NEEDS OF FAMILY MEMBERS DURING THE PERIOPERATIVE PERIOD

A PHENOMENOLOGICAL STUDY

by

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Abstract

In my practice as an operating room (OR) nurse, I have observed that family members experience distress, uncertainty, and anxiety during the perioperative period. However, little has been documented about their specific needs related to these unpleasant feelings, and the single existing quantitative instrument suffers from reliability and validity problems. The purpose of this descriptive phenomenological study was to understand family members' experiences during the perioperative period. Using Colaizzi's (1978) method of data analysis, family members' own perceptions of their needs were identified.

Eight family members of eight patients undergoing extensive surgery were interviewed twice: during the perioperative period and two weeks after surgery. Participants expresssed several concerns, all of which centred around what could happen in their own lives if something "bad" happened to the patient. Also evident was their lack of trust in the health care professionals who were or would be caring for their relatives. Lack of trust increased participants' concerns about the wellbeing of the patient and, thus, their concerns about how their own lives could be affected. Participants used a number of coping behaviours to decrease the distress, uncertainty, and anxiety generated by their concerns; most of these related to remaining connected to the patient. Five needs became apparent: (a) to be with the patient or have the option of being with him/her, both preoperatively and postoperatively; (b) to receive regular updates about the progress of the surgery and the patient's condition; (c) to wait somewhere that is both readily accessible and known to physicians and hospital staff; (d) to be able to make informed decisions about when it is "safe" to take breaks away from the waiting area; and (e) to have the company of others.

The findings are practical and significant in that they have immediate implications and

applications; right now, OR nurses can begin to intervene to help family members. The findings are exciting because they generate more research questions. The answers to these questions will add to the body of nursing knowledge about family members' needs, and will help nurses to reach the ultimate goal of caring effectively for all family members of patients undergoing surgery.

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CHAPTER ONE

Fore-Structure

Background to the Problem

My interest in the needs of family members has developed over the 11 years that I have been an operating room (OR) nurse. In my day-to-day practice, I have observed that family members frequently accompany patients to the pre-surgery waiting area and/or come to the OR desk during patients' surgery, often asking the staff for information and reassurance. Yet interactions between staff members and family members are very brief. As well, some family members do not come to the OR but request that the surgeon call them as soon as the surgery is finished. These examples of eagerness for information about what will happen or has happened in the OR indicate to me that people experience distress, uncertainty, and anxiety during the time their relatives are in the OR.

Because family members seem to have these unpleasant experiences during the time patients are in the OR, I believe that someone should be responsible for providing care for *them*–for helping them to meet needs related to this distress. I also believe that OR nurses are well suited to provide this care because we are skilled in developing short-term therapeutic relationships and have detailed knowledge of OR activities and procedures. However, before we can provide effective care for family members, OR nurses have to know what these people's needs are.

Purpose of the Study

As a result of my day-to-day observations of family members, I wanted to learn more about family members' needs during the intraoperative period, the time patients are in the OR itself. However, a review of the literature indicated that very little has been documented

about these needs. The one study reported is not only methodologically flawed but also based on the researchers' preconceived ideas about family members' needs. Similarly, the programs that were developed to meet these needs were not based on research findings but rather on what nurses assumed about these needs. My purpose in designing this phenomenological study was to learn about family members' *own* perceptions of their needs.

As I spoke to the study participants, I soon realized that they do not separate the time patients are in the OR from the whole experience of having a relative undergo surgery. Participants could not talk about the time patients were in the OR without also telling me about the feelings they brought with them to the hospital on the day of surgery, about their preoperative experience at the hospital, and about their immediate postoperative experience. Consequently, I felt it was necessary to study their needs during a wider time frame, during the 'perioperative period'. For the purpose of this study, I define 'perioperative period' as the period of time from the patient's admission (preoperatively) to the nursing unit on the day of surgery through the first hour in the Post-Anaesthetic Recovery Room (PAR) or the Critical Care Recovery (CCR). Family members' needs during the perioperative period are identified through analysis of their descriptions of their experiences.

Phenomenology, "the study of human experience from the actor's particular perspective" (Knaack, 1984, p. 107), is an appropriate method to use for this study. The study's findings reflect family members' perspectives of their needs during the perioperative period, and start to build nursing knowledge about this subject. I believe that the foundation of this knowledge will be solid only if it is based on information provided by family members themselves. Dunst, Trivette, and Deal (1988) support this belief: "Unless there is an indicated need for a resource on the part of a help seeker, there may not be a need regardless of what a professional believes

to be the case" (p.13). After the study is completed, further input about family members' needs may be sought from other sources, such as literature related to the needs identified or health care professionals who have experience interacting with family members.

This project is the first of two: Using the knowledge that this study has generated about family members' needs, I envision conducting subsequent research to determine what nursing interventions are effective in helping family members to meet these needs.

Research Question

The question addressed in this research is: "During the perioperative period, what are family members' perceptions of their needs?"

Conceptual Definition

Because this study focuses on family members' needs, it is necessary to explain the intended meaning of the term 'need'. Dunst et al. (1988) describe a need as "something (e.g., a resource) that is desired or lacking, but wanted or required to achieve a goal or attain a particular end" (p. 13) and, in The UBC Model for Nursing: Directions for Practice, Campbell (1987) defines a 'basic human need' as "a fundamental requirement for survival and growth of the behavioural system" (p. 35). Combining these two perspectives for the purpose of this work, I use the term 'need' here to mean something that is essential for a family member's overall wellbeing. In other words, I believe that it is not simply *nice* for OR nurses to meet family members' needs, it is *necessary* for us to do so.

Two other beliefs about needs are relevant to this study. Firstly, I believe that people are not necessarily conscious of all their needs nor do they always express them directly. Nurses may have to look beneath the surface–and consider the context–of people's words and actions in order to understand what needs people are indicating they have. Also, because a coping

behaviour is a "response that satisfies a basic human need" (Campbell, 1987, p. 35), nurses may be able to extrapolate a person's needs from his/her coping behaviours. Secondly, I believe that different people may satisfy the same need in different ways or with varying amounts of the same thing. For example, if two people want information about their relatives' surgery, one may find that written information meets his/her need; the other may want the information presented verbally. Furthermore, the amount of information that one person requires to satisfy his/her need may completely overwhelm the other.

The Role of Fore-Structure

Addison (1989) emphasizes the importance of the qualitative researcher examining his/her "fore-structure of understanding" (p. 52) or biases, attitudes, and assumptions about the research problem. This examination is necessary because the fore-structure influences the entire research process–how the researcher approaches the problem and collects and interprets the data. Only after this examination has been done can the researcher bracket or suspend the fore-structure "in order to fully understand the experience of the subject and not impose an a priori hypothesis on the experience" (Riemen, 1986, p. 90).

As a result of my experience as an OR nurse, I planned this study holding certain beliefs and making certain assumptions about the needs of family members. My main beliefs are disclosed in the background discussion of my observations about family members during the time patients are in the OR. My interpretation of the word 'need', the central concept in this study, is revealed in the conceptual definition. The pertinent assumptions are:

1. People have four types of needs–physical, psychological, social, and spiritual (Henderson, 1961).

2. All people share the same basic (i.e., survival) needs. As well, each person has

individual needs related to his/her specific life situation.

3. Family members who participate in studies such as this share their experience and their interpretation of it honestly and to the best of their ability.

My beliefs and assumptions influenced which bodies of literature I chose to review and how I critiqued them. As a result, the following literature review reveals my perspective on family members' needs when I planned this study–my "fore-structure of understanding" (Addison, 1989, p. 52). I endeavoured to suspend this fore-structure until data collection and analysis were complete.

CHAPTER TWO

Literature Review

In a phenomenological study, the literature may be reviewed at the time the research question is formulated and again when the findings are interpreted (Ray, 1990). For this study, the preliminary literature review served three purposes.

The first of these was to examine the role of OR nurses with their patients' families. In this section, it is established that OR nurses are mandated to care for family members as well as for patients, affirming the need to conduct the study. The second purpose of the preliminary literature review was to document what is already known about the needs of family members during the time patients are in the OR. Work pertaining to stress and uncertainty is discussed briefly because these concepts help to explain why family members have specific needs. Studies pertaining to needs of family members of surgical patients, some pertaining to needs of family members of critical care patients (but relevant to this study), and some intervention programs for family members are also analysed. The third purpose was to identify how the findings of this study would enhance current knowledge. As Polit and Hungler (1991) state, "The more one's study is linked with other research, the more of a contribution it is likely to make" (p. 88).

Although the study's method was modified in response to data analysis to include the perioperative period rather than just the intraoperative period, there are two reasons why I believe that my more restricted literature review is applicable to the wider time frame. Firstly, the intraoperative period is central to the perioperative period. In other words, unless patients are going to the OR, there is no perioperative period. Secondly, much of the argument for studying family members' needs during the time patients are in the OR was built around facts,

ideas, and research findings drawn from literature not directly related to that particular time period. The argument was easily adapted to support studying family members' needs during the perioperative period. Consequently, the literature that I initially reviewed is now discussed in the context of the perioperative period.

Further literature is reviewed in Chapter Four when the findings of the study are interpreted. The purpose of revisiting the literature is explained by Ray (1990) who states, "Select literature enables the researcher to reflect more deeply on the experience [of the participants] and can add to the development of phenomenological theory" (p. 178).

Operating Room Nurses' Mandate

Groah (1990) and Fairchild (1993) describe the role of the 'perioperative nurse', a term they prefer over 'OR nurse' because they believe it better reflects how OR nurses should ideally practise. The scope of the perioperative nurse's practice includes three phases– preoperative, intraoperative, and postoperative. Both authors support the premise that it is the mandate of OR nurses to care for family members during the perioperative period.

Groah (1990) states that each hospital's OR should have a perioperative nursing philosophy. She cites as a model the philosophy of the University of California Hospital and Clinics in San Francisco. One of the beliefs stated in this philosophy is, "Surgical intervention not only alters physiological functions, but may also generate stress, anxiety, and/or discomfort that can disturb individuals, families, and significant others" (University of California Hospital and Clinics, cited in Groah, p. 55). This belief would not be stated were it not relevant to perioperative nurses' practice, and it supports the notion that perioperative nurses do have a mandate to respond to family members' needs as well as to their patients' needs. Further, Fairchild (1993) states, "Perioperative nursing represents a multifaceted

challenge to today's operating room nurse. In this role, the nurse has an opportunity to...provide comfort and support to patient and family" (p. 7). This statement also supports the argument that providing care to family members during the perioperative period is within the scope of OR nurses' practice. The remainder of this preliminary literature review is based on this premise.

Family Stress and Uncertainty

The Life Events Inventory (Cochrane & Robertson, 1973) and the Life Experiences Survey (Sarason, Johnson, & Siegel, 1978) are tools that were designed to measure an individual's stress. Both list serious illness of a close family member as a significant stressor. This fact is relevant to this study because many patients who undergo surgery are seriously ill. As well, some family members may equate the need for surgery with serious illness, whether this belief is grounded in fact or not.

McCubbin and McCubbin (1993) are the researchers/theorists of the Resiliency Model of Family Stress, Adjustment, and Adaptation. In this model, a stressor is defined as "a demand placed on the family that produces, or has the potential of producing, changes in the family system" (p. 28). They state that illness in one family member is frequently a significant stressor for the family as a unit as well as for individual family members (the focus of this study). McCubbin and McCubbin's work supports the theoretical position that family members likely experience distress during the perioperative period.

Because I have frequently observed family members seeking information during patients' surgery, I believe that some of their distress is related to uncertainty. Hilton (1992) defines uncertainty as "a cognitive state created when an event cannot be adequately defined or categorized due to lack of information" (p. 70). Citing the work of Strauss, Corbin,

Fagerhaugh, et al., she affirms that uncertainty "is a major source of stress for critically and chronically ill individuals and their families" (p. 70). The family members that I have observed in my day-to-day practice were likely seeking information to decrease their uncertainty and thus their distress.

Hilton (1992) emphasizes the importance of nurses intervening to help family members cope with uncertainty. She states, "Interventions have been identified that can help individuals to cope with uncertain states. Initially, however, it is essential to assess the individual's perception of their [sic] situation in order to identify their general state and their type of uncertainty" (p. 72). Hilton's statement reinforces the need to conduct this study, especially as the first step in a two-step process aimed toward intervention. In other words, the ultimate goal is that OR nurses help family members to meet their needs during the perioperative period; however, before this goal can be achieved, nurses must know what family members' needs are. These needs are identified by understanding family members' perceptions of their experiences.

Needs of Family Members of Surgical Patients

Silva (1977, 1978, 1979) published the findings of an experimental study of the effects of an orientation program on spouses' anxieties and attitudes toward hospitalization for surgery. The study had a convenience sample of 48 spouses, in a Solomon four-group design (Silva, 1979). Three different reliable and valid instruments were used to measure anxiety and attitudes, with data being collected the evening prior to surgery and in the days following surgery. Three of Silva's findings are pertinent to this study and support the need to conduct the investigation.

First, as a group, spouses' scores on a self-report anxiety scale (the evening prior to

surgery), were "higher than those reported in the literature for preoperative major surgical patients who responded to the same scale" (Silva, 1978, p. 1082). Silva (1978) asks, "Have we [nurses], in terms of psychological care, been directing our attention to the wrong group?" (p. 1082). This finding highlights the importance of OR nurses carrying out our mandate to care for family members during the perioperative period.

Second, when spouses considered the period of time from diagnosis until the evening of the day of surgery, the majority found that the time the patients were in the OR was the most anxiety-producing (Silva, 1978). In a replication study, with a sample of 75, spouses once again reported this time to be the most stressful (Silva, Geary, Manning, & Zeccolo, 1984). This second finding further supports the need to conduct this study. Not only are family members in need of care during patients' hospitalization for surgery, but they are most in need of this care during the time patients are in the OR, during the central portion of the perioperative period.

Third, Silva (1977) found that there was minimal interaction between spouses and nurses during the time patients were in the OR. Of 35 spouses who remained at the hospital during the time patients were in the OR, 31 reported that no staff member (nurse or otherwise) spoke to them during this time. A similar finding is reported in the replication study (Silva et al., 1984). This is significant because it supports what I have observed in my own practice about interactions between family members and OR staff members. Therefore, my research findings do not provide information about a problem specific only to the agency in which the study was conducted. Instead, this investigation contributes to OR nurses' general understanding of family members' needs during the perioperative period. As well, the findings may provide a starting point for the development of nursing interventions to care for family members.

The research by Silva (1977, 1978, 1979) and Silva et al. (1984) involved spouses of patients undergoing cholecystectomy, hysterectomy, prostatectomy, or herniorrhaphy for "anticipated nonmalignant" conditions (Silva, 1979, p. 130). These participants reported experiencing distress due to temporary lifestyle changes caused by their spouses' hospitalization and surgery. It seems reasonable to assume that family members of patients undergoing more extensive procedures or cancer surgery expect to experience more dramatic or more permanent lifestyle changes and thus experience more distress. This view is supported by Watson and Hickey (1984) in their description of a program designed to help family members of patients undergoing cancer surgery. These authors believe that uncertainty about the future or about possible lifestyle changes is a major stressor for these family members. Family members who may be experiencing more distress and more uncertainty (than the participants in the studies by Silva and her colleagues) are in even greater need of nursing care during the perioperative period.

In a study to "explore stress in the family during and after hospitalization for coronary artery bypass surgery" (Gilliss, 1984, p. 103), the author compared the stress reported by patients and by their spouses. This longitudinal descriptive study had a convenience sample of 71 patient-spouse pairs. Data collection began several days following surgery using semi-structured interviews and the Impact of Event Scale. Scores on this instrument, which was "designed to measure an individual's subjective stress in relation to a particular event" (p. 104), "demonstrated a significantly higher amount of stress among spouses" (p.105) than among patients. The reliability and validity of this instrument are not reported. Gilliss (1984) concludes that "there are numerous stresses and unmet needs [particularly for spouses] that might be addressed by hospital-based nurses" (p. 111). This conclusion supports the need to

conduct the current study; until OR nurses know what family members' needs are during the perioperative period, we will be unable to intervene to help family members meet these needs.

Another study that is relevant to the needs of family members of surgical patients was conducted by Carmody, Hickey, and Bookbinder (1991). These authors describe a survey done to evaluate a program developed by OR nurses, and "designed to reduce the stress of families waiting for patients undergoing surgery" (p. 561). In the evaluated program, OR nurses acted as "liaisons who provide current information, communication, and support to families" (p. 562). They visited the patient and any family members preoperatively to "explain the program, plan interventions for specific problems, offer support, and help decrease their anxiety" (p. 562). At this point, the program nurses were caring for both patient and attendant family. These nurses also informed the family of the patient's status at regular intervals during the time patients were in the OR and PAR. It is interesting to note that in their attempt to reduce the stress of those waiting (the stated objective of the program), the program nurses provided care for families during a period that included more than just the waiting time. In other words, this program seems to be based on an assumption that family members require care throughout the perioperative period (rather than just during the intraoperative period), an assumption that supports my decision to focus on a wider time frame.

This evaluation research, with a convenience sample of 49 family members, used what Polit and Hungler (1991) refer to as a "goal-free approach" (p. 190). In other words, Carmody et al. (1991) did not evaluate whether the objectives of the program were met. Instead, they assessed the impact of the program on family members' need satisfaction. The instrument used was the Perioperative Family Needs Questionnaire (PFNQ), an adaptation of

the Critical Care Family Needs Inventory (CCFNI). The latter tool was developed from research conducted by Molter (1979) about the needs of family members of patients in intensive care units; the tool has established reliability and validity (Forrester, Murphy, Price, & Monaghan, 1990; Lynn-McHale & Bellinger, 1988; Norris & Grove, 1986).

Carmody et al. (1991) asked the subjects to complete the PFNQ, rating the importance of each need listed and the level of satisfaction achieved. For 9 of the 10 most important needs, the authors state that "80% to 100% of family members reported their needs moderately to completely met" (p. 565) by the program designed to reduce their stress. The effectiveness of the program, however, cannot be determined because the reliability and validity of the PFNQ itself are uncertain. The issues concerning this instrument's reliability and validity are as follows:

First, Duli (1989) and Polit and Hungler (1991) emphasize that established reliability and validity of an instrument apply only to the population for which the instrument was developed. The PFNQ was adapted from the CCFNI, designed for family members of patients in intensive care units. In addition, Carmody et al. (1991) state that they made modifications to the CCFNI to "specifically address issues relevant to the heightened anxiety of the perioperative period [i.e., the program period]" (p. 564). However, the authors do not cite a reference to back up the claim of heightened anxiety; heightened anxiety is assumed. These modifications changed both the reliability and validity of the instrument (Polit & Hungler).

Second, the reliability of the adapted tool is not reported by Carmody et al. (1991). The PFNQ's reliability should have been checked as a routine step in the research process (Polit & Hungler, 1991). Furthermore, when Carmody et al. developed the PFNQ from the CCFNI, they decreased the number of items on the instrument from 45 to 20. This additional

modification also affected the reliability of the PFNQ relative to the CCFNI (Polit & Hungler).

Third, Carmody et al. (1991) report that the PFNQ is a valid instrument because "15 surgical oncology nurse clinicians evaluated the content and format of the instrument and confirmed the validity of the questions [need statements]" (p. 565). However, if the PFNQ is supposed to represent family members' needs during the perioperative period, it would seem more reasonable to ask family members themselves to voice an opinion about whether the needs listed on the PFNQ are relevant. Therefore, the PFNQ may not have measured what it was intended to measure–how well each need on an *accurate* list of needs was met. As a result, it may not be a valid instrument.

The issue of the reliability and validity of the PFNQ is significant to the proposed study. If I were confident that the needs listed in the PFNQ were an accurate assessment of family members' needs during the perioperative period, I could use the PFNQ to find out how well the needs of family members in my setting are being met (with the intention of intervening to meet needs that are not being met). However, because the reliability and validity of the PFNQ are questionable, it is unsuitable for the assessment of family members' predetermined needs. Instead, it must be determined what their needs really are. This phenomenological study achieves this end because it describes family members' perceptions of their needs during the perioperative period. Surely these needs are more reflective of family members' needs than the needs described on the PFNQ, simply because those developing the PFNQ did not consult the best 'experts', family members living the experience of having a relative undergo surgery.

Needs of Family Members of Critical Care Patients

The results of the following three studies raise issues relevant to this research, despite the fact that they were conducted in critical care settings. The issues are relevant because there

are some similarities between the OR and critical care. For example, both are specialized, isolated units where patients receive intense, technology-laden treatment from a multitude of health care providers during critical life events. One can assume that the two settings render the experience of being a relative quite similar.

In the first of these studies, Lynn-McHale and Bellinger (1988) "gathered information about the level of need satisfaction as perceived by family members and the extent to which critical care nurses are able to accurately identify those areas of high and low family member satisfaction" (p. 447). This comparative study had convenience samples of 52 family members and 92 nurses. A 46-item adaptation of the CCFNI was used; estimates of the instrument's acceptable reliability and validity are documented in the report. During data analysis, the authors divided the 46 need statements into six overall categories and ranked the categories in order of level of need satisfaction. For 4 of the 6 categories, family members and nurses differed markedly in terms of the category's rank. This finding suggests that OR nurses may seriously misinterpret how well family members' needs are satisfied during the perioperative period. It also emphasizes the importance of understanding family members' experiences during this period in order to prevent such misinterpretation. Inherent in the data about family members' experiences are their perceptions of how well each of their needs is currently met. Future nursing intervention can then focus on needs that family members identify as poorly satisfied.

In another study, Forrester et al. (1990) explored "the relationship between critical care family members' perceived needs and the assessment of these needs by a confederate sample of intensive care unit nurses" (p. 655). This, too, was a comparative study. A revised version of the CCFNI, which has documented acceptable reliability and validity (Forrester et al.), was

used with a convenience sample of 92 nurse-family member pairs. Nurses and family members reported that they saw 15 of the 30 family members' needs listed on the CCFNI as similar in importance. For the remaining 15 needs, the family members' ratings were higher than the nurses' ratings. Significantly, the six needs perceived as most important by family members all appeared in this latter group of needs. These findings are relevant because they indicate that if OR nurses intervene based on what *they* assume are family members' needs, they may miss those needs that the family members themselves think are most important. Thus, it is important to conduct this study to provide nurses with a solid basis on which to understand family members' experiences. Like level of need satisfaction, family members' own perceptions of the relative importance of each need are inherent in the data. Ultimately then, through application, nursing intervention can be focused on needs that family members themselves perceive to be most meaningful.

In a study that ties in with the work of Forrester et al. (1990) and Lynn-McHale and Bellinger (1988), Kleinpell and Powers (1992) "compared family members' needs and ratings of importance and satisfaction with those of nursing personnel" (p. 3). An adaptation of the CCFNI was used in this study also. The unmatched convenience samples consisted of 64 family members and 58 nurses. Two related findings are relevant to this study: First, family members rated about one-third of the needs as more important than did nurses, and second, family members "indicated that several needs [of the one-third described above] were both more important and less satisfactorily met than nurses perceived" (p. 6). The findings of this study, like those of the two previous studies, reinforce the importance of examining the emic perspective. If nurses cannot accurately identify the importance and level of satisfaction of a need on a reliable and valid list (i.e., the CCFNI), they cannot presume to know what family

members' needs are when there is no such list–in other words, during the perioperative period.

A phenomenological study has the potential to make a better contribution to understanding family members' needs during the perioperative period, as it is possible to describe those needs accurately–from the participants' own perspective. The data generated in this study include information about the importance and level of satisfaction of each need, information that will be essential when nursing interventions are developed.

Intervention Programs

There are several articles in the literature that describe formal programs developed to assist family members during the perioperative period (Donnell, 1989; Eldridge, 1984; Mitiguy, 1986; Watson & Hickey, 1984). These programs were instituted because OR nurses thought they would be beneficial; the authors do not mention whether family members were asked for input into the design of the programs. These nurses had noted that family members seemed to be anxious and frequently sought information about the surgical procedure and the patient, especially during the intraoperative and immediate postoperative periods, observations similar to those I have made in my day-to-day practice. They assumed that family members were "coping with a major life crisis" (Eldridge, p. 241)), were "under a great deal of strain" (Mitiguy, p. 388), were "wondering, worrying, and imagining the worst" (Donnell, p. 1088). The main objectives of each of these programs were to provide support to family members and to reduce their anxiety by giving them scheduled updates about the progress of the surgery and the patient's condition.

The nursing interventions implemented in the programs described above were not apparently based on research findings. Although all the authors (Donnell, 1989; Eldridge, 1984; Mitiguy, 1986; Watson & Hickey, 1984) state that family members expressed their

appreciation for the care provided them by program nurses, I believe that family members' satisfaction could have been greater if the programs had been based on family members' own perceptions of their needs. As Lynn-McHale and Bellinger (1988), Forrester et al. (1990), and Kleinpell and Powers (1992) found, nurses and family members often disagreed about the importance or level of satisfaction of family members' needs. Therefore, although family members appreciated the help they did receive, these programs may not have met family members' most important needs and/or nurses may have misinterpreted how well certain needs were being met.

Donnell (1989) and Watson and Hickey (1984) state that some nursing and medical staff were sceptical about the necessity for or benefits of their programs. If the nursing interventions implemented in such programs were based on research findings–on family members' own perceptions of their needs–both the effectiveness and the credibility of the programs would improve.

Summary

During the perioperative period, family members experience distress, uncertainty, and anxiety, and have specific needs related to these experiences. I believe that it is *essential* for OR nurses to intervene to help family members meet these needs. However, the literature does not provide credible knowledge about family members' needs on which to base effective intervention. The PFNQ (Carmody et al., 1991), the one tool developed to measure family members' need satisfaction during this time period, may not accurately represent family members' needs. As well, studies conducted with family members of critical care patients found that nurses and family members often did not agree about the importance of family members' needs or the level of need satisfaction even when reliable and valid instruments were

used (Forrester et al., 1990; Kleinpell & Powers, 1992; Lynn-McHale & Bellinger, 1988). Consequently, before OR nurses can help family members effectively during the perioperative period, it is necessary to understand family members' own perceptions of their needs. This phenomenological study aimed to achieve this goal.

CHAPTER THREE

Methodology

From the preliminary literature review, it is apparent that the proposed research is relevant to OR nurses' practice, and that the study's findings could ultimately lead to an improvement in the care provided to family members during the perioperative period. In this chapter, I provide a brief rationale for phenomenology as the research design and focus on the procedures followed throughout the study.

Research Design

The purpose of this study is to understand and describe family members' perceptions of their needs during the perioperative period. Phenomenology is an appropriate method for this work because it "seeks to uncover the meaning of humanly experienced phenomena through the analysis of subjects' descriptions" (Parse, Coyne, & Smith, 1985, p. 15). Phenomenology is also a suitable first step toward pursuing my ultimate goal–determining what nursing interventions are effective in helping family members to meet their needs. In other words, OR nurses must understand family members' needs before they can effectively care for them. This premise fits with Lynch-Sauer's (1985) statement that phenomenology is valuable in helping nurses to "understand those individuals being cared for in order to know how to care for them" (pp. 106-107).

Ray (1994) states, "Phenomenology is, first and foremost, a philosophy or a variety of distinctive, yet related, philosophies. But it also is concerned with approach and method" (p. 118). She discusses two types of phenomenology, descriptive and interpretive. In descriptive phenomenology, which is based on the work of Husserl (cited in Ray, 1994), "the phenomena of experience are probed with the participant until '*the thing itself*' [italics added]

is illuminated and described" (Ray, 1994, p. 129). Interpretive or hermeneutic phenomenology, which is central to the philosophies of Gadamer, Heidegger, and Ricoeur (cited in Ray, 1994), goes beyond the level of description. In interpretive phenomenology, theory drawn from the "textual discourse illuminates the *meaning* [italics added] of an experience as it is lived" (Ray, 1994, p. 130). In this research, descriptive phenomenology is used because it fits the purpose of the study–to understand and describe 'the thing itself', family members' perceptions of their needs during the perioperative period. It is also, perhaps, a more suitable approach for a novice researcher.

Sample/Participant Recruitment

In this study, a family member is defined as the spouse/significant other, parent, child, or sibling (19 years of age or over) of the surgical patient. Those under 19 years of age would have required parental/guardian consent to participate in the study and were excluded to simplify the recruitment procedure. As well, the vast majority of family members whom I have observed in my practice have been adults.

Purposive sampling was used to select family members. Polit and Hungler (1991) define purposive sampling as a "method in which the researcher selects subjects for the study on the basis of personal judgement about which ones will be most representative or productive" (p. 652). This definition fits with Omery's (1983) description of how the sample for a phenomenological study is selected.

Eight family members of eight patients undergoing extensive elective surgery participated in the study. (The actual surgical procedures are listed at the beginning of Chapter Four.) As I was recruiting participants, I defined 'extensive' rather loosely. However, some of the factors that I considered were: (a) the length of the procedure, (b) the mortality rate

associated with the procedure, (c) the patient's long-term prognosis, and (d) the complexity of the procedure. Each participant was interviewed twice: during the perioperative period and about two weeks after the surgery.

As discussed in Chapter Two (p. 11), extensive procedures likely cause more distress, uncertainty, and anxiety for family members than the procedures described in the studies by Silva (1977, 1978, 1979) and Silva et al. (1984). Because the family members in the cited studies needed nursing care during the perioperative period, I assumed that the participants in my study would be in even greater need of nursing care. For this reason, I believed they would probably be good informants about family members' needs during this time. Although I selected family members of patients undergoing extensive procedures, it is important to note that a procedure does not have to be extensive to be distressing for family members (Watson & Hickey, 1984). Possible examples are a breast or lymph node biopsy.

As the data provided by each participant were analyzed, I considered selection of the next participant based on a technique that Strauss and Corbin (1990) describe as "looking purposefully for data bearing on categories, their dimensions, and properties" (p. 183). That is, I decided what type of surgery the patient related to the next participant should be having, depending on emerging descriptive labels and themes (Colaizzi, 1978). In general terms, the themes related to concerns that family members brought with them to the hospital on the day of surgery and to the need to remain connected to patients during the perioperative period–to be with them as much as possible and to get information, especially during the times family members and patients were separated. As I talked to each participant and analysed his/her expressed ideas, he/she contributed a variety of divergent pieces to each theme. Because of this, I wanted the next participant to tell me more about the experience of having a relative

undergo extensive surgery; I wanted to try to connect the divergent pieces. Therefore, the criterion 'extensive surgery' remained static throughout the study.

Woods and Catanzaro (1988) state, "Maximum variation of sampling...will provide detail about the many specifics that give the phenomenon under study its unique flavor" (p. 135). The fact that the participants' relatives (i.e., the patients) all had different diagnoses and all underwent different surgical procedures helped to achieve variation of data. In other words, the participants' experiences were likely more diverse than they would have been if all the patients had had the same surgery. I also achieved variation of sampling, and thus variation of data, by recruiting participants who are related to the patients in different ways; four husbands, one wife, two daughters, and one mother participated in the study. Furthermore, because I knew that participants would not necessarily relate expected needs, stories, or experiences, I used a variety of interviewing techniques (see Interview Guide, Appendix A, p. 76) to aid them in the telling of their rich and varied experiences.

Participants had to be able to communicate verbally in English. Because the follow-up interview would be conducted after the patient's discharge, they also had to live or be staying in the Greater Vancouver area. If a patient's family member or the patient worked at St. Paul's Hospital (where the study was conducted), the family member was not eligible to participate in the study. The rationale for this was that such a person may have received extra attention from hospital staff, which may have helped to meet some of his/her needs during the perioperative period.

According to the literature (Ray, 1990; Woods & Catanzaro, 1988), the sample in a phenomenological study is usually small, sometimes as few as 5 to 10 participants. Although the ideal sample size is determined by data saturation (Omery, 1983), saturation was not

reached within the period of time available for data collection and analysis in this study. However, I believe that because I carefully adhered to the principles of the phenomenological method, I have produced useful conceptual categories from which to describe participants' general experience during the perioperative period.

Procedure for Approaching and Informing Participants

Participants were recruited through the Pre-Assessment Clinic at St. Paul's Hospital. Most surgical inpatients (8 to 10 per day) are seen at the Clinic during the week prior to surgery, then admitted on the day of surgery. I reviewed the appointment schedule with the Nurse Clinician and, from this, identified patients undergoing 'appropriate' procedures. When these patients arrived at the Clinic, the nurses who were assigned to care for them briefly explained the purpose of the study to them and to their family member(s), if the family member(s) had come to the Clinic. The nurse then either gave the family member(s) a copy of the Information Letter (Appendix B, p. 77) or, if no one was accompanying the patient, asked the patient to take the letter (with an addressed, stamped envelope) to his/her family member(s). If family members wanted more information about the study or wanted to participate, they filled in the tear-off section at the bottom of the letter and either gave or sent it to the Nurse Clinician, and she passed it on to me.

I telephoned family members who indicated that they were interested in participating in the study. During our conversations, I briefly reviewed the purpose of the study and what their participation in it would entail, and offered to answer any questions. A couple of them said that because they had decided not to remain at the hospital during their relative's surgery, they were unable to participate. I explained to those who were willing to participate when and where I would likely come to meet them on the day of surgery. I also told them that I would

keep abreast of any changes in the OR schedule or the patient's location and would be able to find them, wherever they were. In other words, I did not want them to have the added responsibility of keeping me informed of changes. As well, I did not want them to have to leave the patient to meet me at a designated time and place.

Before we began the initial interview, I reviewed the Information Letter (Appendix B, p. 77) and the Consent Form (Appendix C, p. 79), and gave participants another opportunity to ask questions. At this point, they were asked to sign the consent indicating that they were informed and consenting to participate in the study.

Data Collection Setting and Procedures

The eight initial interviews with family members were conducted during the perioperative period. Six were conducted during the time the patient was actually in the OR, one while the patient was waiting to go to the OR, and one immediately after the patient arrived in PAR. Seven of these interviews took place in a private office arranged for my study; one participant preferred to talk on the rooftop terrace (where she could smoke).

The follow-up interviews were conducted about two weeks after surgery to provide an opportunity for family members to explore further thoughts about their experiences. At this point, I also summarized what I understood about these experiences and asked for validation or refutation (Sandelowski, 1993). When we were planning the follow-up interview, I suggested to participants that we could meet somewhere in the hospital (including the private office), at their home or office, or any other place they chose. Five of them invited me to their home, two invited me to the patient's home, and one asked me to meet her at a coffee shop. Participants were aware that we had the option of meeting a third time about three weeks after the surgery. However, by the end of the second interview, all felt that they had told me

as much as they could; I, too, was satisfied that we had fully discussed their experiences.

The interviews were unstructured (see Interview Guide, Appendix A, p. 76) and lasted anywhere from 20 minutes to one hour. Most were about 40 minutes in length. The first interview with each participant began with something like "Could you please tell me what is it like for you while (the patient's name) is in the operating room?". Subsequent reflective comments, probes, and questions were used to help the participant clarify or elaborate on ideas or statements and were guided by the participant's story. As Ray (1990) states, "The interview process relies upon the life experiences of the participant through genuine dialogue, which can be spoken or silent. The essential element of genuine dialogue is seeing the other or experiencing the other side" (p. 177).

Interviews were audiotaped and transcribed verbatim. I transcribed all but three of the tapes; these three were done by a professional transcriptionist. I also made field notes. Schatzman and Strauss (1973) describe good field notes as "a 'constant companion'–a sort of alter ego composed of factual and reliable data, a running account of fleeting and developed interpretations and reflections, and a chronicle of operational decisions made at stated times, places, and circumstances" (p. 98). In my field notes, I recorded my immediate impressions of participants and their experiences. I also noted details that I thought may have influenced these experiences (e.g., a delay in the start of the surgery, the fact that there was nowhere to sit because the waiting room was being painted). In addition, I made notations on the transcripts to remind myself about the context of some specific comments.

Basic background information was collected from each participant: (a) relationship to the patient; (b) age; (c) gender; (d) occupation; (e) patient's diagnosis, age, and type of surgery; and (f) whether or not he/she has previously experienced a relative having surgery.

Data Analysis Procedures

There are several data analysis methods described in the literature, all of them quite similar. Ray (1990) summarizes the goal of these methods. She states, "Phenomenologists reduce observations, impressions, and experiences of the reality of concern to descriptions and thematic interpretations or linguistic constructions of the meaning of a phenomenon" (p. 176).

Colaizzi (1978), whose approach to phenomenology is descriptive rather than interpretive, describes seven steps that were used for data analysis in this study. He states that these steps should be viewed as typical rather than definitive. He adds that each researcher should feel free to modify the steps to suit his/her approach and phenomenon.

The seven steps (Colaizzi, 1978), as adapted for this study, are:

1. Listen to the audiotape of the interview to acquire a feeling for it. The transcript of the interview provided a written working copy.

2. Extract significant statements that "directly pertain to the investigated phenomenon" (p. 59).

3. Try to formulate a descriptive label for each significant statement.

4. Repeat the first three steps with each interview. Organize the descriptive labels into clusters of themes. Validate the clusters of themes with the original interviews. Colaizzi states, "This can be achieved by asking whether there is anything contained in the original protocols [interviews] that isn't accounted for in the cluster of themes, and whether the clusters of themes propose anything which isn't implied in the original protocols" (p. 59). If this occurs, the preceding steps must be repeated.

5. Compile the results (so far) into an exhaustive description of the phenomenon of interest.

6. Try to "formulate the exhaustive description of the investigated phenomenon into as unequivocal a statement of identification of its fundamental structure as possible" (p. 61).

7. Validate the findings with each participant. Incorporate any new data obtained into the findings. In addition, I validated the description with a few other people–friends, acquaintances, colleagues–who have been through a similar experience. (The reason I did this is discussed in the following section on methodological rigor.)

Data analysis began during the first interview with the first participant. Data collection and data analysis were conducted almost simultaneously in order to constantly compare the content of the interviews with the findings to date. The findings then guided further participant selection and data collection. Using the steps outlined by Colaizzi (1978), data saturation would have occurred when no new descriptive labels emerged from participants' significant statements. Saturation did not occur within the time available because of the complexity and diversity of participants' experiences during the perioperative period.

Methodological Rigor

Guba and Lincoln (cited in Sandelowski, 1986) discuss four criteria that can be used to assess the rigor of qualitative research. They are credibility, fittingness, auditability, and confirmability.

For a study to be credible, the descriptions and interpretations of the participants' experiences must be accurate (Sandelowski, 1986). In other words, participants should be able to recognize themselves in the research report. To ensure that they would recognize themselves, Lynch-Sauer (1985) recommends that they validate the researcher's interpretation of their experiences. As previously mentioned, this was one of the purposes of the second interview with each participant. In addition, I periodically checked with participants during

our conversations to ensure that I understood their stories and their concerns.

Sandelowski (1986) also states,

> Since a major threat to the truth value [credibility] of a qualitative study lies in the closeness of the investigator-subject relationship, the credibility of qualitative research is enhanced when investigators describe and interpret their own behavior and experiences as researchers in relation to the behavior and experiences of the subjects. (p. 30)

This recommendation was incorporated into my field notes and my interpretation of the data. For example, I recognized–and several participants told me–that I was meeting/met some of their needs during the perioperative period, especially their need for information.

A study has fittingness when others, who have had experiences similar to the participants, can see that the findings are applicable to their own experiences (Guba & Lincoln, cited in Sandelowski, 1986). This is most likely to occur if the description of the phenomenon of interest accurately depicts all aspects of the participants' experiences. In this study, fittingness was enhanced in three ways. Firstly, by maintaining an awareness of and bracketing my fore-structure, any tendency to 'edit' the data collected was limited. For example, after my conversations with participants, I thought about how I might feel/act in each of their situations. I also thought about how I, as an OR nurse, might react to them in my day-to-day practice. Only after I understood my own perspective was I able to make a conscious effort to set it aside, to bracket it. Secondly, as suggested by Drew (1986), interviewing techniques were continuously evaluated. For example, I discovered that, generally, I learned more from participants when I asked fewer questions. Lastly, having two interviews with participants (and offering the option of a third interview) allowed them to express as much as they wished about their experiences. Fittingness was checked by taking the description of the phenomenon of interest–at various stages in its development–to the following people: (a) the participants

(at the second interview), (b) a few of my colleagues who have also observed/interacted with family members during the perioperative period, and (c) a few of my friends and relatives who have experienced a loved one undergoing surgery. The description did "fit" with these people's experiences as well as with my practice experience.

Auditability is the third criterion used to assess rigor. A study meets this criterion if another researcher can understand why the investigator made specific decisions throughout the study (Guba & Lincoln, as cited in Sandelowski, 1986). Furthermore, another researcher should reach similar conclusions when analysing the data. In this study, auditability was achieved by carefully detailing (in this report, in field notes, and in memos) the rationale behind significant decisions in all phases of the study, from its inception to its conclusion. Others can have access to the field notes and memos if they so request.

Confirmability, the fourth criterion of rigor, is achieved when the other three criteria–credibility, fittingness, and auditability–have been met (Sandelowski, 1986). In this study, confirmability was achieved because strategies to meet the other three criteria were included in the method.

Ethical Considerations

The risk/benefit ratio in this study was low. My nursing eduction, experience, and skills enabled me to interact with participants in a way that was beneficial to them. Although talking about a stressful experience is considered therapeutic by most people, the interviews could have raised disturbing issues for some people. Had this occurred, I would have referred the participant(s) for appropriate help. By sharing their experiences, participants were helping family members of future patients by contributing to nurses' knowledge about family members' needs during the perioperative period.

As previously mentioned, potential participants were given the Information Letter (Appendix B, p. 77) and signed the Consent Form (Appendix C, p. 79). A key point in both documents was that participation was voluntary and that whether or not a family member participated, the patient and family member would receive the same treatment from hospital staff. As well, participants were told that they could withdraw from the study at any time, could refuse to answer any question during the interviews, and could have any responses deleted from the tapes or transcripts of the interviews.

Participants' privacy was also an ethical concern, and was discussed in the earlier section on data collection (p. 25). Confidentiality was maintained by safeguarding the audiotapes, diskettes, and transcripts of the interviews. These materials were available only to me and my thesis committee, were stored in a locked cabinet, and will be destroyed when the study is completed. (Tapes and diskettes will be erased, paper shredded.) The remaining field notes and memos, none of which contain any identifying information, will be stored in my home office. I may want to refer to them when I plan subsequent research to determine what nursing interventions are effective in helping family members to meet their needs. Also to maintain confidentiality, I referred to each participant by a code number during data analysis and when I shared the data with my committee.

Another ethical concern was informing participants about the study's findings to date without providing too much information, and thus influencing their descriptions of their experiences. During the interviews, participants were informed, in general terms, about the findings. Updating participants was also used as part of the interviewing technique. For example, summarizing what other participants had said about a particular aspect of the perioperative experience sometimes helped interviewees to discuss their experiences and

feelings. Participants, had they so requested, could have listened to/seen the tapes/transcripts of their own interviews. Participants were also offered a summary of the final report of the study, and all of them were eager to receive one. These will be mailed to them as soon as this report is completed.

Before the study proceeded, the research proposal was approved by the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects and the St. Paul's Hospital Ethics Committee for Human Experimentation. As well, the nurses whose workload was to be affected by the study (even though I expected the effect to be minimal) were oriented to the study's purpose and method. Had they had any concerns, these concerns would have been taken seriously and would have been addressed.

Summary

In this study, descriptive phenomenology was used to understand family members' perceptions of their own needs during the perioperative period. The study is a first step toward determining what nursing interventions are effective in helping family members to meet these needs.

Purposive sampling was used to select eight adult family members of eight patients undergoing extensive surgical procedures at St. Paul's Hospital in Vancouver. Variation in sampling was achieved by selecting participants whose relatives were having different types of surgery and who are related to the patients in different ways. Participants were recruited through the Pre-Assessment Clinic, where the initial contact was made by the nursing staff. To give participants the opportunity to describe their own experiences, two unstructured interviews were conducted with each of them: one during the perioperative period and one

about two weeks after the surgery.

Data collection and analysis were conducted almost simultaneously; Colaizzi's (1978) method of data analysis was used. Although data saturation was not reached in this study, I believe that I have produced useful conceptual categories from the data. From these categories, which are explained in detail in the following chapter, emerges an understanding of participants' needs during the perioperative period.

CHAPTER FOUR

Findings and Interpretation

In order to provide context for the findings that are reported and discussed here, this chapter begins with a brief description of the participants. Next, the findings related to the relationships between the participants and their relatives who underwent surgery are explained. The fact that these relationships exist is the key to understanding what family members experience during the perioperative period. In other words, because these relationships exist, family members were affected and concerned when their relatives needed surgery. Their concerns, in turn, generated feelings of distress, uncertainty, and anxiety.

From the data, four categories of family members' concerns were identified; the findings pertaining to these categories are reported and discussed next. This leads to a presentation of the coping behaviours that participants used, or attempted to use, to decrease the unpleasant feelings that were generated by their concerns. From the findings related to participants' concerns and their coping behaviours, family members' needs during the perioperative period emerge.

Description of the Participants

Eight family members–four husbands, two daughters, a wife, and a mother–participated in this study. They range in age from 21 to 80; their occupations are diverse (e.g., homemaker, fish plant packer, supermarket cashier, professional engineer). The participants' relatives, who range in age from 45 to 79, underwent a variety of extensive surgical procedures. These included aortic and mitral valve replacement, craniotomy for tumour, total hip arthroplasty, bilateral mastectomy, laparoscopic splenectomy, coronary artery bypass, tranlabyrinth excision of acoustic neuroma, and resection and grafting of abdominal aortic aneurysm.

All participants are Caucasian. Three of them immigrated to Canada–from England, Italy, and Poland. The participant from England has lived in Canada all her married life (i.e., about 50 years). The one from Italy came 38 years ago, as a teenager. The participant from Poland immigrated about five years ago with his wife and children. The youngest participant talked about how she was struggling financially; she and her mother live in a small, plain, one-bedroom apartment. Another works at two jobs, one full-time and one part-time, in order to support his family. The rest–judging from their attire, their homes, and their descriptions of their lifestyle–appear to live comfortably, to be financially secure. From my observations of their interactions, I concluded that all participants have functionally stable, caring relationships with their relatives who were having surgery, though analysis of these specific relationships is beyond the scope of this study.

The Relationship Between the Participant and the Patient

As stated in the introduction to this chapter, I believe that the fact that there is a relationship between the participant and the patient is the key to understanding what family members experience during the perioperative period. Because family members are connected in some emotional way, what happens to one (e.g., undergoing surgery) affects the other(s) (Bahnson, 1987). On the other hand, if someone to whom a person has no connection undergoes surgery, that person may be empathetic or sympathetic toward the patient, but is unlikely to feel anxious, uncertain, or distressed and would thus be unlikely to have needs related to the experience.

The three fundamental premises of symbolic interactionism, as described by Blumer (1969), help to explain this phenomenon. They are: (a) "human beings act toward things [including situations that they encounter and other human beings] on the basis of the meanings

that the things have for them" (p. 2); (b) "the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows" (p. 2); and (c) "these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (p. 2). These principles affirm my position that the meaning each participant attached to the experience of having a relative undergo surgery (i.e., his/her perception of the experience) was influenced by the "meaningfulness" of his/her relationship with that relative.

Participants described their "connectedness" to the patient in a variety of ways, as the following quotations illustrate:

- "We've been together over 60 years, and now my right hand needs help."
- "She's been a single mum most of my life so it's just me and her against the world."
- "There's a bond...she's my eldest, she's my firstborn."

Some participants explained that their feelings about the whole surgical experience fluctuated according to how the patient felt. This, too, indicates a connection between the participant and the patient. For example, one participant said that when his wife felt scared or upset, he felt the same way. If she seemed relaxed, he was able to relax.

Learning that their relatives (these people to whom they feel connected) needed surgery raised concerns for participants. Their concerns generated feelings of distress, uncertainty, and anxiety. When I spoke to participants during the perioperative period, some of them voiced concerns that they had been carrying for months. Several of them reported that they had not discussed these with the patient (at least not in any detail) because they did not want to make him/her more anxious.

Concerns That Generated Distress, Uncertainty, and Anxiety

At this point, it is necessary to define the word 'concerns' because it is a thread throughout this report. I use 'concerns' as a general term to describe the thoughts that both preoccupied and troubled participants, that consumed their time and energy. 'Concerns' range from the concrete to the intangible, and can produce varying types feelings, such as distress, uncertainty, and anxiety, and varying depths of feelings.

Participants' concerns are categorized into four main groupings: (a) concern about the effects of the diagnosis/prognosis on the patient's life and, consequently, on the research participant's life; (b) conflicting thoughts about the necessity of the surgery; (c) unpleasant past experiences with illness and/or surgery; and (d) fear of errors during hospitalization and surgery. The findings related to each grouping are reported and discussed.

Although I have separated participants' concerns into four groupings, the first grouping actually encompasses the other three. For example, the participants who had conflicting thoughts about the necessity of the surgery were worried that something untoward might happen to the patient if he/she had the surgery. If any of these "things" happened to the patient, the participants' lives would also be affected. Likewise, when participants related unpleasant past experiences and/or expressed fear of errors being made, they were thinking about what could happen to the patient and to *them* should history repeat itself or errors occur.

The other major issue that is apparent in the data about conflicting thoughts, unpleasant past experiences, and fear of errors is participants' lack of trust in those who were or would be caring for their relatives. Their lack of trust increased their concerns about the wellbeing of their relatives and, consequently, their concerns about effects in/to their own lives. Not only

were they concerned about the "usual" possible complications attributed to the diagnosis or surgery, but they were also concerned about complications due to poor judgement or even incompetence. Inherent in participants' concerns was a reluctance to relinquish their relatives to health care professionals whom they did not completely trust. An analysis of how this concept links with existing literature is presented at the end of this section (pp. 45-46).

Effects of the Diagnosis/Prognosis on the Lives of the Patient and the Participant

Participants reported that as soon as they learned that their relatives needed surgery, they began to think about the short-term and long-term effects of the diagnosis/prognosis on the patients' lives and, consequently, on their own lives. They also began to experience some of the short-term effects on their own lives. Examples of these short-term effects were having to take over household or child care responsibilities, rearranging work schedules, and having to change their daily activities with their relatives because of their (temporary) physical limitations. With short-term effects, participants had a clear idea of how their lives would be altered; they described specific plans to deal with expected effects. They could also see an end to these; they knew that their lives would return to normal relatively soon.

The long-term effects, however, were an unknown entity for most participants; they either reported or alluded to vague concerns about their relatives having permanent disabilities after surgery or even dying. For example, one participant simply said, "What if she dies? That would be awful". Another mentioned repeatedly the possibility of his wife having "nerve damage". These participants clearly expressed that they knew that their lives would *somehow* be very different if their relatives were permanently disabled or died, though they were unable to elaborate on specific concerns related to disability or death.

These findings indicate to me that the uncertainty attached to long-term effects made them

more distressing for participants than short-term effects. For example, if their relatives died, many aspects of participants' lives would be changed forever. However, until that happened, they could only speculate about the effects of death and how they would cope with them. Because they could not make specific plans to deal with *known* effects, they could not decrease their uncertainty. As Hilton (1992) explains,

> Uncertainty is usually threatening because a clear perception of what will happen may not be possible. Uncertainty limits the individual's sense of control over the danger and thus increases the sense of helplessness. When individuals cannot decide on a path of action, and resolution of the problem is unavailable or not possible, fear, excessive worrying, rumination, and anxiety can result. (p. 70)

Interestingly, the participant whose daughter had a brain tumour was different from the others in that she articulated concerns about specific long-term effects of her daughter's diagnosis/prognosis on her own life and was taking control by making plans to deal with them. She reported that she was worried that her distress about her daughter would affect her own health, especially her hypertension. She talked about how she might react–and was concerned that she might have difficulty coping emotionally–if her daughter developed specific disabilities postoperatively. She had already made tentative plans to sell her home (where she has lived for 35 years) so that she could be available to her daughter if her daughter needed her on an ongoing basis.

One question that arises from the findings about short-term and long-term effects is: What happens when short-term effects become long-term effects? At the second interview, several participants reported that during the postoperative period, they worked all day and in addition spent several hours visiting their relatives in hospital. They said they became exhausted, that they could not have kept up this pace indefinitely. This effect (i.e., having to visit, as well as live their usual lives) was tolerable because there was an end in sight. If their relatives had

developed complications or had disabilities that required indefinite hospital stays, participants would likely have had to make further adjustments to their usual routines (e.g., working fewer hours, staying closer to the hospital). In other words, the length of time an effect is expected to last, rather than just the effect itself, influences how people cope with it.

This concept pertains to participants' concerns about the effects of the diagnosis/prognosis on their relatives' lives and, as a result, on their own lives. When participants discussed the next three categories of concerns–conflicting thoughts about the necessity of the surgery, unpleasant past experiences, and fear of errors–they were actually thinking about possible effects on their own lives if something went wrong during the surgery. Short-term effects with obvious solutions and ends in sight cause less distress than long-term effects veiled in uncertainty.

Conflicting Thoughts About the Necessity of the Surgery

Although only two participants described their conflicting thoughts about whether their relatives' surgery was necessary, these thoughts dominated their stories. It was evident that this specific concern significantly increased their anxiety during the perioperative period. As one of them pointed out, "It [his relative having surgery] is enough of a yo-yo sort of thing *as it is*, without all the other emotions going on [for him]".

One participant had serious reservations about his wife having the surgical procedure for which she was scheduled. He said, "I mean she's sick, but she's not that sick and, you know, we could probably get by with this thing [her illness]". He explained how his anxiety had increased greatly over the previous two days as he had learned more about what the procedure entailed, some of which conflicted with what he and his wife had originally been told by the surgeon. He had felt almost panic-stricken that the surgery was going to take

place, and had desperately wanted reassurance that they were "doing the right thing". However, he had not requested the reassurance he needed for three reasons: Firstly, and most importantly, he did not want to let his wife know how worried he was because he did not want to "upset" her. The day before her surgery, he had taken time off work to stay home with her; this made it difficult for him to gather information surreptitiously. Secondly, he could not decide whom to ask. Thirdly, he thought that he was "maybe overreacting". He said, "I just finally decided not to [call someone] and cross our fingers and say our prayers and hope it all works out".

On the day of surgery, he received more conflicting information and explanations about his wife's surgery from both physicians and nurses. He interpreted this to mean that either: (a) he was being told about further changes to the original plan, changes made without consulting with/informing him and his wife; or (b) physicians and nurses did not really know what they were talking about and, consequently, what they were doing. He commented, "When the game plan changes...or it appears that the game plan is changing...your confidence drops down". As his confidence in health care professionals decreased, his anxiety about the risks of the procedure increased, as did his lack of conviction that he was doing the right thing in "allowing" his wife's surgery to proceed. Throughout our conversation, his lack of conviction about his wife's surgery was evident. At one point he said, "I don't know whether we're doing the right thing or not". Almost immediately he added, "You know, we're going to assume that we're doing the right thing". A few minutes later he said, "It's still going around in my head, around in my head, around in my head". Obviously he was not convinced that his wife should be having the surgery.

Another participant also had reservations (from the time of diagnosis) about the necessity

of his wife's surgery. Then, when she had to wait six months for surgery, he had difficulty understanding what he perceived to be a mixed message. He commented, "The doctors all said, 'The sooner you get it [the tumour], the better'....and when the wait [six months] came, you know it's growing and you're waiting this time". In other words, if the argument for having the surgery was that the tumour should be removed as soon as possible, waiting six months seemed to weaken this argument. On the other hand, he kept thinking that when his wife finally had the surgery, the procedure would be more complicated because of the increased size of the tumour.

The issue of trust is evident in the findings related to conflicting thoughts about the necessity of the surgery. Because conflicting or confusing information was provided by health care professionals who would be involved in the surgery, participants found it difficult to place their relatives in the care of these people–people whose credibility they questioned and whom they did not really trust. Furthermore, participants were concerned about the complexity of the surgical procedure and about its success. In other words, their lack of trust was one more reason to be concerned about the wellbeing of their relatives. Their degree of concern about the wellbeing of their relatives directly influenced their degree of concern about what could happen in their own lives, perhaps for the long-term, if something went seriously wrong during the surgery.

Unpleasant Past Experiences With Illness and/or Surgery

When I designed this study, I wondered whether having previously experienced a relative undergoing surgery would affect participants' experience during the perioperative period. I therefore asked all participants about any such experiences; none of them felt that these had much, if any, impact on their current feelings. However, several participants spoke about

unpleasant events related to "nonsurgical" illness, to hospitalization, to treatment, and/or to their own surgery. As they told their stories, it became apparent that concerns raised by these experiences affected how they felt during the perioperative period.

One of the participants who had conflicting thoughts about the necessity of his wife's surgery explained how his experience with his own surgery fuelled his conflicting thoughts and increased his anxiety. He said, "I got talked into that decision....It didn't seem like a good idea but you don't want to argue....It got really messed up, pretty scary. It scared me about surgery....This time I wanted to be really convinced".

The participant whose daughter had a brain tumour related her experience when her husband had a stroke. She envisioned her daughter having many of the same physical and emotional problems postoperatively as her husband did after his stroke, even though these problems had not been mentioned as possibilities for her daughter. For example, she talked about how she would cope if her daughter was paralyzed or if her speech was affected.

This participant also described her experience with health professionals who, she said, "gave up" hope that her husband would recover from his stroke. She believes that it is only because of her determination (and his) that he recovered as well as he did. She told me, "They didn't listen to us....They said he'd never get out of bed....They said he'd never walk; he walked with a cane". She also told me about another similar experience related to "giving up"; this one occurred a number of years ago when her daughter (the same one) was seriously ill in hospital (with a problem unrelated to her current one). She said, "I flew out there [to Rome]....And they had given her up. [According to them], she wasn't going to recover. She was too far gone". She believes that her daughter recovered only because she persuaded the physicians to continue treating her. The participant spoke about how she was ready once

again to "struggle", to ensure that no one gave up on her loved one this time. She felt that she was carrying the burden of responsibility for her daughter's recovery.

Participants who spoke about unpleasant past experiences were thinking, "What if the same thing happens in relation to this surgery"? For example, if this surgery was "messed up" or if health care professionals "gave up" this time, the patients would suffer the consequences and the participants' lives could be affected–once again, perhaps for the long term. Inherent in these stories are participants' concerns about health care professionals' judgement. This suggests to me that participants were having difficulty placing their trust in the people who were or would be caring for their relatives during the perioperative period.

Fear of Errors During Hospitalization and Surgery

Several participants expressed concern about drastic errors occurring during surgery or talked about errors that had affected people they knew. One participant, whose husband was going to have an epidural anaesthetic said, "Evidently something can go horribly wrong....We have a friend who's paralyzed from the neck down because he went in for poor circulation in his feet–and it turned out like that". The participant whose wife was having the excision of an acoustic neuroma said, "You'd like to be standing behind them [during the operation], be sure that nothing goes wrong". The participant whose father was having a total hip arthroplasty said several times that she wanted to make sure that the surgery was done on the correct hip.

These participants all commented that they were concerned about serious errors even though they knew that the likelihood of such errors was remote. They also wanted their concerns to be recognized as valid by the health care team, as the following quotation illustrates: "Please don't think we're crazy. You just want to make sure, you know. You just want to make sure."

Participants' fear of errors occurring is one indication of lack of trust in the abilities of those who were or would be caring for their relatives. It also indicates lack of trust in the adequacy of hospital protocols, such as the means of identifying patients prior to carrying out procedures. If serious errors occurred during surgery, the patients' lives and, thus, the participants' lives could be affected.

The Issue of Trust

Participants' lack of trust in health care professionals permeated the concerns of all but two participants. Clearly, these six did not have complete trust in the abilities or intentions of those who were or would be caring for their relatives. Thorne and Robinson (1988, 1989) discuss reciprocal trust in health care relationships (between patient/family member and health care provider) when the patient has a chronic illness. These authors make a number of points that help to explain the findings of this study–to explain participants' relationships with health care providers when the patient had an acute, rather than a chronic, condition.

Thorne and Robinson (1989) state that "relationships evolve over time through three predictable stages: naive trust, disenchantment, and guarded alliance" (p. 153). Naive trust and disenchantment seem to be relevant to my findings. In the first stage, family members (including the patient) believe that the health care providers share their perspective about what is best for the patient and will involve them in care. Then, when it becomes evident that the health care providers have their own agenda, family members become disenchanted with these people; they lose their initial trust in them (Thorne & Robinson, 1988). Several of the participants in my study did not trust as a result of previous experiences with other health care providers who had misled them or had not listened to them. These participants became disenchanted in these previous relationships, and brought this stance to their current

situations. The participant who described being almost panic-stricken that his wife's surgery was going to take place (pp. 40-42) told me that when he first met the surgeon he liked and trusted him. He became disenchanted and angry when he perceived that the surgeon had withheld information about the complexity and newness of the surgical procedure.

Fosbinder (1994) examined nurse-patient interactions to "identify elements of interpersonal competence among nurses from the perspective of patients" (p. 1085). One of the four elements identified was establishing trust; nurses "who knew what they were doing" (p. 1089) were trusted by patients. From the data related to participants' concerns, it is apparent that many of them had encountered health care professionals who appeared not to know what they were doing. These encounters seem to have broken participants' trust in specific people and in health care professionals in general.

Summary

In this section, I have reported and discussed the findings pertaining to four categories of concerns that participants brought with them to the hospital on the day of surgery. These centred around the effects of the patient's diagnosis/prognosis on the participant's *own* life and around the issue of trust. Because participants did not completely trust those who were or would be caring for the patient, they were more anxious about the patient's wellbeing. Increased concern about the patient translated into increased concern about the effects of the patient's diagnosis/prognosis on the participant's own life.

Coping Behaviours to Decrease Distress, Uncertainty, and Anxiety

Because a coping behaviour is "a response that satisfies a basic human need" (Campbell, 1987, p. 35), nurses may be able to extrapolate a person's needs from his/her coping behaviours. During the perioperative period, participants used three different categories of

coping behaviours to decrease the distress, uncertainty, and anxiety generated by their concerns; that is, in efforts to meet their own needs. These coping behaviours are: (a) remaining connected (or attempting to remain connected) to the patient, (b) reassuring themselves, and (c) occupying their time with activities (e.g., spending time/conversing with others, going for walks, going to eat). In this section, each of these categories of coping behaviours, as well as the associated needs that emerge from them, are discussed.

Remaining Connected to the Patient

As they talked about their experiences, all participants used or described coping behaviours that reflected the need to remain connected to the patient during the perioperative period. This need has three main components: (a) wanting to be with the patient or wanting to have the option of being with him/her; (b) wanting regular updates about the progress of the surgery and the patient's condition during surgery; and (c) wanting to wait at the hospital or at a specific location in order to be immediately available to receive information, especially in the event that complications occurred during surgery. The findings related to each of these components of the need are presented in the following subsections. Also included is evidence of the how physicians and hospital staff, hospital protocols, and the physical environment affected participants' attempts to cope.

Wanting to be with the patient. In this discussion, I have not included wanting to be with the patient, or wanting to have the option of being with him/her, during the time he/she is in the theatre (i.e., the room where the surgery is performed). In my experience as an OR nurse, I do not recall a family member ever requesting to remain during a surgical procedure (except Caesarean section, where family members are permitted); I therefore assumed that the participants would not want to either. My assumption stems from an unwritten rule that

family members do not enter the theatre, that aseptic technique would be compromised and family members upset seeing their relatives undergo surgery. This rule is in effect in virtually every OR; it is so prevalent that people (i.e., OR staff, physicians, patients, family members) do not think to question it. When one participant, talking about his fear of errors, said that he would like to be "standing behind them [the surgical team]", it never occurred to me to ask him if he meant this literally. In other words, I cannot comment on whether participants wanted the option of remaining with the patient *all* the time, including the time the patient was in the theatre. Instead, I report and discuss the findings pertaining to their wanting to be with the patient preoperatively and postoperatively.

Preoperatively, all participants' relatives were admitted to the Surgical Daycare (SDC). Upon arrival to the SDC, patients are interviewed and assessed briefly by a staff nurse. The patients then change into hospital garb and wait, either in the waiting room or on a stretcher, until it is time to move to the pre-surgery waiting area. The length of time between admission to the SDC and transfer into the theatre varies greatly; however, for the majority of the patients whose relatives were participating in this study, the length of time was less than an hour. Participants reported that they, and often other family members as well, remained with the patients most or all of this time.

Although I did not ask each participant whether he/she had remained with the patient during the patient's nursing interview and assessment, two of them told me that they had. I went on the assumption that any patient and his/her family member(s) would usually decide together whether or not a family member would stay during the nursing interview and assessment. In other words, a participant may have wanted to remain with the patient but the patient may have chosen another family member or preferred to be alone with the nurse.

One of the participants who stayed with the patient during the interview and assessment, and one who wanted to sit with the patient in the nursing area, described similar nonverbal messages that they received from the nursing staff as they (the participants) entered the unit. They explained:

- "I walked in with my dad [the patient]; she [the nurse] completely ignored me."
- "I walked in and they–I don't think they said anything–but I didn't feel exactly, you know, I was welcome there."

The climate in the unit did not support the coping behaviours that these two participants were attempting to use to meet their need to stay with the patient.

One of these participants stayed with her father (the patient) despite the fact that the nurse continued to indicate to her that she was unwelcome. The participant described the nurse's behaviour, and her feelings about such behaviour, in this way:

> She talked over my head to my dad....I don't think she ever looked at me or acknowledged me....The body language spoke volumes and she completely ignored me....So, this morning I didn't feel very comfortable....I think really I was in the way....I don't want to be bowed to or anything but I am a human being....There should be a little bit of sensitivity.

The participant was obviously upset by her experience with this nurse. She eagerly recounted the episode, wanting me to "do something about it" (to prevent the same thing from happening to someone else), and repeatedly returned to the issue, during both our initial and follow-up conversations. As is apparent from the following quotation, she also found it difficult to understand why the nurse did not want her to remain with the patient:

> If there is a life-threatening type of reason that I should not be beside my family member, I want you to let me know. And if there isn't, I want you to–I would feel that you could acknowledge me....I wasn't there to make life harder. I was there to make it easier.

This participant also described the effect that her encounter with the nurse had on her

father. She commented,

> I could feel my dad putting pressure on me–squeezing my arm, pressing against my leg. He didn't want me to say anything. And I think it was because, you know, they may not look after him. They may hold something against him.

Her father's concern increased the participant's concern about relinquishing him into the care of health care professionals whom she *already* mistrusted to some degree. She told me that even before she arrived at the hospital that day, she had been concerned about errors during his hospitalization and surgery.

This participant was in a double bind or "no-win" situation, a situation similar to that described by Robinson (1985) in relation to parents of hospitalized chronically ill children. For a double bind (Bateson et al., cited in Robinson) to exist, there must be "a sequence of two contradictory messages, one explicit and the other implicit or subtle, repeated over time and enforced by punishment....A third negative injunction that prevents escape from the relationship completes the requirements" (p. 112). Although the participant was staying with her father because she believed she could contribute something to his care, the nurse clearly indicated that her contribution was not valued, that she was unwelcome. This situation created conflict for her; whatever she decided to do would be "wrong". If she remained with her father, the nurse would be displeased; if she left her father, she would be giving in rather than doing what she believed to be in his best interest. The participant could not divorce herself from the nurse–she could not escape from the relationship–because the nurse was a member of the team who was providing necessary treatment for her father. Both the participant and the patient feared reprisal if she upset the nurse by behaving "badly". They feared that the nurse, as well as other members of the team, may not provide as good care for him.

Because the other of these two participants felt so unwelcomed in the SDC, he and his wife (the patient) went to sit in the hallway outside the unit. When his wife was called back into the unit a short time later, he simply followed along. Because he had continually received conflicting information about her surgery, he wanted to remain with her to see for himself what was happening; he found it hard to trust those who were or would be caring for his wife. He, too, expressed the belief that he should be able to remain with his wife without feeling that he was "imposing" on the nursing staff. He also feared reprisal by health care professionals because of his behaviour. He said,

> How hard do you push the system to get what you want?...It's really tough....You're playing that little game of being nice to everybody and trying to get the best service by being nice to them....[If you're labelled] as a jerk, then you [self] don't get the same care [consideration].

These two participants had a need to remain with the patient. The nursing staff, by making it very apparent that participants were not welcome in the SDC, interfered with their attempts to meet this need. They interfered with participants' attempts to decrease their feelings of distress, uncertainty, and anxiety. Both participants had to be assertive in order to remain with the patient; both felt that having to act assertively put an additional burden on them during this already stressful time. They believed that wanting to remain with their loved one was natural and reasonable and should not have been challenged.

During my conversation with the participant who was upset by the nurse in the SDC, I mentioned that she could have stayed with her father in the pre-surgery waiting area. She said, "Oh, wonderful. Now you're making me feel comfortable; you're making me feel more comfortable....I just need to be allowed to do what I feel I need to do and if I feel I don't have to do anything, fine". In other words, knowing that she had had the *option* of being with him

seemed to meet her need.

Family members wanted to reconnect with the patient as soon as possible after surgery. With the exception of one family member whose relative was having open heart surgery, participants either expressed a desire to see the patient as soon as possible after surgery, or described, during our follow-up conversations, how seeing the patient in PAR reduced or would have reduced their anxiety. The following quotations illustrate this point:

- "We [participant and her mother–the patient's wife] would like to be here [as soon as the surgery is over]...holding hands with him making sure."
- "About a quarter to eight she was in recovery and we...shortly after we went in there and talked to her, and were relieved."
- "I still [despite assurance from the surgeon] didn't feel secure in the knowledge that she was OK until I saw *her*."

One participant was notified by telephone about complications that had occurred during his wife's lengthy surgery. He imagined the worst; he clearly felt less anxious after seeing her. He said, "I was over at the hospital in about 10 minutes....I went straight into the PAR....I just walked straight in there....you know, she really didn't seem to be too critical, she was snoring away". Another participant, who knew that his wife would be intubated and thus unable to speak when he first saw her, described how they had developed and practised hand signals preoperatively so that his wife could communicate to him that she was "OK".

These data suggest that participants needed to remain with the patient preoperatively and to reconnect as soon as possible postoperatively for three main reasons. The first is that the participant and the patient are related and emotionally/socially connected. Anywhere they go together in their day-to-day lives, they probably want to remain together, to be in one

another's company. The second is that because participants cared about what was happening to their relatives, they actually wanted to *see* that they were alright. (The expression "seeing is believing" seems to apply here.) They cared not only out of concern for the patient, but also out of concern for the effects of the patient's diagnosis/prognosis on their *own* lives. The third reason that participants needed to remain with the patient was that by remaining with him/her, they could watch over him/her–could maintain some control, especially when they did not completely trust those who were or would be caring for their relatives.

Wanting regular updates. During the time the patient was in the theatre, most participants would have liked to receive regular updates about the progress of the surgery and the patient's condition. Regular updates would have helped them to remain connected to the patient during this period of physical separation.

For the most part, participants believed that the physicians and hospital staff were unaware or unconcerned that they were anxiously waiting during the surgery. For example, one participant learned, a day or two after his wife's 10-hour surgery, that the two surgeons had taken breaks during the procedure. He was incredulous that it had not occurred to them to let him know what was happening. As he pointed out, "It would have taken 30 seconds to pass it on".

The time factor was very significant to all the participants. They knew what time the surgery was scheduled to begin, how long it was scheduled to take, and thus what time it should be completed. Most of them, however, considered the latter time as the time that the surgery definitely *would* be completed. When the "allotted time" was up, participants' wondered if something was wrong and, as a result, their anxiety increased. As one participant commented, "Every minute past that time your anxiety increases, increases, increases. You

wonder if something's gone wrong because they're not there when they said they were going to be". Another participant attempted to control his mounting anxiety by minimizing the significance of the delay. He said, "After a while I thought, well, if something is going wrong, they wouldn't be treating me like this [ignoring him]".

Three participants, whose relatives' operations took several hours longer than they expected, asked for information at the OR reception desk; one of them asked every half hour for several hours. All were told that their relatives were still in surgery, but that no other information was available. One of them described what this time was like for her: "I was freaking out. I was crawling the walls. Oh, I was praying–I was making deals with God–and walking and crying and just all these emotions. It was incredible."

Thorne (1985) "conducted an informal survey of expert waiters" (p. 48). Although she spoke to patients, much of what these patients said was echoed by the participants in the present study. Patients claimed "that the indignity of being pacified compounds their anxiety and magnifies the stress of waiting" (p. 49). The participants who asked for information at the OR reception desk were pacified inasmuch as their anxiety was not acknowledged. In addition, because these participants were not given any useful information, they could not interpret the meaning of the prolonged surgery time. This, too, increased their anxiety. Thorne reports that, according to some patients, "not knowing what to expect is even more distressing than the anticipation of a predictably negative experience" (p. 49).

Nurses involved in the intervention programs which are discussed in Chapter Two (pp. 17-18) made several observations about the waiting period that support the findings of this study. Donnell (1989) states, "The longer they [family members] wait, the more stress they feel" (p. 1088). She adds, "Fear arises when the surgery is not completed when the

surgeon said it would be" (p. 1092). Watson and Hickey (1984) explain one of the reasons for initiating their program: "We found that families were having trouble getting information during and immediately after surgery" (p. 604). Discussing their impressions of the benefits of their program, they state,

> Time becomes tremendously important to waiting families. When a surgeon has told a husband,"'I'll talk to you about noon", and by 12:30 there is no word, it can only mean that something has gone wrong. Helping families cope with such worries is one of our biggest problems. (p. 607)

During the time the patient was in the theatre, participants anxiously awaited news about him/her. Their concern may have been intensified by their lack of trust in those who were caring for the patient–and caring for him/her in a place where the participants had no control, where they could not see and were not told what was happening. As they waited, participants were thinking about the patient's wellbeing; the direction of their own lives hinged on the outcome of the surgery and the patient's prognosis. To decrease their distress, uncertainty, and anxiety, they needed regular updates about the progress of the surgery and the patient's condition.

Wanting to wait at the hospital/specific location. All but two of the participants either remained at the hospital during their relatives' surgery or went home or to their offices. A couple of those who left the hospital wanted to make sure that their telephone numbers were on the patients' charts. A couple of those who remained had a note placed on the chart, saying that they were in the waiting room. One participant, commenting on the hospital staff's apparent lack of concern about how to contact him during or after the surgery, said, "There's no system set up...I mean, nobody's come up to me and said, 'If there's anything goes wrong, we're going to phone this number'....To me, that's kind of basic....That's pretty darned

important". These family members needed to know–they were not willing to assume–that the surgeon or hospital staff could reach them.

Those who chose to stay at the hospital explained that they felt more comfortable being close at hand; they were staying in case something happened. One participant explained, "The closer you are the better. If something has to be done or if there's a problem, you want to be there....You can make decisions". Another said, "I feel that if something happened, she'd never forgive me if I wasn't here". If serious complications occurred during surgery, participants wanted to have some degree of control; they wanted to be informed and/or consulted about the patient's treatment. Once again, most participants' concern about the patient was intensified by their lack of trust in those who were caring for him/her.

Participants also wanted to wait at the hospital or at a specific location so that the surgeon would know where to find them after the surgery. Although most of the surgeons did speak to the participants, several felt that if they had not organized the meeting themselves, the surgeon would not have sought them out.

Summary. Participants described and used (or attempted to use) coping behaviours that indicated an overall need to remain connected to the patient during the perioperative period. Three specific needs emerge from the overall need. They are: (a) the need to be with the patient or have the option of being with him/her–preoperatively and postoperatively; (b) the need to receive regular updates about the progress of the surgery and the patient's condition; and (c) the need to wait somewhere that is both readily accessible and known to physicians and hospital staff.

Reassuring Themselves

During the perioperative period, all participants attempted to decrease their distress,

uncertainty, and anxiety by frequently reassuring themselves, usually about the physicians, hospital staff, or hospital. Examples of self-reassuring comments are:

- From the participant who was very apprehensive about his wife's anaesthetic, after meeting the anaesthetist preoperatively: "She seems to be very good. I liked the idea of her being young and keen."
- From one of the participants who was very concerned about errors being made: "I've heard that Dr._____ is a very good surgeon, so we don't have that worry."
- "Well, we have no qualms about (patient) going through the operation [open heart surgery]....We believe she's in good hands."
- "Well, this hospital, compared to (another local hospital)–I've found it's a lot better–the atmosphere, and the work, and the outlook towards work is a lot better."

The participant whose daughter was having the craniotomy also reassured herself. She was very concerned that her daughter would not do well and spoke about her fear that she (the participant) would "break down" if the news was bad. She was the only participant who was visibly distressed (e.g., tearful, trembling) during our conversation. In the midst of her distress, she suddenly said, "Everything's going to be fine, so that's a plus for me". At another point, she said, "I have a great belief that God only sends you what you can stand".

The prevalence of self-reassuring comments in our conversations during the perioperative period led me to conclude that participants made them in *attempts* to cope with unpleasant feelings generated by their concerns. For example, several participants were relinquishing their relatives into the care of people whom they did not completely trust. These participants likely used self-reassurance to minimize the discrepancy between what they felt and what they were doing (i.e., "letting" the patient undergo the surgery). These reassurances, however,

were only "band-aids"; they did not resolve the participants' much deeper concerns.

I believe that the prevalence of self-reassuring comments in our conversations underscores participants' distress, uncertainty, and anxiety. They underscore participants' need to remain connected to the patient; remaining connected or attempting to remain connected was participants' primary means of decreasing their unpleasant feelings.

Occupying Time With Activities

All participants described specific activities–spending time/conversing with others, going for walks, going to eat–that they did while the patient was in the theatre. They reported that the time seemed to pass more quickly while they were engaged in these activities; the activities also helped to distract them, to take their minds off the surgery.

Participants spoke about the emotional support that they received from others, either family members, friends, or strangers–others who understood because they, too, were waiting. Two participants who waited alone at the hospital described the helpful relationships that they formed in the waiting room with strangers, people whose names they could not even remember. One of the participants who waited for hours–and who had told me that he *preferred* to wait alone–eventually called his son to come to the hospital to keep him company. As he explained,

> I was beginning to get anxious because no information at all, and it was well past the time the surgery was supposed to be done. So I told my son, "Come on down"....And that was a lot better having somebody with you while you were waiting, to sit and discuss.

Another participant, who waited with her daughter, told me, "It wouldn't have been good if I'd have been all alone. Actually, I wouldn't even consider being alone". One who did wait alone said that she spent a lot of the time on the telephone, talking to friends and relatives who live in other parts of the country.

Two participants went walking in Stanley Park. Both said that the physical activity and the natural surroundings were calming for them. One of the two said that she would have been a "nervous wreck" had she had to spend the whole time in the waiting room. Several participants talked about going to eat to pass the time. One went out to eat with people she met in the waiting room. A couple of participants reported that because they did not know when the surgeon would come to speak to them (because they could not get any information) they felt compelled to remain in the immediate vicinity of the OR. They believed that had they been able to leave for a snack or a meal or a walk, these activities would have decreased the anxiety they felt while waiting.

What, then, is the significance of time-occupying activities, other than distracting participants and/or dissipating some of the unpleasant feelings generated by their concerns? What needs emerge from these coping behaviours? I believe that these activities demonstrate that participants needed to be able to get away from the waiting area; they needed information so that they could make informed decisions about when it was "safe" to leave. In other words, even though they needed to get away, they also needed to remain connected; they did not want to miss any news about the patient. Had participants' need for updates been met, they would have received much of the information that they needed to make these informed decisions. For the most part, participants indicated that the company and concern of others helped to diffuse some of their anxiety. Therefore, they also needed contact with others who recognized and acknowledged their feelings.

Summary of Findings

The research question addressed in this study was, "During the perioperative period, what are family members' perceptions of their needs?". Participants, however, did not use the word

'needs' when describing their experiences. Instead, they talked about their concerns and about the unpleasant feelings generated by these concerns; they used or attempted to use a number of coping behaviours to decrease these feelings. From the findings related to participants' concerns and coping behaviours, I extrapolated their needs during the perioperative period.

Eight family members of eight patients undergoing extensive surgery participated in this study. Because each family member and patient are related and emotionally connected, family members were affected and concerned when their relatives needed surgery. I identified four major categories of concerns that generated feelings of distress, uncertainty, and anxiety for participants. These are: (a) concern about the effects of the diagnosis/prognosis on the patient's life and, consequently, on the participant's life; (b) conflicting thoughts about the necessity of the surgery; (c) unpleasant past experiences with illness and/or surgery; and (d) fear of errors during hospitalization and surgery. The first category encompasses the other three. In other words, participants' concerns all centred around what could happen in their *own* lives if something "bad" happened to the patient. Also evident in their concerns was their lack of trust in the health care professionals who were or would be caring for their relatives. Lack of trust increased participants' concerns about the wellbeing of the patient and, thus, their concerns about how their own lives could be affected.

Most of the coping behaviours that participants used to decrease the distress, uncertainty, and anxiety generated by their concerns relate to remaining connected, or attempting to remain connected, to the patient. Five specific needs emerged from their coping behaviours. These are: (a) to be with the patient or have the option of being with him/her, both preoperatively and postoperatively; (b) to receive regular updates about the progress of the surgery and the patient's condition; (c) to wait somewhere that is both readily accessible and

known to physicians and hospital staff; (d) to be able to make informed decisions about when it is "safe" to take breaks away from the waiting area; and (e) to have the company of others who recognize and acknowledge their feelings.

Most participants had difficulty meeting some or all of these needs during the perioperative period. Hence, there are several obvious ways that nurses could intervene to help family members meet similar needs, to prevent them from having such distressing experiences. These nursing interventions, as well as other implications and applications of the findings for nursing practice, education, and research are discussed in the following chapter.

CHAPTER FIVE

Implications and Applications

Significance of This Study

Very little research has been done about the needs of family members during the perioperative period. The findings of this study indicate that family member participants had significant needs and that, for the most part, these needs were not met. Although preliminary, the findings provide significant insight into family members' experiences, and obligate nurses to intervene to help other family members to meet similar needs. The findings also provide a starting point; because we have some understanding of family members' needs, we can begin to plan, implement, and determine the effectiveness of nursing interventions. I envision personally conducting subsequent research to determine what nursing interventions are most effective and practical in helping family members to meet their needs.

Prior to discussing the implications and applications of the findings for nursing practice, education, and research, it is necessary to discuss two issues that affect the rigor in this study. The first issue is that the study focuses on individual family members rather than on the family unit; the second is that data saturation was not reached.

Rigor in This Study

Individual family members as the unit of analysis. In this study, I chose to focus on individual family members rather than on the family unit, even though Gilliss (1989) and McShane (1991) state that considering the family as the unit of care is usually preferable because it deepens the understanding of the family. Because considering the family as a unit is a more complex approach, my limited research experience and time factors may have made it difficult for me to complete a study focusing on the family unit. Nevertheless, my findings are

significant because caring for individual family members is part of caring for the family unit. As Gilliss, Roberts, Highley, and Martinson (1989) state, "The family nurse attempts to deliver service to the family group while serving the individual family member" (p. 65). In addition, the findings are useful because I have often observed family members waiting alone during the perioperative period; these people clearly have needs and would benefit from nursing care. Effective intervention with one family member frequently influences the whole family (Gilliss et al.; Wright & Leahey, 1994).

Failure to reach data saturation. Due to time limitations, as well as the diversity and complexity of participants' experiences, I did not reach data saturation, which threatens the fittingness of the study (Guba & Lincoln, cited in Sandelowski, 1986). Because I did not continue data collection until no new descriptive labels emerged, my description of family members' experiences during the perioperative period is not exhaustive. Although my description "fit" for participants, as well as for a few colleagues, and a few friends and relatives who have experienced a loved one undergoing surgery, it is less likely (than if I had reached data saturation) that everyone would see the findings of this study as reflective of their own experiences. Others may have experienced something that I have not "uncovered" and have not included in my description. Therefore, when I use the findings of this study to suggest nursing interventions for other family members, these interventions will both further verify the findings of the study and validate other family members' experiences.

Implications/Applications for Nursing Practice

Although nursing research is needed to determine what nursing interventions are most effective in helping family members to meet their needs, my experience as an OR nurse, coupled with the findings of this study, enables me to suggest possible interventions. Because

the study participants were so obviously distressed, I believe that we should begin to intervene now in an effort to help other family members. Although I am referring to my work setting in the following interventions, many of them could be implemented in any OR.

We could begin by developing a protocol for updating family members of patients undergoing extensive surgeries. The protocol would have to include a number of points, such as who would provide updates (e.g., the nurse looking after the patient in the theatre or one nurse assigned to give all updates), what specific information would/would not be given, and who would provide ongoing support for family members when the update news was guarded or negative. Family members could be informed about this update protocol at the Pre-Assessment Clinic. On the day of surgery, an OR nurse could meet them preoperatively, develop an individualized plan (e.g., where family members would wait, how often they would be updated), and gather the information for/provide the updates. After the patient was out of the theatre, family members could be asked for feedback about the updates. These data could then be used in a study designed to evaluate the effectiveness of nursing interventions.

As mentioned in the report of the findings, participants expected the surgery to be finished at the predicted time; they became very anxious when this did not happen. Family members could be given a handout (on the day of surgery) explaining that scheduled times are only approximate, that the OR sometimes runs behind schedule, and that the length of time allocated for a surgical procedure does not include anaesthetic or preparation time. This information, along with updates, would likely decrease family members' anxiety.

Another possible nursing intervention is to give or send family members a handout (via the Pre-Assessment Clinic) explaining what family members may experience during the perioperative period (i.e., a handout summarizing the findings of this study). I suspect that

many family members would have concerns and feelings similar to those expressed by participants in this study; this information could be helpful to them because it could validate *their* feelings. Included in the handout would be a telephone number of a staff member whom family members could call with feedback, or to discuss their concerns. Information provided by them could become data for a continued study about family members' perceptions of their needs.

The study's findings also indicate that family members want to remain with or have the option of remaining with the patient preoperatively and want to see or have the option of seeing the patient immediately postoperatively. Although I think these needs could be met relatively easily, at the moment I can only suggest to nurses in those units that they consider ways to provide family members more access to the patient. Eventually, I anticipate that nurses in each of the areas (i.e., Surgical Daycare, Operating Room, Post-Anaesthetic Recovery Room, and Critical Care Recovery) will work together to develop, implement, and evaluate a comprehensive care plan for family members.

Operating room nurses could develop some interventions to meet family members' need for the company of others during the time the patient is in the theatre. For example, family members could be told in the handout (mentioned above) that others have found it helpful to have company while waiting. It could be suggested that they bring someone with them. Volunteers could perhaps be taught to "befriend" waiting family members. If an OR nurse were providing updates to family members of several patients, he/she could introduce family members to one another.

As mentioned in the previous chapter, participants reported that information about the progress of the surgery would have told them when it was "safe" to leave the waiting area.

Most found it helpful to get away for a walk, a snack, or a meal. If an OR nurse were providing updates, he/she could encourage family members to take breaks between the scheduled updates. If they wanted to remain in touch at all times, family members could tell the nurse exactly where they were going.

Nursing interventions should be systematically evaluated at three levels. The first level is the continuous, informal nursing assessment/evaluation that is part of any nurse-client interaction. It encompasses nurses' conscious and intuitive decisions to modify interventions for the individual client. At the second level, feedback about specific interventions should be formally obtained from family members, as in quality assurance audits. If necessary, interventions can be changed based on this information. At the third level, research is done to determine the effectiveness of nursing interventions. Depending on the research findings, interventions are either continued or revised. The nursing care provided then becomes based on theory, rather than on tradition or personal beliefs (Polit & Hungler, 1991). As sample sizes are often small in intervention studies, data from two or more sites can be combined . Increasing the sample pool in qualitative studies deepens nurses' understanding of the phenomenon of interest by providing increased variability in concepts (Ray, 1990; Strauss & Corbin, 1990); in quantitative studies, "The larger the sample, the more representative of the population it is likely to be" (Polit & Hungler, p. 265).

Implication/Applications for Nursing Education

Clearly, nurses have to intervene to help family members to meet their needs during the perioperative period. Because the time the patient is in the OR is central to the perioperative period, I believe that OR nurses should take the initiative in caring for family members. Before this can occur, OR nurses would do well to remember that our mandate does include

caring for these people, and that, as a group, we are committed to caring for patients' relatives. Admittedly, it may be a challenge to "convert" nurses who work in our present health care system where resources are scarce and nurses express concern that they barely have enough time to meet the *patient's* basic needs. However, I believe that education about family members' concerns, feelings, and needs during the perioperative period is the key to bringing nurses on side. In addition, as OR nurses care for family members, they will see the benefits to both family member and patient. As Gilliss et al. (1989) point out, "The nature of families and their members is so intertwined that both will be affected by nursing care" (p. 71). Wright and Leahey (1994) affirm these authors' position when they state, "A change in one family member affects all family members" (p. 19). Nurses may, for example, see that a calm family member has a calming effect on the patient.

The first step in educating nurses is to disseminate the study's findings and to discuss their implications and applications. I have already begun to do this in day-to-day conversations with colleagues and superiors, many of whom ask me about the findings. I will also provide inservice education sessions for OR nurses and other nurses (e.g., nurses in Surgical Daycare and the Post-Anaesthetic Recovery Room) who care for patients during the perioperative period. I plan to publish the findings in different types of nursing journals. For instance, if other 'perioperative period' nurses understand family members' experiences better, they can examine, and perhaps modify, their practice. If nurse researchers are aware of the findings, they can build upon this small contribution to nursing knowledge. If the general nursing population, including students, understand what family members experience at one of the most critical times in the course of a patient's illness, this will surely help them as they care for family members.

I plan to sensitize local post-basic OR nursing students, whom I will teach, to the needs of family members. I believe that caring for family members should be a thread throughout the curriculum of any OR nursing program. Other health care professionals, primarily physicians, who are involved with a patient's surgery, also need to learn about the study's findings. I plan to address them as a group. Some nursing interventions, such as providing updates during the time a patient is in the theatre, will require their input and support in all phases–from planning through evaluation. Making physicians aware of family members' needs may also cause them to alter their behaviour–for example, to remember that waiting family members need information, both during, and immediately, after surgery.

Implications for Nursing Research

The findings of this study raise a number of other research questions, in addition to the one about the effectiveness of nursing interventions. We have to learn about the needs of those whose relatives are undergoing all types of emergency surgery, or less-threatening or even "minor" elective procedures. Their needs may or may not be similar to the needs of the participants in this study. We also have to consider whether dyads with closer relationships have different needs than those whose relationships are less close. Also, do family member-patient pairs who are related in different ways (e.g., husband-wife versus parent-child) have different needs? We need to understand more about the experiences of those who are waiting for a crucial decision or result (e.g., whether a tumour can be resected, whether a biopsy is malignant or benign), rather than the outcome of a planned procedure. We also have to think about those family members who wait at home. They, too, may need to have updates about the progress of the surgery and the patient's condition. Finally, we should study the experience of the family unit during the perioperative period.

Because descriptive phenomenology was effective in this study, I believe that research questions such as those just posed would be enlightened by qualitative research. In this study, the benefits of the method were obvious. Participants welcomed the opportunity to talk about their experience; most told me that they felt "better" after our conversation and/or that they were pleased to be able to help family members of future patients. Participants were articulate about their experience with their relative's surgery. The meaning and significance of the findings were clear from their stories; the interpretation is truly grounded in the data. Because the five needs identified are described within the context of participants' lives, specific nursing interventions can be developed "around" them.

It seems reasonable to conclude that qualitative methods would also help nurses to understand the complexity of family dynamics, and thus to better understand the experience of the family unit during the perioperative period. Gilliss (1991) emphasizes the need for family nurses to develop "adequate approaches to capturing data about the family" (p. 22).

Turning to issues of measurement, the PFNQ (Carmody et al., 1991), the one tool developed to measure family members' need satisfaction during the perioperative period, suffers from validity problems. The findings of this study, however, offer some validity to the PFNQ; the five needs that I identified are all clearly reflected in the following items on that 20-item instrument:

- to speak to the surgeon once the surgery is completed
- to be kept informed of the patient's condition
- to be with the patient as much as possible
- to have specific facts about the patient's progress in surgery
- to have family and/or friends waiting with you
- to be assured that it is all right to leave the hospital for a while
- to have a restaurant or coffee shop near the waiting area. (p. 566)

Furthermore, participants' central concern–what could happen in their own lives if something

"bad" happened to the patient–is reflected in two PNFQ items: "to know the probable outcome of the patient's illness" and "to feel there is hope" (Carmody et al., p. 566).

Although these findings do provide validity for the PFNQ, the limitations of such a tool are apparent. For example, the item "to feel that hospital personnel care about the patient" (Carmody et al., 1991, p. 566), may very well be related to my findings about the concept of family members' trust in health care professionals. However, because the authors do not provide detailed rationale for their items, I am unable to conclude that there is a link with this concept. I am unable to locate that need statement in the context of family members' experiences during the perioperative period, and in the context of their total lives. Therefore, if I were to use the PFNQ in a future study, the findings related to this item would be difficult to interpret and, consequently, difficult to apply in practice. Before I, as a nurse, could intervene to help family members meet their need to feel that hospital personnel care about the patient, I would need more information, such as family members' interpretation of the word 'care'. Similarly, the PFNQ lists the need "to be encouraged to talk about your feelings" (Carmody et al., p. 566). Again, what does this mean? What type of feelings should family members be encouraged to talk about? Who should encourage them, and to whom should they talk? Even if the PFNQ "told" me that all family members had this need, I would have to have more information before I could intervene effectively. In other words, I believe that the PFNQ is best used in conjunction with qualitative data that provide context for the need statements.

Family Members' Experience With a Relative's Surgery

Before OR nurses can help family members effectively during the perioperative period, it is necessary to understand their perceptions of their own needs. Through analysis of

participants' descriptions of their experiences, concerns, and coping behaviours, I identified family members' needs during the perioperative period.

Participants' concerns all centred around what could happen in their own lives if something "bad" happened to the patient. Also evident in their concerns was their lack of trust in the health care professionals who were or would be caring for their relatives. Lack of trust increased participants' concerns about the wellbeing of the patient and, thus, their concerns about how their own lives could be affected. Most of the coping behaviours that participants used to decrease the unpleasant feelings generated by their concerns related to remaining connected, or attempting to remain connected, to the patient. Five specific needs became apparent: (a) to be with the patient or have the option of being with him/her, both preoperatively and postoperatively; (b) to receive regular updates about the progress of the surgery and the patient's condition; (c) to wait somewhere that is both readily accessible and known to physicians and hospital staff; (d) to be able to make informed decisions about when it is "safe" to take breaks away from the waiting area; and (e) to have the company of others who recognize and acknowledge their feelings.

The findings of this study provide nurses with some understanding of family members' needs during the perioperative period. The findings are practical and significant in that they have some immediate implications and applications; right now, OR nurses can begin to intervene to help family members meet their needs. The findings are also exciting because they generate more questions than they answer. I anticipate that the findings will stimulate others to seek answers. These answers will add to the body of nursing knowledge about family members' needs, and will help nurses to reach the ultimate goal of caring effectively for all family members of patients undergoing surgery.

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Appendix A

Interview Guide

The following examples of interview questions, reflective comments, and probes were enhanced by the use of therapeutic communication skills and empathetic strategies (Egan, 1986).

1. Could you please tell me what it is like for you while (the patient's name) is in the OR?

2. You have said (such and such), can you tell me more about that?

3. From what you are telling me, it seems to me that you may be thinking or feeling (such and such). (Wait for a response from the participant.)

4. I have observed that you (describe a specific behaviour). Could this show that you are concerned about (such and such)?

5. Some other family members in the study have told me (such and such). Have you had a similar experience?

Appendix B

THE UNIVERSITY OF BRITISH COLUMBIA

and

St. Paul's Hospital

1081 Burrard Street, Vancouver, British Columbia V6Z 1Y6 (604) 682-2344

School of Nursing
T206-2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5

Information Letter

Needs of Family Members
During the Time Patients are in the Operating Room

My name is Susan Wynne. I am a registered nurse and have worked in the Operating Room (OR) at St. Paul's Hospital for the past 11 years. As well, I am a student in the Master of Science in Nursing (MSN) program at the University of British Columbia. For my thesis, I am conducting a study about the needs of family members during the time patients are in the OR. The purpose of this letter is to explain my study and to ask if you are willing to participate.

Having a family member undergo surgery causes a variety of feelings. I believe that OR nurses, such as myself, should provide support and information to family members during the time patients are in the OR. However, before OR nurses can help family members effectively, we must know what their needs are. By participating in the study, you will be helping family members of future patients.

If you participate in the study, I will talk with you two or three times. Each conversation will last up to one hour and will be conducted in a private room or a place of your choice. The first conversation will take place during the time your relative is in the OR. I will not ask you set questions; instead, I will ask you to tell me in your own way what it is like to have your relative in the OR. The second conversation will take place about two weeks after the surgery and will give you an opportunity to share any further thoughts with me. As well, I will summarize what you told me during our talks and check that I understood you correctly. We may decide to meet a third time about three weeks after the surgery. Although talking about your feelings may be difficult at times, most people find it helpful to discuss their feelings.

You are under no obligation to participate in the study. If you do, you may withdraw from the study at any time, may refuse to answer any question during our conversations, or may ask that any response or information you have given be deleted. Whether or not you participate, you and your relative who is having surgery will receive the same treatment from the hospital staff. You may wish to discuss your decision with your relative and the rest of your family.

Information Letter–continued

The conversations will be audiotaped. When I transcribe them into printed format, I will delete any information that could possibly identify you. Your tape and the printed copy of your conversations will be marked with a code number, will be stored in a locked cabinet, and will be heard/seen only by me, a professional transcriptionist, and my thesis committee, two UBC faculty members. When my study is completed, I will destroy the tapes and the printed copies. At any time during the study, you are welcome to listen to/see the tapes/transcripts of your own conversations. As well, you will be offered a copy of the final report of the study.

If you want to participate in my study or if you want to discuss it further before deciding, please fill in the tear-off slip at the bottom of this letter and give it or send it to Faye Forster, the Nurse Clinician in the Pre-Assessment Clinic (St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC, V6Z 1Y6, telephone 682-2344, local 2598). I will then telephone you. You may also call me at 922-7675. (However, please still fill in the tear-off slip and give/send it to Faye.) You may also contact Dr. Virginia Hayes, the chairperson of my thesis committee, at 822-7477.

Thank you.

I am interested in participating in Susan Wynne's study of needs of family members during the time patients are in the operating room or would like to get more information about the study. Susan may contact me.

NAME:_____

TELEPHONE NUMBER:_____

Appendix C

THE UNIVERSITY OF BRITISH COLUMBIA

and

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Consent Form

Needs of Family Members
During the Time Patients are in the Operating Room

1. The study "Needs of Family Members During the Time Patients are in the Operating Room" will be conducted by Susan Wynne, MSN student, for her thesis. Having a family member undergo surgery causes a variety of feelings. The researcher believes that operating room (OR) nurses should provide support and information to family members during the time patients are in the OR. However, before OR nurses can help family members effectively, they must know what family members' needs are. By participating in this study, I will be helping family members of future patients.

2. I understand that I will talk with the researcher two or three times. Each conversation will last up to one hour and will be conducted in a private room or place of my choice. The first conversation will take place during the time my relative is in the OR. The researcher will not ask me set questions; instead, she will ask me to tell her in my own way what it is like to have my relative in the OR. The second conversation will take place about two weeks after the surgery and will give me an opportunity to share any further thoughts with her. As well, she will summarize what I told her during our talks and check that she understood me correctly. We may decide to meet a third time about three weeks after the surgery. Although talking about my feelings may be difficult at times, I understand that most people find it helpful to discuss their feelings.

3. I understand that I am under no obligation to participate in this study. I also understand that I may withdraw from the study at any time, may refuse to answer any question during the conversations, or may ask that any response or information I have given be deleted. I understand that whether or not I participate in the study, both I and my relative who is having surgery will receive the same treatment from hospital staff.

4. I understand that the conversations will be audiotaped. When they are transcribed into printed format, the researcher will delete any information that could possibly identify me. My tape and the printed copy of my conversations will be marked with a code number, will be stored in a locked cabinet, and will be heard/seen only by the researcher, a professional transcriptionist, and the researcher's thesis committee, two UBC faculty members. When