellow human beings have if only we would come out of the laboratory and take the time to explore their worlds and experiences. As de Sales (2006) states “a story has power and life”. And it was power and life that I hoped to capture as I wrote each narrative. With the
research methodology explored, the data collected and the narratives written, we move into the study’s findings. What did the participants tell us in order for us to gain understanding of their ERACS experiences?
CHAPTER FOUR : FINDINGS

As I sat and looked at pages and pages of transcribed interviews, I could not be anything but overwhelmed. On these pages were the lived experiences of others that were being entrusted to me. I was given gifts of information from the participants as they willingly shared their lived ERACS experiences with me. Some information was very intimate as they discussed taboo social subjects like bowel movements and incontinence after surgery. I had to protect identities as I tried to portray their lived experiences through stories that had coherence and sequence (Clandinin & Connelly, 2000; Holloway & Freshwater, 2007).

I knew I was present in each of their narratives as I wore many hats during this study. I was an empathetic human being, novice researcher, surgical nurse, graduate student and co-developer of my organization’s enhanced recovery program. I had personal and professional stakes in these interviews since I needed them to complete my graduate nursing program, plus I wanted to hear positive feedback about the ERACS program. I desired to hear the ERACS program was a great success as it provided surgical and recovery benefits for our patients. Narrative inquiry is the art of “stories lived and told” (Clandinin & Connelly, 2000, p. 20), but how can they be relived and retold through phenomenological writing?

PHENOMENOLOGICAL WRITING

The challenge became to write in a phenomenological manner that captured truths and relayed understandings and meanings of each participant’s lived ERACS experience. I was cognizant that there would be multiple truths, and that these truths could never be captured in their entirety. For example, were voices silenced and things not said that should have been? Did the structured storied interviews guide their stories without allowing them to take on their own directions? Van Manen (2002) states phenomenological writing is like “writing in the dark“, as he aptly entitled his book. The writing process is hard to articulate, and is often a very personal,
solitary and unique experience for each author. Van Manen describes six steps that work together as a whole for the process of phenomenological writing to unfold, and include: seeking; entering; traversing; drawing; gazing; and touching.

**Seeking**

Seeking is finding that physical and emotional space that is conducive to writing (van Manen, 2002). It is finding a personal twilight zone where you can be transported to write. It is the space where the “writer dwells... when the words open up” (p. 2). It is that comfortable spot in the world where you can allow the process of writing to enfold you. Here I sat before my computer and silently stared at the transcripts waiting for writing to begin. This experience highlights the intensely personal position of the writer and the tensions in trying to understand the temporality, or the past, present and implied futures, found within narrative inquiry (Clandinin & Connelly, 2000). I was trying to enter the “midst”, or along a dimension of time, place, context... a place where “my” and “their” stories could collide (Clandinin & Connelly, 2000).

**Entering**

Entering is when you slip into the writing zone (van Manen, 2002). It is solitary, subtle and without obvious notice. It comes without clear cognition or awareness that it is happening. Writing is not always immediate and it does not always happen. Sometimes I had to walk away, coming back later to try it again. At times, only a single word would be written, or perhaps a line or a paragraph if lucky. It is where tension with language can occur, when the words and insights are challenging to connect. It is hard to deconstruct the layers of lived experience and reconstruct its’ meaning through written text.

**Traversing**

Traversing is the loss of self into the world of writing (van Manen, 2002). It is the neutral silence of the external world and self as reading and writing occur. It is becoming fully engrossed
in the writing process. When it truly begins, time is lost and words flow without conscious thought. The outside world fades, it becomes quiet and distant, as the inner process of writing takes over. As the noises of the outside world diminish, the noises of writing become louder. I did not suddenly think, “oh, I am writing”, I just was. My fingers moved and typing began once in this zone. I was not aware that I had become absorbed in writing, but the pages that filled with words proved that it I had. Words filled my head as my mind connected with my fingers. They worked together to get the words out and down. Both the external and internal worlds, and senses like hearing, fade and become oblivious.

**Drawing**

Drawing happens when the words draw you in and the perplexity of wonder awakens (van Manen, 2002). Van Manen describes this as “a mesmerizing consciousness, evoking worlds, insights, emotions, and understandings” (p. 4). This is where the pages of transcripts became surgical narratives of meaning and wonder for me. I started to see and hear what the participants were trying to tell me. I gained better understandings of their lived ERACS experiences, but did not fully understand them. I had emotional reactions to many of their stories, and in particular, to what I perceived as a lack of nursing care. I felt a strong sense of responsibility and obligation to protect these participants. I experienced compassion and empathy for them. I was reacting to their stories as my own wonder awakened. I was emotionally charged as I wondered about the concept of aloneness and why I felt sad as I listened to the interviews, read the transcriptions and wrote the narratives. I felt these participants were alone in their journeys, but yet they were not. Despite the fact that I thought that they had invisible nursing care at times, they had others who supported them along the way. But as a surgical nurse, I was drawn into their sense of aloneness, suffering and non-care that resulted from the absence of nurses.
Gazing

Gazing is the aspect of wonder (van Manen, 2002). Phenomenological writing begins and ends with it, bringing forth questions that may not always have answers. This is also true for this research study. It has produced wonder as many questions have come forth that do not have any answers. For example, why did the participants not complain of lack of nursing care? How did they define and perceive care? How would nurses define care? All of the unanswered questions are acceptable outcomes in qualitative research as it refutes the notion of absolute truths and complete understandings (Mayan, 2009). Wonder keeps inquiry going. It is hoped that these surgical narratives provoke wonder in others who will continue to ask more questions. It is the search for these ongoing answers that will continue to build our knowledge about ERACS.

Touching

Touching is the realization by writer or reader that they have been moved by human insight (van Manen, 2002). I am not an ERACS patient, but I have gained some understanding of what it was like for the seven participants. Their stories moved me both as a human being and as a nurse. In particular, I had an emotional reaction to their stories of solitary suffering. I felt that as a nurse, they were not always given compassionate care. And with this, I encountered moral distress.

My nursing empathy was jolted awake, and I pondered the balance of nursing science and art of care. I wondered if nursing was becoming more task-oriented than people-oriented? Was care being placed at the bottom of the task list? If so, how and why was this happening? Did the ERACS program encourage only the science of nursing to be recognized? From the interviews, could I see the full landscape of each patient’s ERACS experience, or was I simply given but a glimpse of each? Did I collect enough data to see the full pictures, and was this even a possibility in the qualitative research realm? What was missing? What else should I have asked or they said?
Landscapes of Experience

I struggled to see the participants’ full stories or their landscapes of experiences from the data they shared. It was difficult to gaze upon pages and pages of transcription and see whole, clear pictures emerge. Some parts will always remain hazy without ever gaining a clear view. It is like looking towards a distant horizon and visualizing the physical and emotional items that shape it. Some items are closer and clearer than others, and you can state what they are and what they mean. Then other items are further back and harder to see. And some so far back that they never come into view despite their presence. There are layers to the truths and meanings of the horizon upon which you are gazing.

This is true with phenomenological writing as the truths and meanings found within are hard to capture in thought and written text. You must gaze to see both the obvious and hidden items contained within the many layers of the transcribed interviews. Not only are the words important, but the silence and words not uttered as well. As I gazed towards their landscapes of experiences, their narratives were formed that contained truths and meanings of their ERACS experiences. However, complete absolutes were not possible.

NARRATIVES

In narrative inquiry, Clandinin and Connelly (2000) identify boundaries of tension that occur as one shifts to think in narrative fashion, and these include temporality, people, action, certainty and context. These tensions were present as I moved through the process of phenomenological writing in an attempt to understand the truths and meanings of the participants’ lived ERACS experiences. Temporality was present as I produced coherent and sequential narratives with past, present and implied futures. Each narrative followed a temporal framework that began with diagnoses (past), moved to surgical intervention (present) and concluded with discharge home to continue life (implied future). Each narrative featured people
who were experiencing change due to life disruption that caused them to move into action. The notion of time and motion were not taken for granted, and in fact, became important findings within this study.

Certainty could never be obtained and uncertainty always remains present (Clandinin & Connelly, 2000). It must be stated that it is my interpretation of the narratives that are presented. “I” influenced the interpretation of all narratives as a novice researcher and an acute care surgical nurse, along with my personal values, beliefs and context. There will always be other possibilities when people with differing views and contexts review this work (Clandinin & Connelly). To help make sense of each participant’s experience, context in relation to time (or phases of disruption), space (hospital and its’ physical space) and others (like family, friends, health care members, other patients) was incorporated. With these tensions, narratives were created, but how are they classified? Frank has been instrumental in defining illness narratives, stating people become wounded storytellers through the process of disease and illness (Frank, 1995).

Frank (1995) describes three types of illness narratives, including: (a) restitution; (b) chaos; and (c) quest. In restitution narratives, an individual becomes ill, seeks treatment and is restored to baseline health and function. The illness is a temporary life disruption that medicine can fix. In chaos narratives, the illness is a present interruption that is currently being experienced, and therefore, reflection and forward motion cannot occur. The individual is still caught up in the experience. In quest narratives, illness is accepted, along with its’ associated gains and losses, and the individual creates a new self-body and story as a result. With colorectal diseases, the participants became wounded storytellers as they relayed their ERACS experiences. But, can their narratives be declared as one of Frank’s three types of illness narratives?

The short answer is no, and these narratives cannot be named by Frank’s classifications. They are but portions of overarching quest narratives that are whittled down into a surgical time
frame that featured the ERACS program. They are comprised of a distinct and small section of time found along a much larger and longer disease and illness continuum. Start and stop points for the narratives were purposely chosen to embrace the surgical era only. Yet, the participants’ stories started long before and continued well past these chosen points. Their disease and illness continuums are not being fully comprehended. Full stories, and quest narratives, are not relayed because the research lens zoomed into a specific period of time, containing surgical intervention via the ERACS program. Hence, surgical narratives were created and classified as such.

The surgical narratives brought forth many prevalent questions that helped guide the analysis and discussion sections, with the main one asked of “how were the participants able to encounter, understand, accept and navigate through major life disruption?” What was “it” that they had and possessed that allowed movement through this disruptive and chaotic time with a sense of ease and grace? What allowed them to continually move forward despite physical and psychosocial suffering experienced along the way? What protected “self” when the “body” had betrayed them? Findings came forth that provided clues to the answers of my questions, and they are presented as phases, themes and sub-themes.

**THE FINDINGS : PHASES, THEMES AND SUB-THEMES**

From the collected data and associated analysis, three phases of disruption surfaced that contained the study’s overall themes and sub-themes. There was not one, but multiple disruptions that became cumulative, continuous, and consecutive. Participants were not given time to rest and recoup between them. A trio of disruptions came forth that included: (a) life and the diagnosis; (b) time and the wait; and (c) surgery and the intervention. Within each phase of disruption, smaller episodic disruptions materialized. For example, within the surgical disruption phase, complications such as bowel (paralytic) ileuses occurred that disrupted the recovery process. Yet,
despite all of these disruptions, participants continued to plod forward. This provoked consistent wonder of “what did they have or possess that allowed them to do this”?

The trio of disruptions took the participants from a current sense of normal into an altered state as they encountered major life challenges that required surgical interventions. Disease interrupted their current stories, and their challenged bodies forced the creation of new ones (Frank, 1995). The experience of these disruptions impacted and changed their perceptions of self, body and life. Such as, with one spoken word of “cancer”, participants went from a status of healthy to wearing a label of disease and illness. Goals then became to regain a sense of health and continue living with newly created and ever-changing stories of life.

Although the study’s findings are presented in a coherent and sequential mannerism that parallels that of the surgical narratives, they were not that obvious. Sjuzet has been stated, being the organizational pattern used to construct narratives (Holloway & Freshwater, 2007). This term becomes similar to emplotment that is often used within narrative inquiry, being defined as “the structure through which sense is made of events and the way in which things are connected” (p. 11). For general structural purposes that fostered understanding, I chose to move the participants in a linear and circular fashion from their home, into the medical world, and then back home again. It must be mentioned that the phases, themes and sub-themes intertwined and overlapped while the participants moved in and out of them as they recounted their ERACS experiences. The study’s findings are presented as follows:

I. Phase One : Life Disruption
   a) Being asymptomatic to minimizing the symptoms
   b) False sense of security
   c) Getting the maximum diagnosis
   d) Getting on with the show – is cancer the new normal?
   e) Getting off lucky or not

II. Phase Two : Time Disruption
a) Hindsight of the past
b) Staying in the present
c) Waiting for the future
d) The Changing Speeds of Time

III. Phase Three: Surgical Disruption

a) Entering the medical world – putting on the clothes (role) of a patient
b) Within the hospital room – the concept of physical and emotional space
   1. Sharing physical space with others – the negative
   2. The emotional support & incentive of others – the positive
   3. The curtain that tries to divide
c) Introducing the health care members
d) The Centrality of the Guidebook and Navigating Alone & Along the ERACS Path
   1. The Central Force that Guides the Path – The ERACS Guidebook
   2. Moving forward and on track on the pathway – who is responsible?
   3. The guilt of not minding the pathway
   4. Solitary suffering along the way
   5. Going full circle and ready to go back home
   6. Overall impressions of the ERACS Program
e) The elusive bowel movement and the mild obsession that ensued

PHASE ONE : LIFE DISRUPTION

Within Phase One, the participants encountered a life disruption that challenged their current stories and normal senses of self and life. They came out of their homes and into the medical world for diagnostic tests for a variety of reasons, such as familial screening guidelines, rectal pain or blood in stool. Five participants obtained a diagnosis of colorectal cancer, one of a large colon polyp, and one had confirmation of a pre-existing condition of diverticulitis. Varying degrees of life disruption were encountered based on the severity of their diagnosis, with cancer carrying the heaviest burden of disruption.
Life disruption spanned the time of feeling normal that nothing was wrong, to minor symptoms that could be rationalized away, to some being utterly shocked with a cancer diagnosis. In Phase One, five themes were uncovered and included:

1. Being asymptomatic to minimizing the symptoms.
2. False sense of security.
3. Getting the maximum diagnosis.
4. Getting on with the show – is cancer the new normal?
5. Getting off lucky or not.

**Being Asymptomatic to Minimizing the Symptoms**

The first theme “being asymptomatic to minimizing the symptoms” described the start of participants’ journeys to reaching the diagnosis. The participants’ symptoms ranged from feeling nothing abnormal to subtle body clues they rationalized away. As Frank (1995) states the “body eludes language” (p. 2), but finds ways to communicate through pain and symptoms. The body’s clues can often be rationalized away as seen with some of this study’s participants.

Three of the seven participants felt absolutely “normal” before two were diagnosed with colorectal cancer and one with a large pre-cancerous colonic polyp. They were simply following the medical world’s screening guidelines for colorectal cancer based on family history.

Participant #5 explained:

Uh, the only way I found out was we spend the winter in Yuma. We got back the first of April, and there was a message on the phone because my colonoscopy was due after the five years... I was going on six. So I said okay, fine, I’ll go and get the colonoscopy. And that was taken in May, and I was informed then that I had colon cancer. I had no clue, no symptoms. I didn’t even feel sick. I just came back, like ‘what the hell is going on?’ you know.

The remaining four participants had body clues that something was wrong, and all but one who had a preexisting diagnosis of diverticulitis, reasoned these clues away. They did not suspect
a life changing diagnosis. They simply thought their problems were trivial and would resolve
with smaller medical interventions (i.e. relief of constipation to minor surgery for removal of
suspected hemorrhoids) to rest alone (i.e. stop working out to heal sore muscles). Participant #2
stated:

I was doing like a pretty heavy kind of a workout program sort of thing, so I thought I had
hurt myself when I was doing exercises, so I thought, well okay, I’ll just, you know, wait
and see how it goes sort of thing. But what was happening was I was feeling a little bit of
pain down in the rectum area and I thought maybe I had ripped a muscle or something like
that. And, so I, I just continued on, but it just seemed it didn’t get any better, and it was
starting to get a little bit worse, and then I was having more problems going to the
bathroom sort of thing... so I said this isn’t right. So that is when I went to the doctor and he
checked me out, and he thankfully... well not thankfully, but his sister had just gone
through this whole thing, so he said, ‘Well, I better check it out’. So he checked me, and he
said, ‘Yeah, something is there’ sort of thing. So he then got me in touch with the on-call
GI doctor.

While Participant #3 shared:

So I guess it was either January or February... well, I had hemorrhoids so I thought that was
the problem because I was having some blood in my stool. So I went to see the surgeon,
and I thought he was going to take the hemorrhoids off, and he said, ‘Well, it could be
hemorrhoids or it could be something else, we don’t know, we can’t tell. It’s your choice if
you want to have an operation or have a colonoscopy’. And I had had a sigmoidoscopy in
the fall, but it showed nothing. So he said to me, ‘Well, it’s your choice if you want to have
it or not’. And I was humming and hawing about it, and for some reason, I almost said no,
but I said, ‘Yes, I guess I will’.

Some participants had no symptoms to mild acceptable symptoms that led some to a false
sense of security. They thought the diagnostic tests would be negative with no issues identified.
This led to the emergence of the second theme of “false sense of security”.

**False Sense of Security**

Pre-diagnosis, some participants had a false sense of security. They did not have any body
cues; they felt normal and simply thought they were going in for routine screening given family
histories. They thought nothing would be found. Two participants even thought it was a waste of
time and resources to have a colonoscopy done. Despite his familial history, his mother had died
from colorectal cancer, Participant #4 considered himself to be the “healthy one” in his family. He felt his siblings were more at risk of cancer, and this had delayed his screening. He said he had been too healthy all of his life, without any symptoms, and stated:

Well, it was my wife in my ear all the time, because my mother had colon cancer and my brother and sister who are older than me... they don’t have anything. And so maybe that was a false sense of security for me. And my father had bone cancer, so he died of bone cancer. So I do have a cancer gene in me.

Some participants had prior colonoscopies without incident, while others had previous symptoms that could be used as explanations as to why their body clues were normal for them, such as hemorrhoids. Participant #3 pondered the need for an invasive diagnostic test, and said:

I wondered if it [colonoscopy] was a waste of time. I wondered if it was just the hemorrhoids that were bleeding, so I didn’t really know if I needed to have the colonoscopy done... because I didn’t have any symptoms. I didn’t have stomach pains, other than constipation which I’ve had most of my life.

This false sense of security quickly faded for some participants and they got a tremendous shock as their diagnoses were revealed. They did not anticipate that they would soon hear the word cancer. This brought the third theme “getting the maximum diagnosis” into view.

**Getting the Maximum Diagnosis**

Once the diagnostic tests were complete, the participants were given the results. Five of seven participants were diagnosed with colorectal cancer and all five stated that they were shocked with this news. They could not believe this was happening to them. Participant #2 relayed, “I think I was kind of in a daze because I was thinking ‘it cannot be me!’” Participant #3 said, “I was totally shocked... I had no idea he would tell us that!” Participant #4 stated, “when you are a perfectly healthy person your whole life, and then when someone tells you ‘you have cancer’, it’s hard to understand”.

There were two participants who had non-cancerous diagnoses. Participant #1, diagnosed with a large colonic polyp, was not concerned as he had polyps before. This particular polyp was
too large to be removed during his colonoscopy; and therefore, he required a bowel resection.

Participant #7, previously diagnosed with diverticulitis, had his colonoscopy to confirm his diagnosis and upcoming surgical plan. These two participants did not receive shocking news. Once the diagnoses were made, the participants wanted to quickly move into the fourth theme. They all wanted to get on with the show.

**Getting on with the Show – Is Cancer the New Normal?**

Once the diagnosis was reached, whether colorectal cancer, colon polyps or diverticulitis, the participants wanted to get on with the show and move into the surgical phase as soon as possible. They did not want to wait, were ready to deal with what had been given to them and do whatever was needed to take care of their self and body. Participant #2 shared, “I just knew I had to do whatever it was to just take care of myself. I had to just do whatever I needed to do”, while Participant #5 said, “I figured what the hell... if I got it, I got it. You gotta’ go on. Let’s deal with it and go from there”.

The participants did not appear to struggle with their diagnoses; and in fact, they seemed to readily accept it in order to move forward. They began to prepare for their upcoming surgeries. This brought forth the following questions: (a) is cancer the new normal; (b) do people expect to hear this diagnosis during their lives; and (c) do people no longer use the social metaphor of engaging in battle with cancer? Participant #6 shared the following that summed up her thoughts on the normalization of cancer:

Cancer isn’t the word that it was many years ago and death sentence. It - this can be curable. You hear this from other people. It’s like... my daughter is blind. I didn’t know any blind people before I had a daughter who is blind. Then they come out of the woodwork, and you met all these people that are blind. The same thing happened with this. When I knew there was something wrong with the colon and it was looking like we were heading in that direction of surgery, people just came out of the woodwork that had bowel resections and colonoscopies and similar experiences... and they were alive and well and looked good, you know.
This new idea of normalizing a cancer diagnosis led to the fifth theme of “getting off lucky or not”. And do people really get off lucky with a cancer diagnosis?

Getting Off Lucky or Not

Two participants felt that they got off lucky with their cancer diagnosis because it was caught before spread to their lymph nodes. Participant #4 shared how despite having colorectal cancer, he felt that he got off lucky as he was healthy, did not have prior symptoms and that the cancer was caught before it spread past his colon walls. He did not have to endure any adjuvant therapies, such as radiation or chemotherapy. Hence, he felt he got off lucky with his colorectal cancer. His words were, “I got off Scot-free. I just feel so, so lucky after all of this”. Participant #6 also felt lucky, as she too did not have to endure any adjuvant therapies after surgery as her cancer was contained. She humorously stated:

My doctor made the comment ‘it’s got to be your good Ukaranian bowels’. I guess I have strong walls, and that he did not see anything that was impacting the lymph nodes and there was nothing that he could see abnormal of the liver.

Two of the five participants with colorectal cancer “got off lucky” and did not have to endure adjuvant cancer treatments. Unfortunately, other participants had to continue forward in their cancer journeys as they moved into adjuvant therapies.

For those with colorectal cancer who did not “get off so lucky”, they were faced with the need for adjuvant therapies. Participant #1, diagnosed with colon polyps, was generally fearful of adjuvant cancer treatments, and in particular, chemotherapy. He had watched his sisters endure it, along with all of its’ side effects. He recounted:

And I haven’t had chemotherapy either, so I don’t know... I know that it is not nice. I’m not sure I would do it. Yeah, I went to Alaska with my sister, about maybe five months before she died, and she was on chemo then. She was taking things on the boat, but it really wrecked everything... her taking that. Well, it wrecks, like what she says ‘it’s coming out both ends’. Yeah, so you just don’t ever feel comfortable.
Participant #3 shared thoughts about chemotherapy as well. She captured the personal losses encountered because of this treatment that included missing the birth of her first grandchild:

So, when we went to see the cancer doctor, she suggested having treatment, having chemo as soon as possible, so I had to cancel my trip to see my daughter, and she was having a baby. She had her baby on the day I started chemo. I could have postponed the chemo. That was a big choice, but the nurse and the doctor... they both said if it was their mother that was in my shoes, that they would advise her to start chemo as soon as possible. After I decided to go ahead with the chemo, and she [my daughter] was fully understandable about that.

She continued with, “I was really... again, it was a shock. It was disappointing. I didn’t realize that that was going to be part of this”. She was shocked not only with her cancer diagnosis, but with the need for adjuvant therapies.

Within Phase One, the participants moved out of their homes and into the medical field to obtain diagnoses. Many felt normal, others minimized subtle symptoms, and some had a false sense of security. This led several to a maximum diagnosis of colorectal cancer. Once diagnosed, they wanted to get on with the show and proceed quickly into surgery. Despite cancer diagnoses, some felt that they got off lucky as their cancer was contained within the bowel walls and had not spread into any lymph nodes, avoiding the need for adjuvant therapies. Others faced continued cancer treatments and started down yet another new path. As participants moved through Phase One of life disruption, time was no longer a silent notion as its’ sounds began to tick louder and louder. The concept of time became prevalent in Phase Two, or time disruption.

**PHASE TWO : TIME DISRUPTION**

In Phase Two, the participants wrestled with the disruption of time. This phase was described in a temporal sense, or according to the wheels of time of the past, present and future, along with its’ changing speeds. The participants reflected on the past, tried to stay in the present, and wondered about the future. They moved back and forth between these time dimensions, but did attempt to stay in the here and now. Some felt that time began to speed up, while others felt
that it slowed down. Time was no longer a muted or taken-for-granted notion. Life was now in jeopardy, especially for those with colorectal cancer. Cancer can end life and bring death. Phase Two was represented in the following four themes:

1. Hindsight of the past.
2. Staying in the present.
3. Waiting for the future.
4. The changing speeds of time.

**Hindsight of the Past**

Within the first theme of “hindsight of the past”, participants struggled with their cancer diagnoses. They reviewed the past to see what they had missed, and what they should have seen, heard and done. Had they ignored what their bodies were trying to tell them? Had they been in denial about the subtle symptoms being relayed by their bodies? Some even blamed themselves for not taking action sooner, like participant #4’s regret at not arranging his colonoscopy sooner because of a familial history with colorectal cancer:

When I found out I had cancer, one part of me was bitter that the colonoscopy took so long, but then it was like [name], you should have gone and taken care of that yourself, you know, ten years ago.

He spoke of how he moved around for his job and was never able to secure a consistent family doctor in one place. When screening tests were booked, he would move before they were done. He had few concerns as he felt and lived healthy. Would it not be his unhealthy siblings who would be plagued with cancer? He questioned “so far, they were cancer free so too should he, right”? He had felt secure in his health status.

Participant #6 reflected on hindsight and on advice that she had given others, but had not taken herself. She had counseled a friend to have someone there to “hear” what the health care team was saying in order to fully capture the information. However, she did not do this in her
initial consultation with her surgeon regarding her upcoming surgery and felt like “a deer in the headlights” as she left the surgeon’s office. She shared:

I should have had someone, you know. When I went to see [the surgeon], I went by myself, but then I don’t have anybody, you know, to go back in and debrief or that I felt comfortable enough having someone else [there with me].

Some did look back in retrospect, but most struggled to stay in the present. They tried to remain in the immediacy of the here and now, or within the second theme of “staying in the present”.

**Staying in the Present**

Many participants attempted to stay in the present. They tried to stop their minds from wandering back to the past and what they should have realized, or from drifting towards the future to a time of unknown uncertainty. Participant #4 said “some days are really positive, even before surgery, and then other days your mind wanders where it shouldn’t go... then you have to slap yourself”; and Participant #6 shared “you are kind of sort of a little stunned and you are thinking, ‘well, if I have to go through with it, I’ll just take the step by step approach’. It is easy to run ahead and go into those dark places”.

Even the surgeon attempted to keep the participants in the present by focusing on the surgical intervention in the here and now. He told Participant #6 that they would cross the next bridge of adjuvant therapies if and when they needed to. But currently, they would deal with her upcoming surgical plan. Many participants waited and worried about what the future would hold for them as it loomed before them. This brought forth the third theme of “waiting for the future”.

**Waiting for the Future**

The third theme of “waiting for the future” was a time of great uncertainty for participants with colorectal cancer. They had to wait for pathology reports to tell them whether or not there was spread of cancer into any lymph nodes and what their next steps would be. If the pathology reports were negative, the participants would evade adjuvant therapies. But if they were positive,
discussions would have to begin about the next steps to take along their cancer paths. For many, this “waiting game” was difficult. Two participants spoke of waiting for and receiving negative pathology reports, or clean lymph nodes. Participant #4 explained:

There are all the lymph node checks... until they all came back, and um... so although you’ve gone through surgery, there is that waiting game and every day you’re still thinking ‘well, what if they come back and they’ve perforated the colon wall and it has spread’. Well uh... it was a Friday night around 7:30 and my call display on the phone said [the hospital] and my wife yelled out, ‘you’d better take that’ and I was thinking ‘oh no!’ And it was my surgeon. He was just out of surgery and he had just got this. So, because it was good news, he decided to phone me at home to tell me it was great news.

While Participant #6 shared:

I belong to a church and we were all praying for all the good results. Everything that the cancer was contained, the cancer that he got it out and there was no chemotherapy... all of those things that we had been praying for. Then he comes in and he says all this stuff. And I’m thinking ‘you’re saying everything like... oh that’s exactly what I wanted to hear’. But you know, I’m glad you got in there and found out it was contained and the lymph nodes weren’t... and I remember almost turning back and thinking I was going to fall asleep and I said ‘Dr.’, and he said ‘what’, and I said ‘thank you’ and he walked off.

Participant #3, who received a positive pathology report, was in shock as two of thirteen lymph nodes came back positive. The surgeon and oncologist explained the upcoming treatment and surveillance program that included chemotherapy and future colonoscopies. She stated she had not bargained for this, or for cancer for that matter. Her surgeon told her that he did not know what the future would hold for cancer reoccurrence, but stated she had a 50/50 chance of this. She continued on in uncertainty as no absolute answers could be provided for her. Even her doctors did not know.

Despite an attempt to stay in the present to deal with the immediate needs, there was uncertainty that shrouded the future. Participant #4 summed this up as he said “every day that goes by, I’m putting it out of my mind, sort of, but it’s always in the back of your mind”. With temporality, the participants moved back and forth across the past, present and future; plus they
felt the speeds of time either accelerated or decelerated based upon their unique experiences. The fourth theme embraced the idea of “the changing speeds of time”.

**The Changing Speeds of Time**

The participants spoke of the changing speeds of time, with it either speeding forward or coming to a concerning halt. With a diagnosis of colorectal cancer, there was a medical urgency to get the participants into surgery, and the speed of time accelerated for these five participants. They shared how quickly their surgeries were booked, often within a couple of weeks from the time of diagnosis. The actual wait period ranged from two to six weeks for them. Participant #4 said:

...it was obviously a shock, and he [GI doctor] said ‘we’ll have to get this out really quick’. So then I was hooked up with a surgeon and he said ‘we’ll try to get this out within seven days or less... wait for a call from my office and be prepared to go.

The same participant also shared “it had such a good ending so fast, between finding out of cancer, having the surgery, getting the lab report back, it was sort of like bang, bang, bang”.

Participant #5 had his colonoscopy in May and surgery in June. He said, “I was in to see [the surgeon] about two weeks prior and that was it. Boom, boom - I figured, ‘well hell, let’s do it’”.

Participant #6, also diagnosed with colorectal cancer, had additional stressors to manage as she prepared for surgery. She had to plan respite for her disabled daughter, plus think of her own care needs once discharged from the hospital. She explained:

I’ve got to plan because I have a daughter with special needs that I have to get into care and then for me, I have to figure out who is going to be there for my care when I get home and to me that was overwhelming.

She initially thought she would have a two to three week wait for surgery, in which time she would get an ulcer from worry. But instead, her surgery was booked very quickly. For those who had a colorectal cancer diagnosis, time accelerated as they quickly moved into the surgical phase.
Yet for other participants, they experienced a deceleration in the speed of time. This occurred as some waited for diagnostic testing or non-cancerous surgical interventions. Participant #4 explained:

We have four doctors in our running club and I just brought up that I don’t have a doctor here, so he said, ‘if you want one, come on’. So I went to see him and I told him a little bit of my history and he says ‘well, you sound like a healthy guy, but your mother has had colon cancer’ and I hadn’t had a colonoscopy which was certainly my fault. Anyway, he says ‘well, we will arrange one for you’. So I believe from the time we registered for the colonoscopy to the time I had it was around two and a half years and somewhere in the middle, I got a call to say do you still need the colonoscopy. So I said ‘yeah, sure’. I think they were just calling to see if I had had one. So anyways, so I just thought ‘well okay, we’ll just keep on waiting’.

Time also slowed for Participant #7 who was diagnosed with diverticulitis. He waited eight months for an urgent, but not emergent, surgical date. During this time, he felt his symptoms had escalated and shared:

It took eight months to be booked for surgery... between the time that I talked to him [surgeon] and surgery was booked, I felt like things were actually progressing as far as the bouts that I was having and I went back to my doctor and suggested that he just write a letter to speed up the date. We didn’t know what else we could be doing. I mean, you’re on a list... you wait your turn.

Time became a major concept for the participants as they moved between the past, present and future. With this, the speeds of time accelerated or decelerated based on their diagnoses. For those with colorectal cancer, time warped ahead to their surgical dates; and for the others, time slowed down. Some had to wait extended periods of time for their diagnostic tests and surgical interventions. But eventually, their turns came for surgery that led them into the final phase of surgical disruption.

PHASE THREE : SURGICAL DISRUPTION

Phase three, or surgical disruption, brought the last of the trio of disruptions that constituted the surgical narratives. This phase began as participants entered into hospital for their anticipated surgeries. They came armed with their ERACS guidebook that became the central force of the
surgical program as it directed their surgical journeys and experiences. The ERACS guidebook possessed power as it contained guidelines for a smoother, faster surgical recovery. But, it also gave power back to the participants as it educated them on the rules of the hospital and how to become an active force in their own recoveries.

All participants shared how they read the ERACS guidebook multiple times in preparation for their upcoming surgeries. They knew what to expect, plus what was expected of them. The ERACS program attempts to minimize known complications of bowel surgery, yet it does not educate on the episodic disruptions that can be encountered. This gap provided senses of guilt and concern when the participants’ experiences did not match that of the predicted ERACS guidebook. During this third phase of surgical disruption, five themes, two with sub-themes, emerged that included:

1. Entering the medical world – putting on the clothes (role) of a patient.
2. Within the hospital room – the concept of physical and emotional space.
   a) Sharing physical space with others.
   b) The emotional support & incentive of others.
   c) The curtain that tries to divide.
3. Introducing the health care members.
4. The centrality of the guidebook and navigating alone and along the ERACS path.
   a) The Central Force that Guides the Path – The ERACS Guidebook.
   b) Moving forward and on track on the pathway – who is responsible?
   c) The guilt of not minding the pathway.
   d) Solitary suffering along the way.
   e) Going full circle and ready to go back home.
   f) Overall impressions of the ERACS Program.
5. The elusive bowel movement and the mild obsession that ensued.
Entering the Medical World – Putting on the Clothes (role) of a Patient

As the participants entered the hospital for surgery, they were transformed into patients. Gottlieb (1994) as a patient himself, quoted by Frank (1995) stated, “we stop being people and start being patients... we become their patients and we live in their hospital” (p. 10). The participants in this study were no different from Gottlieb when they too became patients. They felt uncertain as they waited for next instructions, handed their bodies over and donned hospital gowns. Many were confused as to what next steps to take and where to go. Many spoke of how they waited to be told what to do. For example, Participant #2 stated:

I was maybe getting a little bit more nervous because again, I didn’t know where I was going or what I was doing, but then the anesthesiologist came up and right away there was someone there to go through and tell me exactly what they are going to do. They told me again what they were going to do so I knew, you know, exactly what was happening to me.

While Participant #4 said:

I think I was okay all the time except, you know, you come in and you go to admitting, then you go here, and then you go there, and then you wait in a room. So you’re moving around for the next step in the process, and you’re not quite sure what the next step is. It’s just you go with 1, 2, 3, 4, 5 sort of thing, but you don’t know what is coming and maybe that is good too.

Participant #1 shared how he voluntarily gave up his control as he relinquished his body to the health care experts. He stated he felt his body was an “object” to be used by the “self”. Thus, any physical interventions would be done to his body, not to his self. He stated:

I look at it in a totally different way... most people do think they are the body. It’s an object... you can see it. Or when they are putting in the needle, you know. That’s a needle going into your arm, that’s not you. It’s just into the arm. The arm is an object for you, so it’s a whole lot different... most people don’t think like that.

Participant #7 challenged the notion of his body becoming the main focus of modernized medicine as it “claims the body as its territory... for the duration of the treatment” (Frank, 1995, p. 10). This participant believed that all aspects of his “being” should be treated. He felt patients
“needed to be treated [holistically]... their bodies needed to be treated, the psyche needed to be treated and the emotion within the person needed to be treated”.

Other participants relayed the concept of putting on a gown and becoming the same as others within the hospital setting. They all willingly removed their clothes to put on hospital gowns. Participant #4 said:

...and then when I got my clothes, I put them on and my wife leaves, and then you just go on a stretcher into this operating room. So then it’s a little uncomfortable, you know... your nerves start then because now you realize ‘yikes, this is it’.

He had become a patient in waiting. Participant #6 recounted:

...even prior to going into the theatre, you are sitting out front and there are other people waiting to get their... they are going through the same steps as you are, but different surgeries. We’re all dressed the same. We’re all going in the same direction.

The participants entered the hospital and became patients within the busy and confusing hospital system. As Gottlieb (1994) states, even the admitting form requests patient name, not individual’s name (cited in Frank, 1995). Although they had different diagnoses, the hospital culture changed them into patients who dressed the same, were treated the same, and walked similar paths to surgery and recovery. Participant #1 voluntarily handed his body over to modernized medicine, while Participant #7 struggled to remain whole within it. Through recovery, all participants encountered the inner workings of a hospital room.

**Within the Hospital Room – The Concept of Physical and Emotional Space**

The participants began their recoveries within the hospital rooms, and from this came the second theme that embraced the concept of physical and emotional space. Three sub-themes emerged: (a) sharing physical space with others; (b) the emotional support and incentive of others; and (c) the curtain that tries to divide.

**Sharing physical space with others.** All participants shared a room with others. The participants discussed negative aspects of sharing the physical space of a hospital room with
others; including visitors, sounds, smells and bugs. Bugs will be discussed in the upcoming section entitled “the curtain that tries to divide”. Participants raised concern over the issue of the hospital visiting policy, or lack of one. There was a discrepancy between the information in the ERACS guidebook and what they actually experienced. They understood there should be no more than two visitors at a time, for short periods only, with a mid-afternoon rest period. With a “Patient and Family Centered Care” model, this policy is not stipulated and visitors can come at their convenience. Yet, some participants took the ERACS guidebook’s visitor suggestion as a steadfast hospital rule, wondering why it was not enforced. Participant #3 said:

The only thing I noticed, um, in the room, in the booklet it says about having only two visitors between certain hours, and whether I wasn’t in that room, whether that room was beside me, I don’t know. But, they had visitors coming in early, like way before lunchtime and staying until supper. Three or four of them at a time, and they would just you know, constantly be... they were having a great time, but there was four of us in that room, and there was some very, very sick people in that room. And I found it very annoying that I couldn’t rest. Because I couldn’t get out of bed at first, you know, you can’t even sit up. I found it very uh... I was wondering why they didn’t have a quiet time for sleeping.

Participant #6 was concerned for the others in the room, and with the visitors that stayed for extended periods of time. She stated:

I didn’t like when people came into the room and visited other people in the room, how they [patients] just wanted to lie back and rest, and they were politely staying awake. I didn’t have to deal with that. My friends did what I asked them to do.

Not only did some visitors cause concern, but the sounds and smells found within the room did too, especially when sharing a bathroom. Participant #4 was very sick, stating he had made a terrible mess of the bathroom as he simultaneously vomited and passed diarrhea. He had been in the bathroom for three hours, and said it was awful that his roommate had to see, hear and smell his mess. He was also concerned for the nursing and cleaning staff that would have to clean the bathroom, and stated, “no one should have to deal with that”.


The nursing station generated a lot of noise for the patients, especially at night. The nursing station is located in the middle of the ward and is not fully enclosed. Sound travels. During the night shift, nurses would addressograph (stamp) documents for the charts for the upcoming days. Participant #4 said this sounded like “hammering... bang, bang, bang”. He realized that it was part of their job, but still could not sleep through it. He tried to block the noise by closing the door, but both he and his roommate did not sleep.

Other noises from within the room caused lack of sleep. This included noises from confused patients who would call out, alarms ringing from different machines such as intravenous pumps, and patients who came and went at all hours of the day and night. The participants were not annoyed by the other patients in the room, but more by the physical equipment that would alarm. Participant #3 stated how hard it must be for the nurses to constantly keep up with the changing equipment and all the noises it can make. The hospital entity never rests, and its’ environment is not conducive for the needed rest of patients housed within it.

**The emotional support and incentive of others.** Despite the constraints of the physical space and the difficulties it caused for some, strong emotional relationships developed within these same walls. Participants spoke of the “others” in the room, and the care and support they gave to and received from them. The participants relayed the camaraderie found within the hospital room and friendships that ensued. They all shared similar experiences of becoming surgical patients in a modernized medical world, and thus, found common ground on which to build the emotional relationships. These were reciprocal in nature with both parties benefiting from the support given and received.

Participant #1 discussed how there was a confused patient in his four-bed room. He and the other two patients stayed up all night and looked out for him. They rang their call bells on his
behalf because he was not able to do it for himself, and continued to help him until the nurses moved him into the hallway for closer observation. The participant even checked in with the confused man’s family the following day and provided additional information for them.

Participant #6 also spoke of roommates who looked out for and protected each other. She was in a four-bed room with two women and one man, with the male patient being the sickest of them. The participant stated they “protected him” and looked out for him. When he got up with the platform walker, they applauded and cheered him on. When he rang his call bell and there was a delay in assistance, they rang their bells too. When they used their incentive spirometers, they encouraged him to do the same. They cared for him by protecting, encouraging and supporting him. They became joint partners in each of their own personal recoveries.

The roommates spoke openly and honestly, and many shared personal stories that were helpful to others. Participant #4, having colorectal cancer, stated he was amazed at his female roommate. She was battling cancer for the third time and was loosing her battle with it. He called her “a pillar of strength, although her 4’10’, 80 pound body could be perceived otherwise”. He said she never complained despite being in pain, and focused on the good in her world, such as planting flowers. He decided that he would not complain as he watched her silent strength.

Participant #6 described how her two female roommates became her friends within the hospital room, and that these friendships have continued after discharge. This participant used humor throughout her interview, and laughter was obviously very important to her. She felt it was good medicine and relayed, “yeah, there was a little ‘kahootzing’ going on in the room... it really did become part of the recovery because we laughed, and it hurt to laugh, but that was okay”. In regards to the friendships made, she shared:

…they actually, the two women, became part of the recovery. Because you get to know people, because you share the big word [cancer] and um...they don’t know what your
results are, or where you’re heading with your cancer, and unless they’re divulging where they are going with theirs...and they did.

Participant #1 described his roommates as friends as well. He said that if he had to be in a hospital bed, he would have fun doing it. He made friends with the others in the room, and in particular, he bonded with a woman kiddy-corner to him who had the same surgeon and similar surgery. They shared similar experiences and were able to support each other. They engaged in friendly competition, such as who was better with the incentive spirometer, in order to encourage each other along. They went for walks, and even watched television shows together in the lounge.

The participants formed emotional relationships and made connections with the others in the room. It brought forth the question of who is truly caring for the emotional wellbeing of the patient - the nursing staff or the other patients in the room? In a time of financial constraints and lack of resources, nursing staff often work short staffed and over census. There is also an ever-increasing list of physical tasks that become the focus. Do patients notice this as others attend to their emotional needs that may provide a sense of holistic care within the hospital? The emotional relationships formed despite the closed curtains that acted as physical dividers within the hospital room.

The curtain that tries to divide. There is limited space within a hospital room. Frank (1995) wrote, “hospitals treat patients in close enough proximity to each other to obviate any meaningful privacy, but at just enough distance to eliminate any meaningful contact” (p. 36). This statement did not materialize within this study as patients found emotional relationships despite the attempt at physical division.

Hospital rooms now house a mixture of males and females in each room. The curtains within the rooms have been used to provide privacy for the patients, but in reality, they are simply panels of fabric that can block views, but not sounds. The curtains are even more
important as men and women now share rooms, and gender privacy is more of an issue. The curtains often remain closed to partition off each patient’s space and provide privacy. But, they do not block sounds or prevent emotional relationships from forming. This study’s participants spoke of the caring and sharing that occurred despite open or closed curtains, and relationships that transcended the barriers of closed curtains. This may not be true for all hospitalized patients.

Participant #4 compared the phenomenon of the closed curtain and subsequent relationships that developed through it to the popular television sitcom “Tool Time”. On this TV show, fences divided property lines and people. Tim, the show’s main character, often sought help from his neighbor across the fence. The viewer never got to see the neighbor in his entirety as the fence blocked him. But, the viewer heard his voice and all his important counsel. Tim and his neighbor had an emotional relationship despite the physical barrier that divided them. This rang true for the participants and their roommates as well. Fortunately, they were able to break through the barrier of the curtain to form emotional relationships. They did not need a view of one another for this to happen. The closed curtain was not powerful enough to block the reciprocal care and concern that was shared back and forth.

Closed curtains were also used as isolation techniques, but really, did it provide a false sense of security against the transmission of bugs? Two participants shared stories about bugs, with the first suspected of having one and the second worried about catching one. Participant #3 was thought to be clostridium difficile (c. diff) positive. Her curtains were closed around her following a single bout of diarrhea after her surgery. Many patients do experience loose stool after bowel resections, so having a bout of diarrhea is not uncommon. She did not have ongoing or unrelenting diarrhea, but was isolated as a precaution anyways. Her curtains were closed around her, and a poster pinned to them to alert others of her isolation precautions. A sample to test for c. diff was not obtained because she did not have any further diarrhea to send for culture.
She remained within her four-bed room, and was advised to not use the bathroom. Upon leaving her area, she was to wash her hands, put on a clean gown and gloves and be careful as to not touch anything on the ward, or enter into the common kitchen. She did not mind the isolation precautions because she did not want others to become infected. But, she felt the closed curtains with the poster pinned to them put others at unease. She thought that they would not fully understand why she was placed behind the curtains and for what isolation reason. The isolation protocol and subsequent labeling of this participant seemed harsh for a single bout of loose stool following her bowel operation. Her curtains remained closed for the next 48 hours. She had no further diarrhea and was discharged home.

Participant #6 was nervous about catching a superbug, or antibiotic resistance organism (ARO). She had a fresh surgical incision and she did not want to catch an infection. A surgical patient, who was friends with one of her female roommates, was on the same ward under ARO isolation. This particular patient was not maintaining isolation precautions and the participant was nervous as she saw breaches in isolation policy take place, such as being in the common kitchen. She did not feel it was up to her to police her actions, but was nervous about catching a superbug. The participant felt stronger isolation protocols should have been implemented. There are infectious disease algorithms within hospitals, but do these change based on the daily needs of the organization? Isolation policies have constantly changed over the recent years, with more and more people flagged with ARO statuses.

The patients provided emotional wellbeing to each other despite the curtains that tried to divide them. Although both negative and positive factors were found within the hospital room, the positive outweighed the negative. Negative factors were visitors, sounds, smells and bugs; and the positive factors were emotional relationships, incentive and support. The participants shared much about the others in the room, but where was the health care team’s presence?
Introducing the Health Care Members

The health care members are challenging to discuss for confidentiality purposes. For this reason, all surgeons and all nurses will be discussed collectively with general comments made. The participants had many positive descriptors of their surgeons, including trustworthy, likable, gentle, caring, understanding, and professional. Participant #1 stated his surgeon was “a good guy, a likable guy”; Participant #4 said his surgeon was “an excellent man who many spoke highly of, and that he was very statistical, but gave the numbers in a caring way”; Participant #7 said he “would trust his surgeon with his life again if needed”. All participants felt comfortable with and trusted their surgeons upon their initial meetings. Participant #6 appreciated the extra attention to detail that provided her the safest surgery possible. This included the need for additional cardiac tests to ensure the best objective data was obtained before surgery.

There were some negative comments made regarding the surgeons and their associates. This stemmed from Participant #7 who waited eight months for surgery. He did not appreciate what he considered to be bad body language or surgeon’s standing at a distance from him. He said a surgeon stood behind the curtain and peeked in at him, and another stood as far away as possible with his back against the wall. He had heard some doctors talking over him, and this conversation had made him uneasy as he was unsure what their comments meant. He spoke of post-operative pain and suffering. He discussed a defunct epidural that left him in extreme pain, which was then removed. This was followed by a PCA pump that also did not work for him. He suffered for 48 hours until his pain was finally managed by oral medications. He had a stressful pre- and post-operative course and felt an apology was needed from some.

Participants described the pre-operative nurses, who initially explained the ERACS guidebook, as thorough, providing good detail and instructions, taking the time to explain, encouraging the patients to ask questions, and speeding up or slowing down the pace as needed.
The post-operative nurses were described as friendly, in a good mood, fantastic, sympathetic, and pleasant. The participants thought the nurses answered their questions, had good bedside manners and provided exemplary care. Despite the descriptors of exemplary care received, I felt their stories revealed discrepancies in the care provided. This came from my perspective as an acute care surgical nurse, and is explored further in the upcoming theme regarding solitary suffering.

Even though high praise was given to the nursing staff, despite issues with non-care, the next theme featured the centrality of the ERACS guidebook. It outlined the requirement for a multi-disciplinary health care team approach of medicine, nursing, pharmacy, physiotherapy, social work, dietary, etc., to work alongside the patient for the best surgical outcome. But, the nurses seemed to be invisible members despite their needed presence.

**The Centrality of the Guidebook and Navigating Alone and Along the ERACS Path**

The central force of the enhanced recovery program was the ERACS guidebook, or ERACS bible. It contained power that controlled and guided the participants. However, it also gave power back to the participants in the form of personal engagement in, and ownership of, their recoveries. Six sub-themes emerged from this and included: (a) the central force that guides the team and patients – the ERACS guidebook; (b) moving forward and on track on the pathway – who is responsible?; (c) the guilt of not minding the pathway; (d) solitary suffering along the way; (e) going full circle and ready to go back home; and (f) overall impressions of the ERACS program.

**The central force that guides the team and patients – the ERACS guidebook.** The ERACS guidebook dictated the entire program from beginning to end. It stated the what, when, where and why’s of the enhanced recovery program for all involved. This included the patients, medical and nursing staff, plus all other health care disciplines needed. ERACS patients moved through a four-day post-operative surgical course that promoted safe and fast surgical recovery.
The ERACS guidebook was used in the pre-, intra- and post-operative phases to guide surgical preparation and to promote recovery. Patients were asked to review the guidebook at home and become familiar with the four-day path. It was then reviewed with them in the pre-surgical department prior to surgery. Patients were requested to bring their guidebook to the hospital for use during their surgical stay. And if forgotten, one would be provided on the surgical floor. The guidebook was intended to educate, engage and guide the patients in their surgical recoveries, and be with them every step of the way.

All participants and their partners reviewed the ERACS guidebook, many of them multiple times. They had a good understanding of the ERACS pathway, and the daily goals along the four-day surgical recovery period. Often, the participants knew the pathway better than the nursing staff that cared for them. Many participants stated the guidebook was easy to read, understand and follow. Participant #1 said he left his book on the coffee table in order to go through it every couple of days before his surgery; and Participant #4 stated it was so well used that coffee was spilt on it. Participant #5 stated it [the ERACS guidebook] was like a movie – if he watched a movie again, missed pieces were picked up. By reviewing the guidebook many times, additional information and understanding of the ERACS program occurred. Participant #3 shared:

Um, I thought it [guidebook] was excellent. It was a great guide. You could sort of monitor yourself to see how you were doing in the hospital and, you know, kind of gauge when you were going to be out and all about the medicines and things like that. I thought it was great because I did feel like I was healing quickly. I was pretty well on track with this.

The participants came prepared for their interviews and some even had file folders that were filled with important papers that portrayed their surgical stories. In a sense, it was like a personal document documentary. Many showed photos from their colonoscopies, copies of their pathology reports, and most had their ERACS guidebooks. These were important items for them that depicted their personal stories of surgery. Frank (1995) relays that people may still relinquish
their bodies to medicine, but “increasingly they try to hold onto their own stories” (p. 16). Did these filled file folders allow them to own pieces of their personal medical history that is often contained in charts that they do not have access too? Did their pictures and papers help solidify their surgical experiences? Did they help to construct their new stories?

Although participants and their partners went through the ERACS guidebook multiple times, did the members of the health care team? Ideally, this program has a multi-disciplinary team focus, with all disciplines working together to keep patients on the ERACS pathway. But who ultimately became responsible to ensure that this happened?

**Moving forward and on track on the pathway – who is responsible?** During the four-day post-operative recovery, the patients were expected to meet daily goals with the help of the multi-disciplinary team. However, participants often described navigating the path themselves, and this was not meant to be a solo journey.

Due to proper pre-operative education and preparation, the participants were able to keep themselves on the ERACS path. Once in the hospital, Participant #1 stated that no one discussed the ERACS program with him and he simply tried to remember the rules. He remembered he was to stay out of bed as much as possible, so he sat in a chair for meals, to do puzzles and to read the newspaper. He tried to walk as much as possible, but he did this all on his own accord. Two participants shared how they had their guidebooks on their bedside tables and reviewed them every morning on their own initiative. Participant #4 even went so far as to say it was more relevant to read the guidebook than magazines that were brought in for him. Participant #3 relayed how she felt on par with the pathway, using the guidebook to monitor her recovery process. She shared:

I thought I was doing pretty good. I thought I was on par with what they were expecting. I don’t think I was ahead of the schedule at all. Um, I don’t think I lagged behind. I think I was pretty much on par with what they were saying. I think it helped because when you see
how much you’re supposed to walk, and at first you think, oh well, you will just walk around once, but as the days go on, you have to walk several times, plus several times a day. So, and I could see other people doing that, I could see them, so I thought... that gave me an incentive to get out there and go again.

The participants kept track of their own course along the pathway. Some delegated tasks to nurses, while others corrected them when they were not on top of the daily goals. For example, Participant #6 was aware of her blood pressure readings, and on post-operative day three (PO#3) she requested to the nurse to have her blood pressure medications re-ordered as per the ERACS guidebook, even though the nurse insisted she was only on PO#2. It was the participant who was correct, and her home medications were re-ordered. Participant #7’s wife came in to visit him on PO#2 and asked why his bladder catheter was still in. She said, “it was day two... the foley was supposed to be removed on day two”. He was upset as he felt that he and his wife navigated the ERACS pathway alone. He sharply stated:

No one mentioned it [ERACS], no one went over it, no one gave me any indication of any of the steps within it. As a matter of fact, in my letter you will see I ran your program for me. And no patient should have to do that either. It should be initiated from your staff, not initiated from the patient. And in my case, I believe that the general aspects of the program worked for me. I’m not saying it didn’t, but I am quite appalled that I had to manage it.

Despite the ERACS program promoting a multi-disciplinary team approach, this was not apparent in most participants’ narratives. Participant #5 spoke of how he anticipated help from physiotherapists, but they never showed up. He ambulated on his own with a small oxygen tank, and once this was empty, on a short length of oxygen tubing attached to the wall. Participants navigated the ERACS pathway on their own and followed the ERACS rules as best they could. They felt responsible for keeping themselves on track, and some felt guilt when they were not able to do so. This brings forth the next sub-theme of “the guilt of not minding the pathway”.

**The guilt of not minding the pathway.** The participants were engaged with the ERACS program and took seriously their responsibility for complying with the ERACS pathway. They
prepared themselves for their surgeries and knew the guidebook well. They used it as a tool to gauge how they were progressing along the pathway, but not all were able to achieve the daily goals due to surgical complications. The participants were individual in their surgical recoveries, and they tried their best to follow and stay on the ERACS path. Participant #6 was light-headed and nauseated after surgery and had trouble mobilizing. She felt guilty that she was not doing the amount of activity that was stated in the guidebook. She appreciated that the health care team did not push her, and allowed her to go at her own pace. She said:

But as soon as I sat up, I could just feel myself a little lightheaded. But, let’s try walking, let’s just get up and start doing this, you know. And I got as far as the doorway and I just turned to him and he said, “how are you feeling?” and I said, “my head is a little light... and of course, the last thing you want is me to fall flat on the floor”. So, we went back to bed. And he said, “yeah, we’ll just do it tomorrow”. I thought that was nice because I was feeling guilty about not keeping up with the plan.

One night, Participant #4 became nauseated and began vomiting. He could not manage food the following morning, but he began to feel better in the later afternoon. He started eating and ambulating again, and felt a sense of relief because he felt “back on track”. Each participant had a unique surgical experience, and some encountered complications along the path. It was with these complications that many of them experienced solitary suffering as nurses became absent in their time of need.

**Solitary suffering along the way.** Many of the participants were first time surgical patients, and therefore, could not compare and contrast any previous experiences to their enhanced surgical experiences. Many did not even realize that their stories spoke of lapses in nursing care. I am a surgical nurse, and I was concerned with the solitary suffering that six of the seven participants encountered along the ERACS path as they often walked it alone. This caused me to ponder many questions:

1. Where were the nurses and their care for these patients, and how is care defined?
2. Is health care in such a state, with an obvious lack of nurses and resources with an excessive number of patients, that care has become lost to objective tasks?

3. The nursing profession has prided itself on being a combination of science and art, but where is the balance?

4. Does the ERACS program, being a medical model, encourage the science of nursing to overshadow the art of nursing?

5. What did some patients endure as they travelled along their enhanced surgical paths?

Most participants shared stories of solitary suffering, but many were not aware that they had endured non-care. This sub-theme is presented as six unique mini-stories of solitary suffering that stem from the actions of others. Five as a result of health care professionals and one from her family member.

Participant #2 struggled with lack of information regarding his bowel ileus. He felt he might have caused this complication by continuing to eat the food that was brought to him, and he questioned whether he should have done this. He did not receive adequate information from the surgeon, whom he said saw him for only minutes a day, or from the nurses about his bowel dysfunction. Even during his interview, he still pondered and questioned his actions. Thus, he continued to carry a sense of responsibility for this common complication, and he himself took full ownership of it.

Participant #3 described the added stress she had in getting an ERACS guidebook before her surgery. Surgery had been scheduled immediately following her colonoscopy. Her surgeon, who normally would consent and give the ERACS guidebook, did not have access to one in the GI unit. This evoked complaints from the nurses at her pre-surgical screening (PSS) appointment. Unable to obtain an appointment at the surgeon’s office to obtain the guidebook, as “there was no
time available for this”, she finally obtained a copy from the PSS nurse who stated, “it was not part of her job to do so”. She became lost in the process of the system.

Participant #4 described a night where he spent three hours alone in the bathroom with simultaneous vomiting and diarrhea. He said he was lying in bed and he knew he was going to be sick. He made it to the bathroom and started vomiting. He was on his hands and knees, vomiting into the toilet, and then loose stool began as well. He had to use the toilet and the wastebasket as both ends were going at once. He had his roommate ring the call bell for the nurse, who did ask if she could help. He asked for a washcloth, which was provided, and then he was left alone until he was able to make his way back to bed three hours later. He said it was an awful experience. When asked if a nurse came back to check in on him, he replied no.

Participant #5 had trouble with loose stools post-operatively. He had trouble getting to the bathroom with the ferocity of the stool. He did not like asking for help to clean himself, but he could not do it properly as he could not reach. He was given a towel, facecloth and clean gown and told to “do it himself”. The first nurse did not stay to help him, but luckily a second nurse assisted him. He thanked her for her care, and said, “some people feel their body is being invaded if somebody else comes to help them. If your body happens to react that way and you need help... accept the help”. His first request for help was denied.

Participant #6 suffered from comments made from her unhealthy mother when she told her that she had colorectal cancer. When her mother heard the news, she said “well, do not ask me for any help, because I am no help to you”. The participant said this hurt, but understood where her mother was coming from as she had her own health concerns. Her mother could not help her on discharge, but her estranged sister came to assist her at home. Despite all of the negative aspects that cancer can bring, it allowed her to heal her divided relationship with her younger sister.
Participant #7 suffered as he had ineffective pain control over the first 48 hours post-operatively. His epidural did not work, nor did the PCA pump that replaced it. He was in obvious distress that was not picked up by the doctors or the nursing staff, and he was upset with the lack of care and concern he received. He was having trouble mobilizing, and other patients observed and commented on his pain level. He said his own nurses and physiotherapists did not seem to observe his distress. This bothered his wife, a retired nurse, who stated the “nurses’ observational skills lacked”. He echoed this and stated:

Nurses were very good at carrying out the minimum they needed to do in order to make sure I was still there and still functioning, but their observation was hugely lacking and the implementation of the program was practically nil.

When he was switched to oral analgesics, he had a complete turn around as his pain was finally managed. He was finally capable of doing and reaching the daily goals, such as activity.

These six participants endured solitary suffering along the ERACS pathway. This came from many areas, from pre-operative screening to post-operative recovery, and from a family member’s comments. As an acute care surgical nurse, my concern was with the apparent lack of nursing care and support provided to the participants. To me, they appeared to navigate both the ERACS pathway and its’ associated complications “alone”.

**Going full circle and ready to go back home.** Participants all knew when they had completed their ERACS pathways. They all stated that they could not wait for discharge, and some were disappointed if and when this was delayed. Participant #1 stayed an extra night to get stronger before going home, as he had some discomfort getting in and out of bed. Participant #3 had a delayed discharge because the nurses believed she had c. diff after one single loose bowel movement. Participant #4 had a single documented temperature during the night so the surgeon wanted to monitor this for another 24 hours. His temperature never resurfaced.
Upon discharge home, the participants felt mentally and physically ready. They knew they needed to continue with recovery at home. Participant #5 said he would do much better at home as he would get more rest and eat better. Participant #6 summed it up by stating, “I felt as ready as I could be ready to go”. The participants were ready to leave the hospital, but what were their feelings of the ERACS program?

**Overall impressions of the ERACS program.** All participants were asked what their overall impressions of the ERACS program were. Here is one quote from each participant, in order from #1 to #7, to sum up each experience with the ERACS program:

**Participant 1:** I really was happy with the whole thing, and I loved all the nurses and the doctors and everybody. They were just wonderful.

**Participant 2:** Well, it was helpful for me because I knew what to expect and what I should be aiming for sort of thing, you know, and then the pain thing and all that stuff. But it did... it gave me a guide of where I should be and what I should expect at certain times and where I was during the whole procedure.

**Participant 3:** Well, I thought it was a good program. It was well researched. It was proven to work. Um, I think that the staff at [the hospital] had researched it of course, and they were promoting it, so I thought that we were really excited to be a part of it. It was going to be a good thing for me.

**Participant 4:** Whereas this [guidebook] was a bit of a tool for me everyday to follow. And I didn’t need a babysitter with that program. You know you took ownership of it so you did it. And that may be the mindset too because I wanted to get out, so the faster I get better, the faster I do what I’m supposed to do and the faster I’m getting out.

**Participant 5:** Give it to anybody and everybody. Uh... if they follow the instructions, they are going to come out of it like I did, without any pain, without any after effects and they are going to feel much better about themselves, and uh, they don’t need to be worried about going into the operating room. They’ll be able to walk in and walk out if they come out awake before they go to the recovery room. But they’d be able to walk. So, no, I would recommend that you give it to anybody and everybody.

**Participant 6:** I did not feel that anyone was rushing you through. I did not see the Enhancement Program as let’s see how fast we can get them in and out, but I saw the Enhancement Program as how do we get them in and out and feel stronger. And my sister said it well “heal strong”.
Participant 7: I think it’s great. I think it’s great from both aspects that it will help the patient and it will potentially shorten the stay in the hospital, which has got to help the hospital load as well. It has a two-fold effect and I think it’s a wonderful idea, but the real push in my opinion, has to be the patient. It has to be the patient. – I think the program has the potential to be awesome.

Overall, the participants gave positive reviews on the ERACS program. As they concluded their surgical experiences, it came to view that the ERACS program began and ended on the subject of bowel movements, like a full circle or right of passage.

The Elusive Bowel Movement and the Mild Obsession that Ensued

The participants stepped onto the ERACS pathway because of bowel issues that ranged from no symptoms, to blood in stool, to being constipated, to increased pain in the abdomen or rectum. Once diagnoses were obtained, they underwent surgery that caused disruptions to their bowel function. This varied from bowel ileuses with no bowel function, to straining to move with no success, to explosive loose stools. Once normal bowel function was restored after surgery, the participants stepped off of the ERACS pathway and went home. Their surgical journeys began with bowel movements and ended with bowel movements.

The surgical narratives featured bowel movements, being a taboo subject of conversation in today’s world. However, the participants freely discussed and described their bowel movements during their interviews. Some even commented that they became mildly obsessed with their bowel movements as their current world focused on it. Participant #6 described:

I mean I could feel, you know, like the peristalsis and everything would move down and then it would just dissipate. It would crescendo and then poof... nothing. And I’m feeling the urgency and I’d be in the washroom and I’d sit down and that made me more tense. The more tense you are, and I’d think “just relax, just relax, it will come”. And it wasn’t coming, and that just made me more anxious because I knew it was about to, but it wasn’t doing it. So when you have the surgery, and you start having bowel movements... my sister said “you’re getting bowel, poop, stool obsessed!” But I’m thinking it feels so smooth and regular. And I’d look at it and think “that’s what you’re supposed to look like!”
After surgery, bowel health and function became a priority for the participants, as well as for the medical and nursing staff. Passing flatus and stool became normal topics of conversation. Despite this body process being normal and imperative to life, it is not something that is openly discussed. Bowel movements are a hush-hush matter, done in privacy behind closed doors, and without inquisition from others. However, during this time, they became a public matter that was openly discussed, and sometimes viewed. Participants even asked nurses to come and view their stool in the toilet.

The participants knew that their discharges depended upon restored bowel function. Once home, they were still nervous of disrupted bowel movements as this could lead them back to the hospital. Participant #4 explained:

I was just concerned about having a bowel movement... like the first day or two, because again, it’s a different feeling. You don’t have stomach muscles anymore. So you can sit and nothing happens you know. So then you get up and you think “what’s going on?” You know, I should be going to the bathroom, but I’m not. And then it starts to evolve, and things just take over, and as soon as I got home, peeing was not a problem... but going to the bathroom, a bowel movement the first day was a little hit or miss. And uh... the doctor said at the time “under no circumstance, if you start to back up, come back in. Don’t let it go more than a day. Don’t wait and readmit yourself or call your family doctor and tell them what is going on”.

The participants ERACS journeys began and ended with bowel movements, an unusual and uncomfortable topic of conversation. When bowel disruption was identified, they left home to enter the hospital to step onto and start down the ERACS pathway. Once bowel function was restored after surgery, they were able to step off the ERACS pathway and return home.

From the participants’ interviews, surgical narratives were created that allowed a glimpse of their landscapes of experiences. From collected data, findings emerged that had three overarching phases of disruption that included life, time and surgery. Within these phases, associated themes and sub-themes were identified. With such constant disruption, how did the participants carry on towards the end of the ERACS pathway? When episodic disruptions were
encountered, they did not falter for long and they quickly continued on. What gave them this strength to do so? Absolute and accurate answers may not be found to these posed questions; however, key concepts that may provide some clarity are explored in Chapter Five.
CHAPTER FIVE : DISCUSSION

The discussion of findings relates back to the participants’ experiences with the new ERACS program within my organization. My interest in obtaining information about the program, with its medical focus and strict guidebook, may have constrained the participants’ recounting of their experiences. Another constraint was the limited time span of the narratives that featured the peri-operative surgical period only. Each participant’s disease and illness continuum started before and extended beyond this specified period of interest.

The surgical narratives were constructed from patients’ stories that reflected vulnerability. This was similar to the vulnerability reported in other research of patients’ experiences with traditional and ERAS surgical approaches (Mizuno et al., 2007; Norlyk & Harder, 2009). With cancer diagnosis, many negative emotions are experienced, such as shock, fear, anxiety and uncertainty. Loss of normal life, self and control became reality, and disruption with chaos was now upon them. Once considered healthy, they suddenly had labels of disease and illness, and required the services of the medical world, including surgeries, treatments and offers of potential cures. What choice(s) did the participants have at this stage, especially if the medical world could give them a chance at life, and surgery could give the possibility of removing the disease from their bodies? The chance for cure may have been the reason for their assumed lack of hesitation to proceed with surgery.

When presented with surgical options, and the choice between traditional colorectal surgery and the new ERACS program, how was the information relayed to each participant? Did they have a choice between the two approaches, or did the surgeon encourage them in such a way that they felt compelled to consent to and participate in the ERACS program? Was the information given in such a manner that the ERACS program became the only logical choice to make as it could provide a faster, smoother recovery process (Kehlet & Wilmore, 2002)? Did a possibility
of minimizing surgical disruption, when already immersed in a major life disruption, provide further incentive for them to consent to the ERACS program? Plus, were decisions influenced by a socially constructed choice to accept surgery if faced with a diagnosis such as cancer? The extent to which they may have resisted both the medical system and ERACS program remains unknown. Yet, it appeared that they all readily accepted surgery and the ERACS program as the best option.

Despite the constant, compounding disruptions encountered, it was evident that the participants had or developed “something” that propelled them along their surgical trajectories. But, what exactly was “it” that enabled them to move forward? Wonder surfaced as I moved in and out of the data looking for truths, understandings and meanings. Findings have suggested that participants experienced three phases of consecutive disruption with highlighted themes and sub-themes. Using sjuzet for organizational flow (Holloway & Freshwater, 2007), the idea of linear motion was used to recapture phases of life, time and surgical disruption within each of the narratives. This helped create surgical narratives that had similar structure and flow for ease of analysis and promotion of understanding.

To gain a logical sense to the pattern of concept appearance, I again used sjuzet to arrange these for presentation. This helped to gain an understanding of the “it” factors that participants seemed to possess as they walked along their ERACS pathways. Key concepts that seemed to appear and were recognized by me are: (a) motion; (b) compliancy; (c) resilience; and (d) post-traumatic growth. In addition, a 5th concept of non-care emerged from my perspectives as researcher and acute care surgical nurse, plus from my personal experiences of working with post-operative patients. I had an empathetic reaction as the participants recounted stories that featured elements of non-care. Van Manen (2002) refers to this as ‘drawing’ forth concepts that depict the lived experience.
MOTION

Motion was a key concept featured all throughout this study. The participants strived to stay in constant forward motion as evident in their references to action terms, like walking, moving, navigating, falling off and getting back on track. A sense of sequential flow that emerged from the narratives was at times interrupted by surgical complications that created temporary set, or steps, back. As soon as they were able, they resumed forward motion along the ERACS pathway. I wondered what propelled them forward in such a continuous and relentless way? It appeared motion was due to the combination of three factors; (a) medical system; (b) ERACS program; and (c) themselves.

Medical System and Motion

The medical system has its own set of stated and unstated rules with the implied social understanding that hospital admissions are for necessary and short periods of time only. Patients are admitted and treated based on gravity of illness, and once medically or surgically stable, are discharged home as quickly as possible. All hospitals keep numerical statistics, including length of stay. They have projected time frames for surgeries performed and recovery time required for each. This is no different with the ERACS program.

The ERACS guidebook clearly states the predicted length of hospital stay is four days. By stating this as a pre-determined physical block of time required for recovery, questions can be raised. Does this provide a false sense of security that recovery will occur within this four-day period? What happens if surgical complications arise and length of stay exceeds this? Does this provoke guilt, or encourage a sense of failure if they do not complete their ERACS journeys in these four days? Does it encourage them to try to prove themselves as “good” patients and push through to recovery as indicated? What do nurses think when patients fall off of the ERACS pathway due to episodic complications? Does this hinder nurses’ acceptance of this new surgical
incentive? Motion within the health care system was integrally related to time. And in particular, clock time in regards to surgical wait and recovery time frames. But first, clock time and embodied time are explained.

**Clock time.** In a study by Lovgren, Hamberg and Tishelman (2010), the authors explore “clock time and embodied time experienced by patients with inoperable lung cancer” (p.55). Although this study contains patients with operable colorectal cancer, much was similar in regards to the concepts of clock and embodied time. The health care entity runs on clock time that differs from embodied time of individuals. Although some argue time “cannot be seen, felt, heard, tasted, or smelled”, most interpret it as a “linear and sequential” symbolic force (p. 56). Clock time is viewed as a socially constructed notion that can be physically measured by the likes of changing seasons, tides, calendars, and clocks. Clock time has become a concept of physical measurement.

Clock time is used within hospitals and can control its services and practices. It can be used to measure tasks regarding “hand and brain work” (Lovgren et al., 2010, p. 57). Does clock time become an enforcement agent used by health care systems to control the work and staff within? Is clock time used as a determinant in resource allocation? Health care systems have predetermined length of stays and predicted recovery times for each treatment and procedure performed. But, what happens when a patient needs more clock time for recovery? Does the health care system wonder why and require objective reasons as to why? From my own nursing experience, I have spent clock time explaining why my patients need more time in the hospital. The human body is not a predictable entity, and not all will respond the same to surgery. There are many factors for this, such as age, medical and surgical histories, and social and economic status. The ERACS program has a predicted length of surgical stay of four-days, but this will not always become a reality for some. When we introduce evidence-based practices, along with its’ integrated care
pathways, we must remain cognizant that patients are individuals. We must remain flexible in care and assessments of our patients, being mindful to not assess or judge in strict relation to medical programs, such as ERACS.

**Embodied time.** Embodied time cannot be measured because it embraces experiences of time that have relational and context dependency (Lovgren et al., 2010). Embodied time has a psychosocial nature and contains the “heart work” of health care professionals (Lovgren et al.). In health care systems, when clock time takes precedence over embodied time, it can have negative impact on both nursing care and patient experience of care. Moen et al. (2006) reported findings regarding embodied time and wait to surgery in the context of a benign or malignant diagnosis. If benign, less anxiety was experienced during the wait for surgery; but if malignant, more worries, anxiety, and doom were present.

The impact of surgical wait (clock time) on embodied time was present in the current study, but in opposition to Moene et al.’s (2006) findings. For the participants with cancer (malignancy) their surgical dates came very quickly, within 2-6 weeks of diagnosis, and this may have helped with decreasing levels of anxiety as they were ready to get on with the show. Some did worry about what their futures would hold, and feared cancer spread and need for adjuvant therapies. Their waits for pathology reports caused increased anxiety. For the participant with diverticulitis (benign), surgical wait had a negative impact on his embodied time, as he experienced increased feelings of anxiety and loss of control. Thus, clock time can have positive or negative impact to embodied time, or the experiences of time in context to situation.

**Clock time and waitlists.** Health care systems struggle with ever-decreasing resources (Fogarty & Cronin, 2007). Health care waitlists become a consequence of this, and reflect a discrepancy between the supply and demand for health care services. Patients diagnosed with cancer have been found to have a heightened sense of time, and if long waits occur for admission
or diagnostic tests, this can negatively impact their embodied time (Lovgren et al., 2010). During waits, increased feelings of uncertainty, perceptions of non-care or the need to act on behalf of self may be experienced (Lovgren et al.). Patients desired time perspectives and notifications of any delay to decrease stress, anxiety and uncertainty (Lovgren et al.).

In the current study, participants all experienced different wait times for their surgery, and cancer surgery took precedence. Those with colorectal cancer waited two to six weeks, with one participant having a non-cancerous diagnosis experiencing an eight-month delay in surgery. This was despite being placed on the “urgent” waitlist. He did not have cancer, and therefore, clock time extended and his sense of motion halted as he waited for his surgical turn. Clock time continued to forge ahead, and this participant began to experience high levels of stress and concern as his physical symptoms exacerbated during this time period.

One wonders if this extended wait negatively impacted his surgical experience? Fogarty and Cronin (2007) suggest that shorter wait times correlated with higher levels of satisfaction with care received. For those with long wait times, increased anger, uncertainty, powerlessness, psychological distress, physical symptoms, and poorer outcomes were reported. This does support the idea that clock time has a direct impact on embodied time and surgical experiences when waits occur. The health care system not only encouraged motion and tracked clock time, the ERACS program did as well.

**ERACS Program and Motion**

The ERACS program required participants to move early and quickly after surgery. Mobilization is important to reduce post-operative complications, but it becomes accelerated for patients in an enhanced recovery program (Wilmore & Kehlet, 2001). The ERACS program has an aggressive post-operative rehabilitation period with strong emphasis on early mobilization that begins on actual surgical day. This not only helps prevent complications, but aids in the return of
normal baseline activity and function. The ERACS guidebook directed activity in a steady and progressive manner over a four-day recovery period. The guidebook suggested the appropriate amount of clock time to be spent out of bed each day, and this continued to increase over the surgical stay. In regards to motion and clock time with ERACS, many quantitative studies on enhanced recovery monitor length of surgical stay, citing a decreased length of stay as a benefit of the program (Chalabi et al., 2010; Scatizzi et al., 2010; Zargar-Shostari et al., 2008). Both the program’s activity and predicted recovery period becomes measured in clock time.

Some participants experienced guilt if activity levels could not be maintained for various reasons, such as pain, nausea or dizziness when standing. They wanted to remain in motion not only for program goals, but also for themselves.

**Themselves and Motion**

The participants themselves wanted to move forward to meet their ultimate goal of going home. For this same reason, they may have used the ERACS guidebook to their own advantage since they sought quick recovery times and early discharge dates. They realized that if motion stalled, their discharges home would be postponed. When they encountered episodic surgical disruptions, such as bowel ileuses, they became frustrated as goals became delayed. Their own physical “bodies” caused disruption when they did not respond to surgery as per the predicted and outlined recovery process in the ERACS guidebook. The discrepancies in recovery evoked guilt and steered the participants off the ERACS pathway. They could no longer use the guidebook to gauge their recovery progress or predict discharge dates. They did monitor clock time by way of the ERACS guidebook as they were cognizant of what post-operative day they were on and what goals needed to be met. They knew when they exceeded the four-day period and were frustrated with the complications that caused extensions, such as diarrhea or fever.
Once back on track, they felt a sense of relief. When discharge day came, they all knew it was time to go, stating they felt mentally and physically ready able to go home.

Within this study, I do not think motion can be considered a neutral term as it appears to possess power and control. Motion and clock time appeared to become enforcing agents that dictated the length of surgical wait, stay and recovery times required as per medical direction. Once inside the hospital, if motion stalled along the predicted clock time of surgical trajectory, negative impact was felt to embodied time. This was expressed as increased guilt and sense of ownership for same, leading to consequences of delayed discharges.

In addition, did clock time possess power and control over the practices of medical and nursing staff? Did “hand and brain work” (associated with clock time) take precedence over “heart” work (linked with embodied time), (Lovgren et al., 2010)? And to this, I would answer yes. Not only does clock time run hospitals, but it becomes a constant presence and pressure in a nurse’s day as technical and psychosocial care is delivered. There is only so much clock time in a shift to provide all of the care needs to patients with technical care taking precedence. Despite the power and control of clock time, the participants engaged in participation and compliancy during their surgical journeys.

**COMPLIANCE**

As the participants set out on their surgical journeys, they appeared to give consent to both the surgical intervention and ERACS program. They accepted terms of the surgical intervention as they became a patient, plus they knew the expectations of the ERACS program as laid out in the guidebook. For those with colorectal cancer, surgery could aid in their cancer management and ultimate life survivorship. Was their motivation a chance for cure?

The once historical threat of colorectal cancer is being “transformed from a deadly disease to an illness that is increasingly curable” (Denlinger & Barsevick, 2009, p. 883). In addition,
many patients do not want to accept paternalistic relationships with their health care teams, and are actively participating in their own health care decisions, needs and care. They want to “own” their own disease and illness stories (Frank, 1995). Did the participants take advantage of the preparation and education that the ERACS program and guidebook supplied? Did the ERACS program foster both a sense of compliance and control over their recoveries and stories? Can it not be considered an agent of control for both health care and patient?

To illustrate the concept of compliance, it helps to understand it within the entire peri-operative period. Pre-operatively, compliance began during the surgical consultations. The surgeon gained consent from each participant to undergo surgery within the context of the ERACS program. At this time, participants were given the ERACS guidebook and asked to review, educate and prepare themselves for upcoming surgeries. With proper preparation, “a well-informed patient copes better during the care period... feels less anxiety and pain... [and has] a quicker recovery and shorter stay at hospital (Aasa et al., 2013, p. 2). Participants and their family members complied with the pre-operative preparation, and they often knew the program better than the health care professionals who cared for them.

In a qualitative study by Taylor, Richardson and Cowley (2010), restoration of embodied control was important in the recovery of patients who underwent traditional colorectal cancer surgery. The authors stated their patients became disembodied with diagnoses and surgical intervention. With a high loss of control, they gave their bodies over to the health care team and became patients. Restored embodiment for them occurred after discharge, only when they were finally able to reflect upon their new health, bodies and experiences.

This was similar, yet different, for the participants in this current study. Although they handed their bodies over to the health care experts, it was for an abbreviated period of time. It was only during the intra-operative period that they fully relinquished their physical bodies and
control. During the pre- and post-operative phases, the ERACS program helped them to maintain a higher sense of control due to proper preparation, education and engaged responsibility. Their ERACS guidebooks were readily at hand, and this enabled participants to be controlled and take control of their recovery processes.

Post-operatively, compliance continued as participants attempted to stay on the ERACS pathway. They used the ERACS guidebooks as a measurement tool, comparing the expected to their own realities of recovery. They felt guilty if and when discrepancies occurred. They clearly understood their participation in their recovery processes. Norlyk and Harder’s (2009) participants also understood the expectations placed on them by the health care system and by themselves, with the authors calling this “responsible participation”. They contended that the ERAS program created a “high degree of personal responsibility and a low degree of influence” (p. 174). In Aasa et al.’s study (2013), the theme of “participation” was too described as their participants became active before, during and after admission. To keep on track, there were program checklists at their bedsides to complete. Patients on enhanced recovery programs are expected and want to comply, but what about the members of their health care team?

The participants in the current study experienced little to no sharing of the ERACS program and its’ responsibilities with the nursing staff. The participants spoke of carrying the majority of the program’s weight as they navigated its’ path alone. They stated nurses did not even mention the ERACS program, nor did they review the ERACS guidebook or daily goals with them. As a surgical nurse, the relative absence of nursing staff in the participants’ recovery process is very difficult to explain and understand. This also occurred in Aasa et al.’s (2013) study as their participants felt their hospital nurses were disengaged with the program, often not overseeing it or the daily activities required.
The ERACS program was recently introduced and required change to our traditional practice. Many questions are raised regarding ERACS and nursing staff, and this relationship would be a good field to explore in upcoming research studies. At present, I do not have any answers to the questions I ask in this regard. Were the nurses skeptical about the new program and uncertain of their roles in this shared model of recovery? Or perhaps they stepped back as they expected the patients to take over active management and navigation of the ERACS paths. Did nurses lack of involvement impact embodied time and experience of the participants? Did this positively lead the participants to an increased sense of resiliency?

**RESILIENCE**

Resilience is defined as “the capacity and dynamic process of adaptively overcoming stress and adversity while maintaining normal psychological and physical functioning” (Wu et al., 2013, p. 1). The participants encountered challenge and change, yet remained resilient. It could be suggested that the participants had the capacity and ability to manage the phases of disruptions that altered their current sense of life and self, while positively and constantly remaining in motion. With disruption, the “person” cannot help but become permanently affected and altered due to the influences and experiences that come with it.

Despite diagnosis and its associated disruptions, the participants found their bearings and continued to move forward to both physical and emotional health and wellbeing. They did not become entangled in the chaos of disruption, or stall on any self-woes. They seemed to possess both physical and psychosocial resilience that may have been present prior to, and enhanced by their ERACS experience.

**Physical Resilience**

The participants were physically capable of handling the ERACS program with the strength to endure both major surgery and the aggressive four-day recovery period. Most spoke of healthy,
active lifestyles prior to their diagnoses, so felt physically strong as they entered into hospital. After surgery, they experienced many negative symptoms, such as pain, nausea, vomiting, diarrhea, and dizziness, but they still plodded forward according to the ERACS guidebook. They desired quick recoveries and discharges home, so they continuously pushed their bodies forward by attempting compliance with the ERACS program. In addition to physical resilience, they appeared to possess psychosocial resilience that further managed the disruptions and suffering encountered.

**Psychosocial Resilience**

Psychosocial resilience was found in participants’ strong sense of self, hardiness, social support and benefit finding (Stewart & Yuen, 2011). For clarity, reference to active coping, suffering and vulnerability is made in addition to the four characteristics found within this definition. Most participants stated they wanted to “get on with the show” and proceed with surgery as soon as possible. This showed “active coping” since they “accepted the issue at hand and actively attempted to deal with it through problem solving, planning and seeking emotional support” (Coughlin, 2008, p. 61). Despite shock, they understood the diagnosis, accepted the surgical intervention, and engaged and prepared themselves for surgery. Not one participant demonstrated “avoidant coping”, or mental and physical avoidance (Coughlin, 2008). They appeared to be actively in motion in the management of their personal life disruptions.

**Sense of self.** The participants had a strong sense of self and knew what they were mentally and physically capable of. No one stated they were overwhelmed by the ERACS program, guidebook or expectations of it. They appeared to manage stress and suffering that came with their diagnoses and surgical interventions.

Cancer abruptly disrupted their lives and challenged their futures that were now uncertain. For some, their own mortality was brought into view. The lives of their families and friends were
also impacted since cancer has a rippling affect to many more than just the afflicted (Rowland & Baker, 2005). An impression of diagnostic suffering came forth with a sense of vulnerability. This notion was present in Norlyk and Harder’s (2013) study with the first theme called “facing vulnerability”. Their participants also described many negative emotions including fear, anxiety and vulnerability, as they too faced the threat of cancer. These negative emotions, such as shock and disbelief, are normal reactions to new cancer diagnoses (Miller & Massie, 2006).

The current study’s participants encountered negative emotions as many were “shocked” with their news of cancer. They were not expecting to hear this because they felt healthy without having major symptom(s) that caused alarm. Jim and Jacobsen (2008) relayed that “individuals who believe they are cautious and good people may have a difficult time understanding why cancer happened to them” (p. 414). By simply hearing the word cancer, they endured suffering. This became a chaotic time when immediate answers were not possible and futures now insecure. Because of resilience and a strong sense of self, they adequately managed diagnostic suffering and accepted its required surgery.

**Hardiness.** The participants had hardiness, being defined as “specific set of attitudes toward challenge, commitment and control that relate to the stress response” (Stewart & Yuen, 2011, p. 205). A hardy individual has a strong sense of physiological, psychological and spiritual wellbeing. Steptoe, Dockray and Wardle (2009) relayed “positive psychological well-being is associated with reduced risk of physical illness and prolonged survival” (p. 1747). Some participants stated they felt very lucky that their cancer was caught early. They accepted and adapted to the phases of disruption and they did not appear at this point to “engage in battle with cancer” as social metaphors have portrayed (Canadian Cancer Society, 2013). The participants wanted to move towards a new life and self. They wanted to start living again.
Hardiness has been associated with “compliance of treatment, satisfaction and size of social support network, and mixed-focused coping strategies” (Stewart & Yuen, 2011, p. 205,). As stated, the participants showed compliance as they accepted terms of the medical system and ERACS program. They showed strong social support networks with family, friends and church groups. Many had partners who studied the ERACS program alongside them. This was to prepare and educate themselves in order to help their loved ones during hospital admission and recovery.

**Social support.** All participants expanded their social networks as they bonded with other patients within their hospital rooms. For them, not only did they share physical space, but also personal, medical and surgical information and experiences that helped form strong, reciprocal emotional relationships. They shared their own vulnerabilities, and were open and honest when sharing with others. A united patient front was created as they supported, encouraged and protected each other. The whole became greater than the sum of its parts as they came together as a unit, moving through their unique surgical journeys and recoveries.

**Benefit finding.** The participants found benefit despite their obvious losses. Stewart and Yuen (2011) relayed that benefit-finders were “better adjusted, had lower morbidity over time and better spiritual and mental well-being” (p. 205). Benefit-finding occurs when people “reinterpret trauma as an opportunity for personal growth” (Jim & Jacobsen, p. 414). Participants found benefit despite losses, that included strengthened family bonds, enhanced social supports, newfound compassion and empathy for others, plus acceptance of life and death issues.

Through both physical and psychosocial resilience, the participants successfully managed disruptions and suffering that were encountered along the ERACS path. Despite understanding and accepting the negative aspects of their journeys, the focus became positive facets that were realized due to post-traumatic growth.
POST-TRAUMATIC GROWTH

The participants experienced life disruption when diagnosed with colorectal diseases, above all cancer. Many would assume that this type of disruption would bring only negative effects, yet literature counters this with positive outcomes, such as benefit-finding and post-traumatic growth (Mols, Vingerhoets, Willem, Coebergh & van de Poll-Franse, 2009). Jim and Jacobsen (2008) state that post-traumatic stress occurs when trauma-related information cannot be integrated with the core belief system. It occurs when intrusive thoughts and avoidance become chronic, and integration into the core belief system does not happen.

On the positive side is post-traumatic growth, defined as “positive psychological changes that are experienced due to challenging life circumstances” (Jim & Jacobsen, 2008, p. 414). They say integration occurs if and when opportunity for personal growth is realized, and loss due to trauma is understood and accepted. But loss does not become the focus. Positive adaptation and ability to thrive becomes possible (Coughlin, 2007).

Post-traumatic growth has been shown in the enhancement of social resources, personal resources and coping skills (Jim & Jacobsen, 2008). Enhanced social supports lead to improved relationships with family and friends (Jim & Jacobsen). This occurred for the participants who strengthened their family bonds through supportive and renewed relationships. They cared for and shared with the others in the hospital rooms that further increased their social support networks.

Increased personal resources can cause improved outlook on life with greater compassion, sympathy and concern for others (Jim & Jacobsen, 2008). This was apparent as some participants said they found compassion and empathy for family and other patients who had endured, or were enduring, similar experiences. Some even had more concern for family over themselves, and questioned what would their family do without them? For one participant, his cancer diagnosis
disrupted his overall family life plan. He cared for his wife, who was considered the unhealthy one, with many medical issues. She was supposed to die first as who would care for her? What would she do without her husband?

Increased coping skills included acceptance of circumstances and taking things as they came (Jim & Jacobsen, 2008). Despite shocking diagnoses, the participants did not dwell on the “why me’s”. They moved into positive action and began to prepare for surgery. Thus, benefit-finding encouraged post-traumatic growth through increasing social supports, personal resources and coping skills.

In regards to enhanced relationships, they did not mention this occurring with any nurses. Because of this, the concept of care was exposed, and the question of “why was there an essence of non-care in the surgical narratives?” asked. This came from my own perspective as researcher and nurse, and this final concept of care will be discussed.

CARE

The participants were mixed in their perceptions of care they received. Two of them were highly vocal in regards to negative care received, while the remaining five commented on good care given by the nurses. But, even those satisfied with their care unknowingly described lapses in nursing care they had received. As a health care professional, I heard elements of non-care in some aspects of their stories. For most participants, this was their first surgical experience, so without any previous experience as a basis for comparison, they may have had few or differing expectations.

In Patistea and Siamanta’s (1999) literature review regarding the perception of care, nurse clinicians focused on psychosocial aspects of care, while the patients focused on technical care. They looked at studies dating back to 1972, and these showed patients favored technical care that included: physical care of body, minimizing side effects, competent clinical expertise, advanced
technical skills and knowledge, monitor and follow through, plus explaining and facilitating. The idea of technical care versus psychosocial care may explain the difference in expectations of care between the nurses and patients within the current study.

The study on the perception of care with patients favoring technical aspects (Pastistea & Siamanta, 1999) was echoed in the ERACS program. All but one participant desired technical care of their bodies to decrease the surgical stress and system dysfunction for which the program was designed. The guidebook reinforced these technical aspects by discussing the use of medical drains, tubes and tests. It does not highlight any aspects of psychosocial care.

Does the ERACS program support technical aspects of care and encourage aspects of psychosocial care to be placed at the bottom of a task list? Does the ERACS focus on the physical body and normalizing its’ function take precedence? The concept of clock versus embodied time is now brought back in. As a surgical nurse, I was a “clock watcher” as I struggled during my shift to complete an objective task list that never seemed to become shorter, only longer and longer. This led to the technical aspect of care overriding the psychosocial aspect of care since I needed to get the tasks done. In acute care, I brought the physical body forward as priority. Did this cause a negative impact on my patients’ sense of embodied time? Lovgren et al. (2010) proposed that if greater attention was granted to the psychosocial needs, it would have a positive impact on the “patients’ experiences of time and uncertainty” (p. 56).

In Lovgren et al.’s (2010) study, patients recognized the lack of clock time that doctors and nurses had in general, plus with them as patients. They stated the health care professionals had “too little clock time… for the amount of work to be accomplished” (p. 58). Negative comments were made on feeling they were viewed as medical cases, not as people cases. They felt they had too little time available with the physicians in hospital, and that nurses worked under pressure and prioritized objective tasks. They expressed desire for the relational aspect of embodied time,
when a nurse was simply available to sit and talk. It appeared clock time took precedence over embodied time, and patients were aware of this time hierarchy.

Could the apparent lack of psychosocial care be a result of compassion fatigue, or “stress resulting from helping, or wanting to help, a traumatized or suffering person” (Figley, 1995, cited in Sabo, 2011)? Compassion fatigue can occur due to high-stress environments that include high nurse to patient ratios, little to no administrative and peer support, and demands to provide the same high quality of care when working with fewer resources” (Kret, 2011, p. 35). Although literature indicates nurses favor psychosocial care, do medical systems and hospital environments hinder this and encourage compassion fatigue? Why is psychosocial care not more obvious within the surgical narratives? Are the nurses working with less, but still expected to do more? Does the ERACS program demand clock time and place yet another element on the nursing task list?

The medical system promotes a separation of mind and body. Taylor et al. (2009) discusses the disassociation with the physical body that occurred when their participants faced colorectal cancer and underwent surgery for it. In their study, they found both the bowel and body became objectified, and the patients experienced a sense of disembodiment. This was potentiated within the hospital as they handed their bodies over for invasive tests, surgeries, examinations, and health care experts who often made medical decisions for them. This gave them a feeling of a “low level of involvement” (p. 951). Further distress was caused by unpredictable bodily functions, such as post-operative bowel incontinence. Despite disembodiment becoming a coping mechanism for invasive insults needed to treat colorectal cancer, the “normal body relationship has been upset... [the body has] become fragmented, deconstructed and disowned” (p. 952).

Disembodiment occurred with the participants in the current study as well. Although they may not have used this exact term, they spoke of the shock of diagnosis, of handing their bodies
over to the experts, of receiving technical care, objective monitoring and embarrassing situations of unpredictable bodily functions after surgery. Even with increased disembodiment that can occur in hospital, the majority of participants did not suggest that they had lack of care. What balanced the scales between technical and psychosocial aspects of care for them?

All participants relayed stories of sharing and caring with others in their hospital rooms. In a study by Berg, Skott and Danielson (2006), patient-patient interactions were explored, and two themes emerged of (a) caring for fellow patients, and (b) sharing with fellow patients. These were strongly evident within all surgical narratives of patients within the current study. Did the sharing and caring between the patients meet their psychosocial needs and compensate for its’ lack by nurses? Did participants experience holistic care by having both nurses and patients present during their recoveries? And, could this be why more complaints of non-care did not emerge?

Non-care has been described as “physical and emotional absence, belittling and inhumane actions and lack of recognition of a patient’s uniqueness” (Patistea & Siamanta, 1999, p. 302). The non-care that I recognized within the surgical narratives involved a physical and emotional absence. The nurses were absent in the ERACS program as they failed to discuss the program, review the guidebook, or set daily goals with the participants. By not acknowledging the program, the nurses appeared to be disengaged and unsupportive of it. This was also present in the study by Aasa et al. (2013). Nurses are an integral part of the ERACS multi-disciplinary team, as they are needed to not only help manage the program, but also the care needs of the patients. ERACS is a new surgical program that requires time for change, and ongoing education for the acceptance and understanding of the new nursing practices, roles and responsibilities that it brings.

In summary, the participants were able to manage life, time and surgical disruptions, along with themes and sub-themes that were experienced. The concept of motion and time emerged as
participants started down and completed their paths. They constantly propelled forward under the influences of the health care system, ERACS program and themselves. They desired recovery for discharge home to restore their embodied life. Other concepts that came forth were compliance, resilience, and post-traumatic growth, along with non-care from my own nursing perspectives. This study has provided a general understanding of the ERACS experience, but is immersed with my personal interpretation of it. With any research study, there are always areas for improvement and future growth. Through reflection, these areas are identified and discussed in the upcoming sections of Limitations and Recommendations.

**LIMITATIONS**

Research studies can be commended for what is uncovered, and criticized for what has not been said or done. The study limitations were apparent from the inception, plus enhanced by the fact that I am both novice researcher and graduate student. I have never done such a project, and I found the process challenging as I simultaneously learnt about, and worked, as a researcher. With qualitative research, there are no concrete rules to follow. As a researcher in this domain, I had to become flexible, creative and patience as the process of meaning unfolded (Mayan, 2009). Although I had preliminary ideas of how this study would unfold, its’ anticipated route changed many times before conclusion. As I reflect back on this study, the limitations that were identified included; study question, research methodology, inclusion and exclusion criteria that determined sample size, and interview process.

**Reflections on Study Question**

My research focused on the question “what do patients with colorectal cancer experience as they travel through an ERACS program”. I realized I wore many hats in this study, with tensions obvious between the two of researcher and program developer. I agree with the statement that a researcher can never be neutral (Mayan, 2009). But, did I influence the overall study more than
truly desired by being actively involved in the development and implementation of the ERACS program? Was I trying to kill two birds with one stone as both my nursing career and university work now focused on the ERACS program?

I found two major issues with the research question asked and answers sought. First, the question contained the words “with colorectal cancer” which sparked vast discussion on cancer itself. Thus, there were two featured concepts throughout this study, being cancer and enhanced recovery. Second, there are issues on actual program efficacy being sought, not just experience. What became evident was that the narratives focused on multiple concepts, being cancer and its’ diagnosis and treatments, plus the ERACS program and its’ experience. Revision to the research question was needed with the removal of the concept of colorectal cancer. The research question used had significant implications in my approach to the research methodology.

Reflections on Research Methodology

As a nurse and learner, I favored stories as teaching tools as their learning lessons often move me, causing an empathetic reaction. Also, I feel comfortable in my abilities to tell stories about myself and of others. Narrative inquiry was a natural, obvious fit for me, and thus chosen as the research methodology for this study. Despite an initial fit, it might not have been a perfect match for various reasons.

First, my professional involvement with the ERACS program may have strayed me off the NI methodology path into understanding the efficacy of the program. I needed to try and remain true to, and cognizant of my stated research question. The purpose was to explore participants’ lived experiences of ERACS, not the actual ERACS program.

Second, from a graduate student and novice researcher perspective, NI is a challenging methodology to select. It contains elements of science and art, and it blends relationships of the researcher, participant and data. While narrative inquiry has constituent elements and processes,
these can vary from flexible to rigid depending upon researcher. Within NI, there is acceptance
for a narrative, or journalistic style of writing that can be challenging to use within an academic
arena (Holloway & Freshwater, 2007). And as the experiences and stories of the researcher and
participant become blended, the study’s writing style becomes stories layered within stories that
accommodate a narrative writing style.

Third, NI features the relationship between researcher, participant and data, and is a very
personal interpretive process. In addition to this, another relationship was present that stemmed
from the academic world and thesis committee. This brought more interpretations and increased
the number of gazes that looked upon the landscapes of experiences. At times, these layers of
relationships were in tension as they proved to be challenging to incorporate all views brought
forth. This is simply to acknowledge that additional layers of relationships and interpretations
were present that helped shape the study’s findings and discussions.

Reflections on Sampling

To create surgical narratives, I had to hear the experiential stories from ERACS patients. I
recruited potential participants by using stipulated inclusion and exclusion criteria, and created a
homogeneous sample. I wanted a sample that had certain characteristics in order to appropriately
answer the research question, and allow for thick, rich description (Mayan, 2009). By creating a
criterion-based sample that included colorectal cancer, I might have denied experienced ERACS
patients from participating. They may have been able to contribute even further rich data.

Recruiting a sample size of seven, by use the existing criterion, is an appropriate sample
size in narrative inquiry. However, one of the seven participants did not have colorectal cancer,
but diverticulitis, yet his experience still vastly contributed to an understanding of ERACS. In
retrospect, using a diagnosis of colorectal cancer became a limiting factor. It would have been
beneficial to eliminate “colorectal cancer” from the research question, plus “cancer diagnosis”
from the inclusion criteria. Then a more concentrated effort on the actual experience of enhanced recovery surgery would have been achieved.

**Reflections on Interview Process**

The interview process proved to be a challenge as well, especially since I wore a novice researcher hat and possessed limited interview skills. It was stated in the methodology section that the ERACS program and guidebook constrained the interviews. This is not congruent with narrative inquiry, and is acknowledged. However, the first participant and his interview set the stage for all remaining interview sessions. He was a man of very little words and he stated this fact about himself. He answered questions as succinctly as possible with little to no elaboration. I constantly found myself probing for more information with use of multiple questions, speaking and interruptions. This is not to place blame on this participant, but myself as novice researcher and interviewer.

Instead of struggling through the remaining interviews, I created and used a structured storied interview guide to move all participants through their ERACS experiences. In addition, questions regarding the actual ERACS program were asked, including what did you like best about the ERACS program? And least? Did I blur the lines since I asked questions about experience and program? I wonder what the remaining participants may have said if given a chance to express their experiences in an uninterrupted, free-flow manner. What if I had not placed assumptions on them that stemmed from the first interview?

Despite the limitations that I have recognized, I feel this study has provided an overall understanding of the lived ERACS experience. I was able to gain greater understanding and empathy for what these seven participants experienced on their ERACS journeys. Yet, there is always room to improve and continue forth with such a research study, and I hope inquiry into this area continues. Implications are now reviewed.
IMPLICATIONS

From this qualitative study, much has been learned, but much more is available to capture with both ERAS and ERACS programs. However, this study does continue to contribute to the limited knowledge database that exists regarding lived experiences with enhanced recovery. But, if this is the tip of the knowledge iceberg, where do we go from here?

Implications for Research

As there is little qualitative research available on enhanced recovery experiences, the study built on Norlyk and Harder’s (2009) and Aasa et al.’s (2013) findings. Although sounding cliché, further research is necessary within this area because we need to continue to “make the taken-for-granted world visible” (Mayan, 2009, p. 9). As medical and nursing professionals, do we assume that this is a beneficial program simply because the objective data tells us so? We cannot forget the patients who are placed upon it, and what they experience as a direct result of it. By hearing the lived stories of these patients, we can learn much. This will help expand and strengthen our medical and nursing knowledge, practice and care worlds.

Within this study, limitations were caused by the stipulated inclusion and exclusion criteria that restricted the recruitment process. By broadening the criteria to include all colorectal disease conditions, more ERACS patients could have been invited to participate. With focus on the lived ERACS experience, a larger homogeneous sample could have been recruited, leading to deeper, richer data and understanding on this subject.

Recommendations for future studies include direct focus on the lived ERACS experience, with fewer inclusion criteria stipulated. Research studies that compare and contrast the different surgical approaches of open versus laparoscopic experiences of ERACS would be beneficial as this study invited only those with open procedures. In addition, research studies with different sampling populations (heterogeneous), from nursing to other health care disciplines, plus patients.
from pre-operative through post-operative and discharge stances would be of interest and benefit. Of note, saturation is not sought within narrative inquiry, because each story that is listened to and subsequently analyzed is unique (Holloway & Freshwater, 2007).

**Implications for Practice**

For health care professions, such as nursing, evidence-based practice (EBP) has become the standard of care in order to decrease discrepancies in care (Gurzick & Kesten, 2009). EBP reduces variations in care where evidence for improvement already exists, providing the best data to support best practice that can lead to improved patient outcomes (p. 42). This is reflective of an ERAS program, as it takes evidence-based data with an attempt to minimize surgical disruption to enhance recovery. It takes a proactive approach, trying to decrease known complications and unwanted side effects of major surgery (Wilmore & Kehlet, 2002).

The ERACS program can be classified as an integrated care pathway, as outlined by the ERACS guidebook. Integrated care pathways are defined as “task orientated care plans which detail essential steps in the care of patients with a specific clinical problem and describes the patients’ expected clinical course” (Campbell, Hotchkiss, Bradshaw & Porteous, 1998, p. 133). They are used to “promote evidence-based practice to benefit health care quality and reduce costs” (Gurzick & Kesten, 2009, p. 43). Problems identified with these are: (a) knowledge translation from research into clinical practice; (b) resistance to practice changes in clinical setting; and (c) the appearance of “cookie cutter” medicine without regard for individualized patient care (Gurzick & Kesten).

In the practice setting, a designated ERACS clinical nurse specialist would be of immense benefit to all aspects of the ERACS program, plus help decrease associated problems identified with an integrated care plan. The CNS role “improves patient care and staff development, links research to evidence-based clinical practices and outcomes at the patient, staff, ward and
organization levels” (LaSala, Connors, Pedro & Phipps, 2007, p. 262). The CNS could continue to move the program forward by aiding with knowledge translation and education for both staff and patients. As well, other surgical sites and services can benefit by enhanced recovery, and the CNS could aid in development of ERAS in additional areas. By employing the CNS, the ERACS program gains a familiar “face” of the program, one who is ever present to oversee all aspects of it, including development, implementation, leadership, mentorship, education, support and future research. The CNS can be an active agent of change.

**Implications for Education**

I understand ERACS is a multi-disciplinary team approach, but coming from a surgical nurse perspective, nursing will be my focus here. Nurses have a responsibility to advance not only their profession, but also their nursing knowledge and skill sets to provide the safest and best care for and to all of their patients. The medical benefits of an ERACS program, including patient education and participation in their own recovery process, are well documented (Aasa et al., 2013; Kehlet & Wilmore, 2008). Yet, this program does not negate the need for nursing presence and care as patients travel along its’ pathway. Nurses need to be aware of the need for, and acceptance of, EBP and the beneficial changes that it can bring. Nurses cannot be stagnant and continue to support the existence of sacred cows in practice that need to be retired.

Nurses have a professional obligation to engage in change, especially with EBP, to support positive nursing practices and patient outcomes. However, change is challenging especially in the context of a busy hospital environment that runs on clock time. Thus, ongoing ERACS education and mentorship is required to support all nurses during the change in practice. By increasing their education and knowledge base of ERACS, they can become more confident in both the program and their new roles. Hopefully, this can lead to improved engagement with the program and its’ goals as they care for and walk beside their patients on the ERACS pathway.
In regards to ERACS education, the pre-operative education sessions have been effective. However, information on potential surgical complications is not provided. Does this grant a false sense of security that recovery will be flawless without any bumps along the way? What does a patient experience when complications occur and the length of stay exceeds the suggested four-day period? Will patients think that this is something they caused or did wrong along the path? Will feelings of guilt and failure emerge as patients take on ownership of these complications? By being upfront about possible surgical complications, the patients can be better prepared to manage them if and when they arise. This is not to instill unnecessary fear in patients, but they do need to be informed of all surgical and recovery positives and negatives.

**CONCLUSION**

There is always more to learn in all aspects of our lives, both professionally and personally. Consciously and unconsciously, we are constantly engaging in the learning process as our worlds influence us, and we influence our worlds. As we step out of our homes, to go about our business, we never know when simple words will disrupt every sense of our lives and selves that we now currently know. What happens when someone hears the words “you have cancer and you need surgery to remove the tumor as soon as possible”. Your taken-for-granted sense of normalcy is forever disrupted. It is gone in this brief moment of time. You can no longer be that person you once knew and were. You have been changed, your life is in jeopardy and you are now at the mercy of the medical system and all the chaos that comes along with it. What will you experience as you start down this new path that has suddenly appeared before you?

This study sought to answer the research question of “what do patients with colorectal cancer experience as they travel through an ERACS program? The answer(s) to this question cannot be found in the quantitative world as it looks beyond objective numbers and towards the lived experiences of people. When searching the qualitative database, studies on the experience
of enhanced recovery surgery were sparse with only two articles of relevance being located. This encouraged the need for this study, especially as my organization recently implemented the new “enhanced recovery after colorectal surgery” program. We recognized that ERACS had medical benefit, but we did not understand a patient’s lived experience with it. And this is what I set out to uncover.

Through narrative inquiry, I listened to the stories of ERACS patients. I created formal surgical narratives that were analyzed for both their spoken words and silences. I intensely gazed upon their landscapes of experiences in order to understand what they had lived and experienced. From this, I identified three phases of disruption; labeled as life, time and surgical, and these all occurred consecutively without pause. Despite these constant disruptions, people remained in motion. This became a major concept of discussion, as did time, compliancy, resilience, and post-traumatic growth. From my surgical nursing perspective, the concept of non-care emerged as an empathetic and professional reaction to their stories was awakened. No patient should ever relay elements of non-care from invisible nursing care described. To end with a positive notion, what happened within the hospital room, as the patients shared and cared for one another, became an amazing highlight of the study and its’ findings. It showed the true and naturalistic caring spirit of one human being for another.
REFERENCES


Moene, M., Bergbom, I. & Skott, C. (2006). Patients’ existential situation prior to colorectal


APPENDICES
## APPENDIX A: ERACS Table of 25 Components

<table>
<thead>
<tr>
<th>ERACS COMPONENTS</th>
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<tbody>
<tr>
<td><strong>Pre-Operative Phase</strong></td>
</tr>
<tr>
<td>1. Patient and family education</td>
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<tr>
<td>2. Carbohydrate loading prior to surgery (Vitajoule)</td>
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<tr>
<td>3. No prolonged fasting</td>
</tr>
<tr>
<td>4. No mechanical bowel preparation (except L side)</td>
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<tr>
<td>5. Antibiotic prophylaxis</td>
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<tr>
<td>6. Venous thromboembolism prophylaxis</td>
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<tr>
<td><strong>Intra-Operative Phase</strong></td>
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<tr>
<td>7. Thoracic epidurals and minimal opioid use</td>
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<tr>
<td>8. Short acting anesthetics</td>
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<td>9. Maintenance of normothermia</td>
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<tr>
<td>10. Zero fluid balance</td>
</tr>
<tr>
<td>11. Short midline or transverse incisions</td>
</tr>
<tr>
<td>12. No nasogastric tubes if able</td>
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<tr>
<td>13. No drains if able</td>
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<tr>
<td>14. High flow oxygen for one hour in recovery room</td>
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<td>15. Sugar-free chewing gum</td>
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<td><strong>Post-Operative Phase</strong></td>
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<td>16. Early removal of thoracic epidural</td>
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<td>17. Minimal use of oral opioids</td>
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<td>18. Early nutrition with nutritional supplements</td>
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<td>19. Early removal of intravenous fluids</td>
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<td>20. Early mobilization</td>
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<td>21. Early removal of bladder catheter</td>
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<td>22. Early removal of all tubes and drains if present</td>
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<tr>
<td>23. Routine medications to prevent symptoms</td>
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<tr>
<td>24. Stimulation of gut motility</td>
</tr>
<tr>
<td>25. Audit of compliance factors and ERACS program</td>
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</table>
APPENDIX B: ERACS Pre-Operative Instruction Sheet

Enhanced Recovery After Colorectal Surgery
Pre-Operative Instructions

Patient Information

www.interiorhealth.ca

After your consultation with your surgeon, you have been selected to participate in our Enhanced Recovery After Colorectal Surgery (ERACS) program. This pathway, or road map, will enhance your surgical recovery and allow you to feel better faster in order to get back to the comforts of your own home sooner.

With this pathway, we hope to prevent complications like pain, nausea, fatigue, constipation, breathing and mobility issues that can negatively impact your recovery process. We wish you well on your surgical journey.

**Surgical Date**

**Hospital Arrival Time**

**Diet:**

• 24 hours prior to your surgery, please reduce your diet to clear fluids only.
• Clear fluids are pulp-free juices, jellies, broths, coffee or tea without dairy products, and other clear liquids. No alcohol.
• You may drink clear fluids up to 6 hours prior to your surgical time.
• Please remember to bring in your choice of sugar-free gum to chew after your surgery. Chewing sugar free gum has been shown to stimulate the gut and this will aid in faster bowel recovery after surgery.

**VITAJOULE: Carbohydrate powder supplement**

• You will be given a carbohydrate powder supplement to be taken 12 hours and 3 hours prior to your surgical time.
• Vitajoule 100gm in 500 mL (2 cups) water 12 hours pre op
• Take at __________
• Vitajoule 50gm in 250 mL (1 cup) water 3 hours pre op
• Take at __________
• It is a neutral-casting powder that you dissolve in water, then drink.
• It is imperative that you consume this drink as it will help your body manage its stress reaction to surgery which will improve your surgical recovery.
• You will be asked to come into the hospital 2 hours prior to your surgical time, so please ensure you have taken both drinks before arriving.

**Bowel care:**

• Your surgeon will decide whether or not you will need any oral and/or rectal bowel preparation for your surgery.
  □ Citro-Mag - an oral bowel prep to drink the day before surgery (instructions to be provided).
  □ Rectal fleets - a rectal bowel prep to be used the day before and morning of surgery (instructions to be provided).

**Skin and body care:**

• Please shower on the morning of your surgery, using either liquid soap or a new bar of soap.
• No colored nail polish, make-up, jewelry, body piercings or scented products to be worn (we are a scent free environment).
• Artificial nails may be left on with clear or no nail polish.
• At the hospital, you may receive further skin care instructions.

**Antibiotics:**

• Your surgeon will decide if you require any oral antibiotics the night before your surgery.
• If so, your surgeon will provide a prescription for this for you to fill and please take as directed.

**Blood clot prevention:**

• You will be given a dose of heparin undermesh your skin 1 hour before your surgery.
• You will need to wear TED stockings which are snug white stockings that aid in circulation.

**Smoking cessation:**

• If you smoke, it is in your best health interest to stop.
• If you require help with this, please contact your family doctor or access quitnow.ca (1-877-455-2233) for assistance.

**BC Healthlink**

Dial 8-1-1
Talk to a Nurse 24 hours/day, 7 days/week
Pharmacist available between 5 p.m. - 9 a.m. daily
Dietitian between 9 a.m. - 5 p.m. - Monday to Friday
www.healthlinkbc.ca
APPENDIX C: ERACS Patient and Family Guidebook

Last page removed for confidentiality purposes of ERACS committee.

Enhanced Recovery After Colorectal Surgery (ERACS)
Patient and Family Information
Enhanced Recovery After Colorectal Surgery (ERACS) Program

In the 1990s, Dr. Henrik Kehlet (a Danish doctor) and his surgical team developed the enhanced recovery after surgery pathway. Over the years, this surgical program has provided thousands of people with a smooth and quick recovery after their major bowel operation. It has been adopted by many surgical teams, in many continents and countries, and we are proud to bring it to our very own patients here at the Kelowna General Hospital.

Our ERACS program is adopted from Dr. Kehlet’s original work, and aims to accelerate your recovery by using his proven surgical methods before, during and after your operation. This program has many components, but four main ones are: (1) carbohydrate loading prior to surgery (please drink your Vitajoule® as directed!), (2) good pain control, (3) early mobilization and (4) early eating.

We hope you do well on our surgical pathway, and we wish you a speedy recovery!

Preparing for your surgery

We want to help you get ready for surgery - the more prepared you are, the smoother and faster your recovery will be.

After your consultation with the colorectal surgeon, the doctor will notify the Surgical Booking Office of your upcoming surgery. A surgical booking clerk will call you with your pre-surgical screening (PSS) appointment date and time, plus your surgical date.

On the day before your surgery, you must contact the Surgical Booking Office at 250-862-4481 between 11am - 12 noon to receive your hospital arrival time. If they do not hear from you, there runs a risk of surgical delay or cancellation.

Please ensure we have a correct local, home or cellular number that we can reach you on for any changes that occur to your surgical plan.

The Pre-Surgical Screening department will try to see you at least a week prior to your scheduled surgical date, depending upon their available appointments. At this appointment, you will have any required pre-operative tests done, like EKG’s, x-rays, lab work, etc. An anesthesiologist will speak with you to discuss your past medical and surgical history and develop anaesthetic and pain control plans for you. They will discuss the potential use of an epidural catheter to manage your post-operative pain needs.

A nurse will interview you to document your health history, answer any questions you may have and provide you with home instructions to do before your surgery. At this time please discuss your discharge plans with the nurse, such as who will pick you up from the hospital to who will be your main support once home.
It is important that we know what current medications you are taking, so please bring all of your medications to this appointment. We need to have a current list of the medications you are on for what reason, and how much you take of each in a day. The nurse will document this on your file, helping us to ensure that you are on the right medications after your surgery.

**Coming to the Hospital**

Our doctors and health care team are dedicated to ensure that you have the best possible care during your stay with us. This handout provides you and your family with a general outline of what to expect during your stay. By providing you with this information, and by knowing what to expect, we hope you are better prepared for your surgery and recovery. This will help decrease your anxiety and allow you to fully participate in your personal recovery.

The information is presented in the form of a “pathway”, or road map that outlines the expected steps in recovering from colorectal surgery. We understand that each person is individual in their/her recovery, so your own progress along the pathway will be assessed daily. This will indicate whether or not any changes need to be made to your personal care plan and/or anticipated discharge date. If you and your family have any questions or concerns, please ask a member of your health care team.

When you come in for your surgery, please pack only the basic necessities and toiletries to keep yourself comfortable during your stay. The hospital does not have room to store big suitcases or large amounts of personal belongings. Do not bring any valuables or more than $20.00 cash, and if you wish to rent a TV / telephone, you can do so with a credit card or cheque. **Kelowna General Hospital will NOT assume responsibility for any items that are lost or stolen.**

You will need to bring your health care card, extended benefits card and red hospital card if you have one.

Please report and register at the admitting desk (located in the main lobby) on the day of your surgery. You may request a private or semi-private room that comes with an additional cost (often covered by your extended benefit plan). These rooms are dependent upon bed availability. You will then be escorted to 2W and brought to the surgical waiting room. Then, an admitting nurse will call for you and help you prepare for your surgery.

Surgery may be postponed at any given time depending upon emergencies, bed availability and your current health. You must let us know in advance of any changes to your overall health status. If any changes occur (like the flu, cold, chest congestion, diarrhea, etc.) please call PSS at 250-862-4285 Monday to Friday 8 am—4 pm to discuss. We make every effort to NOT delay surgeries, however this can unfortunately occur. You will be kept informed as to what is happening with your surgery should a delay occur.

**Post-Operative Care**

With our ERACS pathway, **the anticipated number of days in the hospital is 4**. You will be on 3East – our general surgical floor during your surgical stay, and the direct phone number to this floor is 250-862-4424.
The ERACS pathway is specifically designed to prevent the problems that make you feel lousy after your operation. These include things such as pain, nausea, fatigue and constipation. By preventing these symptoms, you will have a smoother recovery, allowing you to feel more like yourself sooner. This will give you the strength and confidence needed to return to the comforts of your own home sooner. At home, you will continue in your recovery process.

The Postoperative Wellness Model was developed by Jocelyn Reimer-Kent, RN MN (1995) and shows you a visual of what the ERACS pathway attempts to prevent.

**Some members of your health care team**

**Surgeon:** The doctor who performs your surgery and directs your care after the surgery.

**Anesthesiologist:** The doctor who will insert your epidural catheter, put you to sleep for your surgery and ensure your pain is controlled after your surgery.

**Patient Care Coordinator (PCC):** A registered nurse who oversees the surgical unit and helps guide your surgical stay.

**Registered Nurses (RN) and Licensed Practical Nurses (LPN):** Nurses who provide direct nursing care to you as you recover from your surgery.

**Entero-stomal (ET) Nurse:** A registered nurse who has specialized training in stoma, wound and incontinence care. She will see you if you have an ileostomy or colostomy, and help manage wound care issues. If needed, she will teach you to care for your new stoma and help order the supplies you will need at home.

**Pharmacists:** They will help ensure that you are getting safe and effective medications while you are in the hospital.

**Physiotherapist:** They will help you with your deep breathing, coughing, and leg exercises plus walking after surgery. They can help you with any equipment needs that you may have for discharge, such as a walker.

**Dietitians:** They will help ensure that you are eating a normal diet as soon as possible after surgery, and help you with any diet concerns that you may have.

**Transition Liaisons:** Registered nurses who are trained to help with complex discharge needs if any should arise.

**Unit Clerks:** They work in the nursing station and help with the general function of the surgical floor, from entering doctors orders to answering telephone calls.
The Pathway Home – Highlights

The next few pages outline what you and your family can expect during the first 4 days after surgery.

<table>
<thead>
<tr>
<th>What I can expect</th>
<th>Day 0 (Day of Surgery)</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
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<tbody>
<tr>
<td>Use a Pain Rating Scale</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
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<tr>
<td>WORST POSSIBLE PAIN</td>
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<td>NO PAIN</td>
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To help describe the pain you are experiencing you will be asked to pick a number between 0 = No Pain and 10 = Worst Possible Pain.

Pain medications are delivered a variety of ways:

- By epidural catheter (tube) that is inserted into your back by an anesthesiologist before your surgery.
- By intravenous (IV).
- By rectum if your doctor decides that suppositories are appropriate and safe to use with your surgery.
- By mouth.

Epidural catheter removed when you are tolerating your oral intake.
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<th>What I can expect</th>
<th>Day 0 (Day of Surgery)</th>
<th>Day 1</th>
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<tbody>
<tr>
<td>Pain medication around-the-clock to help prevent pain—regardless of your pain rating</td>
<td>Acetaminophen (Tylenol®), if no liver concerns or allergy to, Anti-inflammatory drug, if no kidney concerns, stomach ulcers or allergy to</td>
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<td>Pain medication as needed to treat pain that is more than mild</td>
<td>You may have extra pain medication if you have pain that is more than mild (3 plus on the pain rating scale). Ask your nurse if you require additional pain medication.</td>
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<td>Eating and drinking</td>
<td>Chewing gum (sugar free), Full fluid diet (soups, puddings, milk, oatmeal, yogurt). Drink a nutritional supplement (like Boost® or Ensure®) 2 times a day. A dietitian will be available to see you if you have any diet concerns or questions.</td>
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<td>Other medication</td>
<td>Antibiotic through your intravenous (IV) just before surgery to help prevent an infection after surgery.</td>
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<td>Then as needed.</td>
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<td>An injection twice a day to prevent blood clots from forming in your legs or lungs.</td>
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<td>Medication to prevent and treat any nausea, vomiting, or heartburn regularly.</td>
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<td>Medications that you were taking at home before your surgery when ordered by your doctor.</td>
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<td>Receive an oral laxative twice a day. Let your nurse or doctor know if you are experiencing diarrhea.</td>
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<td>What I can expect</td>
<td>Day 0 (Day of Surgery)</td>
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<td><strong>Intravenous (IV)</strong></td>
<td>An intravenous line (IV) will be started in your arm just before surgery.</td>
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<td>It will keep you hydrated and allow medications to be given to you through your IV.</td>
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<td>It will be capped when you are drinking 4 or more glasses of fluid a day.</td>
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<td><strong>Oxygen</strong></td>
<td>In the recovery room, you will receive 1 hour of oxygen by mask</td>
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<td>Oxygen as needed.</td>
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<td><strong>Vital signs</strong></td>
<td>Your vital signs will be taken regularly (blood pressure, pulse, temperature, breathing rate and pain rating).</td>
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<td>What I can expect</td>
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<td>and toileting</td>
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<td>Use commode by your</td>
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<td>bed or walk (with help)</td>
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<td>Wash your hands</td>
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<td>Bladder catheter (tube)</td>
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<td>What I can expect</td>
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<td><strong>Rest and sleep</strong></td>
<td>Any sleeping medication will be ordered by the anesthesiologist while the epidural is in. Use earplugs to cut down the hospital noise.</td>
<td>Nap (or just relax and rest) for 2 hours a day, from 1:00 PM to 3:00 PM. Request NO visitors during this time in order for you to rest after your surgery.</td>
<td>After the epidural is out, you may resume your normal sleeping medication if approved by your surgeon.</td>
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<tr>
<td><strong>Bandages and care of your incision</strong></td>
<td>Your bandages will be checked to see if they are leaking.</td>
<td>Your bandages will be changed daily, and also when needed.</td>
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<td>You will go home with your staples in. You will be given a follow-up reminder to see your family doctor to have them removed.</td>
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<td>What I can expect</td>
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<td><strong>Activity</strong></td>
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<td>Do deep breathing and coughing exercises.</td>
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<td>Do foot and ankle exercises every hour while you are awake.</td>
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<td>Get in and out of bed by log rolling with instruction and help.</td>
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<td>Sit in the chair or at the side of the bed.</td>
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<td>Total activity time: 10 to 15 minutes.</td>
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<td><strong>Activity</strong></td>
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<td>Walk around the ward with help (at least 1 lap) 2–3 times per day.</td>
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<td>Total activity time: 1 to 3 hours out of bed.</td>
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<td><strong>Activity</strong></td>
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<td>Increase walking distance around the ward with help if you need it (at least 2–3 laps) 3 times per day plus.</td>
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<td>Total activity time: 6 hours out of bed.</td>
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<td><strong>Activity</strong></td>
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<td>Walk around the ward on your own (at least 4 laps) 3 times per day plus.</td>
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<td>Total activity time: 6 hours plus out of bed.</td>
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<td><strong>Activity</strong></td>
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<tr>
<td>Walk around the ward on your own (at least 4+ laps) 3 times per day plus.</td>
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<td>Total activity time: 6 hours plus out of bed.</td>
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<td><strong>Activity</strong></td>
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<tr>
<td>Sit in the chair for all meals if able.</td>
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<td><strong>Activity</strong></td>
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<td>Get in and out of bed on your own by log rolling.</td>
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<td>Total activity time: 6 hours out of bed.</td>
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<tr>
<td>What I can expect</td>
<td>Day 0 (Day of Surgery)</td>
<td>Day 1</td>
<td>Day 2</td>
<td>Day 3</td>
<td>Day 4</td>
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<td><strong>Where you will stay</strong></td>
<td>After surgery, you will be in the Recovery Room until you are awake and your pain is under control. You will then be transferred to 3E, the general surgical floor. 3 EAST – 250-962-4424 (direct line).</td>
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<td><strong>Visitors</strong></td>
<td>Brief visits from immediate family only on the day of your surgery. Visitors, even if they are your loved ones, can only visit, as can people visiting a room mate. There should be no more than 2 people at your bedside at a time. Visiting is also discouraged during your “Rest Period” between 1:00 to 3:00 PM. This rest period is not mandatory but highly recommended for your personal recovery and wellness as you are on the ERACS program.</td>
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<tr>
<td>What I can expect</td>
<td>Day 0 (Day of Surgery)</td>
<td>Day 1</td>
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<tr>
<td>Discharge planning and learning</td>
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<td>Go over your discharge plans with your nurse and other members of the team as needed (such as the transition liaison) and have any questions answered</td>
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<tr>
<td>Stoma (ET) nurse</td>
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<td>Your doctor will place a referral to the stoma nurse if she needs to be involved in your care.</td>
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<td>Final visit from ET nurse to finalize your discharge plan, review and answer any questions regarding your stoma care.</td>
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<td>Community care referral</td>
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<td>A referral will be placed to community care if you require their services when discharged (i.e., for wound care, stoma care or heparin administration). They will call you to arrange your appointments. Most people are required to attend a community clinic for their care needs, rather than home nursing visits.</td>
</tr>
</tbody>
</table>
APPENDIX D: ERACS Post-Operative Order Set

### Enhanced Recovery After Colorectal Surgery (ERACS) – Post-Op Order Set

#### DIET
- Sugar-free chewing gum anytime PRN
- 1 can of nutritional supplement BID every day
- Day 0 and 1: full fluids (FF)
- Day 2 and on: diet general
- Dietitian consult

#### ACTIVITY
- Day 0:动荡 at side of bed once up to chair as tolerated
- Day 1 and on: up to chair for all meals and ambulate
- Physiotherapy referral

#### VITAL SIGNS / MONITORING
- With epidural, vital signs Q4H X 48 hours and then TID
- Monitor urine output Q4H over first eight post-op, then Q8H if urine output accurate
- If urine output less than 30 mL/hr X 3 consecutive hours on Day 0, give:
  - Volumen* 500 mL IV x 1, and run over 30 minutes
- If urine output does not improve in the next hour, give furosemide 10 mg IV x 1 dose
- Remove indwelling catheter Day 2, and may do in and out catheter if urethral retention greater than 600 mL upon bladder scan

#### DIAGNOSTICS
- Post-op days 1 and 2: CBC, Renal Panel

#### INTRAVENOUS FLUIDS
- Ringer’s Lactate at ________ mL/hr OR D5½ NS + 23 mEq KC1/L at ________ mL/hr
- IV TKV 0 if drinking well (1200–1500 mL/24 hr)

#### MEDICATIONS
- Hold ACE inhibitors and NSAIDs
- Pantoprazole 40 mg PO DAILY x 48 hours, then re-assess
- Metolazone 10 mg IV Q6H x 24 hours, then Q8H PRN
- omeprazole 4 mg PO / IV Q6H x 24 hours, then Q4H PRN
- magnesium hydroxide laxative (Magnesia)* 30 mL PO BID to start Day 2 (hold if diarrhea)
- antacid 16 to 30 mL PO 1Q4H PRN
- dimenhydrinate 50 to 50 mg PO / IV Q4H PRN
- zopiclone 3.75 to 7.5 mg PO HS PRN (APS approved with epidural)
- heparin 5,000 units SUBCUTANEOUSLY Q12H OR heparin 5,000 units SUBCUTANEOUSLY Q4H

#### VTE MECHANICAL PROPHYLAXIS
- TFO stockings: discontinue Day 2
- intermittent compression device at night on Day 0 and 1

#### ADDITIONAL ORDERS
- ET consult
- Jejunostomy
- Colostomy

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Date (dd/mm/yyyy):  Time:  Physician Signature:  Printed Name or College ID:

819210 Aug 16/1

Fax page to Pharmacy  page 1 of 1
APPENDIX E : ERACS Discharge Booklet

Interior Health

Enhanced Recovery After Colorectal Surgery
Discharge Booklet

Kelowna General Hospital
Enhanced Recovery After Colorectal Surgery (ERACS)

Post-Op Patient Information

Congratulations! You are ready for discharge from the hospital in order to continue your recovery process at home. This process takes time, and for each individual, this will vary. This is due to your age, general health condition, type of surgery and any complications you may have had after your surgery. Please do not get frustrated if it takes you longer than you expect. You have just undergone major surgery, and your body needs time to continue to heal and adjust. However, you should see slow and steady recovery over the upcoming weeks. Please give yourself time to heal after surgery!

Diet and Bowel Function

After colorectal surgery, it will take time for you to fully regain your appetite. This should continue to improve as you continue your recovery at home. You may need to eat smaller, more frequent meals throughout the day, instead of our typical three big meals at breakfast, lunch and dinner. You may also continue to use protein drinks, such as Boost®, at home if desired. If you are concerned about your diet, our hospital dietitian can provide you with food instructions prior to your discharge home. Please ensure you keep up your fluid intake at home.

Please do not drink alcohol, especially if you are taking narcotics, when you return home.
It is not unusual for your bowels to act up after surgery. Your bowel movements may be unpredictable for the first couple of weeks, ranging from diarrhea to constipation. Please ensure you remain active and have a balanced diet with plenty of fluids. If you have frequent, non-resolving diarrhea, please see your family doctor.

If you are on narcotics for pain control (such as Tylenol #3®), please watch for constipation as these medications may slow your bowels down. Your doctor may need to prescribe a gentle laxative for you (such as Colace®). Please do not administer rectal suppositories or Fleet® enemas without doctor direction.

**Medications at home**

Generally, once you are discharged home, you will resume your normal medications that you are usually on. If there are any changes, your doctor will instruct you prior to your discharge.

If you are given additional medications, such as antibiotics, please take them as prescribed until they are finished. Please do not stop your antibiotics simply because you are feeling well. If you require pain medications at home, your surgeon will prescribe these for you upon discharge. If you find they are not relieving your pain at home, please contact your family doctor.
**Care of your incision at home**

Your incision line will not be fully healed upon discharge home. You will leave the hospital with staples (or clips) in your incision line. Your surgeon will tell you when you need to see your family doctor for staple removal. Once the staples are removed, strips of tape (called steri-strips) will be applied to continue to support your incision line. Please do not remove them yourself, but rather let them peel up on their own. You may trim the edges as they peel up with clean scissors. The steri-strips will stay on for 5–7 days.

If your incision is not draining, you may leave it open to the air. If there is any drainage (this fluid should be a watery, light colored fluid), you may have to use a small strip dressing over your incision line. If the fluid from your incision changes, and becomes thick, mucous and/or odorous, please see your doctor.

If your surgeon feels that you require homecare nursing for your wound, this will be set up prior to you leaving the hospital. In many communities, you will be asked to attend a community-based wound care clinic. Once you are home, you will be contacted by the community care nurses to arrange this.

You may shower with your new incision, but please do not soak in a bathtub, hot tub or pool until instructed that you may do so. When showering, do not have the shower spray directly on your incision, and gently wash the area, then pat it dry with a clean towel.

Take careful attention to protect your incision line. If you need to cough or sneeze, please hug yourself or place a pillow over your abdomen to protect the area. As well, please no heavy lifting or strenuous activity for 4–6 weeks after your
surgery. This includes household chores such as vacuuming, carrying groceries or outdoor activities like yard work (raking, mowing lawns, etc.). But remember to keep active with light activities such as walking.

Return to Work and Driving

Please discuss your return to work and driving with your surgeon, as this will vary for each individual. Your return to work will depend on the type of surgery you had, your personal recovery and the type of work that you do.

If you are taking any type of narcotic, do not drive as this type of medication may impair your coordination, concentration and reaction times. Please keep yourself (and others) safe on the roads. Your abdominal incision does not prevent you from wearing your seatbelt. It must be used at all times in your vehicle. If it feels uncomfortable, try using a small pillow or pad for increased comfort while wearing it.
Please seek medical attention if…

- your incision line begins to open up
- your incision line looks infected (it may be red, warm, swollen, painful, and/or draining mucky fluid)
- you have a persistent low-grade fever (≥38°C)
- you have a fever spike (≥39°C) ± shakes and body chills
- you have nausea and vomiting and cannot eat or drink
- you feel suddenly short of breath
- your calves (lower portion of your legs) become swollen and painful
- you have increasing pain that is not controlled with the medications prescribed

Follow-Up Appointments

Please call to set up your own appointment times that work with your personal schedule.

Please see your family doctor in:

___________

Please see your surgeon in:

___________

We wish you well in your continued recovery at home. Please contact your family doctor and surgeon as directed above, as they will continue to monitor your progress in the community. If you have questions or concerns, please contact them sooner than later as we want you to have the best surgical experience and recovery possible.

Thank you from the Kelowna General Surgical Team
**APPENDIX F : ERACS Recruitment Flyer**

**Patients’ Experiences of Participating in an Enhanced Recovery After Colorectal Surgery (ERACS) Program**

*We all have a story to tell... we all have unique experiences that shape us!*

We want to hear your story regarding the ERACS program in order to learn from those who have experienced this new surgical program. Without you, we cannot learn and change what we do today. We want to ensure we offer all patients the best health care services possible, and by sharing your story, you can help others who face similar challenges that you have.

*We need to learn from you!*

Are you willing to share your ERACS story with us? We would love to hear it! For further information about this research study and / or to participate in this project please contact:

Shannon Desilets RN RSN  
Master of Nursing Student  
University of British Columbia – Okanagan Campus  
250-861-4114 or 250-801-6853  
shannon.desilets@interiorhealth.ca

Principle Investigator:  
Dr. Kathy Rush RN PhD  
Associate Professor – School of Nursing  
University of British Columbia – Okanagan Campus

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**ERACS Program**  
Changing colorectal surgery in all phases

**Before Colorectal Surgery**

**During Colorectal Surgery**

**After Colorectal Surgery**

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Version 1.0 ERACS Recruitment January 28, 2012
APPENDIX G : ERACS Letter of Consent

CONSENT FORM

You are being invited to participate in a research study called:

Patients’ Experiences of Participating in an Enhanced Recovery After Colorectal Surgery (ERACS) Program

Principal Investigator:

Kathy Rush, PhD, RN
Associate Professor - School of Nursing
University of British Columbia - Okanagan
Phone: 250-807-9561
Email: kathy.rush@ubc.ca

Co-Investigators:

Penny Cash, PhD, RN
Associate Professor – School of Nursing
University of British Columbia – Okanagan
Email: penny.cash@ubc.ca

Shannon Desilets, BSN, RN
Vascular Clinical Nurse Specialist
Master of Nursing Student
University of British Columbia – Okanagan
Phone: 250-861-4114 (h) or 250-801-0853 (c)
Email: shannon.desilets@interiorhealth.ca

Purpose:

The purpose of this research study is to understand your experience of being a patient in Kelowna General Hospital’s new surgical program, called “Enhanced Recovery After Colorectal Surgery” (ERACS). The ERACS program has been shown to have beneficial medical outcomes, but we have little understanding of patients’ experiences of participating in this surgical program. We hope to enhance our ERACS program by hearing patient’s perspectives of the program.

Shannon Desilets is completing this research study as part of a graduate thesis in the School of Nursing at the University of British Columbia – Okanagan (UBC-O). She is the Vascular Clinical Nurse Specialist at KGH and the nurse leader for the ERACS program.
Shannon is aware of all ERACS patients, but has not provided “hands-on” nursing care to any. Shannon has had access to all ERACS patients’ medical charts in order to review the ERACS program and its components, as well as to screen eligible participants for this research study. Shannon continues to be the ERACS nursing lead and contact person for KGH staff, and has provided education and training to those who are caring for ERACS patients.

The Patient Care Coordinator (PCC) of 3E will provide recruitment packages to patients participating in ERACS within the hospital, or mail it to those already discharged. This will help ensure your decision to participate in this research study is voluntary and without coercion.

**Who Can Participate?**

To participate in this study you must speak English, be over 19 years of age, have a diagnosis of colorectal cancer, be post-operative from a colorectal surgical procedure, have participated in the ERACS program, and consent to have the interview audio recorded for future analysis.

**What Does the Study Involve?**

You will be asked to participate in at least one interview that will be recorded. It will be scheduled within two to three weeks of your discharge home, at a time and date that is convenient for you. There may be a need to follow-up with you to clarify information you provide in the first interview by an additional interview, telephone call(s) or email(s). During the interview you will be asked to talk about your experiences in the ERACS program, from before surgery to being discharged home. There are no right or wrong answers. The interview will be recorded and later typed up in printed form for analysis.

In addition, you will be asked some personal background questions such as your age, marital status, education, work status, and health history regarding colorectal cancer. We would also like your permission to obtain specific information from your medical record that will be important in understanding your overall experience in the program. The information from your record will include your medical diagnosis, the surgical procedure(s) you had performed, and your participation in the components of the ERACS program.

You may decide to share any other personal information, such as personal documents, journal entries or pictures. If so, these will be used only to supplement your interview, story and themes found in the research study.

Completing the background questions and interview should not take more than one to three hours of your time. The information you provide will be written up as your story and combined with that of other participants and summarized as themes. This will provide a picture of what it is like for patients to participate in the ERACS program. No personal names or identifiers will be used in any of these written or oral formats.

**Costs and Compensation:**

There will be no costs to you. Also, we do not pay for your participation.
Risks:

There are few anticipated risks associated with this research study except the time involved. As well, some challenging emotions may surface as you reflect on your surgical experience with colorectal cancer, the ERACS program and those caring for you. If you share any information about harm that you encountered during your surgical stay at KGH, it will be reported to the appropriate party (i.e. a nurse manager). This will be done in a confidential manner, and will not affect your future health care needs.

Potential Benefits:

The findings of this study may not benefit you directly, but may help future patients participating in the ERACS program. You will have the opportunity to share your story with others who want to listen and understand what you have been through. Participation may aid in your own personal healing.

Confidentiality:

A number of measures will be used to keep your identity confidential. The recorded and printed interview will be kept in a locked cabinet, made available only to Shannon Desilets and the members of her Master’s supervisory committee, and destroyed in five years. All materials relating to your personal information will be identified only by code number and will be kept under lock and key in Kathy Rush’s, the principal investigator, UBC office. Any information stored on the computer will have password protection.

The information you provide will be shared with others who oversee the ERACS program to assist in ensuring it is of high quality. It will be communicated in written papers (including a thesis paper which is a public document) and oral presentations. Your name will not be used in any reporting of the results from this study. As well, the study’s findings may be used in future research projects that involve enhanced recovery after surgery.

We are asking your permission to use information in this way without personally identifying you. Results from the study may be used to guide future development of the ERACS program. If you would like a report of the findings, please include your mailing address in the space provided at the bottom of this form. You will also be provided with a copy of the signed consent form.

A professional transcriptionist, who will sign a confidentiality agreement in order to protect your information, will be hired to type your recorded interviews.

Contact Information for the Study:

If you have questions, concerns or require further information about this study, please contact Shannon Desilets by phone at 250-861-4114, by cell at 250-801-0853, or by email at shannon.desilets@interiorhealth.ca. Please contact Shannon within two weeks of receiving this recruitment package, or discharge from hospital, if you are interested in participating in this research study. Interview sessions will be arranged within four weeks of your agreement, but can occur later should you require.
Contact Information for the Rights of Research Participants:

If you have questions, concerns or require further information about your treatment or rights as a participant in this study, please contact the following:

* Research Subject Information Line in the UBC Office of Research Services: #1-888-822-8598.
* UBC Okanagan Research Services Office: #250-807-8832.
* Interior Health Research Ethics Board (Research Office): #250-870-4602

Withdrawal from the Study:

Your participation in this study is entirely voluntary. You may refuse to participate or you may withdraw from the study at any time during the course of this study without penalty. Your choice to withdraw will in no way affect the care you are receiving through Interior Health. If you choose to withdraw and do not give permission for any of your information to be used, it will be not be used. Audio-recordings and computer files will be erased, and all hard paper copies of your materials will be shredded.

Your signature below indicates that you have received a copy of this consent form for your own records and that you agree to participate in this research study.

Participant Name & Signature to Participate in Study:

I hereby consent to participate in this study:

__________________________________________  __________
Participant Signature                          Date

__________________________________________  __________
Printed Name of Participant                    Date

I, the undersigned, confirm that the above informed consent procedure has been followed.

__________________________________________  __________
Researcher Signature                          Date

If you would like a report of the study’s findings, please include your mailing address below:

__________________________________________  __________________________________
                                      

Thank you for your consideration in participating in this valuable research study.
APPENDIX H : ERACS Demographic Information Sheet

ERACS Demographic Information

In order to write your personal narratives to the best of my ability, information from the following questions may need to be utilized. Please remember that names and personal identifiers will not be used in the study's findings or publications, and confidentiality will be maintained at all times. The following form will not be shared publically.

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<th>Name:</th>
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<td>Age:</td>
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<td>Gender:</td>
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<td>Marital Status:</td>
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<td>No. of children:</td>
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<td>Key Support at home:</td>
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<td>Educational level:</td>
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<td>Occupation:</td>
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<td>Initial symptoms:</td>
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<td>Diagnostic tests done:</td>
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<td>Date of diagnosis:</td>
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<td>Date of surgery:</td>
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<td>Date of discharge:</td>
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</table>

This provides background information regarding you as a person. Much of this information may come out as you share your story and experience of participating on the enhanced recovery after colorectal surgery program with me. I thank you for your participation in this research study.

Version 2.0 ERACS Demographics May 12, 2012
APPENDIX I: ERACS Interview Guide

ERACS Interview Guide

**Introduction:**
- Explain the study's purpose, research ethics and rights, plus confidentiality.
- Explain the purpose of digital recording and field notes (before, during and after session).
- Complete consent form if participant is willing to proceed.
- Complete demographic form.
- Ask if participant has any questions or concerns before session commencement.

**Research Objective:**
The purpose of this research project is to gain an understanding into the experiences of colorectal cancer patients who have been placed on an enhanced recovery after colorectal surgery program. It is to answer the unanswered question of “what do patients with colorectal cancer experience as they travel through an ERACS program?”

**Broad Open-Ended Question:**
1. Tell me your story of your experience on the ERACS program.

**Informal Interview Probes to be used to allow for more in-depth exploration of the participants ERACS experience:**
- Start at the beginning... tell me what you experienced at the colorectal surgeon’s office and pre-surgical screening appointment.
- Then move to the middle... tell me what you experienced when you came into the hospital on your surgical day, and what was it like moving into the operating room?
- Then move towards the end... tell me what you experienced when you recovered in the PAR (recovery room) and on the surgical floor until your discharge home.
- Then move to the finale... tell me what you experienced when you returned home.
- How did you feel about what you encountered?

**Reflections on the ERACS Program**
- Is there anything you would change about the ERACS program?
• Is there anything you would like to see added to the ERACS program?
• Is there anything we can do differently to enhance the ERACS program for others?
• Is there anything else you would like to add to your story in order for others to understand what you experienced? And in general of what it will be like to be on the ERACS program?
• Is there anything else you would like to tell me?

I thank you for your time and energy in sharing your ERACS story with me. I will have your interview session transcribed, and then write your story from what you have shared with me for others to learn from. Your name and any personal identifiers will not be used, and you will have access to your story to confirm its truth before it is used.

THANK YOU!
APPENDIX J: Collective Surgical Narrative

I guess the first time that I was really having difficulty with my bowels was before Christmas. I was constipated terribly, and was having to take all of these drugs. My doctor told me to eat bran buds and bran cereal. I was visiting family, not really doing anything or being stressed, but I was still constipated. I had had issues with constipation all of my life, but this was the worst. I also had hemorrhoids and was having some blood in my stool, so I thought the hemorrhoids were the problem.

I went to see the surgeon and thought he would just take off the hemorrhoids. He said that hemorrhoids could be the problem, or it could be something else... he did not know and could not tell. He said it was my choice to undergo hemorrhoid surgery or to have a colonoscopy. I had had a flexible sigmoidoscopy in the fall, but it showed nothing. It was clear. I hummed and hawed about the colonoscopy because I wondered if it was a waste of time. For some reason I almost said no, but then I said yes to it. I was informed that I had colon cancer and I was like “what the hell is going on?” Then I thought, if I got it, I got it... lets get going.

Cancer is not the same word and death sentence that it was many years ago. It can be curable. When I found out that something was wrong with my bowels and that I needed surgery, people with similar experiences came out of the woodwork. They too had colonoscopies and bowel resections. They were alive and looked good. So, I thought I would just take this step-by-step because it is easy to run ahead into those dark places. I needed to get my affairs in order - did people know where my important papers were? I needed peace of mind with this.

At my surgical consultation, my surgeon was excited to tell me about the new ERACS program and gave me the information that I needed for it. He told me it was a new surgical program that other patients seem to like. I was comfortable consenting to it despite it being new. The program made a lot of sense to me as the body would not be taken to its’ weakest state. I thought it promoted early recovery and normal body function within a shorter period of time after surgery. I was given the ERACS booklet that I thought was very well written and self-explanatory. He did not go through the booklet with me, but I did it many times at home. I kept it on my table and reviewed it every couple of days.

I re-read the guideline booklet before going in for my pre-surgical screening visit. This was going to be my first time in the hospital so everything was new to me and I did not know what was going on. The nurse was very thorough, but I had no medical background, so I was not sure about some things like catheters, etc. I could slow her down and ask questions, and then we would move on. My significant other and I went over it several more times. The information was going in, but not sinking in, and all of a sudden I have cancer. It is now too late, so I began to zone in on the details.

I was not nervous on the day of my surgery because I just wanted to get on with the show. They took my clothes and I got dressed in my gown and stockings. The nurse prepped my skin and then I went and sat in the waiting room. I felt relaxed, but wondered what the next steps would be. Other people were there and waiting for their own surgeries. They had just gone through the same steps, and there was casual bantering about “what are you here for?” We were
all dressed the same and going in the same direction. The mood was very casual. No one was uptight.

During my stay, I loved all of the nurses. They were very busy and never stopped, but they still were able to care and support me. They did not go over the ERACS booklet or daily goals with me. I thought I was doing pretty well and I thought I was on par with what they were expecting. I could see what I was supposed to do, and saw others doing it, so that gave me incentive to get out there and go. I tried to do all the activity that was in the booklet and tried to stay out of bed as much as I could. I would sit up in a chair for all meals, to read my newspapers or to do puzzles. I walked around the ward as much as I could. It helped that I was very active and walked a lot before my surgery.

My only drawback came on day two... I got sick that night. I was lying in bed, getting the cold sweats and I knew it was coming. I got up as fast as I could and made it into the bathroom, but I was sick for two to three hours, with both ends going. I knew I was weak from the surgery, but I still felt physically and mentally strong, other than this stomach thing. Up until this point, I had been eating and drinking all the time.

I was on my hands and knees in the bathroom, with a catheter in and hooked to a pole, and sharing a room with another lady. It was not comforting to her to listen to this and the smell was awful. I was really sick that night and I asked the lady in my room to ring for somebody. The nurse came in and I asked for a wet facecloth because I needed to cool off. I could have used a little more help that night. The nurse asked if there was anything she could do, and I said I just have to continue on, and she left. I was in there for about two to three hours, on my hands and knees, by myself. The nurse did not come back and did not check on me. I cleaned everything up, including the bathroom, before I left because I was not sure if the lady would need to use it. I wet the facecloth and went back to bed. I felt exhausted. Once I got up in the morning, it was all still there in the bathroom waiting for the cleaning people, so maybe this was not a nursing issue.

My roommate was my pillar of strength. She had cancer three times and was loosing her battle with it. She was dying. Even though there was a curtain between us, we spoke all the time. She talked about concentrating on the good in your life, and the good that you wanted to do. She would always talk about planting flowers and going fishing. She was 4’10” and 80 pounds. She would lie in bed in a fetal position, and she would never complain. She never complained of pain, so I thought I am not going to say anything. You develop a bond in a day or two, and if you can do something for the other, you do. The curtain was there, but it was like the fence on the show “Tool Time”... like when the neighbor is always talking over the fence. The camaraderie in the room kept improving as we got to know each other better. We would laugh and others would come in to see what was so funny. It hurt to laugh, but that was good as laughter is good medicine. We shared information back and forth, and we encouraged and inspired each other.

I could not wait to go home. I was ready to go. Mentally I was ready, but physically I was still slow, like getting in and out of bed, getting up and walking, but it was so nice to be home. I did not feel like I was being rushed out of the hospital, especially since I had the invite to stay another night. I did not see the ERACS program as “let’s see how fast we can get them in and out”. I saw it as “how can we get them in and out feeling stronger and better”. A family member
said it the best “heal strong”. And that is how I describe the ERACS program... it is a real heal strong program.

I was still poo-obsessed when I got home. I thought for sure the surgeon fixed my hemorrhoid because it felt so smooth to pass stool. Before, I had to strain as the stool tried to pass through the obstructing cancer cells. It had to squeeze through them. Before, I did not have regular movements, and the consistency was getting softer with more flatulence. Now, I have regular bowel movements. I told my family member about my new bowel movements and he/she said, “that is way too much information”. But it is just wonderful to have normal bowel movements again.

I had to see a cancer doctor, as two of the 12 or 13 lymph nodes came back positive, and she suggested that I start chemotherapy as soon as possible. Again, I was in shock and I was so disappointed. I did not realize that this was going to be part of the plan. Both the cancer doctor and nurse stated that if their parent were in my shoes, they would advise him/her to start chemotherapy as soon as possible. I was given the choice to postpone the chemotherapy as I was supposed to travel to attend the birth of my first grandchild. After discussion with my family, I opted to start treatment. My grandchild was born on the day I started chemotherapy.

Cancer can be a positive thing. It allowed my younger sibling and I to heal our relationship. We had been over 30 years estranged from one another, and he/she wanted to help me after surgery. I said OK and took him/her up on this offer. We are now closer than we have ever been, and it was cancer that brought us back together. Cancer is not always a negative thing... it can be positive as well.
Appendix K : Structured Storied Interview Guide

Reason Component Not Met:

- home - body clues

Diagnosis of problem & tests for same.

- Seeing surgeon - ERACS induction

- PSI visit - prep instructions & guidebook

- hospital admission

- OR

- PAR

- SE

- home again

- ERACS likes

- ERACS dislikes

- ERACS changes

- ERACS pamphlets - guidebook