THE ILLNESS EXPERIENCE OF CLIENTS UNDERGOING SURGICAL INTERVENTION FOR CORONARY ARTERY DISEASE: CLIENTS' PERCEPTIONS AND CONCERNS

By

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ABSTRACT

THE ILLNESS EXPERIENCE OF CLIENTS UNDERGOING SURGICAL INTERVENTION FOR CORONARY ARTERY DISEASE: CLIENTS' PERCEPTIONS AND CONCERNS

This study was designed to investigate the perceptions and concerns of clients who underwent surgical intervention for coronary artery disease. The purpose of the study was to determine clients' viewpoints of their illness experience.

A phenomenological approach was used to guide data collection. Questions from a semi-structured interview guide elicited clients' retrospective perceptions and concerns regarding their illness experience. An analytic framework of "benchmarks" and "themes" was developed to examine the data which arose from the interviews.

The clients perceived and explained their illness in ways different from professionals. Clients relied on past experience and socially accepted ideas to make sense of their illness and health care. Throughout their illness, clients were primarily concerned with concrete phenomena that they perceived might hamper their recovery from illness. Determining progress was an important way clients coped with illness.

The findings indicate that nurses must consider the client's viewpoint if effective care is to be given. In order
to reduce the discrepancy between clients and professionals, nurses must incorporate clients' viewpoints into the plan of care. The findings of this study have implications for nursing education as well as research.
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CHAPTER 1

Introduction

Background to the Study

Two widely accepted principles of nursing practice are that health professionals can understand clients' illness experiences and that interventions are patient-centered (Abdellah, Beland, Martin & Matheney, 1960; Sundeen, Stuart, Rankin & Cohen, 1981). However, although nurses attempt to individualize patient care, their perceptions about clients' illnesses arise primarily from a professional viewpoint. Because most clients are not health professionals, their views on illness can differ from nurses. A barrier to effective care may result from the discrepancy between the client's perceptions of the illness and the nurse's perceptions of the same illness. Thus, because perceptions of clients and nurses do differ, it cannot be taken for granted that nurses will understand the client's illness experience.

Why do gaps in understanding between clients and professionals occur? Levanthal (1982) suggests that discrepancies occur because the lay person's interpretation of illness is based on an entirely different model from that of the professional's scientific one. Clients perceive sickness in terms of concrete symptoms and causes, past experience or
socially accepted ideas (Levanthal, 1982). These perceptions, in turn, influence the way people cope with illness (Field, 1973). Thus, clients explain and deal with illness in their own characteristic fashion.

Personal accounts of illness provide insight into how clients perceive their experience (Cousins, 1976; Halberstam & Lesher, 1976; Lear, 1980). Written from lay persons' viewpoints, these accounts reveal that professionals and clients do interpret the same sickness in different ways. For example, Cousins' experience with illness demonstrates the disparity between lay and professional models of sickness (Cousins, 1976). Whereas professionals diagnosed a scientific basis for his symptoms (ankylosing spondilitis), Cousins searched his own past experience and beliefs in order to make sense of his concrete symptoms. Instead of accepting the professional viewpoint, he embarked on what he believed to be an appropriate cure for his illness—laughter therapy. With the support of his physician, Cousins followed his own “Rx for cure” and recovered. Such personal accounts of the client's illness experience demonstrate the value of recognizing and incorporating the client's beliefs into the plan of care.

In contrast to the lay person's interpretation of illness, the professional's approach can be characterized as scientific and rational. Care is directed toward disease, abnormalities in the structure and function of body organs and systems. Here the Western medical paradigm makes the distinction between disease and the personal, interpersonal and cultural reaction to it—
illness (Kleinman, Eisenberg & Good, 1978). Although sociocultural factors may be of some relevance in professional practice, the predominant custom is to structure the client's behavior into preconceived entities--disease states. Little consideration is given to how clients actually perceive and experience illness. This lack of consideration of sociocultural factors may result in ineffective care.

In relation to the experience of convalescing from surgical intervention for coronary artery disease (coronary artery bypass grafting surgery), this professional concern with disease is reflected in the literature and research. Commonly, the experience is described in terms of complications arising from the surgery (bleeding, emboli, metabolic/cardiovascular irregularities, arrhythmias) (Brener, 1972; Brogan, 1972; Calhoun & Bozorgi, 1974; Garrett, 1977) or disruptions in normal function (diet, activities of daily living, sexual relations) (Chow, 1976; Holland, 1977). The professional's pre-occupation with disease even appears when subjective aspects of the experience are discussed; Hasser (1979b) describes post-operative pain as an "oppressive discomfort that is less severe than pre-operative angina" and due to wound healing or a pericardiotomy syndrome (p. 91). Would clients agree with this description?

From the literature, it is apparent that professionals' preconceived notions about illness and recovery can interfere with the true identification of client needs (Smith, 1981). Although both lay and professional perceptions are necessary to
plan care, the client's viewpoint may be very important—especially when dealing with subjective phenomena like intractable angina and pain. "How the patient perceives his own situation is important . . . what he thinks is far more important than what I think" (Wickware, 1978, p. 32.).

Clients convalescing from coronary artery bypass grafting surgery, like any person recovering from serious illness, are confronted with major changes in their lives—physiologically, socially and emotionally (Smith, 1979). The concerns they perceive during and after hospitalization affect the way they cope with these changes and how they recuperate. In order to foster the client's recovery process, nurses must understand the client's own knowledge and values concerning heart surgery and incorporate these into nursing care (Brown, 1981; Nuttman, 1977). Thus, clients' perceptions are important to consider when planning and giving effective patient-centered care.

By studying the illness experience from the client's viewpoint, a more valid basis can be formed to set priorities for in-hospital care and plan effective teaching programs. In this way, clients' actual concerns can be addressed in order to help them cope with the changes that occur following coronary artery bypass grafting surgery. Patient satisfaction, trust and a positive response to care can result from negotiating two different perspectives of illness—that of the client and nurse (Dagslund, 1978).
The discrepancy between lay and professional interpretations of disease and illness has been addressed by Kleinman's cultural system model (Kleinman, 1978). In this framework, health, illness and health care-related aspects of societies are conceptualized as cultural systems: symbolic systems built out of meanings, values, behavioral norms and the like (Kleinman, 1978, p. 86). The model recognizes that an individual's experience with sickness is structured within a social and cultural context (Kleinman, 1978). Because people's beliefs, roles, expectations and relationships affect their perception of reality, different groups in society may have disparate viewpoints on the same phenomenon. Consequently, patients and professionals may perceive the same sickness in different ways. In Kleinman's model, sickness is not conceived of as an isolated psychologic or biologic event, but rather a complex experience shaped by the body, mind and sociocultural milieu (Kleinman, Eisenberg & Good, 1978).

Kleinman proposes that within the cultural system of health care, three distinct but interacting domains of interpreting and experiencing sickness are in operation. These are the professional, popular (individual, family, social network, community) and folk (non-professional healers) sectors (Kleinman, Eisenberg & Good, 1978). Each domain can be distinguished from another because each has a different way of explaining, experiencing and reacting to sickness based on
different explanatory systems, social roles, interaction settings and institutions (Kleinman, Eisenberg & Good, 1978) (see Figure 1). How individuals subjectively construct distinct forms of social reality and make sense of ill health is based on explanations of sickness specific to the social positions they occupy and the systems of meaning they employ (Kleinman, Eisenberg & Good, 1978). Thus, perceptions of illness and disease are related to whatever domain of health care an individual occupies in society.

Figure 1. Kleinman's conceptualization of the health care system: internal structure (Kleinman, 1978, p. 86).
In order to cope with and make sense of sickness, people use explanatory models specific to their reference domain. These explanatory models reflect the sector's norms and values and are an expression of how each domain constructs the illness experience (Kleinman, 1978). Commonly, the professional domain perceives sickness as a physiological event—a disease. The popular sector, on the other hand, explains sickness in personal and social terms, as an illness. This is reflected in the commonsense lay approach to sickness as described by Leventhal (1982). Kleinman's model would therefore propose that the experience of convalescing from coronary artery bypass grafting surgery could be differently explained by clients as compared to health professionals.

It is apparent that the differences between the professional and popular explanatory models can create a gap between nurses and clients. If nurses allow the professional model to dominate their practice, they will be ignoring an essential aspect of care—how patients perceive their illness experience. Only through understanding the popular domain of health care can the discrepancy be reduced and patient-centered care given.

As the conceptual framework of this study, Kleinman's cultural system model provides direction to elicit the client's perceptions and viewpoint of illness. Because it recognizes the sociocultural nature of sickness, it allows one to account for the discrepancies between lay and professional interpretations of illness and disease.
Nurses caring for clients convalescing from coronary artery bypass grafting surgery assume that they understand the illness experience. However, the literature indicates that nurses understand, but from their own professional viewpoint. Patients' concerns, subjective experiences and how they make sense of their experience are not given priority. The failure to recognize the client's perspective may hamper delivery of effective nursing care. Therefore, in an attempt to understand clients' perceptions of their illness experience, this study addresses two relevant questions. How do clients perceive and interpret their illness experience? What are the concerns of clients discharged from hospital following coronary artery bypass grafting surgery?

To understand the illness experience from the client's viewpoint, this study proposed to:

1. determine clients' perceptions of their illness experience, and
2. identify the concerns of clients discharged from hospital following coronary artery bypass grafting surgery.
The Theoretical and Methodological Perspectives of the Study

Kleinman (1977) argues that clients' subjective experiences of illness can be investigated by using the phenomenological approach. As a philosophy, approach and type of qualitative research method, phenomenology recognizes the importance of understanding experience based on the individual's inner or subjective understanding of events, behaviors and surroundings (Oiler, 1982; Rist, 1979). In using this approach, one can understand how sickness is constructed by clients in the popular sector of the health care system.

The phenomenological approach is congruent with Kleinman's model because each stresses the importance of subjective meanings and perceptions in everyday life. Phenomenology is based on the notion that people construct a unique inner subjective world from their own interpretations of phenomena as they are lived (Wagner, 1970). Schutz (1967) argues that experience is lived as a "stream of consciousness" and as experiential phenomena are lifted out of the consciousness as discrete entities, the individual attaches meaning to the phenomena (p. 215).

Because people can be understood not as objects in the outer world, but as unities of sense and meaning in the inner subjective world of the conscious individual, one must consider the subjective aspect of everyday life (Wagner, 1970, p. 6). Thus, understanding another can only occur by seeking out the other's point of view and determining the subjective context of
meaning (Schutz, 1967). This inter-subjectivity and understanding can be accomplished by explicating one's own subjective meaning system and contrasting it to another person's (Schutz, 1967). In phenomenological research, the bias of the investigator is not eliminated, but rather it is recognized and incorporated into the process (Davis, 1978). Phenomenology recognizes that research is a socially ordered phenomenon (Davis, 1978).

The insight gained from using qualitative approaches such as phenomenology results from the type of information collected. Because both the participant and researcher can clarify their points of view and socially construct experience, the data is "richer" than in quantitative methods. Being "close to the data" lessens the problem of validity and increases reliability (Filstead, 1970, p. 6). Because interviewing produces descriptive data that represent participants' understandings of the social world, qualitative methods such as phenomenology increase validity (Rist, 1979).

In the qualitative approach, the sample is selected because it is a valid source of the desired information, not because it is representative of a larger group. For this reason, the sample size in qualitative methods may be smaller than in quantitative research, depending on the type and richness of material obtained.

The assumptions about phenomenology provide direction to understand clients' subjective experiences and how they perceive the world. As an inductive, descriptive research method,
phenomenology enables one to determine the cognitive and subjective meanings of individuals from their own frame of reference (Bogdan & Taylor, 1975; Omery, 1983). It allows one to describe experience as it is lived and to know human beings rather than just know about them (Oiler; 1982). Lofland (1971) suggests that as a research method, phenomenology entails immediacy and taking on the viewpoint of another. Through describing the individual's perceptions and interpretation of reality as well as how these relate to behavior, one can better understand social phenomena (Schwartz & Jacobs, 1979). This is useful in understanding the nature of illness and recovery.

Kleinman's model and phenomenology direct the investigator to elicit the client's own subjective viewpoint of illness. Because the client's subjective meaning reflects the meaning, values and norms of the popular domain of the health care system, understanding how clients attach meaning to illness will elucidate the commonsense explanatory model of this sector. Increasing nurses' insight into clients' perceptions of their illness can help provide a more valid basis for care.

Definition of Terms

In this study, the following definitions apply:
1. adult--an individual 18 years of age or over.
2. concerns--those phenomena identified as arousing feelings of anxiety or worry.
3. coping--the manner in which concerns or perceived
problems are managed.

4. coronary artery bypass grafting surgery (CABG)--an operation performed in order to bypass blocked areas of the coronary arteries. This is done when an individual has been diagnosed as having coronary artery disease and cannot be managed by medical treatment alone.

5. explanatory model--explanations of sickness which influence expectations, perceptions of symptoms, the way labels are attached to symptoms and behavior during care (Kleinman, Eisenberg & Good, 1978).

6. perception--act of observing, understanding, apprehending through one of the senses (Sykes, 1976, p. 819).

7. recovery--the process whereby clients return to an optimal level of health following CABG.

Assumptions

This study is based on the following assumptions:

1. CABG has meaning for the client and this meaning has an effect on the person's life.

2. Individuals can communicate subjective meaning to others.

3. The information people impart about their illness experience validly represents its essential nature.

4. Contradictions in people's perceptions of phenomena can occur. Because people interpret things differently at different times, this is an accepted aspect of the commonsense experience
(Bogdan & Taylor, 1975).

5. Certain commonalities exist about the experience of having CABG and these can be identified as general "concerns".

6. Although the investigator has a professional perspective, she can understand the client's point of view.

Limitations

The following limitations are recognized:

1. Due to transportation constraints, all participants in the study were selected from one urban area.

2. All participants were recruited from one setting. Because illness is socioculturally constructed, any particularities of this setting may have influenced the client's perceptions of the illness experience.

3. In qualitative methods such as phenomenology, a disparity may occur between what people say and what they mean (Schwartz & Jacobs, 1979). However, this limitation was reduced by clarifying and validating participants' accounts during data collection.

Organization of the Thesis

The succeeding chapters of this thesis will discuss pertinent aspects of the research process and address the study's questions. Chapter 2 will discuss how data were
collected as well as ethical considerations of the study. Chapter 3 will more explicitly describe how data were analyzed under a central organizing structure. Chapter 4 will contrast clients' accounts with the professional view as found in the literature. Chapter 5 will conclude with a discussion of the implications of the study for nursing practice, education and research.

**Summary**

This chapter has identified and discussed the problem and purposes of the study in relation to background information. The conceptual framework which provides direction to determine the client's perspective has been related to the actual theoretical and methodological approach utilized. By gaining insight into clients' perceptions of their illness experience, gaps between professionals and clients can be reduced.
As described in Chapter 1, phenomenology was the research methodology used to investigate clients' perceptions of their illness experience and their explanatory models. Because qualitative methods such as phenomenology advocate that data reflect how participants view their world (Bogdan & Taylor, 1975; Filstead, 1970), information was collected in the natural setting (participants' homes) and from people who could share their first hand knowledge about CABG. Phenomena were thus understood and explained on the basis of the participants' perceptions of their experience.

In this chapter, the application of the methodology will be discussed in terms of selection of participants, data collection, data analysis and ethical considerations of the study.

**Selection of Participants**

In order to elicit clients' perceptions of recovery from CABG, a source of information was needed. Phenomenology directs one to collect the data from those who have lived the experience
(Omery, 1983). Thus, clients who were hospitalized for CABG were identified as pertinent sources of information.

A purposive sampling technique was used to select clients who could participate in the study (Schwartz & Jacobs, 1979). In this technique, the researcher gained access to subjective meaning by searching for individuals who were "competent" to answer the study's questions--those adults who had actually experienced CABG. In this sense, competency was determined by the presence of four criteria.

Criteria for Selection

Clients were selected to participate in the study based on the following criteria:

1. 18 years of age or over.
2. having had CABG during the current hospitalization.
3. ability to speak and read English.
4. alertness and orientation to time, place and person.

These criteria aimed to eliminate those clients who could not speak about their experience either due to communication difficulties or not actually having had the surgery.

Selection Procedure

The setting where the participants were located was the cardiac teaching unit of a 550-bed urban hospital. People
recovering from all types of heart disease were found there. A teaching program for CABG clients was in operation at the time of participant selection. This consisted of a slide-tape presentation, a booklet (Barbarowicz, 1976), and one-to-one teaching by the staff nurses. The clients were admitted and discharged from this unit, with temporary stays in the Post Anaesthesia Recovery Room (PAR) and Intensive Care Unit (ICU) following surgery.

Prospective participants for the study were assessed in terms of their meeting the criteria for selection by referring to the hospital unit's Nursing Kardex as well as questioning the staff. Because the Kardex is a centralized source of information about clients' diagnoses and nursing care, it was ideally suited as a tool to select potential participants. The nursing staff also provided valuable information regarding clients' physical, emotional and mental ability to tolerate recruitment as well as their readiness for discharge. Clients were approached three to four days prior to anticipated discharge.

An introductory letter was given to the prospective participants by one of the nursing staff (see Appendix A). This letter explained the purposes of the study and what was entailed. After clients had read the letter, they were asked to inform their nurse if they desired to talk to the researcher further. At this point, the investigator introduced herself to those clients who expressed an interest in participating.

The researcher explained the study in more detail, using
the introductory letter as a guide. If the client agreed to participate, the investigator proceeded to read the consent form aloud. The client also read the consent form and subsequently signed it (see Appendix B). One week after discharge, the clients were phoned to arrange a convenient interview time. This one week "rest period" was requested by the initial participants in the study and was subsequently honored in the remaining interviews to standardize the experience as much as possible.

At the time of participant selection, it became apparent that the client group was also being recruited for a study on the psychological aspects of heart disease and CABG. Although this presented a potential barrier to client participation, no real conflicts emerged. The two clients already engaged in the psychological study declined to participate.

Characteristics of the Participants

Eight clients gave their consent to participate in the study. One man withdrew prior to data collection due to difficulties encountered at home. Of the remaining seven participants, six were male and one, female. Their ages ranged from 50 to 74 years, with three clients being over 64 years of age.

All of the participants were Caucasian with the exception of one individual who was Chinese. All were married and living with their spouses during the course of the illness. Of the
five individuals who were not retired, two were seeking employment. The other three people were on sick leave from their previous places of employment.

All the clients were admitted to hospital in order to undergo CABG. Of the seven, one person had six bypass grafts; two people had three, with the remaining four receiving quadruple bypasses. One individual also had a permanent epicardial pacemaker inserted at the time of CABG.

The participants' stay in hospital ranged from 10 to 16 days in length. They were discharged approximately 10 days post-operatively with the range being 8 to 12. All were discharged within 2 to 5 days following recruitment into the study.

There was considerable variation among the participants in the onset of their symptoms and the duration of their illness. The longest course was 20 years, with the shortest being 6 months. The amount of time spent waiting for CABG to be performed also varied. One participant waited 6 months while another was able to undergo CABG within 12 days following coronary angiography.

Data Collection

The data regarding clients' illness experiences were collected through indepth interviews. At least one semi-structured interview was conducted in participants' homes within 9 to 17 days after discharge from hospital. The scheduling
varied according to the participant's perceived readiness to tolerate the interview. (This was approximately 21 days post-op.) This particular time frame was selected in order to identify concerns of the discharge period and elicit perceptions about the recent hospitalization.

All interviews were audiotape recorded and lasted from 75 to 90 minutes. However, the actual time spent with the participants was considerably longer. After the formal interview regarding the client's illness experience was completed, there was a shift to social conversation. A subsequent interview was done to clarify information from the first session, with one participant refusing a second interview. Participants were interviewed a maximum of two times. In total, 13 interviews with 7 individuals were completed over a 10 week period.

An interview guide consisting of open-ended questions was used to direct the conversation and collect data relevant to the research question. The interviewer's questions arose from Kleinman, Eisenberg and Good's framework for eliciting the patient's explanatory model (Kleinman, Eisenberg & Good, 1978) (see Appendix C for sample questions). The intent of the questions was to direct the conversation toward clients' perceptions and concerns regarding their illness and recovery from CABG.
Interviewer's Role

When interviewing the participants, the investigator used communication and interpersonal skills to establish rapport and a trusting atmosphere for the opinion-giving process (Abrahamson, 1983; Cicourel, 1964). The purposes of the interview were again clarified and the format for discussion was compared to that of a "friend talking to another friend". The experience of the participants was accepted as expressed. If a person appeared to evade a topic, the investigator attempted to approach it from a less threatening perspective.

Construction of Accounts

In phenomenology, the way to understand the client's perspective is to focus on the accounts that arise from indepth interviewing. The inter-subjective nature of the interview cannot be minimized if this understanding is to occur. By clarifying and validating what was expressed during the interview, the researcher was able to understand how the participants perceived their illness and how this differed from the investigator's viewpoint. In order to reduce idiosyncratic bias, it was necessary for the researcher to be aware of her own professional perspective during the interview (Bogdan & Taylor, 1975; Cicourel, 1964). Thus, the investigator could more clearly understand the client's viewpoint by being aware of the
differences in viewpoint between herself and the client (Giorgi, 1975a).

**Data Analysis**

The tape recorded interviews were transcribed and individually analyzed by the investigator. Each interview was read through to get a sense of the whole as well as what constituted different parts as expressed by the participants. Spouses' comments were eliminated but otherwise all parts of the interview were retained for further analysis (Giorgi, 1975b).

The similarities and dissimilarities of the parts were then examined and related. The experience as expressed by the participants was organized around common conceptual themes that emerged. The emphasis in phenomenology is to follow those procedures which best allow the participants to speak for themselves (Bruyn, 1970). Thus, the investigator reflected on the participants' accounts and integrated the insights from them in order to create a descriptive structure of clients' experiences (Giorgi, 1975b). Throughout the analysis, the investigator brought her own subjective experience to the process in order to attach meaning and make sense of the data. Giorgi (1975a) states that this does not "vitiate the findings" but rather sets the limits of the context in which the findings are valid (p. 95). In Chapter 3, the process of analyzing the data will be discussed in more depth.
Ethical Considerations in the Research Process

Ethical issues regarding participant selection have already been discussed. The researcher also ensured that the clients were informed about the study prior to giving consent to participate. The purpose, use of audiotape recorded interviews, time involved and frequency of contact was discussed. Any questions regarding the study or data collection methods were answered. The prospective participants were informed that they were not obliged to participate in the study and could withdraw or refuse to answer any questions at any time without any effect on their care. Methods to ensure confidentiality were also discussed. The researcher explained to the clients that confidentiality would be maintained in the following manner:

1. Clients' names would not appear on the transcripts. Each client would be assigned a code name.

2. The list of client names and codes as well as the consent form would be kept separate from the data and accessible only to the researcher.

3. Any information that might identify the participant would not be revealed.

Provision was made for the interview tapes to be erased and the transcripts shredded at the completion of the study. The participants were informed that they would be contacted regarding the results of the study.

In the course of gaining access to the hospital setting, the consent of the attending surgeons was obtained (see Appendix
D). Two of the three physicians gave their written consent for the clients under their care to participate in the study. One physician declined to consent because he did not support the study.

Summary

This chapter has discussed the application of the phenomenological method in order to determine clients' perceptions of their illness experience. Methods to select participants, collect and analyze data have been identified. Ethical considerations of the research process have also been addressed.
CHAPTER 3

The Process of Analyzing the Data

Using phenomenology as a method to collect information about clients' perceptions entails that the investigator bring her own viewpoint to the analysis of data. When trying to understand clients' subjective experiences and explanatory models, the investigator must make sense of the data in a way which is meaningful to her. By making explicit the data analysis procedure, the reliability of the study can be increased (Oiler, 1982). Thus, if another researcher assumed the attitude described by this investigator, similar meanings would be perceived and understood (Giorgi, 1975b).

In this chapter, the data analysis procedure will be discussed more explicitly so that a basis is provided to present the results of the study. Two relevant concepts, "benchmarks" and "themes" will be presented as useful in understanding clients' accounts and constructing their illness experience.

Benchmarks in the Illness and Recovery

From their accounts, it is evident that the participants perceived the illness experience of CABG as being more than just
the operation and recovery. Rather, CABG was described as one event among many which comprised the entire illness experience. Although the participants attached different meanings to certain aspects of the experience, all commonly described similar "benchmarks" which highlighted their illness and recovery. These reference points provided the investigator with a means to analyze and understand the data.

The notion that patients conceive of illness and treatment in terms of time was proposed by Roth (1963) in his study of patients convalescing from tuberculosis. Using a qualitative approach, he identified that clients use certain aspects of diagnosis and treatment as reference points to mark time during the course of illness. These benchmarks become almost timetable norms, especially when applied to institutional settings where time is a commodity. Roth (1963) concluded that searching for clues indicative of benchmarks in the passage of time was a significant way that clients coped with illness.

For timetables to develop, Roth (1963) identified two necessary conditions:

1. The series of events or conditions under scrutiny must be thought of in terms of a career—a series of related and definable stages or phases of a given sphere of activity that a group of people goes through in a progressive fashion . . . in a given direction or on the way to a more or less definite and recognizable end-point or goal or series of goals (p. 94).

2. There must be an interacting (not necessarily
face-to-face) group of people with access to the same body of clues for constructing the norms of a timetable (p. 95).

In terms of the illness experience of CABG, these two conditions were present.

Firstly, the clients themselves perceived the illness experience of CABG as a career. As will be evident in Chapter 4, the participants explained their illness as a series of different phases of coping and managing the personal and social aspects of their disease. As the illness ran its course, various events which marked the passage of time were attached significance—for example, the initial diagnosis of coronary artery disease. By establishing benchmarks, the clients were able to make sense of their experience and see progress toward the goal of health and the absence of angina.

Secondly, although the clients did not actually interact as a group of people, they did have similar access to the source of clues necessary to identify benchmarks. Because illness is a sociocultural phenomenon, clients' interaction with the health care system provided them with the necessary information to construct benchmarks. Thus, because timetabling is culture-bound, the benchmarks the participants identified were a reflection of their own culture, background and associations (Roth, 1963).

The notion of dividing up large masses of information into more manageable parts is not foreign to humankind. Many different examples exist which are perhaps aspects of the same
phenomena (e.g. dividing up a thesis into chapters, dividing up subject matter into courses) (Roth, 1963). In this study, the idea of division is applied in two ways in order to make sense of the client's illness experience.

The clients, in attaching meaning to the events and phenomena of their illness, created their own benchmarks and phases. Through their accounts it is apparent that they perceived their illness as comprising different phases, each marked by certain significant events. Thus, the clients, themselves, set up divisions within their own experience of illness.

The investigator also brought her own sense of timetabling to the analysis procedure. In trying to make sense of clients' accounts, the entire experience was divided into phases as understood by the investigator. Throughout this process, the investigator was guided by what participants had identified as benchmarks in the experience. The resulting phases, therefore, were not arbitrary, but rather accurately reflected the experience of the participants and preserved the essential nature of their timetabling.

Common Aspects or Themes of the Illness Experience

While analyzing clients' accounts, it became evident that there were aspects of the experience which were common to all the phases of the illness experience. These aspects were described by the participants as feeling-states or ways of
coping with illness. Along the time axis, these aspects formed a series of recurring themes throughout the experience. Thus, although the illness of the clients progressed through different phases, these themes recurred, albeit in varying intensity. Throughout the trajectory of the illness, then, variations of the themes were a significant aspect of the entire experience. The investigator identified six threads of the illness experience:

1. hope,
2. trust,
3. choices,
4. determining progress,
5. unique coping strategies, and
6. the shared nature of the illness.

Relation of Benchmarks to Kleinman's Framework

As discussed in Chapter 1, Kleinman's cultural system model, proposes that clients make sense of their illness experience in a socially constructed fashion (Kleinman, 1978). Because structuring time is also a sociocultural way for clients to explain illness, benchmarks are congruent with Kleinman's model. Within the framework, benchmarks would be one aspect of the explanatory model of the popular domain. They would not only assist clients attach meaning to certain phenomena but also help them cope with the illness.
Implications of Benchmarks and Themes for the Study

Benchmarks and common aspects of the experience provided direction for the investigator to analyze the accounts in specific ways. By analyzing the data in terms of phases and common themes, the investigator was able to understand the illness experience from her own perspective while still preserving clients' viewpoints. The result of the analysis was an organized description of clients' perceptions of the illness according to different phases and common aspects of the experience. In the following chapter, this descriptive structure of the illness experience will be presented with reference to pertinent literature.

Summary

This chapter has presented background information to explain how data were analyzed in keeping with the phenomenological approach. The concepts of benchmarks and themes were discussed as useful ways to understand participants' accounts and construct their illness experience.
CHAPTER 4

Clients' Perceptions of their Illness Experience

Using the phenomenological approach to elicit clients' viewpoints resulted in a descriptive account of the illness experience. Participants not only expressed their views, but also explained how they made sense of their illness. In their accounts, clients' explanatory models of the popular domain of health care became explicit.

As discussed in Chapter 3, participants' accounts were analyzed according to expressed and perceived benchmarks of the experience. Out of the data analysis, four phases of the illness experience emerged:

1. the realization of illness,
2. the plan to undergo CABG,
3. the recovery from CABG while in hospital, and
4. the recovery at home.

In addition to benchmarks, common themes were present in the phases. These were:

1. hope,
2. trust,
3. choices,
4. determining progress,
5. unique coping strategies, and
6. the shared nature of illness. Although these themes varied in intensity during each phase, their presence was a significant aspect of how clients explained their illness.

Table I.
Phases, benchmarks and themes

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In this chapter, participants' accounts will be presented according to the phases, the identified benchmarks and the
common themes of the illness experience (see Table I). The ways clients perceived their illness and identified concerns will become evident in these accounts. Pertinent literature will also be discussed in relation to participants' accounts. By examining literature pertaining to clients' descriptive accounts, a comparison can be made between the popular and professional viewpoints on the illness experience of recovery from CABG.

The Realization of Illness

During the initial phase of their illness, clients explained how they became aware of changes in their health. Although it is unclear whether all or some of the participants actually suffered a myocardial infarction, it is evident that all experienced angina as a symptom of coronary artery disease.

Realizing that they were ill was a gradual process as clients attempted to make sense of their symptoms. Throughout this phase, the participants relied on past experience to interpret their symptoms. When clients became concerned about their symptoms, they made choices about whether or not to seek medical care. After their illness was diagnosed, hope and trust emerged as significant ways clients coped with implications of having a disease.

The first phase of the illness occupied the time from the appearance of symptoms of coronary insufficiency until the illness worsened. The benchmarks which highlighted this phase
were symptom appearance, the seeking of medical care and diagnosis, and lastly, the worsening of the illness.

The Appearance of Symptoms of Coronary Artery Disease

In retrospect, the clients were able to clearly identify the first signs of illness. They had insight into their body's functioning and were aware that the changes they perceived were abnormal.

I knew something was happening to me, you know. Because I knew myself how I felt.

I just felt this awful, terrible feeling. Like, I, I couldn't describe it. But, it, it wasn't natural. . . I knew it wasn't a strain of any kind. It was just something that just happened that made me feel ill.

I was having ah, these telltale signs that something wasn't quite right. But I just didn't always feel good. I usually always feel good, full of energy. And there were times, I just didn't feel good. I think kinda, that's kinda where it started.

It is evident that clients knew when their bodies were not functioning normally. Attempting to understand the meaning and significance of their bodily cues was an important activity surrounding this benchmark.
Attaching meaning to bodily cues.

Once the participants became aware of changes in their bodily functioning, they attempted to attach meaning to these cues. One way to do this was through making comparisons to their usual activities of daily living. Because their bodily cues were perceived to interfere with their normal routine, these symptoms became a concern.

I went fishing. And packing all the stuff out, gettin' the trailer ready, puttin' in the truck, you know, all the fishing stuff like the motor and that--these pains, and I would have to stop, and rest for a few minutes. Once in a while, I would get dizzy spells... It was pain that, it wasn't ah, you know, it was something that would stop you from doing whatever you were doing.

Clients realized that their symptoms were significant because they differed from their norm.

The participants also recognized that their symptoms were abnormal because they perceived them as "painful" and uncomfortable.

Well, it was, ah, just, ah, it was, ah, wasn't a low pain; it was a tingling, sharp pain... At first, I used to get the, ah, that pain, plus heart burn. And then, the heartburn started to go away. I just started getting the, the, ah, chest pain... Once in a while I would get some numbness in my hands,
mostly this [left] hand.

Well, this pain, this pain I used to get here in the chest, that tightness. Um, it come down my arms to here [indicates wrists]. The chest--oh yea. I'm telling you, it really felt miserable.

The heart pain tried to strangle you, just get ahold and squeeze you.

I was choking. I felt like I was choking.

Clients' accounts are similar to professional descriptions of angina. Health care literature has characterized the symptoms of coronary insufficiency as dull, aching, squeezing, pressing, heaviness in the sternum or choking in the throat—rarely as stabbing, throbbing or pulsatile (McGurn, 1981; Sanderson & Kurth, 1983). Radiation of the pain to the arms (usually the left) has been an accepted aspect of the illness (Underhill, 1982). The literature has also recognized that anginal pain does vary significantly among people (Sanderson & Kurth, 1983). This professional perception would be borne out by the variability expressed in clients' accounts.

Although professionals believe that it is rare for clients to experience no chest discomfort as a result of myocardial ischemia (Underhill, 1983), one participant did present with atypical symptoms.

I got this terrible pain in my head, top of my head.
And it hurt so bad. Thus, even with an extensive explanatory model about angina, professionals might have difficulty diagnosing and treating this symptom.

From clients' accounts, it is apparent that they were intuitively aware of the possibility that they might be ill. They interpreted their symptoms as marking the beginning of their illness. Mechanic (1962) has proposed a theory to explain how clients attach meaning to bodily cues.

Mechanic (1962) has argued that clients perceive bodily cues to be symptoms of an illness if: (a) the illness occurs frequently, (b) the population is familiar with the illness' symptoms, (c) the outcome of the illness can be predicted, and (d) the amount of threat and loss likely to result from the illness is high. In this theory, interpretation of symptoms is dependent upon clients' prior knowledge and how they perceive the danger of the illness.

With coronary artery disease, professionals have considered that lay people's perception of the heart can interfere with an accurate estimation of the threat of the symptoms. Carnes (1971) and Levanthal (1982) have suggested that clients associate the heart with love or courage, not the threat of an oxygen deprived myocardium. The tendency in the professional sector would be to question clients' abilities to accurately interpret bodily cues and estimate threat. However, from clients' accounts, it is apparent that they were able to recognize ill health. Although they may not necessarily have
associated their symptoms with heart disease, clients still saw their symptoms as a mark of ill health and deviation from "normal" physiologic function.

In addition to realizing the significance of their bodily cues, the participants also tried to understand what caused the symptoms.

I wondered, gee, I wondered, "what's happening in there?", you know [laugh].

During their anginal episodes, clients were cognitively trying to make sense of their perceptions. This aspect of angina has not been discussed in professional literature.

In thinking about the causes of their symptoms, clients used lay explanatory models. They did not relate their symptoms to having coronary artery disease but rather drew on past experience to help them make sense of their bodily cues.

When my wife drove me to the hospital, and I'd been really in agony for hours and hours and hours. And finally I said to M [wife] that "I've got an ulcer and I'm afraid it's going to perforate." Ah, my dad had ulcer problems; that's why my mind was on this.

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I just chalked it up to too much coffee, you see, because I've had these pains years ago and doctors always told me, cut down on my coffee and cut it out for a while. And I, you know, I, I went on Sanka for quite a while there and there was no more problems. And I started getting these pains again and I thought,
"Well, it's the coffee."

--------

When they took me away in the ambulance, I was sure that it was something like my brother had had. That aneurysm [in the head].

--------

Ah, ah, now everybody tells me, well, I, I forget, you know, that some of my relations had heart troubles. But I never paid much attention, you know. They were old and I figured, well, their heart gave up; you had this wrong with their heart. Never paid too much attention.

Even though clients knew about "heart troubles", none of them attributed their symptoms to heart disease. From these accounts, it is apparent that clients had unique ways of interpreting their symptoms. Although they realized that something was wrong with their bodies, they did not determine the true nature of their illness. In their explanatory models, they related their subjective experience to their past. By comparing and matching their feelings of coronary insufficiency to other organ systems or to past experience, they were able to make sense of their feelings. Whereas the professional model would direct the care-giver to identify the physiological nature of the illness, the lay perspective of the clients resulted in an entirely different approach. Only when the clients sought out medical care and were diagnosed did they consider their symptoms could be cardiac in origin.
At the same time clients were cognitively trying to make sense of bodily cues, they also were emotionally responding to their symptoms. The feelings which were predominant during the anginal episodes were that of fear and anxiety.

I was damn scared.

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I was really frightened, because I thought I was going to die. I felt like I was going to die. . . . And I didn't want; I wasn't prepared to die and I thought I was going to. And that was very stressful. . . . and I thought it was something that was gonna go on.

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There was a couple of times I was hoping I would die [to be] . . . free of the pain.

One participant remarked,

All the time I was never really, ah, scared, you know. Afraid or anything.

But later in the interview, he remarked,

Well it [the angina] kinda worried me, all right.

From the accounts, it is apparent that making sense of their bodily cues entailed dealing with two different aspects of the symptoms—the emotional as well as the cognitive.

Fear and anxiety have frequently been mentioned as normal reactions to the unexpected threat of coronary disease (Cassem, Nelson & Rich, 1979; Cook, 1979; Cook, 1980; Croog, Levine & Lurie, 1968). The magnitude of the anxiety has been found to vary with previous cardiac history (Gentry & Haney, 1975).
Generally, professionals have tended to expect clients to be anxious depending on their past experience and other variables. Based on clients' accounts, it is apparent that this professional perception is realistic.

Although angina was the predominant presenting symptom, two clients also experienced arrhythmias with their pain. The interplay between fear and awareness of bodily cues is evident in their accounts.

And then when I'd get these attacks, mind you, ah, which I found out later, could have been sudden death for me, I used to feel sometimes like I wasn't going to make it. And ah, but I always did. . . . My pulse used to be very erratic and it would go, maybe three or four beats and then it would stop and start again. And go faster and slower and it was very chaotic, you might say.

And I had these, ah, these flip-flops, these, which it turned out to be atrial of [sic] the nature. And, ah, supposedly some are self-induced by stress, is that not correct, and others are caused by irritable--irritable heart. Mine was a little bit of both. At that time, who knows, who knows where it came out that time. . . . just an awful feeling. When you feel like your heart may go out of control, and may stop; that's the way you feel about it. So it brings in that certain amount of ah, panic. Ah, whereas, you want to
get it stopped. Slowed down a little bit. Corrected. . . . It just; it was just when my heart was doing flip-flops in there and, more it did this, the more, you know, upset I became. I just could not accept it and say, this is the way it is. Ah, I did that the first night that it, that it occurred up here [X City] in full bloom. I went through the whole night with my heart just, not knowing whether I was gonna stop or go.

Because the feelings were so unusual, the participants readily realized that their symptoms were significant.

The whole process of attaching meaning to their symptoms was a complex one for the participants. Not only did it entail emotionally responding to the new feelings, but clients also had to interpret their symptoms. Clients relied on their past experience to help them decide if their symptoms warranted medical attention.

**Seeking Medical Care and Diagnosis**

After the clients experienced their symptoms and made sense of them, they had a choice whether or not to seek medical care. Professional consultation and diagnosis was a benchmark in the illness experience since it revealed to the clients that they were indeed ill. The theme of making choices was first evident in relation to this benchmark.
Deciding to seek medical care.

The decision to seek consultation for their symptoms was an individual one. There was variation in when clients chose to see physicians. Some participants sought out medical care immediately after their first symptom.

And, ah, it was, the first time was in 1975. I used to do a lot of travelling. So I was on the road about an hour and a half from home, this happened to me. So I checked into the nearest hospital, and, ah, they ran an EKG, listened to my heart.

Other participants waited until their symptoms became more frequent.

Well, it was, get bad, you see. . . . to a point where everytime I'd try to do something, I got these pains. So I gotta do something.

One client sought out medical care when advised by his boss to do so.

We were going through a lot of trouble at work, too. And, ah, ah, they decided they wanted to make some changes. Nothing really to do with me directly. And, um, they kept hiring new bosses; they were going. But this woman that I knew for a long time came over to take over. And, ah, knowing each other for a long time, she was more interested in me as a person. And she insisted, eh, M [wife]? That, that I do something. She says, "But you can't work. You," she
"your, your staff were terrified. You'd go in your office and you were white as, as a ghost--in agony. And the girls were afraid to open the door and they think you're dead." Said, "You've got to do something, right now." And I said, said to her, "You're right."

It is apparent that clients elected to seek medical care after attempting to make sense of their bodily cues based on their own explanatory models. When their symptoms became a concern, they decided to seek professional help.

How patients decide to seek medical care has been studied. Generally, professionals have agreed that deciding to see a physician depends on the client's subjective experience and interpretation of symptoms (Croog & Levine, 1973; Gentry & Haney, 1975; Hackett & Cassem, 1969; Zola, 1978). Gentry (1979), King (1970) and Hackett and Cassem (1969) have suggested that choosing whether or not to seek professional help is also a social event. Factors such as presence of family, location and day of the week have been found to influence the client's decision (Gentry, 1979).

Zola (1978) has attempted to describe how clients determined which bodily discomforts were significant enough to warrant medical care. From his data, five non-physiological patterns emerged which triggered the decision to seek professional treatment. Zola (1978) identified these as: (a) occurrence of an interpersonal crisis which called attention to the symptoms, (b) perceived interference with social or personal
relations, (c) sanctioning (someone else taking the primary responsibility for the decision), (d) perceived interference with work or physical activity, and (e) setting external time limits on the recurrence of symptoms or when to seek care. In his schema, both subjective and social factors were important.

Another way to conceptualize the decision process has been suggested by Moss, Wynar and Goldstein (1969). In this theory, seeking medical aid was seen as a decision requiring three cognitive functions: (a) the perception of the presenting symptoms, (b) the appreciation of the meaning and seriousness of the symptoms, and (c) the realization that medical help was indicated for the recognized and appropriately interpreted symptoms. Tuckett (1976) has constructed a similar framework where he proposed that clients recognize, define and act on symptoms. In both theories, professionals have characterized clients as rational problem-solvers.

In a study of clients deciding whether or not to undergo surgery for stroke prevention, Sayner (1982) has developed a framework to explain the process of decision-making. In her theory, clients moved through five passages prior to making a decision—threat, trust, holding, contemplation and compliance. For Sayner's study group, trust in the medical team was a recurring factor in the decision-making process (Sayner, 1982).

Generally, then, professionals have explained how clients chose to seek medical care based on differing variables. Perhaps the lack of a clear-cut theory to explain this aspect of client behavior is indicative of the uniqueness of decision-
making.

In addition to deciding whether or not to seek medical care, clients also tried to make sense of the diagnostic process. Putting their medical care into perspective enabled them to better understand this important benchmark.

Clients' perceptions of their medical care.

After clients sought out medical care, they expressed their feelings about the diagnostic process and treatment. One client with atypical presenting symptoms described a situation where the physicians disagreed with his beliefs about his illness.

I was, ah, I kept feeling really good and ready to go to work. And this would come upon me. And, ah, one morning I just, I just had to go to the doctor. And I said, "Can you make room to see me? I got a real problem." 'Cause I felt like I was gonna pass out, you know... 'Cause I couldn't breathe, and, ah, I went down there. Once again, he had an EKG in his office and he ran a strip off. He read it, and, ah, went through these things including knocking the knees. And he said, "I tell you what, B," he said. "I think the whole thing is in your head."... It made me so damn mad, I didn't go back to him for months. For any reason, even though I felt bad at times... Well, I didn't know. I didn't know what
it was. Whether—I just knew that I was having circulation problems. . . . or I wouldn't be feeling like this.

The discrepancy between the client's view of his illness and that of his doctor is apparent. The participant had interpreted his symptoms as being ill; using professional explanatory models, the doctor disagreed. The lack of a diagnosis as a benchmark created conflict for the client. He perceived he was ill but there was no professional support for his beliefs.

The same client also was confused over conflicting medical opinions.

My doctor got so fed up with me comin' in there, he finally referred me to a specialist who came down from X City—one of these hot-shot cardiologists that, ah, knows it all. And he set up a clinic in our little town up there; he was, was there twice a week. This guy, doing the same thing, only, supposedly better. 'Cause, say, X City, where all these magnificent things are done. . . . And so, my doctor referred me to him. Now I don't know what my doctor told him. I only have a suspicion that my doctor said, "This guy—it's in his head, I think. But could you, would you take a look at him please?" I don't know this for a fact; I just know human nature. So, he gave me the fast once over. . . . This doctor, this guy from X City—when I told him that I had, ah, was told by this
other doctor—I think, they just tried to find something to satisfy my little chest pains and my problem. Told me that I had a clicking of, ah, this particular valve. And I told him that and he said, "No way." He said, "You don't, you don't have such a thing." I said, "Well, Dr. so and so . . .". He said, "Well," he said, "I dunno," he said. I said, "This was a mis', misdiagnosis." He said, "Well, let's not call it that, shall we?" He said, "I trained Dr. E. how to, how to read these machines and these things. But let's not call it a misdiagnosis, shall we?" Jesus, they stick together. Like thieves, you know. Some of them.

The problem of differing medical opinions and methods of treatment has been studied (Baker & McCoy, 1979). Of the seven participants enrolled in a cardiac exercise program, clients were found to perceive that different medical opinions were a common source of conflict. To resolve this conflict, Baker & McCoy (1979) found that clients selectively listened, chose the answers which they agreed with and developed a trusting relationship with their physicians. For the participant who perceived conflict in diagnosis, he did not appear to resolve his conflict in the ways identified by Baker and McCoy (1979). Instead, the client made sense of the conflict in his experience with medical care by suggesting improvements.

The doctors should not be allowed one answer that solves the whole problem, all their problems, like,
"It's, it's nerves. It's just the condition of the world today. We're all nervous. It's a nervous world. You gotta case of the nerves buddy. You just think you're having what you're having. We'll see you later. Here's your bill for twenty-five dollars"... . That's why there must be a medical answer to the problem. One, when we've read our cute little strips out of little EKG, ECG's; after we've read that and the guy seems like, he's, you know, a perfect specimen of a man, and he's still having symptoms of possible problems or heart attacks, there must be something else we can do. And if, if it's, angiogram is [sic] costs too much money or it's too much trouble, or it's unavailable, let's invent something else that will tell us that this guy has blockage of his arteries... . . You see, there's got to be a clue to these guys. Or a way.

In this account, the client's frustration with the inaccuracy of the diagnostic process is apparent. He appears to be arguing that professional explanatory models need to be made more precise. When a diagnosis was finally made, the benchmark was anticlimactic.

The doctor on, the doctor on duty in Emergency came around and proudly announced; he was overjoyed, in fact. "You sir, are having a cardiac arrest!" And I thought, "Geez, thanks for the good news," you know. Instead of him just getting me up there and they were
gonna work on me, he announces so proudly. They've found out finally what the hell I was there for.

In order to make sense of his experience with this benchmark, the client allocated blame for the treatment he received.

And, ah, but, ah, I, I just think that, ah, due to the fact that there is such a shortage of medical people and I think X City, maybe it's everywhere. Maybe, maybe, maybe it's just that they don't have time to really help you.

Croog and Levine (1973) have found that clients recovering from myocardial infarctions often perceived that communication problems exist between patients and physicians regarding the diagnosis and treatment plan. In their study, clients commonly stated that physicians were too busy, too unapproachable or too unconcerned for them. This conflicted with Miller's findings that the health team was consistently viewed as helpful to the clients through action and instruction (Miller, 1981).

Clients used their contact with the professional sector to find out more information about their illness. The kind of care they received affected how they felt and how they perceived their illness. One client felt that the inadequate care reflected that his illness was worsening.

Then I got this other doctor. And, uh, my treatment just went downhill. And I was going downhill with it, and, you know. I figured, well, if the doctor doesn't seem to know what to do, there's nothing that can be done.
Croog, Levine and Lurie (1968) have suggested that physician's attitudes can affect the cardiac patient's recovery. They believe that clients can interpret clues furnished by the physician to mean pessimism about their situation. For this participant, his doctor's attitude toward care did affect his perception of his illness. When the client changed doctors, he felt there was an improvement in his care and his condition.

I was certainly pleased when I saw Dr. X. Yes. . . . as soon as I went in to see her, I just liked her. And she had, ah, a nice, a nice friendly attitude and competent attitude. And, ah, then I noticed that we both came from the same area, which gave [sic made] me feel better. We both came from X City, within a few blocks of one another. And, um, I thought that she looked after me very well, eh, M [wife]? She started me on proper medicines, and, um, it was amazing the change.

It is apparent that the kind of medical treatment affected how clients saw progress and improvement in their condition.

In addition to understanding their medical care, this benchmark also resulted in clients making sense of the diagnosis of their illness. Because they had new information from professional explanatory models, their view of their illness and its course underwent change.
Coping with the diagnosis.

The diagnosis of the illness was perceived as a significant event in clients' illness experiences. Field (1976) has proposed that the attachment of a diagnostic label is not an unimportant event. Rather, the label serves to legitimate the status of the sick person as ill while releasing him or her from social obligation. Labelling also structures behavior because it directs the ill and healthy toward socially appropriate attitudes and actions (Field, 1976).

When clients learned the causes of their symptoms, they initially coped by denying that they had coronary artery disease.

I always; never occurred to me that I'd have heart trouble. And ah, when I went to a specialist and he, and ah, he said, he says, "it sounds like your heart." I said, "well, it can't be", I says. "I've got this hernia. Everytime I eat", I said, "I've, I get these pains. And ah, even when I, ah, when only time when they go away is when I lie down."

The clients continued to rely on past experience rather than professional explanations to make sense of their illness.

The use of denial has been portrayed in the literature as a common way people cope with anxiety by reducing the threat (Burke, 1981; Cook, 1979; Hackett & Cassem, 1969; Kiening, 1978; Olin & Hackett, 1964; Scalzi, 1973). Professionals believe that clients follow a characteristic pattern in responding to the
threat of myocardial infarction which includes denial, anger, anxiety, regression and depression (Cook, 1980; Scalzi, 1973).

Although Mechanic's theory of illness recognition has suggested that familiarity with the illness reduces denial (Mechanic, 1962), Olin and Hackett (1964) would not support his view. Even when clients were familiar with symptoms of coronary disease, it was found that they still attributed it to something other than the heart (Olin & Hackett, 1964). To explain this phenomenon, Abram (1969) and Kiening (1978) have proposed that denial is an expected defense mechanism utilized by all clients in order to resolve conflict and preserve a concept of oneself as healthy. Regardless of one's prior experience, then, denial has been conceptualized as a natural coping strategy.

One client explained why he did not attribute his symptoms to angina.

Well, I guess that [believing the pains were due to an ulcer] was a little better than a heart attack, eh? Denial, thus was an effective way to cope.

When the clients began to realize they had heart disease and what effect the illness would have on their lives, they attempted to incorporate the professional explanatory models into their own. The meaning they attached to the symptoms changed as well as how they felt about their illness. They now perceived their illness in terms of heart disease.

I, I, I sort of half-expected to have a heart attack at any time.
I guess I was pretty anxious. Because I didn't know where it was all going to lead.

As time passed, the clients became aware of the progressive and potentially fatal nature of their illness. They recognized that their illness was a threat. They were also aware that the illness would worsen and that no "cure" was available.

Oh, I'd knew they'd [the symptoms] get worse. . . . I recognized it was serious. Yes. I didn't think much could be done about it, though. I realize that I'll always have coronary artery disease. . . . I could have the same problem again and probably will because I don't think that [CABG] stops the disease. . . . And it'll [coronary artery disease] probably, it'll come back again. And it's probably what eventually I'll go from.

--------

But then of course it's taken all these years to build up. I don't have that much time left, I really don't think. So, I don't know, you see.

From these accounts it is apparent that clients used information from professional explanatory models in order to anticipate the course of their illness. They did not perceive improvement in their condition but, rather, a worsening trend. As a benchmark, the diagnosis of their illness was valuable in helping the clients make sense of their illness.

Once clients incorporated professional explanatory models into their own, they seemed to accept the illness and its
ramifications on their lives. In the professional literature about emotional responses to myocardial infarction, Scalzi (1973) has described this acceptance as moving from denial, shock and disbelief to developing awareness and resolution.

In their accounts, the clients expressed their fatalistic attitude about their illness. The theme of hope appeared in this phase as a way clients accepted their illness. Although the uncertainty of the disease's extent and pervasive effects on their lives may have left them feeling hopeless, none remarked that they felt hopeless. Rather, their attitude would appear to be matter-of-fact and accepting. In one participant's statement of his prognosis, it is apparent that he still hoped that medical treatment would help him improve. "I thought either I was going to get better or die, you know." The theme of trust was also a means to cope.

Professionals have tended to describe clients with coronary artery disease as feeling hopeless or depressed (Cassem & Hackett, 1973; Cook, 1979; Cook, 1980). This depression has been hypothesized to result from clients realizing that their heart is damaged and the implications this has on curtailing their lives (Cassem & Hackett, 1973; Cook, 1979; Cook, 1980). Foster and Andreoli (1970) have argued that clients who have suffered myocardial infarcts normally grieve their loss of health and adopt a hopeless attitude. Other losses related to the self concept have also been proposed to further create hopelessness (Carnes, 1971). Granger (1974) has argued that the fatalistic attitude of giving up is really another aspect of
denial. In any case, hope would seem to be portrayed as a means to manage the illness even though its intensity may vary. Lange (1978) has postulated that hope exists as a continuum ranging from despair to faith. If this is so, then clients' acceptance may be one aspect of the hope continuum.

In addition to being hopeful, clients also coped with their diagnosis by testing themselves. One client described how she went about confirming if her angina would recur.

I was to go on Tuesday for this, ah, for this electrocardiogram. And on Monday, I felt great. I was . . . oh, Sunday, we had company for dinner on Sunday. And our stove went haywire. It was something wrong with the fuse in the oven. I was cooking a chicken. And I left it quite late because I had it in, in the oven an hour before, 'til I discovered it wasn't even--the oven wasn't working. The chicken was cold. So we went down to the Rec' Room, down the hall. And I put it in the oven there. And I kept going back and forth. And I tested myself to see, am I going to have another one of those attacks? And I did, I went as fast as I could. And I was just running. And I felt great.

For this participant, the testing served a useful purpose in helping her cope with the realization that she may have heart disease. She saw progress and improvement in her illness by the absence of symptoms. The testing may also have helped her retain some hope that her illness was not so serious after all.
Once the clients had coped with their diagnosis, they continued to try to make sense of their illness. Instead of non-specific bodily cues, they now had a diagnosed illness to understand and incorporate into their lives.

Making sense of their diagnosed illness.

The ways clients made sense of their illness and searched for reasons behind their disease were varied. Most clients tended to connect their symptoms to concrete factors. Pathophysiology was not mentioned as a factor in the appearance of angina. Typical of the kind of connections made were the following accounts.

Two clients felt general health was a factor in their illness.

And then I was in pretty bad shape there for a while--that is, I was overweight, extremely overweight.

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I thought it [angina] [was due to] the lack of exercise.

Psychological feelings and stress were felt relevant by three participants.

I think quite often it could have been nerves, just stress and tension--excitement... Part of it could have been just nerves, or just fear and fear does terrible things to people.
It's funny, you know. And then, or sometimes I'd get to the far corner [walking] and, ah, it would, ah, I'd have it there—the pain. And then, on my way home, it would disappear. It wouldn't bother me. . . . It'd be funny. Maybe, because I'm going home and, ah, I dunno. Psychological, psychological, I guess.

Three clients associated the angina with the level of activity.

But, ah, it was always when I was doing something. Not when I was driving or, ah, just relaxing.

Professionals would agree that coronary insufficiency can be precipitated by the events identified by the clients. Sedentariness, stress and the "Type A" personality have been described as factors which increase the risk of developing atherosclerosis (Jenkins, 1979; Scalzi & Burke, 1982).

The accounts indicate that clients understood the causes of their illness in their own terms. Although elements of the professional explanatory models are present, the clients interpreted these in a popular manner. Clients described concrete behaviors or aspects of their lifestyle which were perceived as causative factors. Biochemistry and pathophysiology were not perceived to be as significant in their explanatory models as in professionals'.

I think, one, is heredity. And I think the other is the heredity and I've got very small blood vessels. . . . And I guess the other thing is I worked awfully
hard. I didn't take proper recreation. And I let my weight get out of hand... that brought it on. I got high blood pressure which led to the, to the disease... I'm not too sure it could have been prevented, you know.

Dietary habits were perceived to be the major contributing factors in the illness.

I think it does go back. Because, ah, as far as nervous, I don't think I was that nervous. Or, or, high strung... Like, ah, like they say, you know, you, hypertension or whatever it is they want. I don't think I, I, I was that way. So I think, I think, ah, myself at least a good 80% of the food I ate... ah, I dunno how much hereditary it could be. But it was, ah, if it was anything at all, it was probably poor eating habits as a youngster... 'Cause you don't get the blockages that I had overnight.

Other lifestyle factors were mentioned as harbingers of illness.

If I had not of, ah, smoked all those years. If I had taken better care of myself when I thought I was taking care of myself, in pretty good shape. I was just pushing my body to the limit. No, I was stuffing it full of bad fuel.

It is apparent the participants made sense of their illness through drawing on information from professional explanatory models. However, one client did not understand his illness in
this manner. He was not able to articulate what might have caused his illness. "I couldn't even give you a clue why it started."

When participants did relate their illness to pathophysiology, the popular flavour of their explanations was apparent. In the next account, the intermingling of the popular and professional models is again evident.

After I found out that it was my descending ventricle, the most important, well, the, the aortic arch is actually the most important, isn't it? But the descending sends the clean blood through your body, and it wasn't pumping right.

Although a professional would disagree with this client's description of anatomy, it was the client's understanding of what caused her illness. Winslow and MacVaugh (1976) have argued that clients have a distorted idea about their cardiac anatomy. Abundant literature exists on the pathologic basis of coronary disease and atherogenesis (Braunwald, 1980). However, this emphasis is not apparent in participants' accounts. The popular explanatory models, instead, more closely resemble public education efforts aimed at risk factor modification in heart disease. These programs have emphasized that concrete behaviors such as age, sex, heredity, weight, smoking, exercise, diet and blood pressure can cause coronary artery disease (Wiley, 1980). These are similar to the factors identified by the clients as relevant in the development of their illness.

Clients also made sense of their illness by reading or
speaking to other ill people. One client sought out further information about one of his medications, an experimental anticoagulant.

I thought, you know, the dindevin would help me. But, ah, some other theory, some other people, they not agree with that. . . But I talked to . . . my brother. Yea, he is ah surgery [sic] in X Country. Ah, he is quite well known. Yea, ah, I, I, I, wrote to him. He would know about dindevin.

In order to make sense of the relationship between this medication and his illness, the client sought out professional explanatory models.

Thus, in making sense of their illness, clients adapted aspects of the professional explanatory models to help them understand. This enabled them to manage their illness and see improvement in their condition.

**Managing their diagnosed illness.**

Once clients had attached meaning to their symptoms and made sense of their illness, they devised ways to cope with it. The theme of the uniqueness of coping strategies first appeared in this phase. Although clients managed their symptoms and illness in unique ways, some coping strategies arose from the professional sector. Taking nitroglycerin, for example, was common to all participants. However, the manner in which
nitroglycerin was taken varied considerably in terms of amount and timing.

So, I, I never usually had to take more than four an hour. Take a couple and relieve it enough just to where I wasn't too concerned. Then I would come back and I'd take a couple more. Before long, you'd taken ten or fifteen. . . . Then it began to, to make you worry or . . .

I had to go and see her [neighbour]. And she came in here and took my nitro's out of the freezer, out of the 'frig, I should say, where I still keep them. And, ah, and gave me a couple. And, ah, one, about ten minutes apart. And I started to; my pulse started to settle down and I was fine.

Sometimes I would take it, just when it started, then I'd, I'd take one. And especially when I got a long way to go, and I would take one soon's it came, came up on me. But most of the time, I would wait for it to, ah, really, got, you know, really started to burn, then I would take one.

Well, when, sometimes, ah, when I would get pain, pains in my left arm and in my arm pit and, ah, and, ah, in my head sometimes and a lotta times I just couldn't breathe. There were times when I had no
pain, no discernable angina and I would take, ah, nitro', just so I could breathe.

The clients judged, themselves, when to take nitroglycerin and how often. They individualized their use of nitroglycerin according to their own perceptions of pain and the usefulness of the medication to relieve it. Again, their decisions seem related to how serious they perceived the illness to be and the particular anginal episode. One client who was hospitalized managed his own nitroglycerin therapy.

Now, at first, they took it [nitroglycerin] away. "If you need one, ask the nurse. That way we know how often you're getting the pains." But then, after a day or two, I said, "Well, why can't I have my own? Why can't I keep them in my pocket?" And they said, "Yea, you're right." They gave 'em back to me.

Although most clients recognized the value of this medication in controlling their symptoms, two remarked that they "didn't like taking nitro'." One thought it was better to ride out the chest pain. He explained his reluctance to take nitroglycerin in the following way.

And, I don't know why I didn't take a, a, nitroglycerin. And half the time I had the nitro' so long, it would be no good and I wouldn't know that. They [pharmacists] didn't know that. They'd sell me a dozen nitro' in a little bottle . . . . Yea. And if I'd only known just by taking some nitro' pills, it would have gone. But, usually, I'd let the pain go
too long and I'd take the nitro' and it wouldn't work. Instead of taking the nitro' at the beginning, and again, I was under the impression that I shouldn't be taking the nitro' pills, that they were--it was good not to take them . . . . No, I didn't want [to] take my nitro' 'cause it gave me migraines. . . . which was a mistake. I should have been taking them. . . . And I started taking the nitro' when I found out I could get one two hundred [1/200 grains]. And then as the nitro' got older, it would be, get weaker and it didn't take much to get rid of it. And so then I found I could take it without getting a headache. . . . I still really didn't, up until last, I really didn't use the nitro' pills properly.

Even when he realized the value of using nitroglycerin, the previous practice was almost instinctual.

Just got that hot flush, got a little angina. I didn't want to take a nitro' pill, but they gave me one anyways. Again, I still resisted that. . . . I think I'll do that the rest of my life, eh M [wife]?

That was so ingrained in me, you see.

Another client also perceived that it was beneficial to postpone taking the pills for as long as possible.

But for some reason, I would put off taking them. Like I didn't like to start taking them in the afternoon. Just cause I got a little pain in my arm. I would wait'll I got several pains or maybe a harder
one. Then I'd start taking them... I, that's just, ah, that's just a matter of being ignorant, really. Because, I felt that, you know, once I got on the nitro's, I would have to be on the nitro's to exist, all the time.

These two clients' accounts demonstrate that use of nitroglycerin entails more than just complying with medical orders, but rather a complex process of weighing pro's and con's (concrete situations) and making decisions. The value of the drug would also seem to be in terms of concrete symptom relief, not pharmacologic principles. Because clients understood this medication in concrete ways, its use can lead to misconceptions as described by one participant.

And the odd time, I would; this one thing that confused me. When I would take a nitro', I would seem to get a movement of gas. And that seemed to relieve me. And that's why I kept thinking it was my stomach. And somehow I got the idea that nitro' would help your stomach [laugh].... Fact, I think it's a defense mechanism. You don't wanta, you don't wanta believe it's your heart.

The clients described the action of nitro' in terms of symptom relief. Only two explained their understanding in physiologic principles. One participant stated its action as "release, you know, the blood vessel." Another explained it in this way.

Well, ah, Dr. X explained the nitro' pill. What it
does, it makes your heart beat faster again [rhythmically beats fists together]. And those other pills [Inderal], those, they, that widen your, stretch your arteries or something like that. So your blood can go through. And then when you took a nitro', it just made that ol' heart just pound away real good.

Professionals would disagree with the client's explanation of the action of nitroglycerin and Inderal in lieu of a pharmacologic model. In professional explanatory models, nitroglycerin is the vasodilating agent while Inderal tends to lower the heart rate (Burke, 1982; Felthous & Underhill, 1982). Again, the client's way of making sense of medical treatment intermingled professional and popular explanatory models.

Clients learned about nitroglycerin primarily through their physicians.

The doctor told me that they were actually good for your heart. Especially when your heart wasn't getting enough oxygen. And, ah, to not be afraid to use them. And that you could use up to 40 a day. But that if you used over three or four, you should call your doctor because, ah, you maybe have something that's starting up.

However, the amount of information received about nitroglycerin was not always perceived to be sufficient.

And I think that, that the doctors could explain it to the patients a lot better about nitro'. I didn't understand. And I thought it wasn't good to take it.
This client felt he needed more information in order to make sense of his illness and manage it.

In addition to nitroglycerin, clients were also placed on medications of various types in an effort to control their symptoms. Their understanding of these medications is evident in the following accounts.

And that's when he put me on, ah, Cardizem which has only been on the market for two years. And I was allergic to the beta blocker, incidentally. I had an attack of asthma at the hospital and found out later it was beta blocker. And so he put me on the Cardizem. And after that I didn't have to take so many nitro's.

They put me on, um, Inderal. And that kept it [pulse] steady. But I found that when I needed the reserve, my pulse rate wouldn't go up. When I did activity, it wouldn't go up. And so it [Inderal] had disadvantages, too.

I was on Inderal for years until Dr., ah, Y changed me to Corgard. And she changed me to Corgard 'cause I was getting a lot of nightmares. And that's the only reason she took me off Inderal. it might not have been the Inderal. But I responded well to the Corgard. And I responded well to the Dyazide. It keeps my blood pressure [down] and doesn't make me
Throughout the accounts, it is apparent that the clients drew heavily on the professional explanatory models to manage their medication regime. They perceived the medications to be beneficial since their symptoms had abated.

In addition to using medication to manage their angina, clients routinely attempted to reduce their level of activity and rest.

I just sat on the side of my bed, or some nights, I'd sit up on that chair all night. Yea. Just wrap blankets around me and wait to die.

I noticed that when I was getting some pain, I was taking my pulse and I noticed my pulse was always around a hundred. So I'd try and do everything I could to lower my pulse. Rest or whatever.

And I'd have to walk up a hill to either to my car or catch a bus. And, ah, I'd miss lights and rest. Then I'd cross over the street and miss another light. And I'd rest and then, then I'd start climbing up that hill. And then about halfways up, I'd lean up against the building.

Clients also made efforts to curtail their usual activities.

Well, at work, I, I, I, ah, mind you, I had a helper. But, I, ah, I wouldn't walk around as much. And I,
ah, I wouldn't lift as much as I normally do. And, ah, I used to walk upstairs, the second floor, third floor, I'd walk up. And then, after that I started taking the elevator . . . I just knew it in myself; I should cut back.

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I think we led a pretty normal life, eh M [wife]? There'd be things I would be careful about. And it used to annoy me, like when my son grew up and left home, and, and like M would have to do the lawn. I didn't like that. And we couldn't get anybody to come and mow the lawn. And I couldn't mow the lawn or things like that.

Clients found a reduction in the level of activity helpful in managing their anginal episodes. This was perceived as a useful way to reduce the symptoms of their illness, and therefore helped them to feel more healthy.

In addition to changes in activity, clients also decided to alter their diets.

At that time, you know, I, since, ah, 1974, I was very careful to take any foodstuffs. . . . It was, ah, you know, some, ah, cholesterol content, oh everything. Clients perceived that changing their eating habits would halt the progression of their illness.

During the early phase of their illness when clients were attempting to interpret and manage their symptoms, they seemed willing to make changes with their life and follow their
doctors' treatment plans. However, these lifestyle changes were not always permanent. One participant explained.

I did [change] for a while, but I think we went back, eh, M [wife] to our old habits? I think so.

Professional literature on patient compliance with drug therapy and lifestyle change is abundant. Various factors have been examined to predict compliance—demographic, illness and social-psychological variables (Marston, 1970). Different theories have been proposed to explain compliance, for example, locus of control (Arakelian, 1980) and the health belief model (Becker, 1976). However, no clear understanding exists to explain compliant or adherent behavior. For the participants in this study, compliant behavior seems to have occurred when the clients perceived the medical regime reduced the anginal episodes and improved their condition.

Although clients attempted to adhere to medical regimes prescribed for them, they also managed their illness by drawing on their own resources. Spiritual faith helped one client cope with his illness.

But then after this heart attack, 1974, I changed all my life. . . . And then everything, you know, depend on God. And then, in [sic if] something happen, quite serious, you know, up [sic increase] in my pain. I just only pray to God. . . . Nothing to be worried. This characteristic way of coping was a valuable way to manage the illness.

Another client utilized his own coping strategy to manage
his illness and carry on his life. He tried to avoid thinking about his illness.

I know my wife used to get after me and say, "now don't think about it, like that. Because that's giving you stress." And she says, you know, she'd say, "don't, don't", you know. "Think of something else. Think pleasant thoughts", you know. . . . But sometimes it would work and sometimes it wouldn't.

And then you, and then at night, now it's quiet and you wait, especially when you wake up, you know, I fall asleep right away. But then, in two hours I wake up. And then, then I just lie there. And next thing, everything magnifies, you know, and, ah, then I start thinking of everything.

I didn't think about it most of the time 'til I had pain.

Well, I didn't think about it because I, I knew you know, the doctors, they just said, well, "just take the nitro'." And, ah, I guess I didn't, I dunno. I figured, well, I'm going into the hospital. And, ah, so I figured, well, something, something I lived with.

Thus, clients made sense of their illness and managed it in ways unique to them. They drew on past experience and characteristic strategies to help them cope.
That clients were able to manage their illness in complex ways is evident in one account. Here problem-solving enabled the client to reduce the frequency of the anginal episodes while in hospital.

When I started getting these angina pains, I knew, ah, like, ah, soon's I went over [bends down and mimics scrubbing lower legs], I started gettin' these pains, you see. I got these darn pains. So, ah, I told the nurse, you know. "Everytime I come out [of the shower]," I said, "I wanna nitro'." Because I got this pain. . . . I started washin' my legs, you know, and then I saw a stool outside. And I thought, "I'm gonna use that for, in the shower. I'll sit on that." When I wanna wash my feet and legs, you know. . . . I told the nurse what I was gonna do. She said, "That's a good idea." So I took, put the shower on. . . . I put it on, get myself all set. I'd reach over and get that stool, sit down, turn the water on and then I'd start. I'm all wet now, I start doin' my legs. And when I was finishing doing all my legs and that, I just stand up, put the stool out, out of my way. . . . And then still, keep on soapin' myself, washin' myself and then I would turn the water on, and rinse myself off.

Although he could not explain the physiologic basis for his actions, his commonsense approach allowed him to anticipate his needs and act appropriately. He had made sense of his illness
and decided how he would manage it.

Clients were not alone in choosing what coping strategies would help them manage their illness. For all the clients, families and spouses were seen as helpful. The theme of the shared nature of illness was evident in the many client references to spousal or familial support.

Well, ah, I started cuttin' back a little bit all right. She [wife] was cuttin' back on me. . . . She started cuttin', you know. "You're only gonna get this," and "you're only gonna get that." She would, ah, grab my hand when I would grab the salt shaker. And, "That's enough," you know. Cut back a little bit, yea.

The family's role in the illness has been studied from various perspectives. Protective behavior on the part of spouses has been a common finding (Wishnie, Hackett & Cassem, 1971). Tyzenhouse (1973) found that there was no relation between the wife's knowledge about her husband's coronary artery disease and the client's recovery or family stability. However, Miller (1981) found that clients perceived family concern and support systems were helpful. Although the exact relationship between family support and client recovery is not fully known, professionals do view the support network as having an important role in helping the client emotionally through treatment (Monteiro, 1979).

As the clients moved through the first two benchmarks of this phase, they learned how to cope with their illness.
However, because ischemic heart disease is not static, they also had to deal with its progressive nature. As the anginal episodes increased in severity or frequency, clients also had to cope with the worsening of their illness.

The Worsening of the Illness

Being aware of bodily cues and having attached meaning to them, the clients were able to monitor the nature and severity of their symptoms. They knew that their illness was worsening. During this phase of the illness experience, the theme of determining progress made its first appearance. However, instead of ascertaining that they were progressing toward health (getting better), clients found their illness worsening.

Making sense of changes in their illness.

Clients perceived that their illness was worsening because the anginal episodes persisted. And I thought, I'm gonna to be a lot deader after this because it [the angina] won't go away. Comparisons were useful in gauging that their illness was worsening. Each chest pain became a personal benchmark in the progressively worsening illness.

Clients also understood they were becoming more ill because their activities became increasingly limited. In this way,
clients clearly determined that their health was not improving. And then I noticed it [angina] was getting worse, worse. I was getting it before I went to bed at night. I was getting it as soon as I got out of bed in the morning. And, ah, or, I'm coming to get my breakfast, come and sit down here and read the paper, and then . . . uh, shake just like that. I could hardly read the paper.

Well, ah, it was getting a little worse, all right, all the time. Like getting, you know, ah, as time was going by, it would come quicker. Ah, ah, for instance, I could, like in May, I, I packed all my stuff, you know, out to the truck and, yea, I was gettin' them. And, but not bad, you know. I could keep on going. But, ah, month and a half later, there was no way. You know, I would have to stop. Stop it.

Cay, Vetter, Philip and Dugard (1973) have found in their follow-up study of 203 male patients admitted to a Coronary Care Unit, that clients do go about interpreting their symptoms in order to assess their status. Perception of the severity of their symptoms was found to affect the kinds of activities they undertook. Thus, clients' activity levels were found to relate to how severe they perceived their illness.

As clients realized their illness was chronic and progressive, they also expressed feelings about living with the disease. Fear was one emotional response.
And, I had this awful feeling all the time. And I didn't want; I wasn't prepared to die and I thought I was going to. And that was very stressful.

Other participants chose not to worry.

So I says, made up my mind and then, I wasn't going to worry about it.

Although all the clients realized their illness was worsening, they felt very differently about it. To deal with their feelings and make sense of the increased limitations on their life, clients relied on characteristic coping strategies. The theme of the uniqueness of these ways to manage illness again appeared.

Coping with the illness worsening.

Clients coped by minimizing their worry and maintaining their normal activities. Professionals, however, have tended to characterize that living with heart disease entails living with impending death (Granger, 1974). In this study, only two clients expressed that they feared death. Thus, pre-occupation with one's mortality would not appear to colour the entire experience as professionals have expected. Some clients were able to make sense of their progressive illness and cope with the possibility of their death by actively minimizing their worry.

Once the clients realized that their illness was worsening,
they changed the way they sought medical care. Instead of managing on their own, they tended to rely on their physicians to interpret their symptoms and care for them. Their trust in the professional sector regarding diagnosis and care is reflected in the following account.

I just thought that if something should happen, I'll just . . . M [wife] said, "don't worry. We'll get the ambulance and you'll be in; we'd go over to X Hospital and they could take it from there."

Even though one participant perceived that his condition was beyond help, his trust in the judgement of the medical profession remained intact.

I didn't think there was anything I could do about it [his illness worsening]. . . . No. Just go and see the doctor occasionally.

The value in seeing his doctor outweighed his belief that nothing could be done about his illness. Through their trust, clients were able to cope with their illness worsening. The theme of trust therefore was valuable as a coping strategy.

During the first phase of their illness, clients were confronted with making sense of bodily cues, medical management and their own feelings. By the time CABG was being considered, they had developed coping strategies to deal with their illness. The plan to undergo CABG marked a change both in how clients perceived their illness and managed it.
The Plan to Undergo CABG

During the second phase of their illness experience, clients became more aware of the exact nature of their illness and that CABG was an option in their care. They were primarily involved in making choices about undergoing CABG and then preparing for the operation. The trust in the professional sector was more strongly voiced here than in the previous phase. Hope also emerged as an important coping strategy for the clients.

The benchmarks which marked this phase were undergoing coronary angiography, deciding to have CABG, waiting for the operation and having the surgery. Although professionals often consider admission to the hospital an important benchmark, clients did not remark on this as a significant aspect of their experience. Thus, this phase contains perceptions of both the hospital and home experience.

When the illness had worsened to the point where medical management was not controlling the symptoms, surgical intervention became a possibility. Before clients could proceed to undergo CABG, however, further definitive testing was required. This took the form of coronary angiography.

Undergoing Coronary Angiography

In the professional sector, angiography has been considered
a prerequisite for undergoing CABG even though other sophisticated tests are available to gauge the extent of coronary disease and assess the need for surgery (Wade, 1978). This predominant belief is reflected in clients' accounts as all underwent elective coronary angiography.

Clients understood the angiogram in concrete ways. They did not rely on professional explanations about the procedure but made sense of it in terms of what the experience was like for them.

Making sense of the procedure.

Although professionals have considered the angiogram to be an invasive procedure and not without risk, only one client expressed concern about it.

[When] she [Dr. X] suggested the angiogram I was a little bit worried. I was more worried about the angiogram than I was about the heart operation. . . . The idea of this catheter going up the vein just didn't appeal to me, eh [laugh]. . . . I didn't think anything would happen. I just didn't like the idea of it. It upset me. Yea. No, no, I wasn't scared of it. I just didn't like it. . . . Then after it was over I sort of wondered why I was scared.

Other clients were not concerned but explained how they made sense of their feelings and perceptions during the
procedure itself.
I didn't mind it. I didn't have any problem with it. 'Cause I was so sleepy. They'd given me a Seconal. And then he gave me ah, ah, some, whatever drug--dye they use and I was allergic to that. And he gave me a shot of Gravol and I had no problems. And, ah, I couldn't feel anything--no pain, nothing when he was doing this test. . . . I was sleepy but, you know, but yet I could hear everything the doctor said to me. It's funny, isn't it? I was sleepy, but yet I heard him, like, ah, as clear as a bell. Everything he told me to do, I did it. And yet I didn't: I just wanted to sleep . . . I didn't: I saw the screen but I didn't even wanna look at it. Normally, I would have wanted to look at it.

It [the catheter] was up there before I had even any idea. And then she [Dr. X] was pumping. I could feel this pumping motion. What she was doing was pumping the dye, and I thought she was pumping the tubes. But I was awfully glad to find out it was the dye [laugh]. She told me to look over. And I could see my heart and I could see the two little pins going. I decided I didn't want to see anymore.

I saw the thing [catheter], you know. . . . I didn't know what I was lookin' at, but I saw the stuff
squirtin' out, you know. And, and, ah, just looked like a big long snake, you know—goes in and out . . . Then they'd be shuttin' the machine off and doin' something, you know. And there was about six, seven nurses around.

From the patient's viewpoint of living through the experience, the angiogram was not perceived as being particularly threatening nor remarkable. Clients understood the procedure through what they felt and saw, relating their perceptions to previous images ("pins", "snakes").

The clients varied in the amount they discussed the angiogram. However, all commented on the significance of the results of the angiogram as marking the point at which surgery was considered. They interpreted it as being important in determining the future course of their illness and progress. In comparison to the first phase of the illness, however, this theme of progress was perceived positively. Clients understood that their condition could improve.

The angiogram also was meaningful to the clients because the results of the procedure enabled them to more clearly understand the perceived pathology in their heart.

As they explained to me, that of the, ah the three arteries into the heart, two were completely blocked and one was 90%, the other was 90% blocked. And one obviously from the first heart attack had developed, ah, good, was it capillary action? [collateral circulation]. And, um, was seen functioning not too
bad. And they told me they would be doing five bypasses.

One client felt that the results of the angiogram were easily understood and helped to explain why she was ill. And he [Dr. X] explained it, like I said, in terms--very, very simple terms that, ah, I found very easy to understand what was wrong.

The same client found that the angiogram was significant because knowing what was wrong helped her cope.

And I've been, I was a different person after I had the angiogram and found out what was wrong. . . . I wasn't worried anymore--wasn't anxious. I was just absolutely fine. I was different. Yea. I relaxed. I was happy. I knew I had a chance.

The benchmark, thus, was important in helping the clients understand their illness. Because the angiogram identified the exact cause of their illness, clients perceived that something could be done to remove that cause. Instead of perceiving themselves as getting worse, they realized that they could get better. Undergoing the angiogram changed the way clients perceived their illness.

Changes in clients' perceptions of their illness.

Once clients knew the exact cause of their illness, their previous perceptions of their symptoms and illness changed. One
client changed the way he perceived his illness after discovering that he required urgent CABG.

I figured, well, geez, it [the angina] must be [serious] you know. Because I've known, a friend of mine just had his operation in May. And he had waited nine months... [Needing the surgery right away] told me that I must be, ah, you know, in bad shape. But I'm feeling fine.

Simply undergoing the angiography raised the hopes of one participant that CABG was being planned.

I felt that they were gonna operate on me. Well, a lady came in, took blood. And I said, "What's this for?" She says, "For your surgery." You know, I didn't even have the results of the angiogram. And that spooked me out. You know, I thought, "What the hell was going on here?" And I said to her, "What surgery?" And then she got quiet and left quickly. [laugh]. So then Dr. X came and I said, "Well, you know, I guess we'll have to have the surgery. But I want a couple of months to get ready" [laugh]. Which, I guess, well, it made her laugh because I thought they were gonna whoop me in the next day, you know... Then I thought it meant the, that the situation was real bad. I had no idea what she'd found.

Clients understood the results of the angiogram in terms of the progression of their illness and the availability of a "cure".

In her personal account of open heart surgery, Yuille
(1977) also found the angiogram raised her hopes that the results would be favourable. Clients appeared to focus on the implications the test would have for their illness rather than on the risk of the procedure. The possibility of undergoing CABG overshadowed other aspects of the experience.

Deciding to Undergo CABG

After the angiogram results were available, the clients and their cardiologists discussed the possibility of surgery. In all cases this occurred while the clients were still hospitalized for the angiography. Further discussions with the surgeon were done in hospital or during an office visit.

Contrary to professional belief, the choice to undergo CABG was not a difficult one for participants. The theme of choices was very strongly voiced during this phase of the illness. Clients described their decision to undergo CABG in commonsense ways. One client relied on spiritual guidance in his decision-making.

Even this time, you know, some, the, the doctor advised me if I go to the operation. At first, you know, I thought, you know, I just offer my praying. I don't know. If God promised to go, [sic] to go to the hospital, I will find out. At that time, I not make up my mind to accept and to go to the hospital. No. .. And then I think this, you know, I thought maybe this is God will. So that I accept.
The theme of trust also emerged as clients relied on faith in their physicians to decide whether or not to undergo CABG. All the clients expressed their belief that undergoing CABG would be beneficial to them. They trusted the medical judgement of their physicians.

I got, ah, I, ah, trust them, you see. I trust. I trust my own family doctor. And if he send[s] me to a specialist, he's gonna be a good one, I know that.

I was thankful for that—the patient had the choice to make, ah, it, it's up to them, isn't it? If they want to make a mistake, okay, that's, that's the way it should be. But then, I'm not, I wasn't knowledgeable enough to, you know. I feel, it's up, it's up to a patient to make a choice, but then I feel the doctor knows much more because he's trained. And I'd be a fool if I didn't, ah, do what he suggested. And because I trusted him, ah, and he seemed to be a very sincere man, with a great sense of humor, which I certainly appreciate. And, also because he gave me the choice of whether I should or shouldn't even though I didn't know what was best. I knew, in a sense, that was what I was going to do, anyway.

Trust has been an accepted part of the patient-professional relationship. Thomas (1978) has suggested that trust stems from an expectation that situations will be good. When clients trust, they become willing to accept new
experiences and are comfortable with an awareness of themselves, goals and motivations. From clients' accounts, it is evident that faith in the professional sector (primarily, their physicians) was very strong. As such, trust seemed to be an important factor in clients consenting to undergo CABG.

In describing how they chose to undergo CABG, the clients identified other factors which influenced their decision. A significant factor were the "odds" that the physicians quoted to represent surgical risk.

He [the doctor] interviewed me and examined me there. And told me of the risk. And he said 1% risk. And, ah, it sounded real fine then . . . He said, "You may die of this, though. I want you to know that." He said, "Some people do. Things happen." He says, "But normally for a man your age and your, with your other, your vitals and so forth, 1% risk is, we're looking at."

They told me, ah, that, ah, it was only one out of a thousand that had problems. Well, that's, you know, pretty good odds. [The odds about my risk of death] meant that I better have surgery as soon as possible. That was my message. And that was the reality of the situation. . . A 3% risk after all. You take a fair risk when you go outside these days. And, ah, 3% was very small compared to 75 and 90. So there was no risk at all, was there?
It is apparent that the quantification of risk was meaningful to the clients. The clients made sense of their decision by interpreting the professional explanatory models regarding risk. The odds helped them weigh the pro's and con's of having the surgery. When surgical risk was compared to chance of death from myocardial infarction, the choice became clearer to the clients.

Although risk was an important factor in choosing to undergo CABG, the client's belief that the surgery was the only alternative was also significant.

I said, "I'll have the surgery." Well, ah, I told, ah, Dr. X, "well," I said, "there's no alternative but the surgery, is there?" And she said, "not really." And I said, "Well, I will have the surgery." . . . I just knew I had no alternative but to have the surgery. Given any alternative, I'd [sic] probably would have taken it. I didn't want to have the surgery. You know, and, I, I kinda have, you know, I knew there was a good possibility that I might not wake up. And I felt that my chances weren't as good. Because I'd been quite sick . . . I was resigned to it, eh. Well, I've been having a lot of pain. Before.

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I'd felt I had the choice not to take the operation, yes. But I think that the alternative of not having the operation would have been dying.
I made up my mind. That when I, when ah, I figured if I'm gonna need the surgery, I was gonna go right in there and have it done. . . . I never doubted it. I, ah, I made up my mind. I said, "Well, this is it. If that's what it is and that's what I need, then that's what I'm gonna do." . . . I didn't, ah, hesitate.

The clients perceived that undergoing CABG was the only way to become healthy.

For one client, the decision to undergo CABG was made solely by his physicians.

Nobody asked me whether I wanted an operation or, ah, ah, Dr. X at Y Hospital, he just said, "You're goin' there and you're goin' be operated on Monday morning." . . . Like this is on the Thursday morning. He says, "You're goin' to the X Hospital by ambulance and you'll stay there 'til we get a a bed in, ah, in Y Hospital." He says, "We figure on Saturday morning." And he said, "On Monday morning, you're gonna be operated on." Just like that! Nobody said, "Well, do you wanna? or, ah, "Look at," you know. . . . I, ah, thought, well, if I gotta have an operation, I gotta have an operation. There's no point in me, ah, going along the way I was.

From this account, it is apparent that the client accepted the decision and appeared to trust the medical plan. He made sense of the necessity of CABG by perceiving that it would improve his
Deciding to undergo CABG also related to the expectations the clients had about the benefits of surgery. Clients felt the operation would help them in various ways—some related benefits to activities of daily living; some to life-saving aspects of the surgery and others to symptom relief.

Other friends, ah, good friends, have had this bypasses [sic]. And, ah, so I knew, you know that . . . they were fine. They told me they were fine. They could do anything, just watch what they were eating and, and, ah, gettin' rest and exercise and they were fine. . . . I knew that if I had this operation, that everything would be fine.

All I knew was that the operation was gonna help. I mean it was gonna save me from having a heart attack and be, ah, just sitting in an easy chair, you know.

And that [CABG] was going to improve my chances of, ah, probably extending my life.

I felt, I, it would help. I, at first, thought it would take it [angina] away a hundred percent.

I assume now that this is gonna mean that my, ah, heart's gonna function regularly. It's gonna have a
good supply of blood and it's not going to stop me having another heart attack, though. That this could still happen. You know, I could have another clot, or I could have the same problem again. . . . It should be good for at least five years. And I expect to have a pretty pain-free time.

The benefits of undergoing CABG were again seen in terms of concrete effects and behaviors. Clients understood that the operation would return them to a well state. Thus, CABG was perceived as a potentially vital benchmark in clients' getting better.

Once the clients had decided to go ahead with the surgery, they were pleased.

I was very happy to know that, that something could be done. . . . I was very pleased that I was going to have the opportunity [to have CABG].

They interpreted CABG as a very positive step in helping them manage their illness.

In addition to deciding whether or not to undergo CABG, some clients were also asked to select a surgeon.

And, ah, I, I, elected to go with Dr. X. . . . Dr. A told me about him. And, ah, he said, "The main," he said, "They are both excellent." He said, "I'd trust my life to either one of them." He said, "The main difference is that Dr. Y is so busy with, ah, he's been there longer--he's got more patients, more things to do and he's affiliated with the university and
things like this. Dr. X will probably find more time for you. Be able to talk to you after it's all over with. I said, "That's the guy I want, right there."

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I still had the faith in him [the surgeon] because I heard that he was a great physician, surgeon. And, ah, a good one.

Satisfaction with their surgeon was a common feeling expressed by all the participants. They relied on information from their personal physicians and friends in order to confirm their trust in the surgeon's abilities. The lay person's grapevine was found to be an important source of information for the clients. The perceived personal qualities of the surgeon helped to engender faith.

Clients' trust in their surgeons was apparent throughout this phase. This theme of trust was very strong. Even though clients spent little time with their physicians, they still accepted and respected these doctors and their advice.

He [the surgeon] didn't come in to see me that day, but he come in on Tuesday. Just pulled my underwear down and took a look at my legs. Here, he was looking for those veins. Took a look at that and then, ah, pulled my shirt open and looked at my chest. He said, "You'll have an incision here, have two here, one down, one here." He walked out of the room and that was it. . . . Very small conversation. . . . I think the less I knew about it [CABG], the better.
You don't know that anybody's going to care about you in the operating room, eh. It's not like you're family doctor's there or even Dr. X [the cardiologist] would be there. And I met the doctor [surgeon] once, that was after the, the angiogram. And then I met him again, ah, the day before the operation in the hospital. ... But then after, I didn't feel that way, when it came time for the operation, I felt, I felt like I trusted them. ... I had complete faith. I knew they were going to look after me. ... But I wasn't worried for a long time. And, remember, I'm going out of my community to the hospital, too. And most people are there from long way from home, too. [You have a feeling] it's just a process [to the hospital staff].

Trust in the professional sector helped the clients decide that CABG would ameliorate their illness.

Making sense of CABG and choosing to have surgery, thus, was a complex process. Clients primarily relied on their doctors to advise them but they explained their decision in ways characteristic of the popular sector. Their decision was, therefore, based on both lay and professional understandings of what the operation entailed and represented.
Waiting for the Operation

Once the decision and arrangements had been made to undergo CABG, the clients went into a waiting period. The time spent waiting varied for each participant.

Concerns.

During this time, many clients expressed concerns that surfaced about the illness and surgery. These concerns were part of the process of waiting which encompassed time spent at home and in the hospital.

Course, you're always thinking about heart attacks, you know. I mean, I don't mind getting a heart attack, but it's only--I don't want to get a stroke. . . . That's another thing that I was worrying, hoping that I wouldn't get a stroke. . . . Before I had the surgery. Yea. I, 'cause we had a neighbour that had a stroke. And he was terrible. And I figured, gosh, I mean, I'd rather, 'cause I was, well--I've seen so many people that have had heart attacks and they just survive it. They just go in there for the operation and then they're okay. And, ah, but I was lucky. I guess I just was lucky to get in and get done before I had my heart attack.

Some clients were concerned about experiencing the
operation and convalescence.

I didn't like the idea of having to go through it all because, ah, you know, you, you don't like the thoughts, you know. It's the thoughts more, you know. But I wasn't afraid, or, ah, worried. They told me, ah, that, ah, it was only one out of a thousand that had problems. Well, that's, you know, pretty good odds. . . . And, ah, that didn't really bother me too much.

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Fact, only thing I was thinking about, well, actually what I did think about was, aftereffects. You know, like after the operation. You know, all these aches and pains, because I have friend[s] who've had it and they'd say, "Well, oh gee, we've got a little bit of discomfort, you know."

During the wait in hospital, clients' concerns were focused more on the actual surgery and convalescence than long term goals such as returning to work. Anxiety regarding the unknown was apparent.

They [the nurses] gave me a sleeping pill, but it wore off in two hours. And I woke up, well, after midnight and I was wide awake. . . . And, I said, "ah, gosh, I'm wide awake." And, ah, things like going to the bathroom [following surgery]. "How will I go to the bathroom, you know?" . . . and, ah, "What happens if I'm on the operating room table and, you know
[laugh]." And, ah, I'm wide awake. So I got up and I went up to the nurses' station. I says, "I'm wide awake." I said, "I'm getting a little anxious."

Clients also perceived that concrete aspects of the convalescence aroused concern.

I was dreading that sitting on a damn [bed] pan [laugh]. Oh, I dreaded that.

One client believed that contact with a post-op patient could have caused worry.

There was one fellow in X Hospital that, ah, was, ah, oh I think he was going back over the years. He was a man about my age; he'd had his operation... He was not a violent, or anything, just a little funny. Well that kinda, you know. I figured that that guy shoulda been--the doctor shoulda had him in a, maybe in a private room somewhere where he wasn't mingling with the rest of the [patients]. But he didn't really bother me. It didn't really scare me into thinking that ah, but, ah, like one of the other patients there... Well, ah, he used to look at this fellow, you know and tell me about it. I kinda thought, well, maybe, you know, he could be a little bit worried.

In this account, the client anticipated what the convalescence would be like by observing his fellow patients. When the outcome did not appear to mark progress and health, the client perceived this could be a concern.

Professionals have considered anxiety and fear to be
natural responses of the client and family toward the approaching surgery (Brener, 1972; Brogan, 1972). Winslow and MacVaugh (1976) have written that clients fear the procedure itself, the dependency, loss of control, pain and death as well as being concerned about their families. From the clients' accounts, it would appear that they also feared concrete aspects of the experience.

In addition to raising concerns about the impending surgery and sorting out their thoughts and feelings, clients were also engaged in trying to understand why they had to wait. The length of the waiting period proved to be a concern to all the clients, regardless of the actual time spent waiting.

I waited too long, really. I think that was a bad thing, eh M [wife]? Um, I went in for my angiogram in March, which was a three month wait for that. And I expected a three month wait for the surgery and it ended up a six month wait. And it kept getting—we were waiting for a phone call all the time and it was, ah, nerve-wracking. . . . I'm all ready to go and then find that we're not going in. I phoned—"Oh, no. You won't be going for another two to three months."
That's a real let-down. . . . All I wanted was to have a month or so to sort of psych myself up for it, but I would have preferred not to have had six months, you know. . . . I think that's bad, but what can be done about it?
Even when the wait was comparatively short, clients
disliked the idea of waiting. They seemed to want to "get it over with."

They told me Monday and then, well, the surgery was cancelled. Of course, I was wanderin' around this hospital. "Why can't I be laying at home?" You know, I coulda done the same, you know, just stayed right at home here and sat in this easy chair. . . . Actually, it wasn't a long wait. Other people in there for days and months, you know--weeks.

If the wait involved numerous cancellations and delays, the concern was voiced even stronger.

First time, I say nothing. Second time, say nothing. Third time, also, okay. And at last, fourth time, they also asked me to change. I told them that, "What can I do? If today I'm not a minister, I would have very bad temper with you." . . . So I don't mind the change of time. But cannot change it again, again, and again. . . . This is very unfair. I think this, the hospital administration is very poor. I heard. The operation room moved to a new room--very chaotic, nothing coordinated.

The cancellation was the only thing. They, they coulda, they could have, they could have said to me, "We have an emergency. And we'll give you another day." But nothing was said until, ah, the night nurse came on and she says, ah, she said, quite innocently,
you know. She said, ah, "Did you, ah, when are you gonna go for your operation?" I said, "Monday." She says, "No." So, I, I felt kinda upset. Well, the assistant surgeon saw me on Saturday morning and he says, ah, "I hear you've been feeling kind of upset." I says, well, I says, "You know," I says, "here I planned on Monday and all of a sudden"... He says, "Well, there was an emergency." I said, "Okay, that's fine. If it's an emergency," I said, "Well, nobody said anything to me. But if it's an emergency, that's fine." I says, I says, "I, I, I'll go for that because," I says, "I'm sure if I was an emergency, I'd appreciate if someone let me have their spot." And he says, "Well, that's very nice." He says, "That's very good." And, ah, he says, "I tell you what--why don't you take a day pass?"

Waiting for surgery raised many concerns for the clients.

Coping during the waiting period.

Overall, the clients appeared to determine progress and improvement by the passage of time. Although their condition may not have improved, they perceived the waiting period as an important aspect in regaining their health. Clients made sense of their wait by managing their illness and preparing themselves for the operation. This preparation was a positive way of
managing the waiting period as well as anticipating their needs in hospital. During the waiting period, the preparation for CABG was the primary coping strategy used to handle this passage of time. Again, the theme of the uniqueness of these coping strategies was apparent.

Clients used the waiting time to further interpret their illness and attach meaning to its effects on their lives. Clients continued to reflect on what might have caused the coronary disease.

There was times when I was wondering, ah, ah, "why now," you know, like that. "Why wasn't it ten years ago, or, or longer, or why, why now, you know?" . . . Ah, "what the heck have I been doin'? What are, the heck we've been eatin'?" Ah, because I, like I say, I ate as many--I was drinkin' as much coffee and, ah, drinkin' as much milk, cheese and, ah, ah, eatin' as many pork chops as I was, ah, ten years ago than I am now, you know.

They sought further understanding by reading. This helped them make sense of their illness as well as prepare themselves for the surgery.

I had been studying, of course. I got books from the library. . . . Some of them didn't help too much. I suppose I shouldn't have maybe involved myself so terribly much, because at the time, you see, some of them were pretty morbid. And, ah, maybe I overdid it a little. I think it used to worry [my husband] a
bit, too, what I used to read. But I never, I never was scared, in a way to read because I wanted to know.

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You know, you gotta, you gotta read up. I mean, you can't--I couldn't find myself just walk in the hospital, blind to everything, you know. I had to know why, what was wrong, and what they were gonna do. And, ah, so I had an idea what they were gonna do. Information helped the clients understand CABG and prepare for the experience. The following accounts reflect how they perceived the operation would be performed.

At first I thought that when they, they cut a piece out, the blockage out, and put this piece in. But now I understand they, they go, they put another piece in; they don't cut anything out. They just graft below and above.

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They'd take a vein from the inside of my left, my left leg. And it would be quite, because I was gonna need, they told me it was going to be four, ah, what is it, vessel--a four vessel operation. One more than a triple, he said, so I figure, I call it a quadruple. And, ah, and it didn't, it kept, it was quite a natural thing that I was going to have; it was gonna be me and not something foreign that I wouldn't reject my own self. 'Cause so far in 69 years I haven't really, rejected myself.
And I understand that what they have done was that they have bypassed those plugged areas to allow the blood to flow more freely. And they didn't do it the way I thought they would do it. When he explained to me what they were gonna do, I liked that much better. Because it seemed to make more sense to me going from like a main artery directly in, instead of just bypassing it like this. I thought they just made a loop. 'Cause they said, "bypass".

The influence of professional explanatory models is apparent in participants' accounts. However, two participants did not voice any thoughts regarding the actual grafting procedure and its purpose.

In addition to finding out more about the actual surgery, one client used the waiting period in hospital to determine what the experience would be like.

I knew when my wife went, they were gonna come around and start, ah, because I'd seen it. A few days before, they were preparing another fellow. . . . They were gonna shave me and, ah, the nurse was gonna come in and take more blood. And another nurse would come in and put these thing in my hand here ready for the intervenous [intravenous]. And, ah, that I would have to go for a shower and come back and, ah, when I woke up in the morning, ah, I had to go for another shower. And they would be starting preparing me, because I was
awake when the other fellow. I knew what they were
doin' with him.

In her study of open heart surgery patients, Miller (1978) found that in order to receive what they perceived helpful and accurate information about the experience, clients consistently sought out other clients who had the surgery. Throughout the illness, many of the clients did seek out information from friends regarding what the experience would be like.

We sorta talked. And, and, ah, we'd phone each other up and, I'd ask him questions. And he'd say, well, "I feel fine and this had happened; that happened."

Three clients prepared themselves for the operation through reaffirming their faith and trust in God. The theme of trust was important as a coping strategy.

And the thought of going to a Catholic hospital meant more to me than, ah, probably the heart condition.

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When I first went into the hospital there was a chap in there and he was a, a minister. And he said, he says, "As long as you have faith," he says, "you'll be okay." . . . So I took it, took it to heart.

Another way that one client used the time was to get in shape for the operation.

I was going to cut down smoking, do a lot of walking—which I did. Try and lose some more weight. But, then, when it went on too long, I lost all my psyching up.
While the clients waited at home, their thoughts focused on being healthy enough to survive until their admission into hospital.

I was just going to wait it out. And hopefully hope that I would get in.

Rakoczy (1976, 1977) has studied the waiting period for open heart surgery clients and found that clients worked through their thoughts and feelings about surgery in order to cope. She suggested that clients' affective needs were more apparent than their cognitive ones. In making sense of their illness in relation to the benchmark of CABG, the participants in this study also cognitively and affectively responded to their wait as a means of coping.

In addition to preparing themselves for surgery, clients also were involved in coping with their illness on a day-to-day basis. During the waiting period, two different kinds of activities surfaced—those centered on maintaining the status quo (no deterioration in condition) and others toward preparation for surgery. During the wait, one client tried to carry on her usual activities.

I kept doing little things around the house that, I hadn't I think that I hadn't done before. I just felt better.

A normal life was maintained with the spouses, families and friends supporting the clients. The theme of the shared nature of the illness was made apparent through many references to clients' spouses. Especially in the waiting period, spouses
emotionally supported the clients in coping with the wait and preparation for surgery.

Because the length of the waiting period was a concern for all the clients, they had to cope with this. Clients found distraction to be beneficial in the waiting period.

I worked right to the day before I went in the hospital. . . . I figured I'd be better off working. . . Ah, because if I'd a [sic] been home, I coulda been, ah, thinking about it all the time. And, ah, I'd be thinking about it and thinking about it all and it would magnify itself. This way, I, I was at work and it was a distraction.

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In the X Hospital, I got bored there. I started playing around with those things there, you know [monitoring cables]. Ah, you know, these things all over my chest, here. And I would look up at the screen and I could make that line go way up and down and of course they would take a look at that from the desk there, you know and come running in there. And I knew what was going on all the time and they would say, "That darn thing there, well; it's all right now", you know.

Char (1978) has postulated that boredom occurs when a situation is monotonous, tedious, low or devoid of interest. The client subjectively perceives him/herself captive and may attempt to control, suppress or express the anger arising from
the situation. What factors actually triggered the participant's boredom is not known.

Clients also coped with the length of the waiting period by making sense of it. One client who had his surgery cancelled clearly allocated the blame for his delay.

When Monday come along and I wasn't gonna be goin' in, on account of shortage of staff. So that got me. And then when he [the surgeon] come and told me about the [shortage of blood for the surgery], well, I couldn't blame anybody for that. That's as much my fault as it is anybody's fault. . . . The, the, ah, shortage of staff, I, I, right there I kinda got my dander up on the "galdarn" government.

This client made sense of his experience by seeking out more information and allocating responsibility for the delay.

As Rakoczy (1977) identified, the one day period immediately prior to the CABG was perceived by the clients as passing slowly. One participant expressed displeasure at "going second", but dealt with it in his own way.

I wasn't too happy about being operated in the afternoon, too. . . . I waited, yea. And I figured, well. There were gonna operate on the lady first, eh, and I figured that she probably needed it. Well, I felt that she was, ah . . . she seemed to be very worried. And I thought it was better that she went first.

Although the participant wanted to be past the benchmark of
CABG, he realized that the wait was an integral part of the experience.

Thus, it is apparent that clients used the waiting period to prepare themselves for the surgery. Professionals have tended to perceive that they have an important role in helping clients prepare for surgery. The waiting period has emerged as an important time to help clients understand their hospitalization, reduce their fear and have a positive attitude toward the operation (Winslow & MacVaugh, 1976). To accomplish this, professionals have concentrated their efforts on developing teaching programs to supply clients with the necessary knowledge and ability to recover. The content of these programs has been similar—pathophysiology of the heart, purpose of CABG, feelings post-op (American Heart Association, 1981). Although the language is less technical than in professional journals, the content and organization of the programs reflect the professional rather than lay perspective.

Professionals have assumed that patient education is valuable even though there is no definitive research to support this belief. Different factors have been postulated to affect clients' learning and retention, for example, timing of teaching and anxiety (Christopherson & Pfeiffer, 1980; White, Lemon & Albanese, 1980). Brundage and MacKeracher (1980) have also suggested that adults possess unique characteristics which affect how they should be taught. They believe teaching can only be effective when it capitalizes on adults' past experience and focuses on the immediate present.
Miller (1978) has examined the effectiveness of teaching programs by assessing how clients perceived the value of pre-operative information. She found that patient education programs did not capitalize on what the patients already knew, but instead consisted of content that the nurses felt the clients needed. Because of this, she concluded that the patients' actual learning needs are largely unknown and unmet. Thus, appropriate and effective pre-operative patient education would appear to be an issue for professionals.

Although a patient education program existed at the hospital where the clients were admitted, only three clients commented on it. Instead of mentioning the "knowledge" they acquired, they explained the usefulness of the program in terms of helping them cope with the recovery. This differs from the professional's tendency to focus on the client's cognitive learning.

Pre-surgery were great. The, the physiotherapists were there, ah, to show you how to cough and tell you what to expect. Tubes down your throat. I went to that film, you know, a general film. You know what to expect when you wake up. So you don't wake up. So you don't panic now when you have this water hose stuck down your throat. Felt as big as a water hose, anyway.

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They [the nurses] tell you all about that [the operation]. Oh, I think it's pretty good.
Thus, patient education was perceived valuable in helping the clients make sense of what the experience would be like. Their viewpoint differed from the professional's, however, in its focus on concrete events rather than facts about pathophysiology. Clients were more interested in understanding what the experience would feel like for them.

In addition to coping by ascertaining what the experience would be like, patients also retained their hope. As a theme, hope was more strongly voiced during this phase than the earlier part of the illness. The plan to undergo CABG triggered many hopeful statements about a return to health.

I wanna feel good. Because that's the way I am. I just, I wanna get a job done. I don't wanna be sick. I hate being sick. Ah, I'm the world's, like most men, I guess, the world's worst, ah, patient.

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And, ah, I rather suspect that when all these heals and I get my body in better condition, that I won't need any [medication]. That's what I'm hoping for. Just keep 'em around, just in case.

The participants were hopeful that the operation would mark improvement in their health. However, one client did not believe that the surgery would help all his cardiovascular problems. Instead, he tended to be more guarded in his hope.

I was pretty sure my blood pressure would stay high because it was high before I had the heart attack. And I couldn't see anything in the operation that was
going to lower my blood pressure. Maybe a little, but I'm sure that problem will still be with me.

Hope is an aspect of the client's experience which has resisted rigid scientific analysis and the development of well-defined explanatory models. In further explaining how hope can be viewed as a continuum, Lange (1978) has attempted to define the concept as a complex mixture of feelings and thoughts which center on the fundamental belief that human problems can be solved. She conceptualized it as a coping strategy which draws on past experience to deal with an uncertain present. For Lange (1978), hope has affective and cognitive aspects—faith and trust as well as the selecting out of information to support hope. From clients' accounts, these parts of the definitions may be evident.

In addition to being hopeful, the clients also had a positive attitude toward the surgery and recovery.

That's what a friend of mine told me from X City, too—had the operation. He said the matter of attitude was—your attitude was, was very important. I think that's gotta be true in anything.

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I figured I had a feeling that I was going to be okay. Yea. I felt positive. And I thought, "Nothing's going to happen to me until I'm gonna go through the surgery." And I'm gonna be fine . . . . I don't know; I just became determined and positive. And I felt my attitude was good. And I liked myself. It wasn't
because some of the things that I thought or went through were good--it was, but I liked myself personally. I didn't always like myself the way I felt, but I liked myself. And I thought in order to like other people, you have to like yourself.

I've just got to make up my mind I've got to get better and keep that in mind and just keep going along.

Positive thinking enabled the clients to perceive the benefit of the surgery as a return to health.

Another client expressed an attitude toward life that helped her cope with the surgery.

I think that everything you learn is a stepping stone, higher and higher; and each, each little experience you have, or big one is a stepping stone for the next one 'til finally you make it to that great beyond. . . . It is part; it's part of life. We grow as long as we're alive, we grow. And if we, if we don't, you know, if I, if a person does not accept this kind of thing, they die. Their spirit dies anyway. . . . And [I] don't worry about tomorrow. 'Cause you only have today, don't we? Actually we only have--how do we know?

For this client the entire illness experience was perceived as another kind of benchmark in her life. She understood her illness and surgery by attributing positive characteristics to
the experience.

As well as being optimistic about the CABG, clients prepared for their operation by deciding what would be an appropriate "patient role" during their hospitalization.

I think, I also, too, that I wanted that, do well to please the people looking after me. . . . I made up my mind that I was gonna be a good patient. . . . I wasn't going to be a damn nuisance. Also, too, you know, you, you like to look after yourself.

Well the thing is, when I went in the hospital I, I said to myself. I'm not going to lie around. I'm going to get up and walk. I made up my mind that I was, I was gonna get healthy. . . . I really worked at it. And I, I, I knew that I was gonna get up and, ah, like, a lot of times you see people---they, they, they groan and they and they're forever groaning and complaining. And I wasn't going to do that. I never did complain about anything.

Thus, while waiting for the operation, clients used the time to continue to manage their illness and make sense of it. However, because the surgery was imminent, their main activity centered around preparing themselves physically, emotionally and mentally for the operation. They were hopeful that the time spent waiting would help them actually undergo the surgery.
Having the Operation

Undergoing the CABG was the last benchmark in the second phase of the client's illness experience. However, because clients were sedated during the surgery, the only perceptions of this benchmark centered around the trip to the operating room and surgical theatre, itself. Nevertheless, having the CABG marked an important benchmark in the client's illness. Although most of the clients had vague memories from this period, three people remarked on their experience.

And then when I got into the operating room, it seemed, boy, I wasn't even in the operating room. It was the anteroom, eh, seemed to be a bit of confusion. And everybody was happy and cheerful. And they were pushing me here and there. And I felt, ah, quite, ah confident. I was aware, though, that I could die. I, I quite, ah, I'd quite prepared myself for that eventuality. And then the girl said, "Oh, you're ready for Mr. P now." And they said, "Here you go in." And I remember going in, just to the room and I remember seeing the, um, lights, and, ah, I remember seeing some green hangings. And then I was gone.

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In fact I never seen that operating room door yet... . I don't know. I think they operated on me in the hall getting there because [laugh]... . I don't know nothing... . It's the first time I don't remember
going into an operating room... The [nurse] talked to me going down the hall about the--how cold it was in that new part. The new wing was so cold. Oh, but she says, "It look so much nicer, though don't it?" And I said, "Yes, it does look very nice." And that's about the last darn time I think I spoke or knew anything 'til somebody was slapping my face.

I says, "Can I, do I get anything that, where I don't notice the run to the operating room?" And they said, "Oh, we'll give you something." And, ah, and, ah, I remember the fellow lifting me up on that stretcher. And, ah, I kind of dozed off and, ah, and, ah, I don't remember anything. I don't remember.

Although the clients did not remember anything from the operation, they did perceive this a significant benchmark. Because it changed the way they managed their illness and perceived their health, CABG marked a change in the illness experience. After the CABG, clients focused on recovering and getting better rather than on being sick.

The Recovery From CABG While in Hospital

The in-hospital convalescent period covered the time following CABG until clients were discharged home. During this phase of the illness, the clients were involved in stabilizing their physiological condition and coping with threats from the
CABG. They continued to be hopeful and trusting of their caregivers.

Because the environment was structured and other patients were visible, the clients were able to more readily identify benchmarks in this phase. The clients noted progression in their recovery by the removal of equipment (endotracheal tubes, chest tubes, monitoring cables, pacemaker wires) as well as by changes in their environment (from PAR to ICU and then to the ward). Thus, the benchmarks of this phase were of both a personal and environmental nature. For purposes of clarity, the benchmarks of this phase will be discussed in terms of environmental changes--PAR/ICU and the ward setting. Personal benchmarks will become evident in clients' accounts.

The Experience in the Post Anaesthesia Recovery Room and Intensive Care Unit

Professionals have considered the time immediately following CABG to be a critical period in clients' convalescence due to the instability of the body systems. Many complications can ensue which are life-threatening (Calhoun & Bozorgi, 1974; Rees, 1976-1977; Young, 1981). However, the participants in this study did not concern themselves solely with complications or regaining stability. Rather, clients focused on feeling-states and how to cope with this aspect of their recovery.
Clients' perceptions of the critical care areas.

In retrospect, clients' memories of PAR and ICU were blurred. How much the clients actually perceived and remembered about events in the critical care areas varied. Some were able to differentiate the two areas while others could not. Nevertheless, all the participants attached meaning to their perceptions and made sense of their experience in terms of getting better.

When I woke up, I was in the Recovery Room. And, of course, all I see is masks, you know, lookin' down at me [laugh], you know.

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I remember, I remember this woman calling my name . . . And, ah, I heard her, you know, clearly. And she says, "Are you awake?" And I, ah, and I looked and I couldn't talk. And I, I opened my eyes and, I was in this room. And I could see somebody else walking back in the background. A nurse, I guess; she's all in green. And, ah, I looked and I, and I dunno what to think you know. All of a sudden, I kind of got excited and I, I'm trying to talk and she says, "Are you all right?", you know. Well, how can I tell her I'm all right when I got a tube down my throat. And so I, ah, I, I kind of wrote with my finger. I remember saying to her, "Did I--operation?" She says, "Yes, you had the operation." And I said, "What day
is this?" And she says, "Thursday." And I was up there Wednesday morning. ... so then I, then I knew I had my operation.

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I knew I was ill. But I knew I wasn't going to die then. Once I woke up and felt the tube in there I knew I wasn't going to die. I knew I was alive. And that was the first thing I said to myself, "Well, I'm alive."

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I don't remember [my husband] coming to see me in Recovery. He said I tried to talk and I was clinging to his hand and I don't remember a thing about it. And the nurse said to [my husband], "You know, she's heavily sedated." And I don't even really remember. I remember vaguely going to Intensive Care.

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I can remember them [nurses] just askin' me all the time about, "Are you, are your feet cold? Are your toes cold?", you know. 'Cause they were stickin' out all the time, you know. Cold. And they'd slide this big thing, look like, you know. I dunno which way they were sliding, but they'd slide it and they'd take pictures of my chest. X-rays. I remember that very well. And then I remember when they come and told me, "Well, you're gonna go now and we're gonna take this stuff outta your mouth." And, "It's gonna be a little
discomfort at first." It was--little like gagging, little bit, you know. . . . I was, you know, had that, all that stuff around me. That, you know, that makes you a little bit, ah, uncomfortable, you know. And the fact that you can't move on your side, you know. You're layin' on your back . . . and they're callin' you "darling" and "sweetheart". . . . Here I got my teeth out and I haven't shaved. How in the hell could anybody call me that, you know?

Throughout their stay in PAR, it is apparent that clients' perceptions of their experience varied. Although their memories were blurred, they attached meaning to people and events. Waking up and the first sensations after the surgery were interpreted with relief because clients understood they had survived the operation. During this phase of their illness experience, the theme of determining progress was prominent. Clients interpreted their progress and getting better by concrete events such as being extubated and not feeling pain. This markedly differs from how professionals describe progress in the critical post-operative period in terms of assessment data (cardiac output, stable heart rhythms and arterial oxygenation) (Calhoun & Bozorgi, 1974).

People figured prominently in clients' perceptions of their experience in PAR. The perceptual world of the clients consisted largely of health care personnel and procedures. Even though family visited during the client's stay in the critical care areas, this was not remarkable. Clients made sense of
their experience by relating to their nurses.

Once the clients were extubated and moved to ICU, their memories tended to be clearer.

I don't remember anything about Recovery. I just remember in Intensive Care. . . . Well, I remember seeing, ah, ah, this lady I was telling you about through a sort of a mist. . . . I thought it was somebody sitting there in a hall. That I didn't think it was a room. . . . And then after I started to become, ah, aware of my surroundings. . . . I recall, ah, that I was being--I knew I was being moved somewhere. And I figured it must be Intensive Care. . . . And, um, and I remember them; they just stopped the bed. They just stopped moving the thing and left me there. And I thought I was in a hall.

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Oh hell, I thought, I just worshipped her [the nurse caring for the client]. But I couldn't tell you what she even looks like.

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But I'd wake up and he'd [friend] be sitting there and it sort of gave me a feeling. . . . And I could talk to them for a few minutes. And then they would go. Then I'd come to and there'd be another friend there. And then there would be [my wife].

From the accounts it is evident that not all clients remembered being transferred from PAR to ICU. Although
professionals perceive the transfer as a positive one (the client requiring less critical care), the clients did not understand it in the same way. Instead, they focused more on bodily concerns and signs of progress rather than environmental changes. From the viewpoints of the clients, there was little difference between the two areas. Nurses still figured prominently in their memories of ICU.

Although PAR and ICU are considered procedure laden areas, the clients did not perceive this to be disturbing. None of them commented on the frequency of the disturbances or procedures done. One client, however, did perceive that the therapeutic plan reduced the amount of control he had.

I was getting like a little kid [laugh] you know . . . You're at their mercy [the nurses]. You gotta be careful [laugh].

This client understood nursing care in terms of how it affected his independence.

Of the many procedures that were carried out for the clients, the ones that were mentioned were those dealing with removal of equipment. Three participants commented on how they felt with the removal of the endotracheal tube, chest tubes and pacemaker wires.

I thought it [extubation] was gonna be a lot worse. I figured I could feel 'this thing comin' from my stomach, you know, and I would be really--but I hardly felt it at all. Just that once, you know, I started gaggin'.
Well he took--it wasn't painful at all. It was, he just did it so fast that you could hear the elastic snap, you know when he pulled it out like that [chest tube] . . . No, it didn't bother me one bit.

That was strange when he pulled those [pacing] wires out . . . oh, really strange. I, he, I'm glad he didn't tell me what he was doing. He just pulled them out. I said, "My God. That . . . ". "Well," he said, "They were in your heart, you know." I said, "Thank God, they're out." . . . It was a strange feeling inside there--like a tickle.

All the clients expressed pleasure when the tubes and equipment were removed. For them, the removal of equipment was perceived beneficial as it marked progress. One client remarked,

One thing I will say, though, that, that I think that they did which was really good, all over is that they gave you goals, eh. They say, "Now when we can take this off", or when they took the tube out of my chest. . . . The girl said, "I have good news for you. We're going to take the tube out of your chest." And she took it out and she said, "Oh, what a mess." And I said, and I, I believe this, too, because I said, "Well, that's good because that all has to come out of there." . . . But they kept giving me these goals and,
eh, they were very encouraging which I think was very, very important. . . . There's something you can hold on to, eh?

Thus, the removal of equipment was a personal benchmark, a concrete event, that clients perceived as marking progress.

The staff in PAR and ICU frequently care for clients who are moribund and do not appear to be aware of their surroundings. Taylor (1971) found that staff in ICU presumed that clients were unconscious and incapable of communicating—nurses became "machine oriented". From these participants' accounts, it is evident that some clients do retain their understanding and awareness. As one participant stated,

I think one thing they [care-givers] should be careful of is that, I think, that you aware of a lot more that goes on than they think you are. . . . And I think even if they think the person is not conscious, they should be careful what they say. 'Cause I think we maybe are understanding more, you know.

Derrick's and Yuille's personal accounts of CABG has corroborated the participants belief that hearing and understanding are present even though the client may appear unconscious (Derrick, 1979; Yuille, 1977).

Even though clients may have appeared not to understand, it is apparent that they made sense of the environment by drawing on past experience. They related their perceptions to previous contact with critical care areas. For example, the monitoring equipment was not threatening.
I remember, I just, I think my feeling--so many pipes, tubing, you know. Nose, everywhere and, and, ah, lines, you know.

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You're not even aware that they're [the equipment] there. I was wondering how I got around with all those things on me. . . . I felt sort of like a computer. I seemed to be hooked up to all kinds of things. And there seemed to be both arms were hooked up. If I remember right now, and remember, I'm, I'm not sure. But these things seemed to have all kinds of things coming out and they were giving these things shots, needles. . . . And the girl said, "Well, I'm going to give you something. I have a needle." And I was amazed that when she didn't give me the needle, she gave the needle to, ah a piece of apparatus. . . . and I would know I was only semi-conscious and I thought this was terrific.

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I came to and I was watching the machine [monitoring equipment]. . . . I could see, um, cardiogram and I was pleased to see that it was nice and regular. And I could see, you know, like they measure the chambers of the heart. And I remember seeing that from having the, ah, angiogram. And I was watching that and that looked good. And I saw my pulse rate. But then, I was watching my blood pressure go up and down. It was
changing. And I had two thoughts about that: one, maybe that's not good, but secondly, maybe the machine was crazy because if it changed that, that quickly, that much, what good information was it? But then someone was saying, "Look, he's reading this. He shouldn't be reading it, but he's reading it." The other one said, "Don't be silly, he can't read it." But I could read it and I could understand it.

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I was aware of everything. . . . No, it didn't concern me at all. . . . I, ah, just adapted myself, I guess.

The acceptance of their surroundings would seem to indicate that the clients were not frightened of the equipment. Although professionals have anticipated that clients fear the technology or the environment (Gowan, 1979), Jarvis (1970) found in her study of 47 clients recovering from open heart surgery that 65% remembered the equipment but only 6.3% voiced their anxiety about it. The relation of this low level of anxiety to pre-operative preparation and prior experience was not studied. However, it appears that the clients in this study were accepting of the technology in the critical care areas. They made sense of it in terms of their past experience and prior conceptions of what it would be like.

I guess I figured that [monitoring equipment] was part of the scene, you know. So it didn't surprise me to see them because I know. I had an intravenous, too. And, ah, and, of course [my roommate] did, and, ah, I
guess most other people around me had, so I don't think it really registered very loudly. ... I figured, in Intensive Care that you're apt to see a lot of things that you won't see on other wards. Or else it wouldn't be Intensive Care, would it?

In addition to making sense of the equipment and environment, the clients also were involved in determining how they felt.

I was just surprised and I was sort of floating in air. And I, I, I didn't know what to think, you know. All I could think to myself was, "Gee, I've been cut open." And I said, "Gosh, I've been cut open already." ... I didn't feel any discomfort. I didn't feel anything. I just felt like I was floating in air and, ah, and I didn't know what to think.

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I knew there was stuff in my mouth but, ah, when you're groggy like that you, I dunno, I just, I tried to talk, you know and I couldn't talk. And, ah, I didn't know whether it was the hoses that were in there or what, you know. ... Whether it was myself; whether it's something gone wrong.

To understand their feelings, clients tried to determine the reasons for their present state. They did not perceive themselves in pain or uncomfortable.

Professionals have assumed that clients are uncomfortable and in pain immediately following CABG (Thorpe, 1979). In
Swan's account of her own experience with CABG, her feelings in ICU were painful. "I felt torn to pieces and loosely mended, like a battered marionette and only more pain distracted me from total pain" (Swan, 1975, p. 2145). However, the primary feelings expressed by the clients were that of being relatively pain-free and amnesic. How much this absence of pain and vague memories is attributable to the analgesia used (morphine and diazepam) has not been studied. From the viewpoint of clients, CABG would appear less traumatic than professionals tend to believe.

Generally, it is apparent that participants' perceptions of PAR and ICU centered around concrete events and feelings. They made sense of their feelings and perceptions by relying on preconceived notions of what the experience would be like. Although their memories were blurred, they were able to have concerns about certain aspects of their experience.

Concerns.

One participant expressed concern over not being able to definitely state what was real during this period. He had difficulty making sense of the unusual thoughts and senses he experienced.

Well, I don't really now know what's real and what isn't. I could have, woulda said more definitely it was real earlier if you'd asked me in the hospital,
but now it's, it's fading away [laugh]... I saw a nun; it was standing at the end of my bed. She was mad at me... I dunno. And I thought that maybe it was because I hadn't been nice to the nurses or something, you see... That is another strange thing, too, that, ah, this thing was dangling down my leg. It hit my leg. And I saw something with sign "Scott I" or "Scott." And I blamed that name for all the pain I was having down here [from the urinary catheter]... I picked up on that, would stick in my mind, you know. And I'm, I'm going to hate that name as long as I live.

Unusual sensory and perceptual events have been known to occur after open heart surgery. When cardiac surgery was first attempted, considerable research was done into this phenomenon (Ellis, 1972; Elsberry, 1972; Heller, Frank, Malm, Bowman, Harris, Charlton & Kornfeld, 1970; Kimball, 1972; Layne & Yudofsky, 1971; Trace, 1974). Although the clients studied did not undergo CABG, their experience was similar to the participants in this study (being on cardiopulmonary bypass, recovering in critical care areas, etc.). Thus, the fact that these clients perceived themselves as having changes in perception similar to those documented in professional literature would indicate that open heart surgery may potentiate unusual perceptual events.

The specific concerns that the participants experienced in the critical care areas were related to somatic as well as other
feeling states. Events and objects became concerns because the clients attached significance to them. Although the concerns varied for each client, all appeared to worry the clients because the concerns interfered with normal activities or were bothersome. For example, the endotracheal tube concerned two clients.

Actually, the, the hardest thing I found about my operation was this thing in my mouth and I couldn't talk [laugh]. That's the thing that bothered me more than anything. That I just couldn't say anything.

And, ah, course, I couldn't talk. It didn't bother me at first, you know. But, a little later on, it started to bother me. I couldn't talk. And I was wonderin' then if something went wrong.

Another client perceived that the urinary catheter was a concern.

But I remember being very upset about the catheter, too, you know. And it was really hurting me. . . . Yea, and it felt like I wanted to go the bathroom all the time--that I couldn't go because this was in.

Another participant was worried about his episodes of nausea.

The other thing that bothered me was I was getting nauseated--a lot. . . . And I was scared of being sick, eh. I could just imagine the pain.

For one participant, the environment was bothersome and a
And the lights they drove me crazy. Lights all, everywhere—lights, lights, lights. I guess that has to be in an Intensive Care Unit. I don't know why. Would you know why? But I found that hard on my eyes, but I got used to it. . . . I was wishing I had my sunglasses sometimes . . . I used to ask them, ah, if they wouldn't mind pulling the drapes around so that the lights weren't so vivid. But they didn't like to do that, in a sense, because then it's harder to, to, ah, keep track, I suppose of what's somebody doing.

Thus, clients became concerned over specific events when they hampered progress toward a well state. As in the previous phases, the theme of determining progress was a significant aspect of the illness experience.

Clients also expressed concern over some aspects of the care they received. Although all were grateful for the care they received in the critical care areas, their perceptions were colored by these concerns.

Perceptions of care.

Because so much of clients' experiences were shaped by care-givers and procedures, clients made sense of their experience through understanding people and events. They understood their surgery and recovery by attaching meaning to
nurses' behavior and the care they received. When they perceived the care was not helping their recovery, they became concerned. One man was concerned about an incident that occurred in ICU.

Well, my heart starts acting up. It's the lack of verapamil. . . . It was atrial. And I told this . . . nurse. She says, "What do you know about atrial arrhythmias?" . . . I said, "I gotta had a verapalin [verapamil] to stop this." I said, "It's going wild for me." I said, "It's really bothering me." And I said, "unless you can prove to me that it's detrimental to the healing in my heart or detrimental or life-threatening, I don't see why you should hold back." [The nurse said], "Ah, well, we know it won't kill you and your doctors told you that it's atrial, not life-threatening. It's not gonna kill you."

And the doctor came in and he was very nice. . . . He came in and talked to me, very quietly. Shook his head and I said, "Will you please check it out?" I said, "Call my cardiologist, call this guy, call that guy. They'll all tell you that I need this stuff and it's obviously running out." And my heart was just goin' crazy. And I said, "It's really botherin' me a lot. I dunno if it'll kill me," but I says, "It's botherin' me a lot."

Well, this nurse she got so upset. Doctor left. She went— -- the doctor was considering giving this to
me. . . . She went right out there and said, "You have an M.D. behind your name." They're right outside the curtain. "You have an M.D. behind your name. Now if you give that, give in to that guy--that is going to be pretty darn, ah, it's, it's gonna show your lack of authority and this sorta thing." And she just went--carried on and on and on.

And then she came back in and she huffed around the room. And she came over to me and I'm a sick man, you know. I just, it's within two hours of [transfer from] Recovery. And she came over to me and said, "There is no way we're gonna make any special, ah, compensation for you over medicine that you think you need when doctors and medical people who have worked around here for 15 years say you don't need it. You're not gonna get it. You keep carrying on about it and you're upsetting everybody else and you're upsetting me and you're just gonna lie there and be quiet." Well, we were nose to nose. And, I mean, if I had not been so sick, I'd a really told that lady something. I was so sick that I couldn't think of anything. I was . . . full of disbelief that she could attack me like that, in the condition that I was in. . . .

Pretty soon, here comes a verapamil. . . . I said, "That's a verapamil!" . . . [The nurse said,] "Here, down, here down." Down the hatch it went. [I]
said, "Gee, that's great." I said, "Did they just order one?" And she said, "Well, that's better than nothing. You're lucky you got that." And I said, "Well, I need at least three, ah, over the course of . . . the day, to keep this thing down. She said, "Well, you got it ordered and you got it. Stop your complaining" [whistles].

The doctor didn't think obviously that I was out of my head. He, he looked into my records; said, "This guy's been using verapamil--one tablet's not goin' kill him. Let's take care of his needs." But the nurse, her stand on that is what scares me. That there--I felt like, ah, the Macon County Georgia, if you saw that movie. The guy that goes and gets in jail and he hasn't got a friend in the world. He can't call anybody; he's just got these people putting him in jail. And brother, what they say is the law. You have no rights. You have no appeals. That's the way I felt. And I felt trapped. . . .

There was no way that they knew me. They thought I was just bein' a trouble maker. And so, in particular, in concert with this nurse carrying on. And she was doin'--just aggravating the situation. You got a sick man and as far as I'm concerned a sick nurse on your hands. . . .

She came to work the next morning and, and I was, I dreaded it. When she walked into the room,
"God, I just dread this." And she said, I said, "Good morning," trying to [take the] edge off things. I thought I might as well make it as light as possible. I knew I was gonna get blasted. But I didn't realize how bad. "Good morning, sir," just in that tone [cold, clipped, officious]. And then she went about her business of tidying up. "Your breakfast will be here. Ah, it's soft and it's this and that." It was--you could see it was . . . hurting her to have to speak to me. And then she came over and says, "By the way, do you know where you are this morning? Do you know your name? Do you know who you are?" I said, "Yea, I know where I am." I said, "This is X Hospital. My wife graduated from this hospital as a nurse. I know where I am!" And I was getting real upset. I said, "I can't believe this is happening." And I gave her the answers that she asked for.

And I told the . . . nurse. I said, "I know you're gonna get rid of me. I caused you a lot of problems." And the doctor came up, ah, this nice doctor and shook my hand and said, "Glad to know you." I said, I"m sorry if I caused you any problems." He said, "You didn't--don't worry about it."

In this lengthy account, the client expressed his feelings about (as he called it), the "Great Verapamil Incident." In addition to the actual exchange between the nurse and himself, he also seemed to take offense at her assessing his level of
orientation (a standard part of the care plan in ICU). He seemed to perceive that the intent of her questioning was to discredit his rationality rather than assess his cerebral function. The client's concerns reflect the perceived discrepancy between the nurse and himself.

Benoliel and Van de Velde (1975) have argued that critical care areas evidence a growing tendency toward depersonalization. They believe the lack of common courtesy in care has resulted in a dehumanization of both client and staff. In a broad literature review, Howard (1975) attempted to more clearly define dehumanization. She has argued that people can be dehumanized when they are perceived to be things, machines, guinea pigs, problems, lesser people, isolates or recipients of substandard care. In addition, the health care environment can further dehumanize people when clients feel they are interacting with detached professionals and have no power over their lives or care (Howard, 1975). Based on Howard's operational definition, it is evident that the factors which promote dehumanization were present in the critical care setting. From the client's account, it appears that patients can and do perceive some aspects of what professionals term "dehumanization."

One man expressed his concerns over an incident that occurred while he was in ICU.

And then I remember towards the--just before I got out of Intensive Care. They said that I could go out; now I'm not too sure whether this happened. But I think
it did. And I'm a little bothered by it.

The, the nurse tried to put a, what do you call those things in your arms, to hook up something with? [intravenous line]. . . . Well, she was trying to put it in and she couldn't get it in. . . . And she was upset about that. And then I got the idea or the old man across from me told me that he'd been waiting two hours for his painkillers. And I told her maybe she should leave me alone and get painkillers for him and get a girl who knew how to put this in.

And she got upset. And she said, "Well, I am a nurse." And I said, "Well, I, I know that dear, you know." And she looked to me to be, you know, a child, eh. But I said, "I'm an administrator and I'm [sic] been an administrator for many, many years." And I said, "Things can go wrong every once in a while." And I said, "You've been under tremendous pressure." And I said, "Why don't you just let me be?" I said, "I'm not hurting. You know, I'm fine. You look after the old man and give him his medicine." He was smiling.

In this account, the client not only was concerned about his own feelings but also those of the nurse and another patient. He went on to express how he felt about the incident.

And then after I felt very bad. I thought I must have been mean to that girl . . . But I wasn't quite aware of what I was doing . . . If I think, if I was
completely rational--no, I wouldn't never had said anything to her. Certainly not, because I felt I must have disturbed her and maybe gave, made her feel less secure in herself, you know. I feel really badly about it... I, I really still am concerned about it....

I think I, I was upset about, ah, the IV or what the girl was trying to put into me because she had to get that in before I could leave the Intensive Care. And, of course, this was delaying me getting out of that damn bed. 'Cause I thought when I get out of there, the [ward] bed would be fantastic [for my sore hips].

As in the previous participant's account, the client became concerned when the nurse was perceived to be hindering his progress and recovery. However, it is apparent that he was also worried about the nurse's feelings of security.

One client became concerned over an incident because it prevented her from assessing her progress.

My pulse had been, ah, I noticed it was monitored, of course. That I noticed, that the pulse was--that there was, that there were monitors over, quite high up over the bed. And I noticed that mine was going a hundred fifteen beats a minute, which to me seemed to be awfully fast.... And I asked the nurse about why was my pulse going so fast. And, ah, she said, "Oh, we don't worry about the pulse unless it's a hundred
and fifty [laugh]. And, ah . . . I thought that was rather odd because I had never had heard that before. That, ah, it seems to me that's awfully fast. That's what you call tachycardia, is it, isn't it? . . . That worried me a bit in spite of the fact she, she didn't reassure me by saying that to me because I kept--I remember I kept, I kept looking at this monitor. And then I would take my pulse and I could hardly keep track of the beats.

The discrepancy in explanatory models between the nurse and client created difficulties for the client to assess her progress.

When clients expressed displeasure over their care, it was usually related to the manner in which care was given.

It started out, ah, rather strangely, I guess. I dunno. But I think it was probably having had this tube in my throat and then they took that out. And I had the [urinary] catheter in, too, which was irritating me, because I'm very sensitive in that area. And, ah, I think I was a little bit, ah, sore and maybe when she, when I had my bath, you know she was maybe just a little bit, ah, was a little bit--I wouldn't say rougher, but she wasn't that gentle, really, you know. All these things I suppose didn't help to make me feel any better.

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And there was one nurse down there, that it, she'd
either been getting up on the wrong side of the bed or she was always like that. She looked to me like she coulda killed me. . . . She woulda liked me much better if I, had I not made it, I think. . . . And she come, "Well, what is it?" And she'd get somebody and they'd get--take care of it. For I hadda bother her three or four times and I knew she was busy. But I had a critical need [to be suctioned]. And she responded so sarcastically.

One client was concerned over the constant attention he received.

They [the nurses] were asking me so many times that, you know, that's like an old mother hen lookin' after their chicks, you know. . . . And, ah, I can remember, you know, they were talkin' to me and, ah, always wantin' to know if I'm comfortable. . . . Like I appreciated everything they did for me in X Hospital. Absolutely. But, it was just a little bit too much.

Clients made sense of the care they received by comparing it to what they felt would be helpful to them. Because they were intent on recovering from their illness, care was interpreted in terms of this goal. Thus, when the care did not benefit them, they became concerned. One client explained why the care he received was not more beneficial.

I know X Hospital is a huge place with a lot of people to take care of. And, ah, and just as an outside guess, I think they're way understaffed . . . And so
the doctors don't have time for that. They're short-handed. Ah, the nurses are short-handed, in my estimation in their Intensive Care Unit.

However, not all perceptions of care were negative ones. The clients, for the most part, were grateful to their nurses and praised their qualities.

Ah, like even when, even when I couldn't pick a face out, I knew I was being looked after . . . But it, I always felt; thought that I was being well cared for.

I not complain about nurses. . . . I know, I know they are all busy. But I really grateful some nurses in ah, in, in, in, ah, in ah, Intensive Care and Recovery. They were wonderful. I remember one of the ladies . . . she [sic] well experienced. No, not, no need me to, to talk with her something detail, that she understand. Wonderful.

In Intensive Care, you know, when you can't speak because you got this [tube] down your throat, I had a super gal. Stuck right by me.

And I remember, one nurse that I liked very, very much. But I can't remember her; I don't know her name or anything. . . . I think she just—that she was very sympathetic.

Nursing care was perceived positively when it helped the clients
get better. The theme of trust was implicit in their gratitude. The support and empathy felt by these clients was of significance to them. They valued it because it helped them recover.

In their desire to be healthy, clients also determined their role in the recovery process. One client understood that being a "good" patient would facilitate care and his recovery.

And I was concerned about that I wanted to be a good patient. And I didn't want to create any problems and I couldn't ring the buzzer. And I remember getting--the nurses giving me hell about that because I was doing things and they said I should ring, and "Didn't I know where the bell was?" And I knew where the bell was but I didn't want to bother them. 'Cause I was determined I wasn't going to be a nuisance.

This client's beliefs are probably not unique. Blacher (1970) has written that clients recovering from CABG hide their anxiety in order to present a facade they feel acceptable to the staff. For the professionals, the "good patient role" has been identified as a coping strategy for clients.

During their stay in the critical care areas, the clients made sense of their environment and bodily sensations. They coped with the immediate recovery from the surgery and marked progress by the removal of supportive care. By the time they were ready for transfer to the ward, they had become more independent and fully cognizant of their surroundings.
The Experience on the Ward

The transfer to the ward was a benchmark because it signalled a change in how much clients depended on health care personnel for routine activities. Clients marked progress by the physical move but also in terms of a return to their usual activities.

Making sense of their recovery and illness.

Once clients had recovered from the acute post-operative part of their surgery, they were confronted with making sense of different bodily sensations. Because CABG marked a change in their illness, they had to re-interpret their illness in light of the new information and benchmark. Clients went about doing this in different ways.

One way clients made sense of their feelings was by comparing their expectations of how they would feel and their actual feelings. Overall, they perceived that the recovery was better than they expected.

Ah, I remember being uncomfortable and sore but not the pain I expected. I remember being that I was in as little pain as I was. I expected to be in a lot more pain. . . . I'm still sore but not, it gets better now.
I wasn't feeling any discomfort at all. I, I [expected] to be flat on my back for about a week.

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Oh yea, actually I thought it would be worse. I, I, thought; I really thought it would be worse. And, ah, but actually it hasn't been too bad.

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The reality is that the fact that I had this operation. That I'm alive. And I, ah, tolerated the discomfort very well, I think. 'Cause I think I, well, I think I'm fairly adaptable . . . Because I didn't feel that I was really having a very bad time. . . . but I was expecting--but how could you go through something like that and not expect to feel pain, or, or what I call, ah--just to be different? How could you have your breastbone broken and, ah, not feel something? How could you not feel that, a little different? I wasn't expecting; I would have been silly; I wouldn't have been, ah, normal, I think if I hadn't expected to just feel like, like I had, well, I thought felt better in a way than I had before. Because I felt, because I was accepting the pain, I was getting better. These impressions were going through my mind.

Thus, clients perceived that they were in less pain than they anticipated. This was progress toward recovery and health.

Pre-operative teaching information for clients states that
"most patients complain of being sore but do not have severe pain" (American Heart Association, 1981, p. 14). However, the unanimous surprise with feeling so well would appear to be an aspect of the experience with CABG not well understood.

Clients were also pleased about their recovery when they were able to be more mobile and independent. Two were especially pleased to be up. They associated progress with the amount they could do for themselves.

And I kept trying to sit up. . . . Yea, and they caught me up a couple of times. Said I wasn't supposed to be up. But I said, "Well, I thought I was supposed to get up as soon as I could." And I said, in fact they told me I was supposed to be walking, right away. And that's what, you know, they implied before the operation.

Two nurses came and took ahold of me and said, "Come on, you're going for a walk with us." And I said, "Already?" And they said, "Yea, come on." And they slid me down on the floor and took a walk to the door. And back to the bed. They said, "That's all you're going to get today." And I said, "No, I want one more."

Thus, clients understood they were getting better by the return of their mobility.

Once on the ward, clients were involved in making sense of their bodily cues. Because the surgery had altered their
accustomed ways of dealing with their illness, they were actively attempting to understand what was happening to them. Changes in expected behavior were perceived to be concerns. Again, it was concrete behavior which was perceived worrisome.

Concerns.

Different kinds of incidents were perceived to be concerns for the clients. For example, the loss of appetite proved to be a concern to all but one participant.

No, I didn't feel like eating. I was glad to know I was getting something in the IV. . . . No, I, it took a while for . . . my taste to come back.

Musculo-skeletal difficulties were a concern for two participants.

But I remember being upset about the bed 'cause my hips were terrible sore and I could only lie the one way and they were gettin' very sore. . . . And I was awfully mad at the hospital beds. I thought they were terrible. . . . I was complaining about them all the time. I thought the hospital should really be ashamed of themselves for having beds like that. . . . The other thing is that they didn't give me a was a, a cloth to pull myself up [in bed]. And, now everybody else had one and I felt really done out of that. But I didn't seem be able to get together enough to ask
for one, you know.

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I couldn't sleep. . . . And, ah, I knew I shoulda been laying, they say you're supposed to lay on your sides. Take turns. Well, I couldn't. My shoulder, this, especially in this side, eh--geez, you know, just ache. Always did ache when I laid on it too long. And, ah, I dunno why. I could lay on this side a little bit longer. But most of the time I sleep, sleep on my stomach.

Other incidents were perceived to be concerns when they were out of the ordinary.

About an hour after I was sittin' in my chair and I went to get up and when I got up on my feet, I felt a little bit dizzy. And then I felt a hot spell right in the back of my head. . . . And it went to both my ears, right away--just burning. And I've never felt that again, since. . . . It's, it's the same feeling in the ears and that part of the neck was the same feeling as when I got my angiogram and they gave me that shot of a, of a dye in my heart. It was the same kind of a hot feeling like that.

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I'd have five days and five nights of it [hiccoughing] and one damn pill took it away. . . . after they gave me the one pill--I just was laying in bed a little while and away it went. After hiccopping for five
days and five nights. Oh, that was a nuisance!

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And I felt quite nauseated that day. And then I developed diarrhea which was bad and lasted. And doctor, the doctor told me he didn't know. None of the doctors knew what was causing it. It may have been this medication for, ah, anticoagulant.

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I just got a little bit concerned a few days later when I noticed that my pulse rate was so high.

Although the concerns varied for each participant, clients perceived their behavior as worrisome because they deviated from what the clients expected of their experience. The concerns interfered with their recovery and were perceived as indicating that progress was at a standstill. The fact that they had hiccoughs and diarrhea seemed to be a concern because it was a setback in their recovery.

Non-somatic concerns also surfaced while the clients were convalescing on the ward.

I had a lot of X-rays which kind of scared me a bit sometimes. You know, because of the radiation and because, ah, I have to be careful of the radiation [due to a previous history of cancer]. Otherwise, I figured it was something; I, it was necessary. I had to go through it. It was part of the deal. And, so, I guess I accepted it.

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Dr. X stopped it [medication] to put me on opium which I guess he thought I needed something to, to, I dunno why [to treat diarrhea]. I said, "I hope I won't become addicted to this." Because I sure liked it.

The only thing that bothered me was when I went in there I had a room with a bath. And when I come back, I had a room without a bath. I like to have a bath.

These events became concerns because the clients perceived they might interfere with their recovery and long-term health. Clients anticipated their progress and became concerned when anything interfered with their expectations. This was how they made sense of many events in their convalescence.

One client became concerned when he learned about an incident that occurred in the operating room.

And I do know that something happened to me on the operating table, too. . . . Well, ah, Dr. X told me that there was a problem. And I, ah, said to him, well, ah, the, the lady who gave me the anaesthetic came back to see me And he said, "Well, she should."

She made, you know, he implied that she made a mistake. And I think that what it was, it was, they couldn't get my heart started or something. And, ah, I was a little annoyed when he told me that, at first because, I ah, thought, that everything had gone so wonderful, you see. But now, I mean, it doesn't bother me now. It, whatever it was didn't do that
much damage.
In this account, the client attached concern to the incident because it signified a potential setback in his progress and health. Although he attached significance to the incident, he also appeared to minimize his concerns. Because he perceived that the incident didn't seem to affect his progress, it lost its significance.

Brown and Rawlinson (1975) have found that clients naturally minimize their former illness once they have experienced open heart surgery. They have postulated this to be evidence of clients relinquishing the sick role. Whether or not this is the way the client coped with his concerns can only be surmised. However, it is apparent that clients do minimize their concerns over time.

The kinds of things which concerned clients did not necessarily coincide with what professionals would be worried about. Clients made sense of events and bodily cues in terms of their relation to what was expected of the experience. When events interfered with progress in concrete ways, they became concerns. For this reason, clients often did not have the same concerns as professionals did. For example, one client was not at all concerned about what professionals would term a "complication" of the recovery process.

And that's what caused this infection here, if you knew about that or not [sternal incision]. But it's okay now. I had a little infection and they gave me antibiotics and it's all cleared up. And that's fine.
But the doctor said it was because it was so close to the first surgery [I had].
Again, the matter-of-fact attitude is apparent in this account. Even though professionals would be concerned about the client's complications, the client did not seem to echo this concern. Instead, she minimized the importance of complications. She did not attach the same meaning to the infection as the professionals did. This may be a natural response when reflecting on past experience.

Perceptions of care.

In addition to making sense of their bodily cues, clients were again involved in understanding the care-giving process. Although their contact with health care personnel was less than when they were in PAR and ICU, they still constructed opinions about their care.

For the most part, clients expressed their gratitude for receiving care and felt that it was adequate.
I would say I got good treatment. . . . I got absolutely nothing to kick about the hospital and nurses and everything.
However, certain aspects of care were perceived less than ideal.
I will say the physiotherapist gal was terrific . . .
She was one of my favourites. She's very busy. It's
easy to see that you're all extremely busy. So it's not your fault, necessarily. You slight a patient. And I think most of them do, inadvertently. And sometimes you feel guilty. Most of the time you feel guilty. I did at least, hitting the buzzer 'cause I knew it was a bad time.

One participant perceived that the ward routine was problematic.

Ah, around ah, ah, changing of the guard [laugh]. I, I mean you better, you could die, you could actually die before somebody got to you. Why? Because "We're having report."

Other concerns centered on the communication process and care given.

I was having a problem there with my heart one day, with this be, this would be before surgery. With flip-flops, back to that again. And maybe it was just a matter of timing on the verapamil again. So, but the nurses could hear with their scopes enough to where they ordered immediately EKG so they get a strip on it. And, ah, this doctor was there and he read that strip. And I had to go find out what they thought of it. He did not come to see me, nor did he pass the word on his findings of that strip. Was there anything unusual, what had happened. Shit, they just walk out on problems. . . . But, that's just that they, doctors and nurses, maybe they're too busy. And
that's got to do with budgeting and things, maybe
that, I can, I can't do anything about it or you can't
do anything about it. Except, they're gonna have
hafta be more careful, I think. Don't try to do it
all. Go slower but do it right!
The concerns about the care-giving process related to its
effects on the clients, themselves. When care interfered with
their recovery it became a concern.

During clients' recovery in hospital, professionals have
considered patient education and rehabilitation an important
component of care for clients. Usually booklets, group sessions
or one-to-one teaching have been used to teach patients
(Foxworth, 1978). Content of the post-operative teaching has
tended to include such areas as activity, diet, weight, stress
management, complications and medical care (Barbarowicz, 1976;
Burrows & Gassert, 1979). Hart and Frantz (1977) considered the
content of patient education to be often based on professionals'
speculations of what will be problematic for clients. The
professional sector's explanatory models would appear to
predominate the teaching programs used.

The effectiveness of teaching programs in changing client
behavior has not been conclusively established. Differing
methods of administering the program seem to have no effect on
patient outcomes (Barbarowicz, Nelson, DeBusk & Haskell, 1980).

Two participants expressed their opinion on the
effectiveness of teaching programs in general. One man found
that public education was not beneficial.
Well, you can't help but think about it [heart disease] because they were talking about it all the time and they were talking about, ah, smoking and, you know. . . . But, naturally, I think even before you had the heart attack, you thought about it. I think everybody does. And I noticed after I had my heart attack, a lot of people would ask me about it. Especially young men and I suddenly realized that they were asking because they wanted to know what it would be like when they had one. . . . You could see that, in them. . . . They were scared and so much publicity about it. . . . And sometimes I think that publicity's counter-productive. . . . You get people conditioned that they're going [to] get something, they'll probably get it.

Another client found that patient education was potentially harmful.

Well, my kids, one of them . . . has asked me twice, "Is this hereditary?" And I told him, "No." I may have lied, but I don't, I don't want him worried about it at age 21. How, man . . . ? Maybe I'm wrong but could I get them to change their way of, ah, eating, let's say?

In a study of patients recovering from myocardial infarctions, Miller (1981) found that clients perceived information from the media about heart problems, exercise, diet, blood pressure and smoking were helpful. These findings differ
from how the clients in this study perceived public education. Based on the response from the clients, their patient education program was not mentioned as directly affecting their recovery and progress in hospital. However, as will be evident in the last phase of the illness, some clients did perceive certain aspects of their teaching to be useful.

Clients did not solely rely on nurses and other health care personnel to speed their recovery, however. They also drew on their own coping strategies to help themselves get better. The theme of the uniqueness of these strategies recurred in this phase.

_Coping with recovery and setbacks in progress._

During hospitalization, the clients used many different strategies to cope with their recovery and setbacks. The previous ways of managing their illness were retained but evidenced in different ways.

One client expressed that spirituality helped her cope with the illness.

And he [doctor] has a, a slogan, oh I wouldn't call it a slogan. He has, um, on his wall--it was something I was trying to remember in the hospital, in the last time I was in. And it came to me during the night. You know I stayed awake for about two hours trying to remember the second half of this, ah, quotation,
that's what I would call it. And it said, "We are not, we are not granted freedom from the storm, but we are granted peace amidst the storm." And, oh, that consoled me. Really, really consoled me. And I stayed awake, just deliberately trying to remember and finally it came to me. And it's very, very true. The same participant used humor in order to deal with her concerns.

I was kind of disgusted with everything about that time [episodes of diarrhea]. But I was laughing. I thought it was kind of funny.

For two clients, goal-setting was perceived as helpful in managing their recovery.

I says, "I'm gonna be a hundred percent better today than I was yesterday. And tomorrow I'll be another hundred percent better."

Being optimistic helped these clients see progress toward their goal of health. The theme of hope was again evident as valuable in helping clients cope.

Clients also used commonsense therapies to help them cope with their concrete problems.

When I got up and pulled the bed, I got the darndest pain in the back of my head. . . . It was a sickening feeling. It didn't matter how I moved my head, like this, like that, up and down. It stayed there. . . . So I said to the doctor. He was still sitting on the corner of my bed, writing away on my papers there. I
said, "Gee, I've got an awful pain in the back of my head." . . . And he said, "Ah, what time's your wife—is your wife coming to see you?" And I said, "Yea, she'll be here about four o'clock." He said, "Get her to massage it." . . . One hour I rubbed and I rubbed all around here and then I got rubbing right down in here. And I could feel it really sore there. That's where I really dug into. Then it went away and left me.

When I went out into the ward again I asked for some cough medicine and I got it a couple of days later; they finally come across with cough medicine. And, ah, about three shots of that cough medicine and I wasn't coughing anymore.

These accounts again point out the interplay between professional and popular aspects of explanatory models. When concerns occurred which hampered their recovery, clients coped by dealing with their symptoms in concrete ways. They understood that relief from their concerns could be obtained in commonsense ways, for example, by taking cough medicine for a cough irregardless of the need to expectorate.

The support of family and friends helped clients cope with the recovery as well as setbacks. The theme of the shared nature of the illness was strong during this phase of the illness experience.

I enjoyed her visits [wife]. And, ah, and, ah, but
she'd always come up there [to the ward].

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And my wife know which food I like, which one to select. Help me with this, you know—to select something for me.

During the period on the ward, the clients continued to evaluate their progress. They found this helped to maintain their hope. In this way, the themes of hope and determining progress were linked together as valuable coping strategies. Health care providers were perceived to be important sources of information regarding progress.

Yea, but I knew that he and Dr. X were pleased with my, ah, progress. I knew that without even being conscious of it. You know that M [wife]? Yea. . . . And I, I had the feeling, you know, when I was trying to do these things all myself, all the time. I don't know why. . . . I think it's important that the staff have a positive attitude toward you, too. I think you understand a lot more what's going on, even when they don't think you do. I really do.

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I thought I was doing pretty well. Because the nurses all told me. That, well, they said, "You're doing, you are doing very well." And the next day after, ah, I came down [to the ward], this young, I forget her name. I, I think, the physiotherapist; she came to see me and she said I could walk around the room the
second day . . . I just felt I was progressing very well.

Information from other patients or friends helped to inform clients of how they were doing. Comparisons were made.

I walked up to the nurses' station and I says, "Hey look," I says. "It's okay if I walk?" "Sure." So, and ah, and I and there was another fellow inside the room with me and he says, "You're just out of, ah, ICU?" And I says, "Yea." And, "You're walking already?" I says, "Yea." I says, "Yea." And after that he says, "Gosh," he says, "You're doing good." . . . I said, "I, I feel good." I says, "I feel, I don't feel anything." . . . And then, then I had, then next week I had visitors and they all said, "Look," you know, "Where?", you know, "How come you're not lying down?" I, I'm walking around and sittin up . . . . That was a surprise And, ah, they said, "Gosh, they couldn't get over it." . . . And that helped me, too, you know.

One client compared her progress to a fellow patient. For this client, comparing herself to another helped her to see progress in her recovery and to mark time.

We were just the two of us in the room. And she had valve surgery. And I, I and she was a very sick woman. She was sicker than me. Ah, she was the type of person that seemed to get down easily. And she found, she used to grimace terrible. . . . Maybe, ah,
possible valve is different than, than, it maybe a harder operation? ... I felt maybe it's just possible that the poor woman is having a tougher time than me.

Lange (1978) has suggested that clients make sense out of their reality by scanning the environment for clues. In order to sustain their hope that they are improving, clients rely on environmental cues and comparisons made with others. They also turn to other people for agreement with their perception of the situation. For the participants in this study, it is apparent that they made sense of their recovery in terms of progress toward getting well. They interpreted care and their bodily cues in light of this goal of health.

Once clients had recovered from the major effects of the operation, they were discharged from hospital. This benchmark signalled a new phase in the illness experience.

The Recovery at Home

The last phase of the illness experience began with discharge from hospital and included the interview with the investigator. During their convalescence at home, the clients continued to be trusting of their physicians. Recovery from their surgery entailed using different coping strategies since angina was no longer the predominant symptom to manage. Again, families and friends were perceived to be supportive in helping the client recover from CABG. As in previous phases, the
clients also appeared to retain their hope through making choices and assessing how they were progressing. Although the clients were, on the whole, very optimistic, concerns were voiced about the recovery process.

The primary benchmark of this phase was clients' discharge from hospital. Because progress was assessed in individual terms, other signs of a return to health were very individualistic as well. To facilitate presentation of clients' accounts, their perceptions of this phase will be discussed in terms of how they understood this phase.

The Discharge Home

Release from hospital was a benchmark in clients' illness experiences. Clients made sense of their illness in light of this positive event. The clients not only perceived it as a sign that they were considered "out of danger" but also as another change in their illness.

Understanding discharge and the recovery at home.

While still in hospital, clients were preparing themselves for discharge and constructing expectations of what it would be like for them once home. These expectations included ideas about activity levels and managing the recovery.

I, ah, I never thought of any, ah, of having any
problems, you know.

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I figured I'd do things and do slowly and, ah, and, ah, and then build myself up.

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I, ah, realized that I would be--they told me, like I would have to be doing a lot of resting. And be going out for walks and that would be about it.

In their efforts to understand the benchmark and perceive progress in their health, clients attempted to anticipate what the experience would be like for them. This helped them attach meaning to the event and determine its significance.

Clients perceived that the discharge was a positive benchmark. They all expressed pleasure in going home.

I was looking forward to coming home. . . . I was I wanted to get home because I felt sorry for my wife. She's working and then, the time she'd come home and take the dog out for a walk. And, ah, then she'd come in the hospital and not had any supper. And that kind of worried me.

Generally, they felt well and were not nervous about being home.

I was glad to go home. . . . Yea, I was feeling pretty good. And, ah, I wasn't nervous after I got home. . . . They also warned us that we'd probably be nervous. And I wasn't. And I, I like that. I like the way they, you know, you really don't want to know all, too
many gorey details but you want to know what the hell's going to happen, eh. You know what I mean? And I think X Hospital do a very good job on that.

Oh well, the security, I suppose of, of being in a hospital setting where you, there's somebody constantly there that knows what to do if something should happen. Ah, it occurred to me once or twice but not seriously. It didn't bother me.

Hasser (1979a) has indicated that clients experience a letdown or loss of security upon leaving hospital even though patients are eager to return home to a familiar routine and environment. These actual accounts of the clients, however, indicate that not only were they optimistic about being home, but they felt prepared to continue their recovery. For one participant, the teaching he experienced in hospital was helpful in preparing him for what to expect once home.

Although all the clients were pleased to be home, the recovery process was not without its problems. Five of the seven participants encountered some form of difficulty once home (e.g. constipation). This affected how they were feeling and their ability to participate in the recovery process. The problems that arose interfered with their progress and were perceived as setbacks. However, not all concerns professionals had for the clients materialized.
Concerns.

The problems that the clients perceived were not the same as those depicted in patient education manuals. Perhaps this can be explained by saying the clients learned the discharge information and consequently had no worries about those aspects of care. Or, the answer may be that the nature of client concerns were very different from professional concerns. Dodge (1972) found that patients and professionals do differ in how important they perceive patient information. The two groups differed on information such as activity restrictions once home.

In discharge teaching, professionals have considered pain management to be a concern in the discharge period. Although the clients remarked on their sternal discomfort, they described it as sore rather than painful and did not identify it as an overriding concern.

Oh, I, I still feel sore. I, I, I still feel a bit sore. Especially if, if I, when I'm walking. Like I'm starting to walk now. And, ah, I, I feel like it, up in, up in my upper part of my chest is really sore. and then the next day, it, it's somewhere else . . . I think it's, it's in the process of healing and, ah, maybe it all depends on how, how I sit or, ah, or how I move.

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This bone you know here, it was split here right up and down. . . . It sort of goes past one another in
places once in a while. . . . But they tell me that in the paper [teaching information] they gave me. . . . It's not sore at all when it does that but it clicks. Gives a little nick.

The expectation that the pain would continue once home differs from Boisvert's study of convalescence following CABG (Boisvert, 1976). Of the six patients who attended group sessions following CABG, all were surprised to be uncomfortable at home, even if they were told that muscular pain would continue for a few weeks. As will be apparent in the ensuing accounts, pain was an accepted aspect of the recovery process and did not seem to surprise the participants in this study. Their teaching seemed to prepare them for the possibility that the pain would continue once home. Thus, it did not become a major concern.

I was told to expect pains just about anywhere for up to three months . . . That's what I was told. I could expect . . . to be sore, yea. Well, they have to break, split your breast bone or something; sounds horrible. But, anyway, it's not bad at all. I'm not suffering.

In a British study of CABG clients interviewed over a 24 month period following surgery, Wilson-Barnett (1981) has found that the sternotomy wound was a major problem for her study's clients. Of the 60 patients interviewed, 19 still had severe pain after one year. This is in contrast to this client sample. Wilson-Barnett (1981) has also identified that the leg
wound was another major problem for clients. One third of the clients had delayed leg wound healing requiring dressings while 14 of the 60 suffered pain which interrupted their sleep. The clients interviewed in this study did not perceive the leg wound to be problematic.

The only time I was feeling them was when I walk and the pants slip. . . . Rubbing.

And I, one, my leg, there's a stitch must have come out and it's open and it weeps a little bit. A little bit of soreness down in here, and, ah, that's all.

It's been sore the odd spot, you know. But just nothing to bother me, really. I can just feel it. But today it's fine. But there's a little numbness from here, from where they started cutting; they started cutting from here up. See, but from here down, it's a little numb in here [ankle].

My leg is sore. that is, really, especially in the cold weather . . . kind of a burning.

It's, ah, bit itchy and, ah, like now I can feel it now, if I touch it.

One client described a hematoma over the thigh as "sort of a puddin' coming below the cut." Although health professionals would consider this a concern, the client only mentioned it in
passing. He did not consider it to be problematic or a "complication".

Another complication which one client described appeared to be related to nerve damage involving flexion of the left thumb. She seemed to be accepting of the disability.

Because this thumb doesn't work yet. I think it had, Dr. X said he thought it had something to do with, ah, probably the way my hand was, ah, held, or holding or whatever they do during surgery. . . . I can't bend the thumb. So I have a great deal of difficulty writing, but I'm not worrying about it because I don't worry about anything, anymore.

Again, the client drew on professional explanatory models to help her attach meaning to the phenomenon. However, it was not a concern because she did not appear to relate it to the healing process.

Some clients stated they were stiff and had trouble sleeping.

I've gotta be careful turning [the neck]. . . . When I'm driving the car, I have to be very careful. I have to swing myself around, eh. And I have trouble; I can't sleep on this side. . . . I'm sleeping on my back now which [is] something I never could do before. And it's quite sore in here and the doctor felt, sort of like a dry socket [in the right shoulder].

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Mind you, I, when you get into bed, you don't know
[laugh] which way to lay down. So you lie on your back and then you end up on your side and you get a little bit stiff.

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When I laid on my side, I'd had a pain in here, in that side. When I laid around on this side, I'd had a pain in that side and it made it kind of nasty . . .

But one night I started to cough at 10 o'clock at night and I coughed right through 'til 7 o'clock in the morning. And I kept my pillow in and I held myself and kept coughing away. . . . And it kind of played me out a little bit.

Clients were aware that this stiffness interfered with their normal activities, but did not become concerned about it. They accepted it as "natural" and a part of the healing process.

The available literature on recovery from CABG has remarked that fatigue, weakness and sleeping problems were common. In Wilson-Barnett's study, more than half of the participants expressed that their sleep was disturbed (Wilson-Barnett, 1981). Boisvert (1976), too, found that the patients were fatigued. Although three of these participants remarked on their altered sleep, only one expressed that he felt noticeably weak. Fatigue would, therefore, not seem to be generalizable.

In addition to changes in their sleep, clients also experienced changes in their neurological status.

I'm a little hazy in the eyes. Little hazy. You know the television's not bright; it's, ah, it's bright,
but it's foggy, like.

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I have volts of electricity which I think is normal after this type of surgery. Go through, when I put my arms up like this, I can feel, like what I would think would be volts, when I go a certain way, especially, do you see that?

Clients interpreted their symptoms as part of the experience of CABG. They did not perceive these as affecting their progress. Again, the theme of determining progress was a recurring feature of clients' illness experience.

Rather than being concerned over the traditional concerns professionals have for discharged clients, the clients expressed worry over significant interferences with normal routines and activities. The concerns were very individualistic but they were all perceived as disrupting clients' everyday lives. Clients perceived concerns based on the notion that these events were either threatening or an inconvenience. Boisvert (1976) found that clients convalescing from CABG continued to express uncertainty about activities once home. Thus, progress was not a pre-determined smooth course, but a passage of coping and carrying out usual routines.

One concern which surfaced has not previously been identified in the literature. Two of the clients were worried about voice changes that they perceived to be present following surgery.

But my voice, even now, sounds different. . . . It
still sounds different. . . . It's not as loud. Ah, my voice, before was, was a strong voice and, ah, now, ah, it's kind of like, ah, weak--an old man's voice. . . To me, it doesn't, it doesn't sound like me.

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I worry about that [voice] you know, not easily recovering. Because, you know, as a minister, without voice, how can I do any more job? I worry about that. . . . I don't know. Maybe I, I'm afraid of that lasting a long time you know, not able to speak out right.

The voice changes provoked worry because the clients perceived it departed from their picture of health.

Gastrointestinal difficulties were the most commonly expressed concern.

After I got home I was a bit, um, I think I was, ah, quite hyper' in a way about being home and very pleased and ah, maybe a bit excited. And it [diarrhea] kept on for a little while after that.

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But, ah, in, at home, now you see they had me on medication and then when I got home, he prescribed a medication--two pills in one [anti-platelet agent]. . . . And they disagreed with me. . . . My stomach would be upset. I'd take three a day and, ah, and ah, then for three hours after, it would, it'd be upset.

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Constipation . . . was one that came up. That was pure hell. And trying to deal with that and feeling bad. Hurting all over. Leg and chest. Trying to deal with that was really serious at one point. . . . Oh, I was worried more of straining, hurt that I wasn't worried. I was worrying more about possibly dislodging some surgery. My new vessels.

The client's concern that straining would damage the surgery has been previously described by Blacher (1970). Throughout clients' accounts, it is evident that they interpreted their gastro-intestinal disorders as hampering recovery. They were troublesome because they were perceived as varying from a normal recovery.

Other client concerns were individual ones. One participant expressed worry over his perceived lack of concentration and the implications this had on his life.

Because, ah, after the operation, it seemed to be that I had, the level of the concentration. . . . Sometimes friends came to see me, visit me and talk with me few minutes. At first few minutes I got it. After a few minutes, I don't know that I seem to be that absent-minded [sic]. I don't know about [what] they're talking about. And I have to pay my very, you know, this concentration, attention to listen to them. Otherwise, me, I forget. I dunno whether this, is ah, influenced by the medicines or my age or what, I dunno. I never happen, such happening formerly. . . .
Even no concentrations, that means that—useless man.
Nothing to do in the world. I worry about, you know, to be useless now.

He perceived his symptoms as being a setback in his progress and health.

Professionals have identified that clients can experience changes in their mental acuity following open heart surgery. In a study of patients who had non-CABG types of heart surgery, Frank, Heller, Kornfeld and Malm (1972) attempted to quantify the change in intellectual performance among clients. They concluded that the magnitude in the changes would probably not noticeably affect day-to-day intellectual adjustment. Boisvert (1976), however, found that clients recovering from CABG were able to perceive the change in their intellectual functioning. Clients were irritated by not being able to concentrate on minor tasks like reading. From the client’s viewpoint, then, subtle changes in mental abilities were perceived.

Although Boisvert (1976) found clients were pre-occupied with their health status and concrete behaviors, the participants in this study also voiced concerns about non-somatic problems.

For example, two clients were concerned about their follow-up medical care.

I was nauseated and not feeling very good and, ah, I was a little concerned that I couldn't get to see a doctor. . . . Ah, the other thing that's gone a little bit wrong is that we were misled a little bit. Um, I
thought I had to be here for six weeks after the operation for further medical care. That's why we took the apartment [in town]. And instead, I should have been under the care of my own family doctor who's in X Town. So, this, ah, created some problems. . . . And, ah, then the other complication is been that Dr. X [cardiologist] has gone away. She's away on a lecture tour and a vacation.

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I had to call him [doctor] about the prescription or a question about, ah, activity or something 'cause he was my last cardiologist. I couldn't ask [the surgeon] or my regular doctor. And he, ah, he never returned the call. That upsets me more than anything. That, at least have the secretary call and say, "don't call my office ever again, you clown."

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But I kinda worried a little bit. Because I wasn't taking any pills and I, you know, others [other patients] are taking pills [anti-platelet agents].

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I was concerned about them stopping my medication [Inderal] and I was right. And I also was concerned that my pulse rate went way up after I got home and wouldn't come down.

Professionals were seen as a necessary adjunct to clients' recovery. When access to them was denied or their care was
questionable, clients became concerned. Because clients had clear ideas about what constituted a problem free recovery, any deviation from their plan aroused concern.

In addition to having concerns about their recuperation, clients also began to think ahead. For one client, the uncertainty about sick leave, layoff and unemployment was a real concern.

But there's problems. We don't know what's happening to us. So that, that's a problem, worry, isn't it, M [wife]? What's going to happen to us?

Professionals have identified that feelings about returning to work can range from fear to eagerness (Boisvert, 1976). It is apparent that once clients were assured of their progress, they began to anticipate the future.

The recovery at home, thus, was not necessarily free of concerns. When clients determined that certain events were a concern and potentially harmful to their progress, they went about managing these setbacks.

**Coping with setbacks.**

As in previous phases, clients used commonsense therapies to deal with some of the problems they encountered while home. The theme of the uniqueness of the coping strategies used was evident.

I was so dry-mouthed in the hospital there and after I
came home. It didn't matter what I took to drink, it'd still be there. . . . Just take an apple. And cut it up into bite sizes. Just take three, four of them bite sizes and chew them. By golly, it takes that dryness away. . . . Oh, it stays with you for a long time.

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I understand without eating, not easy to get speedy recovery. So that I try my best and treat all the food as medicine. I have to swallow it. I even try my best but I still have no, no appetite.

By searching their past experience for ways to help themselves, clients went about dealing with any problems that arose. One client felt that taking Dyazide would reduce the swelling in the leg where the vein was removed. For her, it made sense that a "water pill" would help her problem. The concerns which remained were those where these commonsense types of therapies did not work.

Clients also incorporated professional kinds of therapies into their coping strategies. They used their physicians' advice in helping them deal with setbacks and reduce their worry about them.

It's maybe just fat that's built up there, below [hematoma]. . . . He [doctor] said put a hot pad on it and he said that would reduce it, so that's what I'm doing.

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My family doctor suggested I get a ball [for the problem with my thumb]. And try and work it. . . .
Ah, it helps, it helps. It's strengthening my thumb.
When problems did arise at home, clients decided how to deal with them. Two clients chose to resume prior medications without seeking medical approval.
And I was scared to take it [Indocid] and I couldn't-- my family doctor was away at some convention or something and [the receptionist] in the office, she, she wouldn't say. And I said, "Oh no, I didn't expect her to say if I could use it." But I went ahead and used it anyway.

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I also took one chance. I went and put myself back on, ah Tagamet 'cause I was getting nauseous. And I figured it all out and I figured the Tagamet wouldn't hurt. . . . Well, I've been sick for a long time, so, you know, you get to know, eh? . . . You get to know a lot about them [medications] and their effects and you know what you can pretty safely do. Although I don't like to experiment but I couldn't get ahold of the doctor.
In these instances, clients relied on their past experience to help them decide what to do. They explained their choice based on the benefits they perceived would result. The theme of choices was apparent in how they managed their concerns.
In a similar vein, another client decided to embark on his
own activity program before consulting his physician.

And then, ah, about the middle of the week, I decided well, I can't go by their prescription, what they said, you know. So, I, ah, I decided to go outside. And I went out for a block. And I felt good, you know.

The client did not accept the professional explanatory models regarding his treatment regime and decided to follow his own prescription.

One client elected to determine the nature of his pain by himself.

I had some pain. I was a little bit suspicious of it and I took a nitro'. And it didn't touch the pain at all.... I concluded that it wasn't angina so I, I dropped it.

By this point in their illness, clients felt they had built up a repertoire of ways to deal with symptoms. They relied on their previous experience to guide them rather than professionals.

It is apparent that these clients weighed the pro's and con's of their actions in terms of perceived concrete benefits, not necessarily medical ones. Instead of seeking medical attention as in previous phases, they tended to be more independent in their decision-making. Perhaps this was because they perceived their illness as being "cured" and less threatening.

In relation to clients' preparation for discharge, only two of the clients specifically mentioned teaching programs as
benefitting them. In a study of what patients felt helpful for discharge after open heart surgery, Meyer and Latz (1979) have found that the clients did not perceive the content of their teaching booklets particularly helpful. (Content included heart function, incisional care, activities and complications). Rather, areas such as the type and severity/duration of chest pain and more specifics about activity were perceived to be more helpful. Based on what this study's clients remarked upon, they had clear-cut ideas on activities and referred to their printed sheet. However, other sources of information were not generally evident or perceived as useful in recovery.

In addition to using commonsense approaches to deal with problems that arose, clients also used approaches to aid in their overall recovery. They felt these things would help them continue their progress and a new "lease on life". All decided to change their diet.

I don't eat animal fats anymore. I don't drink cream. I don't use cream. I don't use ice cream. I don't use butter. Um, and I haven't used salt for a long time and very little sugar. And all this kind of thing. And we use a lot of grains and make our own bread and things like that.

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Ah, yea, there's a lot of things I wanna eat that I, than I'm not gonna damn well eat, you know. Like, ah, she [wife] had this ham, you know. Great big, beautiful ham. and I didn't have any of it, you know.
... This, these things I hafta, you know, I just gotta realize I gotta cut out.

They perceived the usefulness of diet change in different ways. Some participants drew on their prior knowledge about diet, but even with this information two felt the need to find out more about their diets.

What, the thing that surprises me is that I didn't get any directions at all. I asked one of the nurses, ah, a few days before I was to be discharged about a dietician. I was quite surprised that Dr. X had stroked off, ah, that I wasn't to see a dietician. Because the nurses told me if the doctor wants you to see a dietician, he'll send one up. And apparently there was no guidelines whatever about what to eat or what type of foods, or, ah, sugar. The only thing is I couldn't have salt on my tray. But the food itself was salty that they used to get in the hospital. And there was nothing mentioned whatever. And there still hasn't been anything mentioned about food. ... I'm wondering why it is that this is a cholesterol build-up in my arteries, why they should not suggest, ah, certain things not to eat. Which [sic] would you not think this would be logical? ... I am going to ask Dr., the doctor about that on Thursday.

Meyer and Latz (1979) have also found that diet was a concern to the clients they studied who were discharged following CABG. For the clients in this study, understanding the reasons for
their actions was a coping strategy.

In addition to seeking out information about their diets, clients also expressed curiosity about their care and its relation to a cure.

I was curious. After I hung up [the phone], when he [the doctor] said, "Well, if it [the bypass grafts] would have clotted, it would have happened by now."

and then after I hung up and I said, "Why didn't I ask him? Well, what were the symptoms?"

This client was trying to understand the significance of clotted grafts to him.

During their recovery, clients were still occupied with understanding the nature of their disease.

But then of course a build-up like that through the years, ah, I suppose it, it still keeps on whether I build up this cholesterol in my system, I don't know. Because the doctor told me at one time, I asked about that. And he said, it was, um, not, ah, it wasn't above normal. It was high normal, but it wasn't over the limit--my, the serum cholesterol wasn't over the limit. And, ah, so I took that for granted. And I didn't think too much about it. But then after I found out, then I wondered if, if I'm the type of person that just automatically has an over-supply in my system and if that, if that particular problem will keep on escalating in spite of the operation. Or is this ah, artery that's been or this vein that's been
used will also, ah, gather cholesterol or not.

How do they tell if your, if your, ah, this operation has been successful? Do they have to do another angiogram?

In her effort to see progress and benchmarks, the participant needed more information to make sense of her concerns.

One client remarked that he would now like to know more about the CABG.

Now, what I would like to know is what did the doctor do to, ah, where did he put the bypasses? I'd like to get that.

Meyer and Latz (1979) have also found that some clients remain unclear about what had been done during surgery once they were home. This particular client had earlier remarked that he never thought about the actual procedure prior to the operation.

Two clients coped with the surgery by changing their attitude toward their lives. These participants felt that changing their approach to life would be beneficial.

But I'm tryin' ta, I'm tryin' to avoid all stress. But my wife says I have a negative approach to everything. And I'm tryin' to get out of it, you know. Everytime I, she says, makes a suggestion, I, I, I'm against it, you know, or, or I'll say, "Oh, I dunno that's gonna, you know, gonna happen or whether that's any good or not, you know." But she says, which is bad, you know when I'm, I'm tryin' to get a happy outlook, I guess. Well, I been in pain
for so long that everything to me was negative.

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So now I live from day to day . . . and when I wake up in the morning I say, "Thank-you Lord for another day."

Clients also decided what changes were necessary in their lives to effect a recovery from their illness.

For one participant, the illness motivated him to stop smoking.

They told me and I didn't wanna smoke before the operation. Because they told me, "The more you smoke, the harder it was gonna be." The doctor and those nurses told me that. . . . So that morning I was out there waiting for him [prior to the angiogram], I had that, my last cigarette. . . . It's something I wanna beat. I wanna beat that. I still I have a strong urge . . . And I just wanna beat that more than anything.

Participants also perceived that a plan for activity was beneficial.

Ah, well I had this little paper that . . . Dr. X gave. Yea, and it said from each day I was to do a little more.

The clients had a clear idea about how they were to increase their activity in a gradual fashion. They saw progress in being able to do more each week.

In her study of clients recovering from open heart surgery,
Jillings (1978) found that clients believed their recovery would proceed more quickly at home and that they had concrete plans for daily activity. The idea of planning and goal-setting is apparent in the following accounts.

So, ah, now, course like I said, now I'm walking a little further than the, the eight blocks. And tomorrow, I'll add another block to it. And eventually maybe by the end of this week, I should be able to do a mile.

Well, I was just intending to do more every day unless I felt too tired.

Granger (1974) has postulated that clients naturally formulate goals in response to the crisis of CABG. Based on how the clients managed their activity programs, goals would appear to be an important way to manage the recovery and see progress.

When concerns arose once home, clients seemed better able to use distraction as a coping strategy.

What I'm going to do though, is I'm gonna start, start in on my dark room again.

I just sat down, I took, read, would read and get my mind off it [nausea].

They dealt with their setbacks in ways characteristic of them.

The support of the family in making changes was seen as helpful. The theme of the shared nature of the illness was strong in this last phase.
My wife, ah, keeps, ah, after me, she's, "You're too anxious." She, ah, everytime she talks to somebody, "Well, he, he can't get over the idea that he's still sick, you know. He figures that he should be a hundred percent, you know. Like you wanna be, well you wanna be two weeks, you wanna be four weeks from now, you know, in two weeks." ... I think they're [the suggestions are] good ones. I think she's on the right track.

The social support of families has also been echoed in the literature (Boisvert, 1976; Wilson-Barnett, 1981). That spousal support is essential for the client to recover has been implied.

Although the clients regularly received analgesics in hospital, only three continued their usage. They were reluctant to do so and did not use analgesics on a regular basis.

If need, if pain, take a drug. I don't want [to] take too much. ... You know the drug will help my pain.

On the other hand. ... I don't want to take too much of the, of the drug.

Boisvert (1976) has similarly found that her study group hesitated to take analgesics once home.

Clients also constructed timetables for the pain to subside.

I, ah, was hoping that the soreness would go sooner, but I'm now made up my mind that it'll be a long time before all the soreness goes. I expect it's gonna to go very slow and be two, three months, at least.
Clients were interested in monitoring their progress and improvement at home. The idea of feeling better seemed to strengthen their resolve and increase their hope.

The last two days my strength has been coming back quite well—quite a bit stronger.

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And I felt very weak. I was a little disappointed in that, but I mean, I've come to terms with that. I realize that it's going to take a long time before I get all my strength back. But my mind seems to be clearer. And, ah, I feel better.

Progress was measured in terms of the disappearance of previous symptoms, whether directly related to coronary artery disease or not.

Before, oh for six years, my ankles and up my legs, close to my knees. You'd just think it was a bunch of worms and they're all moving in underneath your hide . . . Some nights I, I just couldn't go to sleep right away for feeling this, ah, movement like that. . . . Since the operation, bingo! . . . Nothing. My God, I haven't got that. It's gone now.

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And I walked with a bus driver that I know. . . . I hadta pretty well keep up with him. And I didn't, goin' up that hill, I didn't get, I was a little short of breath, you know, puffin' but no angina. So, they [doctors] got 'er!
Progress was also measured in terms of a return to familiar activities.

Once I found out that I could turn over on my side and flip over on my other side, I knew I was alright, 'cause that's the way I sleep.

I don't have to . . . gasp to much to get breath. . . . It's easier to breathe because my lungs are getting more blood now than they used to. They function better.

One client assessed progress in terms of the cues received from her doctor.

He [doctor] was very pleased. And he told me that he was pleased with my progress and I guess that meant the operation was successful.

The theme of marking progress has not previously been described in the literature as a recognized coping mechanism for clients. However, it would appear that improved status was a benchmark for clients in their recovery. Comparing themselves with others or expectations was a way for them to mark time as well as maintain hope.

Once home, the clients continued to see progress and to manage their recovery. Because the operation marked a change in the course of their illness, they also were trying to make sense of their health.
Perceptions of the experience.

Generally, the clients perceived the operation to be beneficial. In retrospect, they unanimously had positive feelings about the experience.

I think it was worthwhile. . . . Best thing that ever happened. . . . I, I think so, because, ah, I walk up to the corner and, and, I don't get any pains, any burning pains like I had before. And, ah, I, and I even walk, like up little hills and I don't feel nervous anymore. So, to me, it was worth it.

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He [the doctor] did a good job as far as I'm concerned. . . . Yea, it was more than worth it. I would say, if anybody had any pains now, ah, like a guy my age. . . . I could get it done now rather than wait ten years. I would. In my opinion now, I wouldn't want to wait 'til I'm 65 or 70. . . . Lot of guys, the older they get, the more problems, you know, and I think the more dangerous. So if you're 55 and you got these pains and the doctors says, "Well, we can give you these pills and you know, you'll probably be all right." I would say, "No. Let me have the operation. Now, you know." That's the way, what I, that's the way I figure. If you've got that doctor down there; he knows what he's doin' and, ah, get those bypasses in and you're no more pills and you're
as good as new. Just keep on your diet. 'Cause you gotta stay on a diet anyway, don't you? If you don't get the operation, more stricter. Because you gotta watch that cholesterol like a hawk, don't you?

Clients felt positive because they perceived the operation removed the symptoms of their illness.

They were also pleased with their progress and grateful for a return to health.

I went through with it and I'm very pleased. . . . I'm very happy that I did.

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I feel like the whole thing, like I said, I told M [wife], was almost like a religous experience. It, it was, really. And I'm not particularly a religous man, I don't want you to think that. I wouldn't want to say it was, but I dunno, I feel now that I owe something. I'm assuming that the operation's all a hundred percent success [laugh]. . . . Well, I feel that, ah, also, too, look at the cost to the, the people of this operation. In the States, it would cost twenty thousand dollars. That's a very costly thing and I, I think that I owe society something for that. You know, you have to make it worthwhile.

In addition to feeling positive about their progress, clients also were hopeful about their recovery. The theme of hope was a strong aspect of their recovery at home.

In a sense that I had to do what was necessary for my
recovery, which wasn't always easy. It was simple, but it wasn't easy, if you know what I mean. Because simple is simple and easy is easy and the two don't necessarily mesh always. . . . But since that time, I've been, it's it's been a piece of cake. And I'm very pleased with me.

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I would say the recovery has been real good. They were relieved about the absence of angina. The clients perceived their actions as helping themselves get better. This was positive.
And, ah, so, like I say, so far, so good, you know. I haven't had any angina.
However, one man tempered his optimism about the disappearance of his symptoms.
But it's still hard to tell. I'm not, I, yet really convinced I won't get angina when I start pushing myself. Well, it's; I gotta prove it, eh.
The clients were also very clear in differentiating angina from incisional pain.
Of course, I'm sore, here, right now, but it's not that angina.

Clients determined progress toward health by comparing their feelings to those prior to the operation.
The clients expressed their hope for the future. Of those who were able to work, they had differing views on returning to work as opposed to retiring.
Oh yes, I plan to go to work 'til I'm 65 years old.

So I don't know when, really, as I can work normally. Of course, you know, I am now nearly three weeks. But the church, so many things. You know, but I hope, when I ready to get to work, I'll work.... I believe that God will give me a very fast recovery and then do, ah, my work, the work as usual.

And, I like to retire now before I get too old, you know while I'm still young enough. ... I'd like to stay off for the rest of the year, anyway.... It's [X month] already and, ah, and I still have, I still have, you know, pains in my chest, so, I mean, why, why rush it?

Maybe I might have to work for two, three months of the year to do the extra things we want. But then I could maybe do what I want.... I'm looking forward to it. But as I get stronger, I'm going to see how that works now. And what I intend to do now is to get more and more active, like we had a good walk this morning.... I like walking. And I like to do, well I like to be in the country, too. I, I like to be with people, but I like being in the country, too. And I like to do my work in archaeology.... There's lots of work I'd like to do.
One client expressed a fatalistic attitude toward the ongoing nature of the disease. He felt accepting of a repeat operation if he needed it.

Yea, you can't do nothing about it. If it happens again, I guess you, well just have to go it again.

I, I mean, what can you do about it?

Through his experience in the hospital, this participant became aware that a repeat CABG sometimes was necessary. Although this came as a shock to him, he was able to reduce his concern by making sense of the repeat operations.

My understanding was that it, they, they; I don't care, they did three on me. But some people have had four or five done. So that means there's a lot more arteries that could be, ah, plugged up. Maybe I might have some more that are plug up and then maybe not as bad.

The client made sense of the notion of repeat operations by relating it to the disease process.

Although the clients realized the chronic nature of their disease, they still maintained hope in medical science.

The only thing is, ah, I was reading this article about laser beams. I just hope, they, next one, time I go there, I hope they have that.

As a theme, hope was still a prominent and effective coping strategy.
Summary

In this chapter, the illness experience of the clients has been presented in a chronological sequence according to benchmarks. The explanatory models contained in clients' accounts have been compared to pertinent literature. Where present, common aspects of the entire illness (themes) have also been discussed.
CHAPTER 5

Summary, Conclusions and Implications for Nursing

Summary and Conclusions

The focus of this study has been on the illness experience of clients with coronary artery disease and their recovery from coronary artery bypass grafting surgery (CABG). The purposes of the study were to determine how clients perceived their illness and to identify what concerns clients had about their recovery once home. By eliciting clients' viewpoints on their sickness, insight was gained into how they made sense of their illness and managed it.

Because illness is a personal event shaped by sociocultural forces, people can interpret sickness in different ways. Discrepancies between what clients and professionals believe about illness can occur. In order to plan and give effective patient-centered care, professionals need to understand how clients view illness. Nursing care that addresses clients' concerns about their illness not only can help them manage their sickness, but also speed their recovery. In this way, effective care can reduce clients' dependency on an expensive health care system.

The discrepancy between lay and professional
interpretations of illness has been addressed by Kleinman (1978) in his cultural system model. In his theory, individuals interpret illness based on the social positions they occupy and the systems of meaning they employ. Thus, lay people in the popular domain of the health care system would explain their illness in ways that are different from professionals. The explanatory models about illness would therefore vary between clients and professionals.

To determine clients' viewpoints and their explanatory models, a phenomenological method was used. In this qualitative approach to data collection, the researcher elicited clients' viewpoints through semi-structured interviews directed at exploring how clients retrospectively perceived their illness. The inter-subjective nature of the interview allowed the researcher to understand how clients made sense of their illness. In their accounts, the clients described their perceptions and how they attached meaning to the events that comprised their illness experience. Their viewpoint and concerns became evident as they explained how they understood and coped with illness.

The accounts were analyzed so as to preserve the flavour of clients' explanatory models. During the data analysis, it became apparent that clients understood their illness and recovery from CABG by attaching meaning to certain aspects of the entire experience. Although the clients interpreted these aspects differently, they commonly described similar reference points or "benchmarks" which highlighted their illness
experience. These benchmarks provided the investigator with a means to analyze the data and understand clients' viewpoints.

In attaching meaning to events and phenomena of their experience, clients understood their illness as comprising distinct phases. Their use of benchmarks to structure time was a way to make sense of their experience and see progress toward health. Thus, because benchmarks were sociocultural phenomena, they were congruent with Kleinman's conceptualization of explanatory models (Kleinman, 1978).

To understand clients' experiences, the investigator also brought her sense of structuring time to the data analysis. Thus, the benchmarks as identified by the clients guided how the phases were understood and divided. In this sense, the structure of clients' experiences resulted from both the expressed and perceived benchmarks of the illness.

The phases of the illness experience were:

1. the realization of illness,
2. the plan to undergo CABG,
3. the recovery from CABG while in hospital, and
4. the recovery at home.

The benchmarks were:

1. the appearance of symptoms of coronary artery disease,
2. seeking medical care and diagnosis,
3. the worsening of the illness,
4. undergoing angiography,
5. deciding to undergo CABG,
6. waiting for the operation,
7. having the operation,
8. the experience in the Post Anaesthesia Recovery Room and Intensive Care Unit,
9. the experience on the ward, and
10. the discharge home.

Although benchmarks were one aspect of how the clients explained their illness, they were not the only explanatory models present. Throughout the phases, common themes emerged as significant in clients' meaning systems. These themes were feeling-states or ways of coping with ill health. Although the themes varied in intensity throughout the illness, their presence gave continuity to the entire experience. The commonalities between phases were significant in understanding how clients perceived their illness experience. The themes were:

1. hope,
2. trust,
3. choices,
4. determining progress,
5. unique coping strategies, and
6. the shared nature of illness.

The illness experience as understood by the researcher, then, was a chronological series of experiences with themes present throughout.

It was evident that the clients made sense of their illness and managed their ill health in commonsense ways. Clients'
explanatory models were very different from professional ones. Whereas professionals would focus on the disease model, pathophysiology and causation, the clients referred to past experience, beliefs or socially accepted ideas to explain their illness. In certain instances, the influence of the professional explanatory models was evident (e.g. understanding of drugs). Nevertheless, the overriding perspective was that of the popular domain.

Illness was described in terms of concrete symptoms and causes. The appearance of angina was linked to diet, lack of exercise and other observable phenomena. As clients recovered from CABG, their concerns were primarily focused on concrete behaviors which interfered with their usual pattern of living (e.g. gastro-intestinal difficulties). Throughout their illness, clients assessed their health in this commonsense way of making comparisons between what they perceived to be normal physiological function and their present situation.

Clients had insight into their health and were aware of subtle bodily cues. They made sense of their feelings (angina, post-operative pain) by relying on knowledge acquired through previous experience. Illness recognition had both cognitive and affective elements to it. Although fear and anxiety were present, clients also expressed a need to understand why they were feeling as they did. Understanding (from a lay, not a professional perspective) was a useful coping strategy.

Being ill caused clients to change their behavior in order to cope with the sickness. The majority of coping strategies
employed by the participants were unique ones (humor, spiritual guidance, distraction). Others, however, were more universal such as denial. All clients found that marking progress was a beneficial coping strategy. Regardless of the problems perceived by the clients, illness was managed in a fashion characteristic of each person.

Hope and a positive attitude toward health care was significant to the participants. Hope enabled them to live with their chronic illness and manage from day-to-day. Even when the quality of care was less than ideal, clients continued to trust and have faith in their care-givers. They believed that medical science offered them some hope for a reprieve from illness.

Clients put their trust in physicians and other health professionals based on global criteria. Surgeons were "good" if the grapevine stated so. The symbolic view of the physician as "curer-healer" was very much in evidence. Regardless of their expertise or interpersonal skills, doctors were automatically trusted and valued. Nurses, on the other hand, were perceived to be deserving of trust primarily based on their sympathetic, caring interventions.

However, not all nursing care was perceived to be particularly sympathetic nor helpful by the clients. They expressed concern over feeling depersonalized by nurses. Although all the clients were extremely grateful for the overall care they received, this gratitude was tempered by their concerns about nursing care.

The "busy-ness" and lack of concern on the part of nurses
was cited as a common barrier to effective care. Not only did some clients perceive themselves to be misunderstood, but also poorly cared for. Contrary to professional beliefs about patient-centered care, it is evident that such care is only an ideal; it is not always realized.

The disparity between lay and professional views on illness created difficulties for clients in understanding and managing their own illness. They were aware of the exclusiveness of professional explanatory models. However, in order to become healthy, they tolerated these explanations and managed their illness in popular ways.

Regardless of their perceptions on the quality of care, the strong hope and trust in professionals helped the clients make choices about their care. Especially in relation to deciding whether or not to undergo CABG, clients' faith in their physicians was an important factor in the process. Because they trusted doctors and were hopeful that CABG would be beneficial they were accepting of medical advice. Although the trust, at times, appeared "blind", all the clients expressed how influential it was in their decision-making at various points in the illness.

Clients used commonsense ways in deciding how to manage their illness. When a symptom appeared, the clients relied on past experience or faith to help them deal with their concerns. They weighed the pro's and con's of various options (taking medications or not), but always reduced it to the level of concrete behavior. Risk was perceived in terms of continued
symptom appearance, not distant effects on other organ systems. The desire to be "normal" and without signs of illness was a potent motivator for some clients to decide on a course of action. Choices, however, were often intuitive ones based on feeling-states, not medical knowledge.

Throughout their illness experience, clients referred to their families and spouses as being supportive. In all the accounts, it was evident that clients did not cope with their illness alone, but shared the responsibility for managing it with their families. This sharing was a valuable coping strategy for the clients.

The concerns which arose during the illness were individualized ones. They changed as the illness progressed. Angina was an early concern, but after CABG, this concern diminished in magnitude. Once home, clients' concerns were different than those presented in professional literature. The concerns professionals had about discharged clients failed to materialize. The kinds of problems that did arise were of a concrete nature (e.g. voice changes). These concerns were often not anticipated in hospital. Again, the discrepancy between professional and popular explanatory models created barriers to effective care. Clients were so pleased to go home that they tended to avoid anticipating any difficulties. Nevertheless, effective preparation for discharge and dealing with clients' concerns was not fully realized.

Gaining insight into how clients made sense of their illness revealed how differently clients perceived illness as
compared to professionals. While in the health care system, the popular viewpoint is frequently ignored in lieu of professional explanatory models. Not only does such practice impede clients' return to health but also creates feelings of anger and helplessness on the part of clients. The gap between professionals and clients is not becoming smaller. Unfortunately, the discrepancy persists and is perceived to be a major concern by clients.

Because the focus of the clients was on concrete behaviors and commonsense approaches, the study's findings have implications for nursing practice, education and research.

**Implications for Nursing Practice**

Understanding clients' viewpoints about their illness experience provides direction for effective nursing practice. Care can be made more relevant to how clients understand illness. In this way, the management of illness can more effectively capitalize on clients' intrinsic coping resources. With effective care, clients can be better prepared to understand and manage their illness in ways that make sense to them. They can better adhere to medical regimes if they understand them on their own terms.

Because focusing on lay explanatory models capitalizes on the unique meaning system of clients, care can become more effective. Nursing time and energy cannot be wasted solely on professional explanatory models since clients do not necessarily
rely on these when making decisions about health care. If care is made more effective by incorporating popular explanatory models into nursing care plans, interventions can also become more cost-effective.

Clients' accounts clearly demonstrate the variability in how they perceive illness and concerns. Because this variability is so predominant, nurses cannot assume that the illness experience of recovery from CABG is a generalizable one. Nursing care must be individualized to deal with the uniqueness of the experience for each client. The findings of this study provide direction in using the nursing process to recognize this individuality.

Assessment

How clients perceive their symptoms and illness must be the starting point for nursing care. Only through reaching an understanding of how clients interpret their illness can nurses effectively communicate. Ascertaining why clients attach significance to certain perceptions would help maintain communication between nurses and clients. Their concerns must not be dismissed, but understood. Nurses must not assume that clients perceive their symptoms and illness as professionals do. Because professional and popular explanatory models are so different, nurses need to consciously reduce the discrepancy between clients and professionals. Negotiation must occur between popular and professional explanatory models.
Determining how clients perceive their illness, then, must be an important facet of care.

Planning and Implementation

Recognizing and accepting clients' viewpoints entails dealing with both popular and professional explanatory models. In order to provide individualized, skilled care, nurses must negotiate the two distinct health care sectors. If clients perceive that nurses are trying to understand their viewpoint, trust can be engendered. Acknowledging their views can also help clients maintain control and dignity. Treating clients as people, not as objects or passive recipients of care should be a priority in nursing practice.

Nurses must demonstrate their accountability to their clients by following through on their interventions. Clients were very aware of "busy-ness" or other factors that interfered with their care. Nurses must be aware that clients are not "good patients" but people who have needs and require responsible care.

Informing clients of how they are progressing should be a routine function. Since clients coped with their illness by identifying benchmarks and seeing progress, feedback from nurses can be valuable. This can encourage clients by helping them attach positive meaning to events like the removal of monitoring equipment. Comparing their expectations regarding their illness with their actual progress can help them cope. Hopefulness
regarding their progress should also be fostered as this was perceived to be a valuable coping strategy.

The affective component of this illness must be considered a priority in nursing care. The fear, denial and hopelessness that professionals tend to accept as "normal" can be very real and threatening to the client. Especially during anginal episodes, the client's emotional status must be assessed and managed. Nurses must accept that clients cope with illness by becoming fearful or using denial. Clients must not be labelled or stigmatized for coping or reacting in these ways.

In patient education programs, professionals must develop content around what clients perceive are concerns. The focus should be on concrete behaviors or problems, not the detailed cause-effect rationality of the medical model. Because clients draw extensively on past experience to make sense of their illness, this prior knowledge should be used in any teaching-learning interaction. Nurses must capitalize on how clients make sense of their illness and manage it. If this is done, clients may be able to adhere to medical regimes because they "make sense" and have become more integrated into popular explanatory models.

Teaching must be done in terms of client behavior. Although clients may need to understand basic pathophysiology, other aspects of the illness should be presented in concrete ways. For example, information about nitroglycerin should be learned in terms of when to take the medication, how to take it, what it feels like to take it, the safety of the drug and its
necessity. Knowledge about the actual action of the drug may be
superfluous if the client focuses on concrete aspects of the
medication. Negotiation between popular and professional ways
of understanding treatment must occur if effective care is to
result.

Information alone, however, is not sufficient in patient
education programs. Because illness recognition and management
involves cognitive as well as affective functions, nurses must
deal with clients' feelings. Facilitating discussion of
emotion responses must be an integral component of any program
dealing with illness management.

Care of clients undergoing coronary angiography should
warrant special attention as this marks a significant benchmark
in the illness experience. Nurses must be aware that the
angiogram can represent a new lease on life or a death warrant
to the client. Hopelessness should be dealt with in the event
that CABG is not recommended. Overall, the client is vulnerable
during this period and requires support in decision-making and
dealing with the implications of coronary disease.

Pre-operative preparation of the client undergoing CABG
should ideally begin immediately after the client decides to
have surgery. During the waiting period prior to the CABG,
clients should have the opportunity to have their questions
answered. Group sessions would be one method to discuss their
concerns and reduce their worry about the operation. Since the
waiting period was a concern for all clients, nurses must
consider ways to assist clients cope with this phase of their
illness.

Clients should be honestly informed about events affecting their care. Especially in relation to cancelling surgery, clients need information in order to cope. Otherwise, misconceptions can arise and the client may become needlessly concerned. Trust can be maintained if honesty exists. Since trust was so important a coping strategy, nurses must strive to maintain this.

In critical care areas, nurses should be aware that clients hear and understand more than they appear to. The humanity of the client should not be ignored, but recognized. Their inherent dignity and worth must be respected regardless of their outward state. Blaming patients or using sarcasm is not acceptable nursing practice. Because clients are so helpless when they are ill, nurses must focus on maintaining clients' control and power. Flexible, supportive care, not "the routine" must be realized.

In their perceptions following CABG, clients were acutely aware of the attitudes expressed by their nurses. As the central figures in their memories of this phase of their illness, nurses should strive to communicate a caring attitude to the clients. In our quest for technical proficiency, nurses must not forget that clients are vulnerable and sensitive to care-givers' attitudes. A positive approach and acceptance of clients are necessary to help them cope with illness. Care cannot be effective if clients are fearful or worried that the care they receive will not be beneficial.
Preparation of the clients for discharge should focus on realistically anticipating what problems may occur. The prolonged lack of appetite must be discussed with spouses or family. Gastro-intestinal problems must also be discussed with a plan developed to deal with these occurrences. For any concern, teaching programs must be developed in order to help clients manage their recovery at home. Isolated knowledge is of no value; clients must be helped to make choices and manage their own health.

Because the concerns of the discharge period were so variable, it is difficult to plan teaching to meet all the needs that may arise. As adult learners, clients automatically relied on past experience and focused on present problems. This may explain why discharge teaching often is ineffective. However, because clients do experience concerns once home, it would be helpful if they could confer with professionals about dealing with their concerns. Ensuring that medical follow-up was available would be helpful. Also beneficial would be home visits by nurses to identify ongoing concerns of clients.

**Evaluation**

Because clients do vary in terms of their needs and abilities to manage their own illness, care must be evaluated individually. The effectiveness of interventions must be measured in relation to facilitating the client to manage his or her own illness. Only when the popular domain of the health
care system is the focus can interventions become effective. Thus, clients' abilities must not be evaluated solely on professional models. Recognition also must be given to the effectiveness of commonsense ways that clients use to manage illness.

**Implications for Nursing Education**

Curricula should be developed to help students appreciate that illness is a socially constructed phenomenon. Students should learn that gaps in understanding between clients and professionals are inherent in the health care system. It should be stressed that understanding the client's point of view is central to nursing care. Without understanding and acceptance, clients can be isolated and deprived of care to meet their needs.

Because professionals have so many explanatory models about coronary artery disease, students must be encouraged to explore the meaning of the illness from the client's perspective. In this way, pre-conceived notions which may be a barrier to patient-centered care can be reduced.

Students should be made aware of the importance of interpersonal relations in nursing clients with coronary artery disease. Even when clients appear to be unconscious, students should realize that nurses' attitudes are readily perceived by clients. Communication and empathy must be prerequisites for an effective patient-nurse relationship.
Implications for Nursing Research

Although much research has been done on CABG and coronary disease, little is from the client's perspective. Many fruitful areas of inquiry arise from exploring how clients perceived their illness. How do clients make decisions about seeking medical care or managing their symptoms? What kinds of knowledge do clients use when making sense of their symptoms? What is the relation between the kind of analgesia used post-operatively and altered perceptions? What is the nature of the pain experience post-operatively? How is compliance/adherence to medical regimes affected by popular explanatory models?

Because this study collected retrospective data about the illness experience, further research is also needed regarding how clients actually cope during the early parts of their illness. A longitudinal study would shed light on the question, "Do clients tend to minimize their illness over time?"

In conclusion, further study into the area of client perceptions of illness is required in order to plan more effective nursing care. That gaps in understanding between clients and professionals exist cannot be questioned. Not only do clients explain their illness in very different terms than professionals do, but they also tend to rely on prior experience and commonsense ways to manage their ill health. The importance of narrowing the discrepancy cannot be minimized. As one participant remarked, "If in your thesis, if you just get it across to the medical, ah, public at large and those in medical
school and aspiring nurses and all of that—the fact that there must be something done to close a few gaps of understanding between patient and 'carer'. If you can just get that across, you'll do so many people a favour."


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APPENDIX A

Client Introductory Letter

Dear Mr./Mrs./Miss,

My name is Patrice Yamada. I am a student in the graduate program in nursing at the University of British Columbia. I am interested in learning about your concerns and experiences after your heart operation. I would greatly appreciate your cooperation in helping me learn about your illness.

If you agree to participate, this study will involve the following:

1. My visiting you in your home one or two times in order to interview you about your convalescence.
2. Tape recording our conversation which may last about one and one half hours per interview.

Your name and any identifying information will not be used in the study or revealed. In order to ensure confidentiality, my notes will be identified by a code only, and I, alone, will know your identity.

YOU ARE UNDER NO OBLIGATION TO PARTICIPATE IN THE STUDY. You may refuse to participate without any effect on your future care. If you agree to participate, you may withdraw from the study or refuse to answer any questions AT ANY TIME without any effect on your care.

The information discovered in the study may be used to publish findings. Your identity will not be revealed in any published works.

If you would like more information regarding this study, please inform your nurse. I will then meet with you before you are ready to go home. At this time I will explain the study in more detail and obtain your written consent to participate in the study.

Thank-you for your cooperation.

Yours truly,

Patrice Yamada
APPENDIX B

Client Consent Form

I understand that the purpose of this study is to determine my concerns about recovering from heart surgery and how I perceive my illness.

I understand that this study will involve the following:
1. The investigator will visit me in my home one or two times in order to interview me about my convalescence.
2. Each interview will last about one and one half hours.
3. Our conversation will be taped on an audio recorder.

I understand that my name and any identifying information will not be used in the study or revealed. The investigator will ensure confidentiality by identifying her notes by a code name. She, alone, will know my true identity. If the information discovered in the study is published, my identity will, again, not be revealed.

I understand that I AM UNDER NO OBLIGATION TO PARTICIPATE IN THE STUDY. I may refuse to participate without any effect on my future care. If I do agree to participate, I may withdraw from the study or refuse to answer any questions AT ANY TIME without any effect on my care.

I understand that if I have any further questions regarding the study, I can contact the investigator.

At the completion of the study, I understand that the investigator will be re-contacting me regarding the results.

__________________________
I understand the nature of this study and I give my consent to participate. I acknowledge receipt of a copy of this consent form.

Date
Signature
Witnesses
APPENDIX C

Sample Interview Questions¹

1. Tell me about your illness.
2. What do you think led up to your illness?
3. Why do you think it started when it did?
4. Can you explain to me what your illness does to you? How does it work?
5. How serious would you say your illness is?
6. Do you think it will last a long or short time?
7. How would you say you feel about your illness?
8. What kind of treatment do you think you should receive?
9. Do you think the operation changed the way your body works?
10. What do you hope are the results of the operation?
11. Tell me how you felt when you first came home from the hospital.
12. Would you say anything concerned you about your recovery?
13. What have you been doing to help yourself get better?
14. Has your illness caused you any difficulties?

¹Adapted from Kleinman, Eisenberg, and Good (1978, p. 256).
APPENDIX D

Physician Consent Form

Dear Dr. ,

My name is Patrice Yamada. I am a student in the graduate program in nursing at the University of British Columbia. I would like your co-operation in a study I am conducting of patients convalescing from coronary artery bypass grafting surgery.

The purpose of the study is to examine the concerns of patients discharged from hospital following this type of surgery. The study is not concerned with evaluating the quality of hospital care, but rather to determine the patients' perceptions of their illness experience.

Understanding how patients describe and explain their illness can be beneficial for the following reasons:

1. Patients can increase their satisfaction with hospital care because their concerns are known and can be directly addressed.
2. More effective teaching programs can be planned which are geared to the patients' real concerns.
3. Patients can improve their compliance with treatment regimes because their concerns are incorporated into the plan of care.

In order to determine the patients' perceptions of their illness experience, data will be gathered through an indepth interviewing technique. From 7 to 10 patients will be selected to be interviewed based on their meeting the following criteria: 1) having had coronary artery bypass grafting surgery during the current hospitalization, 2) able to speak and read English, 3) alert and oriented to time, place, person, and, 4) being 18 years of age or older. The investigator will use a semi-structured interview format to elicit the patients' viewpoint. This interviewing will be done in the patients' homes within one week following discharge. The interview will last approximately one and one half hours with a maximum of two interviews to be done. All interviews will be audiotape recorded.

All patients who qualify for the study will be informed that they are not obligated to participate and that refusal to do so will in no way affect their future care. Also, if they do agree to participate, they will be informed that they may
withdraw from the study or refuse to answer any questions at any time without any effect on their care (see enclosed patient Consent Form). Only the investigator will know the identity of the participant.

The results of the study will be reported in a thesis. Upon completion of the project, a copy of the thesis will be available from the Cardiac Teaching Unit, X. Hospital.

If you have any questions regarding this study, please contact me. This study has been approved by the Ethical Review Committee of the University of British Columbia and the Research Co-ordinating Committee of X. Hospital.

Thank-you for your co-operation.

Yours truly,

Patrice Yamada

I agree to have the patients under my care participate in this study if they are willing.

Date

Signature