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Therapeutic relationships in day surgery: a grounded theory study

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Abstract

Title: Therapeutic Relationships in Day Surgery: A Grounded Theory study.

Aim: The aim of the study was to explore patients' experiences of day surgery.

Background: Therapeutic relationships are considered to be a core dimension of nursing care. However in modern healthcare with short hospital stays the formation of these relationships may be impeded. A major theme to emerge from this study was the development of therapeutic relationships in the day surgery setting.

Methodology: The Glaserian method of Grounded Theory was utilised. Semi – structured interviews with 145 patients took place from 2004-2006 in two day surgery units in the United Kingdom. Analysis involved transcriptions of interviews and memos. Lists of key words and phrases were made and constantly compared until core categories began to emerge.

Results: Patients spoke highly of the relationships they developed with nurses during their stay in the day surgery unit. Analysis of the data revealed the core category of therapeutic relationships and four sub core categories: “presence,” “extra special” “befriending” and “comfort-giving.”

Conclusion: This paper adds to the growing body of literature which demonstrates that therapeutic relationships can be developed within the short stay arena of health care : routine interactions which may not be considered to be significant by nurses may be of importance to patients. The patients in this study felt supported, comforted and befriended by day surgery nurses. However a minority of patients were disappointed with the nursing staff responses to patient needs.

Relevance to clinical practice: Anecdotal and empirical evidence suggests that personnel working within day surgery are not always aware of their therapeutic potential. Therefore raising awareness of this through research generated from patients' experiences might encourage nurses to further realise their capabilities in this fundamental area of nursing.

Keywords: Day Surgery, Therapeutic Relationships, Grounded theory, Nurse-Patient Interaction, Patient Experiences.

Therapeutic Relationships in Day Surgery

Introduction

A therapeutic relationship has been defined as one which is perceived by patients to be caring, supportive, non-judgemental and to offer a perception of safety from threatening events. At the same time the relationship is professional and boundaried by professional codes (McKlindon and Bernester 1999). The key elements of a therapeutic relationship have been identified as respect for person, receptivity which involves good listening skills, empathy and awareness of one's own skills and limitations (Hobbs 1994).

Therapeutic Relationships formed between nurses and patients has always been a highly prized attribute of the nursing profession (Armstrong 1983). However in the modern health care setting there are perceived to be many factors which may hinder the development of this relationship. Speed of health care delivery and increased use of technology has been cited as possible reasons for the perceived threat to the formation of therapeutic relationships (Beals 2002, Foster and Hawkins 2005). The modern day surgery unit is an area where nurse –patient interaction is compressed into a very short time frame. However as part of a larger study investigating the social aspects of day surgery (Mottram 2008), the therapeutic relationship between day surgery personnel and patients emerged as an important theme. The relationship between nurses and patients in two day surgery units will be discussed here. The findings suggest that long periods of time are not necessary to allow for the formation of a relationship that is therapeutic in nature.

Background

Admission to hospital can be an anxiety provoking event. It can pose a threat to an individuals' sense of self, a loss of confidence, due to the interruption of habits and routines and fear of death which is the ultimate loss of control (Giddens 1991). There is much evidence to demonstrate that patients are just as anxious before day surgery as in-patient surgery (Swindale 1989, Mitchell 2005, Stoddard et al 2005). Therefore it may be supposed that patients look to day surgery personnel for support.

Historically, the formation of therapeutic relationships has not been encouraged. Indeed it was considered to be dangerous for both nurse and patient and was to be avoided at all costs (Shattell 2004). However during the mid twentieth century nurse theorist such as Peplau, Travelbee and latterly, Watson and Leininger put the nurse – patient relationships high on the nursing agenda. Travelbee (1966, p18) used the phrase “therapeutic use of self” to describe the purpose of nursing which is only developed through the establishment of human to human relationships. Watson believed that therapeutic relationships are two-way reciprocal relationships, through which each grows and learns from the other (Watson 1979). Savage (1995) identifies the therapeutic potential of nurses' personal involvement with patients, whilst more recently, Hagerty and Patusky (2003), and Shattell (2004) suggest that large amounts of time are not necessary for the development of the nurse-patient relationship.

However, in relation to the day surgery patient, Fox (1992) concluded that, because of the industrialised nature of day surgery with its inherent emphasis on speed, it is impossible for nurses to form relationships with patients. Similarly, Mottram (2001), in a survey of 88 pre-registration student nurses, found that many would not like to pursue a career in day surgery because of the perception that there would be no time to establish relationships with patients.

Methods

The aim of the study was to examine the experiences of patients undergoing day surgery utilising the Grounded Theory approach. This paper discusses one of the core categories which emerged: therapeutic relationships.

The Glaserian method of Grounded Theory was utilised (1992). This was considered to be the most appropriate methodology for this study as it examines experiences from the subjects own perspectives, allows themes to emerge from the data rather than have them imposed on the subjects by the researcher and offers a flexible means of data collection (Layder 1992). The ultimate aim of the Grounded Theory research study is the development of theory from the data collected. The theory develops during the research process itself and is a “product of continuous inter-play between analysis and data collection” (Goulding 2002 p 42). Rennie stated that Glaser and Strauss developed “something rather wonderful” with Grounded Theory, “Instead of using data to test theory, they used it to develop theory” (Rennie 1995 cited by Glaser 1998 p7)

Ethical Issues and Sampling

Permission to undertake the study was obtained from the Local Research Ethics Committee on the proviso that a sample size of at least fifty patients was obtained. Although this is contrary to the spirit of grounded theory where sample size is directed by theoretical considerations, I had no choice but to accede to their requirements. However to obtain theoretical saturation I found that I had interviewed 145 patients and one hundred carers over a two year period.

A further requirement of the Ethics Committee was that I produce an extensive information leaflet detailing the aims and methods of the study. Written and verbal assurances were given that the patient could withdraw from the study at any time

without jeopardising future treatment. Anonymity and confidentiality was assured by the use of pseudonyms throughout and destruction of tapes after use and storage of transcripts was by password protected computer package known only to the researcher. If agreeing to take part the patient signed the consent form after further opportunities were given for asking questions about either myself as researcher, or the research project itself.

In grounded theory sampling is guided by purposive and theoretical principles.

Initially the sample was purposively selected from where the phenomena were occurring i.e. the day surgery unit of two public hospitals in urban locations in the United Kingdom. Later to meet the theoretical concerns of the study, sampling was directed by the emergent categories and the need to test, elaborate, refine and explore linkages between the emerging categories (Glaser 1978). Patients were selected and recruited whilst they attended the Pre-operative Assessment Clinic. To comply with ethical restrictions patients had to be over the age of 18 years, undergoing day surgery for the first time, and were excluded if they were undergoing surgery which may have resulted in a cancer diagnosis.

Data Collection

The data collection tool of choice was that of semi-structured interviews. This method was chosen because it was felt that it was the most appropriate method for a qualitative study. Gerson and Horowitz (2002) believe that this approach aids understanding of social processes and taken for granted assumptions.

Semi-structured interviews took place on three occasions: the initial interview took place in the pre-operative assessment clinic, the second one took place forty-eight hours following surgery and the final interview took place one month following surgery. The two latter interviews took place by telephone. Interviews lasted between

half an hour and one hour. The interview commenced with the request to describe their experiences on the day of surgery. This was usually all that was needed to encourage patients to disclose their views. Interviews were transcribed as soon as possible after taking place.

The research interview is a form of human interaction in which knowledge and understanding evolves through a conversation (Kvale 1996). In keeping with grounded theory, the nature of the interview changed as new data suggested new areas to explore. The early interviews were kept very loosely structured. The patients' responses would lead to further topics for discussion.

Rigour

Certain measures were in place to ensure the credibility of the study. Firstly the credibility of the interview process was assessed according to quality criteria devised by Kvale (1996). These include issues such as the spontaneity and richness of the answers, whether the interviewer attempts to verify his or her interpretations of the subjects' answers in the course of the interview, and that the interview is a story contained in itself that hardly requires any extra description and explanation (Kvale 1996). I propose that the data presented below will demonstrate that I have met the quality criteria as proposed by Kvale (1996).

The prolonged involvement of the researcher over a two year period added to the credibility of the study as insights gained by the researcher could be checked at subsequent interviews. Finally an audit trail was created giving extensive details of the decisions made by the researcher and descriptions of the analytic process (Polit and Hungler 2004).

Analysis of Data

The analytical process involved coding strategies: the process of breaking down interviews, observations and any other appropriate data into distinct units of meaning which are labelled to generate concepts. Concepts are described by Glaser as being the “underlying meaning, uniformity and/or pattern within a set of incidents” (Glaser 1992p38). These concepts are then grouped into descriptive categories. They are then re-evaluated for their interrelationships and through a series of analytical steps are gradually evolved into higher order categories, or one underlying core category which suggests an emergent theory (Glaser 1978).

The analysis began with a full transcription of an interview, after which the text was analysed line by line in an attempt to identify key words, phrases and incidents which connect the informants account to the experience under investigation. This was a very time consuming activity but vital as it forced me to open up to all possibilities that the data might yield (Glaser 1978).

The data was labelled line by line as I asked “what is this statement an example of? What is happening in the data?” Glaser advised asking these questions to identify a central phenomenon or core category around which sub-core categories revolved (1978:57). Thus open coding led to the initial discovery of the core category of therapeutic relationships. The properties of this category, identified from the interview data included codes such as : warmth, trust, friendliness, superb staff, joking, humour, recognition, well-looked after, looking after me, one-to-one attention, told jokes, supportive, felt really special, put arm around back to support me, has some regard for you, extra-special, comfort, comfortable.

Four sub-core categories emerged from the data these were: presence, extra special, befriending and comfort giving. These will be discussed further below.

Findings

The day surgery patients were physically present in the day surgery unit for an average of four hours. They could be fully conscious for only a third of the time that they were on the day surgery unit. It therefore came as a great surprise to find that fleeting relationships made by the patients within a short time frame were subjectively very important to them and therapeutic in nature. This was a very strong theme that emerged from the data at an early stage of fieldwork and continued throughout. As the site of data collection moved between the two distinct day surgery units the data remained consistent. Patients felt sustained, comforted and affirmed by the relationships formed whilst on the unit. From a sample size of 145 patients, 138 commented very positively concerning the therapeutic nature of nursing interaction whilst on the day surgery unit.

However before discussing the categories that emerged it is necessary to examine patient expectations prior to day surgery as these may have influenced the subsequent findings.

Patient Expectations

Largely the patients had little knowledge of the day surgery process. Their testimony implied that they were expecting less of the service than they received. Consequently they expressed surprise that so much care was being taken of them:

“I had no idea that there was so much to day surgery. I mean there was coming to the pre-operative assessment and all the things they did to you there and all the questions they asked you. Then when you came in on the day... I mean I was hardly ever left alone for a minute. I had people coming to me all the time. It was wonderful (Claire age 58).

Because the patients were on the day surgery unit for only a very short period of time it could be concluded that it is not possible to establish a therapeutic relationship between staff and patients. Indeed many of the day surgery patients were surprised themselves with the intensity of positive emotion they felt towards the staff:

“I thought that I would be in and out. I thought I would just be pushed along working my way to the top of the queue but it wasn’t like that at all. They really had time for you. The nurse told me she was my “named nurse” I asked her what that meant and she said she would be looking after me all the time I was there. It was lovely. She told me all about her children.” (Hilda, age 55)

The nurse offering this care to Hilda may have considered that she was not offering anything special to Hilda. But the social conversation between patient and nurse was beneficial and affirming to Hilda. This patient received far more from the day surgery experience than she had been anticipating. Although this conversation with Hilda (above) may not be considered to be therapeutic in nature, studies have shown that the judicious use of the sharing of personal information between nurse and patient often acts as bridge to join two humans, each affirming the humanity of the other (Campbell1984, Meutzel 1988, Savage 1995).

Mary was pleasantly surprised by her day surgery experience:

“Although I have had previous surgery, I have never had day surgery before. I must admit I was quite anxious. But I generally found this experience to be a positive one. Nurses were always in the immediate vicinity. I only had to look up from the book I was reading and one would come over to me and ask if I was ok.” (Mary age42)

The mere presence of the day surgery personnel appeared to be a therapeutic, comforting experience. If the sense of that presence conveyed having time for the individual as well as an efficient stance then it appeared to be doubly therapeutic.

The above instances display how individuals' perceptions of the service they received were enhanced because they received more attention than they were expecting.

However if perceived care had not matched up to their expectations then relationships were damaged and the patients expressed disappointment:

“She (nurse) asked me if I was happy to have surgery done as a day case. I tried to tell her that I would have preferred to be in a few days but I have my 93-year-old mother to look after so I could only stay for the day. I might as well have been talking to the wall. She made no acknowledgement of my problems. (Anthea , age 60)

Here Anthea was disappointed. She perceived the nurse's attitude to be non-caring, but her testimony also suggests a non-presence. Although the nurse was physically present she was not engaging with the patient or sympathetic to her concerns.

Eight patients in the sample expressed disappointment in what they felt to be negative staff behaviour in their interactions with patients. Nora had expectations of how nurses should behave from her own training and experience as a nurse.

“I was getting more and more uncomfortable with the situation. The lady next to me was getting more and more distressed. No nurses had been by for a long time. I could see three of them in the nurses' station talking. I felt embarrassed by the lack of attention this lady next to me was getting. You see, I am a nurse (well actually I have retired now) and I don't like to see poor care and this is what it was. I hoped they would be more attentive when I came back from theatre.” (Nora, age 68)

She felt that the nurses here were not fulfilling their professional obligations. This made her feel uncomfortable at witnessing the patients' distress, worried about her own care when she returned from the operating theatre and embarrassed that the profession to which she had once belonged was, in her opinion, being dishonoured.

The number of patients criticising the staff as cited above, represent only a very small proportion of the total number of patients interviewed. Generally the criticism focused upon a perceived failure of the nursing staff to meet role expectations.

Overwhelmingly however the patients expressed warmth and gratitude towards the staff for helping them to get through the day surgery experience.

Sub-categories

Presence

Presence, particularly that of nursing staff, was implicit in all the activity taking place within the day surgery unit and was important to the patients. For some a continuous presence was important. The nurse constantly being at the side of the patient, engaging in “chit-chat”, personal disclosures or other distractionary activity such as reading magazines together was found to be very therapeutic by some patients. However, other patients did not want a continuous presence, they were content to be left to their own devices, but they still appreciated the presence of the nurse “within eyeshot” or as one individual said “coming and going” to give information concerning changes to the theatre timetable or to check if the patient had any immediate needs that could be met.

Josephine appreciated the continuity offered by having the same nurse assigned to her care all the way through her stay on the day surgery unit:

“It was lovely. She met me when I got there; told me her name and everything I needed to know. Then she stayed with me, took me to theatre, brought me back, and then looked after me until I came home. Lovely! First class service.”
(Josephine, age 70)

“Extra Special”

This theme had two strands: that in which the patient was made to feel special and when the patients perceived the staff to be “extra special.”

The patients indicated that therapeutic interactions could take place by both casual verbal encounters and expressions of empathy or physical acts towards the patient:

“Nothing was too much trouble for them. I kept asking for hot water. That was all I wanted. I must have had seven or eight glasses. It must have driven them mad. All those trips back and forward to get them for me. But they acted like I was special as if they wanted to do it for me.”
(Katherine, age 28).

A calm and reassuring attitude can also allow the patient to feel that they were receiving extra special care:

“The nurses were wonderful. They were really special. Extra special. I mean, I was so frightened. I have never been in hospital before. I was crying with fright. But they were so calm and so understanding. Are they hand – picked to work there?” (Shiela, age 47)

When patients spoke of the service they received as being “special” or that the staff were “extra special” it often related to how they, as a result of that interaction, felt valued as individuals. Beatrice praised the staff for recognising how frightened she was. They were prepared to alter their routines to try to help:

“They took the trouble to move my bed round. They turned the bed to face the wall so I couldn’t see anything and that helped. That made me feel a lot better. I said to them “I feel like the Queen of Sheba being moved around on this bed.”
(Beatrice, age 57)

Being extra special did not usually mean, for these day surgery patients, long involved intimate conversations between patient and day surgery staff. Short casual interactions could be beneficial.

Befriending

Like “extra special” befriending means acknowledging the patient as an individual, sharing a common humanity, and engendering feelings of comfort and well being. There can be little doubt that befriending was much appreciated by the day surgery patients. Befriending is different to friendliness. Friendliness can be linked to cheerfulness; can be one-way, and surface. Befriending on the other-hand, is being aware of other, is purposeful and requires effort.

A patient proclaimed his gratitude to a nurse who interceded with the surgeon on his behalf: “she was more like a good friend to me than a nurse!”

However “befriending” did not always need words to convey the process. Practical support and empathic understanding were interpreted as expressions of befriending:

“ My children were so restless when I came but the nurse sat them down at a little table and sent off for food for them. They were thrilled. It came in a box just like McDonalds! Such a little kindness makes all the difference. I told her she was my best friend now”
(Debbie age 30)

Shared experiences and emotions between nurse and patient also indicated a befriending attitude to patients:

“I was waiting in the x-ray department for about two hours before I went to theatre. I enjoyed it though. The nurse told me all about her holidays in (*a site of Christian pilgrimage*).It was lovely to hear that as I had been there to” (Marion age 60)

Comfort Giving

It is difficult to separate the theme of comfort giving from that of “befriending” as it was apparent that patients received emotional comfort and reassurance from the befriending activities of nurses. However because many patients used the word comfort in their descriptions of satisfaction with the day surgery experience it was felt necessary to discuss this as a separate category.

There were many different dimensions as to how the patients experienced the phenomenon of comfort whilst on the day surgery unit. For example, a perception of a calm and smooth running environment was very important to the patients’ perception of comfort. This was perceived it as a reflection of the staff’s professionalism. Gareth expressed surprise at the efficiency of the day surgery process, which, he felt was in great contrast to press reports:

“It was a great comfort to me. They all had a job to do and they did it professionally. No messing about. The nurse held my hand and offered words of comfort to me as they put me to sleep. They were very friendly, but in a professional manner. I felt very reassured with their professional attitude. The NHS gets such bad press. I thought everyone would be fumbling around. I was scared stiff before I came in. But it was not like that at all. I felt really cared for.” (Gareth, age 42)

Feelings of being in control and trusting in the staff also gave rise to feelings of comfort:

I got great comfort from the staff .The entire experience (day surgery) is about entrusting your body and well-being to people whom you have never met before. I think some of the ways in which this trust was engendered in me was, well, by a few things really.....explanations of what to expect...general chit chat with the nurses...being in a ward with other people and seeing them go through the same process. I liked the radio playing quietly in the background; this conveyed a matter of fact feel to my being there.”

(Mary age 42)

The use of kind words, supportive touch, engagement with the patient on a personal level all contributed to feelings of safety and comfort of the patient. These gestures were not prolonged and were unremarkable in themselves. However they were remembered for a long time afterwards by the patients concerned.

Discussion and Reflections from the Literature

On first sight it may appear that the relationships described above appear to be superficial rather than therapeutic. However it is significant that the patients spoke about them at length in the two post-operative interviews conducted at forty-eight hours and one month after day surgery. Other studies have demonstrated that what may be seen to be routine interactions can have significance for the patients (Altshul 1971, Shattel 2004, Ward et al 2007) Neither do these conversations need to be of long duration or of deep psychological meaning to be important to the patient (May 1990)

What is of significance here is that in two busy day surgery units the patients felt supported, made to feel special and befriended by the day surgery staff. Many researchers have pointed out that the formation of therapeutic relationships depends upon reciprocity between nurse and patient: the mutual sharing of personal

information (Meutzel 1988, May 1991, Morse 1991). Certainly the patients in this study appreciated it when nurses gave them some personal information even if it may concern some seemingly insignificant details such as holidays and general family life.

Implicit in all the dimensions mentioned above is the presence of the nurse. The physical presence of the nurse has been found to be a source of comfort to the patient by many researchers (Parsons 1993, Bortoff and Morse 1994, Godkin 2001, Godkin and Godkin 2004, Mitchell 2005). In a review of the literature concerning nursing presence Godkin and Godkin (2004) state that demonstration of nursing presence theoretically results in a caring nurse-patient relationship. Doona et al (1999) states that nursing presence involves seeing the whole patient in context and acting accordingly. Finally, as the term suggests, nursing presence incorporates “being with the patient” (Doona et al 1999).

Teasdale (1995) invoking the attachment theory of John Bowlby (1969), states that patients may become attached to nurses like children to parents. Nurses, like parents, can be seen as a source of strength and protection in threatening situations. Therefore the mere presence of a sympathetic nurse may make patients feel better.

Researchers in day case and operating theatre departments have found this to be an important element of patient care (Parsons et al 1993, Leinonen et al. 1996, Rudolfsson 2003, Mitchell 2005).

In my study of one hundred and forty-five patients undergoing day surgery the presence of the nurse was of concern to the patients. However, how much “presence” the patients wanted was very much an individual matter. Some patients indicated that they felt comfortable if the nurse was within eyeshot whilst others appreciated much closer contact.

Be-friending and being made to feel extra special added to the feelings of comfort expressed by the patients. Kolcaba and Wykle (1997:12) asserted that “comfortable patients heal faster, cope better and become rehabilitated more thoroughly, and than do the uncomfortable.”

The patient’s testimony expressed above would appear to demonstrate that they felt supported during their time spent on the day surgery unit.

Conclusion and Relevance to Practice

This paper adds to the body of literature which examines theoretical and practical aspects of the therapeutic relationship. The data presented here demonstrates that therapeutic relationships can be developed within the day surgery unit even within a relatively short time-frame, and regardless of the business model of day surgery (Beals 2002). Patients felt that they had coped with day surgery not just from their own resourcefulness but because of the actions of the day surgery staff.

Patients coming into the day surgery unit were very anxious. They had little time to familiarize themselves with the unit and the staff. Therefore the presence of professional nurses who are prepared to interact and engage with the patients as individuals was a source of support for the patients.

Patient expectations were also important in contributing to the development of therapeutic relationships. If patients felt that role expectations were not being met then the development of therapeutic relationships was compromised.

It has long been recognised that nurses are central to providing a quality service for patients. Nurse –patient relationships therefore has a major effect on the patient experience. Abramowitz (1987 p218) said that nurses are the hospitals “good-will” ambassadors and “front-line representatives” therefore nurses need to be supported

from an organisational level to deliver this complex, often hidden aspect, of their work.

There is anecdotal evidence to suggest that nurses who work within short-stay environments are not always aware of the therapeutic potential of their interactions. It is important that day surgery personnel are aware of the importance of their interactions with the patients so that these may be strengthened and formalised and written into care plans and training programmes.

Limitations of the Study:

This was a relatively small study taking place in only two day surgery units.

Therefore it may be difficult to generalise the findings across all day surgery units. A further limitation of the study is that it relied solely on patient reports rather than on observed inter-actions between nurse and patients. It may have been useful to interview day surgery nurses to obtain their perspectives on the potential for therapeutic relationships in day surgery.

Furthermore it may have also have been of value if the nursing management and organisational structures of the two day surgery units had been investigated. The organisation of nursing care may have had a positive influence on therapeutic relationships. Although some patients did refer to having a “named nurse” this philosophical and organisational feature of nursing work was not explored in this study.

A further constraint was the sample population which excluded a large ethnic minority population. Unfortunately this study was unable to explore their views. A further study is planned to address this deficit.

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