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The Transition From Hospital to Home Following Coronary Artery Bypass Graft Surgery

by

Beth Ann Goudie ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Nursing

Faculty of Nursing

Edmonton, Alberta

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Year this Degree Granted: 1997

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Date April 30, 1997

"Nothing in the world will take the place of persistence: Talent will not; nothing is more common than unsuccessful men [*sic*] with talent. Genius will not; the world is filled with educated derelicts. Persistence and determination alone are omnipotent".

Anon

Dedication

To my mother and father for their loving efforts aimed at fostering in me a keen sense of inquiry with an element of sensitivity and perseverance.

And to those research participants who willingly shared their experiences and stories with me. Not only have you afforded me the opportunity to learn, you have expanded my understanding and ability to listen.

Thank you; I have been privileged.

Abstract

Ethnographic premises were employed to develop an understanding of what the transition from hospital to home was like for those CABG patients and their primary caregiver who were discharged within 4 to 5 days of cardiac surgery. The findings of this study indicate a theoretical framework surrounding the experience of CABG surgery. This experience is viewed in five general stages; testimonial, preoperative waiting, preparation work, inhospital, and home recovery. Furthermore, each stage was delineated by definitive themes. The core component, central to the progression through the different stages was the development of a sense of personal authority. Also, the importance of the role of the caregiver as exemplified by the degree of protective vigilance and the recognition of a sense of discharge readiness became apparent. In describing the perceptions of the patients and caregivers surrounding their experience, the need for educational strategies reflective of their individualized needs is warranted.

Acknowledgements

I wish to acknowledge and thank the people who have been instrumental in the shaping and completion of this research study. First, my thesis supervisor, Dr. Marion Allen. Her wisdom, genuine enthusiasm, and ability to effect disciplined nursing research made the journey through the tides of discovery less turbulent. Her belief in me as a student were only matched by the untold hours of editing and encouragement.

To Dr. Louise Jensen, for sharing with me her excellence in the area of cardiovascular nursing. Her strong knowledge base and passion for clinical scholarship added much fuel and direction. The insights she shared and the questions she raised served only to further structure and refine the design of this study.

To the other members of my thesis committee, Dr. Arvind Koshal and Dr. Margaret Haughey, for their interest, support, and expert appraisal throughout the course of this research study.

To Donna Anstey, Terressa Earnshaw, and the many staff members of the host institution who patiently addressed all of my questions and assisted me in obtaining the sample.

And once again, much appreciation is extended to my former classmates and friends, Sue and Shauna. For their openness and constancy in the face of life's realities.

I owe all a great debt.

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CHAPTER 1: Research Overview

A recurring theme in the present health care system is one of change. A variety of forces are shaping health care, including the aging of the population, advances in medical technology, and increasingly aggressive efforts to control health care costs. Canada's record of health expenditures to date reveals an increase from $67.0 billion in 1991 to 9.7% of the Gross Domestic Product (GDP) or $74.3 billion in 1994 (Statistics Canada, 1994). In the endeavour to control health care costs, prospective pricing has resulted in efforts to increase the productivity, efficiency, and effectiveness in the delivery of health care services. Hospital mergers, regionalization in the purchasing of supplies and the provision of costly specialized services, hospitals subcontracting for services with other agencies, and shortened postoperative hospital stays play witness to the impact of these cost containment efforts (Armstrong, Armstrong, Choiniere, Feldberg, & Lexchin, 1994; Brooten et al.,1988). As shortened hospital stays become common practice, patients in all areas are affected.

In March of 1992, the University of Alberta Hospital began the 'Early Discharge Program' for cardiac surgical patients in collaboration with the Edmonton Board of Health (EBH). This project was designed to blend the boundaries of the hospital institution with community based facilities by offering home care services as an alternative to acute hospital care following coronary artery bypass graft (CABG) surgery. While in its infancy, the program was only offered to Edmonton residents. Only 2 patients per week were accepted into the program during the initial month of operation. In November of the same year, 3 patients per week were being entered into the program and by February 1993, the program was being offered to 4 cardiac patients per week (T. Earnshaw, personal communication, May 19, 1995). As the number of patients having cardiac surgery at the University of Alberta Hospital increased from 556 in 1990/91 to 849 in 1993/94 (University of Alberta Hospital, 1994), the program evolved, and the mandate broadened to accommodate this growing patient population.

Presently, the University of Alberta Hospital and the Capital Health Authority Home Care Program are cooperating in the administration of the 'Cardiac Surgery Discharge Program' for patients following CABG surgery. As of March 1994, patients who are identified as being medically stable following CABG surgery are being discharged within four to five days postoperatively. If patients choose to become involved with the program, consent is obtained and arrangements for follow up home care services are completed. Otherwise, patients may decide to return home without the provision of any follow up visits from the Capital Health Authority cardiac home care nurses. Even residents from outside of the city are recognized as suitable candidates as long as their recovery period is spent within the Edmonton area. With the advent of the Cardiac Surgery Discharge Program, a considerable improvement in the length of the waiting lists for cardiac surgery has occurred; for "in October 1991, there were 296 patients on the waiting list, and they waited an average of 189 days" (University of Alberta Hospital, 1993, p.5). Presently, there are 269 patients on the waiting list, and the mean waiting time has decreased to 140 days (D. Anstey, personal communication, October 29, 1996).

The concept of a shortened hospital stay is endowed with advantages and disadvantages from the vantage point of both cost and quality of care. The possible advantages include the reduction in the cost of hospitalization (Hamilton, Norris, Wensel, & Koshal, 1994), a potential to decrease iatrogenic problems as the overall length of hospitalization is reduced (Brooten et al, 1988), and individuals are returned sooner to the familiar surroundings and comforts of their home and family. Yet, since a shortened hospital stay results in less time during hospitalization for health care professionals to instruct the patients regarding the self-care practices necessary to further their recovery within the home environment, the possibility for successive readmissions may result (Leiby & Shupe, 1992). A shortened hospital stay has been criticized for placing an additional burden on the patient's family or caregivers. Meneses and Burgess Perry (1993) have identified role reversals, the relinquishment of roles, and the acquisition of new roles and obligations as responsible for disruption in the family unit, when the demands of caregiving are placed on the family unit. Also, due to the complex and often time consuming nature of the provision of care, a shortened hospital stay may result in caregivers losing extra time from employment (Schwartzberg, 1982; Shegda & McCorkle, 1990).

Statement of the Problem and Research Question

The present health care system and the delivery of nursing care is guided and governed by existent health plans and policies. Although a shorter hospital stay can be welcomed for a variety of reasons, its full implications have not yet been examined. For those of us who continue to believe in the underlying value of individual autonomy and consumer choice, our vision must look beyond the inside of organizations of health care to the outside, where the patients and their caregivers reside. If health care consumers are going to benefit from a "seamless continuum of patient-centered care," (University of Alberta Hospital, 1993) during the transition process from hospital to community home care, their perceptions remain a crucial factor in the equation underlining quality care. Since there is no substitute for the richness of consumer perceptions, we must acknowledge the unique and important contributions of these voices in describing the critical period encountered during the transition from hospital to home. The purpose of this study was to explore and describe the perceptions of CABG patients and their primary caregiver regarding the transition from the hospital to the home environment. For the purpose of this study, the CABG patient and his or her primary caregiver were considered one unit of care.

The primary caregiver was whomever the CABG patient identified in that role. The findings of this study have the potential to improve and enhance the quality of nursing care. The identification of similarities and differences in consumer concerns and preferences will provide a base for future practice innovation and development.

CHAPTER 2: Review of the Literature

The adjustment to coronary events, such as CABG surgery, has been widely discussed in the literature. Extensive research has identified cardiac surgery as a 'multidimensional phenomenon', riddled with extreme stress and emotion (Allen, Becker, & Swank, 1990). The patient and caregiver are exposed to a myriad of stresses created simultaneously due to the acute nature of CABG surgery and the chronic stressors related to its underlying etiology, coronary artery disease (CAD). Most of the available research that addresses cardiac health focuses primarily on the individual patient's physiological, psychological, and functional adaptation. Although the physiological and the psychosocial aspects associated with having cardiac surgery are of an interrelated nature, for clarity, they will be addressed separately.

The Physiological Adaptation of Patients Following CABG Surgery

Examination of the patient's perceptions of recovery following CABG surgery, has delineated the prevalence of many physiological symptoms. Redecker (1993) described the prevalence of symptoms experienced during the first postoperative week within the hospital, during the third through fifth postoperative weeks, and at 6 weeks after CABG surgery. The most common and persistent problems included pain, edema, wound drainage, fever and fatigue, sleep problems, and shortness of breath. Similarly, in an anecdotal description of recovery problems, Lovvorn (1982) described weakness and fatigue as two of the most persistent problems. Furthermore, unusual physical sensations (amount and odour of perspiration, loss of taste acuity, and sleep disturbances) are common for 3 months, arrhythmias are frequent in the first few weeks, incisional discomfort occurs for up to 3 months, and up to 60% of patients have postcardiotomy syndrome in the fourth postoperative week (Lovvorn, 1982).

Following cardiac surgery, the patient's recovery may be impeded by the effects of aging and an inadequate functional level for the performance of many activities of daily living. Physiological parameters and the effects of aging have been examined in relation to activity outcomes. Brown, Laschinger, Hains, and Parry (1992), for example, quantified the functional capacity, hemodynamic responses to low level exercise, and self-efficiency (SE) of 21 men on the day of discharge; an average of 6-8 days after surgery. The results revealed a decreased functional capacity ranging from 1.0 to 4.3 metabolic equivalents (METs)(stair climbing requires 4 to 8 METs of energy). Gortner, Dirks, and Wolfe (1992) reviewed the medical records of 215 elderly patients aged 70 and above. The postoperative nursing care and the recovery proved similar to that of patients under 70 years of age, except the pace was noticeably slower. The average length of hospital stay for these elderly patients was 10.5 days, which surpassed the seven days for those patients who were under the age of 70. For the majority of patients, fatigue and activity intolerance are reported to persist for several weeks following CABG surgery (Moore, 1996; Redecker, 1993; King & Parrinello, 1988).

Tack and Gilliss (1990) completed a prospective longitudinal study whereby 75 cardiac surgical patients and their family caregivers received a telephone call at 1,2,3,4,5 and 8 weeks after discharge. The five nursing diagnoses that occurred the most frequently were altered comfort related to increased pain, ineffective coping by the patient, activity intolerance, sleep pattern disturbances, and decreased nutritional intake. King and Parrinello (1988) portrayed similar findings, having conducted telephone interviews with 34 CABG patients over a two month period following their discharge from the hospital. In addition, McKnight Nicklin (1986), in a patient-initiated telephone callback system, discovered that the majority of the calls that occurred in the first week following hospital discharge dealt with cardiopulmonary concerns (31.1%), medication problems (14.7%), and gastrointestinal problems (13.4%).

Researchers have attempted to describe the often complicated sequelae surrounding the recovery phase associated with CABG surgery. Unfortunately, the majority of these studies, have not included information regarding the patient's length of hospital stay, as they have primarily focused on either the in-hospital postoperative period or on the recovery phase at home. As the protocol surrounding cardiac surgery evolves, an increasing number of medically stable CABG patients are routinely being discharged within 4 to 5 days of their surgery. Still, there is little or no evidence to suggest how these individuals are managing during the immediate period following their hospital discharge.

The Psychological Adaptation of Patients Following CABG Surgery

There is an increasing amount of empirical research concerning the psychological implications of cardiac surgery, the concerns of patients, and the process of coping used by the patients as they progress through the experience. The experience of CABG surgery forces the patient to face the possibility of his or her own mortality and the stress associated with having surgery on a life-sustaining organ (Brown, Glazer, & Higgins, 1984). Also, the patient must acknowledge the need for an altered lifestyle and the uncertainty of living with a chronic condition (White & Frasure-Smith, 1995).

While focusing on the hospital recovery patterns of cardiac surgery patients, researchers have identified the negative reactions to cardiac surgery. Postcardiotomy delirium (King, 1985), heightened anxiety, depression (Gundle, Reeves, Raft, & McLaurin, 1980), and intellectual dysfunction (Raymond et al., 1984) have been defined as potential problems associated with cardiac surgery. In the midst of the "dependence phase" following CABG surgery, feelings of helplessness, fear of impairment, and fear of dying interfere with the patient's attempts to evaluate and prioritize the stressors experienced while hospitalized (Bartz, 1988).

Best (1992) compared the perceptions of 33 patients and their nurses of the stressors involved in the CABG surgical procedure. Congruence between the two perceptions did not exist, for contrary to the nurses, the patients ranked "family worrying about patient", "having to depend on others", and "pain and discomfort" as the most significant stressors. These findings were further substantiated by a study conducted by Carr and Powers (1986). As well, less uncertainty and fewer symptoms of psychological stress are associated with increased levels of social support following CABG revascularization (White & Frasure-Smith, 1995).

While studying the process of coping, researchers have directed increased attention toward the existent variations in the coping strategies employed by patients. King (1985) studied the coping strategies, current concerns, and emotional responses of 50 patients during the preoperative period, the hospitalization period (average 8.64 days), and during a three week recovery period at home. The coping strategies included information seeking, direct action, turning to others, and the intrapsychic coping modes suggestive of avoidance, imagery, and positive thinking. Information seeking was perceived to be the most useful strategy during the preoperative period, whereas turning to others (talking with family and friends) was reported to be used the most during the recovery period at home. Curiously enough, positive thinking was the only coping style that remained constant over time. Redeker (1992), discovered that emotion-focused coping appears to be used in relation to uncertainty at both 1 and 6 weeks following surgery. Predominantly, patients used wishful-thinking coping (strategies to escape by using fantasy) and avoidance coping (strategies to psychologically distance oneself from the situation) in relation to ambiguity at 1 week and in relation to ambiguity and complexity at 6 weeks following their surgical experience (Redeker, 1992).

King and Jensen (1994) employed a grounded theory approach to understand the core process involved for women who underwent cardiac surgery. The respondents were initially interviewed 4 to 8 weeks following their hospital discharge. The second interviews were conducted at 2 to 9 months after discharge. The descriptions underlying their experience, began with the identification of their need for surgery and continued through to their present state. The strategies used by these women throughout the recovery phase to 'preserve the self', were relating, making sense of, managing, and normalizing what was happening to them. Keller (1991) also employed a grounded theory approach to explore the behaviours that would culminate in the restoration of patients to the presurgical state. Their descriptions began with the onset of symptoms and entry into the health care system and continued through the postoperative recovery period. The length of time following surgery in which the interviews were conducted ranged from 1 to 19 months. Individuals were primarily engaged in the process of seeking normalcy; characterized by the stages of surviving, restoring, and being fixed. Carroll (1995) examined the importance of the mediating effects of self-efficacy expectations in elderly patients recovering from CABG surgery. Data were collected at discharge (the mean length of stay was 10.8 days), 6 weeks, and 12 weeks after surgery. In this study, self-efficacy expectation is identified as an essential and strengthening mediator of the transformation of self-care from the perception of caring for oneself to the actual productive outcome of self-care recovery behaviours.

The course of recovery for the CABG patient proceeds along social, emotional, and physical dimensions. The patient's self image may change from feeling whole to feeling damaged, from feeling competent and self-reliant, to feeling incompetent and dependent on others (Dracup, Baker, & Edlefsen, 1984). The majority of research that describes the nature of recovery from cardiac surgery focuses either on the in-hospital postoperative period or on the recovery several months after surgery. What is experienced during the immediate period during the transition process after hospital discharge needs to be further examined.

The Experience of the Caregivers of Patients Following CABG Surgery

Besides its effect on the patient, CABG surgery affects the dynamic balance or routine of the entire family (Artinian, 1989). According to a growing body of research, families both aggravate and are affected by the impact of the patient's cardiac surgery (Gillis, 1991). Interestingly enough, considerably less attention has been paid to the impact of cardiac surgery on the spouse or family caregiver. The family caregivers are usually only addressed as context to the patient. Investigators have reported that cardiac surgery impacts the spouse more than the other family members (Artinian, 1989; Gillis, 1984; Hill, 1989). During the hospitalization, the patient remains relatively protected from the realities of life's obligations, while the spouse is faced with an ill partner whose prognosis may be uncertain, as well as other home responsibilities. Feelings of frustration, guilt, and anger have been associated with the increase in spousal responsibilities after a cardiac event (Miller, McMahon, Garrett, Johnson, & Ringel, 1983). Other dominating themes underlying the spouse's reaction to the cardiac event, include fear, anxiety, and depression (Cozac, 1988; Miller, McMahon, Garrett, Johnson, & Ringel, 1983). Coping methods employed included generating hope, seeking information, helping one's mate, remaining near one's mate, distracting oneself, developing a support network, and reorganizing roles and responsibilities (Cozac, 1988). Additional help has been cited as being derived from family and friends, faith in God, and self-confidence (Artinian, 1989).

McRae and Chapman (1991) utilized a grounded theory approach to investigate the experience related to being the spouse of a cardiac surgical patient. Data were collected on the day of hospital admission, during the first 48 hours of the patients' ICU stay, and just before the patients' hospital discharge (4th-6th postoperative day). The core category characterizing the experience of the spouses was identified as 'holding death at bay'. Artinian (1993) identified 4 main themes related to spouses' perceptions of readiness of discharge after a partner's CABG surgery. The themes included: (a) availability of social support; (b) use of coping strategies; (c) personal resources; and (d) knowing what to expect. The findings suggested that 62% of the women reported that they felt prepared for their husbands' discharge. Spouses who reported feeling unprepared believed that they did not have enough information, were alone in the caring for their husbands, or were unsure that they or their husbands could cope with being at home.

Recognition of the psychological difficulties encountered during the acute hospitalization is only the first step, for the emotional distress experienced by both patient and family caregiver may continue, and possibly intensify upon being discharged home. Researchers have documented increased family tension resulting from conflicting interpretation of spouse responsibilities and patient self-care activities (Dracup, Meleis, Baker, & Edlefsen, 1984). Similarly, social activity, role changes, sexual functioning, vigilance, and economic adequacy have been identified as problem areas of adjustment for spouses 4 to 10 weeks after their mates' CABG surgery (Stanley & Frantz, 1988). Anxiety, depression, low self-esteem, marital and sexual dysfunction, and psychosomatic symptoms have been reported among spouses for up to a year after a cardiac event (Miller, Wikoff, McMahon, Garrett, & Ringel, 1990). There have been few investigations that focus on the needs of the family caregiver during the immediate convalescent period at home after CABG surgery.

Hospital to Home Transition

It is important to recognize the historical context in which the preceding research was conducted, since the expectations regarding the health care delivery system are changing. Today, the concept of a shortened hospital stay following cardiac surgery has become the norm. Health care professionals are incorporating earlier patient discharge programs as one strategy for reducing health care costs. As a result, patients and their family caregivers must manage most of the recovery at home. Despite this trend, little attention has been directed toward the perceptions of the patient and their primary caregiver with regard to this shortened hospitalization experience and the transition from the hospital to the home.

Review of the existing literature reveals that the vast majority of research in relation to earlier patient discharge programs revolves around early postpartum hospital discharges (Campbell, 1992; Carny & Bradley, 1990; Hall & Carny, 1993; Harrison, 1990; Messier, 1993; Small, Lumley, & Brown, 1992). As earlier patient discharge programs are becoming common practice within many of the specialty areas, the need to thoroughly examine the effects associated with a shortened hospital stay is being recognized. Taylor, Goodman, and Luesley (1993) evaluated the convalescence of 50 hysterectomy patients discharged 3 to 4 days postoperatively. The establishment of a home care protocol for the earlier discharge of patients with hip and knee arthroplasties successfully addressed all of the postoperative problems (Rothman et al., 1994).

With the intent of accelerating recovery after CABG surgery, a new approach termed 'fast-track recovery' was instituted at the Baystate Medical Center and Hartford Hospital (Engelman et al., 1994). The fast-track (FT) method provided an alteration in the anaesthetic protocol which allowed for early postoperative extubation. In order to evaluate the effects of this approach, a retrospective 1-year analysis was conducted. The FT method was shown to be effective, as patients were discharged within three to four days of their cardiac surgery. Patient satisfaction with the FT experience was 77% favourable, whereas family satisfaction was 54% favourable (Engelman et al., 1994). Accordingly, the aforementioned studies recognize early discharge as a safe option. For the most part, the response to a shortened hospital stay was positive, yet the importance of the support given by the community nurses was greatly stressed.

The reasons for choosing a shortened hospital stay and the feelings associated with this experience have been suggested by isolated comments, rather than rich descriptions designed to provide a broad picture of the experience (Lemmer, 1987; McIntosh, 1984; Waldenström, 1986). Also, previous research has focused primarily on patient characteristics, their knowledge and use of services, functional status, readmission rates, and the identification of assistance provided by family members. What is known about the perceptions of CABG patients and their family caregiver regarding the immediate period following their hospital discharge? What are the perceptions of CABG patients and their primary caregiver to the current practice of being discharged within 4 to 5 days of cardiac surgery? Does the experience of the patients and their primary caregiver during the transition from hospital to home exemplify the findings elicited in previous studies, or are the parameters surrounding this experience unique? Information surrounding the situation encountered following a shortened hospital stay will serve to provide insight into the challenges encountered by these individuals and may provide a framework for developing policy interventions. The research question guiding this study was: What are the perceptions of patients and their primary caregiver of the transition from the hospital to the home following coronary artery bypass graft (CABG) surgery?

CHAPTER 3: Research Method

The art of nursing is reliant upon the knowledge and understanding of human experience associated with human health needs. Generated through research, this knowledge comprises the human science of nursing. In this manner, research is portrayed "as the means by which discoveries are made, ideas are confirmed or refuted, events controlled or predicted, and theory developed or refined" (Morse & Field, 1995, p. 1). Since qualitative and quantitative research methods produce different kinds of knowledge, this section will focus on clarifying the nature and purpose of qualitative research prior to detailing the ethnographic methods underlying this research study.

Qualitative Research

According to Morse (1992) qualitative research is characterized by three distinct features. These include an emic perspective, a holistic perspective, and an inductive interactive process of inquiry. The emic perspective allows the researcher to elicit the meaning or perception from the participant's point of view. This approach requires the researcher to enter into the participant's lived world of purpose, meaning, and beliefs (Robertson & Boyle, 1984). In this manner, qualitative methods "encourage study designs where the researcher and subject are part of a two-way process in which understanding develops in the development of theory" (Corner, 1991). A holistic perspective requires the researcher to value participants as unique individuals involved in the process of becoming and who must be studied in their own environment. No attempt is made to control the 'extraneous' variables or place experimental controls upon which the phenomenon rests (Field & Morse, 1985).

Finally the qualitative method is characterized by an inductive mode of research and an interactive process of inquiry. An extensive literature review revealed that no theory or prior research had addressed the specific research topic under study.

Moreover, the very nature of the research question being posed supported the use of an inductive qualitative research design. This process is directed toward bringing knowledge into view. The researcher's goal is to examine the data and identify descriptions, patterns, and hypothesized relationships between phenomena. Extending from specific examples of data, the researcher is able to conceptualize more abstract generalized ideas which eventually result in the identification of concepts, potential relationships, and the generating of theory development (Morse & Field, 1995).

Ethnographic Methods

Historically, the origins of ethnography are entrenched in the field of sociocultural anthropology, with a typical focus on describing the cultural patterns underlying social groups (Morse & Field, 1995). Spradley (1979) contends that the goal of ethnography is "to grasp the native's point of view, his relation to life, and to realize his vision of his world" (p.3). In effect, ethnographic strategies are a means of gaining access, discovering, and exploring the beliefs and practices of a culture in order to facilitate our understanding of their behaviour. Rather than studying people, ethnographers seek to *learn from* people, to be taught by them (Spradley 1979). Due to the interpretive nature of ethnographic strategies, the ethnographer moves beyond what is seen and heard to infer what people know.

As an appropriate approach to address the research question being posed, these ethnographic premises and strategies were employed. Categorized as a mini, focused ethnography (Muecke, 1994), the reader is reminded of the fact that the goal of this research was not to describe an entire cultural system, for total immersion into the delineated group of individuals experiencing a common surgical procedure did not occur.

Research Design

An ethnographic approach was incorporated to answer the research question. This approach enabled the researcher to explore and describe the "emic" or the participant's perspective of the transition from the hospital to the home following CABG surgery (Field & Morse, 1985).

Sample Selection

The participants for this study were purposively selected from those individuals scheduled for elective cardiac surgery at the University of Alberta Hospital. Inclusion criteria for this study were as follows: 1) the participants had undergone first-time elective CABG surgery; 2) the participants were identified as suitable candidates for discharge from the hospital within either 4 to 5 days or possibly 6 to 7 days of cardiac surgery; 3) the participants were able to speak and understand English; 4) the participants were willing and able to provide written, informed consent. The need for the participants to understand English served to enhance the richness of the narratives via the expression of their ideas, thoughts, and feelings regarding their perceptions. Repeat bypass candidates were excluded from this study as their perceptions regarding the experience might differ from those of patients who had undergone cardiac surgery for the first time. These criteria were introduced to aid in the recruitment of a more homogenous sample.

The only other distinguishing factor that served to differentiate the participants further was determined by whether or not they had consented or not to become involved with the Cardiac Surgery Discharge Program. Thus, the recruitment of patients who have either consented to being involved with the Cardiac Surgery Discharge Program or not existed. If any of the patients developed medical complications during their recovery period and were readmitted to the hospital, the possibility of continuing with the interviewing process would be evaluated. This consideration did not prove necessary. The sample was comprised of eleven participants; namely five CABG patients and their primary caregivers and one patient who returned home without the support of a primary caregiver. Each participant was interviewed on two separate occasions.

Data Collection Procedure

Initial contact was made with the cardiac care coordinators at the University of Alberta Hospital and the Capital Health Authority Home Care Program. Since the Cardiac Surgery Discharge Program is a collaborative project, letters of support were obtained from both organizations. Initially, the coordinator of the Cardiac Surgery Discharge Program at the University of Alberta Hospital assisted the researcher with primary selection, by identifying those individuals who met the inclusion criteria and were scheduled to attend the pre-admission clinic (PAC) each Monday. This approach enabled the researcher to recruit from a single consolidated population pool.

At PAC, the researcher introduced the topic of the research study, addressed any questions, and distributed an information letter to each of the potential participants (Appendix A). Potential participants would relay their interest regarding the study if they returned the reply form to the program coordinator. Since an immediate response was not solicited, the opportunity to reflect upon one's decision to participate was ensured. Failure to return the reply form to the cardiac coordinator indicated an unwillingness to participate. Following this, no further attempts were made to contact these individuals, thereby eliminating the chances of coercion. For those participants who returned the reply form, the researcher would then meet with them in the hospital following their surgery. In hopes of easing entry and establishing a preliminary sense of rapport, my role as a researcher was reinforced, the purpose of the research reiterated, and any additional information provided as required. Once the potential participants had agreed and demonstrated a commitment to the study by signing the consent form (Appendix B, Appendix C), background information (Appendix F, Appendix G) was gathered and arrangements pertaining to the first interview were made prior to their hospital discharge.

However, due to practical and administrative reasons, this approach proved ineffective. For many, the proceedings of the day at PAC were described as exhausting and the volume of necessary information obtained overwhelming as they anxiously awaited their dismissal home. The expectation surrounding the contact of the patients or their primary caregiver with the cardiac coordinator was unrealistic, as the demands of her administrative role reduced the degree of her accessibility and this pursuit of contact was not independently executed by any of the individuals. Consequently, the recruitment process was refined and a more direct approach adopted.

The boundaries of the recruitment pool were expanded beyond the confines of PAC, to include also those potential participants classified as "elective patients" who had not been involved with PAC, yet were routinely admitted to the hospital the night before their scheduled surgery. Although the introductory proceedings followed an identical path to those outlined in the preceding paragraphs, if the potential participant demonstrated a genuine interest in the study then the consent form was signed immediately prior to their surgery. Attempts directed toward achieving a daily recruitment regime enabled the researcher to visit with those consenting participants following their surgery. This humanistic measure not only reinforced my value and interest in them as autonomous individuals, it also established a sense of rapport and marked the beginnings of a trusting relationship. Prior to the participant's hospital discharge, plans were made regarding the first interview.

Interviewing

The major strategy of data collection employed in this research study was that of in-depth interviewing. This mode of interpersonal interaction allowed for self-reflection by the participants as they relived their experiences, conveyed information regarding their perceptions, and shared narratives that highlighted their life-world and their relation to it (Kvale, 1983).

In the comfort of their homes, initial face to face contact was made with all of the participants. The provision for telephone interviews for those participants who lived outside of a 60 km radius of the city proved unnecessary for this study. In order to explore the perceptions of both the patients and their primary caregivers, separate interviews were conducted. Since both individuals were at home during the home visits, a detached area or enclosed room was selected to ensure complete privacy during the interview sessions. An eagerness to be interviewed was demonstrated by both parties, as two separate interviews were conducted during each home visit. The researcher adopted the "observer-as-participant" role and utilized observation and semi-structured, open-ended interviews as the primary means of data collection (Field & Morse, 1985; Spradley, 1979). Participant observation enabled the researcher to register and interpret vocalizations, facial expressions, and other bodily gestures while listening intently to the stories being told.

The interviewing process followed an inductive approach; moving from a broad generalized scope to a more defined and specific focus, once salient parameters were identified. The first interview commenced with global questions at a superficial level designed to elicit the free and indepth expression of the participant's unique perceptions. In the early stages of interviewing, considerable trial and error revolved around the ordering and wording of questions as they were literally field-tested with the participants (May, 1991). These initial interviews were unstructured in nature as the researcher knew very little about the topic and wanted to elicit considerable depth and insightful material without controlling the flow of that information (Morse & Field, 1995). The use of an unstructured format cast the researcher into the role of a "ludicrous tenderfoot"; (Morse & Field, 1995) a learner, thereby minimizing the influence on what was said. The admission of verbal freedom by the participants enabled them to develop personal feelings of comfort and reciprocal respect as they ventured into areas requiring personal expression.

The initial interview with each new research participant was conducted in an identical manner. The participant who was not to be interviewed first departed to another area of the house where they remained throughout the duration of the first interview. During their absence they completed the appropriate biographic questions. After setting up the tape recorder, the researcher attempted to detract from its presence with small talk before the rights of the research participant in relation to the study were reviewed. Accordingly, their anonymity was again emphasized and on-going consent was assured. The first scheduled unstructured interviews lasted approximately forty-five to ninety minutes. On occasion, consideration of fatigue levels or physical discomfort necessitated either the implementation of a short recess period or the termination of the immediate interview altogether.

During the second interviews, as the participant's stories began to unfold, the interview agenda became more structured, in order to explore areas of special interest, test preliminary findings, or discover areas of emerging constructs of commonality and difference (May, 1991). Probing questions were employed to substantiate or elaborate upon prior responses while guiding the inquiry into areas of special interest that warranted further exploration. The use of probing questions allowed the researcher to redirect the discourse or focus the direction of the interview by prompting the participant to discuss areas that had not been previously ascertained.

These additional interviews took approximately forty-five minutes. To allow for clarification on points that remained unclear, the researcher built in the provision of conducting a third interview over the telephone.

All of the interviews were audio taped and transcribed verbatim by a transcriber. The researcher reviewed all of the taped interviews while cross referencing to the typed transcripts. This ensured the systematic consistency of the transcription process, enabled the researcher to know the data, and as well it indicated where additional questioning was needed. Since all of the interviews were transcribed verbatim by a transcriber, this provided the researcher with the necessary time to become enmeshed within the process of concurrent sampling, data collection, and analysis.

In addition to the interview data, an ethnographic record, consisting of fieldnotes, tape recordings, and anything else which documented the proceedings under study, were realized (Spradley, 1979). The biographical data forms (Appendix F, Appendix G) outlined those characteristics used as indicators of this special population. This information served to broaden the researcher's understanding, as it outlined information that had a direct bearing on the participant's implicit perceptions of their experience. Also, this information helped explain the existence of a negative case; a participant atypical of the group.

Fieldnotes added significantly to the thick description necessary in the reporting of this qualitative research as they described the setting, the non-verbal behaviour of the participant, and other relevant occurrences (Rodgers & Cowles, 1993). Thus, contextual fieldnotes, consisting of jottings of salient points were dated and collected throughout the duration of the interviewing process. After each interview had ended, the researcher composed an addendum of descriptive phrases that served to add to the context of the experience. In this manner, the fieldnotes represented an objective, descriptive account of what actually transpired during the interviews. Since the fieldnotes described the subtle details associated with the authentic findings, they explicated a succinct audit trail, thereby enhancing the replicability of the study and the ultimate establishment of trustworthiness (Rodgers & Cowles, 1993).

Methodological and analytical documentation was recorded in the form of memos. These memos highlighted the researcher's rationale for ongoing methodological decisions, and specified the researcher's thought processes during the sorting, categorizing, and comparing of the data. Also, the researcher kept a personal diary in order to collect the personal thoughts, emotions, and insights that arose during the concurrent sampling, data collection, and analysis stages. This diary enabled the researcher to explore her ideas, biases, or any idiosyncrasies that may prove relevant to the study. Again, this documentation substantiated the rigor of this qualitative research.

Overview of Data Analysis

The initial analytic process was involved with the process of recording and analyzing the fieldnotes and interviews. The audio taped interviews and written transcripts were reviewed in a complementary fashion. The written transcripts were double-spaced with a blank line between the speakers and generous margins. This format enabled the researcher to code and add comments regarding the content. Three duplicate copies of the transcripts were made and the original copy remained separate from the working copies (Field & Morse, 1985). In order to become extraordinarily familiar with the data, the various interviews and accompanying transcripts were reviewed and cross-referenced on numerous occasions. Different colored sheets of paper were used to differentiate the different transcripts. Repetitive reading facilitated the identification of common concepts, themes, incongruencies, puzzling data, or folk terms entrenched within the interview data. The transcripts were then cut up and different segments which signified emerging concepts or themes were then pasted together.

At this stage of analysis, the emergence of "sensitizing concepts" or common themes, provided the researcher with a general sense of reference, as the embryo of the emerging theory. Although these concepts did not resemble well-defined elements of an explicit theory, they were suggestive of the directions along which to look and direct further data collection (Hammersley & Atkinson, 1983). The analysis of the interview data was dialectically linked to concurrent sampling and data collection. Alternatively, "definitive concepts", which clearly prescribed the common characteristics and attributes within classes of object revealed more specificity (Blumer, 1954). The definitive concepts were then grouped into analytic categories. By the time the last interviews were analyzed, no new instances of behaviour were identified that did not fit within the previously defined analytic categories. In this manner, saturation of the categories was attained.

The next step in data analysis involved discovering the links between the categories, while adding new ones during the progression of data collection and analysis. The emergence of a theoretical scheme (linkages between the concepts) was achieved by utilizing the "constant comparative method" of data collection and data analysis (Glaser & Strauss, 1967). Each segment of data was taken and compared and its relevance to one or more of the categories was ascertained. This method served to demonstrate and map the patterned range and variation of any given category in relation to the other categories (Hammersley & Atkinson, 1983). The links between the categories were noted, described, and developed, as this is where the initial generation of hypotheses relating to the linkages occurred. The use of flowsheets and maps were designed to depict the evolving interrelationships or linkages between the various categories. The initial group of categories that differentiated a particular range of a phenomena was developed into a systematic typology. The clear specification of the dimensions underlying this typology encouraged systematic consideration of the nature of each category and its relationship with other categories (Hammersley & Atkinson, 1983).

The maintenance of consistent documentation regarding all phases of the analysis was completed. In order to ensure a rigorous analysis, each theoretical insight and speculation regarding possible conceptual links within the lines of inquiry was recorded. Conscientious review of these analytical fieldnotes by the researcher and the members of the thesis committee, served to demonstrate potential sources of bias, as well as, any inconsistencies in the interpretation of the data (Robertson & Boyle, 1984).

Reliability and Validity

Issues of Rigor and Steps Taken to Ensure Rigor

Sandelowski (1986) has developed a framework for achieving rigor in qualitative research. The criteria for the assessment of rigor or trustworthiness; namely, credibility, fittingness, auditability, and confirmability were utilized to evaluate this research study.

Credibility was achieved when the participants were able to immediately recognize the human phenomenon as their own, due to the faithful descriptions and interpretation of discovery revealed in the research findings. Strategies used to establish the credibility of this study included: 1) review of the first interview by the thesis committee supervisor to critique the quality of the interview questions and to determine the researcher's ability to actively engage with the participants; 2) the continual completion of fieldnotes and memos throughout the research study, to explicate the rich nature of the participant's experiences as they are lived and perceived; and 3) the researcher kept a personal diary, in order to interpret personal behaviours and experiences as a researcher and to identify any inherent biases which may ultimately affect the credibility of the research findings.

The fittingness of this research study was reflected in the use of vivid exemplars, which reflected the rich nature of descriptions well-grounded in the lived experience surrounding the transition from the hospital to the home. Strategies used to ensure the fittingness of the research study included: 1) concurrent sampling, and constant comparison during the data collection and analysis stage, in order to derive a theoretical purposive sample that clearly exemplified the identification of phenomena, concepts, and potential factor-relating relationships; and 2) periodic peer review by the thesis committee supervisor of the personal, contextual, and methodological documentation in order to identify any assumptions or biases that may distort the analysis of the research findings.

The study and its findings are auditable, when another researcher can clearly follow the "decision trail" used by the initial researcher, in order to arrive at the same or comparable conclusions (LeCompte & Goetz, 1982). The use of accurate and synchronized documentation throughout the research study created a well-delineated audit trail.

Confirmability refers to the neutrality or freedom from bias exhibited in the proceedings and subsequent findings of the research study. Confirmability is achieved when auditability, truth value, and applicability are established. The strategies employed to facilitate the confirmability of the research findings have been previously outlined and identified in relation to the creation of a logical and clearly documented audit trail.

Ethical Considerations

Informed Consent and Access to Participants

Participation in this study was voluntary. Primary selection of the purposive sample helped to eliminate any element of coercion. Throughout the proceedings of the research study, the participants freely indicated a willingness to be involved in the study. Informed consent was obtained from each participant. The researcher discussed the underlying impetus and purpose of this study and explained the method of data collection and the extent of the time commitment involved. Appropriate discussion ensured that the participant knew and understood the research proceedings and the roles of others who may be involved. Assurance of my role as an independent researcher was reinforced, in order to eliminate the perception of the researcher as someone with power over the care received by the CABG patients.

To facilitate the participant's understanding, the consent form was written at a grade eight level as determined by the Right-Writer computer program. The potential participants were aware of their right to withdraw from the research study at any time without penalty, the right to ask questions concerning the research, and the right to be informed of any potential harm or benefits inherent in the research study (Ford & Reutter, 1990). Two copies of the consent form were signed, one for the participant and the other for the researcher. A summary of the results was sent to those participants who wished them.

Confidentiality and Anonymity

Although the participant's identity was shared with the researcher, strict adherence to the concept of anonymity safeguarded the disclosure of the identities of the participants from others. No identifying information was recorded on the background biographical data forms, as only a code number was assigned to each participant. Corresponding code numbers served to further differentiate the audio tapes and transcripts. The use of a numeral designation ensured the anonymity of the participants when the research findings and detailed exemplars were reported in a thesis, and in papers designed for publication or conferences. Access to the raw data remained the privilege of only the researcher, the transcriber, and the thesis committee members. The information known to these individuals was held in strict confidence. The consent forms and the background biographical data remained safely locked in a cabinet for the duration of the research study. The transcripts and audio tapes were kept in a separate locked cabinet, where they were readily accessed during the data collection and analysis stage by the researcher. Following the completion of the research study, the transcripts and tapes will be retained for seven years, following which they will be destroyed, in accordance with the specifications outlined by the University of Alberta.

Risk versus Benefit

There are no perceived risks, nor any direct benefits for the participants who choose to become involved in this research study. None of the participants found the recall of certain information distressing. Had this not been the case, the appropriate Capital Health Authority agency would have been notified following consultation with the particular individual. Although participants may not have benefited directly from their involvement, perhaps the relating of their perceptions may have served as a method of catharsis providing them with the opportunity to express their personal feelings, increased their awareness of their own situation, and allowed them the chance to tell their stories and to be heard. Other indirect benefits may have accrued to the participants. For instance, they may have volunteered in order to enhance their sense of purpose, to address an altruistic desire to help others in similar circumstances. The sharing of the findings of this study may assist in the refinement of the option of earlier discharge for other individuals by ensuring its smooth functioning.

In accordance with the policy statement designed by the University of Alberta Faculty of Graduate Studies, ethical clearance for this study was obtained from the Faculty of Nursing at the University of Alberta. Letters of support were received from the University of Alberta Hospital and the Capital Health Authority Home Care Program.

CHAPTER 4: Presentation of Research Findings

The overall aim of this chapter is to present an accurate description and understanding of the participant's social world. The reality surrounding the critical period encountered by participants during their transition from hospital to the home following CABG surgery is presented. Diers (1995) noted that "the very nature of nursing practice necessitates hearing and understanding the language of others" and "scholarship requires making that understanding conscious" (p. 4). The very nature of this task forces the qualitative nurse researcher to balance the tensions between the preference for subjectivity (emic approach) that arises from the interview data with the essential measure of objectivity (etic approach) that mediates the stage of data analysis (Robinson & Thorne, 1988).

The researcher quickly grew to appreciate the interview data as important in and of itself, for amid the rich details of the commentaries lies a reflection of the participant's subjective expression. Beyond the initial point of curiosity, the researcher recognized the participants as sources of influence and subsequently struggled to gain access to the processes or perspectives being examined; to see the data as its own members do and to make sense of it. Periods of reflection and immersion with the data were interspersed with segments of temporary abandonment, in order to allow for the generation of objective interpretations and inferences which successfully mirror an understanding of the participant's reality. In order to accurately and fully represent the perspectives of this particular group of patients and their primary caregivers, it remains essential to first describe the representative characteristics of this sample population.

Characteristics of the Sample Participants

The recruitment process proved to be an arduous task denoted by an 8 month period of daily visits to the hospital units. On many occasions, the patients and their caregivers appeared terribly overwhelmed by the circumstances surrounding their impending cardiac surgery. While attempting to preserve a certain reserve of emotional energy and a sense of security, these dyads were very prompt in voicing their decisions to decline. Any added responsibilities were deemed unnecessarily demanding. Likewise, the involvement of still other patients with other concurrent research projects further reduced the immediate pool of prospective participants.

The final sample population was composed of eleven participants; five CABG patients in combination with their primary caregivers and one patient who chose to return home independently without any form of additional support. Ultimately, the composition underlying the two distinct groups; that of patient and primary caregiver did not reflect an arrangement of mixed genders, for the sole female patient who volunteered to participate in the study died shortly after her surgery. The loss of this valuable perspective is deemed a limitation of this study, warranting future attention and research. The findings of this study are discussed in light of the fact that all of the patients were male and the caregivers female.

Within the patient group, the age range was between 45 to 71 years, with two men each in the fourth and fifth decades of their lives. Four of the patients described high school as the highest level of education obtained, whereas the other two men had completed university degrees. All of the participants with the exception of the eldest participant, had been employed on a full time basis immediately prior to this current change in their health status. Although retired for the last ten years, the eldest participant worked on a part-time basis. The specific occupational range included college instructor, social worker, meteorological technician, sales person, construction superintendent, and farmer.

Three patients took part in PAC prior to their surgery, whereas the other three patients, who were classified as elective cases, had been transferred from other hospitals the afternoon prior to their scheduled times for surgery. The time lapse between attendance at PAC and the actual surgery was eight and nine days in two instances. For the third PAC participant, there was a delay of 3 months due to the postponement of his surgery on eight different occasions. For each patient, the results of an angiogram confirmed the need for CABG surgery. The waiting period following this diagnostic test to the occasion of surgery was highly variable across the sample. The shortest waiting times were 11, 14, and 17 days. The two remaining individuals waited for 12 weeks and 6 months, respectively.

Whereas, half of the patient sample had previously experienced a "heart attack" prior to this hospitalization period and three patients had previously undergone other surgery, all agreed that they had never encountered surgery of such a severe nature. The only additional medical conditions presented included diabetes and the existence of back problems in two separate instances. Variance in the length of the hospital stay existed. The length of hospitalization for four of the patients was 5 days. The eldest patient remained in the hospital for 7 days, and the youngest patient returned home after 3 days.

Throughout the event of this research study, the role of primary caregiver was fulfilled by the patient's spouse. Their age range was between 38 to 68 years. Aside from the one couple who shared identical ages, the spouses were generally 2 to 3 years younger than their husbands. The greatest age difference was demonstrated by one female who was 18 years younger. The educational levels of the caregivers clearly matched those of their partner. Three of the caregivers had received high school certificates, and another two women had completed university degree programs. Three of the caregivers maintained full-time employment status as a bank clerk, occupational therapist, and case manager. The other two caregivers described themselves as domestic engineers remaining primarily at home.

Overall each caregiver described their health as being "good". Only one caregiver stated that she had elevated blood pressure and cholesterol, which were well under control. Following surgery each dyad returned to the familiar surroundings of their own home rather than any other alternative environment. The majority of the couples resided at home without the presence of children. One couple and the sole patient who returned home alone, both had two teenage children at home. Each of the caregivers who were employed took time off, in order to remain at home with their partner for the first two weeks following their surgery.

The Stages and Themes of CABG Surgery

When asked by the researcher to share their stories, all of the participants outlined an experience with an unprecedented chronological order. Clearly, five stages delineated the experience of having cardiac surgery. Discussion by the participants began with a description of the onset of the initial symptoms, and ended with the current recovery period at home. This denoted the **testimonial stage** and the **home recovery stage**, respectively. The interval between these two extremes was subdivided into the **preoperative waiting stage, the preparation stage,** and the **inhospital stage.** (see Figure 1)

In addition to these five stages there were two points of reference that participants routinely associated with a heightened expression of emotion, as these trigger points marked the transition into a new phase of the experience. The progression from the first to the second stage was interrupted by the event of being **"placed on the list"**. The second reference point was a sense of "**discharge readiness**" which surrounded the experience of leaving the hospital to return home. (see Figure 1).

Stage One: Testimonial

Placed on the List

Stage Two: Preoperative Waiting Period

Stage Three: Preparation Work

Stage Four: Inhospital Experience

Discharge Readiness

Stage Five: Home Recovery

Figure 1: The Progressive Stages of the Experience of Cardiac Surgery

Within each stage were a varying number of themes characterizing the different challenges faced by the couples and the strategies they used to manage these challenges (see Figure 2). For ease of presentation, the figuration and discussion of the themes are extended in a linear fashion; the order determined by the initial and prominent recognition of each theme in relation to the different stages. This is not to suggest that the themes are themselves distinct or solely limited by this representation, as the characteristics and effects of each theme are ultimately enmeshed within the other proceeding themes. The strong sense of reciprocity that existed within each couple invariably served to foster a partnership throughout the experience of cardiac surgery. Although both individuals encountered and progressed through the five stages together, the challenges and the strategies that they employed within each of the junctures were not necessarily identical in nature.

Stages	**Themes**
Testimonial	**Feeling Different* **Seek Medical Assistance* **Confirmation* **Necessity*
Preoperative Waiting	**Shadow of Uncertainty*
Preparation Work	**Information Search* **Having Faith* **Taking Stock*
Inhospital	**Preadmission Clinic* **Nursing Care* **Monitoring the Progress*
Home Recovery	**Self Improvement* **Being Alone* **Trusting Myself Again* **Futuristic Perspective*

Figure 2. The Underlying Themes of the Experience of Cardiac Surgery

Our Cultural Inheritance

The contextual grounding of human nature is vital to an understanding of the human behaviour that emerged in this study. The state of these men's health was indeed linked with the culture in which they live and their position within it, as well as in the way they live their lives as individuals. As good sons of patriarchy, the patients tended to worship at the altar of efficiency and productivity. Still, it is one's sense of personal authority that predisposes the acquisition of these two principle behaviours. Following repeated analysis of the data, recognition of an underlying vein or principle component which spanned the entire length of the cardiac surgical experience surfaced. The core category which emerged from the data, to which all of the stages were related was termed; " developing a sense of personal authority".

A Sense of Personal Authority

From the onset of symptoms to the final recovery stage at home, the patients and their caregivers struggled to develop a sense of personal authority. In and of itself, authority is characterized in the social science and medical indexes as an external regulatory force designed to govern human behaviour. The perspective surrounding a sense of personal authority portrays an intrapsychic phenomenon constructed of the interface of reality and meaning from which individuals view themselves and their world (Goldberger, 1996). This concept dictates in my mind the expression of self-reliance; the ability of the patients and their caregiver to develop the power in their lives in order to be committed to living, creating, balancing, and enjoying their health. In this manner, a sense of personal authority predisposes the acquisition of control or mastery over all other elements of life's domain.

To suggest that the couples had simply acquired a renewed sense of personal authority would be false, for new directives and strategies to which they had never been exposed were employed. As the different stages and themes underlying the experience of cardiac surgery are discussed, the prevalence and significance of this core category will become more integral and pronounced. Throughout the body of this chapter, verbatim statements will be introduced to illustrate these similarities and differences. In order to protect the anonymity of the participants, a numeric configuration will be used and any other identifying characteristics have been removed.

The Testimonial Stage

The testimonial stage marks the actual declaration of the patient's cardiac condition and the need for CABG surgery. Throughout the testimonial stage the patients were ultimately forced to acknowledge the reality of their situation. The recognition and knowledge of the symptoms moved beyond the patient's own level of awareness, to involve assessment by other health professionals. During this stage, a threatened sense of personal authority was confronted by the patients as the presenting symptoms and the defining diagnosis were perceived to remain beyond their control.

Feeling Different

Although the nature and severity of the initial symptoms proved variable, the onset was described by all as being sudden and without any warning. Although the patients were unable to continue to feel or do what they considered normal, they routinely attempted to downplay the severity of their symptoms. These attempts at normalizing their symptoms provided a means of maintaining and safeguarding their sense of personal authority. In attempts to defend themselves, some patients struggled to maintain a sense of personal authority over their bodies and their lives by ignoring their symptoms altogether, thereby continuing to uphold the status quo. One individual quickly dismissed the severity of his symptoms as they did not match his preconceived ideas regarding the "typical" symptoms of a heart attack.

> I was having back pain. Um, they would come and go with activity...Yeah, and my, all of my angina at that time was in the lower back, nowhere else until it got really severe. And then, then it went into my throat and a little bit into my right arm. No sweating or no other symptoms showed up. (5A)

In three instances, patients tested their capabilities of remedial action thereby treating their symptoms as simply benign conditions.

> If I sat still it would go away. I took some Tylenol for it. Put up with it until supper time and it got quite severe while I was having supper. So laid down on the couch for a few minutes and it didn't go away. And then I laid down on the floor on my back and tried a shot of nitroglycerine just to see if it was angina. There was a major change in the pain of it. With that, it subsided quite a bit. (5A)

Each patient became involved in a cognitive exercise of trying to make sense of the present symptoms by comparing them to past experiences or alterations in their health status.

> Oh, I had angina in the summer holidays, a couple of times without even recognizing that it was angina. Ah, and then when I went back to work beginning at the new semester, I had angina three mornings in a row. Again, I was, it just felt like I had aching lungs from walking in cool air. But I realized then that three times was not according, that there was something wrong. (1A)

Decisions as to the course of action to follow were based on this evaluative process. With the exception of the patients who had experienced a previous heart attack, the remaining three individuals endeavoured to continue on as usual with their everyday lives, rather than seek assistance. On the other hand, the three individuals who were previous heart attack victims, promptly recognized the idiosyncratic nature underlying the persistence of their symptoms and acted accordingly.

Seeking Medical Assistance

Further exacerbations of the symptoms proved unsettling for the patients and their spouses as it reinforced the perception that all indeed was not right.

> Well, I got sick in the month of February, and into March. Not feeling good at all, shortness of breath, my arms were aching, haemorrhoids were bothering me, it went from one thing to another. (1A)

No matter how hard they tried to ignore their symptoms and carry on with their lives, the realization that they were feeling different and the possibility of something foreboding became grounded. Once the magnitude of their symptoms surpassed their efforts to normalize them, they could no longer maintain a complete sense of personal authority and they sought medical assistance. As soon as the decision to seek medical assistance had been made, the patients acted quickly. Curiously enough, all of the individuals who had experienced a previous heart attack wasted no time in reaching that decisive moment and promptly went directly to emergency departments. The others chose to first visit their general practitioner.

In all incidences, repeated urgings and persuasive efforts were used by each caregiver to further encourage their spouses to seek help. In support of their spouse's decision to finally seek medical assistance, the caregivers responded by driving and accompanying their husbands during their medical visits.

> I think it came as a shock. But at the same time, I had suspected it, simply because of the minor attacks that he had and of course I have a very suspicious mind. And, when the first time it happened, I mean when he experienced a little bit of pain in his left arm and a feeling of indigestion, my first thought was; oh, it's the heart. And then the second time it happened, there was just no question in my mind. I was startled and scared actually, because it happened away from home, in a remote area on the way home from vacation. And in a place where I didn't even know anybody there, or the name of the hotel we were in. So, when it happened there was just no question that, I knew we needed immediate medical care. (3B)

Confirmation

Although the results of an electrocardiogram, stress test, and blood work all hinted at the presence of underlying cardiac irregularities, the speculative nature of the symptoms was fully dismissed by the results of the angiogram. The results of the angiogram confirmed the etiology of coronary artery disease and made the patient's predisposing symptoms intelligible.

> So, on the third day I called my wife at work, at the hospital and asked her to come and get me and take me to emergency. And ah, that's when I was diagnosed with coronary artery disease. Not fully, but they suspected it. And then later, some days later I was given an angiogram and ah, verified that it was coronary artery disease. (1A)

In hindsight, it became apparent that many features associated with having cardiac surgery were successfully erased from the patient's memory by the accompanying atmosphere of distress. Yet, this one objective measure, which signified the degree of blockage in the coronary arteries remained definite. In an absolute manner both the patients and the caregivers could cite the confirming results of the angiogram.

> The cardiologist had taken us into a session and showed us a video of how the heart was functioning and how the dye was going through, and how the heart was pumping. He showed us which ones were blocked, and which way the little passages came through and were feeding the heart. I found that extremely interesting and very shocking. But it was a real eye opener! To think that these are the things that have ceased to function and these little channels that come through and work their way in and feeding the heart through these other little areas. It was just very interesting, it was an education. (3B)

The results of the angiogram provided a explanation that ultimately enabled the patient to interpret, define, and "make sense" of the symptoms that they were experiencing.

> Well yeah, I went, they took me by ambulance to the UAH for an angiogram. And they did the angiogram and then they told me I had eighty percent blockage at one place and forty percent in another and I had some blockage in another place because they did a triple bypass. (4A)

The engagement of the patients in the diagnostic workup, the life threatening nature of coronary artery disease, and the impetus for cardiac surgery resulted in the further erosion of the patient's sense of personal authority.

Necessity

Before any effective mode of intervention was planned or agreed upon, the patients attempted to obtain a true understanding of the events surrounding the occurrence of this crisis. In order to make sense of their diagnosis, all of the patients reviewed their life history in order to discover the existence of any antecedent causal attributes. Coronary artery disease was not perceived by the patients to have suddenly arisen from unanticipated events, but was viewed as the likely outcome of poor lifestyle choices, or genetic endowment.

> I mean, I never expected to have heart trouble in my life, never. My whole family history goes against that. The way I have lived, the kind of diet I've had hasn't been that bad, though it's been greatly improved over the last two or three years. But, I did smoke for 35 years, that may have contributed. There may just be some genetic quirk, that I'm not like the rest of my family, whose got the wrong recessive gene, ya know. (1A)

All of the patients were aware of the element of risk that accompanied the experience of having surgery and in their minds, the two sides of a scenario were debated.

> Well, the operation is pretty routine these days, and the chances of something happening are there. My surgeon said, "2 out of 100, might not make it". Now at the time I was thinking I was one of the 2 out of 100, but that's not necessarily true because ah, I didn't figure this out until after my operation, but that's pretty scary odds!...It does, it scares ya. I mean you know you're going in there tomorrow and you might not be coming out. You just might not be coming out. (6A)

The diagnostic verification that ensued from the angiogram forced the patient to confront their own mortality when assessing the need for bypass surgery.

> Well, at one side of this, you know that you may never come out at the other. The chances are small, but you could die on the operating table. Ah, though the chances of dying on the operating table are a lot less than say for if you went in with a severe appendicitis. But, nevertheless, it's one of the risks. Just like when you have the angiogram, it's a risk. Even though a small one, it's always there. (1A)

If an individual considered not having the surgery, then they perceived they would be living on borrowed time.

> I thought, even if this gives me ten years of life, because it doesn't go on..depends on how long your bypasses last. And I mean people have gone for repeat bypasses. But, I thought well, as I am currently, I may have a year left without this operation. (1A)

Although half of the sample had contemplated undergoing chelation therapy, they finally decided that there truly was no way to skirt around the required surgery, as no sound alternative options or choices existed. Thus, the final decision highlighted surgery as the only possible means to possibly prolong one's lifetime.

> It has to be done. And actually it's good, let's get it on here, because I don't want to come back here again next year. Because I know I would have. In your mind you know. I knew I was eventually going to have to have surgery or die. Ya know, so let's get surgery going and ah get it fixed up. (6A)

If one wanted to continue living then the surgery was deemed necessary.

> But the thing is, I'd have had a death sentence, if I didn't have this surgery I would have died of a heart attack one day. (1A)
>
> I didn't, I had to, that was the only way I could go. Cause I couldn't even come home. If they would have sent me home, I'd have been only home a half an hour and I'd a been back..Ah, a little apprehensive, but ah, I couldn't live the way I was, so didn't have to, then you have to go. That's the way I looked at it. (4A)

Placed On The List

As the names of the patients were "placed on the list", they had unknowingly crossed over one of the threshold points affiliated with having cardiac surgery. Once you were placed on the list, there was no looking back for the wheels were set in motion. The burning question on everybody's mind pertained to the speed with which the wheels were to rotate. Placement on the list marked the end of the diagnostic workup and the beginning of the waiting period prior to surgery. In fact, this designation only represented a casual token rather than a specific concrete temporal surgical assignment. In retrospect, the particular meaning of this phrase proved confusing for some of the patients as they associated it with a more definitive term. For some of the patients it conveyed a negative connotation as it symbolized their inability to escape from the critical reality that suggested they had heart disease.

> And after the angiogram they decided against the angioplasty and to go with bypass. I was sent back to the hospital to await my turn, so to speak. I was now on a waiting list after it was decided that a bypass was now mandatory...it could have been a week, it could have been a month, it could have been six weeks. But, they were not going to discharge me until I went in [for surgery]. (6A)

One patient thought that being "placed on the list" was synonymous with having your name placed in a registry, thereby guaranteeing them a distinct position on the surgical roster. They grew frustrated with the discovery that this was not the case.

> And then I got a letter saying that, okay they were going to put me on the waiting list. And I never heard nothing. I never heard absolutely nothing. Ya

> know to be on the waiting list, to me, maybe I'm not very bright or something They tell you that you're on the waiting list, is that tomorrow that you're going for the operation, next week, next month or what. So you're sitting there waiting to go for an operation. Every time the phone rings you think they're ready, and nobody tells you nothing. If they could come up and tell you; "okay you're on the waiting list but don't worry, we're not going to call you for six months", that would be fine. (2A)

The majority of the patients and caregivers recognized the unforeseen quality surrounding this title and they acknowledged it with a realistic degree of flexibility.

> Oh well, I was told initially it might be four or six weeks but it was longer of course, but not tremendously longer, but ah...that wasn't a surprise. We knew that there were waiting lists, that things didn't always work out. Um..when I saw the surgeon before the operation, Um, I did make it clear that I would like it as early as possible. (1A)

For these individuals, being "placed on the list" only personified the entry ticket to the next scene; the waiting period.

The Preoperative Waiting

The waiting period proved to be nothing short of stressful. Without a specific time frame to work around, the patients and their caregivers found that their lives were temporarily placed on hold.

Shadow of Uncertainty

Although there is always an element of uncertainty associated with any surgical experience, a noticeable shadow of uncertainty surrounded the waiting period prior to CABG surgery. This uncertainty which stemmed from the indecision regarding the actual date of surgery, proved to be unsettling as it undermined the sense of personal authority that the patients had previously experienced over the direction of their lives. As the actual time of surgery remained unknown, holiday arrangements and other long-term plans were cancelled. Also, as the actual date of surgery remained undecided and delays were encountered, concern was generated with regard to the patient's prognosis. Additional losses of personal authority were witnessed during this stage as further worsening of cardiac functioning occurred.

> Boring as hell. But other than that, they didn't want me to do anything. I mean, it was just uh, uh, eat, watch TV, read, that's it. They said don't do anything, except the walking. (5A)

> Some days, I didn't even get hardly out of bed. I just, if as soon as I started walking or anything I got, I got this angina. And then it took two days to get rid of it again...And the last two days, I didn't, I didn't even, I just went to the washroom and back and that was it. (4A)

As the realization of decreased efficiency and productivity surfaced, each patient's strong desire to regain a sense of personal authority over their lives fostered a profound eagerness toward having the surgery.

> I couldn't wait to get the surgery fast enough. *Why?* Because I had lots of problems. I couldn't, I couldn't even, like the last four or five days I just walked to the bathroom and back. That's all I did then. Didn't even walk down the hall..No, I, I just couldn't get there fast enough really. (4A)

The element of stress and uncertainty underlying the waiting time became greatly magnified when the procedure was postponed and rescheduled for a later date.

> It was like being on an emotional roller coaster ride. Ummm..not knowing what was going to happen next...was an on again, off again, on again, off again thing. (3B)

The intensity of the emotional response conveyed by the caregivers was a mirror image of their partner's expression. However, the caregivers found themselves encircled by an even thicker cloud of concern and worry. With a definitive diagnosis, their concern and worry were no longer unfounded. The focus of their worry was no longer the surgery itself, but **when** the surgery would be performed. In the face of delays, the caregivers tended to contemplate the worst possible outcomes; the occurrence of a heart attack or the death of their partner.

> The thing that I was fearing the most was the fact that he might get a heart attack. I wanted him to get it over and done with, before there was any heart damage...But, if something should happen, this waiting period I found a little anxious, simply because they didn't classify him as an emergency case. I can understand that it wasn't, now that I've seen other cases that were so much more severe than his, that I can understand that it wasn't, but on second thought, why do we have to wait until it is an emergency. Better to catch it

> now and get it while the getting is good, rather than waiting too long. (3B)

This uncertainty generated anger and frustration in two particular cases.

> I wouldn't say I was irate, I was disappointed. Really somewhat angered at times, frustrated more than anything. I mean let's get this over with, why say you're going to do it when you're not and ah..if you know you can't take us until January, the end of January, tell us that, and we won't go through this on again off again deal. (3B)

In the other instance, the information regarding the rescheduled date was withheld from her husband in hopes of saving him any additional stress should the schedule change yet again.

> Cause my husband was stressed out before, cause his operation was to be booked October 15th. So we went through the turmoil again, then you settle yourself down and then the operation was on November 15th. (1B)

Without any choice other than to continue waiting, the couples approached each day one at a time, while they consciously made an effort to remain patient in the face of this uncertainty.

> At first, it was really hard, the first few weeks I found really tough. It was like a time bomb, kinda like, I felt very hypervigilant. I felt like I needed to hover. I couldn't wait to get home from work. I called him two or three times a day..."Are you okay, are you okay?" Um..and I think it was partly his symptoms had seemed so vague and then you get this angiogram result that there was 100% blockage..is [he] going to be one of those people with hardly any symptoms and then bang, ya know, he pops over dead. So, that was hard, until we kinda got into the rhythm of things, and he seemed to be feeling pretty good most of the time. It got better, I mean it never went away, but it got better that we kinda found a new rhythm and expectation and he was really good about not overdoing stuff. (1B)

Anxious feelings, anger, and frustration did nothing to speed up the process, and were for the most part, successfully curtailed. One patient who had previously had other surgery, coped with numerous postponements in a remarkably positive manner. As the actual date of surgery took on a more dubious nature, the waiting period became synonymous with a game. After being bumped on eight occasions, having an actual date for surgery became less important.

> Just a series of postponements and getting bumped on the list. I think I was bumped six or seven or eight times. I think the eight time was the last time. They would say, "We have you scheduled for such and such and then they would phone back and say there's a back up of surgery and it's going to be next month or next week or two weeks from now. We'll schedule you and get back to you then. (3A)
>
> Well, I learnt after the first time that I just didn't set the time. If somebody said, if they phoned me and said, "Well we've got you scheduled for the second of December", I'd say fine and not really pay too much attention to it, because the possibilities were that they were going to bump me anyway. And that's exactly what happened! (3A)

Although the other patients were frustrated by the delays surrounding their waiting period, this particular patient surprisingly stated that "it wasn't a devastating thing for me in anticipation of surgery".

> Ya know, I hear people complaining about the bumping and the lack of beds and so on. In my situation, I just took a different approach. It seems to me that very often we can criticize somebody for whatever it is, something's always wrong, and I felt this way, that ya know, if I got bumped it's the fact that I'd given way to somebody who needed care more desperately than I did for one thing. (3A)

Preparation Work

Although a considerable amount of anxiety and stress were associated with the waiting period, it provided a time whereby the patients and caregivers actively took stock of their thoughts and feelings surrounding the approaching cardiac surgery. This "preparation work" served to diminish the level of anxiety and fear of the pending CABG surgery. The ultimate goal underlying this stage was the attainment by both the patient and caregivers of a positive attitude toward the impending surgery. This goal was achieved through the directives of an information search, having faith, and taking stock. The details surrounding these directives will be addressed in the following section.

Information Search

The details surrounding the surgery were usually shared with the patient and caregiver following the angiogram by either the cardiologist or the general practitioner. Once in the hospital, information and details surrounding the actual operation were further emphasized by the assigned surgeon.

> I had seen the cardiologist on a separate occasion...So, ah, I knew ahead of time more or less what was to be done, and had some idea of how it was going to be done. I wasn't too bothered about terrible details, but I knew my chest would be opened up, that my heart would be stopped, I've got a heart-lung machine, and I hoped it wouldn't break down(*chuckles*), and I even knew that I would be given medication before surgery that would kinda put me on a high. (1A)

Following this consultation with the cardiologist or the family physician, the patients and caregivers read together the pamphlet material that they had received from the hospital. No specific information was given to the caregivers, rather they read material given directly to their spouses.

> Oh for me specifically, now that's harder because B.[patient] and I talked lots and I'm good at asking questions. But, if I think specifically to me. Well, the cardiac booklet that they give you, that was useful. Now it wasn't handed specifically to me, but it was handed to B.[patient] and of course I read it as well. (1B)

There was no concrete information specifically for the caregivers pertaining to their role and the expectations for them surrounding the recovery stage.

> I was aware of it simply because my own personal interest and I'd read a lot about it. And I received a pamphlet. Ah, [the patient] received a package from the hospital, so I read all that. And ah, that was my own information that I had gleaned. But ah, nobody ever sat down and said well, this is the way it's going to be, or this is the kind of thing you can expect. (3B)

In most cases, the information contained within the pamphlets only reinforced the general knowledge that they felt they had already secured.

> Um, they gave us a book explaining what my kind of surgery entailed. And I never, I pretty well knew most of it, like before I read it. (5A)

One patient who was married to an occupational therapist demonstrated a superior knowledge of CABG surgery, and subsequently found the hospital pamphlet material somewhat redundant.

> Oh I scouted through a lot of those[pamphlets], they're very simple and they don't tell you a great deal. But then they're aimed at the common denominator...most hospital stuff is geared towards a grade 6 education, because that's often the highest level they can be safely able to deal with the majority. (1A)

The amount of information received from these two sources by the patient was deemed sufficient, as no independent information searches were carried out by them. The overall amount of information that the patients and caregivers desired surprisingly enough remained limited. Accordingly, they were very selective about the amount of information they chose to consider. Once the fear of the unknown had been erased by the physician's details, a conscious effort was made to not know too much, so as to not become overwhelmed. To achieve this they remained busy and preoccupied their minds with other things.

> I didn't read much about what was going to be done. I had a reasonable idea of what was going to be done, and...you can dwell on something too much and then get yourself totally scared silly. I just deliberately did not read too much. I knew basically what was going to be done, and I didn't want to know any more than that for then. Because you can really shock yourself out, you can really get yourself into a state if you dwell too long on something. And I know me, I could get myself into a state quite easily if I let myself. So, I just knew basically what was going to be done, and had some idea of the risks..they're not terrible high; but I mean there are risks. And basically kept myself, my mind occupied with stuff. (1A)

As well, a short waiting period limited the amount of time available to spend thinking about the surgery or gathering a substantial amount of pertinent information. One patient perceived this as a blessing in disguise and was relieved by this fact.

> So, I didn't have a whole lot of time to sit and dwell about it, which was good. Because like I say I thought I'd have to be...who knows, who knows, up to six weeks, and then you've got all that time to think about it. So, I was very fortunate in the fact that I didn't have to hang around and worry about it. (6A)

Although one caregiver independently searched for additional information regarding bypass surgery in the library, the remainder of the group suggested that they were content with the extent of the knowledge that they possessed. They had identified the time as being "a bit soon to digest tons of information". And so, they too blocked out some of the information that was available.

> For me, it might have been easier to read some of the surgery procedure stuff after, like out of interest, but not ahead of time, cause I knew enough to know, what was going to happen, but I didn't think I wanted to know all of the details...it's not going to make any difference to his [patient's] functioning or anything like that, but now just as a more intellectual exercise, cause the emotional stuff is done. I'd kinda like to be able to do that. (1B)

Whether they wanted the information or not, the stories relayed by friends, family members, and former patients were another important source of information.

> I think we got more information from people who went through surgery. People that had had..I was told by their wives anyway. (2A)

"Just from talking", the patients and caregivers stated that they had heard about this kind of surgery for a while already.

> Ya know, almost everybody that I talked to or told about this had some story of either, ya know, people as distant in a way as their neighbour, or so many people. Oh, my brother or my brother-in-law. Everybody had at least one story to tell about how people had gone in for this kind of surgery and come out dancing, basically. And every story is consistent, the leg is the worst wound to heal. Um, and that it's amazing how quickly people recover. (1B)

Former CABG patients were also eager to share the circumstances surrounding their CABG experience.

> I've had a lot of experience talking with various people. I went to the cardiac rehabilitation program after my first heart attack. I talked to people there who had heart attacks. Some of who had bypasses. My neighbour, I talked with extensively last fall. He had a bypass in August. Well, he's having trouble with it. He's still not back to work yet. Well, that was, he was actually one of my largest contributors to the information I had. (5A)

For the most part, the stories that were relayed were positive, as nobody wanted to deter any of the patients from having the surgery. Evidently, a precautionary note should have been attached to these stories. One patient who was having surgery for the first time, gained the majority of his information regarding his CABG surgery from his peers. Unfortunately, when his course of recovery did not follow these prior renditions, he grew increasing discouraged and depressed about his own situation.

> No fears at all, and I don't know why! Maybe it's from talking to all these people, it was all positive. *How many people did you speak with?* Oh...four to five. Oh, some guys were pretty close and kept pretty close contact. One guy was calling me all the time, he'd say; "Are you okay?"...Another guy said, "I'm twice the man I was a year ago, nothing to it". It was all positive! *Have you spoken to any of them since?* Ya, I gave one of them a little hell, he laughed. He says,"I didn't want to tell you, cause you maybe wouldn't have". *So there were negative things that they had withheld?* Oh ya, oh ya, most of them, nobody said anything that was bad. (2A)

Having only relied on the informal stories derived from others, this patient's caregiver encountered circumstances upon their return home with which she was not familiar or prepared to deal with effectively.

> I thought the problems would occur more just in recovery, um..the healing process, but I certainly was not aware of, the pain that would be there. Ah, we were concerned about Atrial Fib. cause [he] had that before, he had it twice with his first and second heart attack. So there was a concern about that...Ah, I was not aware of the, once we got home, the palpitations...the loss of appetite as severe as it was. I was not aware of the symptoms that may occur after the operation. (2B)

For those patients and caregivers who had experienced surgery before, they too listened to the stories. Yet, they were hesitant to accept them fully.

> No, because I find lots of times that if you ask people questions about things, you get what they, what they experienced. I wanted to be clear of that and experience this on my own. (4B)

> All kinds of it! There's, there's some kind of a thing about advice. "If you get it for free, that's all it's worth"...And people give you all kinds of recommendations, and I can appreciate that, I think they're out there to help you, but it's the same position that anyone else is in, that you're out there and I know if enough people talk to you, they can sway your ideas; whether they're good or right, can sway your ideas and you're going to follow the

> ration as an alternative way; short cutting maybe the thing that has to happen. (3A)

Having Faith

Another aspect of the preparation stage involved 'having faith' in others. Having faith provided a sense of reassurance for some of the patients and their caregivers. Some individuals placed their faith in the hands of God.

> Prayed that everything would go well...Because if something bad is going to happen, it's going to happen. Even when you pray about it, that it's not going to happen. But if it does, why get upset about it before it happens. (4B)

Faith was also placed in the reputation of the medical professionals who were involved with one's case.

> Well, I think on the basis of my cardiologist. My cardiologist is perhaps a maverick in the business, he's been in cardiac rehabilitation for 27, 28 years, he was one of the forerunners...but ya know, there are some people in my opinion who are visionaries, they see things years ahead, and I think that this cardiologist had the conviction that he was doing the right thing...but I'm feeling better today and I believe in order to recoup, I think you have to believe in the people that are looking after you. (3A)

With great confidence these participants temporarily allowed themselves to relinquish their sense of personal authority to another trusted individual.

> If it's gonna happen, it's gonna happen and I have a lot of faith in medicine, the medical practice and it's like I say, it's fairly common operation now and they've got all the equipment, all the training. (6A)

Taking Stock

During the final theme of the preparation stage, the patients and caregivers were involved in 'taking stock' of their thoughts and feelings in relation to the imminent CABG surgery. During this theme the patients spent time contemplating their expectations.

> Well, in terms of what I would feel like when the operation was over, and when I came to and was recovering. Um, how quickly I would recover, how much pain I would feel in myself. (1A)

> And I think it's going to give me perhaps a better quality of life. Uh, certainly more certainty. Uh, because if it had not been for the surgery, like the doctor said, "Once we're done the surgery, we at least know that the correction has been made. Otherwise, uh, I suppose I could have had a heart attack or what have you, at any time. (3A)

This mental exercise also enabled the patients and the caregivers to diminish their fears and feel emotionally prepared.

> I think one of the reasons that perhaps I progressed well, I've been through surgery before, and I think that one of the reasons why I maybe progressed as well as I did, I think is the fact that I was prepared. I think when it comes down to surgery very often what I think what is really important is to be prepared for the inevitable, is to not be afraid of surgery. A lot of people when it comes even, matter of fact to dying or anything of this nature, we have a tendency to feel scared of the unknown. And I just felt emotionally prepared, and I think that's perhaps one of the better things that...ya know, if you go in there unfrightened, I think it's perhaps a better way of being. (3A)

The ultimate goal underlying this theme was the establishment of a proactive and positive attitude directed toward the surgery. This positive mindset is reflected in the following statements.

> I believe that the most important thing is your mental attitude. Your approach to ah, your approach to surgery. I believe that if you take a positive approach and say, hey I'm going in there to get better, the people that are there are there to help me...But I believe that a lot of it has to do with, with your own, with your own view of what life is going to be like. You get what you go for. (3A)

> But ah, ya know, I talked to a lot of friends who'd had the operation and they put me in a pretty good frame of mind. And I went in there with a good attitude. (2A)

A somewhat more aggressive attitude was adopted by two patients. While refusing to surrender, they communicated the importance of possessing a fighting attitude.

> There were a couple of days there where I was a little apprehensive about surgery. Cause I've never had major surgery before. Um, but then I came to terms with it. I went in with the same attitude that I had with my heart attack. I'm just not ready to go. And it seemed to make a difference...But there never was any thought in my mind at that time that I wouldn't come through. Never occurred to me...if you go in there with the fact that it's going to be a breeze,

> that's the best way to go in, you've got an excellent chance of recuperating very quickly. (5A)

Rather than work towards achieving a positive attitude, the eldest couple demonstrated a more passive stance. They chose simply to wait and see how everything would turn out.

> Take everything, I take everything in stride. I mean, I don't think, I really and truly do not let things upset me. I mean it has to be really serious, really truly serious before I would get upset and then I wouldn't even get that much upset...I mean it's all natural, it's a natural process that has to take place, and I understand that perfectly. (4B)

> I don't know. I just, if you have to go, you have to go. And ah, hope that it's all gonna come out for the best. (4A)

The Inhospital Stage

The inhospital stage primarily reflected the hallmark features and events surrounding the actual CABG surgery. This stage commenced with the entrance of the patient to the hospital and ended with their discharge home. A unified account of this stage proved impossible, for a huge degree of variability characterized the hospitalization period of each of the participants. Not everybody attended PAC or the discharge class, hospital routines varied, as well as the different configurations of physical pain, time disorientation, and fatigue experienced by each patient following their surgery painted a truly diverse portrait.

The unsettling nature created by this variability, led the patients and caregivers to concentrate their thoughts solely on immediate concerns, while the expression or execution of any plans aimed towards the future lay dormant. Attention to this orientation of immediacy uncovered some interesting findings in relation to PAC and the two existent themes that readily emerged from the data. The first theme or feature of considerable recognition was the existence of an informal evaluation of the nursing care that occurred during the hospitalization period. The second theme exhibited during the inhospital stage was distinguished by the manner in which the caregivers remained respectfully at their partner's side, cognizant of their level of discomfort and infirmity. This presence was further exemplified by an astute attentiveness.

Preadmission Clinic

The preadmission clinic was introduced as a vehicle to facilitate the progression of a greater number of patients through surgery. Patients were encouraged to attend PAC prior to the actual date of admission to complete all of the necessary preliminary tests surrounding the surgery. Only half of the sample population went through PAC. The remaining three patients were transferred without due warning from other tertiary hospitals the afternoon prior to their surgery.

When asked to discuss the PAC experience, the impressions of the day were extremely vague, possibly lost in the tempo of the proceedings.

> Okay, it's a bit of a whirl! Let's think...really the day's a blur, because I think quite a lot of things happened, going from one thing to the next and I never had time to feel that I was hanging around for too long. Just as I was beginning to feel that way, there would be some movement. (1A)

For some patients it proved to be a lengthy endeavour.

> It was a fair long one. I remembered that I was destined to be there around 11:00 and I got there at 11:00 and I think it was around 18:00 by the time I left..it was a long drawn out day. (3A)

Regular visits to PAC by the researcher revealed the fact that the patients were often accompanied by their spouses. In a simultaneous fashion, both individuals witnessed the proceedings of the day.

> We came home, and we were pretty stressed out going through everything with the anaesthetist, the doctors, the bloodwork, the x-rays, touring the recovery room. By the time we got home we were played out, and we were wondering what this operation was going to bring to us? I know that evening, we didn't go to bed til quarter to three in the morning. (2B)

Going to PAC together not only provided an element of reassurance and security for the patient, it also encouraged a common basis of understanding in relation to CABG surgery. The distinct importance of this mutual understanding is exemplified by the following observation.

> So, oh and there was a lesser educational program, a little bit about some of the kind, what we could expect to some extent. And, my strongest, strongest impact on me was the reaction of one of the wives actually. Who obviously had no idea, until that day as to what was going to happen. And she was absolutely devastated! (1A)

When asked if there was any teaching done in PAC, the responses were of an indeterminate nature. Each patient's recollections of the preliminary tests far outweighed the recall of specific educational content that addressed the recovery from CABG surgery.

> They chose all of us that were destined for surgery, they took us into a training room and told us all about what was going to happen, and they gave us all kinds of instruction as to how to respond and develop your breathing exercises in anticipation for surgery. (3A)

The only teaching component that had a lasting impression included the instructions and video that highlighted the mechanisms of appropriate postoperative breathing.

> Ah, not really, I wouldn't say so. I guess there was ah we were in there probably for about an hour, when she told us, why you were having the operation, what the operation is going to be like, and what you would be like after. Then there was a physio-therapist who showed a movie. And the breathing, there was a movie on that. And that's about it. (2B)

> We seen a film, I seen a film, that's when. Well, that little breathing thing, when she was in to show us that, she also, there was a film there. She turned a film on, and she said; "Okay, you can watch it if you'd like to, you don't have to". (2A)

> And we had some lectures and stuff..one particular one about the recovery phase. Ya, this nurse..she was very very good for explaining all that had to be done to get your lungs exercised, the coughing, the need of a Teddy to hug while you're doing it. Even gave us some practice at using the sucking up the ball..I don't know what you call it now. And so, that was good. She also showed a film, but I wasn't interested. (1A)

There were no outstanding indications to lead the researcher to conclude that the involvement with PAC actually placed these participants in a more advantageous position in terms of their preparation for CABG surgery.

Inhospital Nursing Care

The majority of the appraisal surrounding the inhospital stage centered around the quality of the nursing care. This evaluation may have been inspired by the current alarm generated by the vast media reviews which have critiqued our current health care system. In any case, these first-hand accounts presented a cooperative opinion that was nothing short of distressing.

Complete satisfaction with this particular hospitalization was held by only one patient.

> The care was excellent really. There's just nothing that I could say that wasn't complimentary. (3A)
>
> I never rang the nurses button to get service, there's always somebody coming along...checking the intravenous or whatever the case was and asking questions rather than ya know, without having to be begged in to come in to say, look after something. They were there on regular intervals without an invitation, and that they felt, at least I felt that that was part of their duty that they were there to look after, rather than being called they'll just double check to see how things are. (3A)

This positive opinion was also expressed by his caregiver.

> The hospital experience was positive, I didn't encounter anything that made me doubt that it wasn't going to be successful. Right from the day he went in prior to surgery, I felt comfortable with that situation, simply because I felt it gave him time to adapt, to become oriented, and to get a feel for the ambience there. And to be prepped the day before, so that gave him time to settle down rather than go in the one morning and be on the operating table a couple of hours later. Cause that's what happened with his surgery that he had a couple of years ago. (3B)

The other five patients and their caregivers were quick to comment; "it's not like it use to be". Concrete examples of their dissatisfaction were readily available. Continual comparisons with past hospital experiences readily amplified the recognition of any immediate or obvious differences concerning the element of care.

> I didn't like the care there. *Can you be more specific?* Well there were a couple of the nurses who were okay. Some of them are not very friendly, just don't have time for you. It's not like it use to be. I went into the hospital once before in 1990, when I went through the hospital, I come out of there with a good feeling towards the hospital. (2A)

Previous hospitalization episodes at other tertiary institutions, also presented grounds for comparison.

> And thinking back. No, actually the UAH is the only place I've ever had any trouble. All the rest, they were great. It was just there, right... I thought you were pretty much a number at the UAH. *But, what's the difference?* At [the other institution] they seem to care. How do you feel? Like they care how, how do you, they actually wanted to know how I feel. They don't care what's the answer, let's go, let's get it. Let's just get whatever it is we have to do, done with. And we're in, we're out. (6A)

Poor avenues of communication were identified as responsible for the further erosion of a caring attitude.

> There were a few of the nurses and aides who were a little bit abrupt. In many cases I don't think their English was good enough and that's what the problem was. But you know, to communicate really well. (1A)

> This makes me think too, one other semi-negative thing I could add though, the nurses at the UAH are extremely busy, but certainly some of them were much better communicators than others. And I think part of that is personality differences, part of that is cultural differences, etc...I periodically got a nurse that kinda was super busy or what not, and or couldn't answer all the questions, and felt she couldn't and kinda didn't make the opportunity for them. (1B)

Without the time to spend talking with patients and answering their questions, the nurses were identified as being overly task-oriented.

> It's an attitude, ya you can put it that way. The people who took care of me at the UAH, as far as I'm concerned, they might as well have machines to take care of you. There was no time to stop and talk to you. There was no time. (1A)

> It's very, very busy. Very, very, busy. And I, I don't, they, they've got a job to do. They're doing a job. You know, that's it. That's it...And then the nurse that came in there was moving so fast, so fast, so fast. Cause everything's so quick, so quick. Everything has to be done real quick, real quick. Oh hurry

> up...She's just going crazy. I don't know if she was so busy or that's the way she is. But, it seemed that she was pretty busy. (6A)

The advent of "being there" was identified by the participants as an undeniable component of quality care. Unfortunately, the presence of the nurse was not felt.

> As far as I'm concerned there just aren't enough people there. Everybody's running around in circles. I think they probably do the best they can with what they've got. I'm not about to blame anyone except the guy who's making all the cuts. I guess I could blame him. That's probably what's wrong more than anything else. But, no you go in for a major operation like that, that's not enough time, that's not enough time. You know, you should have a little more care. (2A)

Without the routine and frequent presence of the nurse, the patients and caregivers often found themselves on their own.

> But it seems like, you know you want a glass of water, there was nobody to ask you if you want a glass of water. And ah.. my daughter knew where the kitchen was, so she was able to go get him a glass of juice, but those things are all gone. Nobody would come around and ask him, "Can I crank up your bed" or "Are you comfortable", or there was none of that at all. Ah. No, I really think it's gone downhill, and I'm not blaming the staff or the doctors or anything. I think that there's been too big of a cut back, just with nurses and they don't have the time. (2B)

As the patients themselves were often drifting in and out of sleep, the caregivers were more aware of this absenteeism.

> I strongly believe that there's a shortage of nurses in the hospital. They don't have time to give the patient any support, they just don't have the time. Ah..cause really, I don't think [the patient] had good care at the UAH. When a nurse did come in, it was just in and out. (2B)

Consequently, the caregivers felt there was a greater reliance upon them to provide help.

> Well, I don't know whether it was because I was there that they didn't do that much. They relied on me to look after his needs. And help him sit up and get down again or what. I really don't know. Because, I mean they, they'd go, they'd stop at the door and they'd look in and see me there and then they'd keep on going. They just came in with his pills when uh, it was time to give him pills and uh, *This wasn't what you were expecting?* I don't know what I was really expecting. But, I mean, I, I just felt that because I was there they

> just figured that they didn't have to come and find out whether he needed to be more comfortable. (4B)

One caregiver suggested that she felt pressured into doing things simply because she was there rather than the nurse.

> I don't think there was enough help and that's just my opinion. There probably was, but I would have to go and ask the nurses to give him pain killers. I'd have to, his first shower, they said, don't have time. You do it. Which of course I don't mind doing anything for him but um, got out of the shower and he started shaking. His whole body was shaking. I wasn't ready for that. You know, so, I really, I wasn't, nothing against the ladies there, because they tried. But there wasn't enough help there. Cause I ended up doing everything because I was there. Or pretty well everything other than giving him shots. Which again, because he's my husband I certainly don't mind doing it, but I felt very pressured...they weren't telling me enough. They weren't helping me enough kind of thing. Cause if you're there and you're left to deal with the person, you're, you're left there. Pretty well on your own. And, my daughter and I, my daughter was there too, she ended up helping the old man beside him too. Or getting him out of bed and he'd need a few things and she'd go and help him. (5B)

Invariably, a rushed atmosphere and the perception of a lack of time accompanied this diminished presence and lack of attention toward the patient.

> Um, we found that when we asked for something, the nurses were quite abrupt. If he'd ask for a pain killer, 15 minutes later, we'd have to go and say, "he's in quite a bit of pain". I understand that the nurses are overworked and I've seen em, how they work, and they certainly are. I strongly believe that they should have more staff, where patients can have a little bit more attention. Where the nurse can stop, take at least five minutes and say, "Okay, this is the way this has to be". But there didn't seem to be any time for that at all. (1B)

> Oh, because they have to go like the clappers. They really have to go from this to this to this. And you know, sometimes you can see, there's not that many people around. Here's all the people looking after, and there's not that many of them. Um..and a few did occasionally complain about conditions, and how conditions have changed...And most of them were under some stress, fearful of their jobs, and doing a bang-o; the utmost to do the job, which is so much harder now. (1A)

In order to fulfill necessary self care measures, the patients were often compelled to exercise a degree of independence. Accordingly, some of the patients began to test their capabilities despite their physical pain. Their drive to exercise their sense of personal authority was reflected in their acknowledgement and adherence to the activity schedule outlined on the progress chart that hung on their door. Motivated by the guidelines specified by the progress chart, they actively confronted the challenge of meeting those goals while monitoring their progress. In appreciation of the busy atmosphere on the wards, some patients willingly attempted to exercise control over their own decisions and perceived needs.

> My problem is I'm pretty easy going about stuff like that. If somebody's busy doing something for somebody else, I don't get upset unless it's really and truly serious with me. Um, like I'm sort of independent in that respect...But, if I called them, then they'd come. After, after about day two, I'd get up if I wanted something, I'd get up and go tell them that I needed some more Tylenol or something. Rather than waiting for them to come to me, I'd just go walk up, it was only a few steps up to the nursing station. I'd just go stand there until they recognized I was there and get what I want and go back to bed. (5A)

Not only did the evaluation of the working conditions lead some patients to attempt to do more for themselves, but the occasional note of sympathy was extended to the nurses.

> I felt sorry for the staff. The service level they were providing I felt was the best that they could do with what they had. But they were overworked. And they're getting close to burnout syndrome. (5A)

Unaccustomed to being delegated the responsibility of performing their own self care measures, some patients believed that things should have been done for them during their hospitalization stay. When this proved not to be the case, the lack of involvement that they experienced was perceived as being unjust.

> There just seemed like, they gave me what I asked for, medication if I asked for it. Constipated, so I get a suppository.."Go give yourself a suppository". I don't know, when I was in the hospital in 1990, I got excellent care. I was impressed with the care. But it just isn't there, they don't have time. (2A)

> And about an hour and a half prior to that the nurse came in, she said; "I would like you to prep yourself". She gave him a sheet of paper; 8 1/2 by 11, with a diagram of the front of the body and the back. Explained to him that he was to shave from the neck down; down to his chest, down the legs; both legs, down the side. I was watching my husband, he was shaking because no doubt. even though as calm he may have been, I'm sure there was a lot of fear within him. And I really thought that that was very degrading. (2B)

Two patients wished they could have immediately returned to the referring hospital following their CABG surgery in order to complete their recovery.
Their dissatisfaction was obvious.

> The nursing care there is altogether different...It was just when you needed something, there was a nurse right there. I never ever had to ring for a nurse. At the UAH I was ringing. Sometimes, I didn't bother because, you just lay there and said to hell with it. (4A)

Caregiver Presence

For the majority of the patients, their hospitalization period was marked by the presence of their respective caregiver. Even the harsh winter weather and poor driving conditions proved to be ineffective deterrents to their steadfast presence. The concern for their spouse and the hope of securing proper care induced the caregivers to remain present in the hospital during the time immediately preceding the surgery and every day thereafter.

> And of course I had gone right up to the surgical studio; the unit where they do surgery, the operating studio and I was there with him until they wheeled him into surgery and ah, I felt comfortable about the whole thing. Again, a bit frightened but ah I felt very positive. There wasn't a doubt that it wasn't going to be successful. (3B)

The caregivers demonstrated 'a great need to be there' on a continuous basis, as they did not want to leave their partner alone.

> I was there in the morning of [his] surgery. We stayed right until he left the case room. We stuck to [him] pretty close my daughter and I. We were in daily, daily and leave about ...one night I left about ten o'clock, the other night I left about nine o'clock. Um..one day at four o'clock. (2B)

This unfailing presence did not go unnoticed, as the patients described the paramount nature surrounding the role of the caregiver. The caregivers proved especially helpful when the nurses were unavailable.

> I didn't have any problems but then my wife was there every day. For people who didn't have a family member available to help it was a crime...it comes back to if you got a family member to help you during the daytime, you're, you'll have no problems, you won't have any additional problems. (5A)

The presence of the caregiver or the act of simply 'being there' denoted a key component of emotional support and companionship for the patients. To them, it made a huge difference.

> Very basic. I can't imagine having gone through this on my own. Well, if I had to do, I would do..but ah, [caregiver] was extremely supportive; particularly after surgery. I'd be lying there and ya know, you can't do too much at the beginning, and then you'd hear the trip, trip, trip of her feet coming through the door at eight o'clock in the morning, and she'd stay all day. (1A)

When 'she was there', the patients perceived an added measure of security and comfort.

> I think it all helps. If you were to go to the washroom, and you collapse..there's someone right there, right there to help you even before the nurse comes trotting along, cause you're monitored in the beginning. (1A)

The significance of the caregiver role was reflected in the statements of appreciation extended by the patients. Often, the researcher perceived that the tone of voice and the facial expressions relayed a greater sense of gratitude than the actual words themselves. Yet, one patient was able to express his impressions particularly well.

> I appreciate her, I cannot it's hard to say, I love her very deeply and I love her all the more, admire her all the more after going through all this..together..definitely. (1A)

Following the successful completion of the CABG surgery, the two younger couples who were accustomed to working on a full-time basis equated this period of intense spousal interaction with a certain degree of delight.

> Yes, and [we] have had more time together. I mean, cause, she has a job that takes a lot of hours. Also the travelling back and forth to work, and we've had more time together this last while. And that's been good, it's been very good for us. Things have always been good for us, but even better. (1A)

In addition to this visible presence, the role of caregiver was denoted by other responsibilities. An awareness of the lingering effects of the anaesthetic were described by the patients, for as they drifted in and out of consciousness their thoughts remained fuzzy and disoriented. Under these circumstances, the caregivers independently made all of the necessary decisions.

> Ah, gee I can't recall..she had different days where we have appointments but they're still coming up. We haven't had them yet and uh, she must have got them all. I don't even know where they came from. (4A)

On many occasions, the patients were hesitant to exercise a strong sense of personal authority and ask for pain medication. On these occasions, the requests for analgesic were followed through by the caregivers.

> They certainly weren't withholding at all in the hospital. But in fact [the patient] was going very long periods between his pain meds..and I would come in..like we're talking 11, 12 hours some times. And this is within, after, soon as he finished the Demerol shots which were, I think day 2, and then he moved on to Tylenol #3. And he wouldn't ask for them, and I don't think that he was being a stoic, but he almost didn't realize that he needed them. I would come and I could see that he was irritable, and he was..he was always really good, but he got a little bit more irritable and he didn't want to move around as much. You could see him stiffer, than say how I'd seen him a few hours ago. "I think you need something". He'd say, "well I don't really feel pain, I feel uncomfortable a little bit". Well okay, uncomfortable is what you are calling pain then, so they need to give you something. And so then we'd ask, but then you feel like a bug, ya know asking the nurse for something, it's nothing that they did, but they're busy. (1B)

Eventually, a sharing of decision making and critical thinking became evident. This critical sharing served to assist the patients in resolving their initial doubts and fears in relation to the activities that they deemed appropriate to undertake.

> Oh, I don't know. I can't remember all the details now, but just in doing things, just having somebody there. I didn't need a lot of physical support, like

> to be held up or anything, but "Do you think it would be okay if I do this?" Somebody to say, "Yes" or "No", to agree or disagree. (1A)

The regulation of the number and frequency of guests and the screening of telephone calls remained another responsibility of the caregiver. Two patients suggested that while they were in the hospital they preferred not to have a lot of visitors, as they wanted to simply sleep rather than experience the 'need to entertain' others.

> Well, basically her presence more than anything else. There wasn't very much more that I needed. So, you know, there was just the presence there. We had some company, she played a very important role in just seeing that there wasn't too much company in the early stages. That has a tendency to really play havoc with the patient. (3A)

Monitoring the Progress

Once the surgery was completed, the patients and caregivers began to look for indications of progress. Capable of listening to the language of their own bodies, the patients found themselves in a highly unique and envious position. The first indication of improvement was an increased level of consciousness which was known only to them.

> I'm conscious right, but coherent only to myself. They don't believe anything. Any of the thoughts that are going through my mind. I remember everything, distinctly everything. And to me, I am coherent and I can tell the way they're ignoring me that they don't think I am. (6A)

All of the patients were aware of waking up and becoming increasingly alert.

> Well, I really didn't know the progression at that point, because I didn't know what to expect. But, I could feel that I was getting better, more alert. There was never a question, I had all my faculties with me. (3A)

> I had no interest. I was still groggy from the anaesthetic. It tends to affect me...But, I was starting to get better as soon as I woke up. The third morning, one, two..no the second morning, I was starting to get better already. Your world sort of expands as you feel better. (5A)

This improved awareness was accompanied by the perception of being out of control. Their role as patients in the intensive care unit (ICU) greatly magnified this belief. The management of their own bodies was lost as they endured many invasive procedures.

> When they were trying to pump up my lungs. I would just gag, every time they tried to do that. When you had the breathing tube down your throat. They were trying to clean my lungs out. Cause they were about six percent collapsed. And ah, they weren't quite pleased with how they were coming back. They tried to suction and I would just, I'd react to that. My gag reflex is unbelievable. It was just like going into seizures. (5A)

While the patients were intubated and their breathing assisted by a ventilator they could not freely communicate their concerns. With decisions beyond their control, the patients felt helpless.

> Now, you can't talk. You can't even, you can't even make a noise...I'm conscious, right, but coherent only to myself. They don't believe anything...They put me back to sleep again because I was uh, they said hysterical. Now, I remember. I remember it very distinctly. I screamed. And I did. I remember screaming. Well, the action of screaming. Okay, like the fear. You know, obviously I didn't scream because you, you can't even hum. You can't, you can't make it. But that's what I did. I woke, like as if to scream but the sound wasn't there. (6A)

This lack of control was exemplified by one patient who routinely did not receive relief from the analgesic that he was receiving. His inability to change the circumstances surrounding his experience of pain proved frustrating.

> So, they thought, well, he's hysterical and they put me back under again. And then when I woke up again the next time the pain was humungous. And you cannot um, talk. You can't communicate. And uh, the saliva was giving me a problem...And uh, they were giving me morphine for the pain, okay. And I could only have every four hours some morphine. But the pain would, the morphine just didn't last very long at all. And I remember watching that clock, the seconds go by. The longest was two hours. It would be two hours in humungous pain. Waiting for that next shot of morphine. Which morphine didn't work on me...Then they, then they, finally I communicated through something. Something's wrong...And I think they sort of caught the drift and they gave me a different pain killer. (6A)

As the cloud of anaesthetic continued to dissipate, the first message that declared the patient's actual survival was the symptom of pain. In recognizing their bodies and their symptoms as one of their biggest allies, the patients quickly learned the importance of listening to this inner guidance. The patients' perception regarding their capabilities often rested upon this sensory input and adjustments to their level of physical functioning were determined accordingly.

> You can't. You can't do something you're not suppose to do, because you'll be told, you know. Cause you hurt. (6A)

The expression of pain was variable. Those patients who did not experience a substantial amount of pain proposed that although "you could feel it", it was merely a "discomfort".

> Even after anaesthetic, ya know. I usually get a little ill after anaesthetics and seemed to recoup quite well in that regard. Didn't feel too much pain. I know that they were giving me, gave me several shots of Morphine for the pain, but apart from that it really wasn't painful. I was surprised for the lack of pain. (3A)

The remaining three patients experienced profound pain that quickly crippled any of their initial attempts to become more physically active.

> But, it is quite a shock when you wake up and the pain killers have worn off a bit. I know the first day that I was back to the ward..there was a fellow who had had surgery just after me, who was struggling with a shower next door. And he sneezed that morning and I could hear him. And, I knew what it was like. I couldn't imagine sneezing, because of the pain I was experiencing at that time. And that's a shock too. A basic function, like sneezing, is terrifying at that time. You know it's going to hurt like Hell. (5A)

> Tremendous amount of pain when I woke up after surgery, when I woke up. I was in, in humungous pain, in my chest. That, that's the only place cause it was so concentrated. There's two tubes...And ah, that was the concentration of the pain. (6A)

The chest tubes were identified as the most significant obstacle to the patient's progress. The pain inflicted and the limitations imposed invariably hindered the degree of patient mobility. Unable to demonstrate a sense of personal authority over this acute pain, some patients remained relatively immobile.

> And so, if you find a comfortable position where there is no pain you just stay there. That's what I did anyway. I would stay, I would stay there as long as I

> could. If it was six hours, that I could make it six hours, that's what it would be. If it was two, or whatever. I tried to avoid any movement whatsoever, once I found a comfortable position. Whatever that might be. (6A)

> Uh, in the evenings I'd be, uh, well, watch TV and uh, most of the time I would just lie still cause it really hurt to do too much, ya know. I could go forward with no problem. I could get the rails on the side of my bed and I could get myself up again, but the way they wanted me to, to get out of bed myself was roll over on my side and then put your feet down. Well, it hurt my back and it hurt my front too. I figured there's no damn way. (5A)

Those patients who did not struggle relentlessly with such pain successfully demonstrated a stronger sense of personal authority as they made decisions to test their physical functioning.

> Well, there wasn't very much time to practice anything, there's no exercising or things like this. Mind you other than the fact that they had me sitting up the very next day. But, I was sitting upright and I had no difficulties with that either. Ya, I did some walking. The porter just got me to walk the first day right around the nursing station and right back, and I never looked back from then on. I tried to increase the frequency according to my strength. So, there was that little extra physical activity back and forth. (3A)

For those patients who had experienced a lot of pain, the struggle to regain some sense of personal authority over their actions and behaviours was not recognized until the chest tubes were removed.

> Oh it was, once the tubes were gone and I knew they were out of me so I wasn't anticipating having them come out, cause I was scared of that, ah, and the pain subsided tremendously. It was like ahh, here we go. Okay, now we're starting. Okay, so now, now that it's over, let's start healing up here. As long as those tubes were in I knew it was still, we're not there yet. (6A)

With the removal of the chest tubes things started getting better, as the pain began to diminish.

> Oh fine, fine, sore...You know, I did, I didn't have a problem. I think by the end of the second day or something, you, you should be able to walk around the ward six times. I thought it meant six times. Walk around the ward six times. And I'd have a little rest and I'd walk around the ward six times and then have a little rest. It was six times during the day. I thought six times at a crack. So, I had no problem that way at all. (6A)

The removal of the chest tubes allowed the patients to overcome the second obstacle; that of having a shower. All of the patients acknowledged the completion of this task as a definite sign of progress.

> I showered..with great difficulty. I staggered around the shower and trying to hurry, cause it was so tiring, that you're just trying to hurry, so I get it over with. It was that bad, it was really bad. (2A)
>
> But that was an interesting experience, yes. Um, I mean the water temperature wasn't that off of my body temperature but, I just sat there and I just turned colours. I would think that it's just, just a shock. After I dried off I was fine. *Probably scared your wife though?* It scared me a little too though cause there's no control. (5A)

The patients were not the only individuals involved in the diligent monitoring of progress. The constant presence and attentiveness demonstrated by the caregivers enabled them to witness any overt changes in the patient's behaviour.

> I spent a lot of time with him at the hospital, so I saw his progression and even hourly sometimes the progression was amazing. (1B)

Review of the progress chart on a daily basis served to index the gradual advances of activity progression.

> Um, we also had the protocol that was hanging on his door in the hospital...Ya, they have a protocol, the first little bit, the nurses check off how much he's done, like is he sitting up at the edge of the bed to eat, now is he sitting in a chair, Um what are his saturation levels in the morning and the afternoon. All of those things so, you can kinda watch that progress, and then there was a part near the bottom of it that the family was suppose to start to mark in. So, I did that. How many walks he had taken in each day, and whether he was up showering on his own or not..those kinds of things. So, we had that kinda to go by. (1B)

Consistently, progress was viewed in conjunction with the degree of mobility that the patients could execute. A greater degree of mobility was indicative of an increase in strength and endurance.

> I believe [he] was much sicker than they really realized in the hospital.
> Ah, that day after his surgery when he went into the ward the next day, ah..he was just laying on the bed. Around 1700 they came around to sit him up. As they sat him up on the chair, [he] got an extreme pain down his neck. He went

> very very pale, his lips seemed like they were just cracking, and he said, "I can not stand this pain any more, I'd like to be back into bed". The nurses put him back in bed, gave him a shot of Demerol, I believe it was. And about two hours later they were going to take him for a walk. As they moved him from the bed onto the floor he walked a little ways, and then he got an extreme pain in, around his collar bone. And he was in immense pain. They got him back into bed and gave him a shot of Demerol, the pain was not going away, but [he] just went grey. (2B)

The caregiver's discriminating regard was further highlighted by their reference to the subtleties of the patient's appearance. These indications were interpreted as indirect signs of improvement or progress.

> Well, in the way he'd move around and just his personality. You know from before and know what his personality is like and he's getting it. (5B)

> It was easier after the surgery. He felt well. His colour was like night and day. That's probably the most obvious indicator to me. And ah, I just hadn't realized how grey in his skin he had become...now, he has his rosy checks back. And if I think about it, he'd always had a really reddy complexion, and he was grey, he was very grey. (1B)

The caregivers were cognizant of the circumstances surrounding their partner's condition and his daily regime, 'they knew'.

> And give him his insulin. And doing his bloodwork. He likes it done in his ear. Of course, then you can't do it yourself. Yeah, just, just the bottom lobe of the ear. (4B)

If there were any changes or signs of deterioration in his progress, 'they knew'.

> When I came into the hospital, [he] was in immense pain, nothing had changed for him. They said they were giving him double shots of Demerol every three hours. But, they were encouraging him that the pain would go away when the chest tubes would be out. The chest tubes came out, I believe it was early in the afternoon when they did that. *This was Friday?* Um..let's see.. surgery was on Wednesday, Friday..Right. They were right, the pain eased off. We were very happy with him then. And approximately 1730 that night they were taking [him] for a walk and I had just gone downstairs to get myself a drink... When I got there, sure enough, something had gone wrong, and he'd gone into Atrial Fib. Ah.. so there he was again..to almost base one. (2B)

In this manner, the monitoring of progress proved to be an essential component in the design and creation of a sense of discharge readiness, thereby preparing them both for the transition home.

Discharge Readiness

In preparation of the approaching hospital discharge experience, the patients and caregivers carefully assessed their sense of discharge readiness. This concept represented the degree to which both individuals felt prepared to embark upon future experiences and return home. The patients evaluated their sense of discharge readiness in terms of their physical capabilities. A strong sense of discharge readiness was noted in the following definitive statement.

> Well, I was able to be mobile sufficiently...I was not in a lot of pain, I felt reasonably fit, I just felt that it was time to go home...But I felt, I felt well enough to go home. And ah, you know, I found the hospital a reasonably good experience, but it's always nice to go home. (1A)

For not only did they want to return home, they felt ready and able.

> I wanted to get out. There's no doubt. I wanted to get out. And I could do everything that they had, they had asked with no problems whatsoever. (6A)

A weaker sense of discharge readiness was apparent when a note of hesitancy was voiced.

> *Were you ready to go?* It was close. I wasn't having any problems. There was no discharge. Um, I had no energy reserves whatsoever. I do a little walk around the ward and I'd come back and I would shiver because I was so totally exhausted and uh, that was the only concern I had. Cause, like there's no energy left for anything, nothing left to work with. (5A)

> How does one know really. You really don't know at least not in a situation like that. I really didn't know whether I was ready to come home. Ready on the basis that I had, our guests came, my guests came, and I would occasionally walk them back to the elevators which was a pretty fair shake..run. So, it gave me a chance to get back some of my energy back and I think I was ready to go home. (3A)

Later, this same patient commented that a longer hospitalization period would have been more suitable.

> Well, as I reminisce now. I don't know that I felt strong enough with the few, with the recall, going back to the emergency. And now as I reflect back I

> would say, a day more would have been much easier for me. Cause there were times where I was taking showers and I just didn't have the strength to, to stand barely. (3A)

Two patients lacked a sense of discharge readiness as they did not feel healthy enough to return home. Whereas, the first patient lacked both physical strength and stamina, the second patient noticed a progressive deterioration in his condition following his surgery.

> No. You're not ready to leave at that time...When we came home, I was so played out that I just went straight to bed. And ah, you can't tell me that you're ready to go home...I just didn't think that I felt I was ready but I was glad to go...No, no I did not feel strong. (4A)

> No, I didn't want to come out because I didn't feel good or nothing! I thought I should belong in the hospital...I never did feel well the whole time I was in..at any time! I think I felt better, maybe the first day after the operation, than I did the second, third day. I just kept going downhill, right to the end. The day I left the hospital, I was really sick. I felt awful! (2A)

The decision pertaining to the time of discharge rested with the physicians. The patients did not see themselves as having any choice in the matter.

> But I think they, they programmed it toward the, uh, I don't know that I was ever given a real choice to say well would you want to stay a day longer. Or do you feel it would be necessary or anything like this. I think it was pretty well in place that the way I was feeling at that time and responding I suspected it was a forgone conclusion that they were going to release me. (3A)

An awareness of their sense of discharge readiness was not sufficient enough to motivate any of the patients to contest the discharge decision. Once they had been told, all of the patients perceived this directive to be beyond their control.

> The last half hour that we were there, they were telling us, "You have to leave, you have to leave, you have to leave". Well, you gotta go, you gotta go, I suppose. (2A)

When this same patient was told that "there's somebody else waiting for your bed", he prepared his things to depart.

> They must have been able to see that I looked really sick...I was too sick to put up a fuss with them. If they want to get rid of me, I might as well go home, maybe I'll feel better. (2A)

For the caregivers, the sense of discharge readiness was composed of two very different components. This dichotomy is best exemplified by the following question; "Do you feel ready to go home and do you feel ready to take him home?" Whereas, the patients were concerned primarily with the first clause, the caregivers debated both sides of the equation. In this manner, the careful monitoring and evaluation of patient progress attributed greatly to the ease and development of a sense of discharge readiness within the caregivers.

> Well the fact that [he] was walking longer distances, so really just the physical things. He was getting in and out bed, certainly still gingerly, but more easily. He knew and I knew how to help him turn properly to the side and use his arm to push up...His pain was in control...he'd been stable, he'd gone through all the things on the sheet on the door in the hospital. (1B)

Steady progress in view of patient physical functioning, served to foster a strong sense of discharge readiness.

> I felt fairly confident and I knew it had to happen. Ya know, I was prepared for it. I guess that helped too actually knowing that there was an expected 5 day stay, that was kinda the norm and that people seem to manage fine. (1A)

Following the appearance of this strong sense of discharge readiness, feelings of excitement with regard to the hospital discharge were evident.

> Sure. Um, mostly I was excited that he was coming home. I remember going to pick him up on Sunday and I thought "Yes". I had everything ready, clean sheets on his bed and I had even worked out a way to prop it up, so that he could kind of have an assimilated hospital bed...He felt really ready to come home, so then I felt fine having him home. (1B)

Another feature that served to foster this particular caregiver's strong sense of discharge readiness was the fact that she could be home for the first week and could take more time off work if she needed to. Although the eldest caregiver thought her husband could have ideally stayed in the hospital one more day, she too exhibited a strong sense of discharge readiness.

> I thought he could have stayed one more day at least. But then everyday he was getting a little bit better, a little bit better...They weren't doing anything more for him at the hospital that I figured I couldn't do at home. (4B)

During the inhospital stage, the presence of the medical and nursing staff provided the caregiver with a sense of security. The thought of returning home without this support caused each caregiver to evaluate their ability to fulfill the role of caregiver.

> But they were there in case I needed them. So, here you're on your own...I didn't have the confidence. I wish I did to take care of him...There is no doubt I was, I was petrified because I don't have the background of being a nurse and uh, then when you're left in charge of this person you care about, it's scary. (5B)

If the assessment of her husband's physical prowess was poor, then this was reflected in the caregiver's sense of discharge readiness. Those caregivers who were leery of this responsibility and expressed a lack of confidence regarding their role of caregiver, demonstrated a diminished sense of discharge readiness. Under these circumstances the caregivers were concerned about "what am I going to do with him?"

> He was very weak, very weak. And ah..I suppose again, there was a fear of complications setting in. Everything was so fresh, so new, the incisions, the mending that was taking place inside, any little thing, I didn't know how much he should be doing. (3B)

Also, the course of recovery immediately following the surgery attributed to the sense of discharge readiness. The presence of any cardiac arrhythmias during the inhospital stage undermined a strong sense of discharge readiness, as the caregivers were concerned that it may happen again while they are at home.

> In some ways the fear is greater, because you don't have like the nurse down the hall that you can call. Or like I said, like the concern about the episode recurring..."What if that were to happen at home and I can't get a pacemaker so quickly!"...they took him off the Metoprolol for a bit, but they did restart him in hospital at half the dose. But, I was still a little bit concerned about

> that, cause they restarted him, I think just a day or two before discharge. I kept saying, Wow if you thought that this was drug induced, like you're giving him the drug again, okay half dose sure but, what am I to do if this happens at home? (1B)

The transition from the hospital to the home progressed more smoothly when evidence of a strong sense of discharge readiness was expressed by both the patients and the caregivers. In this study, those patients who exhibited a strong sense of discharge readiness followed an uncomplicated course of recovery. And, those patients who did not demonstrate a pronounced sense of discharge readiness were confronted with a variety of complications that necessitated additional medical attention.

Home Recovery

The departure from the hospital was the next monumental step along the pathway of recovery. The caregivers were "amazed" at how "relatively quickly", the patients were discharged home. This shift tended to create a temporary illusion that suggested, " he [really] didn't seem as sick in a way".

> To see him kinda in his own clothes again, walking around even doing bits and pieces, like make a cup of tea or come sit at the table for dinner versus on the side of a hospital bed or sitting in his chair in his hospital room. You just look that much healthier and it's a less clinical environment. Um, and he was healthier than he had been a few days in hospital. (1B)

This impression was promptly erased as the patients and caregivers recognized the immediate period at home as being the most vulnerable time, when there could be a relapse or something might go wrong. In response to this realization and the patient's limitations, the caregiver's attentiveness grew into a more pronounced expression of "protective vigilance", as they continued to care for their spouse at home. Even though this protective vigilance acted as a safeguard for the patients, the role of the homecare nurses was identified as an essential contributor in facilitating the transition home. Prior to examining each of the themes underlying the home recovery stage, the discussion will initially revolve around the concept of protective vigilance and the instrumental role of the homecare nurse. With the exception of the youngest patient who returned home without the extensive support of a caregiver or the homecare nurses, the other patients confessed that they could not imagine returning home alone.

> God, I don't know how I'd live if I'm coming home, you couldn't, you couldn't come home that fast without having somebody here. It's, it wouldn't fly. Even with the homecare nurse coming once a day, that wouldn't fly. (4A)

Within the familiar surroundings of the home, the patient's world began to unfold as they proceeded to advance through the four themes underlying the stage of home recovery; namely, self improvement, being alone, trusting myself again, and the possession of a futuristic perspective. As the patients moved through these themes, improvements in their physical well-being corresponded with an expansion of their sense of personal authority. Seemingly, the degree to which the patients exercised control over their personal decisions and behaviour broadened with the appearance of each theme, until they eventually demonstrated a commitment towards a healthier future.

Protective Vigilance

During the inhospital stage, the provision of formal health care services allowed the caregivers to exhibit a more passive attentiveness toward their spouses. Yet, once they were discharged, the caregivers found themselves almost totally responsible for the patient's needs and welfare.

> I was concerned. The main thing throughout this whole thing was concern about him. I wanted to make sure he was getting the proper care which I didn't think I could do. So that was the main thing. Was he getting the proper care? (5A)

In comparison to the patient's world which was gradually expanding, the caregiver's world became temporarily enclosed within the confines of the household.

> I do a lot of volunteering up at the nursing home. Right now, we're doing a quilt for raffling. I love quilting and I haven't made it up there yet. (4B)

> I went to a "Keep Fit" class this morning and worked out and I think that helps me a lot. Which I hadn't been doing for the last two weeks, since he's not been well. (3B)

The initiation into the caregiver role was manifested by changes to various aspects of the caregiver's life.

> I don't drive in the winter. In the summer I drive once in a while. So, I found that actually really upsetting. *Why?* Because I haven't driven and I'm not confident. So, with this, I had to drive. I've got to drive. Oh, he knows I'm scared to death of driving. (5B)

> I drive a standard and I think I'm a reasonably good driver, but a couple of times I must have lurched the car a little bit or bumped it and he said that he really felt that, bothered him in his chest. So, I thought, gee if that bothered him before surgery, now that he's been cut open and his breast bone wired, how's that going to feel? So I was conscious of driving very gently and he had his heart pillow between the chest and the seat belt, so he was okay there. Um and then just the walk to the house. I just wanted him in the house, so that I knew he'd be safe. (1B)

Although the extent of disruptions to various aspects of the caregiver's lives and households were variable, normal routines were indeed interrupted. The challenge of providing care for their spouses came with "extra additional responsibilities" that were not normally part of their normal responsibilities.

> A lot of physical responsibilities, like maintaining the place, yard, the lawn, the snow, moving things, and just manual things that I had to do. For I certainly didn't want him to do anything. (3B)

> I mean it's just an enhanced thing of taking care of stuff around the house totally, almost totally myself, compared to we've always shared that. All the snow shovelling, feeding the birds, and doing the grocery shopping. (1B)

Certainly, the provision of care required an enormous time commitment. Often, the caregivers were immersed in the patient's welfare to the exclusion of their own needs.

> I stayed up most of the night with him. He was not able to sleep. He dosed off for half an hour. I never slept from Monday night..I honestly say that I probably had a few hours sleep Friday, but I stood by him all the time. (2B)

> Physically exhausting because we got up during the night a bit. Mentally, I found it exhausting to a certain point because I was afraid that something was going to happen to him and I wouldn't be able to deal with it. (5B)

The protective vigilance that the caregivers exhibited was best exemplified by the constant need to continually check and watch over their spouses in order to ensure that everything was alright.

> The way he was, I would just look over [him] all the time. I would creep into the bedroom see if he's breathing and he would just tell me; "I'm getting worse". (2B)

> I'm with him all the time, I don't let him out of my eyes really...And I don't feel comfortable leaving him alone as yet, because you never know. (2B)

The caregivers were hesitant to let their husbands out of their sight and the patients found it very reassuring to have their wives at home as a "backup" during the first two weeks.

> So even things that he would do at home, like go downstairs to have his shower that scared the living daylights out of me. I was constantly watching and checking to see if he was okay, because it only takes a split second to lose your balance or get dizzy, or fall or whatever. (3B)

While on the alert, the caregivers devised different interventions to successfully monitor any changes in their spouse's condition.

> She's like a mother hen at the best of times. She would make a good nurse. She's organized, she did all that written work for blood pressure, all the pills and make sure they're on time and she did that all herself...I monitor my blood pressure first thing in the morning, and she writes it all down, along with my weight. (5A)

> One of the things that worried me, was if I'm downstairs or something and he needs something. So, I borrowed a baby monitor. It really felt good for the first day or two. Cause I could be somewhere else, like if I wanted to go and fold laundry or whatever and he was sleeping...he would play music while he was falling asleep, he found that really nice, so I had the baby monitor on and I got his music at the same, and it would click off and I could hear him breathing. Ya, that was very important. (1B)

One caregiver was overly cautious about seeing that her husband did not become overtired as a result of having too many visitors.

> Yeah, there were times that the phone would ring and people would say, "Well, can we come over and visit?" And I'd say, "Well, I think it might be better if we leave it for another week or so. And I would like to think that people respect that. But to begin with, we didn't encourage company. And I found that if we did have company and they'd stay for quite a while he was tired the next day. (3B)

As the caregivers remained vigilant, precautionary notes with regard to the patient's behaviour were readily introduced.

> I was almost an old eagle eye, always concerned and watching what he was doing. Making sure that he wasn't overdoing it and perhaps obsessed with it, I don't know. But overly conscious.."Oh don't do this, you're not suppose to do that"..that type of thing. (3B)

For the majority of the patients and caregivers, the recovery stage was a slow and arduous process, taking longer than most of them had anticipated. This proved to be frustrating.

> When he feels irritated, it irritates me. So, it just takes a lot to control your emotions and be patient. It's an endurance test. (3B)

> Yeah, lately I'm thinking, But I'm just, it's just me trying to rush things a little bit. Because I mean he's feeling good and when you're feeling good, well you, you feel that he should be doing more, right? But then you think, well it hasn't been that long since surgery and this is major surgery. So, let's not push it. (4B)

As the patients continued to witness improvements in themselves, they became somewhat resentful of the caregiver's protective vigilance as they wanted to regain their sense of personal authority and be able to exercise increased control over their own decisions and actions.

> For a few times and then he forgets again. So, I'm like a nag right now. I have to keep telling him what to do. And then of course he makes a funny face and won't do it anyway or he'll do like I say two or three times and then that's it. (4B)

Under these circumstances the patients began to label their caregiver's attention as a form of "nagging" or "bugging" them.

> Even after his heart attack, I was too much of a mother. And he at one point told me that. I was continually saying don't do this, don't do that and he was getting quite frustrated. So this time it wasn't as bad, cause I knew I shouldn't be doing that. But ya know, you tend to be watching every move they make, every breath that they take. (5B)

One patient was actually glad when his caregiver had to return to work.

> Thank God. I work shift work normally so we don't normally see each other on a twenty four hour a day basis... But on a situation like this that it's twenty four hours a day, there's a bit of an adjustment to make. When we're doing the twenty four hour a day basis we're both on holidays and then it's no big deal. (5A)

The criticism of the caregiver's protective vigilance usually developed at the point when the patients could be safely left on their own. Consequently, each caregiver made a conscious decision to no longer hover and to let go.

The Homecare Nurses

The homecare nurses were identified as the vital link that helped facilitate the transition home following the hospital discharge. Their service and care were deemed invaluable by the patients and caregivers, and as well they were perceived as an intermediary between the patient and the physicians.

> And the thing that really bothered me was his irregular heart beat, and the...the ah, the heaviness with which his heart would be pounding at times. And of course, I know that's not normal, that's not natural. So of course I found this very frightening. But ah.. then the homecare nurses were very supportive and they certainly did show concern about the situations that they weren't too certain of themselves, and they took precautions to see that things were done properly. If they were in doubt about anything they always phoned the doctor. (3B)

> But second, having the homecare nurse here was excellent. Um, I think it's just a very sensible and efficient way of doing things. I really do...In the old days you'd be kept in the hospital longer probably, but having that homecare nurse, if you're in reasonable shape, I mean she can pick anything up if it's going wrong. Ya know, we realize that she was concerned about this lobe in my lung, now had that not cleared up ya see, in fact she did notify my GP.. that it might be worth having an x-ray, just to find, to double check. And I did have another x-ray, and it was found to be clear, it was okay the lung had got back into proper action. (1A)

The patients and caregivers were impressed by the compassion and concern that these nurses exhibited toward the patient. They not only made themselves readily available, but they also made sure that the couples knew of additional resources to contact should anything go wrong.

> And then the homecare nurse came for the first week and then twice in the second week. I went back into the Emergency twice, cause I was leaking. No problem there, but in some case there is a problem. The homecare nurse was very reassuring, and she said if you ever have a problem call. And I was very impressed. In fact, my wife phoned her supervisor and complemented the excellent service. I would recommend that to anybody. (5A)
>
> Anyhow, and that's where the homecare nurse was also very reassuring, cause she told us that John would be listed, for the first week with Emergency Medical Services, or whatever. So all I would have to do was dial 911, tell them who we were and very quickly come onto the screen, what his problem was. So at least they would know what they were dealing with. (1B)

Invariably the presence of the homecare nurses "took a little roughness off of the edges" surrounding the transition home, as their involvement eased the anxiety and stress associated with having the patient home during the early portion of the recovery trajectory. Armed with questions and concerns, the caregivers eagerly awaited their arrival.

> Oh ya, the homecare. Right. And, I was looking out for them every day. I could hardly wait for them to get here, because he wasn't well. And they would give me a little encouragement. (2B)
>
> *So what made the transition from the hospital to home easier for you?* The homecare. The girl that came. That was very very helpful. *Can you tell me a little about that?* Well actually, medically she was just terrific. She did everything, showed me how to do everything. We phoned her, sometimes once or twice a day because both of us were concerned, and she was always there to help, and listen to any problems. She was very friendly, it was kinda something to look forward to. *Did it alleviate a lot of your stress?* Yes, it did, cause I always knew that she was coming the next day. So, if there were any problems, other than when we phoned her, she would be there. She was great, just super! (5B)

The positive feedback that emerged from the interviews associated the homecare nurse's role with the concepts of reassurance, reinforcement, and referral recommendations.

The provision of homecare services for the initial four days that the patient was at home proved very reassuring for the couples. The careful assessment and monitoring of the patient's health status often relieved the couple's anxiety regarding the patient's condition while it restored the caregiver's confidence in the care they extended.

> I knew that there was professional help coming to the door. And they were here every day. Uh, not to say that if, if he needed immediate care and attention, like, that he would get it. But they were certainly here to, to oversee anything that, you know that was required and very helpful in the sense that if there was something that they saw needed attention and they couldn't attend to it, they'd leave. They'd phone the doctor. Yeah. So they were very good about it. And uh, I, I can honestly say that they were, they're, they appear to be concerned about their patient. They would phone frequently. (3B)
>
> Assurance that I was looking after things right. Well, I guess just that support. That, that I don't know what else to say. Well she was always in contact with the physician or if we'd talked to the doctor, then we relayed to her what the doctor had said. (4B)

A greater expression of reassurance rested upon the provision of consistent care, when the same homecare nurse remained respectful of the provision of the homecare services throughout the entire follow-up period.

> No, I think the role that homecare played was tremendous, it was just tremendous. The four days when the nurse..and just the fact that, for us it was nice continuity cause it was the same person, but mostly because I felt very confident in her knowledge and skills, and she made herself available, we saw her first thing in the morning, she just reinforced everything that was there...she answered all sorts of questions, she was very open to any kind of questions, she was a wealth of information. She was terrific, she was very competent, secure and knew what she was doing. (1B)
>
> Most definitely and to reassure her the home care nurse was coming every day. If I went to hospital, no, every morning, she would come first thing in the morning. Uh, she'd be here before nine o'clock in the morning. And that reassured C. cause uh, any questions that C. had about what should be happening with me, what she should be doing, she was answering them right away, no problem. Um, we both felt she went above and beyond helping us. (5A)

With the overwhelming nature of the inhospital experience, much of the instructional information conveyed to the couples had been successfully eroded or remained unclear. Fortunately, the homecare nurses were able to act as crucial resource personnel. The skills and knowledge demonstrated by the homecare nurses enabled them to answer the many questions asked or reinforced the means of care exercised by the caregivers. Each caregiver was evidently needing of this support and highly appreciative of the fact that the homecare nurses would "take the time to talk to you".

> So here you're, you're on your own. As it goes we manage by, but um, but not without, if the home care hadn't come I'd have really been upset. *What difference does that make?* Um, because when she came here, we kind of go, and relax for that half an hour or forty-five minutes. If you had any questions that she was there and she was very efficient and made sure that we had all the answers. So, that made a difference to me anyway, and she was great. (5B)

Based on the astute monitoring and assessment of changes surrounding the patient's health status, the homecare nurses were often in the position to make direct recommendations for the couples or initiate any necessary follow-up appointments for the patients.

> She was the one who stepped in there and recommended Dulcolax suppositories, and wonderful effect and then he was fine, again it was getting rid of all that stuff that had piled up because of the iron pills, I guess particularly that he was on. So, that was a bit of a concern. And then, for a while there we were concerned that he had a bit of maybe infection in his leg incision just where it crosses the knee. But we happened to see our GP the day after the nurse was getting the most concerned about it, the GP thought that it was just fine. She got us to do Normal Saline soaks regularly, which he did, showered regularly..so, it's done just fine. (1B)

> And I had a shower sitting down. And uh, the water started to open up one of the stitches. It started weeping. So, the homecare nurse checked it out and decided I should go over to see, get it checked out. (5A)

> The next day there was a home care nurse. And again, very very polite, friendly, helpful person, made quite clear what she wanted to know and what she wanted me to do to get my lungs working a bit better, and this sort of thing. And sucking up my little ball in the tube..."I hate that". And ah.. and she was very attentive, particularly to my lungs, because there was one lobe

> that hadn't fully opened. She couldn't hear motion. And ah, but that did change. And ah, gave me good advice, like how much exercise I should be getting. And ah, that was good. I thought it was a very good idea, to have that four days of monitoring. To check that I was settling home okay. I guess my wife, was here all the time. And ah..getting advice; look, if this happens, if you have angina, use your spray and so forth. Ah, the conditions under which I should get myself into Emergency straight away. (1A)

The initiation of interventions on behalf of the patients by the homecare nurses often ensured appropriate follow-up care. One patient in particular, who was unlikely to have independently initiated his own appointment, followed the homecare nurse's initiative once she had booked his appointment.

> I think as sick as I was, after I came home from the hospital, I don't think I would have gone back into the hospital. I would have probably just said; "Well, just leave it, I'm going to get better now". But the homecare nurse said; "You're going in tomorrow, I made arrangements already". I probably would have waited another couple of days..The next day, when I came out of the hospital..when I was here and the homecare nurse was coming, I was proud that she was coming up. Proud to show her how good I was. (2A)

> And if it wasn't for homecare, I know my husband just would have laid there. (2B)

With the provision of attentive care and support from the caregivers and the homecare nurses, the patients came to recognize improvements in their health.

Self Improvement

Having just undergone major surgery, the vulnerable nature of the first two weeks at home were substantiated by the patient's initial limitations.

> It wasn't like night and day in terms of his function. In fact, when he came home, he probably could do less than he did before surgery, definitely. He was certainly limping around and things like that..actually, it was quite something to see him at home. (1B)

> He's a bit more poky than usual. He's a little slower but that's okay, but he's slower in his planning and his thinking. And I think that's probably anaesthetic too, getting ready to go out, he gets his coat and boots but forgets his hat and gloves. (1B)

At this particular time, none of the patients expressed their satisfaction with having had surgery, as their enthusiasm was drastically undercut by their lack of physical strength and stamina.

> I was limited and I knew I was limited...Just no energy, no energy. I mean, my energy level was way down, because I didn't have a transfusion for one thing. And my energy level was down and you just couldn't do the things that you would like to. After surgery it takes a little bit of time to begin with to get your strength back. But I was limited in the things that I could do. Things like showering for any length of time. Walking. Things like that. (3A)

> Cause I like a lot of physical activity, it's a little dampening for me, I can't go out and shovel snow...That's one of the frustrations that I have to live with for the next eight to twelve weeks, I'm very limited to what I can do physically. But I can walk and I can extend that walk. And I'm going to do it. (1A)

A pronounced level of fatigue surrounded this initial two week period. The patients tired very easily and spent a considerably amount of time sleeping.

> The fatigue was the thing that they missed. They could have emphasized that considerably more, I think. If you're going in for major surgery, you expect to be sore and have some pain, but the sheer exhaustion for the first couple of weeks was a total shock. I mean standing up was an effort. (5A)

> The first day, I spent about four hours in bed asleep. But most of the time, after that, the longest I've slept was one hour in the day, and I was up and about gently...And I wasn't going up and down stairs much in the beginning, and spent more time in bed. There'd be certain times in the day where you'd get tired and go to bed. (1A)

> Well, when I first came home I would be in bed for a couple of hours, then I'd get out of bed for maybe a half, three-quarters of an hour and I was back in bed again. But that's changed all around now already. I'm up more than I'm down. (4A)

One patient remembers having strange dreams right after he left the hospital to return home.

> I would always dream that I was somebody else, it wasn't me in the dream at all..I was just a different person. This one time, I dreamt that I was me, my wife, and my son. I was taking my son to a basketball game, and we were coloured people. I was a coloured person. Not me coloured, just a totally different person completely. What kind of a dream was that, it doesn't make

> any sense really, Next night I was somebody else going up and down a railway track. (1A)

In the beginning, the patients complained of having poor appetites as foods rarely tasted the same.

> I'd eat. Ah, I'd force myself to drink juices and forced..everything I did was forceful, cause I didn't want anything. My wife gave me peach juice of all things, and I thought it tasted like bean juice. I had no taste for anything. (1A)

While experiencing severe nausea, one patient did not eat or drink sufficient amounts and became weak and dehydrated. Eventually, he was returned to a neighbouring hospital, where he was given intravenous fluids in the emergency department.

> I was nauseated, same as I was in the hospital, only so bad, that I was going down hill. There was no colouring left in me. I was just like, it was just like..like I was dying. (1A)

As the patient's appetites improved and they began to eat more, they could feel more energy returning to their bodies.

> Appetite's getting better every day. Yeah, I'm already weighing what I weighed when I went, when I got sick. Now, I'm afraid I'm going to get too heavy. (4A)

> He's just got more energy. I mean before this he was sleeping a lot during the day, and it would take all the energy he had to come to the table and have his meals. But, he wasn't eating or drinking that much before either, and now he's having a lot more, and of course it's giving him more energy. (3B)

> I think the body was starving for energy. And so, as I started more food intake, I started getting my strength back, and getting better and better every day. (3A)

As the patients began to feel better, they began to exercise more control over their actions and behaviour.

> Actually one thing that was really nice is to have control over his pain meds and that'll sound funny, because they certainly weren't withholding them at all in the hospital. So, it's just nice to be home and he can control that a little bit more and take it as he wanted it and he's still never overdone it, by any means. (1B)

As the patients found themselves gradually becoming physically stronger, they became involved in more activities. Attempts were made to extend the amount of time spent performing aerobic and ambulatory forms of activity.

> Um, walking the mall, a few times. Um, watching TV mostly, cause when he goes on the computer or whatever, it hurts his chest. We had company quite a few times. Last night actually we went out to our, we have a shuffleboard tournament. We went out there. Sat there for a couple of hours. (5B)

> I can use my, he told me I can go ahead and start on the treadmill now at home. But he said, take it easy. He said, only five or ten minutes and he said very slowly. (4A)

> Up and down these stairs half a dozen times in the day. When I first came back I did it very slowly. I start part way and take my pulse, now I go up and down just like normal, except for my leg. If I turn my body right, I can feel my heart beating, if I get the right position, cause my pulse is really hard to find. And I think "dum, dum, dum", ya that's usual, that's the usual one. (1A)

While in the company of their caregiver, the patients continued to witness improvements in how they were feeling and what they were able to do. Still, they remained cautious, as they did not want to take a chance and overdo it.

> Oh, I can walk for ten minutes, fifteen minutes. I don't walk very fast. I got no place to go. But I can walk for ten minutes. I haven't tried stairs yet. But, I go up and down this step here. Oh, that's not too bad. But I don't want to go down a whole flight of stairs yet. I think I could if I had to but it's just that I don't think I want to exert myself that much. (4A)

> I walk around the kitchen and living room about four or five times a day. That's about it. Oh, I make my own lunch...But I go till I get tired, and then I think okay, let's not overdo it. (5A)

> I don't want to take a chance. Because if I'm perfectly flat there's nothing to grip onto to pull yourself up with. So even when I'm sleeping on the couch or here I'm okay...but I don't want to take a chance on falling apart. It probably wouldn't do it from what I, the way they described the way they put the wire in there. It'll heal a lot faster if I don't mess around with it. (5A)

The one patient who returned home without the assistance of a caregiver or homecare nurse suggested that he probably did overdo it, as his financial needs and parental responsibilities necessitated him to immediately return to work and drive the children to school.

> We basically ate and watched movies. And slept, that's about all I can remember. Everybody loved it. We just didn't do anything. We were out every day and did some little thing. Went to West Edmonton Mall the second day I was out. And they just went walking around shopping and I just sat there, had a coffee, just sat there...Everything happens downstairs, so I'm up and down the stairs. Not a problem until two days ago when I was real sore and tired...I probably did overdo it a couple of times. (6A)

Being Alone

During the first two weeks of their home recovery, the patients were never in the position of being alone. With the exception of the one patient who returned home unaccompanied, the others spent this early convalescent period with their respective caregiver. Following this intense period of interaction, the task of 'letting go' and leaving the patient unattended proved very difficult for the caregiver to do. The decision to decrease their vigilance was made in view of their evaluation of the patient's progress.

> Just by observing the progression that was taking place. I could tell that he was feeling better and had a little more energy and a little more strength. And I'd just say; "Make sure you don't go downstairs when I'm not here"... But he certainly would understand that he was to be a little more cautious, cause he was on his own. (3B)

> It must have been about three weeks later, I'd go out on my own cause I'd have a meeting to go to. So, I could tell by what he was able to do around the place that there was no need to be concerned about being left alone. (3B)

With the advent of appreciable progress the responsibility of care was shifted back to the patient as the caregivers 'let go'.

> I find it concerning leaving him, but I know now he's on, I think pretty well on the make. So now it's okay. (5B)

> Ah, but yesterday he went for his walk and that's what he asked for. I drove him, I walked with him, got him back home and I kinda told myself; "Okay, it's up to him now. He knows what he can do and what he can't do. And if he overdoes it, he'll know that he did a little too much". So, I'm starting to feel a little more comfortable. (2B)

Greater ease surrounding the decision to depart was apparent when the agreement was determined via mutual accord.

> He was ready..well he wasn't ready for me to go, he was such that I could go back to work, and when we looked at that we thought that that was reasonable. He really was well enough. He could roll in and out of bed without any problems and in fact, he was up most of the day then... So, I didn't have a problem with going back, and I felt almost better about that than when he had been first diagnosed. (1B)

One caregiver had to be persistent in her decision to leave, as her spouse remained doubtful regarding his own capabilities.

> When I initially left the house I worried, because he left that impression with me, by saying; "What if, what if?"..He has got used to me doing all this for him, that he just keeps expecting me to do it. I mean the more you do for him, the more he wants you to do it for him. (4B)

Following this careful scrutiny the caregivers were able to rationalize their departure based upon their impressions that nothing grave would happen in their absence.

> Well, for the first little while I did not leave him alone. There was always someone here with him. And then, when the time came that it was necessary for me to go out, say to the shopping center for whatever reason, I would leave him for half an hour or forty-five minutes when he was resting. So, I didn't feel that there was much that could happen while I was gone, other than something would have to go haywire completely. (3B)

Prior to spending any considerable amount of time away, the caregivers initially executed short outings while their spouse rested quietly. As their outings gradually became more extensive the caregivers routinely called home in order to ensure that all was well.

> *So, you were home for the first two weeks and then you went back to work?* Yes. *How was that for you?* I found it really hard. I work with doctors and so one of the physicians she would come and ask actually how he was doing, what was going on and I would explain and she would say; "That sounds good!" So, that was really helpful, that was really good. But I did find it very difficult working. I'd phone home every two hours to make sure he was still there. Ummm..at least for two weeks, but after that I settled down. (5B)

Although they had physically removed themselves from the situation in attempts to ‘let go’, the caregivers continued to exhibit an air of concern.

> No, even when I went to "Keep Fit" the first time, I phoned immediately after the class was over. Or even maybe half way through at the break I might have phoned and said; "Is everything okay?" But he had a cellular phone. Or a remote phone that he kept beside him all the time. And that was the other thing I felt was comforting, was the remote phone. (3B)

The experience of "being alone" did not conjure a strong emotional response, for the patients were not terribly bothered by the fact that they were left alone.

> Didn't really bother me. Because, I'd sleep half the time when she was gone anyway. (1A)
>
> I know that it affects everybody differently. But in my particular case, no, I never, after the fourth day, I could come home and function quite well. Barring no difficulty, like me falling down the stairs or something. Now, that's a little different, because there would have been absolutely no one home; my kids being in school. (6A)

With their remote telephones at their side, the patients portrayed themselves as being content with their situation. In this position they felt reasonably able to do things for themselves and if anything were to go wrong they felt that the necessary medical aide was close at hand.

> No, not really. No, I had my Nitro. spray, I always had the phone close at hand..it's nice having a wireless phone, cause I could walk around with it, and if I'd go to the can, I'd take the wireless phone with me. So, I knew I could dial 911 and have somebody here basically in minutes probably. (1A)
>
> If there was any problems I know I'm going back in there. Anything that was, if we felt it was getting out of hand or anything. That's what we were told. (5A)

Closer examination of the data, revealed that during these times alone, the patients spent a considerable amount of time pondering their situation, especially their future. Time alone gave them the opportunity to become comfortably aligned with their thoughts prior to taking on the complete responsibility of shaping and controlling their futures. The patients were involved in a period of introspective evaluation.

Often, these thoughts translated into a philosophical view which displayed a value reorientation and valuation of self.

> It's all over and you've been given a new lease on life. I'm not cured, I still have coronary artery disease, but I'm in the place now to do something about it..Now, I have at least ten, I think. Although, something else could get me instead. But, okay then, I'm going to make the most of it. I'm going to live as if I only have ten, and if I end up with twenty or thirty or whatever, than that's great. That's a bonus. That's what I've decided to do. (1A)

One patient suggested that many aspects surrounding his CABG surgery simulated a mid-life crisis.

> It's like a mid-life crisis I suppose..I have needed time to think, to read, to think, to write, and I've been given this. This is, it's a wonderful sabbatical. And ah, already I have done alot, and I feel I've regained contact with my inner self that I had lost for years..I've listened to more classical music in the last two weeks, than in the last two years. I've read more books in the last six weeks than in the last year. I feel back to myself again, this is the person I like and want to be again. (1A)

Invariably, this introspective evaluation acted as an impetus to their desire to regain a full sense of personal authority over their lives aimed at embracing the future.

> It doesn't pay to be. I mean, I'm not a traditional type A, as they call them, but I have elements of that, I know. Now, this has brought me up short. Now, do I want to go through it all again? No...I've now been given a new start. And it forced me to rethink, how did I get myself into this place. It may be partly genetic, and you can do nothing about that. But I had a lot of stress in my life. I was working sometimes 60-70 hours a week. Um..sometimes for several weeks at a go, going in on weekends. I'm never going to do that again, never. It's just not worth it. I'll do the best I can. (1A)

> Ah, your whole priorities change. There was a balance between looking after your health, your job, and your family. Everything balanced out after my heart attack, cause it was moderate to severe. After this surgery, the health has taken over, oh more than half of my priorities and my family and job are in descending order after that. (5A)

In addition to their involvement in this introspective evaluation, the patients began to test themselves, thereby gaining a sense of trust in their own functional status.

Trusting Myself Again

During the initial period of the home recovery stage, existant somatic complaints were identified as the primary factor responsible for the patient's inability to function effectively on his own. As soon as the patients were on their own, they needed to learn "to trust themselves again". However, not unlike the somatic complaints, this mental ideology could also act as a hurdle against a successful recovery.

> And I was learning to go for walks and to trust myself. That took a bit of doing. It was a lack of confidence rather than, not physical ability, but daring to try it! (1A)

The necessary passage through this phase served to further reinforce the patient's sense of personal authority as it gave them a greater sense of confidence in their capabilities.

> Well, even though I know I've had surgery and it should be reasonably okay now, there's always some hesitation. "How far do I dare push myself?" "What if I collapse out there?"...Now that was again, short drives first. Like to go and get the paper down at the corner. For "What if I'm halfway through the busiest intersection and suddenly I get severe angina?" (1A)

As they ventured out on their own, the patients tested themselves and gradually began to extend their efforts.

> I'd just go for a walk around the block and then come in. And then I'd extend on the next day. I'd maybe do a double block and that was fine..And in fact, eventually I was walking a mile, I never felt any problems. (3A)

> I disciplined myself. I've got to go in the morning ride for 10 kilometres or I can drive and then do my walking for half an hour down there. So which one do you want to do? (6A)

The accomplishment of tasks led to increased feelings of confidence about their own capabilities.

> And of course as you keep doing it, you realize that this isn't going to happen and that things are okay. This is not likely to happen. So, the more you do it, the more you realize that that's okay. So, your confidence increases. (1A)

> I wound up walking to buy the paper in the morning, there and back; it's maybe a mile and a bit. For just the confidence that.."Hey, I did it". (1A)

One patient did not demonstrate the need to learn to trust himself again as he did not feel a lack of confidence following his surgery. Instead, he began to question the success of his recovery, as maybe he was feeling better than he really should.

> I almost think there's too much, too much, maybe I feel too good. (6A)

The realization of this trust in self and the improvements in their sense of confidence were evident only at the time of the second interview, four to eight weeks following surgery. At this point as well, there was a noticeable change in the direction of the patient's thoughts. A futuristic perspective was adopted, whereby the circumstances surrounding the past CABG surgery had become somewhat inconsequential.

> It's a big operation, I understand now just how big it really was, now that I look back. Sometimes I wake up and I wonder if I really had gone through it and I have to look at the scar on my leg or something to really believe it. (2A)

Futuristic Perspective

The outstanding characteristic associated with the second interviews was the existence of a futuristic perspective. This futuristic perspective was best exemplified both by the use of the active voice in their sentences and by their plans for the future. Significant modifications in lifestyle choices, employed by the patient to reduce the risk factors associated with their health status, were integral to these plans. All of the patients with the exception of the patient who returned home independently chose to participate in a cardiac rehabilitation program. Even the two patients who had previously been involved in such programs following their initial heart attack, decided to repeat the course again in order to upgrade their current knowledge. The engagement in these programs assured the patients of the thorough cardiac monitoring that they sought in conjunction with a suitable exercise regime.

Physical improvements and a durable sense of personal authority led the patients to practice a greater sense of command over various aspects of their lives.

This was exemplified by the directives and future plans instigated by the patients to incorporate regular exercise into their weekly regime.

> I know that once I get on this exercise program, in another six or eight weeks from now, I probably won't even think about this anymore. (4A)
>
> Exercise is a higher precedence now. A higher priority. Umm..I'm walking. The last days, I walked from here to the restaurant at Westmount and back. As soon as we're finished here, I'm going to do the same thing again. I pick up a newspaper on the way, sit down and have coffee and toast. For about an hour. (5A)
>
> I know I have to get the exercise and I've started riding the bike...I went to the store one time and I ended up 80 kilometres later. But, I love to ride, which I didn't before until the heart thing. I'm still riding, and I will now forever, I'll ride now until I die; for sure! You need that self-discipline to do it for the rest of your life. (6A)

One patient suggested that he felt the need to continue with exercises as a means to alleviate his stress.

> I'm learning that I need to stay on the exercise program. I have to do that, continue to do that. Because as long as I'm on this exercise program, my stress is leaving me. I don't have any stress, it's going away, it's not all gone, and I'm terrible for that. I was loaded with stress. I want to keep doing these things..keep active. (2A)

In addition to following a regular exercise program, this same patient enroled in a stress program at the hospital to learn how to better manage his level of anxiety.

> And I'm entered into a stress program at the hospital, where I'm going. So, I'm trying everything possible. Every Friday morning from 0830 to 1000 for six weeks. (2A)

Evidence of other lifestyle modifications besides exercise were demonstrated such as changes in eating habits and smoking.

> I had a nice chat with the occupational therapist and the dietician. The dietician said to cut sugar out. It helps one to loose weight. That was quite a transition, cause I like it on my breakfast cereal. (5A)
>
> So, I'm in agreement with my GP actually, that I feel physically much stronger than even a few weeks ago. I never felt all that weak, but I want to

> have my diet fully under control before I go back and get stressed or endangered of getting stressed...and you start eating badly. I want to be well established in my new pattern of eating. They're not that different, but there are some differences. I have cut down the saturated fats. I think I've reduced my sugar to a third of what they were before. I'm more careful about what meats I eat and basically avoid all processed foods. (1A)

Determined to quit smoking, the only smoker in the group had not had a cigarette since the day of his surgery.

> Ya, ya, for me that surprises me quite a bit actually. And it hasn't been bad, it hasn't been too bad. Especially when I smoked 2 packs a day. (6A)

With the actual CABG surgery a considerable distance behind them, the patient's were able to voice their satisfaction about the experience.

> Um, No, it's been a good experience, would you believe. It's a funny thing to say. (1A)

> Oh very good! I'm just getting back to myself, so I'm coming along really good that way. I'm glad that I got the operation. The last time I talked to you I honestly couldn't answer that question. I wasn't sure yet, cause I hadn't felt any of the benefits at all. (2A)

> Again, when I spoke to you last time, that was the beginning of the improvement. I wasn't in very good shape then. I'm riding the bicycle and the treadmill and I'm stronger now than I ever was in 1990. Ya know, I went to the same program in 1990..I'm already better than I was when I ended the program after 12 weeks in 1990.. I'm stronger now. (2A)

Relief from anginal pain was identified as a definite benefit associated with having had the CABG surgery.

> I don't worry about the angina. It's not a problem at all. Occasionally, I get chest pains cause they rerouted the mammary artery, and just to make sure I tried the Nitro spray and there's no effect. It's definitely not my heart. (5A)

> *Today, can you say that you are glad that you had the operation?* I think so, yeah. A matter of fact I would say yes. Because I certainly feel much better. You know, I have nitro but I haven't taken it. (3A)

There was a greater degree of freedom expressed by the patients, as they no longer felt the necessity to remain within the boundaries of their home.

> Well, I go for coffee a couple of times every day. If we need to go somewhere, we go. Before, before, I couldn't do that..you know, like once I started going for coffee again, that I guess makes a difference. (4A)

> I actually can't believe that he has recovered from major surgery, done so well..If I'm not going to be here for lunch, well he'll go downtown on his own. I don't have to set out anything for him..and I'm sure he's going to be back there seeing about driving cars. (4B)

Even the patient who experienced the most complications following his CABG surgery was prepared to share his positive perspective and advice with others.

> No, I'm very pleased with the operation. Right now if somebody's having the operation, they can come and talk to me. I'll give them the same story that the boys gave me (*chuckle*). Ya, it's a great operation. (2A)

> I'm going to give him the advice to make sure he has somebody at home for the next couple of weeks to take care of him, cause his wife has passed away. It's just him, he's a bachelor, and don't even think of going home by yourself. You gotta have somebody to take care of ya..especially if you went through what I went through. I would have just died. So, that's all that I could tell him. (2A)

Although satisfied with their surgical experience, most of the participants recognized that life would never be the same again.

> Probably life will be different, cause you're going to have..always going to have a concern. There's always going to be that in the background about eating or exercise, ya, so it has changed. (5B)

> I'm expecting a good quality of life. Maybe not the same as it has been, you know. But, I expect to be able to do a number of things...I'm starting an exercise program on Monday...I can drive as of now. I can get back to driving. (3A)

> Ya, ya I don't want to be obsessed by it, but there have been significant differences. And it takes time to get that in balance. (1A)

If the patients were going to benefit from the adoption of a healthier lifestyle they perceived the need to exercise a great sense of personal authority in order to become committed to the continuation of these practices over time.

> I want to continue that too. I've got two options I'm looking at. I don't know which way to go on that. Whether to buy a treadmill here, I enjoy it very much, for doing it. Or I got an exercise place across the road and that. They have everything I need right there. Whether it might be better to have it right here, maybe I don't know. I haven't sorted that out yet. But, I have got to keep doing it. I have to continue this. I'm not stopping. I'm watching my weight and I don't want it to go up any higher than what it is. (2A)

Although the need to return to work placed limitations on the amount of free time and energy that the patients possessed, the two individuals who were directly affected by this consideration still planned to carry out an exercise routine on a continual basis.

> Ah, there was quite a transition there, because ah, putting in eight hours of work and then trying to do exercise on top of that was very hard. And there were lots of times that I really just really didn't feel up to it. (5A)

> I'm going to try it at NAIT, cause NAIT has got facilities and that's where I work..and then I'd like to go to the gym area and see if I can set something up there. And ah..because once I go back to work, I also want to maintain a minimum of three days a week when I go there for exercise..at least. (1A)

Not only had the lives of the patients been affected, the caregivers proposed that their lives had also been greatly altered. In some mysterious manner, the caregivers perceived this experience as a personal warning about their own state of health.

> Ya your life is changed, you now know that you have this disease, it is there in your body, Um..possibly throughout, and Um..so life has changed for him and I think that it's changed for me too. I've been reminded a few times in my life about the vulnerabilities, my Dad died when he was 50, my brother when he was 38. And I'm going okay..I've just had another reminder of a man in my life that could die of this, or could die of other things too. And then for me something..am I getting warning signs from the outside too, and if so lucky to make myself sit up and take notice, and look at what I can do to live better, live now, and hopefully live longer. (1B)

Consequently, the caregivers viewed the new lifestyle alterations as beneficial. And in some instances, they too gained a greater awareness regarding the importance of a healthier lifestyle.

> That's not normal compared to before, yet I'm really glad he's doing it, we'll both benefit from it. I think we've always been reasonably low fat eaters and

> now we're really low fat eaters..another thing that's not normal, but it's wonderful, is I tried to get him to go with me to the gym on a regular basis, and he would say; "No, I can't exercise for the sake of exercising". But he's beginning to enjoy it. (1B)

While demonstrating enthusiasm and encouragement, the caregivers became directly involved with the adoption of a healthier lifestyle. Ultimately, this change in lifestyle became a mutual goal for the couple to achieve and perpetuate together.

> Now we make a conscious effort to do the walks together. If I'm at work he does his walks himself, but usually we walk two evenings a week together. (5B)

The use of ethnographic premises and strategies throughout this study enabled the researcher to enter into the lived world of purpose, meaning, and beliefs of each of the patients and caregivers. Initially, each narrative portrayed a unique interpretation of the experience. Yet, in presenting an accurate description of the patient and caregiver perceptions of their experience and reconstructing the represented realities surrounding the CABG surgical experience, commonalities as defined by the existing stages and themes became apparent. The progression throughout all of these divisions correlated with alterations in the core concept defined by a sense of personal authority.

CHAPTER 5: Discussion

In this study, the intent was to develop an understanding of what the transition from hospital to home was like for patients and caregivers who were discharged four to five days following CABG surgery. The possibility of limiting the scope of this research by steering the interviews around this specific transitional period was undermined by the participants' continual portrayal of the full spectra of events surrounding CABG surgery. Thus, the research study examined the perceptions of the participants from the onset of symptoms to the final recovery stage at home. Although the narratives reflected individual perceptions, beliefs, and life experiences, commonalities were readily apparent.

The integration of these similar stages and themes led to the construction of a theoretical framework or process that reflected the pattern surrounding the experience of CABG surgery. This surgical experience is viewed in five general stages: testimonial, preoperative waiting, preparation work, inhospital, and home recovery. Although the progression through the different stages was marked by differing time intervals, it became clear that a major theme remained central throughout the process of having CABG surgery. This core component which accounted for a major portion of the variation amid the stages of this adjustment process has been termed 'developing a sense of personal authority'.

In order to present the reader with a fuller understanding of the relationships among the variable stages, themes, and the core component demonstrated in this study, other literature will be examined. By focusing on similar populations and demonstrating the comparability of themes and labels across studies, generalizability is increased (Estabrooks, Field, & Morse, 1994). Current research has identified various stages of adjustment to the recovery process following cardiac and other types of surgery. Even though the categories may not possess the same labels, the required explanation predictive of certain theoretical relationships or human behavioural patterns may remain comparable. The relevance and importance of the research conclusions will then become apparent when they are compared with other current research findings. Furthermore, examination of the concept of "uncertainty" will lend significant insight to the sequential nature of the different stages of the CABG surgery experience and the use of the different coping strategies underlying the themes. The pragmatic value of the findings will surface as the implications for the presented research are related to nursing practice and further research.

The Element of Uncertainty

The current conceptualization of uncertainty is reflective of a cultural bias which values predictability, control, and mastery (Mishel, 1990). Noticeably, individuals will pursue certainty and follow the pathway that leads to obtainable secure outcomes. Whereas accuracy is valued, uncertainty is feared; "seen as deficient and attempts are to avoid it or cast it as a temporary situation" (Mishel, 1990, p. 257). In relation to illness, the end state achieved after coping with uncertainty is adaptation; the ability to achieve stability within the normative pre-illness level of functioning. The orientation to stability and adaptation is consistent with the cultural preference for achievement of personal order through the attainment of equilibrium. For life to appear coherent, the events comprising one's life must be structured, ordered, and predictable (Antonovsky, 1987). Uncertainty associated with an illness is defined as "the inability to determine the meaning of illness-related events and occurs in situations where the decision maker is unable to assign definite values to objects and events and/or is unable to accurately predict outcomes because sufficient cues are lacking" (Mishel, 1988, p. 225). The reduction in uncertainty represents the essential task involved in adaptation.

In an acute or chronic illness situation, such as CAD, the managing of uncertainty involves the structuring of a cognitive schema or subjective interpretation of the illness, treatment, hospitalization, and home recovery. The stimuli that is perceived in relation to the components of uncertainty are structured around the components of symptom pattern, event familiarity, and event congruence. The first concept represents the degree to which symptoms present with sufficient consistency to be perceived as having a consistent pattern or configuration. Event familiarity represents the degree to which the experience or situation is habitual, repetitive, or contains common cues. The meaning assigned to familiar events is associated with events from memory. Event congruence refers to the degree of consistency between the expected and the experienced in illness-related events. This concept implies reliability and stability, which serves to facilitate the level of interpretation and understanding. Unless the illness-related stimuli are cognitively processed and assigned meaning, the uncertainty surrounding illness has the potential to disrupt the person's sense of control, the direction of their life, as well as the attainment of equilibrium (Mishel, 1990).

Review of the characteristics surrounding the different stages and themes outlined in this research study demonstrated uncertainty, alterations in personal control, and the development of a sense of personal authority by the patients and caregivers throughout the process of adjustment or recovery from CABG surgery. Although the reader will recognize the distinct nature of each specific stage, they are encouraged to realize that these stages are all interrelated and best understood in the context of the core variable of developing a sense of personal authority.

Moving through the Progressive Stages and Themes of CABG Surgery

Recovery from CABG surgery is widely recognized and described throughout the literature as a stressful experience personified by uncertainty and a call for caring. This uncertainty appears to be a stressor that influences the degree of coping and adaptation throughout the stages of CABG surgery. Throughout the initial ***testimonial stage*** uncertainty was related to the degree of ambiquity concerning the health status of the patient. Prior to diagnostic confirmation the uncertain disease or illness related factors introduced into the patient's life competed with their previous mode of functioning. Within this stage frequent concerns were associated with the uncertainty regarding the severity of the illness, uncertainty about the success of treatment, uncertainty about the impact of the illness on the patient's life and the uncertainty about being able to pursue life's dreams and ambitions. Physical instability often undermined the predictability of the patient's actions, as failure to achieve their own expectations was experienced in the face of anginal discomfort. Expressions of incompetence were voiced as patients could no longer trust their abilities.

In attempts to defend themselves against the immediate atmosphere of uncertainty and maintain a sense of personal authority over their bodies and their lives, patients in this study routinely downplayed the severity of their symptoms either through employing a normalization process, by ignoring their symptoms altogether, or treating their symptoms as benign conditions requiring only remedial action. This characteristic struggle to uphold the status quo and maintain a sense of personal authority is not unique to this study. In addressing the process of adjustment after a myocardial infarction, other authors have recognized the implementation of these same behaviours and the normalizing of symptoms as a means to "defend against the threat of loss of control" in relation to the core variables of "regaining a sense of control" (Johnson & Morse, 1990; Johnson, 1992). In examining the experience of women having CABG surgery, the core variable of "preserving the self" was also protected by the patient's attempts to normalize the onset of their symptoms (King & Jensen, 1994).

Folks, Freedman, Sokol, and Thurstin (1988) contest that high levels of denial witnessed preoperatively prove to have a positive effect as they can "detoxify symptoms of anxiety or depression and improve outcomes from diagnostic or surgical procedures" (p.90). The nature of this statement is questionable when one realizes that the persistence with which individuals continue to normalize their symptoms may partially attribute to higher mortality rates. The participants in this study who were ill informed about atypical signs and symptoms often delayed medical intervention, as the perceived details of their symptoms did not match the portrayal of text book symptoms associated with cardiac disease. Delays in seeking medical intervention is not a behaviour restricted only to the men of this study, as Hawthorne (1994) identified a strikingly apparent gender bias in the delayed recognition of symptoms of coronary disease in women, whereby diagnosis was postponed and as a consequence, surgical intervention was done almost universally under emergency conditions.

Lack of a consistent symptom pattern (Mishel, 1990), due to the unpredictable occurrence of the patient's symptoms generated increased levels of uncertainty. In this manner, the presenting symptoms were perceived to remain beyond the control of the patients. In order to enhance the degree of event familiarity and minimize the level of uncertainty, the symptoms were cognitively processed and assigned meaning in relation to past alterations in health and the angiogram results. King (1994) and Johnson (1992), in their research have also identified the development of this personal interpretation or the "making sense" of the experience. Making sense out of what has occured, allows the "coming to terms" prior to regaining a sense of control (Johnson, 1992). King and Jensen (1994) recognized the use of comparing, verifying, clarifying, and reasoning as specific to the "making sense" of the CABG surgery experience.

During the testimonial stage, the patients struggled to maintain their sense of personal authority by upholding their own decision-making and problem-solving capabilities. The maintenance of the patient's sense of authority was found in the expression of self-determination regarding the decision to seek medical attention and to ultimately have the CABG surgery. Affirmative data suggestive of a sense of personal authority included such statements as "I decided" and "my decision". Following the decision to have CABG surgery, some patients and caregivers expressed some relief and looked forward to having it done as they felt the surgery offered more certainty of a better life.

In this study a noticeable shadow of uncertainty surrounded the ***preoperative waiting period***. The generation of uncertainty through lack of event congruence (Mishel, 1990) occured when the expectations regarding the time of surgery were shattered by unforeseen delays. The elements of predictability and stability were gradually eroded as the lives of the patients and caregivers were placed on hold. The notes of concern generated in this study regarding the patient's prognosis or the occurrence of a heart attack during the waiting period were repeated throughout other studies. McRae and Chapman (1991) identified the component of "outcome uncertainty" in relation to awaiting CABG surgery. This type of uncertainty was evidenced in relation to concerns about "whether the patient would survive the wait until surgery, the surgery itself, and whether the surgery would result in the desired health status improvement" (p. 16). During the wait for surgery there was an awareness of the possibility of patient death. The recognition of one's mortality resulted in a "rude awakening" to the fact that one is not indestructable and that life is fragile.

In examining the adjustment process following a heart attack the component of "self-determination"; the power to make autonomous decisions was identified as an antecedent of personal control (Johnson, 1991). Concurrent with these results, a decreased sense of personal authority was evident in the waiting period prior to CABG surgery for, without exception, patients indicated that they had no alternative, as it was a matter of survival. Accordingly, the adjustment surrounding the waiting period of the study participants remained particularly difficult. Prolonged waits due to changes in the surgery schedule proved stressful and resulted in spousal anger and frustration with the health care system. Bresser, Sexton, and Foell (1995) in examining patients' responses to postponement of CABG surgery, found that not only did the uncertainty related to surgical postponements generate anger and frustration, it also manifested itself in physical symptoms.

As the heart bears an intrinsic association with life itself, CABG surgery on this vital organ is perceived as a life-threatening situation for which patients and their caregivers must be optimally prepared. In this study, the patients and caregivers engaged in ***preparation work*** to get ready for the surgery. The strategies utilized to prepare themselves were information seeking, having faith, and taking stock. *Information seeking* has been proposed in clinical studies as the primary means for reducing uncertainty, as it enables the patient to form accurate expectations regarding the impending procedure rather than anticipating it in threatening or unrealistic terms. The findings of this study indicate that for some patients only a certain amount of information was found to be useful. Also, the length of the waiting period had no bearing on the amount of information sought, for the majority of the participants made a conscious effort to limit the amount of information reviewed in attempts to not know too much. Davis, Maquire, Haraphongse, and Schaumberger (1994) propose that individuals scheduled for invasive procedures will experience less anxiety if the amount of preparatory information received is consistent with their coping style. That is, "those with an information-seeking style (monitors) will fare better with a high level of information, whereas those with an information-avoiding style (blunters) will be better with less information" (p.131). Johnson (1988) described how differences in patient personalities may alter the manner in which information is received. The three groups of patients identified were avoiders, sensitizers, and an intermediate group. Apparently, information only had a beneficial effect on the last group.

Turning to others, which consisted mostly of talking to family and friends who had been through the experience, was reported to be used predominantly during the preoperative waiting period. However, some participants were inclined to judge such information from others with a grain of salt as they wanted to avoid false reassurances. The findings of this study and other research indicate that information presented during the preoperative period is utilized by the patients in a variety of ways (McRae & Chapman, 1991; King & Jensen, 1994). Another outstanding feature of this study was the absence of specific information that related to the experience of being a caregiver.

In addition to seeking information during the preparatory stage, *having faith* was identified as a preferred affective coping strategy used to control negative emotions and manage uncertainty. In this study, having faith provided a sense of reassurance for some of the patients and caregivers. By placing their faith in the hands of God, participants were able to gain a certain peace of mind as they let go and depended on a higher being to be in control.

Camp (1996) proposed that individuals experiencing CABG surgery need to feel a sense of wholeness which transcends the physical and psychological realms to include spiritual resources. Artinian (1989) also recognized the importance of faith as an instrumental form of support for CABG patients. To bring meaning out of chaos, the concept of faith "includes the idea that faith is a human activity that occurs through relationships, with the most significant aspects being trust and loyalty to someone or some group or to superordinate centers of value and power (ie, the gods), which provides meaning to life and gives shape and order to one's world to provide comfort, security, and a sense of harmony within" (Camp, 1996, p.60). Faith was also placed in the hands of health care providers who possessed "credible authority" (Mishel, 1990) or desired professional validation. In this study the patients temporarily relinquished their sense of authority by giving up personal control to another trusted and confident individual. King and Jensen (1994) identified the same behaviour among some women in her study.

Personal appraisal during the final phase of the preparatory stage found patients and caregivers *taking stock* of their thoughts and feelings in relation to the imminent CABG surgery. In order to preserve a sense of emotional balance, positive thinking was used to help calm them and decrease their worrying. Conscious efforts were made to keep a positive outlook, for many patients reflected the belief that having a positive attitude would ultimately help the course of events. Redeker (1992) has also identified the use of wishful-thinking coping in relationship to the uncertainty associated with CABG surgery.

Initially unfamiliar and seemingly threatening, the hospital environment presented a complexity of events that impeded the development of event familiarity. In this study, the high level of uncertainty exhibited during the ***inhospital stage*** was associated with the great number of cues to be taken into account, the complexity of the treatment and delivery of care, the care described as intervention focused and fragmented, the potential for complications, the unpredictability of the course of recovery, and the lack of information provided. In the face of this great uncertainty, the patient struggled with a perceived loss of their sense of personal authority. This loss of personal control began the moment the patient entered the hospital. Taylor (1995) calls this loss of personal control "sociological sheep shearing", as the patient is forced to assume the role of patient.

Following surgery, the patient's self image changes from feeling whole to feeling damaged, and from being self-sufficient to being dependent on others as the management of their own bodies was lost to experiences of physical pain, time disorientation, and fatigue. Hawthorne (1994) suggested that men experience a dramatic shift in their self concept from that of strength and boundless energy to vulnerability and fragility. Cared for by others (Best, 1992) rather than taking an active role, the patient is robbed of personal decisional power as they are often told what to do. As they endured many invasive procedures during their hospitalization, the lost sense of personal control that the patients experienced often left them feeling helpless.

The classic picture of the hospitalized patient is depicted by an image where the patient is temporarily passive and acquiescent, relatively helpless, and dependent on professional care. Strauss et al (1984) contend that unless they are rendered helpless during the most acute phases of an illness, hospitalized patients do not typify this classic picture associated with the "sick role". In examining the concept of "patient work" when hospitalized, Strauss et al (1984) have identified patients working to "ensure their own comfort, working to catch staff's errors as with drugs and intravenous infusions, and working hard, too, at maintaining composure while undergoing procedures or as they make decisions about whether to go through another operation or to die" (p. 127).

In appreciation of the busy atmosphere on the wards and often in the absence of the nursing staff, the patients in this study were compelled to engage in the undertaking of patient work. Motivated to regain a sense of personal authority, some patients actively confronted the challenge of adhering to the guidelines specified by the activity schedule. Despite their physical pain, the patients began to test their capabilities by having their first shower and walking through the ward while monitoring their progress. Although the exhibition of patient work was demonstrated throughout the exemplars described by the patients, the display of *caregiver presence* and attentiveness during the inhospital stage far exceeded the degree of work undertaken by the patients themselves.

The findings indicated that the presence of the caregivers provided an essential coping resource, varying components of care, and informal social support for the patients following CABG surgery. As the effects of the anaesthetic lingered, the caregivers assisted the patients with self care measures, requested appropriate analgesic coverage, and made the necessary decisions about the care of their spouses. At this time, the coping strategies displayed by the caregivers included generating hope, helping their partner, and remaining near their spouse. The mutuality of the dyads in this study is further substantiated by Neufeld and Harrison (1995) who have identified reciprocity, the bidirectional exchange of valued resources between individuals as one dimension that enhances caregiving relationships. Concurrent with these findings, studies suggest that the provision of social support can be instrumental in facilitating recovery from a cardiac event, as patients with high social support experience less uncertainty and demonstrate fewer symptoms of psychological stress (Mishel, 1990; Moser, 1994; White & Frasure-Smith, 1995).

Social support, however, has been conceptualized as a double-edged sword as the literature reports conflicting findings with regard to the impact of caregiving. Caregiving rewards and salutary aspects of caregiving include: enhanced sense of self-efficacy, improved relationship with the patient, reassurance that the patient is receiving optimal care, satisfaction of living in accordance with one's religious or ethical principles, and the feeling that one has coped successfully with a rather difficult and challenging life situation (Scharlach, 1994). Yet, in addition to such salutary sequelae of caregiving, this study identified the coexistence of feelings of caregiver strain, work accommodations, and social limitations. Other literature reports outline similar findings (Krach & Brooks, 1995; Lindgren, 1990; Wood, 1991). In this study, the majority of teaching resources focused on the heart-health of the individual patient and the caregiver was only addressed as context to the patient. Since the maintenance of this relationship of committed partners, as a form of social support and care requires effort, this approach must be changed.

Although reported retrospectively, the careful assessment of discharge readiness was communicated by the dyad prior to their departure from the hospital. The steady progression in the patient's physical function was the standard used to determine the degree of discharge readiness. A lack of discharge readiness was perceived by the patient when they did not feel healthy enough to return home due to a profound lack of physical strength and stamina. Hesitancy was voiced when the caregivers expressed uncertainty about their partner's recovery and a lack of self-confidence as to their ability to take on the full responsiblity of performing caregiving activities. Spouses reported discharge readiness when they believed that they knew what to expect. For those couples who did not express a strong sense of discharge readiness, complications were encountered at home that necessitated additional follow-up appointments.

Although few studies have examined discharge readiness as a factor to be considered in relation to discharge planning, the findings of this study support its careful consideration. Artinian (1993) identified that the following four main themes: availability of social support; use of coping startegies; personal resources; and knowing what to expect were related to spouses' perceptions of discharge readiness. Schaefer, Anderson, and Simms (1990) used five factors to reflect internal readiness for discharge. Although consideration of level of pain, strength and energy, mood states, functional ability, and knowledge were examined, functional ability proved to be the only significant indicator of discharge readiness.

Home Recovery was the next monumental step along the pathway of recovery. For many, the discharge home was a mixed blessing. During the initial two weeks, the existance of patient concerns and uncertainty regarding fatique/weakness, pain, activity intolerance, gastrointestinal disturbances, irregular heart beats, and incisional discomfort not only led to a period of passivity, it also clearly illustrated the vulnerable nature surrounding this particular time. In this study, the transition from the hospital to the home was greatly facilitated by the role of the homecare nurses and the caregiver's *protective vigilance.*

Temporarily confined to the household, the caregivers provision of care involved a substantial time commitment and the completion of additional responsibilities often at the expense of their own rest. In this study, the outstanding feature of protective vigilance was the caregiver's primary focus on the illness and their spouse's welfare. Their "watch dog" role involved the need to continually check and watch over their spouse. When nearness was not possible, the caregivers devised monitoring strategies, such as a baby monitor, to successfully recognize any changes in their spouse's condition. McRae and Chapman (1991) recognized the importance of using monitoring strategies by spouses as they establish a "safety zone" where they felt comfortable having the patient. This safety zone created an "umbilical cord" to home and was defined as being near a telephone, ambulance service, and hospital.

With continued improvement in their physical functioning and a growing desire to exercise a stronger sense of personal authority over their own decisions and actions, the patients eventually became resentful of the caregiver's protective vigilance as they equated it with a form of nagging or undesirable support. In examining the relationship between social support and cardiac recovery, similar findings are revealed. Moser (1994) identified oversolicitous behaviour or overprotectiveness as problematic social support; instrumental in the development of cardiac invalidism. "Overprotective behaviour has been thought to result in decreased self-esteem and increased disability, emotional distress, and fixation on medical condition" (Moser, 1990. p. 30).

Even though most CABG patients were provided with education and information related to their recovery, many unanticipated problems and concerns were confronted at home. Because many of the concerns had been covered in the discharge teaching, it is apparent that repetition and reinforcement of this information remained necessary. In describing the homecare experience, the nurses were deemed invaluable by the majority of patients and caregivers. The level of satisfaction regarding their care remained consistently high. Their emotional support and additional information resources were central to the validation of perceptions, opinions, and the appropriate exercise of certain self-care measures. This support benefited those participants who were exposed to high levels of stress, as it not only reduced the dimensions of uncertainty, it also "took a little roughness off of the edges". The provision of reassurance influenced the couple's feelings of confidence and competence in relation to the management of care. Astute monitoring and assessment often placed the homecare nurse in the position to recommend and ensure appropriate follow-up appointments and referrals. In accordance with establishing a seamless continuum of care, the involvement of homecare services for the first four days following the hospital discharge was identified as a vital link that greatly facilitated the transition home.

The sense of personal authority as voiced by the patient and caregiver shared an inverse relationship with the perception of uncertainty. As the elements of uncertainty associated with the experience of having cardiac surgery were high, the patient and caregiver felt an erosion of their sense of personal authority. Respectively, perceptions of recovery or adaptation following the CABG surgery were expressed when the degree of uncertainty was perceived as being low and a fuller sense of personal authority developed. In the end, as the participants possessed a pronounced sense of personal authority, their experience of a sense of reconnection and belongingness enabled them to regard their judgements as justicification for action. In this manner, both the patients and caregivers were characterized by an integrated and differentiated self, able to exercise control over their individual destiny, health and well-being (Bray, Williamson, Malone, 1984; Lawson, Gaushell, & Karst, 1993; Rabin, Bressler, & Prager, 1993).

Implications For Nursing

Although the conceptualization of the experience of CABG surgery as a process provides a comprehensive perspective, this is not to underscore the needed understanding of the experience gained only when the cardiac event is considered within a context. The perception of the event is signified by the meaning or personal interpretation assigned to the experience by the patients and caregivers. In capturing perceptions directly, this research exemplified the fact that each participant exposed to a variety of belief and value systems, world views, and differing trajectories of recovery appraised the experience of CABG surgery in a distinctive manner.

The impact of CABG surgery is personified by uncertainty and a need for care. As Watson (1985) suggests nurses who are sensitive to the differing perceptions of individuals and their interpretation of the experience of CABG surgery are in a better position to accurately identify the educational wants and self-care needs of the patients and caregivers involved. Patient and caregiver understanding is increased when their learning priorities are considered and addressed. The need to tailor strategies to each individual remains paramount as a single strategy does not work effectively for all persons.

Following CABG surgery, the patient and caregiver are vulnerable to a myriad of stresses created simultaneously by the acute and chronic stressors related to CABG surgery and its underlying etiology, coronary artery disease. The recognition and implementation of informational support as a type of social support (Gaw-Ens, 1994) may alleviate some of the uncertainty surrounding this stressful event. The reality of our changing health care environment and decreased lengths of hospitalization are compounding the challenge of providing thorough cardiac teaching.

The research findings indicate that individuals not only have needs for varying amounts of information but, that there are a variety of factors that influence their ability to retain what has been taught. Often patient readiness to learn or the ability to focus on patient teaching is dramatically affected by fatigue, incisional and musculoskeletal pain, and narcotic analgesia. The refinement of patient teaching throughout all phases of the CABG experience, while employing a variety of formats and methods of teaching interventions (e.g., slide-sound audiovisual method, telephone follow-up method, multiple education sessions) remains essential. If an inital base of factual information pertaining to cardiac disease, CAD pathophysiology, and progression of the coronary disease process, and risk factor modification was presented during the testimonial stage, then repetition and reinforcement of this information could be executed throughout the waiting period.

The use of video cassette programs within the hospital would then augment patient teaching by providing an alternative mechanism for review or reinforcement of the prior factual information. Closer to the approximate date of discharge, patient teaching should relate to aspects of recovery, symptom management, diet, activity regime, and adherence to medications to assist in the recovery at home. Moore (1994) found that the use of concrete information that is, sensory and orienting information was effective in reducing distress and enhancing the outcomes associated with CABG surgery. Sensory information "acquired through sight, hearing, touch, taste, and smell ...focuses on the concrete properties of the experience, such as 'tingling', 'pressure', or 'pulling' (Moore, 1994, p.171). Orienting information on the other hand pertains to information about the onset, sequence, and duration of the physical sensations (Moore, 1994). The development of audiotapes containing discharge information and recovery experiences described in concrete terms could be utilized to effectively address instructions for coping with CABG home recovery. The tape could then be listened to repeatedly in the hospital, at home, in the car, or while walking with a Walkman in order to engage and motivate the patient in the educational process designed to enhance the home recovery and the living with chronic heart disease.

The challenge of providing care for a family member often comes without warning, and without any choice on the part of the potential caregivers. The results of this study indicate that the education of the caregivers is not yet optimal. If a nurse's interactions with a caregiver are based on the nurse's perceptions, the ability to take on the caregiver role may be impeded. Knowing how the prospective caregivers view their own situation and what they want to know and learn is essential for the provision of effective nursing care. The findings of this study and other literature (Weeks, 1995) illustrate how caregivers only recognize their own well-being as being of a moderate importance. The continuous involvement of caregivers throughout the patient teaching process must be encouraged and the educational content must address the specific concerns and aspects of the caregiver's role. In examining strategies to compensate for the emotional and physical drain experienced as a result of their constant responsibilities assurance of the caregiver's well-being is upheld.

Although patients traditionally are instructed that surgery is a palliative, not a curative treatment, evidence suggests that it may be difficult for the individual to conceptualize cardiac illness as a chronic disease trajectory. Since the life of CABG patients has been positively affected, they often think that they have recovered completely (Hawthorne, 1990; Jaarsma, Kastermans, Dassen, & Philipsen, 1995; Moranville-Hunziker, Sagehorn, Conn, Feutz & Hagenhoff, 1993). By linking the person's past and projected future with the present illness the accountability for shaping care is placed into the patient's hands. Because CAD is not eliminated by surgery, it is vital for the family to understand the need to create a lifestyle that focuses on measures to retard the CAD process in the grafts. The idea of the patient not only responsible for but being able to shape the trajectory of their illness encourages the development of a strong sense of authority and commitment to the necessary risk-factor modification and a healthier lifestyle.

Implications for Future Research

Limited to eleven participants, this focused ethnography successfully explored the range of experiences and perceptions associated with the experience of having CABG surgery. The importance of this study is that it facilitated the recognition of the progressive stages and themes revolving around this experience. Even though some of the findings are congruent with the work of other researchers, the constructs of caregiver "protective vigilance" and a sense of "discharge readiness" appear somewhat unparalleled and taylored to this particular study.

The posing of the initial research question and the learning about research bears a symbolic resemblance to the tossing of a stone into calm waters. Not only is the rippling effect witnessed at the point of entry, but uniform concentric rings are seen expanding beyond that point of reference. In a similar fashion, several research questions have arisen from the findings of this study that are important for future research and practice. All of the caregivers in this study were women. Continued efforts should be made to identify populations in which male caregivers are more readily available to researchers. Future research is needed to explore the perceptions of men who are caregivers to discover whether they exhibit protective vigilance. The inclusion of caregivers of different ethnics groups should also be considered. How do older people and family members manage following hospitalization when the caregiver does not live with the elderly person? How greatly does the quality of the relationship between the patient and the caregiver influence the experience? Does a significant relationship exist between the concept of "discharge readiness" and hospital readmission rates? What is the most effective combination of teaching modalities available? In assessing 'readiness to learn', when is the best time to introduce different teaching modalities? Also, to what extent could the role of the homecare nurse be substituted with consistent telephone monitoring and follow-up care? In order to move from substantive to formal theory in relation to the knowledge surrounding hospital-to-home transition, the quest and call for further research of this nature continues.

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Appendix A

Information Letter

Beth Goudie, R.N., BScN.
Master of Nursing Candidate
Graduate Student, Faculty of Nursing
3-120 Clinical Science Building
University of Alberta
Edmonton, Alberta T6G 2G3
Telephone # 492-6685

June 13, 1995

Dear Sir/Madam:

Thank you for agreeing to receive this letter. I am a registered nurse and graduate student in the Faculty of Nursing at the University of Alberta.

I am doing a study to explore the perceptions of patients and their main helper on the transition from the hospital to home after CABG surgery. I am interested in hearing about your experience. Before deciding whether or not to join this study, let me tell you what I am going to do.

If you agree to be in this study, you will both be interviewed separately two or three times. The interviews will be scheduled when and where we choose. The first interview will last about sixty to ninety minutes, and the other interviews may be shorter. If a third interview occurs, this may take place over the telephone. Each of the interviews will be tape recorded, and typed word for word by a typist. The only people allowed to listen to the audio tapes or read the typed interviews will be me, the typist, and the members of my thesis committee.

Information about you (age, sex, etc.) and the consent form will be stored in locked filing cabinet. The consent form will be destroyed in 5 years. The audio tapes, and the typed interviews will locked in a another cabinet. I will be the only person able to access this information. The data from this study will be kept for seven years, and then destroyed. When the findings of this study are reported in this thesis, published or presented at conferences, your name or any material that may identify you will not be used. A false name will be used in order to protect your identity. If any of the information from this study is used for a future study, permission will be obtained from the ethical review committee.

Involvement in this study is voluntary. You do not have to be in this study if you do not want to be. Even if you decide to take part in this study, you can leave the study, or stop an interview whenever you wish just by telling me. No one will hold it against you if you decide to drop out. You do not have to answer any questions that you do not wish to. Your care by the nurse or doctor will not be affected by whether or not you take part in this study.

There are no risks or direct benefits to you if you are in this study. I hope that the information from this study will help other people following their surgery. If you decide to enter this study, please return the completed reply form to the coordinator of the Cardiac Surgery Discharge Program. Before your hospital discharge, I will meet with you both to address any questions that you may have regarding this study. If you agree to share your thoughts with me, the consent will be signed. Then, I will collect some background information, and arrangements for an initial visit will be made.

Thank you for your interest and time. I look forward to talking with you!

Sincerely,

Beth Goudie, R.N., BScN.
Master of Nursing Candidate

REPLY FORM

Date:____________________

Both________________________________(print name of patient)

and_________________________________(print name of primary caregiver)

would like to participate in this research study, "The Transition From Hospital to Home Following Coronary Artery Bypass Graft Surgery".

Please contact us in order to arrange for an initial meeting.

Thank you.

Appendix B

Patient Consent Form

Project Title: The Transition From Hospital to Home Following Coronary Artery Bypass Graft Surgery

Researcher:	**Supervisor:**
Beth Goudie, R.N., BScN. Master of Nursing Candidate Graduate Student, Faculty of Nursing 3-120 Clinical Sciences Building University of Alberta Edmonton, Alberta T6G 2G3 Telephone: 492-6685	Dr. Marion Allen, R.N.,PhD. Professor Faculty of Nursing 4-112C Clinical Sciences Building University of Alberta Edmonton, Alberta T6G 2G3 Telephone: 492-6411

PURPOSE OF THIS STUDY

The purpose of this study is to explore and describe the perceptions of both the patient and the primary caregiver on the transition from the hospital to the home after coronary artery bypass graft (CABG) sugery.

VOLUNTARY PARTICIPATION

There are no risks or direct benefits to you if you are in this study. You do not have to be in this study if you do not want to be. If you agree to be in this study, you can drop out at any time without penalty. Simply tell the researcher that you wish to drop out. You also may stop the interview whenever you wish, or refuse to answer any question during the interview. No one will hold it against you if you decide to drop out. You do not have to answer any questions that you do not wish to. Your care by the nurse or doctor will not be affected by whether or not you take part in this study.

STUDY PROCEDURE

Before leaving the hospital, the researcher will meet with you to explain this study and to answer any questions you may have. After you have agreed to join this study and the consent is signed, background information will be asked by the researcher.

After this, you will be interviewed two or three times. The interviews will occur at a date, time, and place convenient for both of us. The first interview will last about sixty to ninety minutes and any other interviews may be shorter. If a third interview occurs, this may take place over the telephone. All interviews will be recorded, and the tapes will be typed word for word. The only people who will listen to the tapes or read the typed interviews, are the typist, the researcher, and the members of the thesis committee. Your background data and consent form will be stored in a locked cabinet. The consent form will be destroyed in five years. The tapes and the typed interviews will be stored in another locked cabinet. Only the researcher will have access to these cabinets.

When the findings of the study are reported in this thesis, at meetings, or in articles, any material that may identify you will not be used. The information from this study will be kept for seven years and then destroyed. If the information from this study is looked at in future years, ethical clearance will be obtained before its use. If you have any questions about the study, you can call me at the number above.

CONSENT: I,____________________________________(print name)

acknowledge that the above research procedures have been described. Any questions have been answered to my satisfaction. Whenever questions or concerns about this study arise, the researcher can be contacted at the above number. I have been assured that the records relating to this study will be kept private. I have been told that my name will not be linked with the information that I share. I understand that I am free to withdraw from the study. Also, I do not have to discuss any questions that I do not want to. I have been given a copy of this form to keep.

____________________________________ ________________________
(Signature of Participant) (Date)

__________________________________ ________________________
(Signature of Researcher) (Date)

If you wish to have a summary of the study when it is finished, please complete the following:

Name: ____

Address: ____

____

Appendix C

Primary Caregiver Consent Form

Project Title: The Transition From Hospital to Home Following Coronary Artery Bypass Graft Surgery

Researcher:

Beth Goudie, R.N., BScN.
Master of Nursing Candidate
Graduate Student, Faculty of Nursing
3-120 Clinical Sciences Building
University of Alberta
Edmonton, Alberta T6G 2G3
Telephone: 492-6685

Supervisor:

Dr. Marion Allen, R.N.,PhD.
Professor
Faculty of Nursing
4-112C Clinical Sciences Building
University of Alberta
Edmonton, Alberta T6G 2G3
Telephone: 492-6411

PURPOSE OF THIS STUDY

The purpose of this study is to explore and describe the perceptions of both the patient and the primary caregiver on the transition from the hospital to the home after coronary artery bypass graft (CABG) surgery.

VOLUNTARY PARTICIPATION

There are no risks or direct benefits to you if you are in this study. You do not have to be in this study if you do not want to be. If you agree to be in this study, you can drop out at any time without penalty. Simply tell the researcher, that you wish to drop out. You also may stop the interview whenever you wish, or refuse to answer any question during the interview. You do not have to answer any questions that you do not wish to. Your care by the nurse or doctor will not be affected by whether or not you take part in this study.

STUDY PROCEDURE

Prior to the time of discharge, the researcher will meet with you to explain this study and to answer any questions you may have. After you have agreed to participate and the consent is signed, background information will be asked by the researcher.

After this, you will be interviewed two or three times. The interviews will occur at a date, time, and place convenient for both of us. The first interview will last about sixty to ninety minutes and any other interviews may be shorter. If a third interview occurs, this will take place over the telephone. All interviews will be recorded, and the tapes will be typed word for word. The only people who will listen to the tapes or read the typed interviews, are the typist, the researcher and the members of the thesis committee. Your background data and consent form will be stored in a locked cabinet. The consent form will be destroyed in five years. The tapes and the typed interviews will be stored in another locked cabinet. Only the researcher will have access to these cabinets.

When the findings of the study are reported in this thesis, at meetings, or in articles, any material that may identify you will not be used. The information from this study will be kept for seven years and then destroyed. If the information from this study is looked at in future years, ethical clearance will be obtained before its use. If you have any questions about the study, you can call me at the number above.

CONSENT: I,____________________________________(print name)

acknowledge that the above research procedures have been described. Any questions have been answered to my satisfaction. Whenever questions or concerns about this study arise, the researcher can be contacted at the above number. I have been assured that the records relating to this study will be kept private. I have been told that my name will not be linked with the information that I share. I understand that I am free to withdraw from the study. Also, I do not have to discuss any questions that I do not want to. I have been given a copy of this form to keep.

____________________________ ____________________________
(Signature of Participant) (Date)

____________________________ ____________________________
(Signature of Researcher) (Date)

If you wish to have a summary of the study when it is finished, please complete the following:

Name: ____________________________________

Address: ____________________________________

____

Appendix D

Interview Guide

(i) Patient

Opening Questions:

1. Tell me about your surgery?
2. Can you describe for me how this discharge experience has compared with other discharge experiences?
3. What have been the good things about this discharge experience?
4. What have been the difficult things about this discharge experience?

Probe Questions:

5. What has facilitated your transition from the hospital to your home?
6. What interfered with your transition from the hospital to your home?
7. What is most difficult for you now?
8. What is easiest or best for you now?

(ii) Primary Caregiver

Opening Questions:

1. Tell me about the experience of _____________(patient's name) being discharged from the hospital?
2. How does this experience of discharge compare with other discharges?
3. What have been the good things about this discharge experience from the hospital?
4. What were the difficult things about this discharge experience from the hospital?

Appendix E

Background Biographical Data Form
(Patient)

Date and Time:________________

Code Number: ________________

1. Gender: Male:_____ Female:_____

2. Age:__________

3. Education: (highest level completed)

Junior High School: ______
High School: ______
College/University: ______
Graduate Studies: ______

4. Occupation:____________________

5. Employment Status:

Unable to work:________
Full-time: __________
Part-time: __________
Retired: __________ Since: Year__________

6. Date of Pre-admission Clinic: ____________________
Date of Hospital Admission: ____________________
Date of Surgery: ____________________
Date of Discharge: ____________________
Date Home Care commenced: ____________________

7. Elective CABG surgery : Waiting period =____________

8. Other medical conditions:____________________________
____
____

Appendix F
Background Biographical Data Form
(Primary Caregiver)

Date and Time:______________
Code Number: _______________
1. Gender: Male:_____ Female:_____

2. Age:________

3. Relationship to patient:
Wife: ______
Husband: ______
Son: ______
Daughter: ______
Brother: ______
Sister: ______
Other: ______

4. Living Arrangements:
With patient ______
Other ______

5. Home Situation:
dependents at home
____
Other family members at home
____

6. Education: (highest level achieved)
Junior High School: ______
High School: ______
College/University: ______
Graduate Studies: ______

7. Occupation:__________________

8. Employment Status:
Full-time: _________
Part-time: _________
Retired: _________ Since: Year:_______

9. Description of
Health:____
____