

People's Experience of Vitreo-  
Retinal Day Surgery: A  
Gadamerian Guided Study  
Embedded within an Evidence  
Based Nursing Practice  
Framework

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# CONTENTS

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<b>Contents</b>	<b>i</b>
<b>List of Tables</b>	<b>i</b>
<b>List of Figures</b>	<b>i</b>
<b>Summary</b>	<b>iii</b>
<b>Declaration</b>	<b>vi</b>
<b>Acknowledgements</b>	<b>vii</b>
<b>Chapter 1</b>	<b>1</b>
<b>Introduction and background</b>	<b>1</b>
1.1 Introduction.....	1
1.2 The clinical context: Transformation from inpatient to day-case surgery .....	3
1.3 The clinician–researcher perspective.....	6
1.4 Healthcare within historical events: Religion, science and technology .....	8
1.4.1 Antecedents in Ancient times .....	9
1.4.2 The rise of Christian healing.....	11
1.4.3 Philosophy, science and technology.....	14
1.4.4 Vitreo-retinal care today .....	19
1.5 Nursing care informed by ‘understanding’ .....	21
1.6 Choosing an EBNP model to frame this study .....	23
1.6.1 Historical development of EBNP .....	24
1.6.2 Choosing a model of EBNP.....	26
1.7 A critical view of Evidence Based Nursing Practice as a framework for the conduct of this study .....	34
1.8 Purpose of the study.....	46
1.9 Summary .....	49
<b>Chapter 2</b>	<b>50</b>
<b>Development of an Answerable Research Question</b>	<b>50</b>
2.1 Introduction.....	51
2.2 (P) Population: Identifying population aspects of the experienced V-R pathology and V-R day surgery .....	52

2.2.1	Incidence of visual disability .....	52
2.2.2	V-R pathology .....	54
2.2.3	V-R surgery.....	56
2.2.4	Visual disability .....	58
2.3	(I) The phenomena of interest: A transition of V-R inpatient surgery to day surgery .....	61
2.3.1	The ophthalmology experience .....	64
2.4	(O) Outcome of the study: Understanding of the experience from the patient's perspective .....	65
2.4.1	The patient's voice .....	66
2.5	(T) Timeframe: Surgery within the previous six months .....	69
2.6	Problem statement of this study.....	69
2.7	The research question identified.....	70
2.8	Summary .....	70
<b>Chapter 3</b>		<b>71</b>
<b>The Professional Literature and Experiential Knowledge of V-R Day Surgery</b>		<b>72</b>
3.1	Introduction.....	72
3.2	The aim of the review and the questions asked .....	78
3.3	The review design .....	79
3.4	The search methods.....	80
3.4.1	Sampling.....	80
3.4.2	Inclusion/exclusion criteria .....	81
3.5	The search outcome.....	82
3.5.1	Question 1: What was the experience of vitreo-retinal day surgery?.....	84
3.5.2	Question 2: How was day surgery managed in ophthalmology and other specialties? .....	87
3.5.3	Question 3: How were pain, nausea and vomiting managed during self-care? .....	90
3.5.4	Question 4: What do we know about ocular anaesthesia .....	93
3.5.5	Question 5: Do satisfaction surveys accurately measure patient experiences of care?.....	94
3.6	Policy context of V-R day surgery care .....	97
3.7	Implication of the findings .....	100



<b>Chapter 4</b>	<b>103</b>
<b>An Understanding of the Research–Philosophy Relationship: Choosing Philosophical Hermeneutics to Guide this Study</b>	<b>103</b>
4.1 Introduction.....	103
4.2 The development of phenomenology.....	106
4.3 Existential phenomenology.....	108
4.4 Philosophical hermeneutics .....	109
4.5 The appropriateness of Gadamerian philosophy to guide this research.....	111
4.6 Limitations of Gadamerian Philosophical Hermeneutics .....	112
4.7 Summary .....	113
<b>Chapter 5</b>	<b>114</b>
<b>The Methodology of Philosophical Hermeneutics</b>	<b>114</b>
5.1 Introduction.....	114
5.2 Ontological position .....	115
5.3 Epistemological position .....	117
5.4 Methodology.....	119
5.4.1 Dialogue and language .....	121
5.4.2 Historicity and tradition.....	121
5.4.3 Prejudice.....	122
5.4.4 Fusion of horizons.....	123
5.4.5 The hermeneutic circle.....	124
5.5 Summary.....	125
<b>Chapter 6</b>	<b>126</b>
<b>Methods of the Study</b>	<b>126</b>
6.1 Introduction.....	126
6.2 The design of this study.....	127
6.3 Ethical conduct and this study .....	129
6.3.1 Research consent .....	131
6.4 Selection of participants and data generation .....	132
6.5 How will the data be analysed .....	134
6.6 Issues of rigour and trustworthiness .....	138
6.7 The strengths and weakness of insider research.....	140
6.8 Summary .....	144

<b>Chapter 7</b>	<b>145</b>
<b>Presentation of the Data</b>	<b>145</b>
7.1 Introduction.....	145
7.2 Introduction of participants.....	146
7.3 Coding and theme development.....	157
7.3.1 Phase 1: Declaration of the researcher's horizon .....	158
7.3.2 Phase 2: A fundamental meaning of the experience .....	159
7.3.3 Phase 3: Patterns within the data.....	162
7.3.4 Phase 4: The words of the participants .....	171
7.3.5 Phase 5: From the parts to the whole.....	202
7.4 Summary.....	203
<b>Chapter 8</b>	<b>205</b>
<b>Interpretation of Findings and Establishing trustworthiness</b>	<b>205</b>
8.1 Introduction.....	205
8.2 The findings in relation to the literature.....	206
8.2.1 What was people's experience of vitreo-retinal day surgery?.....	206
8.2.2 How was day surgery managed in ophthalmology and other specialties?.....	206
8.2.3 How was pain managed during self-care? .....	207
8.2.4 What do we know about ocular anaesthesia?.....	207
8.2.5 Do satisfaction surveys accurately measure patient experiences of care?.....	208
8.3 The inadequacies of the acute model of care in meeting the complex needs of individuals' day surgery for V-R pathology .....	209
8.3.1 Cataract surgery versus V-R surgery .....	210
8.4 Understanding in a different way .....	212
8.5 Interpretation of the findings guided by Rutter's (1985) adversity, resilience and resource depletion theory .....	212
8.5.1 Middle-range theory supported understanding:.....	213
8.6 Identified aspects of <i>self</i> and sites of resource depletion .....	219
8.6.1 The physical <i>self</i> .....	220
8.6.2 The psychological <i>self</i> .....	226
8.6.3 The historically located <i>self</i> .....	231
8.6.4 The <i>self</i> within the community.....	236
8.7 Towards a new model of care.....	238
8.8 Trustworthiness of the Findings .....	239
8.9 Summary.....	240

<b>Chapter 9</b>	<b>242</b>
<b>A New Model of Ocular Care</b>	<b>242</b>
9.1 Introduction.....	242
9.2 Sources of evidence on which to base practice changes.....	242
9.3 The physical self.....	244
9.3.1 Post-operative self-care pain, nausea and vomiting .....	244
9.3.2 Current models of pain management .....	246
9.3.3 The protocol.....	249
9.4 The psychological self .....	255
9.4.1 Uncertainty in Illness theory .....	256
9.4.2 Limitations of Uncertainty in Illness theory .....	261
9.5 The historically located <i>self</i> .....	262
9.6 The <i>self</i> within the community.....	264
9.7 Summary.....	265
<b>Chapter 10</b>	<b>270</b>
<b>Evaluation of the New Model of Care in Practice</b>	<b>270</b>
10.1 Introduction.....	270
10.2 The audit .....	271
10.2.1 Aim of the audit .....	273
10.2.2 Identifying measures of quality consistent with good practice.....	273
10.2.3 Methods of the audit.....	274
10.2.4 The Audit sample .....	277
10.2.5 Ethics approval .....	277
10.2.6 Results.....	277
10.3 Qualitative Evaluation .....	280
10.3.1 The participants .....	281
10.3.2 Data collection .....	285
10.3.3 Data analysis .....	285
10.4 Discussion.....	295
10.5 Summary.....	298
<b>Chapter 11</b>	<b>299</b>
<b>Conclusions, Recommendations and Limitations of this Study</b>	<b>299</b>
11.1 Conclusions.....	299
11.2 Recommendations.....	305

11.2.1	Recommendation 1: Transforming current care from an acute model to an ocular model of care.....	305
11.2.2	Recommendation 2: Physical and psychological resource enhancement .....	306
11.2.3	Recommendation 3: Recognition of the historicity of V-R ocular illnesses .....	307
11.2.4	Recommendation 4: Optimised self-care.....	308
11.3	Dissemination of research knowledge and skills .....	310
11.4	Limitations of this study .....	311
11.4.1	The limitations of the dual role of clinician-researcher .....	312
11.4.2	Limitations of the design of this study.....	313
11.5	Summary.....	318
	<b>Appendix 2.....</b>	<b>338</b>
	Ethics Approval Documents	338
	<b>Appendix 3.....</b>	<b>342</b>
	Patient Information Sheet	342
	<b>Appendix 4.....</b>	<b>343</b>
	Consent Documentation	343
	<b>Appendix 5.....</b>	<b>344</b>
	Pain Protocol	344
	<b>Appendix 6.....</b>	<b>346</b>
	Structured Pre-Operative Questionnaire	346
	<b>Appendix 7.....</b>	<b>348</b>
	Audit Tool	348
	<b>Appendix 8.....</b>	<b>349</b>
	Publication	349
	<b>Appendix 9.....</b>	<b>359</b>
	Anatomy and physiology of the eye and V-R disease	359
	<b>Appendix 10.....</b>	<b>363</b>
	Summary critique of four middle range theories	363
	<b>References.....</b>	<b>365</b>

## LIST OF TABLES

---

Table 1.1 Three models of EBNP .....	28
Table 3.1 Summary of Literature review- articles found.....	83
Table 3.2 Summary of reviewed studies in relation to questions.....	83
Table 5.1 Summary of philosophical positions.....	118
Table 6.1 Participants, underlying pathology, surgical intervention and demographics .....	148
Table 6.2 Display of previous ocular surgical experiences .....	149
Table 7.2 Participants and pre-operative visual acuity and elective/emergency status .....	181
Table 7.3 Time trajectory of V-R pathology and participants of this study.....	190
Table 8.1 Summary of adversity and resource depletion across identified aspects of self .....	220
Table 8.2 Sources of physical resource depletion .....	221
Table 8.3 Participants psychological issues and identified sources of resource depletion .....	227
Table 8.4 The historically located self and sources of resource depletion.....	232
Table 8.5 V-R pathology trajectory of participants .....	234
Table 9.1 Patient selection into surgical groups based on complexity .....	249
Table 9.2 Contraindications for participation in pain protocol.....	249
Table 9.3 Pain management protocol, identify groups A, B and C and management variations .....	251
Table 9.4 Raw data from Clarke & Robertson's 2004 unpublished study .....	253
Table 10.1 Age and surgical categories of 100 audit patients.....	278
Table 10.2 Distribution of pain experiences of 100 audit patients .....	278
Table 10.3 Distribution of pain experiences of control group of an unpublished experimental study (Clarke & Robertson 2004).....	279
Table 10.4 Demographics, pathology, episodes of previous surgery and social supports of the 9 participants of Step 5 evaluation .....	282

## LIST OF FIGURES

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Figure 1.1 Steps of the adapted EBNP model used in the conduct of this study	28
Figure 2.1 Incidence of visual disability and blindness across the age spectrum (Beckley et al. 2007)	53
Figure 3.1 Flow chart of the literature review process	78
Figure 7.1 Concepts of <i>self</i> addressed in an acute model of care	161
Figure 7.2 Concepts of <i>self</i> identified by this study	161
Figure 7.3 Segmental analysis of the data that led to identification of the sub-theme of the physical self	163
Figure 7.4 Segmental analysis of the data that led to identification of the sub-theme of the psychological self	165
Figure 7.5 Segmental analysis of the data that led to identification of the sub-theme of the historically located self	167
Figure 7.6 Segmental analyses of the data that led to identification of the sub-theme of the self within the community	169
Figure 7.7 A representation of the holistic experience of V-R day surgery	170
Figure 7.8 Identified aspects of <i>self</i> and the impact of an intervention	174
Figure 7.9 The physical self (sub-theme)	175
Figure 7.10 V-R day surgery and the psychological self	179
Figure 7.11 V-R day surgery and the historically located self	188
Figure 7.12 V-R day surgery and the self within the community	193
Figure 8.1 Site of physical resource depletion-anaesthetic injection	222
Figure 8.2 Site of physical resource depletion, pain and PONV during self-care	223
Figure 8.3 Physical resilience	225
Figure 8.4 Site of psychological resource depletion, fear of blindness	227
Figure 8.5 Strategies for psychological resilience	230
Figure 8.6 Site of historically located resource depletion	233

Figure 8.7 Evidence of resilience	235
Figure 8.8 Sources of resource depletion during self-care	236
Figure 8.9 Evidence of resilience during self-care	237
Figure 9.1 Strategies for physical resource enhancement	244
Figure 9.2 Strategies for psychological resource enhancement	255
Figure 9.3 Strategies for experiential resource enhancement	262
Figure 9.4 Strategies for community based resource enhancement	264
Figure 9.5 A new model for V-R days surgery care	266
Figure 9.5 Display of the sites of resource depletion identified in this study, and strategies proposed to enhance protective factors with the potential for positive patient outcomes	267
Figure 10.1 Domains of the human <i>self</i> influenced by the experience of V-R day surgery	286
Figure 11.1 Recommendations for transformation of clinical practice	304

# SUMMARY

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**Background:** Over the previous three decades, the ophthalmic community has witnessed significant practice changes in both management and performance of vitreo-retinal surgery. Nurses working in the field of ophthalmology have observed the transformation of vitreo-retinal interventional care, from inpatient to day-case care. During this period, a progression from the dominant use of general anaesthesia to regional anaesthesia as standard practice has also been recognised. Day surgery has proven successful for the care of patients requiring cataract surgery. However, the needs of patients following interventions for complex vitreo-retinal disease, now routinely performed as day surgery, remained unknown.

**Aim:** This study aims to understand participants' experience of vitreo-retinal day surgery as guided by the philosophy of Hans-Georg Gadamer. This knowledge development activity is embedded within the structural framework of an Evidence-Based Nursing Practice. At first glance, these two philosophically disparate activities may be considered mutually exclusive. However, such juxtaposition within this study facilitates a synergistic merging of experiential knowledge with nursing practice in the clinical context of vitreo-retinal day surgery care.

**Research design:** Gadamer's Philosophical Hermeneutics proscribes a methodological process; instead, the dictates of Gadamer establish the conditions in which understanding occurs. The present study's structural framework is situated in



research-in-practice and includes a modified five-step evidence-based nursing practice model. The use of this model provides a systematic pathway that defines the clinical problem (step one), explores current knowledge and identifies knowledge gaps (step two). The model's intrinsic component is a knowledge-generating research activity (step three), guided by Gadamer's philosophical hermeneutic perspective. Step three presents a qualitative exploration of the experience of vitreo-retinal day surgery and the thematically analyses of the findings. An emerging understanding of this experience forms the basis for developing new nursing interventions (step four) that are implemented and evaluated (step five) within a clinical setting. The evaluation utilises both quantitative and qualitative methods, thus providing in-depth knowledge.

***Findings:*** The qualitative evidence of this study leads to understanding the participants' needs that include the following aspects of self within a lived experience: *physical, psychological, historically located and within the community*. This understanding is combined with expert clinician knowledge, as well as information and theory from established professional literature. This broadly based evidence provides the foundation for the development of new nursing interventions. These interventions aim to improve patient experiences of vitreo-retinal day surgery and are implemented and evaluated in the subsequent steps of this Evidenced Based Nursing Practice activity. The new interventions address the following issues:

- post-operative pain management,
- pre-operative preparation,
- anaesthetic options,

- isolation following discharge, and
- information needs.

Following the implementation of interventions, evaluation was firstly sought through a 100 consecutive patient audit, followed by in-depth unstructured interviews with nine participants. These evaluation activities found an improvement in patients' experiences of vitreo-retinal day surgery.

**Conclusions:** The present study develops a qualitative knowledge of the V-R day surgery experience and successfully embeds this knowledge within a modified Evidence-Based Nursing Practice framework. The modified framework is utilised in this study and effectively facilitates the following: new knowledge of the vitreo-retinal day surgery experience, the development of new interventions meeting the complex needs of patients undergoing vitreo-retinal day surgery, and the transformation of future care of people requiring vitreo-retinal day surgery. The value of this study exists in bridging the research-practice gap between knowledge generation and clinical care, with a clearly demonstrated outcome of improved patient care.

# DECLARATION

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I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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Christine McCloud (Candidate)

Date 22/04/2013

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# CHAPTER 1

---

## INTRODUCTION AND BACKGROUND

### 1.1 Introduction

Beneath the clinical drapes of a vitreo-retinal (V-R) surgery setting, lies an anxious individual whose unique and known life-world was threatened. This threat was embodied as a potential for visual disability or blindness as a consequence of ocular pathology. Within the highly technical peri-operative environment, there was limited and poorly addressed awareness of this threat's pervasive influence. The clinical context of this study presents evidence of inadequate care following anecdotal reports from patients who experienced significant difficulties after V-R day surgery. Patients described difficulties that included:

- pain,
- anxiety and lack of knowledge, and
- difficulties during self-care subsequent to discharge into the community.

Advances in science and technology within this complex environment have significantly improved surgical outcomes. However, the results appear to have displaced the patients' needs as the central focus of nursing care. The exploration of this displacement is particularly relevant in light of the devolution of many traditional nursing and caring functions that occurred with the adoption of a day surgery model of care. The research reported in the present thesis begins with the

clinically initiated question of ‘What was the lived experience of people undergoing V-R day surgery?’ This question seeks to re-establish the centrality of patient experience in the evidence base of health care interventions within a clinical environment. This research activity aims to develop and implement innovative nursing interventions that would improve patient care, an outcome consistent with the philosophy of Evidence-Based Nursing Practice (EBNP) (Gerrish & Lacey 2010; Polit & Beck 2012). This research-in-practice study aimed to bridge the much discussed research-practice gap (Bellman, Webster & Jeanes 2011; Kjersheim 2003).

Ophthalmic Care is densely populated with terminology and procedures that are unfamiliar to many health care workers. With this in mind short definitions and descriptive diagrams located in appendix 9 will assist the reader to understand some of the most common conditions and treatment encountered within this study.

This first chapter displays the clinical context (1.2) and the author’s position as clinician-researcher (1.3) within this study context. A discussion of the historical events contributing to the science and technology focus (1.4) provides background information also in the context of this study. The role of understanding and experiential knowledge will be detailed as a basis for this study (1.5). A description will be supplied of the modified Evidence-Based Nursing Practice (EBNP) framework (1.6), which provides a structure supporting all the activities of this study and facilitating the transformation of new knowledge into clinical care. Finally, the first chapter delivers an early discussion of the purpose (1.7) of the study, with Chapter 2 presenting a detailed and comprehensive description.

## **1.2 The clinical context: Transformation from inpatient to day-case surgery**

The clinical context of this study was an ophthalmic department within a large metropolitan southern Australian tertiary and teaching hospital. This department offers acute care for a wide catchment area extending from Australia's northern city of Darwin to the south-eastern city of Mount Gambier. This catchment area contains a number of Indigenous communities located within remote rural areas that include Alice Springs, Northern Territory and the South Australian communities of the Pitjantjara Lands. This diverse and extensive catchment area places a high demand on clinical ophthalmic services, as indicated by an excess of 17,000 outpatient appointments and 1,600 surgical events conducted in 2008/09, tabled in the Southern Adelaide Health Services annual report (SAHS 2008/09).

This ophthalmic department site is unique in its consulting clinic service, where patients are assessed, treated or listed for surgery. This service is co-located with the ophthalmic operating facility – a proximity that encourages a comprehensive treatment process. However, this study will argue that a biomedical model of care, which had developed as a consequence of historical influences and focuses on the service's physical aspects, continues to permeate and influence care in a modern clinical setting. Such focus results in fragmented care that is dominated by its physical aspects. Section 1.4 of this chapter discusses in detail the historical influences leading to the development of bio-medically focussed care. The experiences of nursing staff providing care in the ophthalmic operating theatres are also relevant. This is because most staff was experience in acute inpatient care, where emphasis is placed on interventions and physical safety. As a result, the care

focuses on the episodic surgical event, efficiency of service and pain management strategies. Thus, the co-location of services provides the potential for enhanced care. However, the utilisation of this opportunity had not been fully explored.

Within this high demand service, access to care is facilitated by a rapid transformation from inpatient to day-case care. The facility provides pre-, post- and interventional care within a period of usually less than six hours. At the time of this study, the vast majority of patients requiring V-R surgical interventions had been provided as day surgery.

The transformation of services for people requiring V-R surgery from inpatient care to day surgery care engenders much approval amongst the bodies regulating our community's healthcare. Approval had been linked to a reduction in waiting lists that resulted from quicker access to services (Gilmartin 2007; Law 1997), as well as diminished costs achieved through minimal bed day stays (Bodenheimer 2005b; Mirnezami et al. 2007). Day surgery principles utilise a strictly managed timeframe that limits patient–health care provider interactions to the invasive, technologically complex and high cost aspects of care (Cooper 1999; Mirnezami et al. 2007; Mitchell 2010).

As a consequence of adopting the day surgery model, non-invasive patient care activities are reduced to short pre- and immediate post-operative time periods. The majority of low intensity care such as convalescent care devolves to patients, families and communities. Because of this devolution, there is now limited time available for holistic caring interactions that meet the needs of patients outside of pathology normalisation and intervention (Cooper 1999; Mitchell 2002). These limitations lead to unmet needs and dissatisfaction with the care provided (LeBaron 2004; Rhodes



2006), which are evident as anecdotal reports from the co-located ophthalmic consulting clinic. As described earlier (1.1), these reports indicate that patients do not cope well following V-R day surgery, hence prompting the conduct of this study.

The questions surrounding the obvious focus on interventional care include:

- What were people's experiences of V-R day surgery?
- Was the care provided optimal from the patient's perspective?
- Were patients prepared to accept the responsibility of post-operative care?
- Did we have an understanding of this experience from the patient's social, cultural and historical perspective?

The above questions lead to the focussed research question:

*'What was the lived experience of people undergoing V-R day surgery?'*

Chapter 2 analyses the research question and its development. The need for an answer to this question has propelled the clinician of this study into the dual worlds of EBNP and scholarly research. This dual role exerts significant influence on the conduct of the present study and the use of its findings. The role can be viewed in relation to the structural framework (explained in Chapter 1), the chosen methodology (further expanded upon in Chapter 4) and the need to develop interventions based on research findings (described in Chapter 9). Thus it was important and congruent with the belief of Hans-Georg Gadamer (1900-2002), whose philosophical hermeneutics was chosen to guide this study (explained in

chapters 4 and 5) to display the clinician-researcher's perspective so that unseen influences of presuppositions from both the clinical and research environments were made visible (Gadamer 1975a).

### **1.3 The clinician–researcher perspective**

For the past 14 years, this author-clinician has acted as the senior nurse in-charge of the clinical context. This close relationship to the clinical environment has facilitated an identification of people's experiences of V-R day surgery. Upon commencing the investigation of patients' experiences, the author became both clinician and researcher. The role of the researcher was a new pathway that was supported by an academic institution, as well as the clinicians within the ophthalmic department.

This author possesses lengthy experience in clinical practice and has encountered significant changes in ophthalmic care. Cataract surgery – the most common surgical procedure performed in this context (SAHS 2008/09) – had transformed from complex inpatient care involving extended periods of bed rest and large eye wounds, to surgery no longer than 15 minutes that incorporates incisions of less than 2.2 mm and discharges the patient within three hours. Significant transformations have also been witnessed within care for patients with V-R pathology. In the past, V-R pathology had limited treatment options and many diseases routinely cured today were blinding eye conditions (El Amir et al. 2009). Now, most V-R conditions are treatable with varied success rates using available sophisticated tools and techniques. In the case of V-R interventions, the movement to day surgery resulted from the

success of day surgery for cataracts. In addition, it was a response to the need for fiscal rationalisation, a point that is discussed further in this chapter.

As a consequence of these changes, nursing care has evolved in the peri-operative ophthalmic environment. The equipment utilised in most ophthalmic procedures now requires a high level of technical expertise. Competence within the peri-operative environment is measured by knowledge and proficiency in dealing with such complex instrumentation (ACORN 2008). It could be suggested that the dominance of this aspect of practice contributes to a focus on interventions and predominantly physical aspects of patient care. This study aims to redress this prevalence by developing experiential knowledge that would be valued as an evidence source for establishing nursing practice.

Peri-operative environments have displayed many of the outstanding achievements of modern science. Tools and techniques are now available to visualise (the operating microscope), manipulate (the microprocessor-driven ophthalmic instruments) and repair (advanced surgical techniques) anatomical pathology that past surgeons could only dream of. Nurses who spend their careers in such environments are required to demonstrate advanced levels of technological expertise (ACORN 2008; Barnard 2002; Hawthorne & Yurkovich 1995; Mellish 1990). However, have we been captivated by the wonders of science in our efforts for technological competency? Have we neglected our fundamental role of caring for the frightened patient who has entered this alien world as the recipient of interventions dominated by science and technology? How did this situation develop and how can nurses reconnect with the patient in the peri-operative day surgery environment?

To understand how science and technology dominate and influence the focus of nursing care, it is necessary to look to the past. As the eminent medical historian Castiglioni (1947) stated:

*No one can comprehend the present accurately and profoundly and look intelligently into the future who is not acquainted with the sources of knowledge or able to follow the roads along which knowledge of the truth has reached us (Castiglioni 1947, p. 3).*

Whilst Castiglioni (1947) refers to modern medicine, his sentiments are pertinent to nursing, as historical healthcare developments were known to exert a tremendous influence on the nursing practice (Barnard 2002). An understanding of the modern western healthcare's historical pathways facilitates a deeper understanding of the present and contributes a historical contextualisation to the findings of this study. Mahoney (1989), when looking at the complexity of modern health and describing the relationship between past and present, believes that this complex inter-relationship is inexplicably linked with the future.

#### **1.4 Healthcare within historical events: Religion, science and technology**

A body of knowledge that developed over the last 3,000 years supports western healthcare practices. Evidence of influential religious, philosophical and political paradigms is woven throughout this body of knowledge (Chang 2008; Hoffman 2001; Risse 1999). Due to these complex influences, healthcare is deeply embedded within social structures and individual psyches. The following section presents a brief exploration of early historical influences, and offers a glimpse of the intricate

forces contributing to the development of modern western healthcare. This journey back in time begins with a view of healthcare and healing in the ancient domains of Greece and Rome, where the ‘father of medicine’, Hippocrates, lived and practiced (Mellish 1990, p. 14).

### **1.4.1 Antecedents in Ancient times**

The origins of western healthcare reside within the emerging knowledge of philosophy and medicine that co-existed in the Hellenic societies of the 5<sup>th</sup> century BC. Socrates (469-399 BC), Plato (423-348 BC), Aristotle (384-322BC) and Hippocrates (460-370 BC), were pre-eminent scholars responsible for the emerging spirit of scientific thought and ethical ideals that characterised 5<sup>th</sup> century BC Hellenic healthcare (Garrison 1929). Prior to this, individuals and societies viewed illness as a sign of divine displeasure, and sick individuals sought succour through supplications to favoured healing deities. Prevailing deities and cults deeply influenced the Hellenic societies and religion was inextricably linked to the everyday life.

Under the influence of Plato, Socrates and Hippocrates, there was a gradual dissociation of healthcare from religion, cults, magic concepts and priestly dogmatism (Castiglioni 1958). Socrates and Plato transformed health and healing through a philosophical rejection of ‘truth’ as found in the traditional theistic and scholarly authorities of antiquity. They sought answers to questions in rational, logical and disciplined thoughts, free from the restraints of accepted beliefs.

Plato’s rational and logical mindset facilitated the development of Hippocratic medicine. Hippocratic doctrines reflected a dependence on empirical observation and

a conceptual unification of mind and body (influenced by Plato's philosophy) as means to understanding human health (Bynum & Porter 1994). Evidence of Plato's belief in the inseparable link between body and soul is seen in the quote below from Plato's *Timaeus* 87, whereby he states:

*... there is no proportion or disproportion more productive of health and disease, and virtue and vice, than that between body and soul (Plato, p. 474 Timaeus 87).*

By today's standards, Hippocratic medicine is considered to have limited knowledge of the workings of the human body (Mellish 1990). However, Risse (1999) attributes the successes of past treatments to holistic care that embraced a mind-body-spirit alliance. Risse's (1999) eloquent descriptions of healthcare practices within ancient Greek healing temples illustrate the prevailing belief in the mind-body-spirit connection. Holistic care was evident as ritual purification, outdoor worship, nutrition, rest, purging and rituals to achieve "catharsis" for the amelioration of anxiety and depression (Risse 1999, pp. 25-7).

Hippocratic medicine influenced healthcare for almost 2,000 years (Mellish 1990), and flourished despite the fall of ancient Greece (146 BC) and the emergence of the Roman Empire (Bynum & Porter). However, the political- social conditions of war, famine and pestilence in ancient times fostered acceptance and eventual pre-eminence of the Christian religion, which exerted 'a profound effect on the attitude of people to the sick and suffering' (Mellish 1990, p. 26). Significant changes in political stability, religious authority and health practices occurred after the collapse of the Roman Empire during the 4<sup>th</sup> century AD (Risse 1999a). These influences provided the conditions in which Christian religion and healing practices exerted a

profound authority throughout the Middle ages (5<sup>th</sup> -16<sup>th</sup> century AD) and into the modern era (Bynum & Porter 1994).

#### **1.4.2. The rise of Christian healing**

As political, economic and social stability declined across the Roman Empire (4<sup>th</sup> century AD), the population fled from rural and remote towns to the protection of major cities. This influx of desperate, hungry people placed an impossible burden on the cities' food, shelter and sanitation resources. Disease, plague and famine were a common feature of city life in the 3<sup>rd</sup> and 4<sup>th</sup> centuries AD (Mackay 2003). Millions of people perished and neither the emerging medical practitioners nor the traditional temple healers could control, treat or explain the ensuing social breakdown (Risse 1999). As earthly life became unbearable, people pursued aid and succour in the humble unitary teachings of early Christian religion, which promised salvation and relief of suffering (Mellish 1990).

Christian healing gradually displaced deity healing cults and mysticism, and facilitated a unification of healthcare and spiritual care within the role of Christ the Saviour (Mackay 2003). An external causality of illness and disease became entrenched within the population under the influence of the Christian religion. Converts to Christianity were promised shelter, charity and eternal salvation that depended on faith, love and benevolence of the Christian God. At this time, Christianity provided not only the ideology of salvation, but also charity and material assistance to the homeless and the poor, who longed for relief and hope (Risse 1999).

Christianity supports a mind-body-spirit connection, and early Christian theology readily accepted the role of medicine within the doctrine of Christ the Healer. Early Christian healing practices offered spiritual care, protection, rest, food and nursing (Risse 1999). However, Catholic Christianity of the Middle Ages (4<sup>th</sup>-16<sup>th</sup> century AD) was philosophically opposed to scientific thought and exhibited an ‘aversion to the view which places man’s fate under the dominion, the inescapable tyranny, of natural law’ (Singer & Underwood 1962, p. 69). Scientific inquiry, which formed the basis of intellectual and medical advancement, fell into decay as the dominance of Catholic Church expanded, since the physical body was considered to be a vehicle for the soul’s transformation (Mackay 2003). Catholic institutions became both the custodian and authority of scientific knowledge for the next 1,400 years.

As the power of the Catholic Church grew, Hippocratic medicine’s holistic understanding of illness (Bynum & Porter 1994) was replaced with an overriding dominance of the individual’s spiritual needs. In the year 1130, the Council of Clermont reinforced this distortion of understanding by barring Catholic monks (who had become primary healthcare providers) from administering medical services to the ailing (Risse 1999). As a consequence of this decree, religious services formed the paramount activity in Catholic hospitals (Risse 1999). Lay medical practitioners enhanced their positions as healthcare knowledge holders with the curtailing of the monks’ healing activities; this movement encouraged the secularization of healthcare (Holzman 1998).

The authority of the Catholic Church was challenged, during the 15<sup>th</sup> and 16<sup>th</sup> century AD, and its position as healthcare providers diminished even further. These challenges were prompted by a perceived failure of the church to protect converts



from the ravages of pestilence and disease (Mellish 1990), and were evident in Martin Luther's (1483-1546) questioning of the church's excesses and decadence, and the Reformation of the 16<sup>th</sup> century. During the 1450's, Gutenberg's (1398-1468) development of the printing press caused the dissemination of new knowledge to the lay population, further challenging the Catholic institution's teachings and authority (Mackay 2003). The church's diminishing influence can be observed in the changing roles of hospitals within society.

During the Reformation of the 16<sup>th</sup> century, hospital ownership transferred from religious to secular organisations and the hospital's role as an instrument of salvation ceased. Hospitals became institutions of care for the 'deserving poor', where patrons and communities developed criteria for admission based on social circumstances and the potential for rehabilitation (Risse 1999, pp. 168). Local and state patrons exerted significant influence in designating paupers, drunks, prostitutes, transient and seasonal workers as 'undeserving', thus excluding them from charitable healthcare (Mackay 2003). From this time onwards, the relationship between patients and hospitals altered significantly, and became what the French philosopher Foucault (1926-1984) described as a contract whereby the rich and the poor participated for the benefit of transforming medical knowledge (Foucault 1973). The hospital inmates, who were the healthcare recipients, were obliged in both life and death to further medical knowledge (Granshaw 1994). Developments in science and philosophy further affected the relationships between patients and care providers through challenging of received wisdom from antiquity during the 17<sup>th</sup> century.

### **1.4.3. Philosophy, science and technology**

Throughout the late 17<sup>th</sup> century, in the period known as the ‘Enlightenment’, a fundamental shift occurred in the understanding of human rationality (Dzurec 2003). As a result, liberation from the authority of Catholic Christian doctrines transpired. Philosophers and scientists of the time were no longer constrained by religious dogma in their search for understanding of the natural world (Kennedy 2004; Mackay 2003; Peacock & Nolan 2000; Rawcliffe 2000). Freed from constraints a medicalization of healthcare advanced through increased implementation of Enlightenment values and scientific methods, leading to the displacement of religious institutions as healthcare authorities.

Philanthropy through Christian charity was still considered appropriate despite secularisation having diminished the Catholic role of the ethos of salvation. However, acts of charity increasingly demonstrated social position and wealth, rather than Christian piety (Risse 1999). Individuals sought advice and assistance from medical practitioners whose treatments were based on scientific facts of the day. The division between medical healing practices and religious institutions broadened, driven by technological advances that resulted from the widespread adoption of scientific thought in understanding human illness .

Augustus Comte (1798-1857) and Rene Descartes (1596-1650) were eminent philosophers of their times, and their radical theories formed the foundation for a modern, scientific worldview. Their belief in human rationality (Audi 2001) challenged the Christian healing paradigm, replacing spiritual treatment with a dualistic and reductionist methodology of scientific healthcare knowledge generation

(Engel 1992; Peacock & Nolan 2000; Playfer 2002). Descartes' philosophy was founded on a dualistic separation of the corporeal body and the incorporeal mind that included a reductionist search for single universal scientific truths (Ripart et al. 2006). Furthermore, his philosophical view was grounded in an epistemology that pursued a reducible, measurable, observable and objective truth (Tebes 2005). The 'scientific methods' of health knowledge generation arising from the era's philosophical positions have established much of today's healthcare knowledge (Loughlin 2009).

In the wake of the scientific revolution, new tools and techniques became available. These developments elevated the role of empirical observation and diminished the role of the patient narrative in the healing process (Reiser 1994). The stethoscope invented by Laennec (1781-1826) in 1819, Wunderlich's (1815-1877) concept of thermometer and its clinical implication in 1868, and Roentgen's (1845-1923) discovery of X-rays in 1895 provided medicine with unprecedented powers of observation and interpretation, as 'doctors exulted in the power and prestige as finders and analysts of physical evidence' (Reiser 1994, p. 833). For the first time, tools and techniques were attainable that met the criteria for objective measurement and quantification, as demanded by the 'scientific inquiry' principles. The patient's subjective experience became superfluous to the scientific and empirically measured observations, as 'sounds and tactile sensations became the exclusive patrimony of professionals, displacing the role of patients as providers of information about their illness' (Risse 1999, p. 330).

During this time period, physicians believed that science was the pathway to understanding all human experience (Wiltshire 2005). Observation and examination were central to medical training and knowledge development, and the search for evidence supporting scientific laws became paramount. The ascendancy of scientific evidence displaced the patient as the principal provider of information regarding the illness (Wiltshire 2005). Foucault (1973) described the changing relationship of the patient and the disease:

*... in relation to that which he is suffering from, the patient is only an external fact, the medical reading must take him into account only to place him in parentheses.*  
(Foucault 1973, p. 8).

During the 19<sup>th</sup> and early 20<sup>th</sup> centuries, healthcare was identified as a biophysical model of care that triumphed over the religious model. Hospitals, which once were nurturing places of physical and spiritual sanctuary, transformed into medical laboratories. Patients became objects of knowledge development and sites for exercising medical power (Peacock 2000). A detachment in caring from the patient's suffering became explicit as the patient was replaced as the epistemological basis of the disease concept, and the capacity of technological medicine to define illness was developed (Hoffman 2001). The power that was once held by religion to influence individuals' behaviour was now held by social sciences and medicine (Powers 2003).

The biophysical model of care supported by scientific methods, offered successful management of many illnesses that had previously been untreatable. However, modern healthcare treatments rapidly increased in complexity and cost, which became an important factor in today's provision of healthcare (Bodenheimer 2005).

A growing demand for fiscal constraint and the relevance of historical developments is explicated in the following discussion on care within the modern world.

The modern healthcare world has seen the spectacular rise of science and technology, propelled by adoption of scientific methods based on a positivist philosophy. A consequence of reliance on scientific methodology as a basis of healthcare knowledge was the devaluing, through systematic exclusion, of dimensions of human existence that cannot be observed, measured and quantified (Peacock & Nolan 2000). These dimensions include the spiritual, social, experiential and psychological aspects of human existence that are frequently threatened during an illness. Clarke (1999) describes the dominance of scientific methods as a

*... hierarchy and power regime whereby natural or hard science and research are considered by some as the only science of worth, with so called social or soft science not being considered science at all, but a loose way of generating explanations, not hard facts and therefore of less value (Clarke 1999, pp. 89-94).*

Thus modern scientifically based healthcare systematically excludes an aspect of healthcare knowledge – experiential knowledge, through a perceived lack of ability to measure and quantify patient experiences.

Positivist philosophy, which formed the basis of the modern health science, embraced a conception of truth that ‘was not dependant on belief alone but on belief that can be verified through examination and observation of external reality’ (Crossan 2003. p.47). Technical inventions supported by positivist philosophy made visible the organic and pathological processes of diseases. ‘Science in the modern Western world has become a powerful lens through which we learn much about

illness' (Le Baron 2004, p.661). Physicians believed that science was the pathway to understanding all human conditions and the application of scientific principles encouraged physicians 'into a reductionist belief that science alone held the key to the relief of suffering' (Le Baron 2004, p.661). The limitations of this belief were overlooked due to the outstanding advances in healthcare arising from science. However, Foucault predicted that the

*... medicine of symptoms will gradually recede, until it finally disappears before the medicine of organs, sites, causes, before a clinic wholly ordered in accordance with pathological anatomy* (Foucault 1973, p. 122).

The invasiveness of scientific medical observation was most evident in the wards and clinics of modern hospitals. The patient was stripped of social and personal context, and encountered what Foucault identified as the clinical and dispassionate 'medical gaze', which has been subsequently described as 'reified, decontextualized, and abstracted from real time, actual location and social space' (Andrews 1998, pp 54-58). The 'medical gaze' is recognised as the basis of medical power and knowledge in healthcare, for it upholds the 'truth' as understood in medicine's knowledge claims about the 'body, health and illness' (Mitchell 1996, pp.201-5). According to Sobel (1995), the virtue of the medical gaze as a valuable tool in understanding illness can also become its vice as a 'consequence of the dehumanizing flight from sensitive subjectivity to sanitized objectivity, from human interest to science' (Sobel 1995,p.236).

The knowledge platform, by which medicine held power and authority in the modern healthcare environment, was further aided by biomedical technology. By the mid-

20<sup>th</sup> century, the medical profession had become ‘sovereign, autonomous and very powerful’ (Jones 2004). Whilst much of medical knowledge is technically-based, patients are not ‘biological machines’ (Clarke 1999, pp.89-90). A detachment in caring from the patient’s suffering occurred through the exultation of science and technology. This detachment was made explicit in the patient’s displacement as the epistemological basis of the disease concept (Hoffman 2001). The power to influence individual behaviour that was once held by religion had been appropriated by social sciences and medicine (Powers 2003). Thus knowledge that was outside of the empirical technical paradigm was devalued, reflective of the power and dominance of medical science in the modern health care environment (Carper 1978).

History displays to us that paradigm hegemonies fail to fully explain the complex and multi-dimensional nature of human illness, and will be eventually supplanted by new philosophical fundamentals that provide greater understanding. In today’s healthcare environment, an emerging acceptance of pluralistic knowledge development methodologies, which value the multiplicity of truths and methods, can be viewed as a continuing evolutionary pathway of healthcare development and practices. The 21<sup>st</sup> century growing body of nursing knowledge recognises the complexity of nursing practices and bases nursing care on expertise from multiple sources (Rycroft-Malone et al. 2003). The following discussion of V-R care today demonstrates the relevance of this historical development analysis.

#### **1.4.4. Vitreo-retinal care today**

In recent years, modern scientific enquiry had resulted in outstanding surgical (Wimpissinger et al. 2008) and anaesthetic advances (Ripart et al. 2006). These

advances support great successes in management and treatment of V-R conditions, as well as the fundamental changes in care for people requiring surgery for V-R pathology (Molina-Prat et al. 2010; Shende, Sadhasivam & Madan 2000). As described earlier, the replacement of traditional inpatient care with day-case care is one of the most recent innovations. Whilst patients appreciate and demand efficient access to technology-supported treatments (Mottram 2009, 2011a), they also seek healthcare that is inclusive of their experiences, values, beliefs and goes beyond biophysical needs (Mottram 2011b; Rhodes, Miles & Pearson 2006). Care that relies on purely scientific evidence fails to consider disease in the context of people's lives and privileged objective knowledge (Risse 1999).

The need to explore peoples' experience of V-R day surgery was demonstrated by the anecdotal evidence gathered in the ophthalmic clinic of this study. This need was consolidated by published evidence that suggested people experiencing sight-threatening events required extra physical, psychological and emotional support to cope with numerous interventions, as well as with the uncertainty of visual rehabilitation (Brennan & Bally 2007; Chia et al. 2003). From a perspective outside of the technical and biophysical aspects (Duffy & Hoskins 2003; Goding & Edwards 2002; Taylor, Kermode & Roberts 2011), knowledge can be important evidence for the foundation of nursing care in this clinical context.

Sources of evidence in nursing practice are widely discussed and identified from several viewpoints. Rycroft-Maloney et al. (2010) identifies four aspects of evidence: research, professional judgments, patient preferences and local contextual knowledge (Rycroft-Malone et al. 2003). Other authors closely align evidence with Carper's



four patterns of knowing consisting of empirical, aesthetic, ethical and personal knowledge (Carper 1978; Newhouse 2007; Porter 2010). These varying approaches to evidence sources provide nursing with broad-based evidence to inform decision-making. In genuine patient-centred care, clinicians must look beyond the biophysical aspect of healthcare experience and place the patient at the centre of the healthcare decision-making process (Mitchell 2010; Robinson et al. 2008). The first step toward broadening the evidence source of V-R day surgery care was an understanding of a patient's experience. Thus, the search for broader evidence began with exploring the concept of 'understanding' from the patient's social, historical and culturally mediated perspective. This concept is capable of providing a source of evidence that enhances the current biophysical understanding.

The following sections present the rationale for the choice of a *research* outcome, that of 'understanding' the experience. Chapters 4 and 5 explore in depth the paradigm and methodological choice. Also included will be a discussion of the development and choice of an overarching *research-in-practice* framework that provides the structure for this study.

### **1.5 Nursing care informed by 'understanding'**

Hans-Georg Gadamer (1900-2002), a 20<sup>th</sup> century philosopher, provides a philosophical position that facilitates 'understanding' and the conditions required to achieve it (Gadamer 1975b, p. 295). The discovery of meaning and nature of experience as interpreted by individuals (Fain 2009) is supported by Gadamer's inductive understanding. Gadamer's philosophy offers the researcher an opportunity

to explore people's unique experiences of phenomena (Dowling 2004; Schneider et al. 2010) beyond the knowledge obtained through scientific methods. As Gadamer stated:

*... the phenomenon of understanding seeks the experience of truth that transcends the domain of the scientific method ... and the experience in which a truth is communicated cannot be verified by the methods of biomedical sciences (Gadamer 1975a, p. xxi).*

Thus, philosophical hermeneutics as described by Gadamer is proposed to guide this study's knowledge development-research aspect. Chapter 4 will further explore the rationale and consolidation of this choice.

Complexity is added to this study by the need to frame, support and conduct the research in a manner that would produce an outcome of improved patient experiences of V-R day surgery. Whilst research methodologies succeed in developing new knowledge, the actual integration of knowledge into clinical practice has been problematic (Fain 2009; Polit & Beck 2012). Thus, this study uses an overarching framework that provide a clear pathway for searching, critiquing and integrating knowledge, as well as the capacity to include the conduct of original research. At this early point, this capacity appears necessary as little published experiential knowledge of V-R day surgery is identified. Having established a potential methodology for this study's research evidence generation aspects, a model of EBNP was required to frame and support the translation of new knowledge into clinical care.

Evidence-Based Nursing Practice models are widely reported as successful pathways for integrating evidence into practice (Fain 2009; Newhouse 2007; Pearson et al. 2005; Polit & Beck 2006). A number of EBNP models have been developed by nurse researchers, with the main variations between models consisting of the research focus (Polit & Beck 2006). The following section describes a process whereby three established models of EBNP are synthesised into a unique framework. The framework is used to translate the new knowledge developed in this study into clinical practice.

## **1.6 Choosing an EBNP model to frame this study**

There has been much discussion in professional nursing literature of EBNP's concept and practice. This discussion is particularly evident in relation to what constitutes evidence in EBNP, and the value of EBNP to nursing (Fineout-Overholt, Melnyk & Schultz 2000; Foley 2011; Pearson et al. 2005; Porter & O'Halloran 2009). Other points of discussion include the methods of integrating evidence into clinical practice (Newhouse 2007; Pearson et al. 2005; Rycroft-Malone et al. 2003) and the merits of specific EBNP models (Burns & Grove 2009; Pearson et al. 2005; Stetler et al. 1998).

For a clinician–researcher, the use of an EBNP model is considered a ‘critical mandate’ of accountable and professional nursing practice (Earle-Foley 2011), and constitutes an appropriate approach for this research-in-practice activity. EBNP has significantly contributed to improving the efficacy and efficiency of patient care despite prompting extensive literary debate regarding what counts as evidence in

nursing care (Levin et al. 2011; Scott & McSherry 2009). The problem that emerged for this study related to which model to use, while aiming to provide the best evidence-based clinical care. The multiplicity of options and discussions regarding EBNP adds to the difficulty of identifying the most appropriate model to utilise. Thus, an understanding of the development and EBNP's specifics was required before making an informed choice of the EBNP model. The following section briefly outlines the development of EBNP, and leads to the chosen model.

### **1.6.1 Historical development of EBNP**

The EBNP concept and practice follows on from the Evidence-Based Medicine (EBM) movement of the mid-90s (Fawcett & Garity 2008). EBM became a new era in healthcare after Cochrane, an epidemiologist, stated that a significant amount of medical care was ineffective or potentially harmful (Cochrane 1989; Scott & McSherry 2009). This ineffectiveness was seen to relate to the failure to base patient care on the best available research evidence (Scott & McSherry 2009). In 1996, Sackett provided an early definition of EBM, which stated:

*The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients* (Sackett et al. 1996).

Sackett's definition was later challenged for its narrow focus on research evidence, specifically randomised controlled trials (RCT), and its failure to identify how research evidence was evaluated (Bauman 2010; Porter 2010; Scott & McSherry 2009). EBM elevated *research* evidence as the primary evidence source for practice foundation. This specifically involved the results of empirical quantitative research where RCTs were seen as the 'gold standard' of evidence (Evans 2003; Goldenberg

2009). The primacy of this evidence led to arguments against EBM as a model for EBNP. Whilst later EBM definitions included professional judgment and critical appraisals of research findings (Newhouse 2007; Polit & Beck 2012; Rosenberg & Donald 1995), arguments continued regarding EBM's pertinence as a basis for nursing practice.

Nurses continue to criticise EBM's implied hierarchical and exclusivist approach to healthcare knowledge (Fawcett & Garity 2008; Mitchell 1999; Scott & McSherry 2009). One point that is heavily discussed is the almost complete exclusion of other evidence sources in clinical decision-making processes (Fawcett & Garity 2008; Holmes et al. 2006). This exclusion is deemed inappropriate to the practice of nursing, which is considered an open and complex system requiring a broad knowledge base for making care decisions (Porter, O'Halloran & Morrow 2011). Despite this controversy, EBM has been enthusiastically embraced by healthcare professions including nursing, whereby the EBM concepts were transposed and integrated into EBNP (Scott & McSherry 2009).

Many nursing scholars actively dispute the use of EBNP, which has sustained lively debate in related literature (Bauman 2010; Fawcett & Garity 2008; Mitchell 1999; Porter & O'Halloran 2009). Levin et al. (2011) acclaim EBNP's benefits, stating that it improves safety and cost-effectiveness of patient care, as well as decreasing patient morbidity and mortality (Levin et al. 2011). EBNP's numerous opponents (Mantzoukas 2008; Miller & Jones-Harris 2005) drew on the reliance on *research* evidence alone to inform nursing care, particularly in light of the widely discussed multiple ways of knowing and evidence sources in nursing (Carper 1978; Fain 2009;

Fawcett & Garity 2008; Newhouse 2007; Rycroft-Malone et al. 2003). Despite the ongoing controversy, it is undeniable that EBNP's principles (that of providing care informed by the best available evidence and inclusive of a variety of sources) play a key role in promoting excellence in patient care (Bellman, Webster & Jeanes 2011; Fain 2009; Taylor, Kermode & Roberts 2006).

For a number of years, 'patient-centred' care has been a compelling demand of patients and healthcare providers (Bothe & Donoghue 2009; Foley 2011; Robinson et al. 2008). Kvale and Bondevik (2008) define patient-centred care as 'respecting, valuing, and inclusion during the decision making processes of their care' (Kvale & Bondevik 2008). Thus, patient-centred care should be founded on the understanding and inclusion of patient preferences into the care received. At its philosophical foundation, nursing focuses on the individual in its care (Foley 2011). Numerous examined EBP frameworks are missing the centrality of patient preferences. The EBNP model, chosen to frame the present clinically based study, demanded the inclusion of multiple evidence sources and patient preferences.

### **1.6.2 Choosing a model of EBNP**

In addition to the complexity of understanding EBNP, French (2002) identifies 14 different definitions of EBNP. However, given the specific clinical context of this study, the most appropriate definition was one that included patient preferences. Ciliska (2001) offers a definition of EBNP that is considered conducive to patient-centred care:

*... integrating the best available research evidence with information about patient preferences, clinical skill level and available resources to make decisions about care (Ciliska et al. 2001).*

Three models are considered appropriate for this study by using the above definition as criteria for evaluating EBNP models. These include the following models of EBP: the Joanna Briggs Institute model (JBI) (Pearson et al. 2005), the Johns Hopkins model (JHNEBP) (Newhouse 2007) and the Fain model (Fain 2009). Each of these models incorporates evidence from a variety of sources comprised of research, clinical context, patient experiences and expert nursing knowledge. Each model offers significant value in achieving improved patient-centred care via the EBNP process. These models are displayed in Table 1.1, with the most successful aspects for the purpose of this study appearing in bold. In the process of identifying aspects that met the specific needs of this study, each of the three models was engaged to develop a synthesised hybrid model. A rationale for the hybridisation process follows.

The JBI model is considered developmental and built on evolving healthcare theoretical frameworks (Pearson et al. 2005). The JHNEBP fosters critical thinking in nurses (Newhouse 2007) and the Fain model emphasises the integration of care decisions with patients (Fain 2009). All of these models have in common the process for developing and delivering EBP, however not one model fulfils all of the needs of this research-in-practice study. In regards to fit-for-purpose to frame this study, each model displays certain limitations.

JBIC offers guidance on how to act when research evidence is unavailable, what constitutes evidence and how to best synthesise evidence from various sources. However, this model fails to address the issue of clearly identifying the clinical problem as an answerable question and is limited in its understanding of how to integrate findings into practice. In contrast, the JHNEBP model provides a clear process on developing an answerable question from a clinical issue, as well as offering an understanding of various evidence sources. However, it also has limitations in terms of what to do when research evidence is unavailable and fails to include processes for evaluation that follows practice changes.

The model developed by Fain (2009) is the simplest of the three and provides a five-step EBP process. A strength of Fain's 2009 model is the cyclical nature of EBNP with the final step consisting of an evaluation of previous actions. However, this model has limitations similar to the JBI model. Most noticeable are deficits in relation to the development of answerable questions from clinical practice. With these evident strengths and weaknesses, aspects of these three models are synthesised to produce a hybrid framework that fulfils the needs of this research-in-practice study.



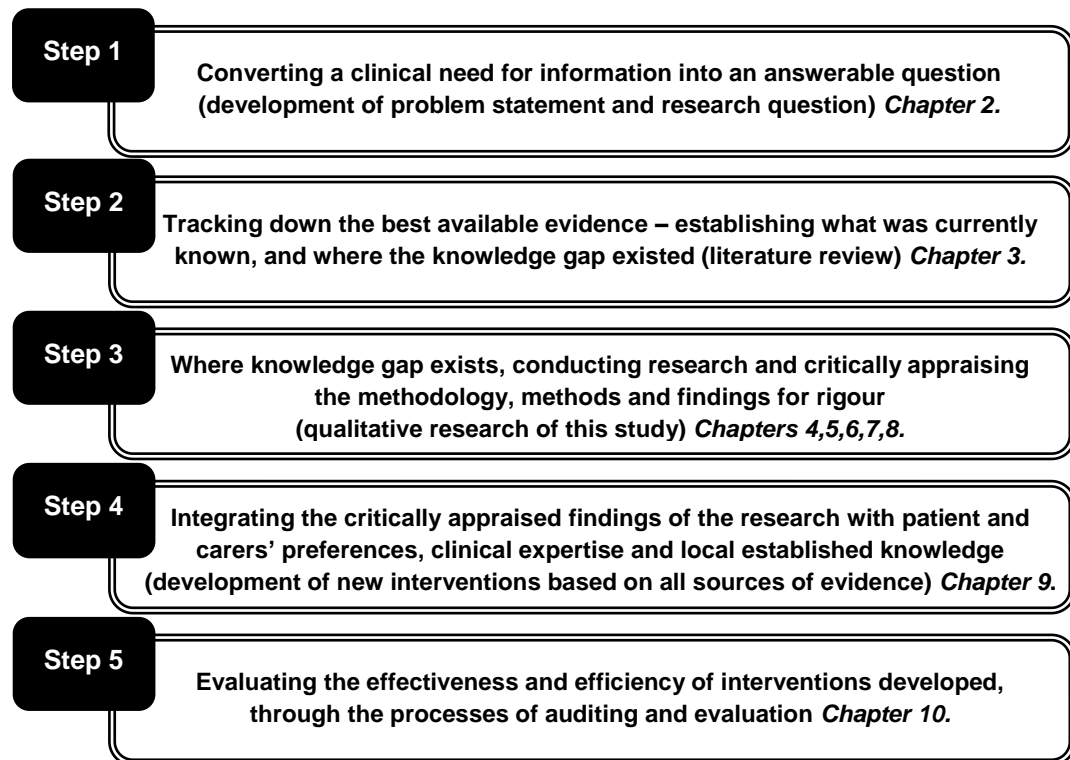
Table 1.1 **Three models of EBNP**

<b>Important aspects of the process</b>	<b>JBI<sup>1</sup> model</b>	<b>JHNEBP<sup>2</sup> model</b>	<b>Fain<sup>3</sup> model</b>
Identification of clinical problem	Provided little guidance on the conversion of a clinical problem into an answerable question	<b>Displayed clear guidelines on how to translate clinical issues into a practice question</b>	Provided a clear definition on how to convert the clinical issue into a problem statement and then researchable question
Sources of evidence	<b>Provided the domains of discourse, experience and research as the sources of evidence in nursing</b>	<b>Built on Carper's patterns of knowing</b>  <b>Differentiated between research and non-research evidence</b>	<b>Inclusive of research, patient and families experiences and professional judgments as evidence</b>
What to do when limited evidence available	<b>Provided a clear pathway for the generation of research evidence</b>	Displayed limited guidance on what to do when no research evidence is available	Suggested that research be conducted when no research evidence is available in regard to the clinical question
Critique and synthesis of evidence	<b>Displayed clear steps for the evaluation and synthesis of evidence prior to utilisation</b>	Provided rating scales for the critical analysis of evidence	There was limited discussion of the critiquing process required for evaluating evidence
Integration into clinical practice	Translation and practice change evident in the model but little discussion on how to achieve translation	Suggested that patients' preferences be included in the translation of evidence to practice	<b>Clearly stated the need and steps of integration of evidence into practice</b>
Evaluation of the process	Limited evaluation of changes to practice	Limited discussion of the steps of evaluation	<b>Evaluation of the preceding processes clearly stated</b>

1. Joanna Briggs Institute (Pearson, Wiechula et al., 2005)
2. Johns Hopkins (Newhouse 2007)
3. (Fain 2009)

The new model appropriates aspects considered appropriate and relevant to the context of this study. This model is congruent with the clinician's need to be open and creative when developing approaches to care that respect patients' wishes and are able to synthesise knowledge from diverse sources (Bauman 2010). Figure 1.1 represents the synthesised model.

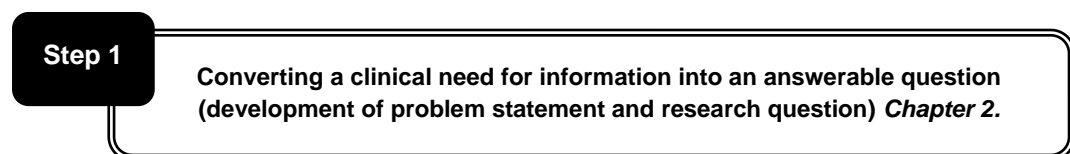
## The steps of evidence-based practice



Adapted from JBI, Pearson, Wiechula et al.( 2005); JHNEBP, Newhouse (2007); and Fain (2009)

Figure 1.1 Steps of the adapted EBNP model used in the conduct of this study

Each of the steps is briefly outlined below.



The first step of the adapted EBNP model requires an exploration of the clinical context, population (P), phenomena of interest (I), outcome (O) and timeframe (T).

This step systematically develops the problem statement that guides the formation of the research question. The following aspects are explored:

- **(P)** the patient population and clinical problem – in this study, this is the *clinical context and background* of V-R day surgery
- **(I)** the phenomena of interest – in this study, *V-R day surgery*
- **(O)** outcome – in this study, the *experience* of V-R day surgery
- **(T)** timeframe – the participants of this study were within *six months of an episode of V-R day surgery*.

This process formalises the development of the research question, allowing for consideration of the clinical context and genesis of the research question presented in Chapter 2. This section also defines the clinicians’ intuitive and experience-related concerns regarding the phenomena at the heart of this study.

## Step 2

**Tracking down the best available evidence – establishing what was currently known, and where the knowledge gap existed (literature review) Chapter 3.**

Step 2 of the EBNP model used in this study establishes what is known about the phenomena of V-R day surgery. All three surveyed models of EBNP provide a clear pathway for sourcing evidence. This synthesised model will follow established methods of evidence collection. Database searches are undertaken, including Medline, Cinahl and Ovid. Chapter 3 provides a discussion of the available research evidence of the phenomena. Where limited research evidence is found, surrounding aspects of blindness, visual disability and quality of life, day surgery, ocular anaesthesia and aspects of self-care are explored in Chapter 3. Further, Chapter 3

incorporates investigations related to providing further support for conducting research into people's experience of V-R day surgery.

**Step 3**

**Where knowledge gap exists, conducting research and critical appraisal of the methodology, methods and findings for rigour (Qualitative research of this study) Chapters 4,5,6,7,8.**

This step comprises a large section of the thesis after having identified the clinical issue and developed a research question. It reports on the processes and conduct of the qualitative study of the experience of V-R day surgery. All aspects of the study are displayed and included – the choice of methodology, methods, ethical conduct, participant recruitment, data collection, data analysis and discussion, presentation of findings and critical analysis of the research (presented in Chapters 4, 5, 6, 7 and 8). This step generates evidence from both research and patient perspectives.

**Step 4**

**Integrating the critically appraised findings of the research with patient and carers' preferences, clinical expertise and local established knowledge (development of new interventions based on all sources of evidence) Chapter 9.**

At the core of Fain's (2009) EBNP model is the integration of evidence into practice. In this step current care is viewed in light of new research evidence and compared with patient preferences, clinical context and professional knowledge. New interventions are developed and become informed by all evidence sources where evidence points to a need for change. This process results in the establishment of a series of clinical interventions based on all sources of knowledge within the study (included in Chapter 9).

**Step 5**

**Evaluating the effectiveness and efficiency of interventions developed, through the processes of auditing and evaluation *Chapter 10*.**

Following the implementation of new interventions, this model's final step is to conduct further research in order to evaluate the new care provided. One hundred patients were surveyed to examine self-care pain management, education needs and the role of the liaison nurse. A final research activity was also conducted for the purpose of gaining qualitative understanding from a further nine participants. These activities assess the effectiveness of the interventions. Chapter 10 discusses the results of the audit and further research.

The framework described above guides the conduct of this study and is utilised in this thesis to present the study's stages and processes. This study began as a research-evidence-generating activity and, as a result of the researcher's close relationship with the clinical context, evolved into an informing practice process. The context of this study is a clinical environment, and the knowledge gained is used to inform practice. Thus, the processes of informing clinical practice require the utilisation of a rigorous EBP framework appropriate to the environment.

## **1.7 A critical view of Evidence Based Nursing Practice as a framework for the conduct of this study**

Evidence Based Nursing Practice: All Australian Nurses practice their profession in accordance with the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Registered Nurse (2005). These Standards encompass the domains of; Professional practice; Critical thinking and analysis; Provision and Coordination of Care; and Collaborative and Therapeutic practice. A core component of the domain of critical thinking and analysis is the requirement to “practice within and evidence-based framework” (ANMAC 2005). As a clinician the need to ground this practice based research within an EBNP framework was evident as a directive based on the ANMC (2005) Standards. This directive was further strengthened by the Australian Council of Operating Room Nurses Standards for Practice (ACORN 2008) Position Statement Eight, Principle Four which states that ‘Nurses must practice utilising EBNP’. However neither of these standards described a model of EBNP. Thus, it was important in the contemplation of an EBNP model to seek what was considered to be the most appropriate model of EBNP that would meet the aims of this study. Underlying this task however, were percolating questions of the validity of this directive, particularly given the strident discourse surround EBNP in the current nursing literature.

It has been argued that directives by controlling bodies, such as ANMC and ACORN (in the Australian context), for EBNP is evidence of a hegemonic influence of politics, economics and post positivist ideology (Bauman 2010). The current debate in the nursing literature as to the role and value of EBNP in Nursing is marked by strident and conflicting claims as to the purpose, and value of EBNP to

nursing practice (Bauman 2010, Holmes et al. 2006, Porter and O'Halloran 2009).

One source of the conflict appears to be seated in the exclusionary hierarchy of evidence that is the basis of many EBNP frameworks that sees research located in the post positivist quantitative paradigm as a privileged knowledge source (Rycroft-Malone et al. 2003; Pearson et al. 2005; Tarlier 2005).

Supporters of EBNP take their position from the belief that EBNP enhances the practice of nursing in the following ways: Firstly, that the interventions of nursing should produce the desired outcomes that are beneficial to patients (Pearson 2006). And secondly, that EBP has been well aligned with that of central interest of nursing that of clinical effectiveness and enhancement of the professional stature of nursing practice (Traynor 2002). Many antagonists to EBNP locate their argument within a critical perspective and believe that the hierarchy of evidence that underpins EBNP is restrictive, exclusionary and fails to allow the multiple perspective of nursing from being explored (Holmes et al. 2006). When EBNP is restricted to only quantitative knowledge with meta analysis of randomised controlled trials as the gold standard of evidence, then the arguments against EBNP could be clearly accepted. However, the evidence of EBNP as described by a number of authors and clearly identified within published models, describes multiple sources of evidence many of which aligned with Carper's (1978) ways of knowing in nursing (Rycroft-Malone et al. 2003; Pearson et al. 2005; Newhouse 2007). Thus the sources of evidence are not excluded to one type of knowledge, that of quantitative research evidence but foster collaborative decisions based on expert opinion, patient preferences and clinical guidelines as well as research evidence (Rycroft-Malone et al. 2003; Tarlier 2005; Mantzoukas 2008).

A second criticism of EBNP has been the belief that it is a product of political and financial hegemony perpetrated by governments and health care institutions (Holmes, Murray et al 2006). There may well be some truth located in these concerns in that EBNP has been used to identify practices that are inefficient or ineffective. However, the question is: is this unreasonable given the increasing demand for health care and ever increasing burden of health care cost to the community (Polder et al. 2002; Bodenheimer 2005; Polder et al. 2005)? A political hegemony has certainly been evident in past funding allocation for research, with the majority of funding allocated to research with quantitative approaches (Darbyshire 2004). Furthermore there has been limited inclusion of health care consumers in the decisions that surround what is important and needs to be researched (Saunders & Girgis 2010). Thus a questioning of the status quo of health relationships and experiences has in the past found limited funding support. However, as Darbyshire (2004) points out, as the quality and experience of qualitative researchers grows the barriers to research funding based on methodology diminishes in favour of the quality and track record of the research question and the researcher (Darbyshire 2004).

Baumann (2010) suggests further limitations of EBNP those of uncertainty of the evidence, dismissal of the clinical context and a minimization of the complexity of people's experience. To overcome such limitations, many nurse scholars have suggested that nurses seek evidence from a variety of sources including patient and carer preferences, clinical guidelines and expert opinions (Rycroft-Malone et al. 2003; Tarlier 2005; Weaver & Olson 2006; Newhouse 2007; Mantzoukas 2008). Furthermore, nurse scholars have concluded that new nursing knowledge from a variety of sources is needed that is respectful of the complexity of human context and



situation (Fineout-Overholt et al. 2000; Mantzoukas 2008; Bauman 2010; Earle-Foley 2011; Porter et al. 2011). Thus the limitations of EBNP can be redressed when a broad-based knowledge source is utilised.

The debate between proponents and detractors of EBNP is at time angry and acerbic; however such conflict is not unique in the history of knowledge development in health care. Polarised and vigorous debate existed in the past between proponents of quantitative and qualitative research methodology (Sale et al. 2002) and more recently between interpretive and critical methodologies. Yet today, mixed methods research is lauded by many professional groups, and triangulation between quantitative and qualitative research paradigms is thought to have the potential to enrich inquiry (Polit & Beck 2012). Weaver and Olsen (2006) suggest a pragmatic approach to methodological choice, as they envisaged collaboration between the critical and interpretive paradigms that meets the needs of the type of knowledge to be developed? The salient point being; those methodologies are aligned but not exclusive to specific types of knowledge development and have the potential to add to our understanding of a health issue from multiple perspectives.

The choice of EBNP to frame this study, where a qualitative interpretive methodology was employed for evidence generation was based on the belief that interpretive research within EBNP had the capability of revealing what was important and meaningful to patients in the experience of V-R day surgery. Furthermore, EBNP provide a structured frame for development of practice changes based on the findings of the qualitative research, other established knowledge and expert opinion. The choice was supported by mandated governing professional

bodies of ANMC and ACORN and the author of this study believed that it would provide a pathway to transformation of care. The question that needed to be answered was, could a critical approach have achieved a similar result and did the chosen interpretive methodology, underpinned by Gadamer's Philosophical hermeneutics have the capacity to promote deep understanding of the experience? These questions will be answered in the following sections.

### *Critical Paradigm an Action research*

One cannot practice nursing in Australia at a middle level management position (Clinical Services Consultant) as the author of this study has done for nearly two decades and not be aware of the multiple daily struggles with inequities of relationships within a multi-disciplinary health care facility and between patients and healthcare systems. Clearly a study that examined the inequities of the relationships between health care provision, participants and consumers that led to transformation of practice would be a valid and enlightening research avenue to take. A methodology located within the critical paradigm and underpinned by Critical Theory perspective could facilitate such an examination (Stringer & Dwyer 2005), and it is evident from the literature that nursing research by such methodologies has demonstrated transformation of practice (Ocloo 2012, Timpka 2000, Xiao et al. 2012). Thus methodologies based on Critical theory could well have been considered as appropriate to guide this study in regard to the phenomena of vitreo-retinal (V-R) day surgery, as a weakness of Interpretive paradigm methodologies is a perceived limited capacity to engender change in the practice environment as they predominantly aim for understanding, description and illumination of the meaning of

experiences (Denzin and Lincoln 2000, Taylor et al. 2006). A summary of the strengths and weaknesses of alternative research paradigm frameworks is located in appendix 10.

Whilst Critical Theory based Action Research methodologies provide clear frameworks for knowledge generation and practice transformation (Stringer & Dwyer 2005; Munhall 2012; Polit & Beck 2012), they are not without limitations which led to a rejection of this methodology in which to underpin this study. An understanding of these limitations will be explored in the following section.

*Critical Theory:*

Habermas (1929-- ) a second generation Critical Theorist believed that the positivist attitude which had dominated knowledge generation was, a “self-subsistent world of facts structured in a law like manner” and was embedded within scientific methods, and concealed the problems of world constitution (Habermas 1968). Such concealment was problematic argued Habermas, when compounded by a positivist rejection of methodological self-reflection, and resulted in a failure to recognise concealed and influential a-prior constitutive elements embedded with facts (Habermas 1968).

In the development of Critical Theory (CT) Habermas invigorated the emancipatory concept of knowledge development through self-reflection, and argued that they key to mutual understanding and subsequent emancipation was effective communication ((Habermas 1968; Mendelson 1979).

The key concepts of CT include:

- All thought is social socially mediated, historically located and deeply influenced by power relationships (Crotty 1998).
- Within any society there is a power imbalance evident as privileged positions over subordinate groups. When the disparity is considered natural, necessary or inevitable then the oppression is most pervasive (Crotty 1998).
- Critical theory advocates the creation of an independent standpoint, external to tradition, from which to examine ourselves and the world in which we live (Guba 1990).

The conduct of nursing research based on CT generally reflects Habermas's delineation of the sciences, with three distinct types of Action Research (AR) identified : those of technical action research with an empirical interest, practical action research with an interpretive interest, and critical action research which serves emancipatory interests (Taylor et al. 2006)). It is the field of critical action research that has captured the attention of many nurse researchers who wished to expose and redress conscious and unconscious oppression of participants within the health care arena (Taylor et al. 2006). Eminent nurse authors have described the aims of critical action research as: seeking of human emancipation from domination and oppression (Bronner 2011), to identify avenues for change using explanatory, practical and normative processes (Taylor et al. 2006) and to be transformative through political and emancipatory consciousness (Denzin and Lincoln 2000).

Critical theory supported AR has been an influential and popular methodology to underpin nursing research projects. Examples of this include a study on patient safety in the NHS in the UK (Ocloo 2012), childhood obesity and social influences (Opalinski 2006) and the social determinates of care within a small health care team and the patient (Timpka 2000). Consistent with the philosophical foundations of critical theory, many published critical action research projects such as those cite above have sought to understand the social determinates of health and illness and power relationships that are sources of oppression. Understanding of inequities within power relationships is thought to provide an avenue for nurses to address the underlying forces in health behaviours and seek answers that would facilitate emancipation from hegemonic influences (Denzin & Lincoln 2000).

The background discussion of this thesis provided a brief overview of the development and dominance of the biomedical model of health and at first look utilisation of a CT supported methodology would have readily flowed from such discussion. However, what the author viewed as immediate and obvious (from anecdotal evidence) was a need to understand the experience of V-R day surgery from the patient's perspective. This view was strengthened by the author's position as an 'insider' researcher, a position where the researcher is known and has knowledge of the context in which the study was conducted (Asselin 2003). Kemmis and McTaggart (cited in Denzin & Lincoln 2000) point out that a strength of AR based on CT is an insistence that the clinical practitioner can be an 'insider' researcher, unlike other methodologies which sees the 'insider' researcher position as problematic. However, the author's 'insider' position led to a decline of the use of AR underpinned by CT, based on not only what clinical experience had led the

author to believe what needed to be explored in this context but also upon methodological limitations that included axiological and ontological issues. The strengths and weaknesses of an ‘insider’ researcher position will be further explored.

Values are integral to all research inquiry, as they influence our choice of subject, the methodology selected and are part of a value system that each researcher brings to the inquiry (Guba 1990). The ownership of particular value systems through which as individuals we view the world has the potential for an imbalance in the power relationship (Guba 1990). In other words, the elevation of ones values or beliefs above those of others leads to the development of a dyad of elite and subordinate players. In CT based AR a framework of emancipation and social justice is intrinsic to the research aim and there is a presupposition that there is a sole possessor of the right conviction that of a “true consciousness” (Mendelson 1979, Guba 1990). The questions that arise from this presupposition included: Can the authority of one conviction based on values systems be supported?; Whose value system is to be used?; The researchers?; The participants?; Who determines what values the inquiry will embrace?; Is one value framework placed higher than another? The answer to these questions were troublesome as it appears that the very aim of CT based AR, that of exposure of overt and hidden inequities, contained preconceived beliefs that were exerted by the researchers and methods, evident in the elevation of one value system over other.

Critical self-reflection a central tenant of critical theory supported research, aims to bring to consciousness our thoughts, values and prejudices. However, does self-reflection always penetrate our preconceptions? Do all of our values and beliefs

become evident? The transparency of our values and beliefs through the process of critical reflection was challenged by the philosopher Gadamer as he questioned the idealism and power of self-reflection, stating that: “the fore meanings that determine my own understanding can go entirely unnoticed” (Gadamer 1975,p. 271). This led to a questioning of the methods of CT based AR where initial research methods included and observation and questioning of the status quo of the research field (Taylor et al. 2006). Again the question needs to be asked ‘whose framework of values was to be used’, are the values of the research fully disclosed and are they important and relevant to the participant?

Critical Theory based AR through its axiological reliance on the process of self-reflection has the potential for authoritarian tendencies through inadequate self-reflection. Such tendencies are evident as the elevation and imposition of one source of values over another when a “better” understanding is sought. Conversely, Gadamer’s described the hermeneutic moment of understanding as not to “understand better” but to “understand differently” (Gadamer 1975, p.276). The potential for authoritarian tendencies can be seen in the initial the methods of AR where planning of a study begins with a thorough observation and analysis of all aspect of the research problem (Polit and Beck 2012). This observation is conducted prior to obtaining knowledge and understanding from the patient’s perspective and is based on a researcher’s presupposition that it was sole possessor of the right conviction (Mendelson 1979). Could this observation phase not be seen a re-emergence of the dispassionate, objective “medical gaze” identified by the philosopher M. Foucault as a source of oppression and domination? (Foucault 1973).

Is there a potential to perpetuate the very inequity of a relationship that researchers contend were redressed through critical theory based methodology?

Criticisms of critical theory have also been related to its belief that all authority is inherently authoritarian (Mendelson 1979). Patients seek the services and advice of clinicians because of the knowledge they possess and this embeds the relationship within a legitimate power relationship (Candlin 2012), Gadamer (1975) argued that authority is not based on blind obedience but on recognition of greater insight or knowledge (Gadamer 1975, pp. 279-82). This led to a reflection on past experiences over many years in the clinical field and the author struggled with understanding the demonization of all power imbalances between patients and service providers. Are all authority relationships authoritarian? Is the relationship that is formed due to the legitimate authority of expert knowledge and moderated by a true therapeutic relationship based on mutual respect and trust, always bad? (Candlin 2012). It appeared to me that the trust patients placed in their healthcare providers, based on the authority of expert knowledge, was a comfort to them in times of great fear and uncertainty (Mishel 1988). Was this an incorrect reading and was the author-researcher a constituent of an ongoing inequity that needed to be exposed?

The Nurse Theorist Mishel's (1939- ) middle-range theory of uncertainty in illness suggest that trust based on recognition of legitimate / knowledge power it is not always bad but is a legitimate way patients cope with threats, through illness or injury to their existential life world (Mishel 1988; Bailey & Stewart 2010).

According to Mishel (1988) the authority figure during times of health crisis exerts a moderating effect on uncertainty and fosters patient's capacity to cope. Whilst there



is no doubt that this relationship has been in the past paternalistic, authoritarian and inequitable, as clearly identified by Foucault (1973) in his treatise “the Birth of the Clinic”. The question in today’s health care world poses is: is the behaviour of those in authority always bad, as the presupposition of CT based AR research suggests?

There is evidence of power inequities in the strident and often angry voice of patient experiences of health care displayed in the popular literary genre of pathographies (Aronson 2000, Graham 1996). Such narratives clearly expose anger; despair and values challenged by oppression and identified authoritarian and paternalistic attitudes. Could the employment of research methods that develop the patient narrative also be of service in exposing inequities of power between provider and consumer of health care? Could such methods facilitate the illumination of what was important and meaningful to patients, and not be constrained by a prior researcher belief as elements of all healthcare interactions? It was the author’s belief that yes, interpretive research methods when carefully utilised could identify these issues will be explicated in the discussion of interpretive methodology chapters 4&5 of this thesis.

A more general criticism of CT based AR is that of a failure of the methodology to effectively obtain equity for oppressed groups, despite rigorous adherence to Habermas’s principles of self-reflection and critique (Taylor et al. 2006). Taylor et al (2006) suggested that research conducted using critical action methodology has been at times superficial and has not led to lasting or effectual resolution of equity and improved health outcomes.

Thus on a number of carefully considered points an interpretive methodology as the knowledge generating activity within and EBNP framework was considered the most appropriate framework for this study. These points included:

- Firstly, the serious criticisms of a critical methodology, as discussed in the preceding sections had legitimate substance.
- Secondly, an interpretive methodology had the potential to discover overt and hidden sites of oppression evident in the understanding and meaning of a phenomenon that arises from the patient's perspective. However, it too needed to be critically examined.
- Thirdly, the need to develop and establish the author as a credible qualitative researcher was the first step towards potential future challenges to the status quo.
- Finally, whilst a critical theory methodology may have added clear knowledge and understanding of power imbalances in the health care arena, one aim of this thesis was to re-establish the centrality of the patient in the sources of evidence that inform health care decisions. Gadamer's philosophical hermeneutics was a philosophical position from which the understanding of patient experiences would be co constructed.

## **1.8 Purpose of the study**

The purpose of this study as a research-in-practice activity is multi-faceted and includes the following aspects. Firstly, to develop an understanding of V-R day surgery from the patient's perspective as no previous understanding exists. Secondly,

to use this understanding to inform clinical care as past care was based on incomplete evidence sources. Thirdly, to develop nursing interventions based on new understanding in combination with other evidence sources, aiming to re-establish the patient perspective at the centre of care. The final purpose of the study is to evaluate the efficiency of care provided following the implementation of interventions developed through this EBNP activity. This evaluation assesses the new interventions in terms of addressing care inadequacies that had presented through anecdotal evidence from the clinical environment. The above aspects culminate in an overarching research-in-practice purpose based on multiple sources of evidence specific to this clinical context. This purpose is to provide high quality, effective healthcare that meets the needs of individuals experiencing V-R day surgery.

Within the clinical environment, innovative and effective healthcare is desirable. An imperative of quality healthcare is the development of informed and supportive care that addresses the reported needs of individuals (Earle-Foley 2011). In recent years, Evidence-Based Nursing Practice (EBNP) frameworks have provided structured and clear pathways that promote quality patient care through incorporating broadly based evidence sources (Newhouse 2007; Pearson et al. 2005). Thus, using EBNP as framework for the present thesis is a sound step towards the overall purpose of this study.

Befitting the first purpose described above, this study aims to understand the experiences of patients who developed complex sight-threatening V-R conditions that required at least one episode of day surgery. In the past, this type of surgery was performed on an inpatient basis where 24-hour post-operative care was provided.

Reports published in literature regarding vitreo- retinal surgery advocate for patients to be admitted to hospital for post-operative nursing care to facilitate pain management, nausea and the instillation of eye medications (Fekrat et al. 2001). The literature also supports the belief that patients with sight-threatening diseases are at risk of high levels of psychological stress (De Leo et al. 1999). It is unknown how people coped in the immediate post-operative period following discharge from hospital to self-care. Chapter 3 further explores these aspects of the phenomena.

The current nursing literature is devoid of experiential knowledge of patients with complex V-R conditions receiving care in day-case surgical settings. Thus, this study's first purpose is to fill this knowledge gap through an exploration of patient experiences that underwent day-case surgery for V-R disease. The use of Gadamer's philosophical hermeneutics to guide new knowledge generation ensures that the participants' voices are heard and that nursing knowledge incorporates what is important and meaningful to the patients.

Once new knowledge is developed, the second purpose of this study can be fulfilled by informing patient care through an understanding of the patient's experience combined with clinical expertise and contextual knowledge. The EBNP framework utilised in this study provides a structured avenue for developing interventions and evaluating their effectiveness, thereby fulfilling the third and fourth study purposes, as well as the comprehensive aim of the study. That aim being the provision of high quality, effective healthcare that meets the needs of individuals experiencing V-R day surgery.

## 1.9 Summary

The present chapter establishes the background, need, and purpose of the study. The researcher has located the study within the historical context of an environment dominated by science and technology, and has indicated how the consumer's voice can be lost within this setting. The chapter has explicated understanding as a fundamental concept and alluded to the use of Gadamer's philosophical hermeneutics. The concept of understanding is developed in a later section of this thesis, which analyses the choice of methodology guiding the study's research activities. Each major section of this study is presented within the steps of the hybrid EBNP framework. This approach lets the reader follow the study's pathway, from a simple research-evidence-seeking activity that emerged from anecdotal clinical evidence, to the translation into practice of new research-based knowledge of V-R day surgery. This movement from the parts (research evidence) to the whole (improved clinical practice) is consistent with Gadamer's philosophical hermeneutic circle. This study anticipates that its direct result will improve people's experience of V-R day surgery. The presentation of this study begins with Step 1 of the EBNP framework, which displays the research questions as they evolved from the clinical environment.

## CHAPTER 2

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### DEVELOPMENT OF AN ANSWERABLE RESEARCH QUESTION

#### Step 1

Converting a clinical need for information into an answerable question (development of problem statement and research question) *Chapter 2.*

The research questions of this study stem from a clinical need for information. These questions provide the foundation for the research design and development (Rios, Ye & Thabane 2009). A clinical problem statement, also known as a practice question, facilitates the development of an answerable research question (Polit & Beck 2012). Moreover a problem statement clarifies the nature, context and significance of the clinical problem and provides the rationale for conducting inquiry research.

The problem statement assists with narrowing the focus of the phenomena of interest, resulting in a clearly defined research question (Collin 2003). The developed question influences the choice of methodology and the conduct of the research, and contributes to the quality of collected answers (Rios, Ye & Thabane 2009; Stillwell et al. 2010). Research questions that are stated clearly are considered essential for the smooth conduct of a study (Beckley et al. 2007). Furthermore, poorly constructed research questions have been said to cause inadequate or weak research results and even a failure to address the clinical issue (Nepal, Brown & Ranmuthugola 2008).

Within this study, the transformation of the clinical issue into a problem statement and then into an answerable research question uses structured reflection on key aspects of the phenomena of V-R day surgery. These aspects include the population, phenomena of interest, outcome and timeframe. This process provides a clear rationale for conducting this inquiry research, resulting in a well-constructed and answerable research question.

## **2.1 Introduction**

By clarifying what is poorly understood in the clinical setting, problem statements provide compelling evidence for the need to conduct inquiry research (Burns & Grove 2009; Polit & Beck 2012). Writing a problem statement for this study leads to a well-developed research question by identifying the important aspects of the V-R day surgery phenomena. This preliminary activity is recognised as one of the crucial steps of the research process (Fain 2009). Construction of a problem statement requires a systematic examination and reflection on the clinical issue to identify elements relevant to the phenomena and the context. As described in the previous chapter, this study uses the following elements to clarify the nature, context, significance and timeframe of the clinical issue:

- **(P)** population
- **(I)** the phenomena of interest
- **(O)** outcome of the study
- **(T)** timeframe

A framework such as this assists in recognising the elements of the clinical issue, as a problem statement, that promotes further development into a research question.

These four elements are described in detail below.

## **2.2 (P) Population: Identifying population aspects of the experienced V-R pathology and V-R day surgery**

The population of this study includes people who had experienced various forms of V-R pathology. The underlying pathology has a significant impact on the type of surgery required and the potential visual outcome. Therefore, in order to understand this patient population, a short overview of the incidence of visual disability, type of pathology, surgery and visual prognosis is necessary.

Within this study, visual impairment is considered as a disability when vision is less than 6/12 (the ability to read the last two lines of a Snellen chart) and as blindness when distance vision is 6/60 or less (the largest letter of the Snellen Chart), or when the visual field is less than 10 degrees (Patton & Thibodeau 2010).

### **2.2.1 Incidence of visual disability**

Across the age spectrum, vision impairment for individuals is considered to be one of the most common disabilities (Beckley et al. 2007). Whilst vision impairment occurs at all ages, it is most commonly a condition of the ageing process. This has significant implications for future health service provision in the ageing Australian population (Beckley et al. 2007; Buch 2005). In the past 50 years, the average life expectancy of Australian adults has increased dramatically – for males, life expectancy increased from 67 years in 1952-1954 to 78 years in 2004-2006; in the



same time period, female life expectancy has increased from 73 to 83 years (Nepal, Brown & Ranmuthugola 2008). During the next 25 years, Australia expects to double the number of people over the age of 65, with a corresponding increase in the number of people requiring treatment for visual disability (Beckley et al. 2007). It has been reported that visual impairment affects 3.9%–4.7% of the Australian population over the age of 40 years, rising to 50% in people over 90 years of age. (Beckley et al. 2007; Teitelman & Copolillo 2005; Weih et al. 2000). Figure 2.1 displays the incidence of visual impairment and blindness across the age spectrum and clearly demonstrates the relationship of age to visual disability.

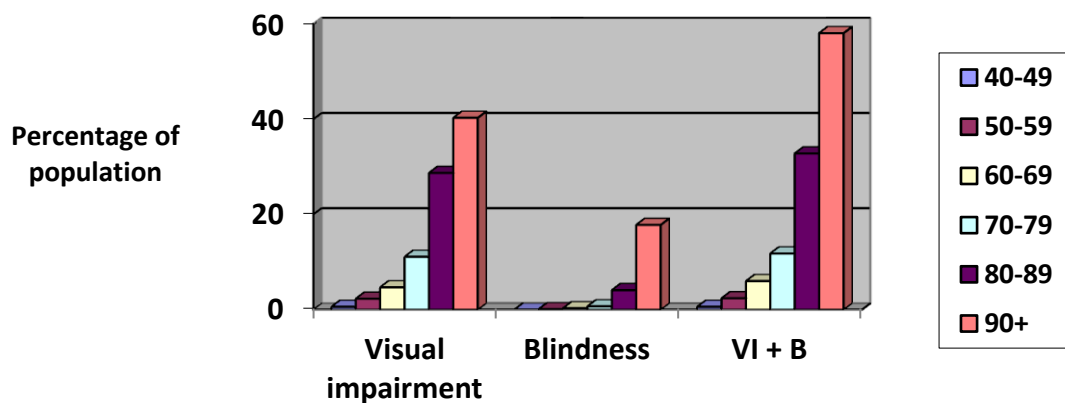


Figure 2.1 Incidence of visual disability and blindness across the age spectrum (Beckley et al. 2007)

The most common causes of vision loss (not correctable by refraction) have been attributed to such conditions as age related macular degeneration (ARMD), glaucoma, lens opacity (cataract) and diabetic retinopathy (Beckley et al. 2007; Horowitz 2004; Teitelman & Copolillo 2005). Within this group of disabling

diseases, the V-R pathological conditions which require surgical interventions are primarily related to diabetic retinopathy, hypertensive retinopathy, retinal detachment and macular disorders (Smith 2002). The focus of this study is the experience of surgical intervention(s) to correct pathology from these V-R pathological conditions.

A literature search identified a number of reports on people's experience of anterior segment eye disease, such as cataract and glaucoma (Dhillon & Gerassimos 2009; Nijkamp et al. 2002), as well as a plethora of information concerning various technical aspects of cataract and V-R surgery (Akçay et al. 2011; Berker et al. 2007; Schwartz & Flynn 2006). In the absence of experiential knowledge of people's care requirements in the V-R day surgery scenario, knowledge gained of anterior segment surgery had been extrapolated to meet patients' needs. Such an extrapolation was found to be problematic. Upon close comparison with anterior segment surgery, people with V-R pathology had significantly different disease aetiology, surgical requirements, post-operative care needs, potential for anatomical repair and the timeframe for visual rehabilitation. Furthermore, several of the above aspects were causative factors associated with anecdotal reports of patient difficulties following V-R day surgery. These reports were gathered in the ophthalmic clinical environment. The following section further discusses the important and influential aspects of V-R pathology, surgery and visual disability.

### **2.2.2 V-R pathology**

The professional literature describes the conditions of diabetic retinopathy, macular hole and retinal detachment as the most common conditions requiring V-R surgical

interventions (Akçay et al. 2011; Spaeth 2003). The following section of this study describes these conditions, thus contributing a contextual understanding of the study's population.

### **Diabetic retinopathy**

Retinopathy is an ocular complication associated with diabetes mellitus. This condition constitutes a growth of abnormal vessels and fibrous tissues in the retina. Diabetic retinopathy often leads to haemorrhage and tractional detachment of the vitreous and retina. Visual and anatomical rehabilitation involves a surgical procedure of vitrectomy and laser therapy. Amongst the American population, diabetic retinopathy accounts for 10% of all new cases of blindness per year (Smith 2002). Moreover, visual disability in diabetic retinopathy is closely linked with the disease's duration. The duration's influence can be observed in patients with Type 1 diabetes of over 15 years, who had an incidence of 80% of some form of retinopathy (Smith 2002). Compounding visual pathology is associated with significant risks that include retinal detachment, haemorrhage and macular oedema (Ross 2002). Diabetes is an incurable condition; hence there will be a concomitant increase in the incidence of diabetes amongst the Australian population, leading to a continuous rise in the occurrence of diabetic retinopathy (Australia 2004; Fenwick et al. 2011).

### **Macular hole**

A macular hole is usually evident as a small break in the centre of the macula, the area of the retina responsible for detailed vision. Macular hole causes have been linked to oestrogen fluctuations, trauma and age (Smith 2002). The repair of macular hole is usually an elective procedure and requires a vitrectomy, followed by intra

ocular tamponade with either an expansile gas or silicone oil. Chances of visual recovery are considered high, however certain factors influence recovery, including the size and depth of the macular hole (larger, full thickness holes are more difficult to treat and close), chronic macular hole, high myopia and association with retinal detachment or trauma (La Cour & Friis 2002; Smiddy 2010).

### **Retinal detachment**

Retinal detachment is a condition where the sensory retina separates from underlying structures, separating the blood supply from the retina. The incidence of retinal detachment is 1:10,000, with 40% of all retinal detachments occurring in myopic eyes (Duguid & Lesnik-Oberstein 2004; Mitry et al. 2010). Retinal detachment repair is an emergency procedure requiring either vitrectomy or scleral buckle and sometimes both methods. Whilst full visual recovery following retinal detachment repair is as high as 85%, there is less certainty regarding visual outcome following re-detachments (Lesnoni, Rossi & Nistri 2005; Ross 2002; Wang & Boerner 2008).

### **2.2.3 V-R surgery**

In recent years, V-R surgery has evolved significantly with new instrumentation that allows greater manipulation of retinal tissues, leading to improvement in anatomical correction (Wimpissinger et al. 2008). This often complex surgery aims to reattach the retina, relieve the vitreous traction and prevent proliferation of retinopathy (Schwartz & Flynn 2006).

Whilst successful anatomical repair can be achieved in 76%–84% of all cases (Schwartz & Flynn 2006), functional rehabilitation is not always as successful

(Kawahara et al. 2008; Lesnoni, Rossi & Nistri 2005; Sharma, Joshi & Shrestha 2010). Thus, people experiencing retinal pathology must confront a unique and uncertain disease trajectory, which often requires multiple surgical episodes with long periods of convalescence. Furthermore, the uncertainty of visual rehabilitation often intensifies their experiences.

Numerous strategies are used to help restore vision for people with V-R pathology, including the surgical procedures of vitrectomy and scleral buckling. In the past, these procedures required lengthy surgery, a general anaesthetic and extended post-operative hospital stay. Today, both procedures are routinely performed patients who are awake and who receive regional eye anaesthesia and are discharged a few hours after surgery. Patients deemed unsuitable for conscious surgery undergo an operation with general anaesthetic, and are also discharged a few hours later. The following section briefly describes the above surgical procedures, which are the mainstays of treatment for V-R conditions.

### **Vitrectomy**

Vitrectomy is a surgical procedure for the removal of vitreous, blood or membranes. It requires small ports at the pars planar site using 20, 23 or 25 gauge instruments. The instruments, infusions and illumination are introduced via these ports into the ocular posterior segment, at which point tissues can be manipulated or removed. Vitrectomy often entails the removal of the vitreous and hyloid membrane, which is subsequently replaced with a balanced salt solution, tamponade gas or silicone oil. In conjunction with vitrectomy, an endolaser coagulation treatment is often performed. This treatment assists in the retina's reattachment to the choroid and prevents

further proliferative retinopathy.

### **Scleral buckle**

The repair of retinal detachment by indenting or “buckling” the sclera inwards, via using external silicone bands, is a well-established practice (Shaw, Lee & Stollery 2012 ). The silicone bands change the eye’s shape, making the retina “attach” with the choroid. Frequently, cryotherapy is employed to help maintain the retinal re-attachment, and intra ocular expansile gas may be instilled to act as a tamponade of the retina to the choroid.

The development of an informed understanding of this patient population in regard to incidence, pathology and treatment of V-R conditions, requires further exploration of the underlying threat of visual disability. This aspect is usually displayed as a fear of blindness and is associated with most V-R pathological conditions.

#### **2.2.4 Visual disability**

Within the Australian and American populations, the two most feared health conditions are cancer and blindness (Taylor 2002; Wang & Boerner 2008). The fear of blindness is directly related to individuals’ regard of visual function as highly important and closely associated with quality of life (Lau et al. 2004). Visual disability is affiliated with a wide range of health issues including depression, activity loss, falls, anxiety and loss of control (Boerner, Reinhardt & Horowitz 2006; Cox et al. 2005; Ormel et al. 1997; Paz, Wu & Varma 2003; Taylor 2002). People, who experience visual disability often lose valued daily functions such as the ability to drive, read, watch TV and do craft work. This loss leads to anxiety about safety in the home, social isolation and coping with everyday activities (Beckley et al. 2007;

Hinds et al. 2003). Visual disability is associated with increased morbidity and has multiple negative consequences on the quality of life through increasing the risk of falls, limiting social interaction and compromising independence (Hassell, Lamoureux & Keefe 2006).

Younger sufferers of visual disability may suffer from loss of employment, of self-sufficiency and of self-esteem, which causes depression and psychopathology (De Leo et al. 1999). Visual disability influences the course and outcome of personal development (Wahl et al. 2004; Wang & Boerner 2008) and fear of blindness and visual disability is associated with greater psychological suffering than the loss of other sensory functions (De Leo et al. 1999).

Furthermore, De Leo et al. (1999) conducted a study on different psychological reactions to sight deterioration and total blindness. The study found that partial sight loss induces a stronger presence of depressed mood, anger and hostility than complete blindness. Moreover, Coyne et al. (2004) found that people with unilateral blindness suffer higher emotional distress than those with bilateral blindness of long standing. De Leo (1999) also found a strong correlation between sight disorders, psychic distress and somatic outcomes, which displayed increasing severity as sight deteriorated.

Social interactions and support enhance an individual's capacity to cope with visual disability. However, the loss of vision often initiates negative changes in personal relationships and a decrease in social networking (Wang & Boerner 2008). Social isolation has been well documented as a result of visual disability. It poses a serious

threat to individuals' life quality and expectancy, as Ray (2004) stated that 'the larger the social support system the lower the mortality rate'. The loss of visual clues in a social setting affects both personal and public relationships. This creates the need for visually disabled adults to find new ways of relating and re-establishing social connections (Bothe & Donoghue 2009; Wang & Boerner 2008). Thus, through an inherent consequence, visual disability inhibits access to the support necessary for people to cope with this impairment.

Social relationships and supportive interactions are crucial to the perceived quality of life (Boerner, Reinhardt & Horowitz 2006; Routasalo et al. 2009; Wang & Boerner 2008). However, it is ironic that rehabilitation programs for visually disabled adults seldom address the need to learn new ways of relating socially (Beckley et al. 2007; Wang & Boerner 2008). Visual disability is often a result of a multifactorial pathology. However, it creates a sensory loss that negatively influences functional effectiveness, psycho-social abilities, the skills to care for oneself and self-reported quality of life (Stevenson et al. 2004).

During the course of developing an understanding of this study's patient population, V-R conditions were identified as having a varied disease trajectory that often required multiple surgical episodes combined with long periods of visual rehabilitation. This trajectory is unlike cataract conditions, where a single surgical event restores vision with a high success rate and there is a short period of visual rehabilitation (Mozaffarieh et al. 2004; Pager & McCluskey 2004). These results are in marked contrast to V-R pathology, which involves a long recovery period and has less certain functional visual outcomes. Lesnoni et al. (2005) reports that only 61%



of patients believed they had gained visual improvement after multiple surgical episodes for recurrent retinal detachment. Thus, failed functional rehabilitation may result in the very real threat of visual disability, which exerted significant psychological impact on the population within this study.

This study has established the incidence, pathology, surgery and disability of V-R conditions in relation to its population. This meets the requirement of the structured framework's first element, which is the identification of the patient population. The next section examines the second element of Step 2 – a description of V-R surgery as the phenomena of interest.

### **2.3 (I) The phenomena of interest: A transition of V-R inpatient surgery to day surgery**

Modern biomedical healthcare supported by innovative science and technology has shown outstanding advances during the 20<sup>th</sup> and 21<sup>st</sup> centuries. However, there is also evidence of the soaring costs of new techniques and treatments with a consequential need for a rationalisation of services (Bodenheimer et al. 2002; Von Korff, Glasgow & Sharpe 2002). This rationalisation sees care that is less invasive and technology-dependent devolve to the patient and the community. One such rationalisation strategy consisted of the recent transition from inpatient to day-case care following V-R surgery.

Whilst advances in healthcare have reduced mortality, modern Western societies now confront an ageing population and 'a concomitant growth in the number of people who are living with chronic illnesses' (Bodenheimer et al. 2002; Von Korff, Glasgow

& Sharpe 2002). An ageing population requires extensive use of invasive high-tech interventions and a heightened need for expensive acute care (Little 2000; Peacock & Nolan 2000). Peacock and Nolan (2000) describe the evolving 21<sup>st</sup> century definition of “care” as an evolution from the bedrock of all services provided to ill individuals to a redefined service that offers the finest financially viable treatment.

Escalating healthcare costs (Bodenheimer 2005) combined with new therapeutic and diagnostic modalities have resulted in higher provider costs, as well as increased State regulation and control of healthcare funds (Polder et al. 2002). As the major funding providers, governments now require accountability in all healthcare activities and demand cost containment strategies that meet the community’s needs. These demands are causing a renegotiation of the social contract between healthcare providers and society in the 21<sup>st</sup> century (Little 2000; Polder et al. 2002). As a consequence of this renegotiation, the modern relationship between patient and healthcare provider has many more stakeholders who influence and determine individual and community care. The exchange between healer and patient now includes economists, policy makers, resource allocators, state authorities, health care professionals, patients and families. ‘The consulting room has become a crowded office’ (Little 2000, p.18). Healthcare has evolved into an outcome-driven economic and political commodity, subject to cost containment and rationalisation (Sakalys 2000). The impact of cost containment strategies, such as the move to day surgery on patient experiences of V-R surgery is unknown.

Cost containment strategies have taken numerous directions, including funding rationalisation, access limitation, outsourcing and a stringent requirement for

treatments to be “evidence based” (Little 2000, p.20). Amongst popular strategies is the removal or relocation of healthcare tasks, which are not technically based and cannot demonstrate positive economic outcomes, away from acute hospital settings and into the community. These tactics have caused many specialties to move to day surgery care, where patient care is limited to a brief daytime episode. High cost and high tech invasive treatments are performed during this short period, while convalescent and caring practices are delegated to the family or the community (Gilmartin 2007). For patients, the move from inpatient to outpatient surgery has resulted in diminished physical and psychological surgery preparation, as well as limited opportunity for nursing-related caring activities (Bothe & Donoghue 2009; Mitchell 2002).

Throughout recent years, the uptake of day surgery has significantly increased across all specialties. Technology is assisting surgical advances and extended duration and efficacy of anaesthetic agents allows more complex surgery to be performed on sicker patients (Aylin et al. 2005; Bernier et al. 2003). Reported rates of day-case surgery range between 60–75% of total surgery performed in the United States, UK and Australia (Aylin et al. 2005). Lagoe and Milliren (cited in Seibert et al. 1999, pp. 23) initially defined day surgery as ‘surgery that was more complex than that performed in consulting rooms but less complex than that performed in inpatient settings’. Although day surgery now involves very complex surgery, this limited definition no longer applies, but the perception of day surgery as simple surgery persists.

The success of day surgery is driven by political and economic pressures of the need to reduce surgical waiting lists (Mottram 2009) and decrease costs per case (Bodenheimer & Fernandez 2005; Richards 2008). However, anecdotal clinical evidence affirms research evidence that patient experiences of self-care following day surgery are not always satisfactory (Costa 2001; Mac Lellan 2004; Mottram 2011b). The following section describes cost containment strategies that have seen the transferral of ophthalmic surgical care to almost exclusive day-case care.

### **2.3.1 The ophthalmology experience**

Within ophthalmology, the progression from inpatient care to outpatient care (day surgery) encompasses the vast majority of ophthalmic surgery performed today (Yashar 2000). This transformation began with minor lid procedures and extended to cataract surgery in the mid-1980s. The success of cataract day surgery influenced the conversion of complex V-R surgery to day-case surgery. However, outside of cost containment, the success of this change has not been explored (Desai et al. 2008; Ellwein & Urato 2002).

In the 1960's and 1970's, cataract surgery was a technically challenging *inpatient* procedure, typically performed under general anaesthesia. Convalescence following cataract surgery required an extended hospital stay. For the first few weeks, patients had bilateral eye pads applied and severe restrictions were placed on their mobility and diet (Brunner 1975). The successful shift of cataract surgery from inpatient care to day-case care was assisted by advances in surgical techniques and anaesthetic efficacy (Yashar 2000). Fewer than 3% of all patients demonstrated medical complications following cataract surgery now performed as day surgery (Desai et al.

2008). The relocation of V-R surgical procedures to day surgery was promoted by effective cataract day surgery, despite significant psychosocial and biophysical variations between patients with cataract and V-R conditions.

## **2.4 (O) Outcome of the study: Understanding of the experience from the patient's perspective**

Through the medium of illness narratives, patients are able to express the truth of an experienced illness in their own voice through the means of qualitative data or published stories (Sakalys 2000). These expressed truths often highlight an ideological difference between dominant healthcare cultures and individual patient contexts (Sakalys 2000; Wiklund, Lindholm & Lindstrom 2002). Furthermore, Sakalys (2000) distinguishes illness narratives from medical accounts of experiences as narratives use the patients' own voices for 'providing the truth of personal experience' (Sakalys 2000,p.1470).

Narratives of illness experiences enable the patient's voice to be heard, at times strident with anger, at other times filled with pathos and emotion of life-changing events. Pathography is a literary genre accommodating these reports, which illuminate experiences from the patient's perspective. The author's intent is a significant difference between the genre of pathography and qualitative research data, as both strive to provide the truth of the experience from the patient's perspective. These, often emotion- laden, narratives are viewed as a reaction to the contemporary healthcare model that separates the life lived from illness and ignores its experiential aspects (Sakalys 2000). Qualitative method returns the patients' voices to the world of healthcare, asserting the phenomenological, subjective and

experiential aspects of illness (Graham 1996). McLellan (1997) describes the qualitative research interview as a narrative about a particular phenomenon of interest, which is not an objective reconstruction of life but rather the way it is perceived (Aronson 2000).

The present study uses a qualitative research methodology to illuminate the voices of individuals. However, first an explication of patient experiences as pathography is given. The intention is to highlight the value of this genre and research methodology to the understanding of illness.

#### **2.4.1 The patient's voice**

*Cyriac, this three years day these eyes, though clear  
To outward view, of blemish or of spot;  
Bereft of light thir seeing have forgot,  
Nor to thir idle orbs doth sight appear*  
(Milton cited in the Great Books 1952, p. 70)

In the past, the articulation of patient experiences of illness and healthcare have taken the form of poems or prose, such as example cited above – a classic poem on the feelings of diminishing vision by Milton (1608–1674). More recent narratives about illness experience provide ill individuals with a voice in a world where subjective and experiential truth is rarely heard.

McLellan (1997) describes pathography in terms of the author's intentions and groups them into: a motivation to help others, an avenue to express anger and, finally, a desire to find the spiritual aspects of suffering. Aronson (2000) adds that

patients write stories due to a need for emotional or intellectual catharsis.

Furthermore, Wiltshire (2005) interprets the voice in pathography as that of authentic and personal patient experience, as opposed to a 'hegemonic, oppressive and institutionalized' medical voice (Lowenfeld 1981; Monbeck 1973; Scott 1969).

Pathography provides patients with the opportunity to comprehend and find meaning in an illness experience. It can be instrumental in exposing ideological inconsistencies between the healthcare culture and patient culture (Aronson 2000; Sperber 1976).

By the 1970s, trust was waning in a medically dominated system and a cultural shift occurred that was characterised by a 'lack of confidence in physicians and an overt fear of hospitalization' (Sperber 1976, p. 5). This caused pathography to rapidly change its tone, becoming an expression of anger at callous or depersonalised treatment. At this point, the genre begins to demonstrate a cultural discontent with a model of care dominated by science and technology.

"A long season in Hell" is the title of Gail Grahams' (1996, p.1) angry account of her struggle to help her son following severe head injuries. It is a clear example of indignant pathography: 'words are my weapons' (Graham 1996, p. 238).

Angry pathography describes cultural inconsistencies between patients and healthcare providers. However, the narrative also illuminates the meaning of the experience, where the subject is illness and care as understood by the ill individual. Such narratives situate the experience within the context and meaning of the ill person's life (Sperber 1976). This is evident in Al Sperber's work (1976), which

recounts the experiences of ten visually disabled individuals and provides great insight into their life-world. These narratives illuminate the experience's human dimensions and include:

- the pain of surgical procedures:

*... it was a terrible experience, I never want to go through that again ... the pain was horrible. (Sperber 1976, p. 13)*

- anxiety about employment:

*... how do I earn a living, how can I support my family? (Sperber 1976, p. 63)*

- the psychological angst of losing vision:

*What happens to all my dreams and hopes and ambitions? It's all over for me, isn't it? (Sperber 1976, p. 63)*

- the life choices that people made:

*My condition is inheritable ... . I would not want to wish what happened to me on anyone else especially my children ... we decided not to have children (Sperber 1976, p. 147).*

These heartfelt words challenge the assumptions and practices of orthodox healthcare by bringing attention to individuals' life-world within the modern healthcare ideology.

The present thesis is a report of a research study that aims to use a rigorous qualitative research process to develop an understanding of peoples' experiences of V-R day surgery. This process clarifies the participants' life-world in the context of their physical, social and psychological experiences. The goal of this research is not to question the success of surgical-medical interventions. This research aims to hear,



listen and understand the meaning participant's ascribed to their experiences. An appropriate framework for this study is a qualitative methodology that offers understanding of the life-world as described and interpreted by the study's participants.

## **2.5 (T) Timeframe: Surgery within the previous six months**

In order to capture the rawness and emotion of the experience, a timeframe of six months between the last surgical procedure and research interview was considered appropriate. Within this timeframe, participants were able to provide full descriptions of the experience without it becoming mellowed by time or memory loss. The data collection timeframe is governed by the guiding principle of "saturation" (Polit & Beck 2012, p. 521). Saturation occurs when no new information or themes are forthcoming and a sense of closure is attained (Polit & Beck 2012).

## **2.6 Problem statement of this study**

Day surgery accounts for 75% of all surgical cases performed in Australia, the UK and America (Chanthong et al. 2009; Older, Carr & Layzell 2009). The transformation from inpatient care to day surgery for people with V-R pathology is a recent development, propelled by need for financial rationalisation. This change of care modality is based on the evident success of cataract day surgery. However, there are significant variations between these two patients groups in terms of aetiology, length of surgery, recovery time and the potential for visual rehabilitation. The experience of day surgery for V-R conditions is unknown, despite the studies on experiences of day surgery care for people with cataract. Anecdotal reports from the

clinical environment suggest that patients experience difficulties during the post-operative self-care phase of V-R day surgery. Nursing practice can be guided and informed by the valuable insight gained from the patients' perspective of this experience. The research question is developed from this problem statement.

## **2.7 The research question identified**

Based on previous discussions, this study's research question is:

*What was the lived experience of people who undergo vitreo-retinal day surgery?*

Once the research question had been identified, it is necessary to further examine the professional literature for current knowledge about this experience. Step 2 of the modified EBNP model framing this study guides the information search. This step explores the knowledge about this phenomenon and identifies a gap in the literature. Where no qualitative research evidence specific to the phenomena of V-R day surgery is available, relevant issues are explored. These include: day surgery, post-operative care, ocular anaesthesia and satisfaction surveys as a measure of successful care. Step 2 provides further rationale for the conduct of this study.

## **2.8 Summary**

The preceding section describes and identifies many aspects of V-R day surgery. It displays the incidence and pathology of various diseases and illuminates the evolution of day surgery. Finally, it establishes the value in listening to the

participant's voice, the importance of self-interpreted meaning, as well as an understanding of an illness and its treatment. A problem statement derived from these points was necessary for further development of an answerable research question (Stillwell et al. 2010).

## CHAPTER 3

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# THE PROFESSIONAL LITERATURE AND EXPERIENTIAL KNOWLEDGE OF V-R DAY SURGERY

### Step 2

Tracking down the best available evidence – establishing what was currently known, and where the knowledge gap existed (literature review) *Chapter 3.*

### 3.1 Introduction

In this stage of the EBNP project it is important to examine and critique all sources of knowledge that inform both research and practice (Earle-Foley 2011; Newhouse 2007). Such inclusion would help avoid the hegemonic influence of one form of knowledge over another that has often been described in nursing literature and is a criticism of EBNP (Clarke 1999; Doane & Varcoe 2008; Earle-Foley 2011; Holmes et al. 2006; Mitchell 1999; Newhouse 2007).

Since Carper's (1978) seminal work in identifying the patterns of knowing in nursing, there has been widespread discussion regarding what constitutes knowledge and the importance of using multiple knowledge sources to inform nursing care (Mantzoukas 2008; Porter 2010; Rycroft-Malone et al. 2003; Scott & McSherry 2009). Carper's (1978) original concept of nursing knowledge sources includes empirical, aesthetic, personal and ethical knowledge and, despite being ground breaking work at the time, it has since been criticised on a number of fronts as a basis for EBNP. An example of these criticisms is an epistemological ambiguity in how

nurses come to perceive the four sources of knowledge (Doane & Varcoe 2008). The implied exclusivity of each knowledge source compels nurses to treat the patterns of knowing as discrete and exhaustive (Bonis 2009).

Jesson et al. (2011) extended the discussion of what constitutes knowledge in nursing with a description of knowledge as either explicit-formal (i.e. found in professional literature) or tacit-informal (gained through practical experience, intuition and observations) (Jesson, Matheson & Lacey 2011). Rycroft-Malone (2003) offers a similar delineation, as knowledge that is propositional (derived from formal research) or non-propositional (developed through practice). Holmes et al. (2006) offers the emotionally charged concept of power imbalance, represented as *fascism*, which is manifested due to exclusionary dependence on empirical evidence (Holmes et al. 2006). In a more rational manner, Porter et al. (2011) argues that using wide-spread knowledge sources not only negate the hegemonic influence of empirical knowledge but help uphold the moral enterprise of nursing from a humanistic perspective (Porter, O'Halloran & Morrow 2011).

Thus, for the purpose of this EBNP activity, the examined evidence sources include empirical research evidence (quantitative evidence), as well as patient views and perceptions (qualitative evidence). The sources are also inclusive of professional knowledge (as protocols and unit specific information) plus theoretical knowledge that has the potential to support analysis and interpretation of the findings. Whilst this examination does not exhaust all forms of knowledge, it helps establish a broad understanding of the phenomena from various aspects. Such an understanding is congruent with the moral enterprise of nursing described by Porter et al. (2011) as

mindful of the individual, the meaning and value attributed to existence by patients, the social context of illness and the autonomy of humans within the healthcare setting.

Many researchers consider a literature review to provide a methodical and transparent process for finding the best available and relevant evidence of a phenomena (Jesson, Matheson & Lacey 2011; Ridley 2010; Taylor, Kermode & Roberts 2006). According to both Ridley (2010) and Jesson et al. (2011), a review displayed in context relates research evidence and theory. Furthermore, Ridley (2010) believes that a literature review clarifies the connections between established evidence and the position of new research amongst those sources. Such clarity is considered essential to engagement with relevant evidence that supports new research and clinical practice (Polit & Beck 2006).

Other authors consider the literature review as a succinct view of background knowledge (Mitchell 2004) or as the establishment of insight into previous work (Cannon et al. 1992). Each of these views has plenty to offer a novice researcher situated within a clinical context. A fusion of these aspects positions the researcher to achieve the best possible and broad-based understanding of phenomena under investigation. In relation to these viewpoints, the following rationales are proposed as a basis for executing the literature review of this study:

- Firstly, a need to locate the study within the available research evidence, thus providing both historical and contemporary contexts within the available body of evidence (Jesson, Matheson & Lacey 2011);

- Secondly, to identify existing gaps in research knowledge and, thereby, substantiate the need to conduct this study (Taylor, Kermode & Roberts 2006);
- Thirdly, to introduce and explore theoretical concepts that will assist in “making sense” of this study’s findings (Ridley 2010, pp.17-24);
- Fourthly, to display the significance of this research through illuminating practice issues that has occurred across other settings (Ridley 2010).

The above rationales are presented as sound arguments for the literature review where current and relevant research evidence is available (Newhouse 2007; Pearson et al. 2005). However, where research evidence is limited, a broadening of the review needed to take place, in order for associated aspects of the phenomena to be elucidated and incorporated into the understanding of the phenomena.

This study commenced with the aim to understand the experience of V-R day surgery amid very limited published knowledge of the phenomena. This knowledge deficiency prompted lateral shifts in the literature search to include aspects associated with the specific and original purpose. These shifts commenced through seeking information about day surgery experiences across other specialties, which compelled the author to explore understanding of pain management and self-care. Added connection with the original purpose was the need to understand what is known about V-R surgery inpatient populations and related aspects of vision impairment and ocular anaesthesia. Finally, it is important to explore the literature

surrounding patient satisfaction and to question the validity of this measurement as support for treatment changes in the clinical environment where V-R surgery is conducted.

Consequently, a fifth feature of the review process was included, that of:

- A broad-based review of literature associated with the phenomena, which would add to and further support the need to conduct this research.

This circuitous journey of the literature review befits the bricoleur nature of qualitative research methodology (Denzin & Lincoln 2000) that is embedded within an EBNP framework. It is an appropriate strategy for the conduct of this literature review due to its congruency with the conditions of understanding as presented by Gadamer, who stated that ‘we must understand the whole in terms of the detail and the detail in terms of the whole’ (Gadamer 1975, p.291).

The present review solicits evidence from both explicit and tacit knowledge, and averts the hegemonic influence of one evidence source over another. An analytical and structured synthesis of available evidence is presented within the following framework, adapted from Ridley and Jesson et al. (Jesson, Matheson & Lacey 2011; Ridley 2010). The framework, displayed in Figure 3.1 and listed below, includes:

- The aim of the review and the questions posed,
- the design of the review,



- the search methods (including sampling and inclusion/exclusion criteria),
- the search outcomes,
- quality appraisal,
- thematic presentation of the results, and
- implication of the findings.

The following sections display the processes and results of the literature review conducted in this study.

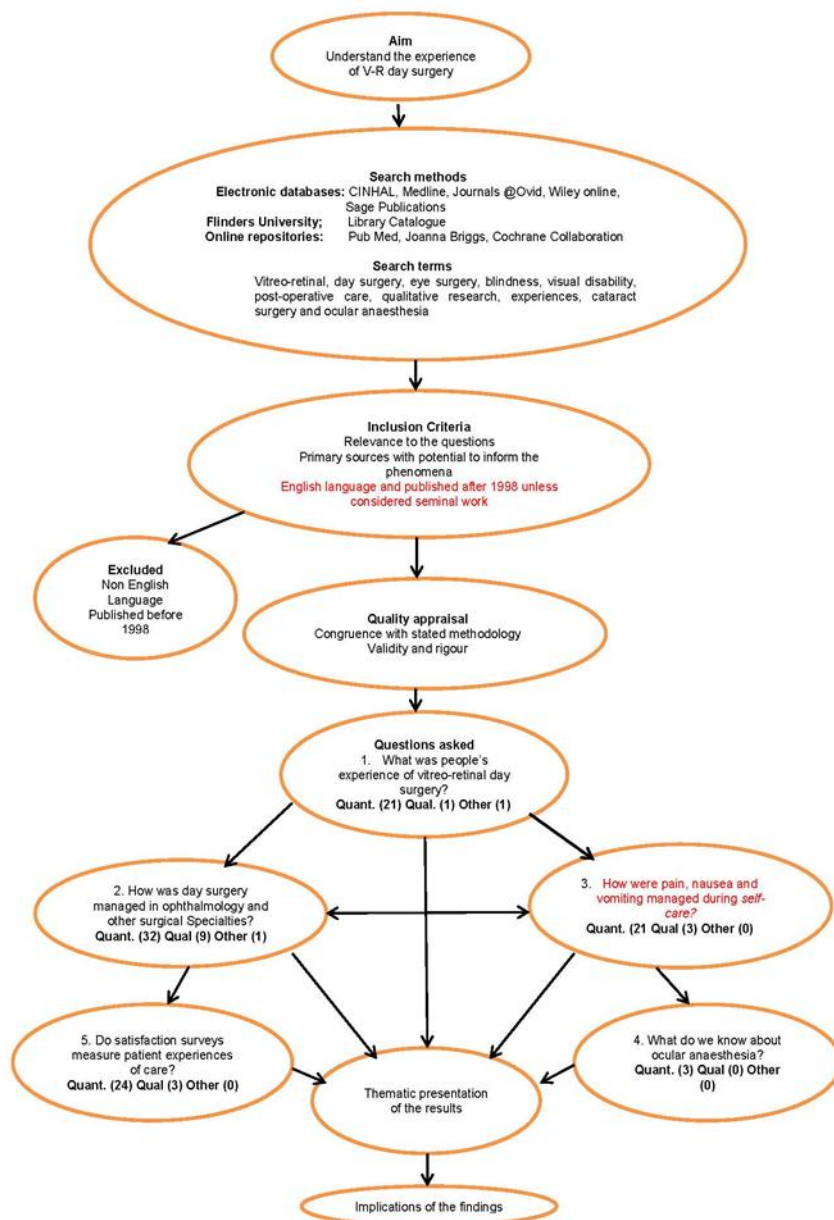


Figure 3.1 Flowchart of the literature review process

### 3.2 The aim of the review and the questions asked

The conduct of this study was prompted by anecdotal evidence of people not coping well after the experience of V-R day surgery. Thus, questions exploring multiple facets of this experience were asked of the literature. They include:

1. What was people's experience of vitreo-retinal day surgery?
2. How was *day* surgery managed in ophthalmology and other specialties?
3. How was pain managed during *self-care*?
4. What do we know about *ocular* anaesthesia?
5. Do satisfaction surveys accurately measure patient experiences of care?

These questions define the clinical, historical and contemporary context of the problem. Likewise, they serve to identify any gaps in published knowledge concerning the phenomena. Furthermore, establishing knowledge will clarify the data, as well as facilitate the emergence of a broad-based understanding of the phenomena and its relevance to clinical practice. The following section discusses the design of the review, having determined the aims and questions.

### **3.3 The review design**

This review is designed to support research and practice enhancement through exploration of research and thematic findings. As described in an earlier section and displayed in Figure 3.1, the review's structured processes align closely with a systematic review framework as defined by Jesson et al. (2006). Jesson et al's (2006) framework has an obvious structure, and a flexibility of outcomes that accommodates the search for knowledge associated with the research question and is an appropriate model for the conduct of the review reported in this study. Uses of the processes described above enhance the transparency and rigour of the literature review, as the flow of the review conduct will be clearly evident. The literature review will incorporate a critical evaluation of both primary and secondary literature

that is relevant to the questions described in the preceding section, with the intent to inform this study and to discover gaps in current knowledge. Having clarified the design of the review, the search strategy employed to locate the knowledge and evidence will now be described.

### **3.4 The search methods**

#### **3.4.1 Sampling**

A number of sites were accessed during the search for evidence to support this research and practice. These sites included:

- Electronic databases: CINHALL, Medline, Journals@ Ovid, Wiley Online, Sage Publications and Blackwell Synergy,
- Flinders University Library catalogue,
- Online repositories: PubMed, Joanna Briggs Institute, Cochrane Collaboration.

The search terms included **vitreo-retinal, day surgery, eye surgery, blindness, visual disability, post-operative care, post-operative pain and nausea, pain management, self-care, qualitative research, experiences cataract surgery and ocular anaesthesia, patient satisfaction.**

Less formal evidence was obtained from practitioners within the clinical context, who were questioned regarding the V-R day surgery patients in their care. The practitioners' thoughts and experiences were noted as field notes to this study, which occasionally influenced the direction of the literature review. The researcher, who

was located within the clinical context, was able to speak directly to patients who had experienced V-R day surgery. The patients' anecdotal thoughts and experiences also influenced the direction of the literature review.

### **3.4.2 Inclusion/exclusion criteria**

Inclusion criteria used to select research evidence comprises papers with the potential to inform the questions asked in the review (as detailed in a previous section of this chapter). However, these questions are not exclusive and, if a new line of inquiry became evident, it is within the scope of this research to follow that inquiry through further literature search. Emphasis is placed on primary research papers located in peer-reviewed journals and written in English. Papers from other geographical regions are also included, as this provides a global context. Papers written before 1998 were included only if no current research on the topic existed or if they were seminal works from established theorists. Evidence from books, such as those dealing with the human anatomy or complex descriptions of surgical procedures, is included if background information is necessary. Generally, papers are excluded if written in a language other than English. Whilst these papers may add a cross-cultural view, their use is restricted by the researcher's linguistic limitations.

Table 3.1 **Summary of literature review – articles found**

<b>Search terms in relation to questions</b>	<b>Raw result</b>	<b>In combination with secondary search term</b>	<b>Final number examined</b>
Question 1 Experience of vitreo-retinal day surgery	1	Vitreo-retinal -88 Qualitative – 1	23
Question 2 Day surgery	1097	Ophthalmology – qualitative -	48
Question 3 Pain management	1444	Day surgery -12 self care - 27	21
Question 4 Ocular anaesthesia	11	peribulbar - 4 subtenon - 3	3
Question 5 Patient satisfaction	268	Eye surgery - 40 Qualitative -15	30

### 3.5 The search outcome

Table 3.1 summarises the literature review findings, displays search terms used and their relevance to the questions. A vast number of studies are identified in relation to Questions 2, 3 and 5. Studies are eliminated if they are not relevant to the topic, not conducted on humans and are not original research. Furthermore, studies are eliminated if they repeat the knowledge generated. Finally, a significant number of studies indicative of the retained issues still exist, i.e. studies of surgical techniques or medication manipulation. Table 3.2 displays a summary of the filtered search after the initial search was examined for conduct, rigour, relevance, currency and language. Appendix 1 contains an itemised layout of all studies that had been further analysed. Following is an in-depth description of the review in relation to each of the questions.

**Table 3.2 Summary of reviewed studies in relation to questions**

The questions asked	Qualitative studies reviewed (n)	Quantitative studies reviewed (n)	Other discussion papers, book sections, literature reviews (n)	Summary of the findings	Limitations of the findings
Question 1 Experience of V-R day surgery	21	1	1	Day surgery was feasible for V-R surgery In-patient V-R surgery was known to be problematic Significant advances in surgical techniques were well described	No patient centred studies on the experience of V-R day surgery
Question 2 Day surgery across specialties	32	6	10	Day surgery across many specialties was problematic. Inadequate preparation for self care led to difficulties. Time for preparation was limited Patients requiring urgent surgery absorbed less information to support self care	Findings were specific to surgical specialties
Question 3 Pain management during self care	12	3	6	Experiences of pain, nausea and vomiting identified. Patients provided with inadequate preparation to self manage pain Medications provided were often inadequate	Findings were specific to surgical specialties or procedures. The needs of patients following V-R surgery were not well described
Question 4 Ocular anaesthesia	3	0	0	A recent move to ocular LA was found to be well tolerated by patients	Quantitative data used to support conclusions that patients tolerated ocular LA well. Some question as to the validity of these findings
Question 5 Satisfaction surveys	24	3	3	Satisfaction surveys were frequently used to assess care provided. Discrepancies existed between patient and health care staff perceptions of what qualitative care encompassed	The instruments and measures of satisfaction were widely disparate. Quantitative measures of satisfaction were questionable as a source of measuring care.

### **3.5.1 Question 1: What was the experience of vitreo-retinal day surgery?**

Numerous studies were found within literature concerning V-R surgery. However, no qualitative studies were found of the overall experience from the patient's perspective. The studies found include:

- Explorations of vision and pain experiences during surgery (Bhatt et al. 2010; Tan et al. 2005);
- The feasibility of V-R surgery as day-case (Desai et al. 2008); and
- The comparison of ocular anaesthetic types (Clarke, Robertson & Plummer 2006; Guise 2003).

Only one qualitative study was found that relates to V-R surgery. A study by Waterman et al. (2005) described the arduous post-operative task demanded of specific patients following V-R surgery. Waterman et al. (2005) found that patients, who were required to position themselves face down for an extended period of time in order to assist with retinal reattachment and healing process, experienced some difficulties, particularly of a communication and psychological nature (Waterman et al. 2005). It is interesting to note that Waterman et al. (2005) found that patients requiring urgent surgery experienced more difficulties during the post-operative period. Whilst Waterman et al. (2005) presented valuable insight into patients' experiences, information was not explored regarding other aspects, such as pain management and anaesthetic experience.



Information is readily available concerning various surgical techniques, surgical outcomes and clinical applications of technology (Akçay et al. 2011; Benz et al. 2004; Sandali et al. 2011; Schwartz & Flynn 2006; Wickham et al. 2010; Wimpissinger et al. 2008). Whilst these studies provide evidence of the surgery's evolving nature and technology intrinsic to this specialty, experiential knowledge from the patient's perspective is absent.

In recent years, advances have evolved in surgical techniques, consistent with other specialties, such as a calculated move to minimal invasiveness. This is demonstrated in a number of papers including those by Sandali et al. (2011), Schwartz and Flynn (2006), and Wickham et al. (2008). These papers describe the advantages of trans-conjunctival sclerotomy with 23 and 25 gauge instrumentation thus, avoiding the need for extensive resection of the conjunctiva. A perceived advantage of this technique is that it would cause less post-operative pain, as described by Wimpissinger et al. (2008). However, Wickham et al. (2010) conclude that there is minimal pain difference between the techniques. These studies illustrate the evolving technology and techniques; however they offer little insight into benefits to patients experiencing such V-R procedures.

The move of complex surgical interventions to day surgery was consistent with other surgical specialties. Desai et al. (2008) describe the feasibility of such a move by reporting that V-R day surgery was achievable and safe. However, when making these conclusions, Desai et al. (2008) fail to elicit the thoughts and feelings of the patients. Of particular note is the absence of consultation with patients' families and communities, who are expected to carry the burden of post-operative convalescent

care. Numerous studies are criticised for an almost exclusive focus on the surgery's physical aspects, with little insight provided of the experience from the patient's perspective.

A clear example of such focus is seen in a study by Desai et al. (2008), which identifies the limited need for medical interventions during the immediate post-operative phase and uses this criterion as a rationale for safe relocation of V-R surgery to a day surgery modality. Whilst Desai et al. (2008) exclude patients from the day surgery group who had extensive co-morbidities; they fail to consider the psychosocial aspects of the experience and the impact of transference of post-operative care to families and communities. Furthermore, patients requiring urgent surgery endure added difficulties as described by Shelswell (2002). Desai et al. (2008) do not appear to incorporate knowledge from this point of view when considering the move of V-R surgery to day-case.

Day surgery for V-R pathology is predominantly performed using regional anaesthesia (Clarke, Robertson & Plummer 2006). However, a study of 65 patients by Tan et al. (2005) found this anaesthetic technique combined with conscious surgery to be a frightening experience. These findings are contradicted by Bhatt et al.'s (2010) study of visual experiences during V-R surgery, which concludes that visual experiences do not frighten patients who receive pre-operative counselling. However, the Bhatt et al. (2010) study does not describe the use or non-use of sedation (a common practice during the instillation of local ocular anaesthesia), with such ambiguity possibly contributing to the contradictory results.

An earlier study by Fekrat et al. (2001) analyses inpatients' experiences following V-R surgery and concludes that 56% of patients suffer significant pain on the night of the surgery. Furthermore, Fekrat et al. (2001) highlight the correlation between the need for rescue narcotic medications and the incidence of post-operative nausea and vomiting (PONV). Whilst more recent studies examine pain in relation to V-R surgery (Wickham et al. 2010; Wimpissinger et al. 2008), the evidence depends on values of satisfaction assessment as determined by the researcher, which had been demonstrated to be an unreliable source for patient-centred information (Shannon & Mitchell 2002).

With limited literature available on the research phenomena, the subsequent questions explore issues surrounding V-R day surgery, which include post-operative pain and nausea, ocular anaesthesia and satisfaction surveys as measures of care. These extensive aspects of the phenomena provide contextual evidence of the problems and issues surrounding the V-R day surgery experience.

### **3.5.2 Question 2: How was day surgery managed in ophthalmology and other specialties?**

Day surgery developed in response to the economic rationing of healthcare services that occurred during the 1980s (Aylin 2005). Polder et al. (2002) studied the age-specific increases of health costs and found that, as a result of the growing survival of the frail elderly, an ageing population increases the demands and costs of healthcare. Escalating costs of high technology healthcare interventions have severely stretched community and state resources, forcing healthcare providers to seek innovative methods for service provision. Day surgery was one such innovation

and now accounts for 70–80% of all surgery, with an expected further increase in both volume and range of procedures performed (Mitchell 2010).

Patients welcome quicker access to surgical services (Mottram 2011a) and funding bodies applaud the cost savings resulting from day surgery (O'Connell, Young & Twigg 1999; Suhonen, Livonen & Välimäki 2007). However, Suhonen et al. (2007) investigated the quality of life following day surgery, finding that nursing care associated with day surgery is treatment-focussed and, as a consequence, patients suffer during convalescence.

Studies of day surgery across various specialties conclude that patients are often unprepared for post-operative self-care (Coll, Ameen & Moseley 2004; Majasaari et al. 2005; Mitchell 2010; Mottram 2011b; Pavlin et al. 2002). The consequences of inadequate preparation are clearly seen in Costa's (2001) phenomenological study of patient experiences undergoing abdominal surgery. Costa (2001) concludes that patients are inadequately prepared for surgery and, as a consequence, suffer needlessly due to inadequate pain management and are not ready to go home at the time of discharge. These findings concur with Gilmartin (2007), Henderson and Zernike (2001), Watt-Watson et al. (2004), McHugh and Thoms (2002), and Coll et al. (2004), who report that information provision is frequently insufficient or unclear. Psychological issues of fear and stress are associated with slower, more complicated post-operative recovery and are seldom addressed (Kiecott-Glaser 1998; Mitchell 2002; Vowles, McNeil et al. 2006).

Inadequate or inappropriate information provision is found to be problematic. Clarity of information and knowledge of events is considered important to patient's well-being. Ray (2004,p.35) describes the most stressful situation as one where 'ambiguity came from awareness that one has inadequate or incomplete knowledge'.

In relation to information provision, Majasaari et al. (2005) found that pre-operative information facilitates the transition from hospital to home care by encouraging family members' readiness. This information is thought to contribute to the patient's physical and social adaptation at home (Majasaari et al. 2005). Moreover, the need for pre-operative education increased significantly as the complexity of day surgery expanded (Coll & Ameen 2006; Gilmartin & Wright 2007; Mitchell 2010).

Pre-operative education and information sharing has been described as an interactive process that goes beyond 'the provision of information and explanations about surgical processes' to involve 'the influencing of emotions and attitudes with the intent of altering behaviour' (Ray 2004, p.37). Pre-operative education aims to reduce anxiety, explain the surgical processes, and prepare patients and families for self-care. It is, therefore, essential that patients with predictably higher levels of anxiety, such as those who have suffered sudden vision loss, have an uncertain visual outcome or have experienced recurrent conditions, receive accurate and appropriate pre-operative advice and information. Cooper (1999) predicts that nurses providing care in day surgery units may need to promote patient learning. The benefits of encouraging learning activities include a reduction in anxiety, promotion of recovery, successful self-medication and increased patient satisfaction, which enables patients to assume more responsibility for their care (Cooper 1999). The literature makes it

clear that pre-operative preparation had not been adequately addressed, despite numerous studies that examine and promote pre-operative education (McHugh & Thoms 2002; Mitchell 2010; Mottram 2011b; Pager 2004). This is particularly true for patients with complex needs or those who require significant post-operative convalescence.

One of the challenges of day surgery lies in reducing pre-operative patient and staff interaction time. Bernier et al. (2003) indicates that not only is the timeframe reduced for pre-operative education, it is also essential to know what information would be most useful to patients and family members, who are responsible for post-operative care. The literature does not identify nor explain the need, quantity and type of educational material for this group of patients. A limited self-care preparation timeframe results in inadequate, inappropriate or misunderstood pain management strategies (Older, Carr & Layzell 2009). The following question further analyses this aspect.

### **3.5.3 Question 3: How were pain, nausea and vomiting managed during self-care?**

Evidence from diverse studies across a broad range of surgical specialties describes problematic pain management and PONV during the self-care period. Numerous studies on patient experiences of day surgery describe high levels of reported pain, ineffective pain management strategies and side effects from rescue medications (Coll, Ameen & Moseley 2004; Kamming et al. 2004; Older, Carr & Layzell 2009; Rosen et al. 2010).

Older et al. (2009) found that patients experience considerable pain during the first 24 hours post-surgery. These findings concur with previous studies that communicate problematic pain management during self-care (Pavlin et al. 2002; Rawal et al. 2001; Watt-Watson et al. 2004). One of the compounding issues described by a number of authors is the lack of information provided regarding pain management, thus making analgesic use either inappropriate or minimal (Older, Carr & Layzell 2009). In 2007, Gilmartin and Wright reviewed the literature concerned with pain management following day surgery and concluded that the evidence was inconsistent and credible research was lacking (Gilmartin & Wright 2007).

Day surgery across many specialties continues to expand. It now includes complex surgery on patients with multiple co-morbidities and greater post-operative needs, who were previously cared for as inpatients. The care provided must not rely on relatively simple care requirements of early day surgery patients, but must be cognizant of the burden placed by increased surgical complexity on patients' families and communities during convalescent self-care.

The Ophthalmology specialty literature is dominated by patient experiences following day surgery for cataract. Cataract is one of the most commonly performed surgical procedures worldwide (Erie et al. 2007) and has been studied extensively. However, Law's (1997) study of day eye patients found that, following eye surgery, only 5 of 38 patients experience pain requiring non-narcotic analgesic medication. This low incidence of pain in the ophthalmic patient group can be attributed to the type of surgical interventions in the study population. The majority of patients in Law's study were post-cataract extraction patients (84%), a procedure that is

routinely performed with regional anaesthesia, which provides an extended period of pain receptor blocking action and minimises the likelihood of PONV (White 2002). Cataract surgery has a low reported incidence of post-operative pain, which Simone (2001) attributes to the surgery's technical advances, such as small incision, phacoemulsification and foldable lenses, reducing the trauma to intra ocular tissues. However, surgery for retinal detachment is associated with a high incidence of PONV and peri-operative pain (Bhatt et al. 2010; Clarke & Robertson 2004; Fekrat et al. 2001). In the past, these conditions required extended inpatient stays where healthcare professionals were responsible for managing post-operative pain (Fekrat et al. 2001).

Fekrat et al.'s (2001) quantitative study of eye pain following V-R surgery found that 56% of patients experienced post-operative pain and 27% required narcotic analgesia. Sixteen per cent of patients experiencing PONV were thought to be suffering from side effects of the narcotic analgesia. Mozaffarieh et al. (2004) studied vitreo-retinal surgery and found decreased patient satisfaction levels with compounding ocular conditions that were linked to inadequate pre-operative education. Furthermore, Mozaffarieh et al.'s (2004) findings support the belief that patients with complex ocular pathologies require high levels of psychological pre-operative care and education regarding pain management. Pager (2003) found that preparatory information is associated with decreased anxiety prior to surgery and increased psychological adjustment following the procedures.

A prospective observational study by Pavlin et al. (2002) considers the pharmacological and physiological variables of pain responses and treatments for



post day surgical patients. The study identifies predictive factors, finding that non-steroidal medications and local anaesthetic techniques reduce post-operative pain. However, the study fails to acknowledge the value of pre-operative education and psychosocial support provided by both staff and family members in reducing and managing post-operative pain. It is apparent that post-operative patients needed an analgesic regime that was adequate with minimal side effects, intrinsically safe and easily self-managed away from the hospital (White 2002; White et al. 2011; Yellen & Davis 2001). Most ophthalmic surgery is now performed as day surgery, including complex V-R surgery. Therefore, a lack of studies about the experience of pain and PONV in the self-care convalescent period following V-R day surgery requires urgent attention.

#### **3.5.4 Question 4: What do we know about ocular anaesthesia?**

Anaesthetic techniques for ocular surgery include regional anaesthesia, sedation and, less commonly, general anaesthesia. The literature contains a plethora of quantitative information regarding anaesthetic techniques, the efficacy of one drug over another and administration routes (Clarke, Robertson & Plummer 2006; Farmery et al. 2003; Ghali 2010; Newsom, Wainright & Canning 2001; Ripart et al. 2006). However, almost all studies on ocular anaesthesia utilise a quantitative research methodology and offer little information regarding the experience of regional ocular anaesthesia.

In 2001, Newsom et al. quantitatively studied patients' experience of ocular local anaesthesia (LA) in 1,479 patients (Newsom, Wainright & Canning 2001), concluding that LA is well tolerated by patients for V-R surgery. However, in Newsom et al.'s (2001) results, 901 patients (73%) recorded no comment, 14%

described mild pain and 1.3% recounted severe pain. These results fail to support the conclusion that LA is well tolerated for V-R surgery. Furthermore, the measurement of the experience was reduced to a linear 4 point Likert scale that provided little opportunity for patients to describe the experience. Whilst satisfaction was concluded as high (Newsom, Wainright & Canning 2001), the study does not detail how satisfaction was measured. Since regional anaesthesia for awake V-R surgery involves a relatively new technique, a qualitative exploration of this experience is needed to understand the experience, including satisfaction, from the patient's perspective. This lack of clarity regarding patient satisfaction and what is measured as satisfaction resulted in the fifth question of this literature review.

### **3.5.5 Question 5: Do satisfaction surveys accurately measure patient experiences of care?**

There is much discussion regarding the use of patient satisfaction as a measurement of care provision quality. Many studies argue that patient satisfaction provides a concept that can be used to evaluate the quality of the healthcare experience; however, there is a wide disparity in the definition of what constitutes patient satisfaction and which method provides reliable information. Avis et al. (1995) argue that measurement of satisfaction rests on two unproven assumptions. Firstly, that satisfaction is the fulfilment of prior expectations and, secondly, that the level of satisfaction can be gauged by asking patients to assess whether pre-determined aspects of care (thought to represent their expectations) had been met (Avis, Bond & Arthur 1995). The questions that emerged from these points include "*Whose expectations were being met and who determined which aspects of care were considered important?*" The evidence from the literature was ambiguous at best.

It appears that most satisfaction surveys do little to determine patients' expectations and it is unclear whether the results demonstrate variations between patient expectations and care provided (McHugh & Thoms 2002). The complexity of patient satisfaction is thought to include physical, emotional, mental, social and cultural factors. Patient satisfaction is reported to have significant influences on behaviour, including the 'consumption of health care resources, compliance with treatments, or steadiness of relationship with practitioners' (Auquier et al. 2005, p.1118). Furthermore, Auquier et al. (2005) stress that the measurement of satisfaction should be a multidimensional concept and should reflect the exclusive concerns of the patients.

Often, satisfaction studies display the problem of what was being measured was not perceived by the patient as the most important. The literature demonstrates a frequently occurring distinct variance between the perceptions of what is important to healthcare providers and what is important to patients (Auquier et al. 2005; Pager 2004; Shannon & Mitchell 2002). Patient satisfaction surveys rest on the underlying reductionism of quantitative methods and, in many studies, the patient's voice is either inaudible or subdued by the aims and methods of a particular research methodology.

Avis (1995) and Yellen and Davis (2001) suggest that patient satisfaction surveys fulfil a number of functions closely linked with the researcher's motives. These authors claim the crucial reasons for the proliferation of satisfaction surveys to include the link between consumerism in healthcare and public policy, the increasing importance of satisfaction as an indicator of healthcare, and its use as an outcome

measure for service evaluation. Multiple studies have used quantitative survey tools with the aim of measuring patient satisfaction to demonstrate quality of care (Fraczyk & Godfrey 2010; Tysome & Padgham 2006). However, Wilcock et al. (2003) studied satisfaction surveys in the UK and found that:

- Quantitative questionnaires may miss issues that are important to patients;
- Survey results are often not used to improve care;
- Results usually relate to limited aspects of care; and
- Patients rarely know what standards they should be expecting.

It is significant to note that many patient satisfaction surveys consistently rated high or very high (Fung et al. 2005; Ghosh & Sallam 1994; Jenkinson et al. 2002; Lesnoni, Rossi & Nistri 2005; Newsom, Wainright & Canning 2001; Yellen & Davis 2001), raising the question of various survey tools' sensitivity in measuring patient satisfaction and quality of care. A lack of sensitivity can be seen in a study by Jenkinson et al. (2002), which uses both a satisfaction tool and a questionnaire relating to specific aspects of care. The study describes a 90% rate of satisfaction with care but finds that 55% of respondents indicated issues with aspects of care. Jenkinson et al. (2002) conclude that patient satisfaction scores present a limited and optimistic picture, and that detailed questions about specific aspects of patients' experiences are more useful for monitoring performance. The study's findings concur with McHugh and Thoms (2002), who found that patient satisfaction was rated highly despite significant instances of post-operative pain (McHugh & Thoms 2002).

Coyle and Williams (2000) suggest that a more sensitive understanding of patient expectations may be achieved through the qualitative exploration of patient dissatisfaction rather than satisfaction, as dissatisfaction ‘highlights more clearly any problems in the lay-practitioner relationship’ (Coyle & Williams 2000,p. 452 ). Qualitative research methods provide researchers with unique insights that facilitate the identification of themes and issues grounded in the subjective, contextualised, humane and value-laden experiences of individual patients.

The explorations of patient experiences through qualitative methods, which include illness narratives, provide patients with the opportunity to express the truth of an experience in their own voices. This process often highlights ideological differences between dominant healthcare cultures and individual patient contexts. Wiklund et al. (2002) describes the research interview as a narrative about a particular phenomenon of interest, which is not an objective reconstruction of life but of how it was perceived. Sakalys (2000, p.1472) states, that illness narrative provide ‘the truth of personal experience in the patient’s own voice in distinction from the medical account of the experience’. Thus, the patients’ thoughts, feeling and experiences need to be qualitatively explored in order to comprehend patient experiences and satisfaction with care.

### **3.6 Policy context of V-R day surgery care**

Discussion of the relevant policy framework that governs health care in Australia adds a contextualisation of the clinical context. Therefore, the policies that guide

Australian health care in general, Australian standards for Day surgery and nursing practice in particular will be discussed in the following section.

Australian Health care is framed within the National Safety and Quality Health Service Standards that have been collaboratively developed by relevant stakeholders including, medical clinicians, nurses, patients and government representatives (Australian et al. 2011). The ten standards include:

- Standard 1- Governance for Safety and Quality in Health Service Organisations 14
- Standard 2 – Partnering with Consumers 22
- Standard 3 – Preventing and Controlling Healthcare Associated Infections 26
- Standard 4 – Medication Safety 34
- Standard 5 – Patient Identification and Procedure Matching 40
- Standard 6 – Clinical Handover 44
- Standard 7 – Blood and Blood Products 48
- Standard 8 – Preventing and Managing Pressure Injuries 54
- Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care 60
- Standard 10 – Preventing Falls and Harm from Falls

The aim of these standards is to provide a set of consistent and uniform measures of safety and quality that can guide health care provision across wide service delivery settings (Australian et al. 2011). These standards propose evidence –based strategies for the improvement of care where variance between best practices have been identified (Australian et al. 2011). This framework of support and guidance is similar to systems developed in both the United States of America where the Agency for Health care Research and Quality (AHRQ) guides public practice and the National Institute for Health and Clinical Excellence (NICE) guide and inform health care in the United Kingdom. A feature of such systems is regular auditing of facilities

against the standards to achieve accreditation. In the Australian context, organisation wide surveys were conducted by the Australian Council of Health Care Standards (ACHS) occurred at intervals of four years.

The clinical health care facility in which this study was located had achieved high levels of compliance with almost all aspects of the audit framework over the previous 12 years (FMC Annual reports, 2004, 08, 12). Moreover, a regular, specialty specific auditing of key performance indicators (KPI) occurred on a six monthly basis. In these audits the ophthalmic department regularly scored advanced levels of compliance with standards. However, the KPI's were a contentious issue as the areas of care measured reflected biomedical and economic factors of health care and excluded patient specific aspects. An example of this exclusion is evident in the measurement of patients who experienced a retinal detachment, where the KPI's were limited to unexpected return to operating theatres, bed day stays longer than disease specific expectations, infection rates and surgical complication rates. The ongoing issues of inadequate pain management during self-care (Rawal et al.2001; McHugh & Thoms, 2002; Coll et al.2004a; Watt-Watson et al. 2004) following day surgery question the capacity of these measures to accurately reflect the quality of Nursing care provided.

Nursing care in Australia is governed by the Australian Nursing and Midwifery Council (ANMC) who have produced a policy document, the Australian National Competency Standards for the Registered Nurse (ANMAC 2005). These standards encompass a wide range of professional practice domains including: Professional Practice, Critical Thinking and Analysis, Provision and Coordination of Care and Collaborative and Therapeutic practice. These Standards provide an excellent

benchmark against which individual nurse performance can be measured. Furthermore, interpretation of clinical standards and policies such as the Australian Council of Operating Room Nurses: Standards of Practice ACORN 2008) is conducted from within the framework of the ANMAC competencies. However interpretation is a unit specific activity and there is minimal external auditing in regard to interpretation with ANMAC competencies at a clinical level. Thus, governance of clinical services is fragmented between the ACHS accreditation processes and ANMAC competencies that require self- declaration of individual nurse competence. As a result of such fragmentation there appears to be a deficit in the measurement of nursing care at a clinical unit level, evident in the content of KPI's examined and the findings of many research papers that examine patients experiences of care.

### **3.7 Implication of the findings**

The present literature review establishes that patients' experiences of V-R surgery are relatively unknown. The present thesis' background information (Chapter 2) infers that loss of vision is greatly feared and that people experiencing a sight-threatening condition report significant anxiety and psychological stress. Many sight-threatening conditions require urgent surgery, which is now commonly performed as day surgery. Day surgery reportedly provides significant benefit to the community through increased access to surgical services. However, the timeframe for individual pre-operative preparation and education regarding self-care is significantly reduced.



The performance of V-R surgery in a day surgery setting is a popular cost containment strategy. However, this modality significantly increases the patient and family responsibility for self-care. Conversely, there is decreased time and opportunity for interaction between patient and healthcare provider prior to surgery, in preparation for self-care. Various studies highlight the benefits of pre-operative psychological and physical preparation. However, there have been no extensive studies on the needs and experiences of V-R day surgery patients.

Changes in anaesthetic strategies have been described as successful and well tolerated by patients, such as the move to predominately utilising LA for conducting V-R surgery. However, these conclusions are based on data dominated by predetermined quantitative surveys, which allow for minimal insight into patients' experiences. The reliance on such surveys results in uncertainty of the accuracy of such conclusions.

There has been serious questioning regarding the use of patient satisfaction surveys as a measure of quality of care, as the results are often ambiguous or lacking in sensitivity. Furthermore, such surveys are rarely used to upgrade services. The literature is missing the patients' voice and the knowledge that could be generated from careful listening to and interpretation of contextualised, subjective experiences.

This chapter has answered the five questions that were developed to search the literature. The literature review and the answers to the questions do not solve with any depth or clarity this study's research problem: *What was the lived experience of people who undergo vitreo-retinal day surgery for potentially sight threatening*

*ocular pathology?* Thus, it is essential that new research be conducted to fully explore and understand patients' experiences of V-R day surgery.

Step 3 of this study will be conducted as a qualitative inquiry and, as such, it will extend the knowledge and understanding of patients who underwent V-R day surgery. It will also address the knowledge deficit evident in current literature by using qualitative methodology to value and amplify the unique and multiple truths located within the voice of patient experiences.

## CHAPTER 4

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# AN UNDERSTANDING OF THE RESEARCH–PHILOSOPHY RELATIONSHIP: CHOOSING PHILOSOPHICAL HERMENEUTICS TO GUIDE THIS STUDY

### Step 3

Where knowledge gap exists, conducting research and critically appraising the methodology, methods and findings for rigour (qualitative research of this study) *Chapters 4,5,6,7,8.*

## 4.1 Introduction

Step 3 of this EBNP activity progresses naturally from the findings of the previous steps. This advancement can be traced from an initial observation of the clinical problem, identified as a questioning of patient experiences following V-R day surgery, to the display of an obvious gap in professional literature regarding this experience. Momentum is added to the progression by an increased understanding of influence potentially exerted on patients by an underlying fear of blindness. The conduct of this study is driven further by the need to hear, respect and attend to the voice of patients as interpreters of an experience and care provided by health professionals. Step 3 adds knowledge and understanding from 18 patients who experienced V-R day surgery, via a methodology that values and amplifies the unique and multiple truths located within the voice of patient experiences. This section will display and include all aspects of evidence-generating research, such as choice of methodology, methods, ethical conduct, participant recruitment, data collection, data analysis and discussion, presentation of findings and critical analysis of the research (presented in Chapters 4, 5, 6 and 7).

In this study, understanding the patient experience of day V-R surgery is a knowledge-generating activity. As such, identification and justification of research methodology is required. The literature review demonstrates that the majority of research methodologies employed for developing knowledge concerning day surgery had been quantitatively supported. Such studies are founded on a positivist or post-positivist philosophy, where prediction and control are expected within the major research aims. In contrast, research aiming to understand experiences and how social experience is created and justified, is effectively supported by non-positivist methodologies and the interpretive paradigm in particular.

All research methodologies are located within philosophical paradigms. A research study's chosen paradigm determines every act, even if it is only loosely associated with the research. Once chosen, the philosophy demands that all decisions within the inquiry are congruent with the paradigm's world views (Guba 1990). A paradigm is defined as a set of world views related to a general perspective of reality that determines the ontological (what is the nature of reality), epistemological (how the inquirer is related to the participants) and axiological (what is the role of values in the inquiry) position of a study (Polit & Beck 2006; Polit & Hungler 1999). Paradigms determine the methods of a chosen research inquiry (Ponterotto 2005) by providing the frames and processes for accomplishing the inquiry (Weaver & Olson 2006). Guba (1990) stated that paradigms are ubiquitous entities that permeate and dictate choices, and that researchers must commit to one or another paradigm and behave in a fashion congruent with its rules.

The works of eminent philosophers since Plato have guided and shaped knowledge generation and associated research activities. As a novice researcher, the task of locating

this inquiry requires a development of sufficient knowledge of the chosen paradigm's philosophical constructs, so that research conduct can demonstrate an informed and appropriate methodological congruency. This researcher's belief in an interpretive research paradigm is emphasized by the choice to explore V-R day surgery experiences through understanding, as the aim is to comprehend the experience rather than seek causal explanations of prediction and control. This choice places the research within a phenomenological framework, where understanding the truth and meaning of an experience had been emancipated from the oppression, dualism and domination of scientific methods (Polifroni & Welch 1999).

The interpretive paradigm encompasses a number of methodologies including phenomenology, ethnography, grounded theory and discourse analysis. The logical and appropriate methodological choice appeared to be phenomenology, particularly the branch of phenomenology that developed from hermeneutic phenomenology that focuses on the meaning and interpretation of the lived world (Polit & Beck, 2012). The aim of this chapter is to justify the choice of philosophical hermeneutics that guide the qualitative knowledge-generating activities of this study.

Phenomenology developed from the works of various German philosophers, including Edmund Husserl (1859–1938), Martin Heidegger (1889–1976) and Hans-Georg Gadamer (1900–2002). Phenomenology has become known as a philosophical position that seeks the reconstruction of reality through analysing language or knowledge (hermeneutics). It emerged from the despair of the human condition brought about through modern scientific and technological advances (Polifroni & Welch 1999). Phenomenology was influenced by the works of Heidegger and Gadamer to evolve

away from Husserl's positivist epistemology and towards the scope of hermeneutics within the concept of understanding as the primordial way of being in the world (Bernstein 1983). The following section describes the evolution of phenomenology.

## **4.2 The development of phenomenology**

According to Jones (2001), phenomenology in the 20<sup>th</sup> century evolved from the Kantian philosophical perspective through the works of Franz Brentano (1838–1917), Edmund Husserl (1859–1938) and Carl Stumpf (1848–1936). Kant first used the term “phenomenology” to define technical meanings in the mid-18<sup>th</sup> century and his work highlights a central tenet of interpretive thinking: that reality was constructed by the research participants (Ponterotto 2005). Edmund Husserl's inquiry methods endeavoured to discover the meanings of a phenomenon via lived experiences rather than from universal principles (Husserl 1970). Husserlian inquiry was known as descriptive phenomenology. His methods were not concerned with reductionist explorations but rather with the description of events discernible through consciousness and understood in the context of the individual experiencing the phenomena (Kleiman 2004; Ponterotto 2005). Husserl believed that the material world was accessed through the consciousness and he extrapolated the meaning of experience to include anything that was accessible to the conscious (Husserl 1970, pp. 142-3). One of phenomenology's fundamental concepts is an understanding of the constitutive elements of “being” and “meaning” of human experiences.

Husserl developed descriptive phenomenology that endeavoured to reach an objective understanding of the nature of experiences. The development was facilitated by methods

that would infiltrate the subjective experience through using techniques known as “bracketing” or “epoche” (Donalek 2004; Husserl 1970; Munhall 2007). Bracketing is described as holding in abeyance the researcher’s pre-conceptions and theoretical impositions, which results in a description of the phenomena under investigation without influences that may short-circuit or bias the description (Polifroni & Welch 1999). Epoche is the deliberate suspension of presuppositions based on the “natural attitude” that assumed an independent existence of perceived suppositions (Hammond, Howarth & Keat 1994). Husserlian phenomenology has been described as the culmination of Cartesian tradition reflecting Husserl’s ontological understanding of people existing in a world of objects (Koch 1999).

Husserlian phenomenology has been criticised for lacking contextualisation and its objectivist positions. Kleiman (2004) states, that the major result of descriptive phenomenological inquiry is the phenomenon exposure without contextual construction or interpretation. An understanding of Husserl’s objectivist ontology results in an essentially descriptive inquiry outcome. Hence, it is then possible to reject this methodology as the underlying philosophy of a knowledge generation activity that seeks to understand a phenomenon. Whilst Husserl was considered the founder of phenomenology, the later proponents of phenomenology are widely divergent in their respective views. It was through the subsequent theories of Martin Heidegger (1889–1976) that a branch known as existential phenomenology developed.

### 4.3 Existential phenomenology

A student of Husserl's, Martin Heidegger developed a philosophical school of thought that rejected Husserl's objective view of phenomena achieved through bracketing and epoche. Heidegger believed that there were no pre-determined human essences; rather, humans were self-interpreting within the context and historicity of their existence (Heidegger 1962). The foundation of Heidegger's philosophy was the complex concept of "Dasein". McCann (1993, p. 60) describes Dasein as "existence", and then expands the concept as an existence that adopts a relationship or attitude to its own existence, also known as "being in the world". Dasein has been defined as the happening of a life from birth to death (Audi 2001, p. 371), whereby human existence in its situation stands in the "event of unconcealment" and understands accordingly. Basic constructs of Dasein in relating to the world through language include thrownness, projection, the living of a life in the concrete context of its situation, our actions' contribution to shaping our lives, and discourse (Heidegger 1962; Polifroni & Welch 1999).

Heidegger was a central figure in the development of existential phenomenology that espoused a philosophical position that brought together modern philosophy in the German tradition with the hermeneutic process of exposing the hidden meanings first used in the historic exegesis of Biblical texts. Hermeneutics is depicted as a critical interpretation that aims to reveal the meaning of a text (Munhall 2007). However, Heidegger's radical approach to hermeneutics alienated the philosophical community with its obfuscation and cryptic pronouncements (Guba 1990). It is Hans-Georg Gadamer's work that mediates the radical elements of Heidegger's hermeneutics with textual interpretations, resulting in the development of another current of phenomenological thought – that of philosophical hermeneutics.



## 4.4 Philosophical hermeneutics

Hans-Georg Gadamer was the central figure in the development of a branch of phenomenology that became known as philosophical hermeneutics. Gadamer's philosophical hermeneutics is grounded in Heidegger's interpretive philosophy and includes hermeneutic traditions. Unlike Husserlian phenomenology, philosophical hermeneutics adopts a non-objectivist and transactional approach to the study of phenomena. The study consists of an interaction between researcher and participants while developing co-created realities based on multiple and intangible mental constructions (Appleton & King 1997; Mueller-Vollmer 1986). According to Gadamer, understanding is always in respect of others and is constantly bound up in language. Gadamer's philosophical hermeneutic underpins research that negotiates the participants' self-understanding by employing the methods of hermeneutics. Gadamer argues that understanding is interpretation that demands the engagement of one's biases and is always bound up with language (Gadamer 1975b; Koch 1999; Lincoln 1990).

The philosophers Schleiermacher (1768–1834) and Dilthey (1833–1911) projected hermeneutics as exposing hidden meanings. This became a method used within humanities to produce conclusions that are intellectually respectable to the prevailing scientific world (Guba 1990; Munhall 2007). Whilst Heidegger integrated comprehensive and radical hermeneutics for exposing hidden meanings, Gadamer focused on the situation in which human understanding transpires, believing that understanding was always through language and within tradition (Fleming, Gaidys & Robb 2003; Gadamer 1975b).

Unlike Schleiermacher and Dilthey, Gadamer opposed the development of hermeneutics as a method and recognised that its fundamental task was the clarification of conditions that make understanding possible (Gadamer 1975a). Gadamer stated that all understanding is interpretation and all interpretation occurs in the medium of language (Gadamer 1975a). The real task of hermeneutics is the transformation of text into language, which establishes the relationship between what was meant and the object of the text (Gadamer 1975a).

Gadamer asserts that understanding is a co-construction between the historicity of the phenomena and the researcher's own beliefs and prejudices (Gadamer 1975a; Richardson-Tench et al. 2011). The researcher's prejudices are the product and function of their own historical existence. Instead of viewing the prejudices as negative influences, as perceived by objectivist philosophers, Gadamer believes that they are a necessary condition of understanding (Gadamer 1975a).

Gadamer sees an inseparable link between the acts of understanding and interpretation. These acts involve overcoming the strangeness of the phenomena under investigation and require a transformation into familiarity, where the historic horizon of the phenomena and the interpreter become fused (Mueller-Vollmer 1986; Tuckett 2004). Gadamer describes the historic horizon as the ability that one learns to look beyond the immediate, not to put the vision aside, 'but rather to see it better within a larger whole and in truer proportion' (Gadamer 1975a,p.299). During the fusion process, the historic is projected into the present and the moment of understanding occurs, resolving the tension between the historic horizon and the strangeness of the text.

Gadamer believes that the phenomena and the researcher are not isolated from each other but are part of a continuum that he names *wirkungsgeschichte*, which translates into “effective history” (Gadamer 1975a, p. 299). Our individual “effective history” is the cause of all our prejudices and needs to be made the object of hermeneutic reflection, where the consciousness of our own effective history becomes apparent and guides our understanding. Our effective history predetermines what phenomena interests us and what appears as an investigation object. However, without hermeneutical reflection we miss the truth of the phenomena (Fleming, Gaidys & Robb 2003). The inquirer’s task is not to discard prejudices but to divide the features of legitimate prejudices from those that obstruct understanding. By cultivating the history within us we are open to the past and new possibilities of meaning that may be evident in the text of an inquiry (Munhall 2007).

#### **4.5 The appropriateness of Gadamerian philosophy to guide this research**

The truth of a phenomenon inextricably linked to understanding is a philosophical position that offers the researcher of patient experiences an opportunity to see beyond the immediate and the dominant knowledge-generation methodology. In the operating room arena, the development of empirical and technical knowledge dominates research inquiries as evidenced by abundant investigations of a scientific or technical nature. In the modern scientific healthcare context, “truth” is the making visible of the biological reality, often at the cellular or micro-cellular level, independent of human perspective and social context. Amongst healthcare workers, this dependence on scientific knowledge has resulted in a perception that technological complexity and mastery equate to “caring” (Almerud et al. 2008; Hawthorne & Yurkovich 1995). In contrast,

“holistic” healthcare is the plea of modern healthcare consumers who are often denied recognition and caring for the ‘humanly narrated pathos, pain and perplexity of the experience of suffering’ (Kleinman, cited in Bynum & Porter 1994, p. 19)

Hans-Georg Gadamer stated:

*Understanding is capable of contributing in a special way to the broadening of our human experiences, our self knowledge, and our horizon, for everything understanding mediates is mediated along with ourselves.* (Gadamer 1975a, pp. 390-1)

This statement resonates with the aim of this study, as the understanding of patient experiences to sensitise the care of V-R day surgery patients is central to the present research inquiry. Guidance by Gadamer’s philosophy presents the researcher with an opportunity to examine and bring to consciousness their own “effective history”, and to achieve interpretation and understanding in a circuitous dialogue between the researcher and the unfamiliar of the text of patient experience. An essential part of this study’s rigour is a well-developed knowledge of the underlying philosophy’s ontological, epistemological and methodological positions (Van der Zalm & Bergum 2000). The next chapter explores in detail the essential constructs of philosophical hermeneutics and how these positions support the present research study.

## **4.6 Limitations of Gadamerian Philosophical Hermeneutics**

As with all methodologies there are associated strengths and weaknesses. Gadamer did not describe any methods for the conduct of research arguing that understanding is possible within the historically mediated text (Gadamer 1975). To overcome the limitation of a lack of described methods the researcher has utilised in this study

qualitative methods including the use of open ended questioning. Such techniques allowed the meaning of the experience to be developed from the participants words. A criticism of Gadamer's philosophy is that it is conservative in nature and it takes as its standard the tradition in which it belongs, by doing so the possibility of self-reflection and critique is lost. Gadamer's understanding of the fusion of horizons between the text and that of the reader provided an opportunity for new understanding to occur that transcended the boundaries of the reader's historicity. Thus as a researcher it was essential to closely examine and reflect deeply when the participant's horizon was markedly different from that of the researcher, as these were moments when the horizon of the researcher was transcended.

## **4.7 Summary**

The present chapter discards the methodologies of positivism and descriptive phenomenology as methodologies to underpin this study. These methodologies fail to centrally locate the patient within the research or to give voice to the participants' multiple experiences. Finally, they fail to move beyond objective description to experiential and contextualised understanding, thus rendering them inadequate for the present study. The constructs of Gadamer's philosophical hermeneutics have been illuminated and accepted as appropriate methodology for this study. Chapter 5 explores Gadamer's philosophical hermeneutics in detail and further displays the appropriateness of this methodology for a study of understanding of patient experiences.

## CHAPTER 5

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# THE METHODOLOGY OF PHILOSOPHICAL HERMENEUTICS

### Step 3

Where knowledge gap exists, conducting research and critically appraising the methodology, methods and findings for rigour (qualitative research of this study) *Chapters 4,5,6,7,8.*

### 5.1 Introduction

In conducting a qualitative research inquiry, the study's processes are defined by the three interconnected constructs of ontology, epistemology and methodology (Denzin & Lincoln 2000). Every qualitative research inquiry proceeds according to the researcher's world views, utilising a theoretical framework (ontological position) that asks specific questions (epistemological position), which are examined in a specific way (methodological position) (Denzin & Lincoln 2000). Gadamer's philosophical hermeneutic theory informs the identification of these three philosophical constructs. This chapter will describe his position regarding each construct and how it underpins this study. The constructs include:

Ontological position,

Epistemological position, and

Methodology.

Interpretive knowledge as generated by qualitative research does not aid in producing prescriptive or predictive theories but reveals the nature of human experiences (Binding & Tapp 2008; Van der Zalm & Bergum 2000) and the experiences of this study's participants. Clear understanding of the philosophical foundations of the methodology embraced by this research project will assist the reader in following the researcher's pathway from a philosophical position to a research methodology that generates knowledge about the experience of V-R day surgery.

## **5.2 Ontological position**

Ontology has been variously defined as: the meaning of human existence (Taylor, Kermode & Roberts 2006), the meaning of Being (Munhall 2007) and the nature of reality (Guba 1990). The ontological position of this study is informed by Gadamer's philosophy, who believed that understanding was an essential characteristic of existence or being in the world (Gadamer 1975b).

The choice of the research topic "Understanding the lived experience of V-R day surgery" indicates a belief that the phenomena of patients' experiences will generate knowledge. This belief sustains a relativist view of reality, featuring multiple human mental constructions and truth not being absolute. Gadamer's ontological position supports this view via three constructs. Firstly, that the truth of the phenomena is relativist in the denial of singular universal truths about the world and the belief in multiple ways of interpreting. Secondly, that the truth of the phenomena is holistic, socially and historically mediating meaning-bound constructions in individuals'

minds. Thirdly, that understanding is a fundamental characteristic of existence and, hence, understanding is ontological (Denzin & Lincoln 2000; Gadamer 1975b).

The understanding of the aim of interpretive research was ontologically refocused from the Cartesian objectivist view of the thinking “I” to a position of being-in-the-world, as described by Martin Heidegger. Gadamer (1975) further develops Heidegger’s position by introducing the idea that the structure of understanding acquires its concrete form within historical understanding, tradition and the observer’s effective history, because ‘the horizon of the present cannot be formed without the past’ (Gadamer 1975b, p. 305). Gadamer views interpretation and understanding as constituting the mode of being of all our cultural traditions, and these traditions are embedded in language (Gadamer 1975b).

In the past, under the influence of the positivist paradigm, reality was seen as a single entity independent of observers’ interests, operating in accordance with immutable natural laws (Koch 1999). The interpretive paradigm challenged this realist view. Under the guidance of interpretive philosophers, reality became relativist, characterised by multiple mental constructions that were socially and experientially based (Guba 1990). Under Gadamer’s guidance, understanding was ontological in the sense that it was our way of being in the world and requiring historical awareness, as consciousness was not independent of history (Koch 1999; Wiklund, Lindholm & Lindstrom 2002).

Koch (1999) describes Gadamer’s ontological position as a world that we live and, as we live it, it is a world that we are. In this study, the stories generated by each



participant are their own self-interpreted constructions of reality. These constructions are multiple and socially constructed, with a mutually negotiated and never a finally correct interpretation (Denzin & Lincoln 2000). The multiple constructions occurring in the participants' minds produce a unique reality, which is located in the context of their time and place. According to Gadamer, understanding is 'not an isolated activity of human beings, but a basic structure of our experience of life' (Gadamer 1975b, p. 87).

### **5.3 Epistemological position**

Epistemology is defined as the theory of knowledge and addresses the questions of what is knowledge, what can we know, and how do we know what we do know (Denzin & Lincoln 2000). Epistemology is rarely addressed without considering the ontological position, as our view of what constitutes reality or truth prescribes our understanding of knowledge.

In the scientific world, empirical truth is believed to be singular, objective and subject to immutable natural laws. It is gained through a subject–object observation, where a dualist objectivist position is upheld. This position is characterised by a detached relationship between the object and the observer – reality is external and can be observed objectively, without the influences of values and prejudices. This detachment between the subject and the observer maintains a distant non-interactive posture that helps exclude biases and values (Crotty 1998; Guba 1990). This position was later modified by post-positivists, who adopted an ontological position with the

belief that reality can only be partially apprehended and, epistemologically speaking, objectivity can only be approximated.

The interpretive paradigm rejects the ontological view of a singular observable truth and proposes a relativist belief in multiple mentally constructed realities that are based socially and experientially. This shift in ontological view promotes intentionality through the subjectivist epistemology, where the findings of a study were a co-created result. These results emerged from the ontology and epistemology positions of philosophical influences adopted by the researcher (Crotty 1998; Guba 1990). Table 5.1 sets out the ontology and epistemology positions of major philosophical influences.

**Table 5.1 Summary of philosophical positions**

<b>Philosophical paradigm</b>	<b>Ontological position</b>	<b>Epistemological position</b>	<b>Philosophical influences</b>
<b>Positivist</b>	Realist external reality that is driven by immutable natural laws	Objectivist – distant non interactive position that excludes values and biases	Rene Descartes
<b>Post-positivist</b>	Critical realist – reality exists but can never be fully understood	Modified objectivist – objectivity is an ideal but can only be approximated	Augusta Comte
<b>Interpretive</b>			
Descriptive phenomenology	Relativism – local and specific constructed realities	An intellectual process where the interpreter objectifies that which is to be interpreted	Edmund Husserl
Existential phenomenology	Truth in the world as it was encountered hermeneutically	Subject and researcher are participants in understanding of being-in-the world	Martin Heidegger
Philosophical hermeneutics	Relativist – reality in the form of multiple mental constructions socially and experientially based	Subjectivist – inquirer and participants are co-authors of the constructed findings	Hans-Georg Gadamer

(Adapted from (Tappen 2011, p. 37)

The present study is guided by philosophical hermeneutics. It aims for knowledge development that will be the co-creation between the researcher as the inquirer and the experiences of the participants as the data source. This co-creation was achieved via the central components of the knowledge development process consisting of sensitive understanding with subjectivity and the researcher's immersion. The following section looks at how the methodology of how knowledge was developed and formulates such concepts as history, dialogue, tradition, prejudice, "fusion of horizons" and the hermeneutic circle. These concepts are integral philosophical components of a research inquiry guided by the methodology of philosophical hermeneutics, as further discussed in Chapter 6.

## **5.4 Methodology**

The question methodology is concerned with is how the researcher should go about finding knowledge (Crotty 1998; Fleming 2003; Guba 1990). Methodologies from the positivist and post-positivist paradigms rely on an experimental framework where truth is determined by empirical tests in the absence of biases and values, while maintaining an observer-subject detachment. In contrast, philosophical hermeneutics supports a hermeneutic dialectic methodology where knowledge is a reconstruction of the hermeneutically examined data. The inquiry enters into a dialogue between the researcher and the researched, considers the temporality and historicity of human existence, and achieves a moment of understanding.

Hermeneutics originates in ancient Greek thought – it is defined as the theory or philosophy of the interpretation of meaning (Bleicher 1980; Fleming 2003). During

the early 19<sup>th</sup> century, the philosopher Betti (1890–1968) utilised hermeneutic methodology to gain insight into the process of understanding, where a meaning-complex created by someone else was transposed into our own understanding (Bleicher 1980). It was in Protestant theologian Schleiermacher's (1768–1834) work that the method of hermeneutics introduced the concepts of linguisticity as a universal medium of humanity and of the hermeneutic circle where individual parts acquire their meaning in relation to the whole. The conception of what was understanding was further developed by the philosopher Dilthey (1833–1911), from the reproduction of a pre-given object to the participation in a dialogue between the past and the present (Bleicher 1980).

Gadamer challenges the concept of hermeneutics as a method and argues that understanding is not an isolated activity of human beings, but a basic structure of our life experience (Gadamer 1975b). Gadamer's philosophical hermeneutics present a departure from earlier interpretive theories by rejecting hermeneutics as a method and believing that understanding is a condition of being human, that socio-historical biases are not negative and undesirable influences, and that understanding is participative, conversational and dialogic (Polit & Beck 2006). Gadamer's position includes the following central concepts:

Dialogue and language,

Historicity and tradition,

Prejudice,

Fusion of horizons, and

The hermeneutic circle.

Congruency between the research conduct and its underlying philosophy can be established via the understanding of the above concepts of philosophical hermeneutics. Each of these concepts will be described in the following sections.

#### **5.4.1 Dialogue and language**

*Language is the middle ground in which understanding and agreement concerning the object takes place between two people*  
(Gadamer 1975b, p. 386).

According to Gadamer, language is the means for understanding existence. An agreement of understanding emerges through dialogue, where understanding is not the reflection of something given but is ‘the coming into language of a totality of meaning’ (Gadamer 1975, p. 346). The conversation between the researcher and the participants is the medium that facilitates the achievement of understanding.

The present study seeks the participants’ narratives in order to disclose the experiences of the phenomena of day case eye surgery. This disclosure facilitates openness between both the text and its interpreter for the possibility of understanding and developing meaning. The conversational dialogue would become the research text and shared understandings would be possible through text interpretation.

#### **5.4.2 Historicity and tradition**

*Understanding is not to be thought of so much as an action of one’s subjectivity, but as the placing of oneself within a tradition, in which past and present are constantly fused.* (Gadamer 1975b, p. 291)

Gadamer (1975) believed that we belong to a tradition long before a tradition belongs to us and that tradition has the power to be constantly determining what we are in the process of becoming. Tradition is part of us and is evident through our effective history. It influences what we consider worthy of investigation and how we go about investigating. Our effective history represents the positive and productive possibilities of understanding. Participants of an inquiry contribute their individual and unique effective histories that evolved through each individual's social, cultural, religious, political, economic and educational situatedness. An individual's effective history is evidence of their connectedness to the world and is known as their horizon.

The researcher's horizon is also unique to the individual. As a care provider located in a predominantly technical and empirical arena, the researcher's horizon (consisting of her values, experiences and background) has been deeply influenced by a dominant scientific methodology. The choice of a research methodology outside of conventional scientific designs was based on a questioning attitude towards the received historical wisdoms and was the beginning of the dialectical process of question and answer that culminated in the moment of fusion of horizons and the development of knowledge. The researcher's task in the present inquiry is to bring into consciousness the effective histories of both researcher and participants, as this awareness assists in the fusion of horizons.

### **5.4.3 Prejudice**

*Prejudices are biases of our openness to the world. They are simply conditions whereby we experience something – whereby what we encounter says something to us (Gadamer 1976, p. 9).*

Gadamer (1975) stated that all understanding inevitably involves some prejudices. This contrasts with the Cartesian conception of knowledge where all biases and prejudices must be overcome or bracketed (withheld). The task of hermeneutics is to distinguish between prejudices that are considered blind and those that are enabling. What was once strange to us makes a claim upon us and has an affinity with us within a dialogical encounter, and we can expose ourselves to the illumination and testing of our prejudices (Bernstein 1983). Prejudices and prejudgments reflect what we are; they are sourced from our past and traditions. In the context of this study, strange or inexplicable participant narratives were clearly encounters between the researcher's and the participants' traditions and prejudgments, and such encounters are worthy of reflection. Reflection on what is unfamiliar in the text is a characteristic of openness and willingness to listen to others. These are the keys to understanding of others, as well as assisting in the illumination of our pre-judgments (Koch 1999).

#### **5.4.4 Fusion of horizons**

*An horizon is something into which we wander and that moves with us*  
(Gadamer 1975b, p. 288).

Gadamer (1975) described the fusion of horizons as the elevation of one's own particularity and that of the participant's into a higher generality, which is what occurs when understanding takes place (Bleicher 1980). Our horizon is a complex concept – it is limited and finite, changing and fluid, and essentially always open. In seeking fusions of horizons between ourselves and the participants, we seek to enlarge and enrich our own horizons. In doing so, we learn from others' horizons whilst increasing our understanding of ourselves. In this research, the researcher

pursued the meaning of the participants' experiences as emerging insights into their life worlds. A fusion of horizons produced shared meanings between the researcher and the participants, which facilitates advanced and informed caring practice.

#### **5.4.5 The hermeneutic circle**

Martin Heidegger emphasises the circularity of understanding through a theory we understand in terms of what we already know. The circularity of understanding was observed in the hermeneutic circle and it describes the analytic movement between the whole and the part, in which each provides the other with meaning (Whitehead 2004). Central to Gadamer's (1975) hermeneutic circle is the belief in an open and anticipatory nature of understanding. Understanding occurs in light of our changing prejudgments and prejudices. As our horizons evolve, so our understanding changes (Gadamer 1975b).

The hermeneutic circle is ongoing and opens up as our encounters with others' experiences "speak" to us, illuminating for us our prejudices that blind us to meaning and those that enable us to understand. We bring our historicity and a critical self-consciousness into the hermeneutic circle, where our prejudgments are biases for our openness to understanding. In the context of this research, the hermeneutic circle describes a circular and ongoing dialectic interpretive process. This includes the orientation of researchers' prejudices and biases that commenced in the literature review and in the critical review of the practice background; the listening of and reflection on everything within the text, both the strange and the explicable; the subsequent deconstruction, then reconstruction of experiences shared by the participants, as well as the co-constructed shared meanings.



## 5.5 Summary

The positivist paradigm demonstrates a philosophical position that is fundamentally inadequate for a study aiming to understand patient experiences. This chapter has explained the ontological, epistemological and methodological positions of Gadamerian philosophical hermeneutics. In the context of this research, these positions support a research product that is a co-construction by the participants and the researcher. During the research process, the understanding of the experiences of V-R day surgery participants became a dialogue between the participants and the researcher, who will read, reflect on and then re-read the text, applying and acknowledging the process, prejudices and preconceptions.

The motivation for adopting this methodology began with the scarcity of knowledge in the literature regarding the experiences of patients undergoing V-R day surgery. The choice of philosophical hermeneutics as the philosophical foundation for this research is embedded in this researcher's belief that the key to understanding the experiences of others is in listening and openness to others as constructed by a dialectical questioning and answering between the text and the interpreter. The next chapter introduces the participants and the methods and states the ethical considerations of the study.

## CHAPTER 6

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### METHODS OF THE STUDY

#### Step 3

Where knowledge gap exists, conducting research and critically appraising the methodology, methods and findings for rigour (qualitative research of this study) *Chapters 4,5,6,7,8.*

### 6.1 Introduction

The previous chapter described theory's place in the present research and informed the central philosophical questions that guide this study. This chapter will describe the study's methods and the associated decision making processes, elucidating how these methods help achieve philosophical congruency, ethical conduct and trustworthiness of the research. The participants will be introduced and the context of their lives briefly described, in order to provide a contextualised view of their unique life worlds.

Unlike quantitative research methods that demand a deductive, highly structured and detached attitude, qualitative methods are often flexible, inductive, value laden and contain knowledge embedded in the rich data of patient narratives. The task of "methods" in research is to provide tools that are: congruent with the study's philosophical approach, define the conduct of the study, and describe the collection and interpretation of data. The choice and application of methods in a research inquiry are influenced by epistemological and ontological positions that are congruent with the underpinning research paradigm. Research methods have in

the past been specific to a particular paradigm, such as manipulation of variables in experimental studies, or unstructured interviews of interpretive studies. However, as research paradigms increase there is a blurring of the specificity of research methods. A number of methods such as observation, or interviewing are now generic in nature, in that they have the capacity to span multiple methodologies and paradigms. Thus it is important to display the methods chosen for this study and their congruency with the interpretive paradigm and the methodology of Philosophical hermeneutics. The following aspects of the study will be answered:

- What was the design of this study? (6.2)
- Ethical conduct of this study. (6.3)
- Selection of the participants and how was the data generated? (6.4)
- Introduction of the participants. (6.5)
- How will the data be analysed? (6.6)
- Issues of rigour? (6.7)

This chapter provides answers to the above and establishes the framework for judging the study's rigour, trustworthiness and ethical conduct.

## **6.2 The design of this study**

As Denzin and Lincoln (2000) explain, qualitative research design situates the researcher in the world of experience. According to the constructs of philosophical hermeneutics, this qualitative study located in the experience of people undergoing V-R day surgery became a co-construction of the experience between the participants

and the researcher. The researcher (who is both clinician and researcher) and the participants were co-located in the understanding of the experience of the phenomena. However, each brought their own unique interpretation to the moment of understanding.

The context of V-R day surgery is a highly technical environment where patients are often de-contextualised from their unique life worlds. Such a system often possesses a systematic blindness to an embodied lived experience in health (Sunvisson et al. 2009). Hence, there is an urgent need to restore engaged, effective and skilful care. This need is addressed by locating the present study within an interpretive research paradigm that aims to understand rather than predict causal events. In human sciences knowledge generation spans a broad range of methodologies and methods. Whilst some author consider understanding to be more powerful than causal predictions ((Stanton et al. 2007;Sunvisson et al. 2009), each methodology of knowledge generation has its strengths and weaknesses. Causal prediction via quantitative research has enriched our understanding of the human condition from broadly social or epidemiological aspects to the micro cellular level. This type of knowledge generation has paved the way for effective control and treatment of diseases. On the other hand, understanding of human experiences illuminates and articulates the incomplete and multiple levels of meanings in people's life worlds and has the potential to restore visibility and voice to the patient and community (Stanton, Reveson & Tennen 2007; Sunvisson et al. 2009). By articulating the practices and meanings of a participant's life world, research enables encounters with the variant social and cultural essences of being human, and informs practice to become more effectively and humanely engaged.

Hermeneutics is underpinned by the assumption that people experience the world through language, and that language is the conduit for understanding and knowledge development. Gadamer (1975b) emphasises the importance of language as text, stating that interpretation of text requires an understanding of the possibilities that it can reveal. This study's methods aim to create text in which the participant's voice embeds their individual beliefs, cultural situatedness and historical circumstances.

Participants are situated within their own historicity and bring their own pre-understandings to research (Koch & Harrington 1998). The patients' experiences are self-interpreted and historically situated meanings are exposed through the language of narratives. The narrative is not an objective reconstruction of events; rather it is an individual's means to create meaning and identity (Wiklund, Lindholm & Lindstrom 2002; Wilcock et al. 2003). The initial role of the research method was the production of "raw data" (the un-interpreted narrative) and the facilitation of the participant's story flow that is cognisant of the influences of their own situation, presuppositions and historicity.

### **6.3 Ethical conduct and this study**

In human research, the principal of ethical conduct that protects participants from either physical or emotional harm developed as a code of practice following revelations during the Nuremberg trials of the late 1940s, of unethical medical research conduct in World War II. The principle known as the Nuremberg Code (1947) declares several aspects of ethical conduct in research, its fundamental features including protection from harm, participants' rights and adequate

qualification of researchers (Fain 2009). Less than two decades later, the Nuremberg Code was upheld and extended by new guidelines that became known as the Declaration of Helsinki (1964). The Declaration includes the rights of participants to be informed of the value of the research prior to consenting. In 2000, a revision of the Declaration of Helsinki occurred and now the conduct of all research on human subjects is guided by the ethical principles of Justice, Respect and Beneficence (Polit & Beck 2006).

In the conduct of research, Justice concerns the rights of individuals to fair treatment. In particular, it protects vulnerable individuals from exploitation for the advancement of knowledge (Polit & Beck 2006). Beneficence in research is exemplified as the production of outcomes that benefit humankind, but must be tempered with the principle of non-maleficence or doing no harm (Taylor, Kermode & Roberts 2006). The individual right for self-determination, including the decision to participate in research, affirms the principle of Respect for human dignity (Taylor, Kermode & Roberts 2006). The conduct of this study addresses these three guiding principles, as described below.

Ethical approval for the conduct of this study was received from the Flinders Clinical Research Ethics Committee on: 4<sup>th</sup> June 2004 130/034; 15<sup>th</sup> November 2007 114/07 and 16<sup>th</sup> February 2010 013/10 (see Appendix 2) Following receipt of approval, as listed above, potential participants were identified from the clinical site's operating theatre lists. Initial approaches to potential participants were made via telephone at least 24 hours prior to a scheduled interview. The delay provided the participants with time to reflect on their participation and offered an opportunity to withdraw.

Only one patient approached for participation chose not to be included. Thus, the research upheld the principle of respect.

Following verbal agreement, written consent was explained, signed and filed in the participants' case notes. Prior to commencing the interview, the patients were provided with a participant's information sheet (see Appendix 3), which emphasises the voluntary nature of their participation and their ability to withdraw at any time. Each stage of the data collection process reaffirmed the participant's consent and provided the option to withdraw without consequence. At the completion of data collection, the participants were advised that they could still withdraw from the research and the researcher's contact number was provided. No participant who elected to be interviewed chose to withdraw at the completion of the data gathering stage. These actions further advanced the participants' right to respect.

### **6.3.1 Research consent**

This research contains written evidence, in the form of an information sheet and completed consent forms that participants had been provided with sufficient details of the study to make an informed choice. The details of the research consent process include:

- An explanation of the context and purpose of the study,
- How and what type of data will be collected,
- Timeframe of the study,
- A pledge of confidentiality,
- Affirmation of the right to withdraw at any time without consequence,

- The provision of contact numbers for the participants should questions or concerns arise, and
- The affirmation that participation in the study is voluntary and would not influence individual treatment.

The above aspects address the principles of non-maleficence and justice. This is evident in the participant information sheet (Appendix 3) and in the “Consent to participation in research” form (Appendix 4).

#### **6.4 Selection of participants and data generation**

Qualitative research calls for the selection of participants based on the likelihood that the individuals had experienced the phenomena in question (Denzin & Lincoln 2000). A core concern of the research project was sampling a selection of participants and this assisted in the project’s success (Tuckett 2004). Sample sizes for qualitative research are generally small with emphasis on providing depth, detail and richness of data (Polit & Beck 2006). This research project interviewed 18 participants, nine during the first data collection period and a further nine during the second period. This sampling strategy is congruent with qualitative research methods, as sample size is not pre-determined but remains flexible and may increase as the study unfolds (Tuckett 2004).

Data collection in Step 3 of this EBNP project consists of nine participants being interviewed during 2006. Whilst the data from these participants was rich and detailed, the researcher felt that an increased sample size would enhance the study in a number of aspects, which include the following points. A larger sample size would



add to the depth of the data obtained and address the gender imbalance of the initial sample. Furthermore, a larger sample size would better achieve the point of data saturation, when no new themes or issues emerged from the data and considered a guiding principle of sample size in qualitative research (Polit & Beck 2006).

Moreover, the need for further recruitment of participants was recognised in response to the changing pattern of surgical and anaesthetic techniques utilised by the medical staff. An example of the change in techniques involved the adoption of sub-tenon anaesthesia for specific participants, as opposed to the traditional use of peribulbar techniques. Whilst sub-tenon anaesthesia is thought to be less painful than peribulbar anaesthesia, it is not suitable for all participants, particularly those who had prior eye surgery. Thus, a further nine participants were recruited and interviewed in 2007 with the intent to fully capture a variety of experiences.

At the commencement of each interview, which was generally conducted in the participant's home, they were asked "What was your experience of V-R day surgery?" This open ended question allowed the participants to direct the conversation and retain answering control (O'Toole 2008). Open ended questions are considered to be less threatening and most appropriate at the commencement of an interview, as it gives participants control over the information they disclose (O'Toole 2008). All interviews were tape recorded with the participant's permission. Field notes were developed prior to each interview and included information from each participant's case notes regarding surgical and anaesthetic procedure, visual acuity, underlying ocular pathology and previous surgical events. This information assisted with developing a layered understanding of each participant's condition. Following the interview, further field note entries were made and relevant information added.

Finally, the researcher transcribed the tape-recorded interviews verbatim. The following section of this chapter introduces the 18 research participants.

## **6.5 How will the data be analysed?**

In his critique of the qualitative research method, Crotty (1998) describes a bewildering array of approaches that is ‘more like a maze than a pathway to orderly research’. When using philosophical hermeneutics to underpin research, as identified by a number of nursing scholars, the problem of “method” is that Gadamer does not offer a system of rules or stepwise methods for research or data analysis. Polit and Beck (2006) discuss a number of data analysis methods, including Colaizzi’s (1978) seven steps, Van Manen’s (1984) four processes and the seven stages of Diekelmann (1992). However, despite their application in hermeneutic research, certain facets of these methods are more consistent with phenomenological research than with research founded on philosophical hermeneutics.

Fleming et al. (2003) criticises each of the above methods, stating that Colaizzi’s (1978) system requires considerable modification and has a limited position of pre-understandings. Fleming et al. (2003) finds that Van Manen’s (1984) attitude to presuppositions was negative, hence inconsistent with Gadamer’s main philosophical position, which was the belief in a historically mediated understanding (Gadamer 1975b). Furthermore, Gadamer describes our presuppositions as a “historically effected consciousness” that mediate the past and the present (Gadamer 1975b,p. 291). They are not to be viewed as negative, be put aside or “bracketed” out, but should be seen as an integral component of the development of understanding

(Gadamer 1975b). Fleming et al. (2003) criticises Diekelmann's (1992) method as being more about controlling bias rather than identifying and incorporating it, thus inconsistent with Gadamer's facilitation of the "hermeneutic moment".

Polit and Beck (2006) propose the nurse researcher Benner (1942–) as offering a suitable model for hermeneutic research analysis. However, close inspection of Benner's methods found that the underpinning philosophy was that of Martin Heidegger. Whilst Gadamer was Heidegger's student and close associate of, he rejects Heidegger's negative attitude towards prejudices and his understanding of being. Gadamer (1975, p. 390) seeks to shift the focus of hermeneutics from "being in the world" to "understanding", as expressed through dialogue and language. Munhall (2007) denounces the wide acceptance by nurse researchers of second generation phenomenologists such as Benner, Van Mannen, Colaizzi and Diekleman. He believes that nurses fail to fully appreciate the underlying philosophy of the research and that the methods used were often limiting and incongruent with the philosophy.

A search for an analysis method congruent with Gadamer's philosophy led to the prototypical styles described by Polit and Beck (2006) and a method proposed by Flemming et al. (2003). Polit and Beck (2006, p. 398) use the "template analysis" style, which organises data in relation to prior theories and finds evidence within the data to support or reject a pre-existing theory. This method would be inadequate in a study underpinned by Gadamer, as there would be limited scope for developing new understandings via the process that Gadamer describes as the "fusion of horizons" (Gadamer 1975b, p. 291). However, close inspection of Polit and Beck's (2006)

editing analysis and immersion crystallisation methods reveal a capacity for knowledge development and the emergence of new understandings. Furthermore, both methods offer repeated cycling between the data and emerging understandings. In the method for data analysis proposed by Flemming et al. (2003), a close relationship is evident between the style of analysis and Gadamer's philosophical hermeneutics. A synthesis of these methods would provide a structure for data analysis that facilitates the positioning of both researcher and participants within Gadamer's hermeneutic circle, while offering conditions for understanding and leading to new knowledge.

The engagement of the researcher and the participants within the "hermeneutic circle" is central to Gadamer's conditions of understanding (1975, p.291). Once positioned within the "hermeneutic circle", an illumination of meanings and understanding occurs through a continual movement between the text's parts and its whole (Gadamer 1975b, p. 291). Within the "hermeneutic circle", the researcher's prejudices or foreknowledge would be clarified and encounter the participants' unfolding meanings and experiences. Understanding evolves from the position of obstruction of understanding to a position of facilitation.

The hermeneutical moment combines the foreknowledge of human experience of both the participants and the researcher, manifesting in the ability to accurately know another's worldview (Finch 2004). Gadamer (1975) resurrects the role of prejudices in research and embraces the idea of historical awareness as a valuable condition of understanding (Fleming, Gaidys & Robb 2003). Achieving the "fusion of horizons" requires certain conditions to be established and for these conditions to be met

through the following steps, which are adapted from Polit and Beck's (2006) editing analysis and immersion crystallisation methods, and Fleming's (2003) method of data analysis:

- The researcher's horizons are articulated with particular attention to the overarching social and historical context.
- The participant dialogue (text) is examined to find an expression that reflects the fundamental meaning of the whole, thus capturing an insight into the participants' experience and displaying the phenomena in the context of the whole.
- The participant dialogue is searched for meaningful segments and each section investigated to expose its meaning for understanding. Individual parts are examined for meanings and experiences, and grouped according to commonalities across the data thematic analysis. This analysis includes the identification of meaningful patterns, stances or concerns, assisting the identification of patterns of convergence and divergence between parts.
- The analysis involves a dialectical process of searching participant data for meaningful segments and themes against the researcher's articulated horizon. Resonances and dissonances are captured, examined against the researcher's horizons, and then re-examined in light of the whole text.
- Exemplars (segments of participant experiences) are extracted from the text of the data, highlighting similarities or contrasts between

embodied experiences. Exemplars articulate the voice of participant experiences that resonate with emerging themes. Through exemplars, the participant's horizon is highlighted and introduced into the hermeneutic circle, where what was unfamiliar or unknown becomes articulated and understanding occurs through a fusion of the researcher's and participant's horizons. Patterns and structures that connect experiences can be identified through a search for relationships between participant experiences and participant attributes.

- The writing of a text of the understanding of participant experiences is cognisant of all emerging themes, patterns and understandings.

These steps facilitate a “fusion of horizons” between the researcher and participant experiences, and lead to the development of new understandings. These steps also provide a congruency between research actions and its philosophical foundations, necessary for establishing trustworthiness and authenticity of the research outcome. The software program NVivo 7 was utilised in this research to aid the process of identifying codes, patterns and themes. The advantages of using computer software for data analysis are described as making the process more manageable, accurate and comprehensive (Holloway & Wheeler 2010).

## **6.6 Issues of rigour and trustworthiness**

Rigour in qualitative research is a widely debated issue in the nursing literature (Crotty 1998; Koch & Harrington 1998; Maggs-Rapport 2001). Early descriptions

and definitions of rigour are often based on quantitative research processes. This borrowing of methods from one methodology and applying them to another has been described as “problematic” (Koch & Harrington 1998). Research rigour is described as a congruence of the study’s methods with its underlying philosophy. This study uses Lincoln and Guba’s (1985) seminal work on trustworthiness in qualitative research as the reference framework for rigour. The classic criteria of credibility, transferability, dependability and confirmability, considered by Lincoln and Guba to be essential for establishing trustworthiness, have been addressed in the following manner (Lincoln & Guba 1985).

Prolonged engagement of the researcher with the participants resulted in the development of a trusting relationship, a relationship that Lincoln and Guba (1985) considered necessary for the credibility of the findings. In the process of prolonged engagement, the context of a day surgery unit became ‘thoroughly understood and appreciated’ (Lincoln & Guba 1985, p. 302). This further enhances credibility, as the researchers are able to recognise salient and distorted elements in the findings.

Peer review of the study occurred at a conference for Ophthalmic Nurses held in London, in 2008, where searching questions by experienced ophthalmic nurses led to the corroboration of the findings. Provision of a “thick description” of participant experiences provided conference delegates and readers of this study with sufficient information to judge its transferability to other contexts. The findings of the study have been published in a peer-reviewed journal, the *Journal of Advanced Nursing* (January, 2012).

The conduct of interviews over a 24-month timeframe reduces the possibility of early closure of data collection, thus limiting researcher a-priori distortions. Dependability and confirmability are satisfied through an audit trail that exists in the layered nodal analysis achieved by using NVivo 7 for thematic coding and coupling of data. Verbatim participant excerpts are used to illustrate the constitutive elements of a reported theme, while establishing a direct link between the findings and the interview transcripts.

The problematic nature of reaching congruence between the foundation philosophy and the research methods is clearly evident when evaluating research supported by Gadamer's philosophical hermeneutics. Gadamer did not provide a method for reaching understanding; however, he did describe the conditions in which understanding occurs. Congruence with the chosen methodology and how the issues of confirmability, creditability, dependability and transferability that are considered essential to trustworthiness have been addressed in this study and will be further discussed in chapter 10. The discussion of trustworthiness at that point will be incorporated within the EBNP framework, and is an essential process of the evaluation of evidence (the findings of this study) as a basis on which to support new nursing intervention within this clinical setting

## **6.7 The strengths and weakness of insider research**

The role of the 'insider' researcher can provide significant benefit to the research process via a number of points. They include: The ability to use knowledge of the context to develop research questions that are clinically relevant (McNair et al.



2008). The researcher is known to the organisation and has ready access to potential study participants (Asselin 2003). Facilitation of deep engagement with participants via pre-existing immersion in the clinical context being studied (Hewitt Taylor 2002). An ongoing commitment to the research population (McNair et al. 2008)

These points could be clearly seen within the processes of this thesis as the researcher had a well-developed clinical knowledge and clear access to potential participants after ethical approval achieved. A further strength of this position was an ongoing commitment to the study population which continued in ongoing research activities. Being a member of the clinical environment facilitated an understanding of the often complex nomenclature of ophthalmology as well as a deep understanding of the interventions and treatment processes. These aspects of the researcher's position as an 'insider' helped to develop a deep connection with the participants as they did not need to expand on treatments, terms and interventions. At all times throughout the interviews the researcher worked hard to develop a trusting relationship with participants and explained to participants that the results of their participation could benefit future patients. The researcher believed that a deep level of engagement was achieved as participants freely shared their hidden fears and painful experiences as well as the more superficial events that occurred throughout their treatment. However, ethical issues of an 'insider' researcher existed and included the following potential points: The potential for coercion of patients to participate in this study; Inequality in the power relationship between researcher and participant (Hayman 2011); The potential for conflict of roles between researcher and clinician.

The potential for coercion of patients who were identified as likely participants of this study was an ethical challenge that the researcher was well aware of at all times.

To prevent participants feeling coerced into participation participants were approached via telephone and explained the purpose and nature of the research and their potential involvement. If a patient expressed an interest they were then asked to consider their involvement over the next few days and a participant information sheet was provided for them to peruse. The researcher then called a few days later to seek their decision and if they wished to be included and if so a time and date for interview to occur in their own home was arranged. At each point of contact including the researcher's arrival for interview it was reiterated that they did not need to participate and that non participation would not influence their care in any way. Participants were informed that they could withdraw from participation at any time even after the interview had been conducted. It was clearly identified that the researcher was a senior nurse and researcher of the unit and that at all times their experiences revealed would be kept confidential and anonymous.

Inequality in the relationship between health care consumers and providers/researchers has been well established in the literature (Foucault 1973; Fulton1997; Powers 2003; Hewitt 2004). Therefore it was essential that an equal relationship was established with participants, that addressed issues of authority, control and knowledge (Hewitt2004). With this in mind the researcher purposively sought to conduct the interviews in an environment that participant's felt they were in control of, most often their homes. The time and date of the interview was also at the convenience of the participant. In regard to authority and knowledge, whilst the researcher clearly identified her role within the clinical field, she sought to ensure that it was the participant's experience that was the authority in the narrative and that

their knowledge was unique and important information. To do this unstructured interview processes and attentive listening skills were used that have been considered as helpful in establishing an equal relationship (O'Toole 2008; Candlin 2012).

It was the dual roles of researcher and clinician that presented the strongest ethical dilemma, when the first three participants' interview described difficulties they experienced following discharge. It was at this point that the researcher's role of clinician became fluid with that of the researcher. Faced with an ethical imperative of 'non-maleficence' to do no harm (Taylor et al. 2006), not reporting the initial findings of the research, that participants were not coping well in the immediate post-operative period the researcher would contribute to the harm of future patients. Thus, initial findings were reported to the nurses of the day surgery unit who were responsible for the education of patients on post-operative management. Also reported were the findings to the V-R surgeon and senior anaesthetist. Preceding the early data collection, reporting of the progress of the study to the staff within the unit had occurred on a regular three monthly basis. The discussions had included the historical basis of health care, the methodological choices and the recruitment of participants. However following the early data collection the discussion of the research changed from informing of the progress to an emphasis on the need for clear education on the management of pain relief medications and the role of the on-call ophthalmologist who was available to advise patients with difficulties. In the absence of an alternative evidence based pain management protocol and a lack of clarity regarding the patient self-managed analgesia behaviour, the current postoperative regime was reviewed and patient education was strengthened. Whilst these actions had the potential to compromise the research findings there was an ethical imperative to act.

## **6.8 Summary**

The present chapter has answered the remaining questions of ethical research conduct and consent. It has explained the methods and data analysis strategy, as well as establishing a congruency between the study's methods and its philosophical foundation. The next chapter begins the interpretive process, which leads to the unravelling of meaning and interpretation of data.

# CHAPTER 7

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## PRESENTATION OF THE DATA

### Step 3

Where knowledge gap exists, conducting research then critically appraising the methodology, methods and findings for rigour (qualitative research of this study). *Chapters 4,5,6,7,8*

### 7.1 Introduction

The previous chapters have accomplished the first two steps of this EBNP activity. They establish the clinical problem, develop the research question and identify a knowledge gap. The first steps have identified what is currently known about V-R day surgery, the history behind today's healthcare systems, and the ethical and methodological considerations applicable to this study's knowledge-generating activities. The present chapter will display the findings of the research activities of this EBNP process. Whilst these findings may be considered as 'stand alone' knowledge-generating activities, their great value resides in the potential to inform nurses caring for people experiencing V-R day surgery. This potential is achieved through their use as an integral component of evidence required in the EBNP activity described in this study. These findings provide the experiential knowledge expected of true patient-centred care, hence laying the foundation for holistic EBNP.

The study has introduced its participants, who shared their experiences, and described their underlying physical and social situatedness. Data as narrative was collected, recorded and transcribed via interview methods described in Chapter 6.

The current aim is to achieve an understanding of these participants' experiences. An evolving understanding is facilitated by a fusion of horizons between participants and the researcher, a salient concept of Gadamer's philosophical hermeneutics. The achievement of such fusion will be displayed in the presentation of data. The processes of thematic development and analysis that have ultimately led to understanding will also be displayed. Thus, Chapter 7 contains an emergence of the participants' life worlds within themes. All themes are representations of common experiences and reflect a deep connection with the rich tapestry of participants' lived experiences of V-R day surgery.

## **7.2 Introduction of participants**

Each selected participant had experienced between two and seven surgical events during treatment of their eye condition. This number depended on the success of earlier treatments and the nature of their condition. Five participants had experienced eye surgery in more than one acute-care institution and the timeframe of their experiences ranged from a few months to several years. This study contains seven female and eleven male participants, with ages ranging from 43 to 84 years old. Table 7.1 contains a summary of each participant's ocular pathology, complications, social situations and supports.

All of the participants had experienced V-R day surgery within six months leading up to their interviews. As Table 7.2 shows, preceding episodes of ocular surgery were influential to their overall experiences. Previous surgery included cataract removal for Albert, Harold, Edgar, Felix, Molly, John, Rita and Tony, and previous

retinal surgery for Greta, Fin, Sarah, John, Sandra, Gunter, Robert and Edgar. Bruce and Adriana had experienced only one episode of eye surgery each.

Consistent with the principles of ethical conduct in human research as described in chapter 6 section 6.3, each participant's confidentiality was protected through the use of pseudonyms. Following the production of the transcripts of the interviews and completion of the thesis recorded tapings were destroyed.

Participant	Ocular pathology	Surgical event	Complication	Age	Employment	Social situation and support		
						Dependants	Carers	Carers
Greta	Retinal detachment	Scleral buckle	Nil	73	Retired	Elderly husband	Self	Self
Fin	Retinal detachment	Scleral buckle + vitrectomy	Retinal detachment	43	Full-time, sole breadwinner for family	Wife + small children	Wife	Wife
Felix	Cataract + retinal detachment	Scleral buckle + vitrectomy	Retinal detachment	62	Retired	Wife	Wife	Wife
Dorothy	Macula Hole	Vitrectomy	Nil	70	Retired	No	Husband	Husband
Bruce	Retinal detachment	Vitrectomy	Retinal detachment	45	Employed full-time	No	Self	Self
Nick	Cataract + retinal detachment	Scleral buckle	Infection + retinal detachment	48	Employed full-time	Wife + children	Wife	Wife
Robert	Retinal detachment	Scleral buckle + vitrectomy	Retinal detachment	76	Retired	Wife	Wife	Wife
Albert	Retinal detachment	Scleral buckle + vitrectomy	Retinal detachment	82	Actively farming	No	Wife	Wife
Edgar	Retinal detachment	RD repair	Nil	79	Retired engineer	Wife	Wife	Wife
Tony	Diabetic retinopathy	Vitrectomy	Nil	68	Retired	Wife	Wife + family	Wife + family
John	Retinal detachment	Scleral buckle	Retinal detachment	69	Retired	Wife	Wife	Wife
Gunter	Retinal detachment	Scleral buckle + vitrectomy	Retinal detachment	51	Disability pension	Wife	Wife + supportive neighbours	Wife + supportive neighbours
Harold	Macula hole	Vitrectomy	Nil	84	Retired	No	Son	Son
Rita	Retinal detachment	Vitrectomy	Haemorrhage	72	Retired	No	Family	Family
Sarah	Diabetic retinopathy	Vitrectomy	Nil	79	Retired	No	Husband	Husband
Molly	Retinal detachment	Scleral buckle + vitrectomy	Nil	84	Aged pensioner	No	Husband	Husband
Sandra	Retinal detachment	Scleral buckle + vitrectomy	Nil	61	Retired	No	Husband	Husband
Adriana	Retinal detachment	Vitrectomy	Nil	80	Retired	No	Husband + family	Husband + family

Table 7.1 Participants, underlying pathology, surgical intervention and demographics



Table 7.2 **Display of previous ocular surgical experiences**

<b>Previous retinal surgery</b>	<b>Previous cataract surgery</b>	<b>No previous eye surgery</b>
Dorothy	Albert	Bruce
Greta	Harold	Adriana
Fin	Edgar	
John	Felix	
Gunter	John	
Robert	Tony	
Edgar	Molly	
Sandra	Rita	
Sarah		

In the cases of Nick, Harold, Sandra, Sarah and Dorothy, retinal surgery was necessary to correct a gradual degenerative condition and was elective. Fin, John, Felix, Tony, Bruce, Robert Gunter, Adriana, Rita, Greta, Albert and Edgar had experienced a sight-threatening condition that required urgent repair. Following is an introduction of each participant, including a short description of their situation.

### **Greta**

Greta was a 70-year-old female, born in Eastern Europe and emigrating to Australia after World War II. During her early years, Greta was a nurse and had undergone a retinal detachment in her left eye some 30 years prior to her current experience. Greta lived in her own home approximately 20 kilometres from the hospital where her surgery was performed. She was the sole carer for her elderly and incapacitated husband. Greta maintained a cheerful attitude to her difficulties, coping with them by staying in touch with numerous friends and spending time in her garden.

### **Fin**

Fin was a 50-year-old married father, living in his own home with his wife and two young children. He had multiple procedures performed on his eyes due to recurrent retinal detachments and was very concerned about his visual prognosis. Fin was a staff member of the facility where his surgery was performed, but was not involved in the clinical environment. He was fit and well, however he expressed anxiety about the possibility of visual disability and its effects on his ability to provide for his family.

### **Felix**

Felix was a 64-year-old retiree and lived with his wife in their own home. Felix had previous eye surgery for cataracts in a private facility, which was a straightforward and uneventful procedure. However, some weeks following the surgery, Felix experienced a retinal detachment. This required several surgical episodes and he was still in the recovery phase, therefore anxious about his visual rehabilitation. The interview was conducted in Felix's home with his wife present. Felix was generally fit and well, with no significant major health threats in the past.

### **Dorothy**

Dorothy, aged 64, lived with her independent and supportive husband. She had experienced two episodes of elective eye surgery and her visual outcome was good. Dorothy had significant health issues in the past; however, she was now physically independent. The interview was conducted in her home with her husband present, and she was very pleased to share her experiences of V-R day surgery. Dorothy

expressed a significant trust in the facility staff; the medical staff in particular, and she felt that all staff members were kind and caring.

### **Bruce**

Bruce was a 58-year-old male who lived alone in a caravan park some distance from the hospital. Some months following his surgery, Bruce was able to resume work. He had good vision in his right eye; however, he had significant visual disability in the left eye and found it necessary to wear an occlusive patch. Living alone compounded the significant difficulties he experienced during convalescence. Bruce's employment situation contributed to his anxiety, as his ongoing contractual arrangements depended on his performance. He felt that the loss of vision in one eye might jeopardise his future employment prospects. Bruce became dependant on friends to assist him with immediate post-operative convalescence. He was careful to point out that he lived alone in a caravan park, indicating that it was safer for the interview to be carried out in the clinic.

### **Nick**

Fully independent despite some minor health issues, Nick was an employed 55-year-old, living with a supportive family. Nick had good vision in the right eye and poor vision in his left one. He had sustained two previous episodes of surgery to correct the problem but the treatment was relatively unsuccessful. At the time of his interview, the vision in Nick's left eye was still very poor. As the problems worsened, Nick expressed concerns about possible vision loss and stated that he appreciated the value of good vision only when vision loss was imminent.

### **Robert**

Robert was a 70-year-old retiree who lived with his independent wife. He had some prior minor health issues but was now independent. Robert and his wife had travelled extensively and wanted to continue travelling. Robert was still able to drive and appeared well adjusted to the loss of vision in his right eye. The interview was conducted in Robert's home with his wife present. In regard to his vision loss, Robert described a period of grief and went on to identify some difficulties caused by his reduced vision. However, he remained optimistic about his quality of life and stated that he should just "get on with things".

### **Albert**

As an artist and a farmer, living with his supportive wife some 50 kilometres from the surgical facility, Albert appreciated good vision in terms of both occupations. Despite a long history of ocular problems, Albert was able to participate in his artistic activities and was still actively farming the property at 84 years of age. At the time of the interview, he was awaiting knee surgery for arthritis, which was causing him a moderate degree of disability.

### **Edgar**

Edgar was in his mid-80s and lived with his elderly but independent wife. Edgar had significant co-morbidities, but lived at home with support from his family. He was an engineer and liked to know all the physical details about his condition. Edgar had a long history of ocular problems including two retinal detachment repairs. He was keen to review his experiences and particularly wished to discuss communication in aspects of his care. Edgar had few problems during post-operative convalescence,

despite his surgery being relatively unsuccessful at restoring good vision. He was proud of his ability to ask questions and to seek extended explanations about aspects he did not understand.

### **Tony**

A cheerful elderly European gentleman of 68 years, Tony lived with his supportive and independent wife. Tony had significant co-morbidities that included insulin-dependent diabetes, but was independently mobile, cheerful and optimistic about his health. He had experienced one episode of surgery for diabetic retinopathy, as well as multiple episodes of laser eye treatment. Tony managed well at home with his diabetic medications, assisted by his wife and family. He felt that his care had been good and he experienced few post-operative problems. He lived a considerable distance from the healthcare facility and relied on his family for transport to various appointments. The interview was conducted at Tony's home with his wife present.

### **John**

An active 69-year-old with a long history of ocular problems, John had three episodes of surgery in Australia and previous experiences of several eye surgery episodes for retinal detachments in the UK and Darwin. John lived with his supportive and independent wife. He felt that he received a good explanation of the surgery and that all of his questions were suitably answered. However, later in the interview, both John and his wife expressed the need for more information to be available to patients in the waiting room. They cited their experience in the UK as greatly beneficial, since information was abundant there. John's experience had resulted in increased sensitivity to any minor variations in his vision and subsequent

urgency for investigating any problems. Whilst John had multiple retinal detachments and his visual outcome was poor, he expressed the view that he had sufficient vision for a reasonable quality of life. The interview with John was conducted in his home and his wife had kindly baked fresh scones to consume during the discussion.

### **Gunter**

Gunter, at 51 years of age, enjoyed volunteering at a local nursing home as he was unable to work due to vision problems. He lived with his supportive wife and family; however Gunter's wife was unable to drive, so he relied on his wide circle of friends and neighbours for assistance. Gunter experienced significant difficulties with each of the six operations for recurrent retinal detachment. During the discussion about his experiences, he described significant physical and emotional pain associated with the loss of the vision in one eye. Gunter's surgery was not very successful in restoring vision to his right eye; however, he had good vision in his left eye. He recounted the caring and supportive assistance of a nurse who held his hand through one of the procedures and expressed how much this comforted him. Gunter felt that it would have been beneficial to speak with someone about his experiences. Whilst Gunter did not wish to know any of the technical details of the procedures, he would have liked additional emotional support.

### **Harold**

Harold was independent with most activities despite being one of the oldest participants at 84 years of age, and his having significant co-morbidities of serious heart disease and prostate cancer. Harold had experienced one episode of elective eye

surgery for a macular hole and his surgery was successful in restoring his vision to a high level of acuity. His original visit to the ophthalmologist was due to increasing trouble with daily activities. Harold had diabetes and his eyes were regularly checked through the diabetic clinic. At the time of the interview he had experienced both cataract surgery and macular hole repair. Harold had few post-operative problems and was chiefly concerned with the cost of travelling to appointments, as well as the length of time he spent waiting to be seen.

### **Rita**

Rita's experience of previous cataract surgery was difficult and complicated, which eventuated in blindness in one eye. At the time of the V-R surgery, she was very anxious due to her previous experiences. When she experienced problems with her good eye, Rita delayed calling the eye clinic for fear of what was happening. Rita was 72 years of age and lived alone at the time of experiencing problems with her good eye, causing her to fall and fracture her shoulder. Rita had supportive neighbours, but no close family members who could look after her. During the interview, Rita was cautious about what she disclosed. As the interview progressed, she willingly disclosed aspects of her experience that she found difficult.

### **Sarah**

As a long-term Type 1 diabetic, Sarah understood the need to monitor her vision. Prior to surgery, Sarah's vision had deteriorated due to diabetic retinopathy and she was terrified of having treatment. At 79 years of age, Sarah lived with her husband who was very supportive during the time of her surgery. Sarah felt that if she experienced any problems she was able to get advice from her daughter, who was a

nurse. Sarah's diabetes was well controlled and she successfully managed the insulin injections and glucose monitoring. Sarah and her husband were keen to discuss the issues and problems that she experienced during treatment.

### **Molly**

Molly's previous experience of cataract surgery was uneventful, but her experience of the anaesthetic was frightening and she was extremely anxious when further surgery was required. Molly's husband and daughter lived with her and were supportive in helping her cope with anxiety. Not being employed and at 84 years of age, Molly was able to accommodate her daily tasks with diminishing vision. However, she realised that eventually she needed to have surgery or would lose her vision. Molly freely discussed her experiences and her anxiety regarding the anaesthetic.

### **Sandra**

An earlier episode of retinal surgery for a macular hole was relatively uneventful for Sandra. She was 61 years of age and lived with her husband. However, surgery on Sarah's other eye for the same condition was eventful and resulted in a retinal detachment, requiring further surgery. This surgical episode was an emergency and the procedure was performed on the same day that she was diagnosed. This gave Sandra little time to prepare emotionally for the surgery. Following the treatment, Sandra experienced significant pain and discomfort that took 2–3 days to settle. The outcome of all of Sandra's operations was good and she no longer needed spectacles after having worn them for 40 years. Sandra was relaxed and appeared happy to discuss her experiences.



## **Adriana**

When the need emerged for urgent eye surgery to repair her retinal detachment, Adriana was worried as she had delayed seeking advice when her eyesight first began deteriorating. Adriana's husband was supportive and helped her through her anxiety of the unexpected surgery. Despite Adriana's advanced age (80 years), her recovery from surgery was relatively uneventful and she experienced minimal pain following the procedure. Her visual recovery was slow but continually improved, which made her happy. Adriana was willing to discuss her experiences, particularly her experience of the eye block.

### **7.3 Coding and theme development**

Analysis of this data required identification of codes and themes in a manner that is congruent with Gadamerian philosophy (as described in previous chapters). A declaration of the researcher's presuppositions and "horizon" provides the conditions of understanding, as does the dialectical movements between researcher and text that occurred during the journey towards understanding. This declaration is accomplished during Phase 1 of a five-phase analysis process that includes:

- Phase 1: Declaration of the researcher's horizon (7.3.1)
- Phase 2: A fundamental meaning of the experience (7.3.2)
- Phase 3: Patterns within the data (7.3.3)
- Phase 4: The words of the participants (7.3.4)
- Phase 5: From the parts to the whole (7.3.5)

These analysis phases are adapted (and described in Chapter 6) from Polit and Beck's (2006) editing, analysis and immersion crystallisation methods, as well as Flemming's (2003) method of data analysis. This five-phase strategy enables the use of participants' voices as exemplars, as well as demonstrating the development of codes and themes that resulted in identifying sub-themes and, ultimately, the encompassing theme. The researcher's horizon is clarified with each identified theme. Phase 1 of this process began with articulating the researcher's horizons, paying particular attention to the overarching social and historical context, as described in Chapters 2 and 3.

### **7.3.1 Phase 1: Declaration of the researcher's horizon**

The researcher is positioned subjectively within this Gadamerian-guided study and brings an established "horizon" to the research. This "horizon" is embedded within the knowledge and understandings of the surgical operating room, where the researcher had been the Clinical Nurse Manager for over thirteen years.

Historically, the surgical operating room had been dominated by science and technology, and this hegemony had influenced the research question. The researcher's horizon was immersed in the environment of an ophthalmic day surgery unit that focussed on technology and science. In this unit, a strong emphasis was placed on technological mastery, efficiency of service and cost containment. On that basis, the researcher had felt that the service provided to patients was efficient and effective, while meeting the wider community's need for access to services. However, when the anecdotal reports of patient's post-operative difficulties grew more distinct, this researcher began to question the "fit" between the service provided and the patients' needs. This questioning was the prompt for conducting the

present study. The utilisation of an interpretive methodology, which is flexible and responsive to the individual's unique life world, presents an opportunity to overcome the hegemonic influence of science and technology. What emerges throughout this study is the participants' "horizon", revealing what is important and significant in their individual experiences of V-R day surgery.

All interviews in this study were conducted by the researcher and, by the end of the first three interviews; it became evident that the services provided by the healthcare unit met only a few of the participants' basic physical needs. It was at this early stage that the researcher's presuppositions regarding care were first challenged. As further interviews were conducted and transcribed, a large quantity of experiential evidence developed regarding the participants' needs not being met, including many of their physical needs, which was an unexpected outcome. Thus, the early research evidence provided much to challenge the researcher's presuppositions. These challenges led to further exploration of the transcripts that, in the second step of the analysis, provide an insight into the meaning of the experience as a whole.

### **7.3.2 Phase 2: A fundamental meaning of the experience**

At the completion of the data collection phase, the researcher transcribed all tape recorded interviews. This task, despite being time-consuming, provided the researcher with the opportunity to hear the participants' voices many times over and to become deeply immersed in the data. On completing the transcribing, a re-reading of the transcripts occurred until achieving an early illumination and crystallisation of the meaning of the experience as a whole. This illumination and crystallisation emerges from the participants' descriptions of varied and significant difficulties during their V-R day surgery experiences. These difficulties include physical

discomfort, psychological trauma, problems with self-care and adjustment to visual disability.

During treatment of a wide variety of pathological conditions, surgical intervention frequently results in anatomy normalisation (cure) and a return to health. This pathway of care includes an identification of pathology, surgery, recovery and a return to health. Along this pathway, the care provided emphasises the physical and, to a lesser extent, the psychological aspects of intervention and recovery, and is described as an acute model of care (Hoffman 2001). This model is utilised in many acute hospitals for surgical care of patients. However, this model becomes inadequate when surgery is required for ongoing conditions or when the surgical outcome potentially threatens lifestyle or independence, (Cumbie, Conley & Burman 2004).

In line with an acute model of care, measures to control pain and nausea are evident, if not always adequate or successful. However, strategies to cope with fear, anxiety, difficult past experiences, convalescent self-care and adjustment to a disability are rarely evident, if at all. It will be argued later that, through the voice of the participants' experiences, their complex inter-related needs extend well beyond the dominant physical self of an acute model of care. From this understanding, an overarching theme is identified, that of: "*Inadequacies of an acute model of care in meeting the extended and complex needs of individuals experiencing V-R day surgery*". This theme eventuated following reflection and immersion in the participants' narratives where they described the experienced difficulties. This immersion led to a deeper understanding of the elements of an individual's persona (*self*) influenced by this experience. The elements of the *self* stretched beyond the

*physical self* to encompass the *psychological self*, the *historically located self* and the *self within the community*. Figure 7.1 is representative of the concepts of *self* as addressed by an acute model of care. In comparison, Figure 7.2 displays a model developed through an understanding of the extended concepts of *self* identified in this study. These figures provide a visual introduction of the limited aspects of *self* addressed by the acute model of care and the broader aspects of *self* identified through the participants' unmet needs.

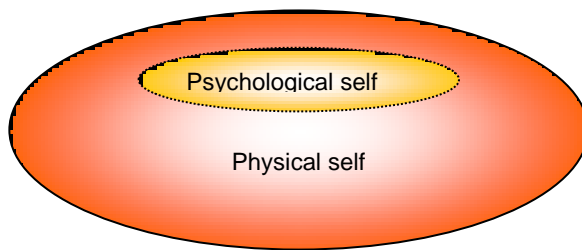


Figure 7.1 **Concepts of *self* addressed in an acute model of care**

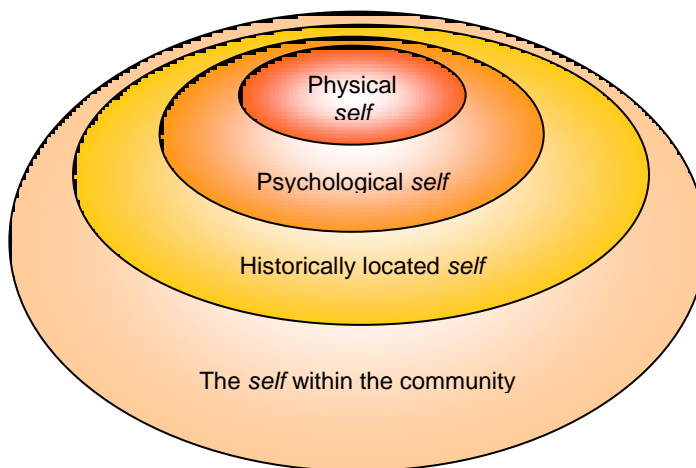


Figure 7.2 **Concepts of *self* identified by this study**

With this overarching theme identified, the third step of the analysis will be described. This step searches for meaningful segments that support the major theme.

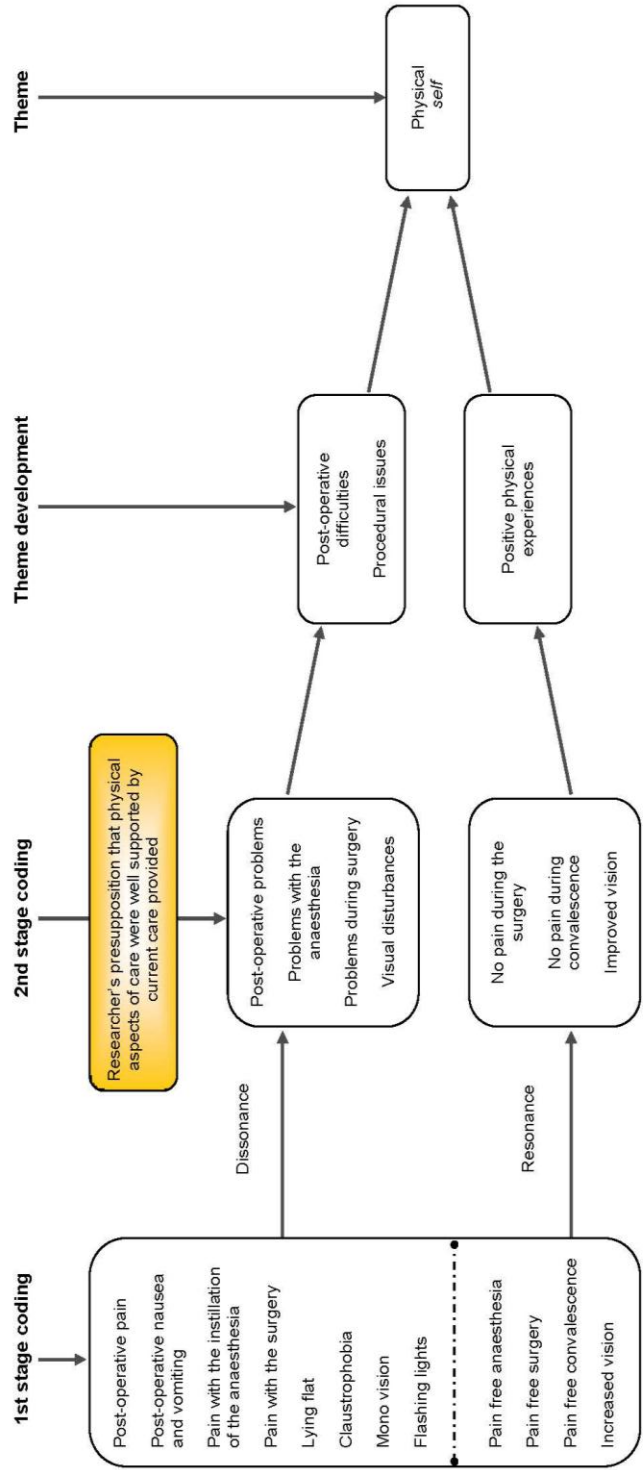
### 7.3.3 Phase 3: Patterns within the data

In this step of the analysis, the participant dialogue is searched for meaningful segments and each section is investigated to expose its meaning for understanding.

Individual parts are examined and experiences are grouped according to data commonalities. Thematic analysis that includes the identification of meaningful patterns, stances or concerns, assists the identification of patterns of resonances and dissonances between parts, and relates to the overarching theme.

First, the physical aspects of the experience are identified from the data. Early consideration of this aspect of the experience may be considered congruent with the researcher's horizon and may also be due to participants' eagerness to discuss vividly experienced aspects early in the interviews. Figure 7.3 displays the process of development for the subtheme of the *physical self*. Individual aspects of the experience are coded broadly and then consolidated through a second stage of coding to theme development and, finally, to subtheme. Figure 7.3 identifies both resonances and dissonances with the researcher's horizon, presented as a pre-supposition and a passage from multiple coded experiences. Dissonances are identified as experiences, such as pain, nausea and vomiting, whilst resonances are considered as pain free experiences. This dichotomy of experience can be followed through from initial coding to subtheme development and plays an important part in developing an understanding of this experience. The participants' voices are heard in the development of all themes in Step 4 of the analysis and provide authenticity to the coding process.

Figure 7.3 Segmental analysis of the data that led to identification of the subtheme of the physical self

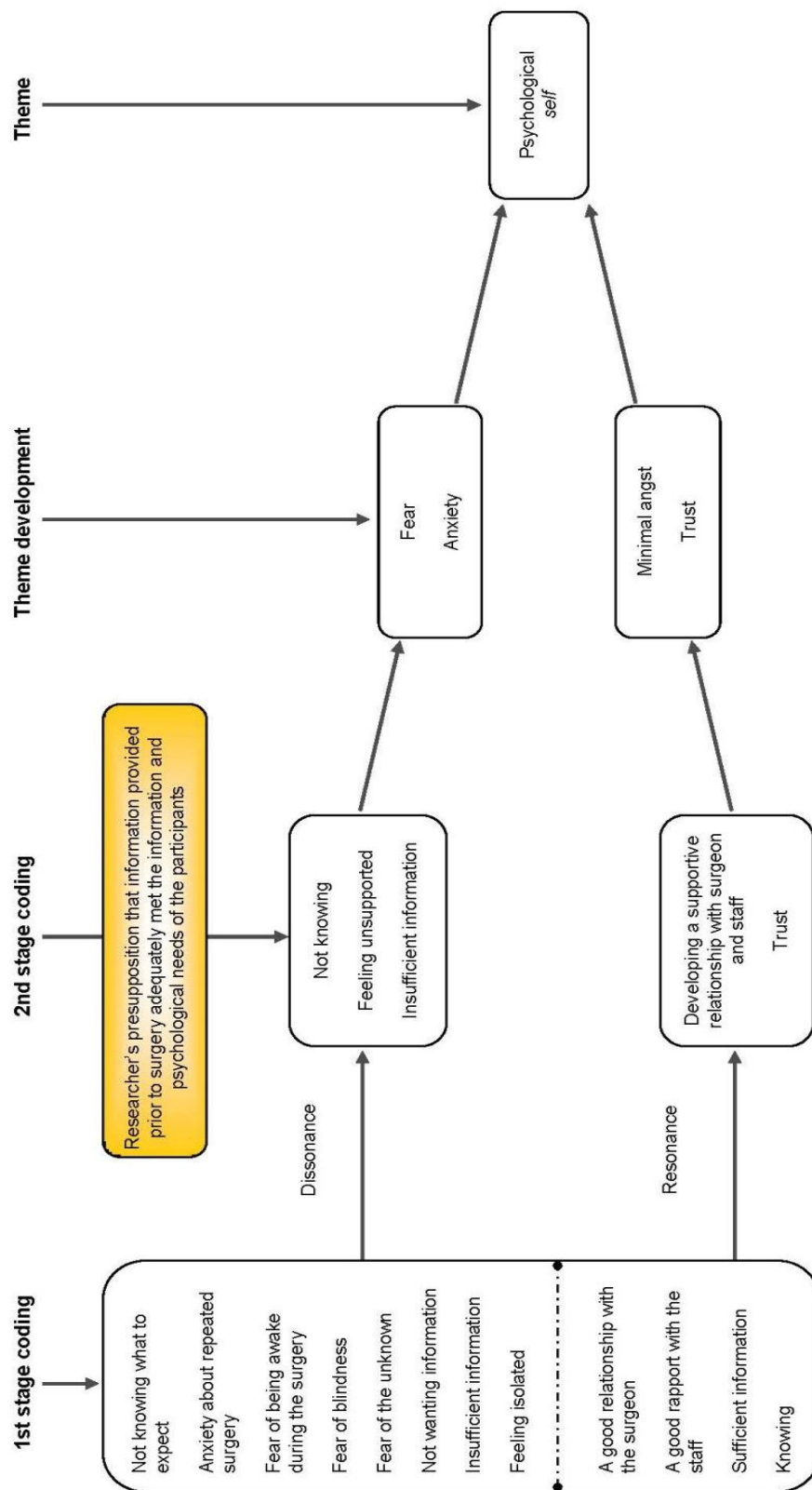


Whilst the participants readily discussed the experience's physical aspects, their fears and anxieties with some aspects of the experience were also obvious. Figure 7.4 displays the development of the second subtheme, that of the *psychological self*.

The heartfelt pathos of this experience emerges from the data. Fear of blindness is clearly evident and is often compounded by the fear of surgery or anaesthetic instillation. The anxiety reduction strategy of information provision is often not needed or wanted; however a number of participants requested detailed knowledge of the experience. Again, a dichotomy of experiences is evident particularly where the participants used the knowledge of previous experiences as sources of either anxiety reduction or anxiety provocation. The relationship of the participant with the healthcare workers also played an important role in their psychological experience. Phase 4 of the analysis further describes and examines this complex subtheme using the words of the participants.



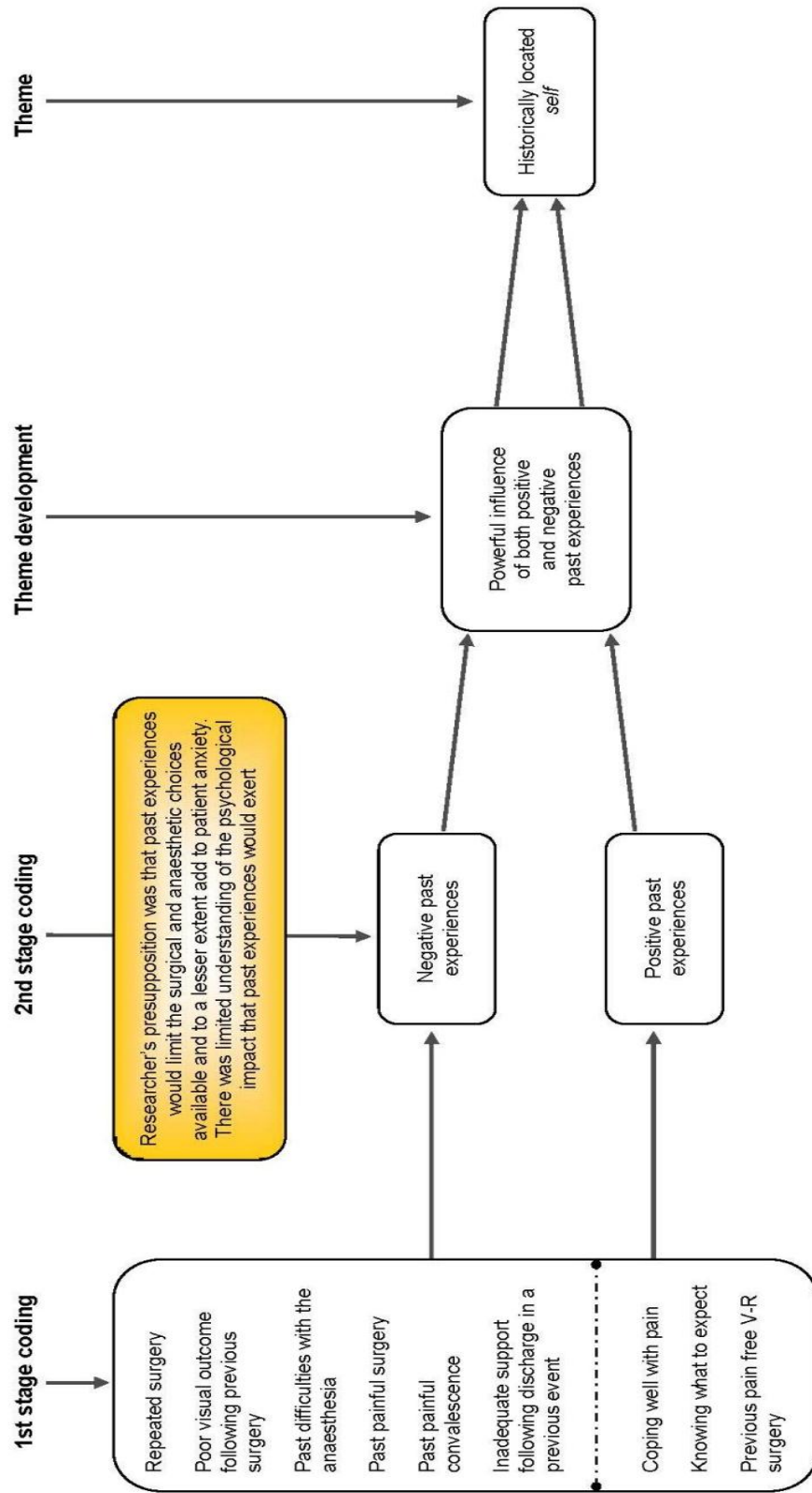
Figure 7.4 Segmental analysis of the data that led to identification of the sub-theme of the psychological self



The third theme identifies and incorporates the influence exerted on current treatment and preparation by past experiences. This theme was unexpected by the researcher, as the presupposition was concerned with the physical limitation imposed by previous surgery. What emerges, as displayed by Figure 7.5, is the identification of a pervasive influence exerted by past experiences, both positively and negatively.

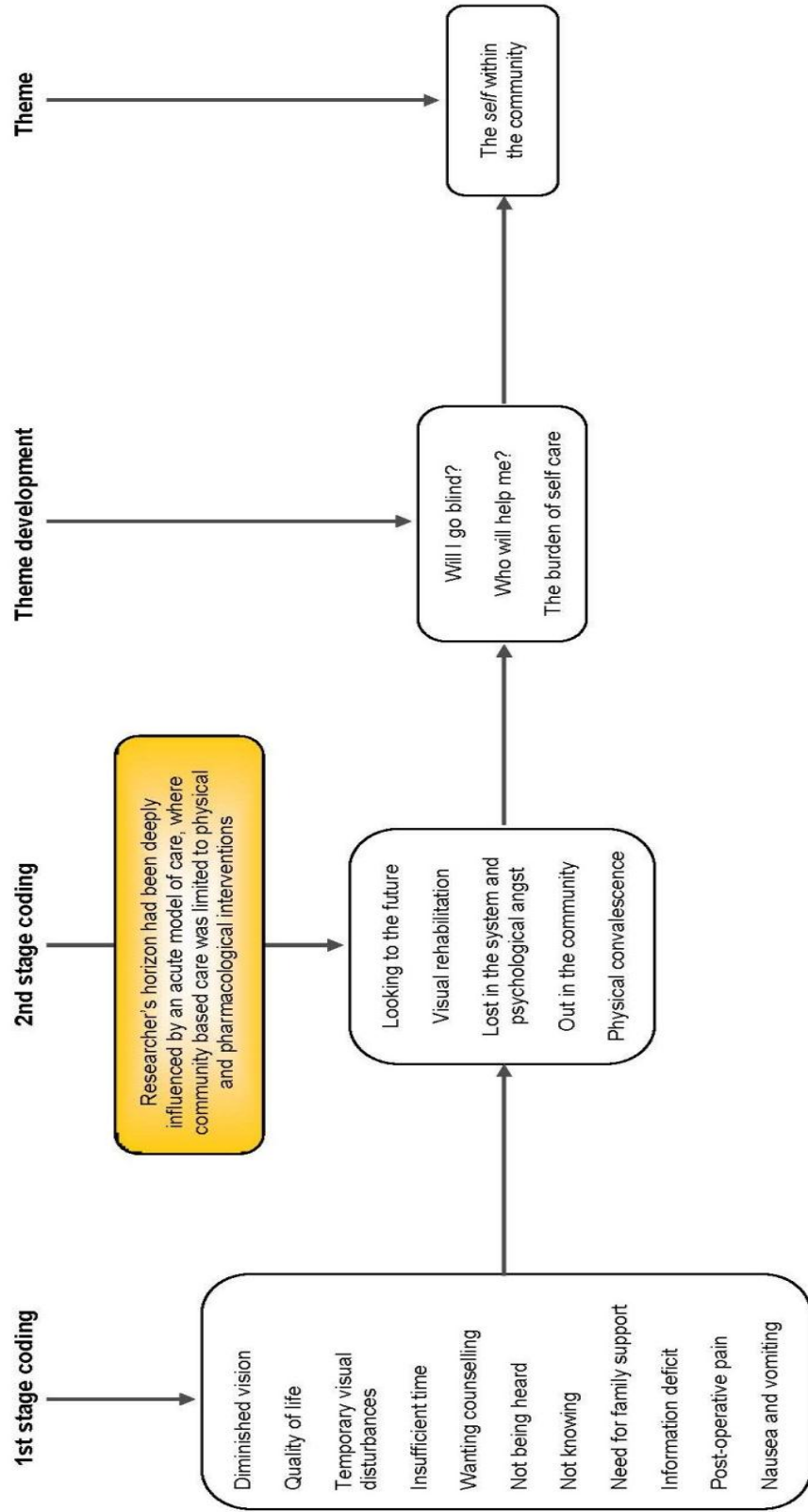
This subtheme development is obvious where past experiences were difficult and fairly recent. Such knowledge exerts a negative influence on the current experience and clearly contributes to both psychological and physical difficulties. Conversely, previous positive experiences assisted participants in dealing with the current episode of care. The following sections and chapters thoroughly explore the polarity of influence of the past experiences.

Figure 7.5 Segmental analysis of the data that led to identification of the sub-theme of the historically located self



The final identified aspect of *self* emerges from the participants' narrated experiences following discharge to community based self-care. Participants described difficulties not only during the immediate convalescent period but also at later stages, after the recovery was complete. They expressed inadequacies of the healthcare facility to meet or even recognise their need for psychological support, either through counselling or through effective communication with the clinic's healthcare workers. This concept (displayed as Figure 7.6) developed through recognising the participant's wider needs once interventional care had ceased. Coding for this sub theme includes coping with visual disability, not knowing, feelings of abandonment and issues related to quality of life.

Figure 7.6 Segmental analyses of the data that led to identification of the sub-theme of the self within the community



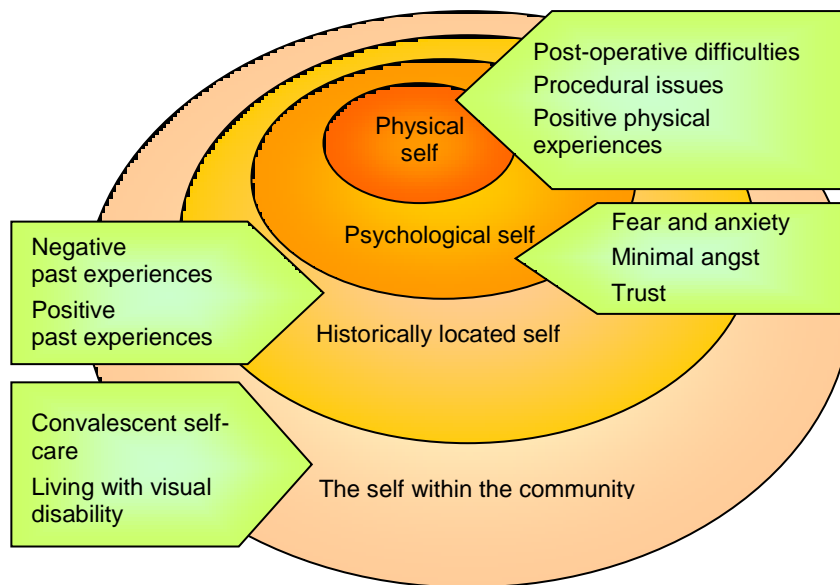


Figure 7.7 A representation of the holistic experience of V-R day surgery

The four themes described above relate to aspects of the human domain and are displayed in Figure 7.7 as parts of a whole. This figure shows aspects of the experience, including the subthemes with a clarified theme development. All themes and subthemes relate to positive and negative segments within participant narratives, a dichotomy which adds to the complexity of the understanding of this experience. In the next step of analysis, the words of the participants as exemplars will be used to provide clarity and authenticity to the thematic development that led to new understanding. Gadamer (1975, p. 291) believes that varying understanding is a result of a “fusion of horizons” between the text and the researcher. Hence, exemplars are important since they provide richness and detail to each subtheme’s development (a fundamental strength of qualitative research). When viewed as a whole, this results in a rich understanding of the phenomena.

#### **7.3.4 Phase 4: The words of the participants**

Exemplars (segments of participant experiences) are extracted from the data text, demonstrating similarities or contrasts between embodied experiences. Exemplars articulate the voice of participant experiences, which resonate with emerging themes. The horizon of the participant is highlighted through exemplars and is introduced into the hermeneutic circle, where what was unfamiliar or unknown becomes articulated. Subsequent understanding occurs through a fusion of the horizons between the researcher and participant.

The participants of this study were at various stages in their life histories of retinal pathology. The pathology ranged from less complex epi-retinal membrane or macula hole, to progressive diabetic retinopathy, to complex and recurrent retinal detachment treatments. The care provided to the participants was based on an acute model of care, evident in the focus on intervention and physical issues of pain management. This model of care displays increasing inadequacies, highlighted in the participants' narratives as the complexity of their pathology increased, visual acuity diminished and fear of blindness intensified.

The participants' experiences provided evidence that care provided by the healthcare facility focuses exclusively on the individual's physical needs. This emphasis on physical needs is consistent with the core concepts of an acute model of care, which is identified as the dominant model of care in today's hospitals (Hoffman 2001), a position consistent with the researcher's horizon. However, participants of this study articulated difficulties across multiple human domains and their experiences clearly demonstrate that an acute model of care (as practiced by the healthcare facility) fails to meet the complex needs of people with V-R conditions requiring day surgery.

At the less complex end of the pathology spectrum were Dorothy, Sarah, Harold and Tony, whose elective and less involved needs were well supported by the care provided.

Dorothy: *The first procedure ... I couldn't believe it was as good as it was* [Participant 11; line 246].

Sarah: *It [the surgical experience] has been marvellous* [Participant 15; Line 7].

Harold: *An operation for a hole in the back of the eye ... I didn't have any problems* [Participant 10; Line 230]

Tony: *I don't think that it [the experience of surgery] could be any better* [Participant 9; Line 293].

However, Felix, Bruce, Molly and Nick suffered increasing anxiety as a result of a sudden and unexpected loss of vision prior to the surgery, and the need for intricate surgical interventions.

Felix: *All this happened in the last month and a half ... to reattach the retina ... I was anxious ... it was quite painful* [Participant 12; Line 19].

Bruce: *My problem started three or four months ago ... the retina had come off ... I was absolutely terrified* [Participant 13; Lines 7-10].

Molly: *I was frightened because I didn't know what was going to happen* [Participant 16; Line 4].

Nick: *I had prolapsed [retina detached] I never recovered my vision ... I was in a desperate manner* [Participant 8; Line 364].

For John, Edgar, Albert, Fin, Sandra, Greta, Robert and Gunter, who experienced complex retinal pathology, multiple episodes of surgery were common to their ongoing treatment. Whilst they endured the difficulties of interventions and



convalescence, their ability to cope was undermined by a real fear of blindness and the long-term consequences of the surgery.

John: *I've had a long history ... it started in 1999 ... I've had three surgeries at ... prior to that I've had two other surgeries one in the UK and one in Darwin ... I wasn't really concerned about the operation; I was concerned about the outcome* [Participant 3; Lines 113-79].

Edgar: *31 years ago I had the first retinal detachment ... seven years later I had another one ... and I had another one then in between* [Participant 2; Line 85-6].

Albert: *Several years later [after the first episode], I suffered flashing lights ... the second time ... I'd been through it ... I was a bit worried about it, yes, because I rely on my eyes* [Participant 5; Lines 10-12].

Fin: *Going back over four years now ... after my third break I sensed that there was really no surety at all* [Participant 6; Lines 8-9].

Sandra: *If anything happened to your eyes you are in a dark world and I just couldn't imagine myself doing that* [Participant 17; Line 80].

Greta: *I had a detached retina 35 years ago in England ... if this one goes this one [other eye] is gone so I will be blind* [Participant 1; Line 32].

Robert: *Going back now 10 years ... The third time was even worse ... the retina did come off again ... you are not relaxed about anything* [Participant 4; Line 23, 29]

Gunter: *It started in 2001 ... after three months ... the retinas' gone again ... the sixth time ... I really thought, you know, it's going to work ... it was devastating* [Participant 7; Lines 22-24].

For participants Dorothy, Harold, Sarah and Tony, whose conditions required relatively simple and generally curative elective interventions, the emphasis on physical aspects of the surgery was a success. However, it was inadequate to meet the multiple and complex needs of the participants who had complex or ongoing retinal pathology.

Whilst the care provided by the healthcare institution to all participants emphasised physical needs, participant’s frequently described physical difficulties and felt that the psychological and broader self-care needs were largely neglected. The participants recounted problems that included pain, nausea, stress, anxiety, adjusting to disability, difficulty coping post-operatively and a fear of blindness. It became abundantly evident that the participants had multiple needs and that these needs were not recognised by the healthcare institution and, consequently, were largely unsolved. Figure 7.8 schematically represents all aspects of *self* evident in the participants’ narratives and displays the encounters between a surgical event and an aspect of *self*. Each of the identified aspects of *self* is discussed as a subtheme of this study through using the participants’ voices and experiences as evidence. The discussion will deconstruct the holistic understanding represented as Figure 7.8 into its constituent parts that are representation of an identified domain of the human *self*.

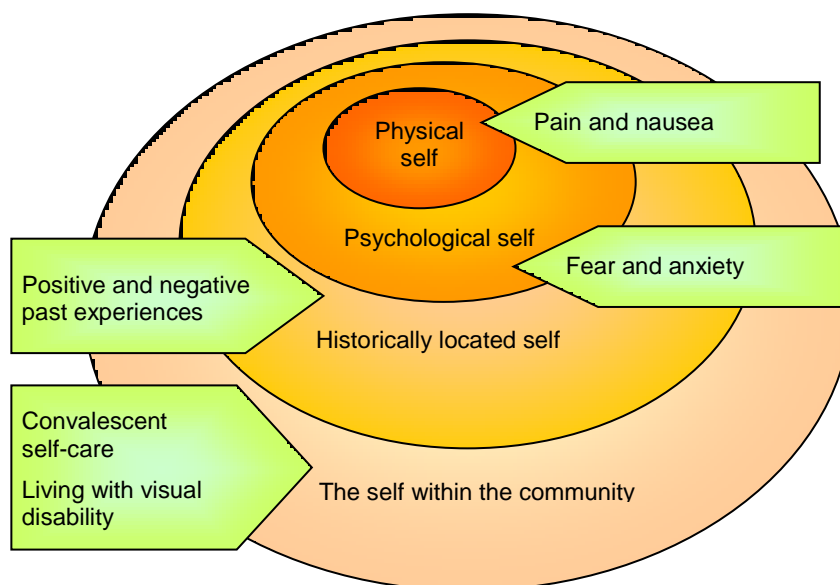


Figure 7.8 Identified aspects of *self* and the impact of an intervention

### ***Multiple experiences and holistic understanding-a hermeneutic event***

As the deconstruction of the participants' experiences unfolded, it became clear that there is heterogeneity across all domains of *self* in the experienced difficulties. Not all participants experienced a common pattern of pain, nausea or adjustment to visual disability. However, understanding occurred through a dynamic movement between the parts and the whole, consistent with Gadamer's (1975) hermeneutic circle. In this study, Gadamer's (1975) conditions of understanding the surgical intervention experience are established through in-depth engagement with the participants' narratives. This results in identifying aspects of *self* that are the constitutive elements of the whole. This identification commences with the physical *self*, as this is a prominent aspect of the participants' narratives and was consistent with the researcher's presuppositions' encouraged by the dominance of a biomedical emphasis in current acute care.

### **The physical self (subtheme)**

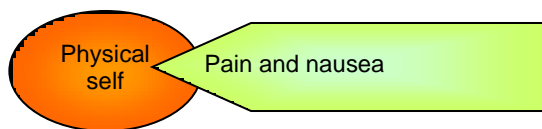


Figure 7.9 **The physical self**

An initial understanding of participants' experiences concerns the *physical self* and this focus is congruent with the dominant scientific influence on the researcher's horizon. The pre-operative preparations received by the participants emphasise the physical aspects of the surgery and anaesthetic. These preparations were varied and included a description of anaesthetic method, the need to lie still during awake surgery, the time and place of surgery, and the need to be accompanied home.

Instructions provided on post-operative care were limited to the possibility of pain on the night of the surgery, the necessity to be accompanied home and warnings not to drive or operate machinery. A contact phone number was provided in case the participant had difficulties that required medical advice.

These preparations were clearly inadequate, as the participants reported physical experiences that included pain, nausea and vomiting, which occurred at various stages of treatment and recovery. Pain experiences were evident during three distinct segments of care that included the anaesthetic, surgery and convalescence. The following sections convey the participants' experiences of each of these factors.

### **Pain in relation to the anaesthetic**

Pain was a common feature of the anaesthetic and was particularly difficult for Dorothy, Fin, Robert, Felix, Gunter, Sandra and Edgar:

Dorothy: *Yes it was well ... painful.* (Participant 11; Line 42)

Fin: *Gee those injections were nasty ... he said to me It's like someone gives you a kick in the ankle, that much pain. The pain is nothing to do with a kick in the ankle, I mean I've been kicked in the ankle and had needles in the eye there is no comparison* [Participant 6; Lines 108-9].

Robert: *The anaesthesia was probably the worst part for me* [Participant 4; Line 38].

Felix: *I knew what to expect with the needles in the eye ... it probably increases the anxiety because I knew what was coming* [Participant 12; Lines 53, 57].

Gunter: *The injections that you get in the eye ball that's the scary bit.* [Participant 7; Lines 73-74]

Sandra: *The pressure [in the eye] was a little bit daunting ... I was glad when it was over [the injection]* [Participant 17; Line 87].

Edgar: *I didn't think any of them have ever had an anaesthetic in your eye ... when they put the injections in I nearly squeezed the nurse's hand off* [Participant 2; Line 308-9].

### **Pain and the surgery**

Most of the participants found surgery to be generally pain-free. However, Greta, Felix, Sandra and Robert experienced suffering:

Greta: *It was quite unpleasant; it wasn't a very pleasant operation if you spend three hours on your back* [Participant 1; Lines 22-23].

Felix: *Unfortunately she didn't give me enough [anaesthetic] and it was quite painful during the surgery* [Participant 12; Line 37].

Sandra: *It was a bit hard on your back because you have to lay still for a very long time* [Participant 17; Line 222].

Robert: *There was a bit of shock you know, I was sort of shaky and very clammy and I wasn't a happy chappie* [Participant 4; Line 108-9].

### **Pain and convalescence**

The physical aspects of convalescence were troublesome for Albert, Robert, Gunter, Sandra and Felix:

Albert: *Yes it was painful ... I was willing to bear with it [the eye pain]* [Participant 5; Line 176].

Robert: *I was in a fair bit of pain and I was taking some fairly heavy pain killers* [Participant 4; Line 114].

Gunter: *The pain behind the eye was just unbearable* [Participant 7; Line 222].

Sandra: *It was very, very uncomfortable ... it was very painful [pain on the night of the surgery]* [Participant 17; Lines 24-25].

Felix: *I think that because of the pain in the eye it took longer for me to recover* [Participant 12; Line 124].

### **Pain-relief strategies**

Following surgery, participants were provided with either medications for pain relief or prescriptions for pain-relief medications. Instructions were provided on the frequency of administering medications. Several participants felt that the medications were inadequate to provide relief from pain and they suffered moderate to high levels of pain. Felix, Robert, Gunter, Edgar, Greta, Sandra and Nick experienced significant and unrelieved pain following discharge from the healthcare facility. Robert, Gunter and Greta returned to the healthcare facility on the night of the surgery due to inadequate pain management.

Felix: *The pain relief was not effective ... wasn't adequate* [Participant 12; Line 133]

Robert: *I had the pain I had a fair bit of pain ... I had to go back to casualty* [Participant 4; Line 121].

Gunter: *We rang a doctor and emergency ... they gave me morphine to kill the pain but it doesn't touch it* [Participant 7; Lines 213-214].

Edgar: *It was mainly pain because of the pressure* [Participant 2; Line 183].

Greta: *I never slept for about five nights with the pain* [Participant 1; Line 216].

Sandra: *It really was ... it was very painful* [Participant 17; Line 24].

Nick: *I felt really bad it was really painful [the eye]* [Participant 8; Line 399].

### **Nausea and vomiting**

The physical distress of pain was frequently compounded by nausea and vomiting, and despite significant understanding in medical literature regarding the high incidence of PONV, no anti-emetic medications were provided. Felix, Greta, Robert, Gunter and Bruce experienced difficulties with nausea and vomiting during their immediate convalescence.

- Felix: *My level of nausea could not have been any worse, I don't believe, especially the morning after. I think we stopped at least three times on the way to the hospital for me to vomit and one time on the way home* [Participant 12; Lines 156-8].
- Greta: *I was sick for five days* [Participant 1; Lines 118].
- Robert: *I was very nauseous ... I had to go back to casualty on a Saturday because the pain and the nausea was really over the top* [Participant 4; Line 119-20].
- Gunter: *I was sick I passed out ... and that happens every time I'm sick and I pass out at the same time* [Participant 7; Lines 126-7].
- Bruce: *I went home and was quite ill to the point where I was almost ringing for an ambulance to be brought back* [Participant 13; Lines 156-7].

There is clear evidence of the physical difficulties experienced by the participants. This was particularly common in cases of complex surgery or previous unsuccessful surgery, suggesting an inter-relationship of physical symptoms with psychological stress. This inter-relationship of the physical and the psychological is the basis of this study's second subtheme, which specifies the participants' psychological needs.

## The psychological self (subtheme)

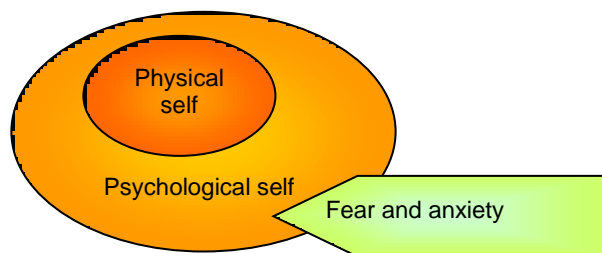


Figure 7.10 V-R day surgery and the psychological self

As the deconstruction of participants' narratives continued, it became obvious that the impact of interventions on their *physical selves* was but one part of their

experiences. From this point on, the researcher's presuppositions were discarded and an encounter occurred with the broader life-world of the participants' experiences. The unfolding stories and frequency of experiences support the proposition that surgical intervention for a sight-threatening condition significantly affects the participants' *psychological self*.

The relationship between the *psychological self* and a threat to sight is evident in the anxieties expressed by the participants. The frequency of this effect supports the development of this study's second subtheme. Psychological issues are evident for almost all participants and concur with findings in literature regarding the value people place on visual ability.

### **Fear, sudden vision loss and the psychological self**

Emergency ophthalmic procedures are often preceded by a sudden and severe loss of vision, and participants who experienced this reported fears of potential blindness. Table 7.3 displays the participants' visual acuity of the operated eye prior to surgery and highlights the degree of pre-operative vision loss experienced by emergency participants. Optimal visual ability is defined as 6/6 (ability to read the sixth line of a Snellen chart at 6 metres), whilst 6/60 is the current legal definition of blindness. "Count Fingers" refers to the inability to see the letters on a visual acuity chart while being able to see fingers held within 60 cm from face. "Hand movements" is the ability to detect hands waving in front of the face; "no perception of light" is an eye that is considered totally blind (Vaughan 1999, p. 30).



**Table 7.3 Participants and pre-operative visual acuity and elective/emergency status**

<b>Participant</b>	<b>Visual acuity of operated eye prior to surgery</b>	<b>Visual acuity in fellow eye</b>	<b>Surgery status</b>
Greta	Count fingers	6/9.5	Emergency
Fin	6/24	6/7.5	Emergency
Felix	Count fingers	6/24	Emergency
Gunter	Count fingers	6/6	Emergency
Bruce	Hand movements	6/6	Emergency
John	6/60	6/10	Emergency
Robert	No perception of light	6/9.5	Emergency
Albert	Count fingers	6/6	Emergency
Edgar	Hand movements	6/6	Emergency
Tony	6/9.5 with field loss	6/9.5	Emergency
Harold	6/15	6/9	Elective
Nick	6/15	6/12	Elective
Dorothy	6/18	6/18	Elective
Rita	Count fingers	6/9	Emergency
Sarah	6/15	6/18	Elective
Molly	6/15	6/15	Elective
Sandra	6/36	6/9	Emergency
Adriana	Count fingers	6/12	Emergency

Sudden, unexpected vision loss is an anxiety-producing experience sustained by a fear of blindness and the fear that surgery might not be successful in restoring vision. Such vision loss had occurred for Bruce, Edgar, Albert, Gunter, Rita and Adriana, who detailed sudden vision loss and fear of blindness.

### **Sudden vision loss**

Bruce: *I went blind in that eye completely blind; it scared the daylight out of me [Participant 13; Line 10].*

Edgar: *I was actually driving to work when it [loss of vision] happened and it went black [Participant 2; Line 262].*

- Albert: *I suffered flashing lights and things ... something had happened I was having all these lights and all flashing going on and I thought I don't know what's going on ... I had lost vision in that eye I was a bit worried about it ... because I rely on my eyes [Participant 5; Lines 10-11,21].*
- Gunter: *I was just driving home ... when I saw this fireworks in the eye it ... sort of went all cloudy I thought ... there's something wrong with the eye. You have no idea how you feel, [when the surgery fails] your world [Participant 7; Lines 22-23].*
- Rita: *I lost vision all of a sudden [Participant 14; Lines 33].*
- Adriana: *I put my hand over my right eye and I couldn't see anything ... how it was going to end up that was the thing [Participant 18; Line 11].*

### **Fear of blindness**

- John: *I wasn't really concerned about the operation I was concerned about the outcome [Participant 3; Line 113].*
- Fin: *I really did have the fear that I would go blind in that eye and as my other eye is not that great either you sort of had that sense that perhaps further down the line I might actually may be blind. I found the experience, well, it was frightening [Participant 6; Lines 367-9].*
- Robert: *A lot of people have only got one eye, I know that, but when you've had something done to that one eye if nothing had ever been done to that left eye, if I had never had a problem with that left eye ... you are not relaxed about anything ... I'd be a lot more content, put it that way [Participant 4; Line 559-62].*
- Greta: *Well, if this one goes, this one [other eye] is gone so I will be blind which wouldn't be funny [Participant 1; Line 372].*
- Nick: *I wouldn't like to lose my vision and now I know how valuable the vision is ... just imagine you lose your eye or your vision, I don't want to be there [Participant 8; Lines 374-5].*
- Molly: *It frightened me ... if I hadn't had it done [the eye surgery] I probably would have lost my eye sight [Participant 16; Lines 34-37].*
- Sarah: *I was so worried ... I thought, oh God, I'm going to lose the sight of my eye [Participant 15; Line 107-8].*

Sandra: *If anything happened to the eyes you are in a dark world and I just couldn't imagine myself doing that* [Participant 17; Line 80].

Participants' experiences make it clear that those who required emergency surgery suffered significant vision loss prior to surgery (see Table 7.3). Sudden vision loss is a frightening event that engenders considerable fear of blindness and compounds the participants' issues regarding "awake" retinal surgery. Fear and anxiety was evident in the voices of Felix, Nick, Albert, Bruce, Gunter, Fin, and Robert.

### **Fear and anxiety**

Felix: *I was a bit anxious* [Participant 12; Line 56].

Nick: *I was terrorised* [Participant 8; Line 53].

Albert: *I don't know what's going on* [Participant 5; Line 77].

Bruce: *I was absolutely terrified* [Participant 13; Line 109].

Gunter: *It got me real emotional* [Participant 7; Line 255].

Fin: *Oh, I was frightened; there is no doubt about that. It wasn't a matter of just being just a little apprehensive like ... that's a nice way of putting it* [Participant 6; Lines 43-4].

Robert: *I was apprehensive ... I was very, very uptight* [Participant 4; Line 223].

Fear and anxiety are silent associates of the participants' surgical events and are largely unrecognised by attending healthcare professionals. Fear exacerbates anxieties and contributes negatively to an already strenuous experience. This aspect was particularly evident among participants who had previous treatment failures or endured sudden and unexpected vision loss prior to surgery. Participants Fin, Bruce, Greta and Adriana reported feelings of being unable to cope with the emotional stress

of their condition and surgery, and their disappointment that their needs for psychological help were not met.

Fin: *All I wanted really was just sort of to have someone there who could answer questions, it just would have taken just a few seconds just to listen and take the time* [Participant 6; Lines 179-81].

Bruce: *I went through the lot, with no-one to talk to ... I found out that there is really no one out there to counsel you* [Participant 13; Lines 231-33].

Greta: *Nobody helped me ... I had to cope with that ... [the surgery]. Nobody in the hospital could advise me* [Participant 1; Lines 153, 408].

Adriana: *They [the staff] were so busy that it's hard to talk to anybody* [Participant 18; Line 125].

Interventions addressing psychosocial factors have been demonstrated to improve adaptation to illness and to strongly influence coping abilities (Gan 2007). However, the interventions provided to this study's participants were largely ineffective or inappropriate and were mostly concerned with providing pre-operative information regarding the surgery and disease process.

### **Anxiety reduction strategies – pre-operative information**

In the past, the preparation of patients for surgery by providing detailed information had been accepted as a legitimate strategy for stress and anxiety reduction (Mitchell 2002). However, participants of this study described significant variation in their pre-operative information requirements. This evidence concurs with the findings of recent studies, which reveal that information provision alone does not always result in anxiety reduction (Mitchell 2002). Participants Dorothy, Gunter, Felix, Adriana, Robert and Molly expressed a very limited need for detailed information regarding the surgery.

Dorothy: *I didn't really want to know a great deal about it.* [Participant 11; line 54]

Gunter: *Actually I didn't want to know anything ... I think I knew enough ... I didn't want to know any more because it was scary enough as it was ... So if you get any more, yeah, you freak out* [Participant 7; Line 302].

Felix: *Having any more information I don't think would have helped me* [Participant 12; Line 101].

Adriana: [the provision of more information] *no I just wanted to get it done* [Participant 18; Line 55].

Robert: *I guess the answer to a lot of that [information regarding the surgery] is it would frighten the living daylight out of you* [Participant 4; Line 399-400].

Molly: *I don't think I wanted to know ... if they told you too much you could ... think what are they doing to my eye now ... I don't think I want to know ahead of the surgery* [Participant 16; Lines 104-8].

In contrast, Edgar, Albert, Bruce, Fin, John and Greta wanted detailed information and technical knowledge regarding most aspects of the surgery. Edgar and John actively sought detailed knowledge and were satisfied with the information they received.

Edgar: *Well, I asked them first off, you see, I said what are you going to do and they said anaesthetise your eye and put three holes through and then we put probes inside the hole. One's got a suction thing on it and one has a light and another one has nippers so they can clean the eye up around in there, the retina, and we will extract all the fluid and vitreous from it and then we'll laser and then we will pump the oil back in there and should be alright* [Participant 2; Line 294-98].

John: *With all the surgeries that I've had I've been adequately briefed beforehand. It's been fully explained what the procedure is going to be and what after effects there might ... I think I really came away from all of them not having any great worries or concern* [Participant 3; Lines 52-55].

Greta, Bruce, Albert Fin and Nick wanted detailed information regarding their retinal condition and the surgery, but did not receive it, which did little to relieve their anxiety.

Greta: *I could have done with more. ... I like to know things. I'm not one of those people who have to be kept in the dark I like to know things [Participant 1; Lines 277-8].*

Bruce: *I've found that if I don't ask a direct question I don't get told anything and when you're going through this you don't know what questions to ask [Participant 13; Lines 383-4].*

Albert: *When I came out from surgery ... I want a sheet explaining all this to me because I don't understand what you are talking about, But once I got the diagrams I could understand it [Participant 5; Line 47].*

Fin: *Yeah, I believe I could have had a little more information on what was actually happening [Participant 6; Lines 31-33].*

Nick: *I didn't ask, I probably didn't have enough explanation of what could happen or what could be done ... I mean there's no point in asking if I didn't know what I should ask [Participant 8; Lines 351-53].*

The provision of pre-operative information as an anxiety reduction strategy was inconsistent and inadequate. The participants' need for information was not assessed and care was not individualised to meet their personal coping styles. A lack of psychological care sensitised to the individual needs caused ongoing uncertainty and anxiety.

Physical, emotional and psychological stress is a known consequence of illness, particularly for ongoing conditions that require multiple surgical interventions.

Stressful physical and psychological events are thought to be buffered by the individual's spirituality, which helps individuals make sense of such events (Mishel

1988). Whilst the spirituality of this study's participants' was not actively explored, it holds an undeniable position and influence in the wholeness of a lived life.

### *Spirituality*

Spirituality has been described as the essence of a human life that synergistically energises and enlivens all other dimensions of existence (Villagomez 2006). Further evidence of the pervasive influence of science and technology is provided by the non-acknowledgement of participants' spirituality in relation to their experience of a sight-threatening condition, as no understanding of this aspect of their experiences was investigated. A dominance of the values of objectivity, causality and impartial observation continues despite Kubsch et al.'s (2007) description of an emerging healthcare paradigm shift, from a reductionist view of healthcare to an "empowering and spiritual healing" philosophy that emphasises a connection between the body, mind and spirit. Given that spirituality can be defined; as a search for meaning (Harrington 2012), a number of participants described a deep connection between the meaning of the experience and the mind and body. This connection was most evident in the following excerpt from Gunter, where the meaning of losing vision was clearly evident.

Gunter: *...the 6th time that my retina was gone you have no idea how you feel your world just collapses its really devastating the effect it has on you like how can you protect your eyes no matter what I did how do you keep your eyes well once there gone there gone and once there gone you realize how much you miss them how precious they are...[Participant 7; Lines 342-350].*

An acceptance and understanding of the mind-body-spirit connection assists in facilitating a post-modern holistic model of care that values individuality, complexity

and subjectivity of personal experiences (Kubsch et al. 2007). Care that is cognisant of the connection between meanings ascribed to an event and quality of life offers a sensitivity to the deeper needs of individuals that extends well beyond the physical aspects of an illness event. Whilst this study does not explore the *spiritual self*; the success or failure of earlier procedures clearly contributed to participants' anxiety. Furthermore, it was often the nature of the previous experience (either good or bad experience) that played a crucial role in participant's ability to cope with further surgery. These previous events and the deterministic influence they exerted (both positive and negative) became the basis of the third subtheme.

## The historically located self (subtheme)

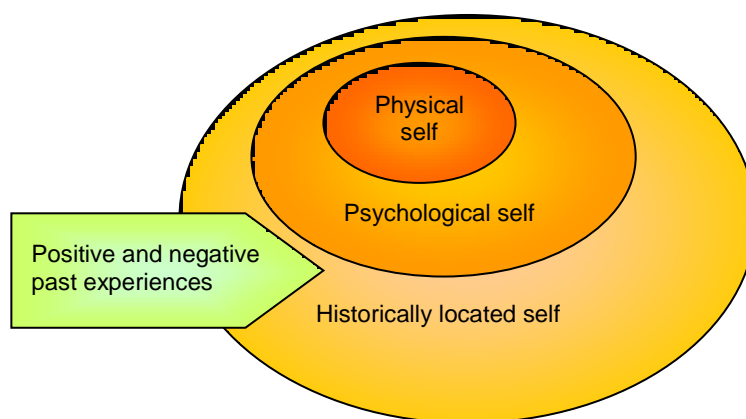


Figure 7.11 V-R day surgery and the historically located self

The inter-relationship between the surgical intervention and the *self*-located in past experiences is identified as an important subtheme. This theme recognises the powerful influences exerted by past surgical events on participants' most recent experience. Gadamer (1975) believes that our past experiences are the lenses and filters through which we interpret our world and the participants make it clear that past surgical encounters significantly influenced their current experiences. Gadamer



(1975b, p. 305) claims that ‘the horizon of the present cannot be formed without the past’.

As this researcher grew deeply immersed in participants’ stories, it became abundantly clear that some coped very well with the surgery and convalescence while others did not. The articulation of the participants’ fears and anxieties added a significant depth to understanding, and helped explain some of the variations between experiences. However, substantial and unexplained anomalies between experiences continued to emerge. The perplexing variations resulted in a search for understanding beyond the immediacy of most recent eye surgery experiences and insights were found within antecedent surgical events. The following subtheme explores these insights.

### **Historocity**

Many of participants in this study had endured multiple surgical events over several years. Table 7.4 displays the time span and the number of previous procedures encountered by the participants. This table provides clear evidence of the life-spanning natures of the participants’ retinal conditions. Whilst not all participants had experienced long term pathology, the potential for this existed. Information regarding previous experiences was available in medical records, as well as in the responses volunteered by participants as accounts of their illnesses. However, the experiences described by participants supply little evidence that their past experiences were valued in the development of their care.

**Table 7.4 Time trajectory of V-R pathology and participants of this study**

<b>Participant</b>	<b>Number of previous eye surgery events</b>	<b>Eye pathology</b>	<b>Time span from first retinal event</b>
Greta	2 retinal detachment repairs	Retinal detachment	35 years
Edgar	4 retinal detachment repairs + 2 cataract surgery	Recurrent retinal detachment	31 years
John	6 retinal detachment repairs	Recurrent retinal detachment	10 years
Robert	3 retinal detachment repairs	Recurrent retinal detachment	10 years
Albert	2 retinal detachment repairs	Recurrent retinal detachment	10 years
Fin	4 retinal detachment repairs	Recurrent retinal detachment	7 years
Gunter	6 retinal detachment repairs	Recurrent retinal detachment	6 years
Nick	2 cataract surgery + 1 retinal detachment repair	Post-cataract retinal detachment	1 year
Tony	2 Vitrectomy for vitreous haemorrhage	Diabetic retinopathy	1 year
Harold	2 cataract surgery + 1 Macula hole repair	Macula hole	< 6 months
Dorothy	2 macula hole repair	Macula hole	< 6 months
Felix	2 cataract surgery + 1 retinal detachment repair	Post-cataract retinal detachment	< 6 months
Bruce	No previous eye surgery	Retinal detachment	< 6 months
Rita	Previous cataract surgery	Retinal detachment	< 6 months
Sarah	2 cataract surgery + 1 diabetic retinopathy	Diabetic retinopathy	1 year
Molly	2 cataract surgery + 1 retinal detachment repair	Retinal detachment repair	< 6 months
Sandra	Macular hole surgery	Retinal detachment surgery	1 year
Adriana	No previous eye surgery	Retinal detachment repair	< 6 months

The participants' descriptions make it obvious that previous surgical experiences (both positive and negative) influenced every aspect of their current perceptions. Positive previous surgical events helped assuage anxieties and facilitated individual coping, while negative surgical events compounded anxieties and undermined coping ability. Furthermore, a failure to locate participants within the trajectory of their condition caused inadequacies of care and insensitivity to their individual experiences. The next section explores how past experiences influence their ability to

cope, commencing with positive experiences and followed by an in-depth description of the influence of negative experiences.

### **Positive past influences**

Past surgical experiences helped Dorothy, Harold, Felix, Nick, Sarah and Sandra to cope with the physical difficulties of retinal surgery.

Dorothy: *It wasn't difficult as much as painful ... I had three children, a couple of hip replacements, so I got through that okay.* [Participant 11; Line 42]

Harold: *You see, I've had my heart bypasses and that there's nothing as sore as that ... And I think when you've had that well you don't feel very much, well you feel alright, you know* [Participant 10; Lines 210-11].

Felix: *That part of it I had no issues at all because I already had the cataract surgery, I knew what to expect* [Participant 12; Lines 53-4].

Nick: *I realised that it wasn't that bad so that was the first time. The second time ... I didn't need any help or any assistance* [Participant 8; Lines 55-57].

Sarah: *Oh, I think it made it easier* [having had previous eye surgery] *I knew what was coming* [Participant 15; Line 47]

Sandra: *I think it made it easier* [the second surgery] *because I knew what to expect* [Participant 17; Line 91].

### **Negative past influences**

The participants provided vivid descriptions of negative past experiences, particularly in relation to pain with the anaesthetic. Fin, Robert, Felix, Molly and Gunter, who had experienced emergency surgery, endured issues in coping with the eye block. As a consequence of their painful first experiences, repeat occurrences of the eye block became increasingly difficult.

- Fin: *I did find it harder as I went along because what happened the first time ... it erodes your self-confidence and I guess your ability to cope a bit* [Participant 6; Lines 107-10].
- Robert: *The second episode it was more traumatic because I knew what was coming* [Participant 4; Line 72-3].
- Felix: *I knew what to expect ... it probably increases the anxiety because I knew what was coming* [Participant 12; Line 55].
- Molly: *I think I was more nervous because I knew what was coming* [Participant 16; Line 18].
- Gunter: *That's the scary bit ... I know what's coming* [Participant 7; Lines 74, 79].

Previous surgery also played a role in influencing the participants' current expectations. Edgar and Greta received eye surgery more than 30 years ago and their memories of past experiences influenced their expectations of current treatments.

- Edgar: *What happened with me 31 years ago ... when I had my first operation on my eye I spent 10 days in hospital there* [Participant 2; Line 254-55].
- Greta: *I had had a detached retina 35 years ago in England ... the first day after the operation you should stay in the hospital* [Participant 1; Line 460].

The need for repeat eye surgery is never predictable and, because of this unpredictability and the influence exerted by past experiences, effort needs to be made to ensure that the first surgical episode is as anxiety and pain-free as possible. The unpredictability is identified in the narratives of Robert, Fin and Gunter.

- Robert: *Nobody knew I was going to go back three or four times ... and things just seem to go from bad to worse* [Participant 4; Line 324-5].
- Fin: *You're told that you've got a very good chance [of success] and then they say well we've put oil there now, that'll hold on the retina and it doesn't ... I guess you think well how far this will go* [Participant 6; Lines 123-5].

Gunter: *You know you hope that everything goes well and I thought that it did after the three months ... the sixth time that my retina was gone you have no idea how you feel; your world just collapses; it's really devastating the effect it has on you [Participant 7; Lines 437-440].*

Previous experiences exert a strong influence on all phases of the participants' retinal surgery, including pre-operative, anaesthetic, surgical and convalescent periods. Fear, pain and anxiety are common features of influential negative past experiences. The features of positive past experiences include reduced anxiety and increased coping abilities. The effects of past experiences, psychological distress and physical difficulties coalesce at the time of surgical intervention; hence, the participants' need for support is at its highest. However, during this period, most support services provided by the healthcare facility were withdrawn with convalescent care being deferred to the patient's family and community. The fourth and final subtheme examines the participants' experiences of self-care in the community.

## The self within the community (subtheme)

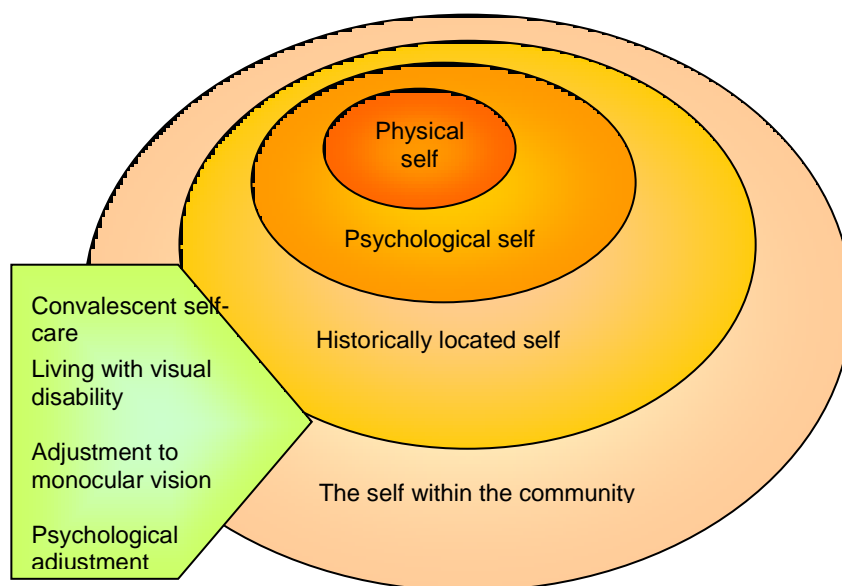


Figure 7.12 V-R day surgery and the self within the community

Whilst the previous subthemes explicate the influence of interventions on the individual, the fourth and final subtheme describes the impact of interventions on the *self within the community*. A salient feature of day surgery is the devolution of convalescent care to self-care in the community, external to the healthcare facility. The success of this devolution varies amongst the participants, with many experiencing significant difficulties during this time. This theme encompasses not only the time of self-care immediately following the surgery but also the long-term experiences of an ongoing retinal condition.

### **Community self-care and convalescence**

Discharge to community self-care following an episode of surgery is a prominent aspect of day-case surgery. This model relies on families and communities to carry the burden of convalescent care, as well as on the assumption that the healthcare institution would facilitate the transition of care through careful planning and supportive strategies. Supported care is required not only during the immediate convalescence but also throughout the period of visual rehabilitation.

Many participants of this study encountered physical and psychological difficulties during self-managed convalescence and rehabilitation. Numerous problems experienced by the participants may have resulted from inadequate support and preparation by the healthcare facility. Greta, Robert, Gunter, Sandra, Bruce and Felix revealed that the night following surgery and the ongoing convalescent period to be a difficult time. Post-operative complications of pain, nausea and vomiting for Robert, Greta and Gunter resulted in them seeking assistance from an emergency department or local doctor.

Reliant on only her elderly and dependent husband for support, Greta found the first post-operative night extremely difficult. As the pain became severe late in the evening, she called an ambulance to take her to the hospital.

Greta: *I went there by ambulance ... they gave me was a couple of pain killers ... I was sick for five days and I vomit ... a terrible time when I got home* [Participant 1; Lines 77-79].

Robert and Gunter also had difficulties with pain and nausea following surgery, which required them to return to the hospital for assistance.

Robert: *I had to go back to casualty ... because the pain and the nausea was really over the top* [Participant 4; Line 122-3].

Gunter: *It was that bad the pain behind the eye ... we rang a doctor and emergency ... I stayed in for three days* [Participant 7; Lines 212,217].

Bruce's difficulties were exacerbated by being alone on the first night after surgery, as he had no-one to support him.

Bruce: *I went home and was quite ill to the point where I was almost ringing for an ambulance to be brought back. It was explained ... that I would be by myself because I've got no-one ... and we were hoping that ... they'd keep me in overnight just to make sure I was OK* [Participant 13; Lines 156, 166].

Felix experienced a high level of pain and nausea in the days following surgery and, despite having a supportive wife, he had significant difficulty coping.

Felix: *My level of nausea could not been any worse I don't believe, especially the morning after* [Participant 12; Lines 156-157].

Sandra had experienced two episodes of surgery in rapid succession. Her post-operative recovery was marked by significant pain that left her debilitated for up to three days.

Sandra: *I have to say that the first 48 hours were painful ... the medications had morphine in them and they made me feel a bit nauseated* [Participant 17; Line 33].

In contrast, John, who had experienced multiple surgical interventions over several years, had few post-surgical difficulties. John attributed his uneventful recovery to the good care and support that he received from his wife, and to the good relationship he shared with the surgeon. John also had the support of his anaesthetist who lived next door and was available for assistance.

John: *I think that in day surgery it is absolutely essential that you have a partner or somebody else in the house who understands what it's about and who is prepared to provide the immediate after care. I find the surgeon that I have there ... excellent ... We get on quite well and sort of understand each other* [Participant 3; Lines 42-44, 74-76].

John's experience highlights the positive effect of having professional help and advice readily available during what may be a difficult post-operative recovery. The complexity of John's latest surgery lends itself towards a difficult and painful recovery. However, he was fortunate to have the close support of his anaesthetist and wife, which exerted a positive influence on his convalescence. Albert also had professional support as his wife was a registered nurse and, whilst he did suffer post-surgical pain, he coped well at home. The reassuring presence of a professional health worker was also evident in Sarah's experience. Her daughter was a registered nurse and Sarah felt reassured that she could obtain advice if necessary.



Sarah: *My daughter's a nurse so I could ring her up at any time and talk to her, it was reassuring just to be able to tell Susan [daughter] about it [the surgery] [Participant 15;Line 98-99].*

Convalescence following retinal surgery usually takes many months. During this time, participants facing uncertain visual outcomes need support and advice from the clinic. However, participants who sought assistance from the clinic experienced difficulties in accessing help. During their convalescence, Fin and Albert endured issues that required expert advice, which they requested from the healthcare facility.

Having experienced a number of retinal detachments, Fin was well aware of the symptoms of a re-detachment. However, staff in the health care facility did not trust his experience and met his concerns with disbelief.

Fin: *He [the registrar] just didn't believe me ... I spent a pretty stressful couple of days ... before I got in ... And then they believed me that it had broken again ... I thought I could trust him and that he could trust me that I wouldn't call him up unless it was something urgent [Participant 6; Lines 124-6].*

Albert also experienced a re-detachment, which he recognised from previous symptoms and his experience with the clinic staff was similar to Fin's.

Albert: *When you've rung up several times and said look I've got dark patches and its getting dark ... and they said don't worry about it you've got an appointment ... by the time I got in there I couldn't see a thing through that eye ... I don't know whether they thought I was dreaming ... it wasn't taken very seriously [Participant 5; Lines 239-241].*

An eye infection following surgery caused Nick considerable pain and anxiety.

However, his efforts to gain help from the clinic were futile and he eventually sought help from his local doctor.

Nick: *I felt really bad ... it was really painful, it was stressful and then I kept ringing and the answer was on the phone that is very common ... I didn't get better I had fever and ... it was very painful I couldn't even open my eyes ... I couldn't hold out any longer so I went to see my local doctor ... he immediately rang up the medical centre and said this patient required attention immediately [Participant 8; Lines 396-400].*

The above experiences illustrate some of the problems encountered by the participants when seeking the advice and help of clinical experts with knowledge and understanding of their conditions. Their experiences explicate the barriers to care of overcrowded clinics and the patient's displacement as the centre and provider of information. Both barriers are symptomatic of economically constrained care and display the patient's displacement from the centre of a healthcare continuum.

Whilst V-R surgery is an outstanding success in terms of treating retinal pathology, a number of participants struggled with a difficult convalescence, a diminishing visual ability and a need for care that extended well past the convalescence period. The trajectory of their individual V-R conditions encompasses a few months to many years and, for some, will continue across their life span. Despite the obvious chronicity of their illnesses, their care was fragmented and episodic, failing to encompass the broader concerns of living with an ongoing and potentially disabling illness. There is an absence of aspects of care for people with ongoing conditions, which include psychological adjustment to disability and engagement with community resources. This resulted in difficulties in their long-term convalescence and recovery. Whilst a good visual outcome is recognised for many patients requiring V-R day surgery, particularly if the underlying pathology is a retinal detachment, this is not always the case. The following section analyses the life-world

effect of failed surgery or ongoing degenerative conditions that result in visual disability.

### **Adjustment to a life spanning V-R condition**

Adjustment to an ongoing condition is a dynamic process that unfolds over time and extends across multiple life domains (Stanton, Reveson & Tennen 2007). It is essential that a healthcare institution provides supportive strategies to patients who are adjusting to an ongoing illness. The participants of this study, who displayed a life spanning condition, experienced little evidence of ongoing support or strategies that extend beyond preserving functional status through disease monitoring and interventions. Issues of adaptation to visual disability, psychological stress and counselling regarding quality of life perceptions were inadequate or non-existent. This lack of support significantly hindered the participants' adaptation to living with an ongoing retinal condition.

### **Adjustment to monocular vision**

The loss of vision in one eye causes difficulty with depth perception and complicated daily tasks for the participants of this study. Bruce, who suffered abrupt and irreversible vision loss, had particular troubles coping with sudden monocular vision.

Bruce: *I've learnt to do a lot of things by experience, knocked myself out once, walked into a pole ... People keep walking up to me ... on my blind side and I'd never know they were there and the number of times I actually walked into people is unbelievable. I keep knocking things off ... Y' know like that cup of coffee there, I know it's there but I can't see it [Participant 13; Lines 390 394].*

Dorothy, Robert and Greta also experienced problems with adjustment to monocular vision.

Dorothy: *I didn't realise that when you can only see with one eye your balance isn't good. Judging a distance isn't good ... we weren't aware that was going to happen.* [Participant 11; Line 338]

Robert: *The biggest problem I have is gauging depth or distance particularly when its close ... when I have to pour out a cup of coffee I will get the coffee and lift it up and see how much I've got ... Actually I rest a bottle on the glass on the lip ... It's the fine work I find a bit harder to do* [Participant 4; Line 579-80].

Greta: *For the first time in my life I had to use a stick to go for my walk* [Participant 1; Line 467].

The physical aspects of diminishing vision compound the psychological anxieties associated with losing the precious sensory function of vision. The participants in this study expressed issues in coping psychologically with their changing health status.

### **Psychological adjustment**

The literature informs us that people with visual disability experience a loss of valued daily functions, often suffering depression, anxiety and anger. These emotions are evident in several of the participants' stories. Participants Finn and Bruce expressed thoughts and fears that their quality of life would diminish or had diminished as their visual disability increased.

Fin: *So it was almost like, well, I can sit down in a nice arm chair and stay there for the rest of your life sort of thing* [Participant 6; Lines 315-6].

Bruce: *Well I thought, well I not supposed to do anything but sit down and lie down. I mean well that's not much of a life* [Participant 13; Lines 652-3].

Participants Robert, Gunter, Bruce, Greta and Felix recounted feelings of depression and increased anxiety at their diminishing vision and possible loss of quality of life.

- Robert: *There was a period through it all when I was sort of thought, oh, you know woe is me, woe is me* [Participant 4; Line 573-4].
- Gunter: *I cried and cried: that the sort of effect it had on me* [Participant7; Line 72].
- Bruce: *I don't know whether I'm more susceptible or I was I thought I could handle things fairly readily and I ended up, I don't know, I've never done this before but I ended up going a buying a bottle of whiskey and I got drunk one night* [Participant 13; Lines 250-1] .
- Greta: *At the moment I can't do nothing* [sic]. *I like to go for a walk every morning ... now I can't even do much gardening* [Participant 1; Lines 245-47].
- Felix: *It would take some adjusting I think* [loss of vision], *if that doesn't work then I have to go to the next stage and manage with what I have got* [Participant 12; Lines 112-3].

The outpatient environment of the clinic is extremely busy and the participants felt that there was no-one who had the time or ability to assist them. Fin and Bruce struggled to cope emotionally and unsuccessfully solicited help from the clinic. Fin wanted support via more information and counselling, and eventually sought help from his local GP. However, the advice he received from the GP did little to alleviate his anxieties.

- Fin: *I think that there really could have a little more follow up as far as after you leave here you are left with all these questions ... there doesn't seem to be any sort of follow up or anything like that. I went to the local GP and he basically said here's some Xanax just go home and lie down and I really didn't have any sort of follow up on how to cope with it all ... everybody seemed to be at 100 mile an hour and you know and it was like everybody was sort of talking to you but on the edge of their seat waiting to see someone else and you were holding them up really* [Participant 6; Lines 36-52].

Living alone, Bruce keenly felt his isolation as he did not have a partner to support him emotionally.

Bruce: *It was that first two or three weeks that where you're trying to come to terms with the loss of something that's always been there. I probably won't get very much back [sight] um in my case by myself to try and grieve to go through all the emotions ... I went through the lot, with no-one to talk to ... I found out that there is really no-one out there to counsel you [Participant 13; Lines 220-39].*

The ongoing uncertainty of visual pathology was a constant stress for Gunter. He felt that this was not adequately understood by the clinic's staff:

Gunter: *It could go at any time you know [his sight], I live with that it, could go any time ... I don't know whether they realise that down there [the clinic] [Participant 7; Lines 245-6].*

It is clear that, as participants struggled with their conditions, the healthcare facility did not adequately meet their needs. They were not properly prepared for self-care during the immediate recovery period and did not receive acceptable ongoing support outside of medical supervision. The participants' convalescent needs extended far beyond initial surgery and encompassed psychological issues of visual disability, anxiety in the presence of recurrent pathological conditions and everyday practical issues of living with monocular vision. The healthcare facility's failure to meet their needs led to feelings of abandonment and highlighted the inadequacies of a healthcare system that exclusively utilises an acute model of care.

### **7.3.5 Phase 5: From the parts to the whole**

The final phase of analysis manifests as the writing of a text that displays a new and different understanding of participant experiences. This writing is cognisant of all

emerging themes, patterns and understandings, through the dialectical movement from the parts to the whole. The process begins in this final step of this section and fully develops in Chapter 8 of this study.

As the participants' stories unfolded, it became clear that many experienced a broad range of difficulties. A number of participants described an initial understanding concerning the obvious and palpable physical difficulties. This understanding resonates with the clinical context that is steeped in a biomedical understanding. A deeper and richer understanding is facilitated by the principles of Gadamer's hermeneutic circle with its emphasis on dynamic movement between parts and the whole. In the present study, the whole is a new experiential understanding of care; the parts are: firstly, the participants as a group, secondly, the participants as individuals and, finally, the deconstructed aspects of their experiences. Constant movement between all of these levels encourages a multilayered understanding of the experience. The integration of the parts with the whole results in the comprehensive understanding that 'an acute model of care was inadequate to meet the complex needs of people experiencing V-R day surgery'.

## **7.4 Summary**

Eighteen participants of this study shared their experiences of V-R day surgery and this chapter has presented their deconstructed experiences. The major theme emerging from the participants' voices is that of the inadequacies of an acute model of care to meet the complex needs of individuals experiencing V-R day surgery. The data reveals multiple layers of *self* that extend further than the physical and psychological *self* of an acute model of care. The participants describe their unmet

needs and inadequacies of care, causing identified layers of *self* to become evident through the inclusion of influence of past surgical events and self-care in the community. The care received by the participants is based on an acute model of care and appears insufficient for their increasing complexity of needs. The following chapter further explored the current acute model of care's inadequacy to support people undergoing day surgery for V-R pathology. Rutter's (1985) established resilience theory will be used to enhance the developing understanding.



## CHAPTER 8

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# INTERPRETATION OF FINDINGS AND ESTABLISHING TRUSTWORTHINESS

### Step 3

Where knowledge gap exists, conducting research and critically appraising the methodology, methods and findings for rigour (qualitative research of this study) *Chapters 4,5,6,7,8.*

### 8.1 Introduction

The qualitative research evidence produced in Step 3 of this study yields important experiential knowledge about the V-R day surgery phenomena. So far, it has been revealed that an acute model of care does not adequately meet the complex needs of this participant group who had experienced day surgery for V-R pathology. The participants encountered difficulties, which are identified across four domains of the human self: the *physical*, the *psychological* and *spiritual*, the *historically* located and the *self within the community*. This study aims to understanding the experience of V-R day surgery, as guided by Gadamer's philosophy (1975), who stated that understanding is interpretation. Thus, the present chapter will examine the intricacies of interpretation. This chapter is the final part of Step 3 of the adapted EBNP process (as described in Chapter 1), including an interpretation of the findings and establishing the rigour and trustworthiness in the conduct of this research. It begins with a further discussion of the main theme, that is, the inadequacies of an acute model of care in meeting the complex needs of participants undergoing V-R day surgery.

## **8.2 The findings in relation to the literature**

The findings of this research need to be viewed in light of what is already known for the purpose of identifying where congruencies and contradictions between new and established knowledge occurred. Thus each of the questions asked of the literature will be re-examined in light of the findings of this study in this section, before detailed analysis occurred.

### **8.2.1 What was people's experience of vitreo-retinal day surgery?**

The literature review conducted in chapter three of this study identified very little research evidence of people's experience of V-R day surgery. In this study participant's experiences have been examined in-depth and this knowledge adds to the body of nursing knowledge of this phenomena.

### **8.2.2 How was day surgery managed in ophthalmology and other specialties?**

Preparation of patients for self-care following day surgery has been well described in the literature, however patients continue to be inadequately prepared for self-care following discharge (Pavlin et al.2002; Majasaari et al. 2005; Mitchell 2010; Myers 2012).This inadequacy of care was clearly evident in the experiences of the participants of this study. Participants were unprepared for aspects such as monocular vision, self-medication for pain relief, the requirement of supported care following discharge and who to contact when difficulties were experienced. Provision of information prior to surgery or discharge has been considered an important aspect of preparing patients for self-care (Majasaari et al. 2005; Mitchell

2010; Myers 2012). However, a number of participants did not want detailed information prior to the surgery. This finding was inconsistent with the findings of the literature and needed to be explored in detail in the interpretation of the findings. The exploration of the needs of participants' for information was further compounded by the diversity of participants needs and led the researcher to seek theoretical explanation for such diverse needs.

### **8.2.3 How was pain managed during self-care?**

It was evident from the literature that across many specialties people experienced significant difficulties in the immediate post- operative period when self- care was expected following discharge. Experiences of pain nausea and vomiting were common (Costa 2001,McHugh & Thoms 2002; Pavlin et al.2002; Watt-Watson et al. 2004). The findings of this study concurred with the previously reported findings in the literature. Participants Felix, Robert, Gunter Edgar,Greta Sandra and Nick all reported high levels of postoperative pain that was not relieved by the medications provided. Furthermore nausea and vomiting was also reported by Felix Greta, Robert, Gunter and Bruce.

### **8.2.4 What do we know about ocular anaesthesia?**

Ocular anaesthesia has been extensively examined in the literature from a biomedical perspective. Ocular anaesthesia medications, techniques and efficacy have been described, however there was very little qualitative research conducted that searched for experiential knowledge of this intervention (Furst & Manning 2001; Farmery et al.2003; Ghali &Hafez 2010). The research that had explored patient experiences of

ocular anaesthesia was inconsistent and ambiguous. This ambiguity was particularly evident in the use or non-use of sedation during instillation of ocular anaesthesia, an omission that muddies the quality of the results. The experience of ocular anaesthesia as described by the participants of this study was one of significant fear, anxiety and pain. This finding was contradictory to the reported knowledge in the literature.

### **8.2.5 Do satisfaction surveys accurately measure patient experiences of care?**

Satisfaction surveys have been widely studied in the literature with many studies reporting high levels of patient satisfaction with care (Yellen & Davis 2001; Yeung 2008). However, on close examination the results of some studies are ambiguous and inconsistent, as study participants reported high levels of satisfaction but also significant difficulties. This disparity lead to a question of the validity of the instruments used to measure satisfaction. In the findings of this study participants described high regard for the staff and facilities provided during their surgical intervention and post-operative care. However, they also described significant difficulties across many aspects of care. This finding supports a questioning of the basis of satisfaction surveys that are not grounded in the identified needs and experiences of patients. These brief discussions contextualise the findings of this study in the current body of knowledge specific to the phenomena of V-R day surgery. The findings of the study are explored in greater detail in the following sections.

### **8.3 The inadequacies of the acute model of care in meeting the complex needs of individuals' day surgery for V-R pathology**

For almost all of the participants of this study, V-R day surgery was a challenging experience. They faced many physical and psychological difficulties when surgery was required to repair retinal pathology. It is evident that the difficulties were enhanced when surgery was an emergency event preceded by a sudden and unexpected loss of vision. As the participants struggled with the physical difficulties of a painful anaesthetic and an eventful and prolonged recovery, their experiences were compounded by an ever-present fear of blindness. Whilst retinal day surgery included both positive and negative aspects, the many negative experiences described by participants of this study formed overwhelming evidence that the current model of care is inadequate in meeting the needs of people undergoing V-R day surgery.

Chapter 7 outlined the care that the participants received, which focused almost exclusively on surgical interventions and the immediate post-operative physical support, congruent with a reductionist bio-medical focus of care (Kubsch et al. 2007). This dominant interest in the physical aspects of illness is evident of a continuing influence of a reductionist healthcare paradigm that espouses the *Cartesian Split* of mind-body (Kubsch et al. 2007). Treatment based on this paradigm fails to incorporate the individuality, complexity and subjectivity of participants' experiences, and is an inadequate philosophical basis of care (Earle-Foley 2011; Kjersheim 2003; Scott & McSherry 2009).

Physical aspects are a major construct of an acute model of care. However, the participants' experiences manifest significant inadequacies of care across multiple human domains, including physical aspects. The impact of life-changing retinal events and the surgery appear incongruent with the depth of care provided by the healthcare facility and can be partially explained by the history of day-case eye surgery.

Whilst today V-R surgery is routinely performed as day surgery, it had previously been conducted as an inpatient modality, where patients spent days in hospital and received 24-hour nursing and medical support. In making the transition to day surgery care, patients are expected to bear the tasks of convalescent self-care. This move was influenced by the spectacular success of day surgery for cataract removal. However, some significant differences exist between cataract and retinal surgery in the disease aetiology, treatment requirements, length of convalescence and patient care requirements. These differences have caused problems in care based on a cataract treatment modality. Whilst the literature carefully documents positive cataract patient experiences, the actuality of V-R day surgery remains relatively unstudied and unknown. The following section discusses the differences between patient care requirements whilst undergoing cataract as compared to retinal surgery.

### **8.3.1 Cataract surgery versus V-R surgery**

Cataract surgery is usually an elective procedure and patients have several weeks to prepare, from both physical and psychosocial perspectives. The need for cataract surgery is preceded by a gradual visual decline, which patients adapt to over a significant time period, until visual disability threatens quality of life. This visual

decline differs from other V-R conditions, where pathology often appears as a sudden and severe visual loss requiring urgent surgery.

There are marked differences in the procedural times between the two types of surgery. Cataract surgery is relatively quick, usually lasting less than 30 minutes, whilst V-R surgery can take between 45 minutes and three hours. Recovery following cataract surgery is usually fast, with many patients experiencing significant visual improvement on the following day. This recovery is in contrast with V-R surgery where convalescence is prolonged and visual rehabilitation may take in excess of three months. Cataract surgery is fairly predictable with positive results in 99.5% of patients (Dhillon & Gerassimos 2009). On the other hand, V-R surgery is much less predictable and often repeat surgery may be needed (Berker et al. 2007). Thus, patients requiring V-R surgery have significant physical, psychological and convalescent issues compared with patients undergoing cataract surgery.

For a successful transition of V-R surgery from inpatient to day care, these variations need to be rigorously addressed. The experiences of this study's participants make it clear that their extended needs were not adequately addressed and this resulted in negative experiences. At this point, the study requires an interpretation of the findings according to Gadamer – *understanding occurred in interpretation* (Gadamer 1975a, p. 390). Such an interpretation would lead the way towards innovative care that will meet the needs of future patients.

## **8.4 Understanding in a different way**

Gadamer (1975) states that ‘all understanding is interpretation’ and elaborates on the process of interpretation as a dialectical movement between question and answer within a closed hermeneutic circle (Gadamer 1975a). Consistent with Gadamer's concept of interpretation is a further immersion in the diverse experiences of the participants. This was presented in Chapter 7 and led to the researcher’s recurrent questioning of the data, including the specific question of: "Why did some participants cope well with the procedures and others did not?" This question resulted in a further search of both the text of the study and the professional literature. Answering of this question is enhanced by the use of an established theory of resilience and resource depletion (Rutter 1985). This theory offers an avenue to interpret the resonances and dissonances of participant’s experiences, which leads to understanding “in a different way”. The following section explicates the use of Rutter’s (1985) resilience theory in interpreting the experiences of the participants of this study.

## **8.5 Interpretation of the findings guided by Rutter's (1985) adversity, resilience and resource depletion theory**

Rutter (1985), a leading author on the concept and theory of resilience, identifies resilience within children’s experience of psychological trauma as the balance of individual protective characteristics and adversity (Rutter 1985). In recent years, the concept of resilience has been widely used to describe individuals’ ability to “bounce back” after adversity, both psychological and physical (Rutter 1985; Tusaie & Dyer 2004). Whilst Rutter (1985) defines resilience in terms of personality characteristics



and traits, such as hardiness and flexibility, recent descriptions have refined the understanding of resilience to mean ‘a dynamic and modifiable process that is a changeable balance between adversity and individual protective resources, contextualised to specific situations and individuals’ (Tusaie & Dyer 2004, p.3). It is within the modification of an individual’s protective resources that the theory of resilience becomes relevant to interpreting the findings and offers a pathway towards research–practice integration within this study. If it were possible to identify the sites of resource depletion within an individual's experience, new interventions that meet the identified clinical needs could be developed via a systematic application of all sources of evidence including research, patients’ experiences and expert opinions (Newhouse 2007; Rycroft-Malone et al. 2003).

### **8.5.1 Middle-range theory supported understanding:**

Peterson and Bredow (2013) have identified 41 middle-range theories, that have been broadly conceptualised by a number of authors cited in (Peterson & Bredow 2013) as : Narrower in scope than grand theories; Concerned with specific phenomena; Representative of a limited or partial view of nursing reality; More applicable to practice for explanation and implementation. Smith and Liehr (2008) suggested a framework for evaluation of middle-range theories that included: substantive foundations; structural integrity; and functional adequacy.

Whilst this frame work offered broad guidance, the critique framework suggested by Peterson and Bredow (2013) offered a more detailed guide in the conduct of middle range theory critique. Peterson and Bredow's (2013) critique looked at the internal

and external consistency of the constructs of a theory, paying particular attention to: Internal criteria of: clarity, consistency, adequacy, logical development and level of theory development. . External criteria of: reality convergence, utility, significance, discrimination, scope of theory and complexity.

Of the 41 middle-range theories identified by Peterson and Bredow (2013) most have been excluded from this evaluation on the basis of inadequate scope, utility and complexity. The theories of: Acute pain management (Good 1998), Lenz et al's (Lenz et al. 1997) Unpleasant symptoms theory; Resilience (Rutter 1985) and Uncertainty in illness (Mishel 1988) were considered relevant to the phenomena of this study and were examined. Table 8.1 displays a critique of these four middle range theories using the criteria identified by Peterson and Bredow(2013). Good's (1998) theory of acute pain management offered clear insight into needs and interventions required to manage acute pain in the inpatient setting, however these insights were not transferrable to the day surgery setting where the patient was expected to self-care and self-medicate.

Lenz et al's (1997) theory of unpleasant symptoms at first look offered a comprehensive theory to support understanding of the V-R day surgery participant experience. However, a very broad abstraction of the theory appeared to limit the specificity in application of this theory. Furthermore, as the complexity of participants' experiences deepened this theory became inadequate to understand the multifaceted aspect of the experience identified in this study. From this critique process Rutter's (1985) resilience theory and Mishel's uncertainty in Illness Theory

appeared to be the most appropriate choices to the understand the complex needs of the participants of this study.

The relationship of a theory to practice is considered collaborative with theory being informed by the knowledge of a phenomenon (Allgood & Tomey, 2010). In regard to this relationship it was the middle-range theoretical constructs of resilience that resonated with a need to understand the data that emerged from this study. Polk (1997) described Resilience theory as a middle-range theory, a description that is supported by Peterson and Bredow (2013) on the basis that middle range theories hold a given level of abstraction that captures the middle ground between grand theory and situation-specific theory. Resilience theory was narrow in its scope in that it was concerned with people's ability to move through an adverse situation (Polk 1997) and had a level of abstraction that could be easily applied to the data collected. Throughout the analysis stage of the research, the researcher was trying to understand the dynamics of people coping with interventions and what "tipped them over" into a state of not coping. Thus the concern was with a very specific practice phenomenon. There no intent to use this theory to uncover the social and political determinates of the experiences phenomena, but rather the processes that occurred in an adverse situation. The directed focus of this view was consistent with the concept of a middle range theory. However, the use of resilience led to the resultant application being very situation specific, evident in the following aspects: it was limited to a very specific field that of ophthalmology; was focused on a specific phenomenon that of the experience of V-R day surgery; the context was a specific time frame; the use of resilience theory facilitated a blue print for action (Im &

Meleis 1999); and knowledge developed from qualitative research was utilised (Risjord 2010).

The application of this theory and the resultant specificity would lead to an enhancement of the study's conclusions from being simple practice dictates to the more robust theory based interventions (Im & Meleis 1999). There is widespread acknowledgment in the nursing literature that underpinning of practice by theory is an essential characteristic of a profession (Peterson & Bredow 2013). However a lower level of abstraction and situation specificity added significantly to the limitations of the findings particularly in regard to generalizability and testability (Im & Meleis 1999). Resilience theory itself has specific limitations that included: Ambiguities in the definition of resilience; The two competing constructs with in the definitions of resilience include a belief in resilience being a personal trait (Block & Block 1980) or a dynamic and modifiable process (Rutter 1985; Tusaie & Dyer 2004). Given the diversity of definition it was essential that the selected construct be clearly described (Luthar et al. 2000). Resilience was described in this thesis as a construct of a dynamic and modifiable process not as the alternative view of a personality trait. The co-existing conditions of adversity ( the experience of V-R retinal day surgery) and a positive outcome (positive patient) (Haaes & Peterson 2013) and the potential to modify the process between these two conditions appealed as an appropriate construct from which understanding and action could be made. Both these constructs have been increasingly examined in the literature, where there is synchronous evidence relevant to support the theory of resilience (Luthar et al. 2000). The ability of disparate constructs to co-exist, supported by evidence adds, rather than diminishes the validity of this diverse theory (Luthar et al. 2000). o the

diversity of adverse situations to which individuals were exposed has been considered as contributing to a destabilisation of the evidence base of the constructs of resilience (Luthar et al. 2000). A theoretical rockiness, which compounded an apparent ambiguity as to what was evidence of resilience (Luthar et al. 2000). Thus it was essential that the contextual influences on individual participants in this study be clearly stated. A gap in the adequacy of resilience theory was evident in that it failed to address all aspects of the phenomena as described by the participants of this study. These aspects included the diversity of information needs of individuals and where/what/who participant's consigned their trust in. A further limitation of resilience theory was a failure to address influential issues of gender, culture and socio-economic status (Ortega et al. 2012; Tocher et al. 2012; Celia 2000; Vallerand & Polomano 2000; Mitchell 2012).

In this study most of the limitations described above have been addressed through the following actions: The use of a clear definition of resilience that encompassed the process construct of resilience theory. The heterogeneity of adversity was accommodated in each of the four domains of self, with specific sites of adversity with corresponding evidence of resilience explored. Through delineation of the four sites of adversity and resilience the context and type of resilience was established, clarity considered essential by Luthar and Cicchetti (2008). The evidence of resilience utilised was a positive patient experience across all four of the domains of the human self-identified. This measure was consistent with what Haase and Peterson's (2013) described essential attributes of resilience. The identified gap in the functional adequacy of resilience theory led to the utilisation of Mishel's (1998) Uncertainty in illness theory to understand aspects of the findings concerned with

pre-operative information needs and development of trust between participants and care providers.

Despite the limitation of resilience theory identified, it offered a clear, adequate and complex theory on which to base understanding of the participant's experience of V-R day surgery. Furthermore, there was a logical movement toward theory supported interventions that developed subsequently. The broad nature of the participant's experiences and a gap in the scope of Rutter's resilience theory to explicate all of the findings encouraged the use of a second middle-range theory that of Mishel's Uncertainty in Illness theory (1988) to underpin specific aspects during interpretation of the findings. This theory was also subjected to close examination of its strengths and weaknesses.

As the participants' narratives unfolded, it became increasingly obvious that their internal strengths and resource were severely tested by a diagnosis of V-R pathology, followed by surgery and self-care convalescence. For many participants, the surgery itself was a difficult and stressful time, whilst the fear of blindness was a pervasive source of psychological angst. It became clear that, at times, they were lacking the resources to deal with the difficulties of V-R day surgery.

Rutter (1985) and more recent researchers have described individual resources as protective factors, which include behaviours that act as buffering agents to minimise negative outcomes when facing adversity (Ahern 2006; Earvolino-Ramirez 2007). Interventions that actively support an individual's protective resources have been demonstrated to enhanced resilience and prevent negative outcomes (Houston 2010;

Nidtava 2008; Windle 2011). The participants' diminished resources were evident in negative experiences, characterised by fear, pain, nausea and anxiety. A failure of nursing interventions to support the participants' protective resources contributed to individual resource depletion and negative experiences.

Evident at each aspect of the “*self*” is the imbalance between personal protective resources and adversity. Table 8.1 presents a summary of this imbalance. By using the concepts of resource depletion and resilience to guide development, new ways of augmenting resources across all identified aspects of *self* were explored and interventions that succeeded in other settings were incorporated into resource enhancement strategies. Where no previously successful strategies were found, the researcher developed novel ways of augmenting resources. Each one of the identified human domains of *self* and a corresponding source of resource depletion is addressed using established theories, innovative interventions, peer reviewed knowledge and intuitive practices.

## **8.6 Identified aspects of *self* and sites of resource depletion**

Table 8.1 displays the participants' deconstructed experiences in relation to the identified aspects of *self*, the site of adversity and the resource depletion. The following sections of this chapter examine each of the identified aspects of *self* for sites of resource depletion, where nursing interventions have the potential to improve protective resources and facilitate a positive experience.

Table 8.1 **Summary of adversity and resource depletion across identified aspects of self**

<b>The human domain</b>	<b>Adversity</b>	<b>Source of resource depletion</b>
The physical <i>self</i>	Painful anaesthetic administration Difficult convalescent experiences	Inadequate pain management experiences Inadequate post-operative pain and nausea management
The psychological <i>self</i>	Anxiety Fear of blindness Fear of surgery	Inadequate psychological support Inadequate or inappropriate psychological preparation
The historically located <i>self</i>	Multiple surgical events	Compounding negative experiences
The <i>self</i> within the community	Inadequate preparation for self-care Visual disability	Inaccessible healthcare personnel Inadequate counselling Potential for diminished quality of life

### 8.6.1 The physical self

The participants' narratives readily and vividly described physical experiences, often dominating early sections of the interviews. The physical experiences included pain, nausea and vomiting; they are displayed in Table 8.2 and have been identified as sources of physical resource depletion.

Whilst V-R day surgery encompasses both elective and emergency surgery, most of this study's participants required emergency surgery, usually due to an urgent need to re-attach the retina. This urgency meant limited time for pre-operative preparation, resulting in participants arriving for surgery unsure of the upcoming procedure.

When time allowed, preparation included:

Description of the anaesthetic;

Instructions regarding medications;

Arrival time in the unit; and

The need to have an escort home and self-care.



However, these preparations were often inadequate or incomplete. A number of participants described harrowing physical experiences that included pain during the anaesthetic and during post-operative self-care.

Table 8.2 **Sources of physical resource depletion**

<b>Participant</b>	<b>Physical <i>self</i> – sources of resource depletion</b>
Harold	No pain
Dorothy	Mild post-operative pain, pain with the anaesthetic
Tony	Mild post-operative pain
John	Mild post-operative pain
Edgar	Moderate post-operative pain
Felix	Pain during procedure, pain post-operatively, severe nausea
Albert	Moderate post-operative pain
Nick	Post-operative pain
Fin	Mild post-operative pain, pain with the anaesthetic
Greta	Severe post-operative pain, nausea/vomiting
Robert	Severe post-operative pain, nausea/vomiting
Gunter	Pain with anaesthetic, post-operative pain, nausea/vomiting
Bruce	Mild post-operative pain, severe post-operative nausea
Rita	Mild post operative pain
Sarah	Minimal post-operative pain
Molly	Minimal post-operative pain
Sandra	Very significant pain for 2-3 days following surgery, found the anaesthetic difficult
Adriana	Mild to moderate pain during self-care

## Pain with the anaesthetic injection

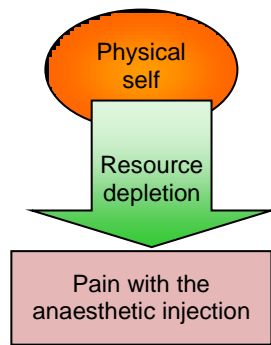


Figure 8.1 **Site of physical resource depletion – anaesthetic injection**

The use of regional anaesthesia, or the “block” without sedation, has not been studied extensively in the professional literature. Most studies describe variations in both injection and sedation (intravenous narcotic and anxiolytic medications) techniques, and study outcomes include patient satisfaction (Ripart et al. 2006; Vann, Ogunnaike & Joshi 2007). Patient satisfaction of anaesthetic techniques is reported as good when the latter has been combined with intravenous sedation. However, the experience of the instillation of sub-tenon, or peri-bulbar injections, without sedation is vastly different. Whilst patients who are sedated may still experience discomfort during the instillation, the amnesiac effect of sedation agents results in patients not remembering if pain had occurred.

Participants of this study were not routinely sedated for the anaesthetic or surgery, a strategy that aimed to reduce complications due to diabetes or other co-morbidities. Whilst this strategy efficiently prevents complications, it results in painful experiences of the eye “block” that become increasingly evident when repeat surgery for complex pathology is required. Participants whose surgery was elective and curative are at the less complex end of the retinal pathology spectrum. Whilst their

overall experiences were generally positive, several had reported pain during the instillation of the eye “block”. As the pathology complexity increases, pain with the “block” becomes more evident.

### **Pain and PONV during convalescent self-care**

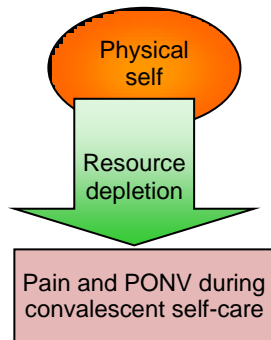


Figure 8.2 **Site of physical resource depletion, pain and PONV during self-care**

Whilst most participants adequately tolerated the surgery itself, a number of their narratives provide evidence of high levels of pain, nausea and vomiting during the convalescent self-care period. The participants were not sufficiently prepared for self-care and there was a mismatch between experiences of post-operative pain, nausea and vomiting, and the participants’ individual protective resources.

Medications and strategies provided were inadequate to alleviate the significant post-operative pain. During the immediate post-operative period, several participants were driven to seek help from the emergency rooms of the healthcare facility or their local doctor.

Following discharge from the day surgery unit, participants were supplied with a pain management strategy that included paracetamol+codeine tablets or oral oxycodone, a narcotic-based analgesia. The choice of strategy depended on

preference and patient needs, as perceived by the attending anaesthetist. These strategies were clearly inadequate, as a number of participants reported intense and debilitating pain during self-care. The physical difficulties of self-care became increasingly obvious in participants who had experienced multiple surgical events. These participants found the adjunct strategies provided by the day surgery unit for pain and nausea management to be insufficient, and they described evidence of physical resource depletion manifesting as high levels of pain and nausea. These findings resonate with Rutter's (1985) theory of resilience and resource depletion, where the stress of the interventions exceeds the participants' resources to cope (Earvolino-Ramirez 2007).

The participants' experiences of pain contributed to overall negative descriptions of the V-R day surgery experiences. Their experiences may have been significantly improved if their pain had been well controlled through provision of successful resource enhancing strategies. It is apparent that the care received by the participants was based on an acute model of care with a focus on the physical domain, hence failing as a resource enhancing strategy. For some of the participants, post-operative pain was compounded by PONV after discharge and there is little evidence of any strategies dealing with these distressing symptoms. Despite abundant evidence of pain and PONV, several participants did report positive experiences.

## The physical *self* and positive experiences

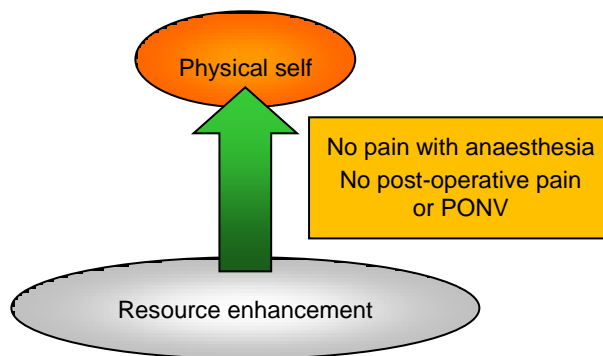


Figure 8.3 **Physical resilience**

The dichotomy of positive and negative experiences illustrates the complexity of understanding the experiences of this group of participants. Whilst many participants described significant physical difficulties at various stages, a small number reported experiences in relation to the *physical self*, which included an absence of severe or debilitating pain, nausea or vomiting at any stage.

Four participants reported mild or no pain during the anaesthetic instillation, the surgery and the convalescence. This may be explained by the elective and less complex nature of their pathology and surgery, which limits the potential for individual resource depletion. Further explanation may be found in the strategies utilised by individuals to minimise potential resource depletion. Harold used memories of his previous painful heart surgery experiences as a comparison for the current event. Dorothy also used prior experiences of pain as a measuring stick and, whilst she did not enjoy the eye anaesthesia experience, she felt that it was not as painful as “having a hip repaired”. Dorothy, Tony and Sarah effectively utilised the medications provided by the day surgery unit to manage pain in the post-operative period. It can be suggested, in relation to resource depletion and resilience that the

less complex nature of pathology combined with the elective nature of the surgery, and adequate pain management strategies does not result in an imbalance between the strength of adversity (the surgery) and individual protective resources, thereby leading to positive experiences.

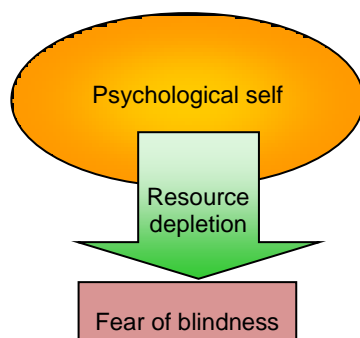
### **8.6.2 The psychological self**

The participants' experiences were influenced by an overtly expressed fear of visual disability or possible blindness. The participants tolerated many difficulties in the hope for an improved visual outcome. As many participants stated, the surgery was not their greatest concern, as they were most worried about the outcome (possible blindness). Table 8.3 shows the participants' psychological issues and identifies sources of resource depletion that demonstrate the pervasiveness of psychological angst. Experiences highlighted in blue are those of the participants who coped well; highlighted in red are those who had significant psychological difficulties. The following section further discusses a pervasive fear of blindness, which was identified as a site of resource depletion.

**Table 8.3 Participants' psychological issues and identified sources of resource depletion**

Participant	Psychological <i>self</i> – sources of resource depletion
Harold	Coped well with surgery; however, expresses some concerns regarding the outcome of the surgery.
Dorothy	Coped well with surgery and convalescence, a little anxious about the first surgery.
Tony	No psychological issues expressed.
John	Anxiety regarding surgical outcome as he had multiple previous retinal surgery.
Edgar	Anxiety regarding outcome, emergency procedure.
Felix	Unexpected emergency procedure. Anxiety regarding outcome, was a complication of cataract surgery.
Albert	Unexpected emergency procedure. Anxiety regarding outcome as he had previous retinal detachments.
Nick	Anxiety regarding outcome, a complication following cataract surgery.
Fin	Anxiety and stress with coping as he had multiple previous retinal detachments.
Greta	Anxiety regarding possible blindness, a retinal detachment 30 years ago in her other eye.
Robert	Stress and anxiety regarding visual disability, unsuccessful three previous episodes of surgery.
Gunter	Anxiety with multiple procedures and loss of vision, six previous retinal detachments.
Bruce	Psychological stress with coping with vision loss, single catastrophic event.
Rita	Very anxious regarding vision loss due to very limited vision in the other eye.
Sarah	Terrified at the thought of the surgery.
Molly	Very anxious prior to the surgery due to previous unsuccessful surgery.
Sandra	Anxious at the development of retinal detachment following elective macular hole surgery.
Adriana	Anxious about the outcome of the surgery.

### Fear of blindness



**Figure 8.4 Site of psychological resource depletion, fear of blindness**

There is evidence of an imbalance between psychological resources and the threat of vision loss in the narratives of Fin, Gunter, Robert, Bruce, Rita, Molly, Sarah and Greta, who all faced the very real possibility of increasing visual disability. Having experienced multiple surgical events, Fin was aware of his decreasing chances of visual rehabilitation. He described increasing anxiety and difficulty in coping with not only surgery and convalescence, but also with the long-term consequences of his diminishing vision.

Gunter's six surgical episodes over four years were punctuated by periods of difficult convalescence and despair as each treatment revealed diminishing results. Gunter suffered significant psychological angst with each episode and endured many dark days without any psychological support.

Robert required multiple surgical episodes over a short time and, whilst he was able to cope with earlier interventions, he was overwhelmed with anxiety regarding diminishing vision when he required a third intervention. He was no longer able to cope with the physical and psychological difficulties of the interventions and sought help through the emergency department. Whilst the emergency department was able to deal with some of his physical difficulties, his psychological difficulties were not addressed, causing a stated decrease in his ability to cope with further surgery.

Bruce had a single catastrophic retinal event that left him with monocular vision. As a single man, Bruce had limited support from friends and family, and he struggled to cope with the anxiety caused by his condition. Whilst trying to deal with his visual disability, Bruce sought assistance from the Royal Society for the Blind (RSB) and



the Low Vision Centre (LVC). However, these agencies were unavailable to him without a referral from the healthcare facility. Overwhelming anxiety about his vision and future resulted in Bruce self-medicating with alcohol, which provided some temporary relief from his anxiety.

Greta faced an uncertain visual outcome following her surgery as she had previously experienced a retinal detachment in her other eye. As the sole carer for her disabled husband, Greta's anxieties manifested as prolonged physical difficulties with pain, nausea and vomiting. This illustrated the inter-relationship between the psychological and physical domains.

Psychological angst is not unique to participants with end stage pathology, it appears in the narratives of most participants who required retinal surgery. Failure to provide strategies to enhance individual psychological protective resources left a number of participants struggling to cope and they expressed feelings of depression, anxiety and loneliness. Fear and psychological angst resulted in the depletion of individual protective resources and contributed to the participants' diminished capacity to cope.

It is obvious that the participants' experiences show little evidence that any assessment of their psychological needs was performed. The participants arrived at the day surgery unit with inadequate or inappropriate psychological preparation for the surgical intervention including the pre-,intra- and post-operative phases. This lack of preparation contributed to high levels of stress and anxiety. High levels of pre-operative fear and stress were associated with greater levels of reported pain, poorer surgical outcomes, increased post-operative complications and inferior

treatment compliance (Glindvad & Jorgensen 2007; Kiecolt-Glaser et al. 1998; McHugh & Thoms 2002). Current biomedical focus resulted in a neglect of the participants' psychological needs, causing frustration, a decreased coping ability and, in some cases, the utilisation of emergency services.

### Strategies for resource enhancement and the psychological self

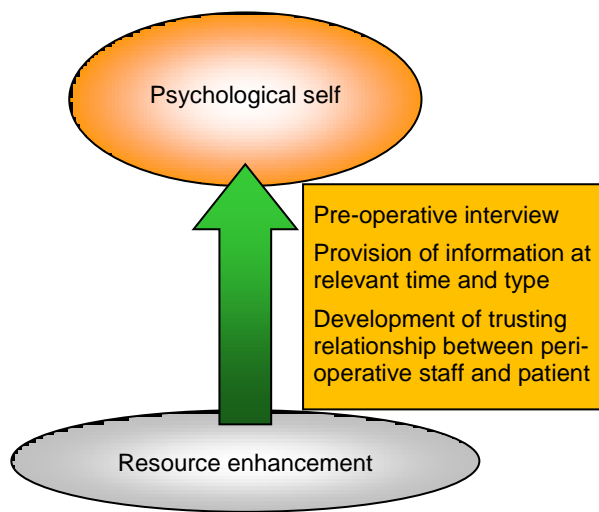


Figure 8.5 Strategies for psychological resilience

The participants' psychological protective resources were severely stretched to cope with the threat of visual disability. However, their psychological protective resources were enhanced when the anxieties were met through: provision of appropriate information, development of trust in healthcare providers, or through unique and individual participant strategies. This was evident in the experiences of Dorothy, John and Tony, who received sufficient information regarding the surgery to assuage their anxiety, and who expressed great trust in the surgical team. Many participants considered it important to develop a trust-based relationship with the surgeon and staff, who would care for them during a time of great stress. When patients had the time to develop this relationship through meeting and interacting with the staff prior

to the surgery, trust was enhanced and psychological angst was not eliminated, but diminished.

Almost all of the participants of this study had experienced repeat eye surgery. The success or failure of previous surgery significantly contributed to the participants' anxiety levels. However, it was often the nature of the previous experience (either good or bad) that played a crucial role in the participant's ability to cope with further surgery. These previous events and the influence they exerted (both positively and negatively) were also examined as sources of resource depletion.

### **8.6.3 The historically located *self***

Distinctly articulated influences of past surgical events (both positive and negative) were embedded within all of the participants' narratives. Positive past experiences helped assuage anxieties and facilitated individual coping, whilst negative past experiences compounded anxieties and undermined the coping ability.

Previous surgical experiences exerted a strong influence on many phases of the participants' surgery, including pre-operative, anaesthetic, surgical and convalescent periods. Fear, anxiety and inability to cope were salient features of influential negative past experiences, whilst reduced anxiety and increased coping ability were features of positive past experiences. Table 8.4 displays participants' positive and negative experiences.

Table 8.4 The historically located *self* and sources of resource depletion

Participant	The historically located self – sources of resource depletion and augmentation
Harold	Previous surgery exerted a positive influence
Dorothy	Previous surgical experiences exerted positive influence
Tony	Previous positive eye surgery
John	Multiple retinal detachment surgery – negative and positive experiences
Edgar	Previous retinal detachments – negative past experiences
Felix	Post-cataract retinal detachment – negative past experiences
Albert	Previous retinal detachments – negative past experiences
Nick	Post cataract retinal detachment – negative past experiences
Fin	Multiple retinal detachments – negative experience of the anaesthetic
Greta	Previous retinal detachments – negative past experiences
Robert	Multiple retinal detachments – negative past experiences
Gunter	Multiple retinal detachments – negative past experiences
Bruce	No previous retinal surgery
Rita	Previous cataract surgery that was problematic
Sarah	One previous retinal surgery event that was positive
Molly	Previous positive cataract surgery and positive but unsuccessful retinal surgery
Sandra	Previous positive eye surgery experiences made following surgery less anxious
Adriana	Previous cataract surgery that was uneventful

Despite clearly described past experiences, each surgical event was managed in a manner consistent with a first episode event. The treatment plans generally did not consider the participants’ past experiences. Past events were incorporated into their care only when the participants requested (and insisted) on additional measures (such as sedation to cope with the eye block or admission to hospital on the night of the surgery). Pre-operative preparation was unchanged irrespective of the surgery’s purpose – whether it was to repair a first detachment or a last effort to save sight following multiple previous surgical interventions. The failure to incorporate the participants’ previous experiences into their care plans is reflective of an acute model

of care that is insensitive to the patient's psychological need. This is particularly evident in the case of negative past experiences.

### Past negative experiences

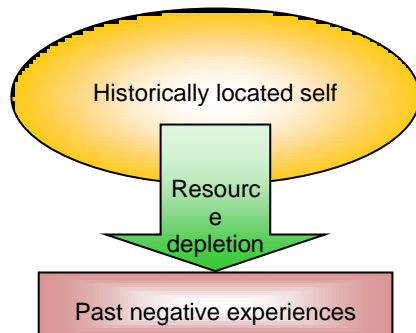


Figure 8.6 **Historically located sites of resource depletion**

First episode participants Bruce, Nick and Felix were inadequately prepared for the difficulties of the anaesthetic, surgery and convalescent self-care, causing a negative experience. The consequence of such experience lay in a compounded influence that a negative experience exerts on subsequent treatments, resulting in a string of increasingly difficult experiences.

The first experience's ongoing influence was evident in the repeat surgery required by Gunter, Fin, Robert, Edgar, Nick and Greta. The difficulties they experienced in the earlier procedures had a negative impact on their capacity to cope when encountering further adversity (repeat surgery). The participants' already stretched protective resources failed to promote resilience and expand their capacity to cope with subsequent interventions. This progression highlights the need for positive first experiences that exert an enhancing effect on individual protective resources. The patients' illness trajectories also illustrate the need for positive first experiences. The

life histories of this study's participants demonstrate an illness trajectory that ranges from a few months to several, as displayed in Table 8.5.

**Table 8.5 V-R pathology trajectory of participants**

<b>Participant</b>	<b>Number of previous eye surgery events</b>	<b>Eye pathology</b>	<b>Time span from first retinal event</b>
Greta	2 retinal detachment repairs	Retinal detachment	35 years
Edgar	4 retinal detachment repairs + 2 cataract surgery	Recurrent retinal detachment	31 years
John	6 retinal detachment repairs	Recurrent retinal detachment	10 years
Robert	3 retinal detachment repairs	Recurrent retinal detachment	10 years
Albert	2 retinal detachment repairs	Recurrent retinal detachment	10 years
Fin	4 retinal detachment repairs	Recurrent retinal detachment	7 years
Gunter	6 retinal detachment repairs	Recurrent retinal detachment	6 years
Nick	2 cataract surgery + 1 retinal detachment repair	Post-cataract retinal detachment	1 year
Tony	2 vitrectomy for vitreous haemorrhage	Diabetic retinopathy	1 year
Harold	2 cataract surgery + 1 macula hole repair	Macula hole	< 6 months
Dorothy	2 macula hole repair	Macula hole	< 6 months
Felix	2 cataract surgery + 1 retinal detachment repair	Post-cataract retinal detachment	< 6 months
Bruce	No previous eye surgery	Retinal detachment	< 6 months
Rita	Previous cataract surgery	Retinal detachment	< 6 months
Sarah	2 cataract surgery + 1 diabetic retinopathy	Diabetic retinopathy	1 year
Molly	2 cataract surgery + 1 retinal detachment repair	Retinal detachment repair	< 6 months
Sandra	Macular hole surgery	Retinal detachment surgery	1 year
Adriana	No previous eye surgery	Retinal detachment repair	< 6 months

Table 8.5 reveals that repeat surgery is a common pattern in treating V-R conditions. As such, efforts need to be made to enhance every experience, particularly important in the first instance, as evident in the findings of this study. Those participants who had positive first experiences showed individual and protective resource enhancement.

## Positive past experiences

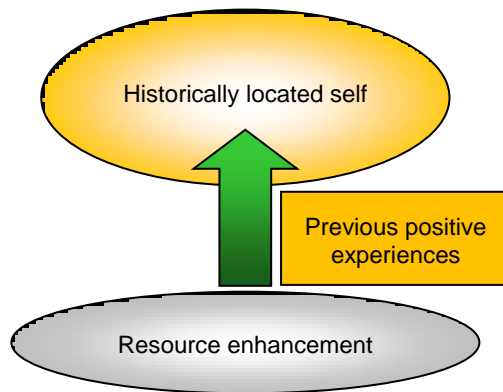


Figure 8.7 Evidence of resilience

The experiences of Dorothy, Sarah and Harold emphasise the influence of positive past eye surgery experiences. Their previous episodes of eye surgery were pain-free and, in the case of Sara and Dorothy, much less complicated than they had imagined. When further surgery was required, they were less anxious and tolerated the interventions with minimal difficulties. When compared with other participants, who had negative past experiences of V-R surgery, it is obvious that a positive first experience enhanced their ability to cope with subsequent eye surgery, an interpretation that is consistent with Rutter's (1985) theory of resilience and resource depletion.

The influence of past experiences (when positive) clearly contributed to the enhancement of protective resources for several of this study's participants who displayed an ongoing chronicity. However, negative past experiences depleted participants' protective resources and resulted in a diminished ability to cope with subsequent surgery. Evidence of resource depletion can also be seen in the fourth human domain, that of the *self* within the community.

#### 8.6.4 The *self* within the community

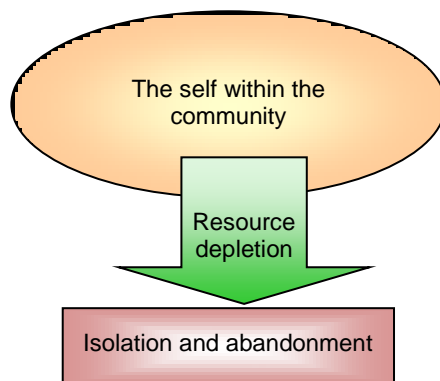


Figure 8.8 **Sources of resource depletion during self-care**

Self-care in convalescence is a salient characteristic of day surgery, where care is devolved to the individual and family within the community. The experiences of this study's participants concur with the findings of recent studies where day-case surgical patients are often unprepared to accept self-care, suffering pain and nausea during post-operative convalescence. However, the participants described experiences of inadequate care for the ongoing difficulties they encountered that extended beyond the immediate convalescent period, as their retinal pathology progressed and visual ability diminished. This was the case for Gunter, Fin and Bruce and it was clear from their narratives that they were not sufficiently prepared or adequately supported to manage convalescent self-care.

Day-case surgery significantly limits the time available for both pre- and post-operative exchange of healthcare information, convalescent support and guidance. Once surgery is complete, patients are discharged within a few hours to self-care, where they and their families are left to cope without assistance and with minimal direction from healthcare professionals. Long retinal detachment repair



convalescence periods, often exceeding three months, have severely affected the participants' quality of life in numerous ways. Daily activities including driving, employment and socialising were complicated by high levels of anxiety, pain and nausea. As participants struggled with a difficult convalescence and a limited visual ability, they often turned to the healthcare facility for help and advice regarding emerging problems and issues.

The clinic is an extremely busy outpatient environment and some participants felt that nobody there had the time or ability to could assist them. Participants independently sought help from the Royal Society for the Blind, the Low Vision Centre (LVC), local GPs, friends and relatives. However, without formal referrals from the healthcare facility, assistance from the RSB and the LVC was unavailable, which resulted in feelings of abandonment and isolation.

### Resource enhancement out in the community

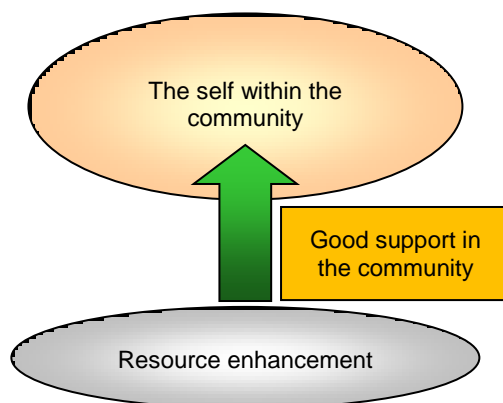


Figure 8.9 Evidence of resilience during self-care

John, Edgar, Sandra, Tony and Albert identified the importance of having good support when discharged to community care. John, Sandra and Albert had the support of a close family member who was a healthcare professional; hence, they were able to seek professional advice when problems or questions emerged. Many of the participants of this study identified and acknowledged the support of their families when they were discharged from the healthcare facility. This support was invaluable in augmenting their physical and psychological resources.

## **8.7 Towards a new model of care**

The above discussion highlights the multifaceted aspects of the *self* that emerge from the participants' voices. Sources of individual resource depletions and augmentations have been identified based on Rutter's resilience theory (1985). This discussion illuminates the inadequacies of an acute model of care and it becomes increasingly clear that a new approach to care is required, one that addresses each of the identified issues. Rutter's (1985) theory of resilience and resource depletion aids the process of interpreting this data through identifying sites of resource depletion and enhancement. Following on from this interpretation, new interventions supporting and augmenting individual protective resources are believed to have the potential to produce positive patient experiences. The following chapter discusses the pathway through the development of interventions based on identified sites of resource depletion and current knowledge. However, the final aspect of Step 3 of this EBNP activity needs to be addressed – this aspect involves the issues of trustworthiness and rigour in the conduct of this research evidence generation activity. The following

section addresses how the conduct of this study fulfils the requirements for rigour and trustworthiness.

## **8.8 Trustworthiness of the Findings**

Guba and Lincoln's (1985) seminal work on trustworthiness in qualitative research is the reference framework for rigour in this study. The classic criteria of credibility, transferability, dependability and confirmability, considered by Guba and Lincoln to be essential for establishing trustworthiness are addressed in the following manner (Guba & Lincoln 1985).

Prolonged engagement caused the development of a trusting relationship between the researcher and the participants, a relationship considered by Guba and Lincoln necessary for the credibility of the findings. During this processes of prolonged engagement and persistent observation, the context of a day surgery unit became 'thoroughly understood and appreciated' (Guba & Lincoln 1985, p.302). These aspects further enhance credibility, as the researcher was able to recognise salient and distorted elements in the findings. Peer review of study findings occurred at a conference for Ophthalmic Nurses, London, United Kingdom 2008, where searching questions by experienced ophthalmic nurses led to corroborating the findings. Provision of "thick description" of participant experiences presented conference delegates and readers of this study with sufficient information to judge its transferability to other contexts. Peer review also transpired when a summary paper of this study's findings was recently published in the *Journal of Advanced Nursing* (McCloud, Harrington & King 2011).

The conduct of interviews over an 18-month timeframe reduced the possibility of early closure of data collection, thus limiting researcher a-priori distortions.

Dependability and confirmability were satisfied through an audit trail that exists in the layered nodal analysis achieved through the use of NVivo 7 (as displayed in the earlier sections of this chapter) for the thematic coding and coupling of data.

Verbatim participant excerpts are used to illustrate the constitutive elements of a reported theme, providing a direct link between the findings and the interview transcripts.

Accordingly, the credibility of the findings is established and the researcher is satisfied that these findings may form an appropriate basis for the development of new nursing interventions. The following chapters describe and evaluate the development of new interventions to address the clinical need that precedes this research.

## **8.9 Summary**

Eighteen participants of this study shared their experiences of V-R day surgery with the researcher. Their outpourings were often laden with emotion and appeared to be cathartic as the participants relived both positive and negative aspects of the experience. This chapter presents what Gadamer would consider a *different* understanding of their experiences, which is anchored in: the time and context of this clinical environment, the researcher's horizon, and the participants' horizons. As these horizons and contexts "fused", it became obvious that an acute model of care fails to meet the complex needs of individuals experiencing V-R day surgery. The

model's inadequacies were exposed and understood via a circuitous movement from the parts of the dialogue, through the researcher's presuppositions, and viewed within the theoretical perspective of resilience. Salient features of understanding this experience include the identification of sources and sites of individual resource depletion that caused diminished resilience when facing the adversity of the V-R day surgery experience. Conversely, resource enhancement sites were identified, evident as resilience to the experience. This new understanding provides valuable knowledge, which can form the basis for interventions aiming to buffer individuals from the adversity of the experience of V-R day surgery. By virtue of this buffering, it is anticipated that nursing care based on this knowledge will lead to improved patient experiences.

The new interventions will incorporate a wide evidence base consistent with the belief stated in Chapter 1 that multiple sources of evidence need to support EBNP. It is proposed that this evidence base includes, firstly, patient experiential evidence (the findings of the present research); secondly, the guidance and knowledge from the clinical context (expert clinical opinion); and, finally, incorporate established research knowledge (knowledge and theory from the professional literature). Hence, the future care of people experiencing V-R day surgery will be broadly based and will avoid the hegemonic influence of science and technology, as described earlier in this thesis. Step 4 of this EBNP activity fully describes the development of new interventions.

## CHAPTER 9

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### A NEW MODEL OF OCULAR CARE

#### Step 4

Integrating the critically appraised findings of the research with patient and carers' preferences, clinical expertise and local established knowledge (development of new interventions based on all sources of evidence).

### 9.1 Introduction

The previous chapter uses Rutter's (1985) theory of adversity and resilience to identify sources of resource depletion and augmentation that contribute to participants' experiences of V-R day surgery, both positively and negatively. Based on these identified sources and supported by current published theory and knowledge, interventions are developed with the aim to improve patients' retinal day surgery experiences. Each domain of *self* identified in the first research phase and its corresponding source of resource depletion are addressed. The following chapter systematically describes each intervention and provides supporting evidence from professional literature in regards to efficacy and usefulness.

### 9.2 Sources of evidence on which to base practice changes

The use of a single source of evidence on which to base practice changes has been widely criticised in the nursing literature. Thus, the design of this study utilised an evidence based nursing practice model that incorporated not only research evidence, but also patient preferences, expert opinion and clinical guidelines. This design was

purposively chosen to overcome the limitations presented by a single source of evidence used to inform the complexity of nursing care today (Rycroft-Malone et al. 2003). Whilst the research evidence of this study was mostly qualitative in nature, the evidence on which the interventions were developed is broad based and was a result of extended consultation with all stakeholders within this clinical context. The stakeholders included: patients and carers, nurses, ophthalmologists, anaesthetists, pharmacists and industry personnel. The consultation occurred over a long period of time that was in excess of 12 months. Each stakeholder contributed information and knowledge that was synthesised with the limited published and unpublished quantitative findings and the current research findings to develop situation specific interventions. It was only when all stakeholders had provided their input that the interventions were developed and implemented. Thus, the qualitative research knowledge of this study provided the catalyst for the collaborative process of intervention development and potential practice improvement. Furthermore the findings resonated with clinical experience of the nurses and ophthalmologists of the health care facility, satisfying the demand for credibility and fittingness in qualitative research (Taylor, et al., 2006). One of the strengths of qualitative evidence is the illumination of the patient's experience of a phenomenon which aids in the relocation of the patient to the centre of the health care knowledge based decisions.

Using either quantitative or qualitative evidence requires a critique of the research processes and findings to be conducted and the rigour of the evidence ascertained. A critique of the qualitative methods is located within the rigour section of this thesis and whilst there are many ways to assess the rigour of qualitative research Lincoln

and Guba's (1985) concept of trustworthiness has been utilised in this study .Given the limitation of generalizability of qualitative research, and the potential for research bias with a single researcher qualitative study (Polit & Beck2012), a mixed-method research, with a wider research team may have assisted in capturing a more complete understanding of the phenomena, ameliorated biases and facilitated application of the findings to other clinical contexts (Polit & Beck2012).

### 9.3 The physical self

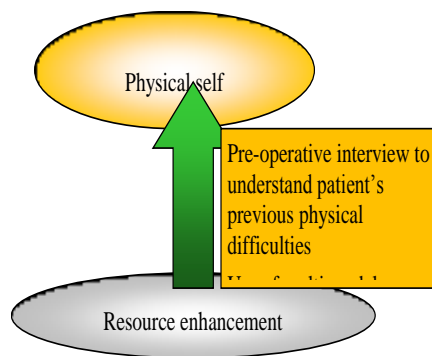


FIGURE 9.1. STRATEGIES FOR PHYSICAL RESOURCE ENHANCEMENT

Resource depletion in the physical *self* domain is manifested as pain and nausea during self-care and pain during the instillation of local anaesthesia. The following sections describe interventions to address these two sites of resource depletion.

#### 9.3.1 Post-operative self-care pain, nausea and vomiting

Formal assessment of patients' pain experiences prior to the conduct of this research was not systematically performed in this clinical context. Patients who received day surgery care in this clinical context (other than V-R patient) were contacted by telephone on the following day, to provide support, information and understanding of



their pain levels. Patients who experienced V-R day surgery were not telephoned the following day. The rationale behind this non telephoning was the provision of an early appointment on the day after surgery. It was at this time that pain was assessed individually by the medical and nursing staff, but results were not collated across the patient cohort. Thus, clear understandings of the extent of pain experiences were not captured. This lack of understanding of the broad incidence of pain, nausea and vomiting contributed to a limitation in the conclusions that can be drawn from the evaluation of the interventions, as a clear cause and effect cannot be established. A recommendation of this research is that patients pain be assessed through auditing, regularly and results disseminated to all staff involved in patient care.

The current self-care strategy includes the traditional medications of oral paracetamol and an oral narcotic if required, 4–6 hourly. No pre-emptive medication is given and the strategy relies on patients managing the timing and choice of their pain relief. According with the participants' experiences and knowledge from the published literature, a post-operative pain management protocol was formulated that meets the following criteria:

- Pre-emptive and long acting;
- Flexible to the variety of retinal surgical procedures and patient history;
- Provides sufficient analgesia without side effects of nausea and vomiting; and
- Easily managed by patients.

The participants' analgesic needs vary depending on a number of variables, including:

- Procedure performed;
- Patient's co-morbidities;
- Previous history; and
- Contra-indications.

Hence, a pain management protocol was constructed that meets the above criteria (see Appendix 5). The pain protocols are separated into three categories A, B and C (see Table 9.1), and the classification of patients into each category was decided in a consultation between the anaesthetist, the surgeon and the senior nurse.

Classification into a category depends on the type of surgery performed, the potential for post-operative pain, previous patient experiences, individual contraindications (see Table 9.2 for contraindications) to specific medications and the patient's co-morbidities. Outlines of the protocols follow.

### **9.3.2 Current models of pain management**

The management of pain both acute and chronic occupies a large segment of the published literature. However, despite this extensive presence in the literature patient's continue to experience pain following discharge from day surgery centres at an alarming rate (McHugh & Thoms 2002; Coll et al.2004b; Kamming et al.2004; Watt-Watson et al.2004). A recent review of current models of pain management, conducted in Australia found that despite research supported models a number of

issues contributes to inadequate management of both acute and chronic pain(Conway & Higgins 2011). These issues included: an over reliance on the biomedical view of pain; a need to develop capacity to respond to increasing demand for pain management; a need to better target services to clients experiencing pain who have differing needs.

Older et al (2009) clearly described the limitations of current care and suggested that how patients viewed and addressed issues of pain during self-care was a 'complex intentional decision-making process based on a matrix of belief surrounding pain, analgesia and surgery (Older 2010). Thus many of the aspects of current acute models of care for pain management had limited applicability to the patient experience pain following day surgery. An example of limited applicability is the prominence in many models of the role of the nurse in assessing, acting and evaluating pain relief interventions such as pharmacological strategies (McNamara et al. 2012; Shaban et al.2012). In the day surgery context the patient is central to the pain decision making process. Thus a model of care for pain management that best suits the day patient needs, supported by research evidence, should include; a clear and multi formatted education program on self-care in pain management (Blay & Donoghue 2005), be multi modal in type of medications (Gottschalk et al. 2002; Sinatra 2010; Lui & Ng 2011), be pre-emptive (Gottschalk et al. 2002; Lui & Ng 2011); easy to self-manage; and inclusive of non-pharmacological strategies (Conway & Higgins 2011).

With these guiding points advice was sought from a range of clinical experts in the development of the model of care described in this thesis. The model of pain

management described in this thesis addressed many of the needs of the individual in during self-care, in that: The pain management protocol was clearly described to participants prior to discharge and all participants were provided with a large print instruction page that included the timing of their first post-operative dose of paracetamol. This protocol was multimodal in that it combined a number of pharmacological strategies for pain management. Furthermore it was pre-emptive pain management which began with the use of local anaesthesia, IV paracoxib before discharge and local anaesthesia had worn off, and paracetamol was advised to be taken at a set time (prior to the local anaesthesia wearing off) determined as six hours post local anaesthesia administration. Given the clear instructions to participants about when to take the paracetamol regardless of their pain status, the need for rescue medications was streamlined thus making the protocol easy for participants to self-manage. If participants continued to experience difficulties the role of the on-call ophthalmologist was clearly described and provided an avenue for advice during the self-care period.

A weakness of this model could be considered the limited education and emphasis placed on the role of psychosocial measures of pain management. Measures such as resting, use of dark glasses, music therapy and relaxation techniques were not explored in detail, although participants were advised to rest, not drive and not return to work until approved by the ophthalmologist.

Table 9.1 Patient selection into surgical groups based on complexity

Category	Type of surgery	Surgical procedures
Group A	Minor retinal procedures	Pneumo retinopexy without cryotherapy Removal of scleral buckle Removal of silicone oil (anterior method)
Group B	Mid range retinal procedures	Uncomplicated 25g vitrectomy and 23g vitrectomy
Group C	High level retinal procedures	Patients with significant pre-operative pain Complex 23g or 25g vitrectomy with operating times of greater than 2 hours Scleral buckling procedures Cryotherapy procedures

Table 9.2 Contraindications for participation in pain protocol

Category	Contraindications
Group A	Known allergy to paracetamol Hepatic failure
Group B	Known allergy to paracetamol or codeine Known allergy to non steroidal anti inflammatory medications (NSAID) Concurrent use of NSAID, cortico steroids, anti coagulants History of previous gastro-intestinal bleed Chronic debilitating disorder e.g. advanced cardiac disease, renal failure hepatic failure
Group C	Known allergy to paracetamol or codeine Known allergy to non steroidal anti inflammatory medications (NSAID) Concurrent use of NSAID, cortico steroids, anti coagulants History of previous gastro-intestinal bleed Chronic debilitating disorder, e.g. advanced cardiac disease, renal failure hepatic failure Known allergy to oxycodone or tropisitron

### 9.3.3 The protocol

Generally, the protocol provides the patient with a planned, proactive and systematic multimodal analgesic regime that is clearly documented on the discharge paperwork provided to the patient. Table 9.3 displays the salient points of the regime, which are described below.

All patients are advised to take two paracetamol tablets (1 gram equivalent) six hours following the instillation of the eye anaesthesia. As regional anaesthesia diminishes, this provides a pre-emptive background that facilitates the development of paracetamol serum levels necessary for analgesia. Patients are provided with an exact time as to when to commence self-medication. The nursing staff stressed the importance of taking this medication, even if the patient is pain-free at the time. A number of studies have demonstrated the success of pre-emptive analgesia as opposed to reactive pain management. The provision of a paracetamol medication is the first post-discharge step in a pre-emptive and multimodal regime that provides an unambiguous strategy easily self-managed by the patients.

For patients classified as groups B and C, administration of IV paracetamol 40 mg prior to discharge provides a COX II anti-inflammatory medication with a 12+ hour duration. This medication has been found to be successful as part of a multimodal strategy in a number of clinical trials.

**Table 9.3 Pain management protocol, identifying groups A, B and C, and management variations**

Category	Pain management protocol	Pain management variations
Group A	Paracetamol 6 hours after anaesthetic instillation. Then 6-hourly, if required.	Patients are advised to take paracetamol 6-hourly after their first dose if experiencing further pain.
Group B	IV Paracoxib 40 mg prior to discharge. 1 gm paracetamol 6 hours after instillation of anaesthetic. If pain occurs within 6 hours of paracetamol, advised to change to paracetamol+codeine 6-hourly as required.	Patients are given IV paracoxib 40 mg (unless contraindicated) prior to discharge. Paracoxib is a COXII inhibiting medication that provides between 6 and 24 hours efficacy. Patients are provided with paracetamol tablets and paracetamol+codeine. If patients experience pain 6 hours after the pre-emptive dose of paracetamol, they are advised to take 2 paracetamol. If pain persists and analgesia does not last the full 6 hours, then patients are advised to take paracetamol+codeine combined medications 6-hourly.
Group C	IV Paracoxib 40 mg prior to discharge. Patients are given IV tropisetron prior to discharge if assessed by anaesthetist as required. 1 gm paracetamol 6 hours after instillation of anaesthetic. If pain occurs within 6 hours, patients are advised to take 5-10 mg of oxycodone every 4 hours if required. May continue taking paracetamol every 6 hours.	Patients are given IV paracoxib 40 mg (unless contraindicated) prior to discharge. Paracoxib is a COXII inhibiting medication that provides between 6 and 24 hours efficacy. Prior to discharge, patients are also given IV tropisetron, a long acting anti-emetic medication. Following the initial pre-emptive paracetamol dose, if patients experience pain within 4 hours, they are advised to take 1-2 tablets of oxycodone 5 mg tablets provided. If pain persists, patients are advised to take paracetamol every 6 hours and oxycodone every 4 hours.

All patients are provided with the phone number of the “on-call” ophthalmic medical staff, with instructions to call if their pain is unrelieved by the medications or they experience significant nausea or vomiting. The phone numbers of the healthcare facility and a senior nurse were also provided.

Following the first post-operative medical visit, patients who continue to experience pain or discomfort are advised (unless contraindicated) to take oral ibuprofen eight-hourly, combined with six-hourly paracetamol.

### **Choice of paracoxib**

Prior to conducting this study, an unreported randomised controlled trial of piroxicam (a COXII inhibitor) for post V-R day surgery pain relief was conducted in the healthcare facility of the research setting. This unpublished study displays promising results (Clarke & Robertson 2004) with significant reduction in the incidence of post-operative pain (see Table 9.4). These unpublished findings have since been supported by more recent and published evidence of the efficacy of COXII inhibitors for post-operative pain management (Chen, Elliot & Ashcroft 2004; Kohli & Kohli 2011; Langford 2009; Schug & Manopas 2007; White et al. 2011). These studies have reported on the opioid sparing effects of COXII medications and on the success of multimodal drug therapies for post-operative pain management. As most COXII inhibitors were developed for chronic pain management, they are relatively new to acute pain management. However, they have been successful for mild to moderate post-operative pain management when combined with paracetamol. A single intravenous dose of 40 mg paracoxib became the first line of pre-emptive analgesia, prior to discharging patients in groups B and C.



Table 9.4 Raw data from an unpublished study by Clarke & Robertson (2004)

	Experienced no pain	Experienced mild pain	Experienced moderate pain	Experienced severe pain	Total participants
IV (intervention group)	20	11	5	1	37
Received pre-emptive COXII					
CG (control group)	11	7	12	6	36
Received standard pain management					

### Choice of tropisetron (5-HT3 receptor antagonist)

Tropisetron is a long-acting (up to 24 hours) and very successful anti-nausea medication that was first developed to manage the side effects of nausea and vomiting following anti-neoplastic chemotherapy (Antonarakis & Hain 2004; Cranwell-Bruce 2009). Tropisetron is a serotonin 5-HT3 receptor antagonist and is well-tolerated, with few side effects (Eisenberg et al. 2003). The most commonly reported side effects associated with its use are headache, constipation and dizziness. Tropisetron is especially suited to post-surgical day-case patients as the 24-hour duration covers the immediate post-operative self-care period, when a number of participants experienced significant nausea and vomiting. A number of studies have demonstrated tropisetron to be an effective anti-PONV strategy (Eisenberg et al. 2003; Fujii 2008; Salvucci et al. 2011).

### Choice of paracetamol

Paracetamol is an oral medication that is an effective analgesic for mild pain and works well to reduce the required doses of other drugs from higher up the “analgesic ladder”. Paracetamol’s pharmacological actions are thought to be related to the

inhibition of the cyclo-oxygenase enzyme in the central nervous system, and there is some evidence that it may act as a weak NSAID at high doses. Paracetamol is well-tolerated with few side effects. However, oral paracetamol requires up to two hours to reach peak serum and therapeutic levels. Thus, a pre-emptive 1 gm oral dose of paracetamol ensures that a therapeutic serum level is maintained before the analgesic effect of the regional eye anaesthesia wears off.

### **Choice of Ibuprofen**

Ibuprofen acts by inhibiting cyclo-oxygenase enzymes (COX-1 and COX-II) and by a subsequent synthesis of prostaglandins and related compounds at peripheral sites. Ibuprofen is readily available in the community and is adequately tolerated over short periods. It can be administered concurrently with paracetamol for a multimodal analgesic effect. Ibuprofen has been found to successfully augment pain management strategies following surgery, thus it was considered an appropriate choice for pain management in this patient population.

### **Pain with the instillation of local anaesthetic agent**

Pain with the instillation of a local anaesthetic is a common occurrence. Almost all studies of successful and painless regional anaesthetic instillation for ocular surgery describe the use of various forms of sedation (Gioia et al. 1999; Newsom, Wainright & Canning 2001). Sedation may utilise such medications as oral temazepam, IV clonidine, hypnoval, propofol. All of the above medications are standard anaesthetic type medications with a choice of sedation technique made by the anaesthetist in collaboration with the patient, peri-operative nurses and the surgeon. One major requirement for sedation is that patients abstain from food for a minimum of six

hours prior to the surgery and from fluids for a minimum of two hours. The requirement for fasting adds complexity to diabetic patients, as close monitoring and education of the fasting period is required to reduce the complication of hypoglycaemia (Di Nardo et al. 2011).

## 9.4 The psychological self

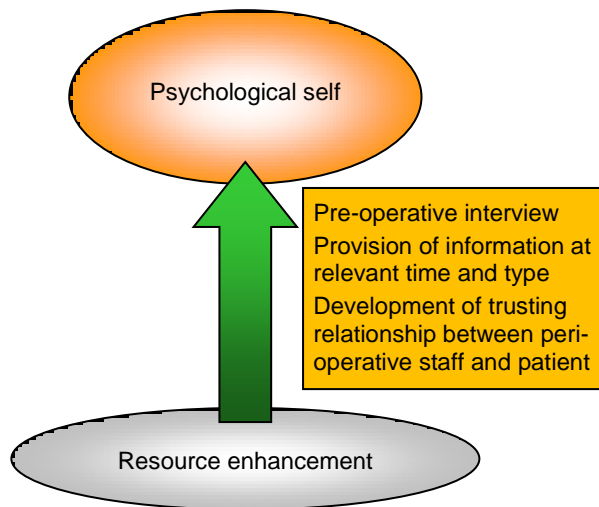


Figure 9.2 **Strategies for psychological resource enhancement**

The provision of information prior to surgery is the most common intervention for psychological support experienced by the participants. Whilst some participants asked for detailed explanations of their treatment and condition, others felt that such information would contribute to higher anxiety levels. This evidence contrasts with the current literature on psychological preparation for surgery, which supports the belief that providing pre-operative information reduces post-operative stress, pain and anxiety (Hughes 2002; Scott 2004; Shuldham 1999; Spalding 2003). The Uncertainty in Illness theory by Mishel (1988) provides an explanation for the

variations between participants' experiences and the knowledge from literature. This theory assists in understanding patient needs and aids in designing interventions that offer psychological support through the enhancement of protective resources.

#### **9.4.1 Uncertainty in Illness theory**

Mishel's (1988) complex middle-range theory of uncertainty in illness has much to offer in understanding and interpreting the experiences of patients undergoing a sight-threatening event. Uncertainty has been defined as a situation where an individual is unable to assign definite meaning or predict outcomes associated with the event (Mishel 1988b). This definition is further developed to include a situation where an individual is unable to predict outcomes accurately because the cues to understanding are vague, inadequate, unfamiliar, numerous or lacking information (Kang 2009).

Important constructs of Mishel's (1988) theory include: the stimuli frame, which encompasses the components of symptom pattern, event familiarity and congruency; the structure providers, comprising credible authorities, social supports and education; and an appraisal of the illness event as either danger or opportunity. These theoretical constructs provide clarity of understanding during the deconstruction of participants' narratives who had experienced V-R day surgery. The participants' narratives will be re-examined using each of these constructs with the aim to understand their needs and actions, thus building a relevant nursing intervention on this understanding.

### **The stimuli frame**

According to Mishel (1988), the stimuli frame refers to the composition and structure of the stimuli. In this study, this indicates the event of a sight-threatening illness and the need for V-R day surgery. The three components of the stimuli framework include symptom pattern, event familiarity and event congruency. Mishel (1988) stated that less certainty exists when symptoms form known patterns and, in relation to the participants' experiences, higher levels of uncertainty are generated when surgical failures or re-detachment occur. Participants lacking previous symptoms on which to appraise patterns are also likely to develop high levels of uncertainty.

Familiarity with patterns within the healthcare environment, described as the construct of event familiarity, is considered antecedent to decreased uncertainty. Since novelty and complexity of an event are thought to impede event familiarity, this construct is important in understanding the participants' experiences.

Unexpected surgery occurred for many of the participants, and the urgent nature of their surgery could be considered a novel event with a corresponding high level of uncertainty. Event familiarity could be seen to decrease the participants' uncertainty if they had positive experiences of previous surgery. However, if the previous experiences were negative, then event familiarity added to the uncertainty.

Event congruence is the consistency between the expected outcome and what actually transpires (Mishel 1988b). Uncertainty diminishes when congruency exists between expectations and the events that occur. This is evident in Dorothy's positive experiences, where her surgery and recovery exceeded her pre-operative expectations. However, for a number of the participants, unforeseen recurrence of

V-R pathology occurred. These unexpected events shattered the congruency between their expectations and the actual outcomes, an incongruence that led to high levels of uncertainty.

### **Structure providers**

Trust and confidence in healthcare providers (HCP) is referred to as the credible authority (Mishel 1988). Mishel (1988) views the construct of structure providers as reducing the patients' uncertainty levels by helping them interpret the stimuli frame. It is this aspect of the theory that provided a platform for new nursing interventions with the aim to decrease uncertainty levels. Within the context of the participants' experiences, structure providers encompass the credible authority, which includes healthcare providers of surgeons, anaesthetists and nurses.

This construct is based on the belief that high levels of trust and confidence in the healthcare providers would lead to lower levels of uncertainty. The credible authority provides and interprets information about disease, causes, symptoms and treatments. These resources enhance an individual's event familiarisation and congruence between expectation and outcomes. Furthermore, Mishel (1988) describes the power relationship between patients and the HCP, whereby the patients expect the HCP to take responsibility for information and treatment plans based on expert knowledge.

The relinquishing of power is evident in the narratives of those participants who expressed trust in the HCP to do what was needed. Participants who relinquished power often expressed the desire not to know the details of the upcoming procedure. This request may be interpreted as an effort to diminish their appraisal of the

complexity of their condition and to reduce uncertainty levels. Thus, a valid strategy for patients' psychological preparation for a surgical intervention is the enhancement of trust and confidence in the HCPs, who are potential sources of uncertainty reduction.

### **Appraisal of uncertainty**

Uncertainty is considered a neutral state until the individual appraises the situation as one of either danger or opportunity. Appraisal of a situation as danger (where potential for a harmful outcome exists) occurs for all of the study's participants, as visual disability is greatly feared. When a situation or healthcare condition is appraised as danger, uncertainty is considered one of the single greatest sources of psychosocial stress to patients (Kang 2009; Shala et al. 2008).

The appraisal of danger to a current situation requires a number of antecedent events to occur, including loss or absence of credible authority, event unfamiliarity and a lack of symptom pattern (Mishel 1988b). People who appraise uncertainty as danger predominantly rely on "credible authority" to lessen the uncertainty of an event. When a relationship based on trust and credibility develops between patients and healthcare staff, then uncertainty is diminished but not eliminated.

When an event is appraised as dangerous, there is limited value in providing detailed information and education, as the patients' heightened stress levels at this point preclude cognition of this type of materials (Rosique et al. 2006). This theory is supported by the findings of the study reported here, as a number of participants did not want detailed information regarding their condition or surgery. Thus, the

establishment of trust with the patient is paramount when caring for people who have experienced a sudden sight-threatening event (a situation for many of the participants) that has the potential for significant negative changes to quality of life.

The findings show that people who had experienced sudden vision loss and required urgent surgery had assessed the situation as dangerous, frequently expressed as a fear of blindness. New interventions were subsequently developed based on this study's findings and interpreted through Mishel's (1988) Uncertainty in Illness theory, aiming to improve people's experience of V-R day surgery. The interventions include a pre-operative interview between nursing staff and the patient, with the aim to foster trust and familiarity between patients, healthcare providers and their environment. During the interview, participants were questioned regarding their information requirements. If detailed information was requested, a detailed description of the condition and treatment was provided. If there was no request for information, emphasis was placed on developing a therapeutic relationship between staff and patient.

Participants were invited to view the day surgery suite to lessen the strangeness of the environment and were introduced to staff who would be involved in their care. At the time of the interview, social support issues were discussed and preparations for post-operative care were established. Participants were given the opportunity to ask questions regarding their treatment and follow-up care.

The above interventions would facilitate a relationship built on trust and participants were given opportunities to explore any potential problems or issues. Unfamiliarity



with the peri-operative environment was lessened by introducing staff to patients, with the aim to reduce uncertainty. The declined uncertainty and associated stress would bolster the psychological resources of individuals dealing with V-R day surgery. A standardised pre-operative assessment sheet was developed, with structured questions addressing each of the above aspects (see Appendix 6).

### **9.4.2 Limitations of Uncertainty in Illness theory**

Uncertainty in illness theory (UIT) is not without limitations. Similar to resilience theory UIT has a diversity of underpinning construct that have evolved over time. Initial UIT construct was a belief that an individual will return to previous levels of functioning (Mishel 1988). However, Mishel revised this to a belief that individual will grow towards a new value system following development of an illness with aspects of uncertainty, (Mishel 1988). Thus it was necessary to declare which constructs were to be utilised in the application of this theory. Furthermore there is a high level of complexity to the constructs of uncertainty. Mishel's (1988) theory offered a comprehensive and dynamic theory to understand the specific experiences of information requirement and relationship development in this participant group. The divergent needs of participants, from wanting large quantities of detailed information to wanting only minimal information can be clearly explained by this theory. The depth and importance of the relationship between patients and health care providers and the potential of uncertainty moderation was clearly illuminated by this theory. Thus, this theory was the most appropriate to inform the interpretation of the specific aspect of information needs and relationships between patient and care provider of this study findings

## 9.5 The historically located *self*

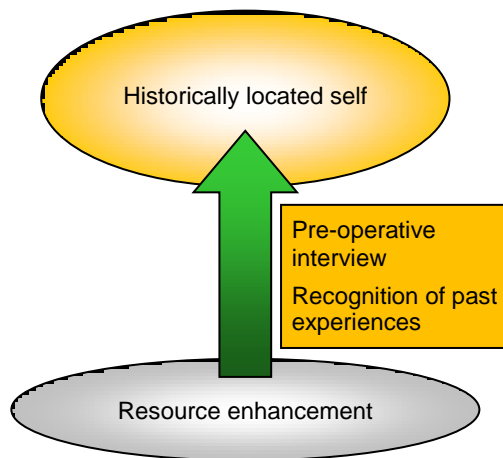


Figure 9.3 **Strategies for experiential resource enhancement**

The participants described varying lengths of illness and numbers of surgical interventions; however, there was little difference in the participants' care despite their diverse health histories. In this aspect, sensitive care that is flexible and cognisant of health histories would contribute to patients' broader needs beyond the immediacies of the current intervention.

The recognition of past experiences and their incorporation into current care occurred in the following manner:

- Past experiences of both ocular and other types of surgery were explored during the participant's pre-operative interview.
- Where participants had previous positive experiences, the salient features of these experiences were identified and incorporated into their current care.

- Where previous experiences had been negative, the difficulties were identified and steps were planned to eliminate the causes during current treatment.
- Previous difficulties with instillation of the eye “block” were identified and strategies identified to improve the experience.
- Previous problems with post-operative self-care were identified and new strategies to improve the experience were incorporated in current care.

A new pre-operative assessment form was used to record the participant’s health history and their ocular history in particular (Appendix 6). Through identifying and instigating relevant actions, past negative experiences were recognised and steps were taken to eliminate the possibility of repeat experiences.

The interviewing of participants with a named nurse prior to the surgery served several functions, including the development and understanding of past experiences. The value of this relationship can be seen in the psychological and historically located self, as described above. This relationship displays a further value to patient experiences in regards to the final domain, the *self within the community*. The following section further explores the benefits of this relationship.

## 9.6 The *self* within the community

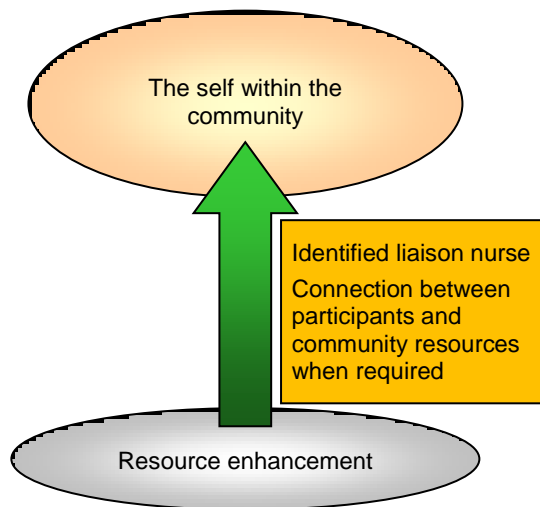


Figure 9.4 **Strategies for community based resource enhancement**

It was clear from the participants' experiences that they were frequently lacking the necessary resources to cope with ongoing visual disability. The connection of the patient with available community resources was unavailable for participants who needed these services.

Convalescence following retinal surgery may be an ongoing process extending over many months. During this time, the management of participants' ocular pathology was closely monitored through outpatient visits to the healthcare facility. However, during convalescence, participants were not assisted in coping with the difficulties of monocular vision, the psychological stress of an unknown visual outcome, the anxiety of possible blindness and a perceived loss of quality of life. As the healthcare facility did not offer any anxiety reduction strategies, the participants were forced to form their own when overwhelmed by stress and anxiety.

Bruce sought help through the RSB (Royal Society for the Blind) and the LVC (Low Vision Centre); however, he was denied access due to a lack of medical referral. Fin, Tony and Robert contacted their local GPs for assistance. In contrast, John (who had significant visual disability) found support in his close relationship with his surgeon and anaesthetist.

The role of the liaison nurse is modelled on successes in other services. This role was developed to facilitate connection between participants, the healthcare facility and community resources. The role of the specialty liaison nurse demonstrates significant value to patients and families across a range of practices, including diabetes, chronic obstructive pulmonary disease, cancer and palliative care, to name a few (Caulfield 2011; Harvey & Wilson 2009; McGinnes et al. 2010). The provision of support through an appointed healthcare professional, such as a liaison nurse, would facilitate proactive care strategies and direct patients to appropriate support services.

## **9.7 Summary**

The proposed new model of care requires extensive changes to be made to current care practices. It incorporates the new interventions developed from this study's findings and establishes theoretical knowledge (as displayed in Figure 9.4). This model aims to enhance the patient's protective resources and promote positive V-R day surgery experiences.

In this study, the protective resources addressed the domains of the human *self* identified as: physical, psychological, historically located and self within the

community. These resources are displayed as a new model of care for V-R day surgery care (see Figure 9.4). It was proposed that optimal self-care and development of proactive care sensitive to the needs of people with V-R pathology would occur through the augmentation of individual protective resources based on this study's findings (see Figure 9.5). An evaluation of the effectiveness of the interventions was required following their implementation in the clinical context of this study (as described in this chapter). This evaluation includes an audit of 100 consecutive patients and an in-depth interview of a further nine participants. This evaluation is congruent with the fifth and final step of this EBNP model.

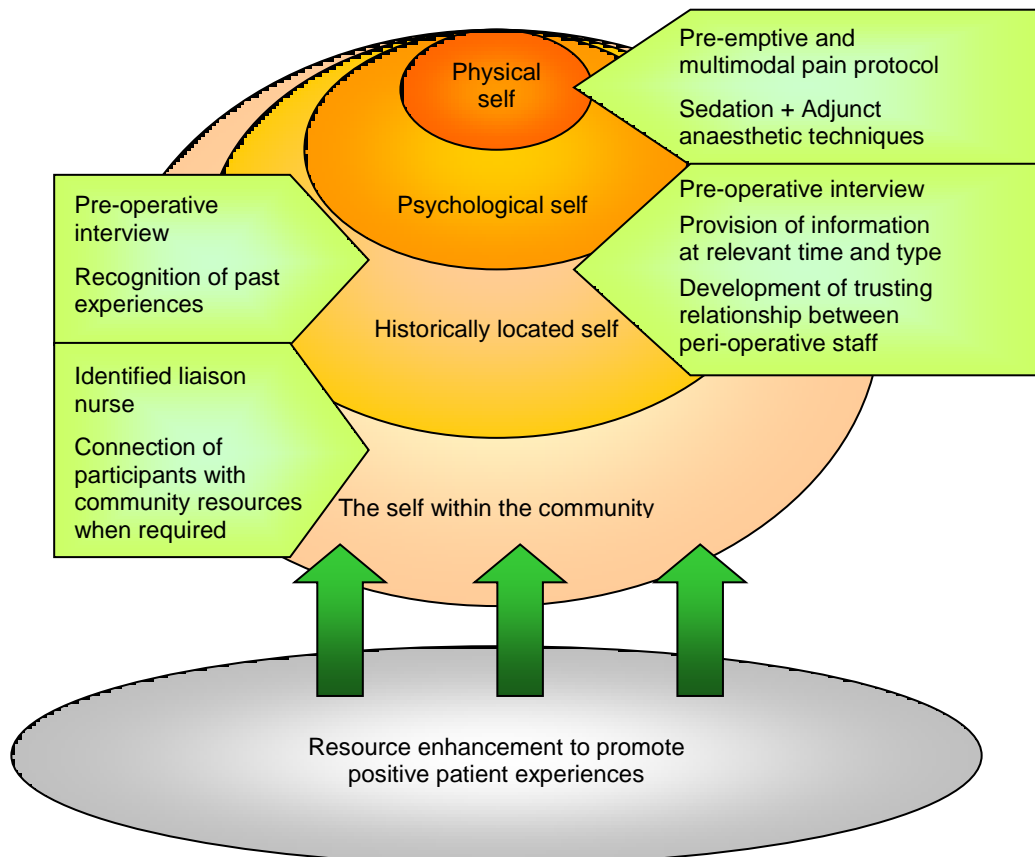


Figure 9.5 A new model for V-R day surgery care

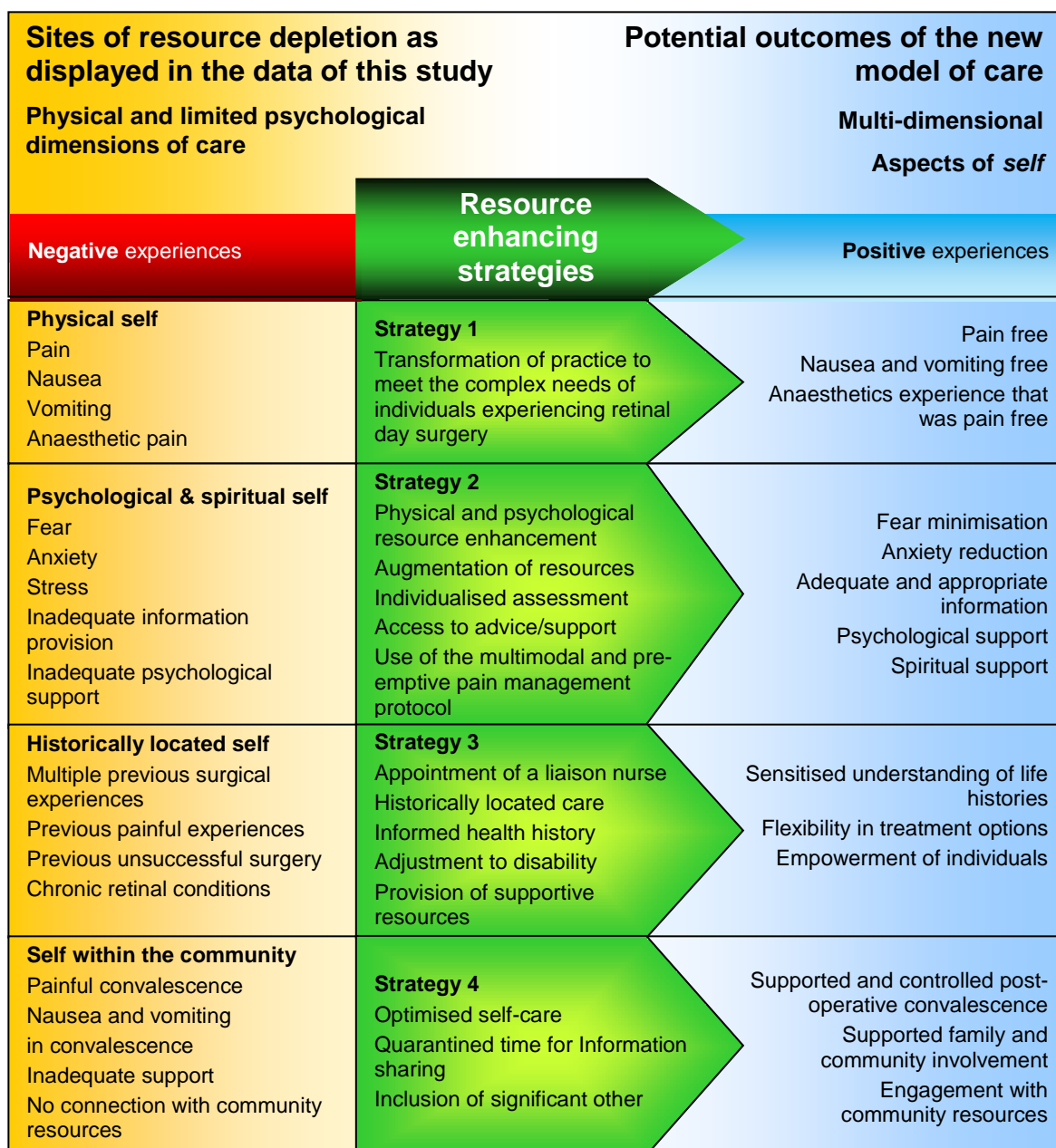


Figure 9.6 Display of resource depletion sites and strategies proposed to enhance protective factors with potential positive patient outcomes

The fifth and final step of the synthesised EBNP model requires an evaluation of interventions developed from new research knowledge, which emerged in Step 3 of this study and was implemented in the clinical setting of this study in June 2010. The evaluation techniques of auditing and interviewing were considered appropriate, as these methods assess the value of new interventions in nursing care. This dual

evaluation process of auditing and interviewing enables a broader appraisal of the interventions that is inclusive of the individual and cohort experiences. The interventions (as described in Step 4) address issues within each of the four domains of the human *self* identified in Step 3. Following is a brief overview of the interventions to assist with the understanding of evaluation activities. The interventions commence with the physical *self*.

A multimodal and pre-emptive pain management protocol was designed to overcome issues of post-operative pain during self-care. This protocol requires patients to be assigned to group A, B or C, which provide varying levels of analgesic support. Assignment to a protocol group depends on surgical categories 1, 2 or 3. It relates to the procedure's complexity and the potential for post-operative pain, and is cognisant of the patient's previous experiences.

Anxiety and pain during instillation of the regional anaesthetic can be alleviated by adjunct anaesthetic sedation techniques or general anaesthesia. Issues of nausea and vomiting are to be eliminated through good pain management that reduces the need for narcotic rescue medications, which can have significant side effects.

The three domains of psychological *self*, historically located *self* and *self* within the community are addressed under the umbrella intervention of a liaison nurse. The liaison nurse is able to perform the following interventions/activities:

- Conduct a pre-operative interview with V-R surgical patients, which provides the opportunity to:



- Assess the individual patient's need for information and supply appropriate documents (psychological *self*);
  - Identify past experiences and potential areas of difficulty, that is – anaesthetic issues, post-operative pain management problems or social support issues (historically located *self* and physical *self*);
  - Identify the need to fast, if sedation or general anaesthetic is required (physical self and psychological *self*); and
  - Identify any activities that would reduce anxiety and help patients cope with surgery and anaesthetics. For example – the use of music, inclusion of significant other in aspects of care (psychological *self*).
- Establish a trusting therapeutic relationship, which is particularly important for patients who use such a relationship as a means of anxiety reduction (the psychological *self*).
  - Provide post-operative support through a named nurse (liaison nurse) who can facilitate access to community-based support services (*self* within the community).
  - Provide information/advice during post-operative care (*self* within the community).

These new interventions are believed to deliver improved care to patients experiencing V-R day surgery. They are the focus of evaluation activities described in Chapter 10.

## CHAPTER 10

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# EVALUATION OF THE NEW MODEL OF CARE IN PRACTICE

### Step 5

Evaluating the effectiveness and efficiency of interventions developed, through the processes of auditing and evaluation

### 10.1 Introduction

Step 5 incorporates an evaluation process that addresses the specific clinical context. It differs from inquiry research only in terms of its purpose. Evaluation is the primary concern of establishing the efficiency of new interventions, while the purpose of inquiry research is mostly knowledge generation. Thus, evaluation is seen as an appropriate activity for this step, which aims to evaluate the effectiveness of newly developed interventions described in Chapter 9.

The methods of evaluation utilised in this study include an audit of 100 patients and subsequent in-depth interviews with nine participants. The audit was guided by known processes and established frameworks. The major qualitative research activities in Step 3 of this study were guided by philosophical hermeneutic methodology. In order to maintain consistency and methodological congruency, the same methodology was used to guide the qualitative evaluation activities. Conduct of qualitative data generation complied with previously described research practices, meaning that there was a conformity enhancing the trustworthiness of the evidence.

## 10.2 The audit

Audits illuminate phenomena existing in clinical context (Burns & Grove 2009) and are useful for assessing care where standards of best practice are already known (Ashmore & Ruthven 2008). Furthermore, audits are beneficial in evaluating patient experience and effectiveness of care provided (Grainger 2010; Patel 2010). Their benefits lay in describing what actually existed and not requiring manipulation or comparison between groups or variables (Gerrish & Lacey 2010). An audit is a particularly relevant evaluation method for this study on a number of fronts: firstly, it describes best practice for post-operative pain relief (a requirement of well-structured audits); secondly, there is a single clinical context; and, thirdly, evaluation follows the implementation of new interventions for post-operative pain management and is measured against the described best practice.

When deciding to conduct an audit following implementation of the new interventions it was necessary to be mindful of the criteria of auditing that included, where known standards of best practice existed and when an evaluation of patient experiences is required (Ashmore & Ruthven 2008; Grainger 2010; Gerrish & Lacey 2010). Thus, by using the known standards of pain management and positive patient experiences an audit was the next logical step in the research evaluation. In the clinician researcher's zeal to have the new interventions in place, the opportunity to conduct a preliminary audit was lost. The researcher's lengthy immersion in the research and clinical practice had provided her with a good understanding of "what was happening" within this unit. This understanding was bolstered by discussions with ophthalmologists who were keen to have an improvement in the management of V-R day surgery patient care, particularly in relation to pain management. However,

the conduct of an audit prior to the implementation of the new interventions would have contributed significantly to the strength of the conclusions of the study. As the findings stand, further research should be conducted that is mixed in methods that would include a wide participant sample and the data collected could be representative of their experiences both quantitatively and qualitatively. Such findings have the potential to provide a rich and generalizable understanding of the experience, which has great potential for transference to other clinical contexts.

As identified in Step 3 and reported in Chapter 9, an intervention to address problems with the physical *self* includes a multimodal and pre-emptive post-operative pain management protocol. The interventions incorporate established knowledge of analgesic techniques that are novel to managing post-operative pain following V-R day surgery. They include pre-emptive (given prior to discharge and prior to development of high levels of pain) and multimodal (using a variety of medications that include paracetamol, ibuprofen, piroxicam, oxycodone and paracetamol+codeine) analgesia. These interventions aimed to improve the patients' self-management of post V-R surgery pain, particularly in the first 24-hour period, which was known to be problematic.

The audit took place between April and September 2010, following approval from the relevant ethics committee (Appendix 2: Ethics approval documents). See Appendix 7 for an example of the audit data collection sheet. Data collection included:

- Demographic details;

- Procedural category;
- Pain experiences using a validated 10 point verbal response tool; and
- Analgesia consumption.

This section discusses the conduct and results of the audit in relation to the effectiveness of new interventions on patients' pain experiences following V-R day surgery.

### **10.2.1 Aim of the audit**

The audit aimed to describe and clarify patients' experience of pain during self-care following retinal day surgery with the view to illuminate the effectiveness of interventions provided. The evaluation related to analgesic efficacy for each procedural category and to compliance with instructions for pre-emptive analgesia.

### **10.2.2 Identifying measures of quality consistent with good practice**

Well-constructed audits require an agreed baseline of good practice that is informed by relevant guidelines (Grainger 2010; Hamer & Collinson 1999). The agreed standard of care in this audit is informed by clinical guidelines (ANZCA 2010) that require a 'minimal patient experience of pain, through successful pre-emptive and proactive analgesia'. The guideline further states that not all patients will be free from pain, only that all patients have the right to a reasonable and professional response proportionate to the pain experience (ANZCA 2010). For the purpose of this audit, evidence of successful pain management is pain scores of mild or nil with the use of self-managed and pre-emptive analgesic, proportional to the expected level

of discomfort as identified through the complexity of the procedure scale. This response complies with the described clinical guideline.

### **10.2.3 Methods of the audit**

The focus of the audit in regard to pain management was restricted to the first 24-48 hours post operatively as this was the time of most difficulties described participants. It was also the time between discharge from the day surgery unit and follow up post-operative visit where dressings were removed, eye examined and pain management assessed. During the first postoperative visit the ophthalmologist prescribed ongoing multi modal pain relief medications that usually included; paracetamol. Ibuprofen and when necessary a narcotic oxycodone. The first 24-48 hours is the time when many patients across a broad range of clinical specialties experience significant difficulties with pain management (Older 2010). The interventions developed from the findings of earlier research and were designed to address this immediate time where the potential for acute pain was highest. The researcher was particularly interested in patient's pain experience; did they take the pre-emptive paracetamol as instructed, did they need to call the on-call ophthalmologist for pain management advice. It was felt that these inquiries would provide a clear picture of the effect of the pain management intervention that had been implemented. However, there were a number of limitations to this strategy. Firstly, the time frame was short 24-48 hours. This was the time frame of the researcher's interest, which could attribute this focus on the immediate recovery period to an ongoing influence of a peri-operative background which has clear roots in a bio-medical model of care. If an extended time of pain management inquiry to a longer time frame occurred then a broader and more comprehensive understanding of the pain experience of people experiencing V-R day

surgery could be ascertained. Such a narrow focus on the immediate post-operative period has limited the conclusions that can be drawn from the findings. Secondly, the inquiry into patient's pain management focussed on only pharmacological interventions. The non-pharmacological actions of people to assist with management of pain have been well described, (Crowe et al. 2008) and an opportunity to explore patients use of adjunct therapies in pain management was not embraced. Thirdly, the role of the nurse-patient relationship in the understanding and compliance with pain management strategies was not explored. Acute pain management theory clearly describes the role of nurses in the education of patients in pain management techniques (Good 1998; Older 2010). An exploration of this relationship and the impact it may have exerted on patients pain management strategies would have provided useful information for informing practice. Finally for a number of participants of this study, pain was an ongoing issue that could well have been explored through longitudinal inquiry into patient's pain experiences

A standard V-R day surgery feature was a post-operative appointment on the following day with the appropriate ophthalmologist. During this visit, dressings were removed, the eye examined, eye medications commenced and post-operative analgesia discussed. It was also during this time that the researcher, in the newly implemented role of liaison nurse, interviewed patients and collected audit data. Patients who did not attend post-operative appointments were contacted via telephone as part of the audit process. One hundred consecutive patients who had experienced V-R day surgery were audited between April and September 2010. An audit instrument was developed that collected data on aspects of the participants' experiences (see Appendix 7).

The audit instrument uses structured interview techniques with pain experiences measured by a verbal response scale (VRS). The VRS is considered a valid and reliable tool for measuring post-operative pain experiences (Aicher et al. 2012; Williamson & Hoggart 2005), with the two extreme ends being “no pain” and “severe pain”. There are nine points within the two extremes on which participants can rate their pain score. Scores are aggregated to four categories, that of: no pain, mild pain, moderate pain or severe pain. During the audit interview, qualitative data was sought regarding aspects that included experiences of anaesthetic and surgery, as well as information needs, with the intention to evaluate the intervention’s success within the new model of care. This data was collected and analysed using thematic analysis techniques, as described in Step 3 of this study.

As outlined in Chapter 9, the patients’ surgical procedure experiences are categorised into groups depending on the complexity of the pathology and the surgery required. Category 1 is the least complex and Category 3 is the most complex. Category 3 participants are at most risk to experience post-operative pain due to complexity of their surgery. Following an assessment by a consultant anaesthetist, surgeon and senior nurses, all participants were allocated into the new intervention of pain management protocol. The protocol includes groups A, B and C, and each group requires specific pain management strategies, described in Chapter 9. The audit focuses on the success of protocol allocation and subsequent management of post-operative pain.



#### **10.2.4 The Audit sample**

The decision to audit 100 patient experiences following V-R day surgery was determined by what was likely to cover the broad range of both elective and emergency procedures. The chosen sample size of 100 participants was believed to be inclusive of a broad range of patients with surgical interventions those from complexity category one, two and three. Such a range would overcome any potential skewing of the data through having too many category one (less invasive) classified patients within the sample. Given that only 19% of the participants of the audit were classified as category one, then over 80% of participants would be expected to have need for pain management following surgery provided, supporting the belief that the protocol was applied and measured to participants who had a true need for pain management. One hundred participants of the audit were representative of one third of the annual V-R patient case load in this clinical context. Thus the sample size of 100 participants was considered to be adequate to reflect on the experiences of this patient cohort. Ongoing audit of the success of pain management would provide a clear and comprehensive view of patient experiences of pain on the night of the surgery.

#### **10.2.5 Ethics approval**

On 16 February 2010, the appropriate ethics committee approval to conduct this audit was obtained. This approval was an extension of that obtained in April 2004, for conducting the research activities previously described in this thesis.

#### **10.2.6 Results**

Gender distribution within the 100 audited patients included 57 male and 43 female patients (Table 10.1). The age distribution (displayed in Table 10.1) demonstrates a

predominance of older adult participants, with 77% over 55 years of age. Eighty one per cent of surgical procedures were Category 2 or 3, indicating that most surgery performed within the audit group was complex in nature and had potential for significant post-operative pain.

Table 10.1 Age and surgical categories of 100 audit patients

No. of participants	
Age	
<25	3
26-45	11
46-55	9
56-65	23
66-85	45
86+	9
Surgery defined category	
1 ( <i>least complex</i> )	19
2	44
3 ( <i>most complex</i> )	37

Table 10.2 Distribution of pain experiences of 100 audit patients

Pain protocol group allocation	Surgical category	Number of patients	No pain	Mild pain	Moderate pain	Severe pain	Pre-emptive paracetamol
Group A	1	1	1	–	–	–	1
	2	1	–	–	–	1	1
	3	–	–	–	–	–	–
Group B without COXII	1	9	4	1	3	1	6
	2	8	2	4	2	–	5
	3	4	3	1	–	–	–
Group B with COXII	1	7	5	2	–	–	5
	2	26	22	4	–	–	16
	3	9	5	4	–	–	21
Group C without COXII	1	1	1	–	–	–	–
	2	5	3	2	–	–	1
	3	4	–	–	2	2	–
Group C with COXII	1	1	1	–	–	–	–
	2	6	3	3	–	–	4
	3	18	8	9	1	–	7
Total		100	58 (58%)	30 (30%)	8 (8%)	4 (4%)	67 (67%)

The results displayed in Table 10.2 show an 88% incidence of patients having mild or no pain, despite 45% of these patients being surgical Category 3. Only 8% experienced moderate pain and 4% experienced severe pain. All of the patients who experienced severe pain had not received pre-emptive non-steroidal anti-inflammatory or COX II medications due to either co-morbidities or allergy. It is useful to refer to a previous, unpublished study conducted in the same clinical context. Clarke and Robertson's (2004) experimental study of post-operative pain management includes a control group, who received standard post-operative pain management. The study's results (Table 10.3) demonstrate a 49% incidence of moderate to severe post-operative pain in the non-experimental group. The 49% of patients in Clark and Robertson's (2004) study who suffered moderate to severe pain was a significantly higher incidence than the 12% of audit patients in this study who experienced moderate to severe pain.

**Table 10.3 Distribution of pain experiences of control group of an unpublished experimental study (Clarke & Robertson 2004)**

<b>Surgical category</b>	<b>Patient numbers</b>	<b>No pain</b>	<b>Mild pain</b>	<b>Moderate pain</b>	<b>Severe pain</b>
1 <sup>a</sup>	8	2	4	2	–
2	14	8	3	3	–
3 <sup>b</sup>	15	2	–	7	6
<b>Total</b>	<b>37</b>	<b>12 (32.4%)</b>	<b>7 (19%)</b>	<b>12 (32.4%)</b>	<b>6 (17%)</b>

<sup>a</sup>Least complex. <sup>b</sup>Most complex

Standard pain management, as used in Clarke and Robertson's (2004) study, utilises paracetamol and oral narcotic rescue medication. No pre-emptive or multimodal medications are provided and this standard pain management strategy exists in the clinical context prior to the development and implementation of the new pain protocol of this study.

An interesting qualitative finding of the audit concerns the need for information regarding both surgery and pathology. Currently, information provision is often utilised as an anxiety reduction strategy for surgical patients (Spalding 2003; Wong, Chan & Chair 2009). However, 33% of the patients in this audit did not wish to gain detailed information regarding their surgery and pathology. This result contradicts existing research evidence that specifies pre-operative information as an essential strategy for anxiety reduction (Majasaari et al. 2005; Ray 2004). These findings concur with the in-depth qualitative knowledge developed in the first research activity of this study. These concise quantitative findings are further explored in the qualitative evaluation of the experiences of nine participants.

### **10.3 Qualitative Evaluation**

After the audit, nine participants were purposively selected and interviewed in-depth about their experiences of V-R day surgery. Participants were informed of the nature and uses of the research data, and were asked to sign a consent form. They were advised that all information is confidential and anonymous, and that they have the right to refuse or withdraw at any time without consequence.

The participants were chosen purposively as they had recently V-R day surgery experience that included the new model of care developed as a result of this study. Participants were identified from surgical lists, with the inclusion criteria of living within 50 km of the clinical context and being able to speak English. All participants had undergone V-R surgery within the previous two months. There were five female and four male participants, with ages ranging from 34 to 78 years.

### **10.3.1 The participants**

As befitting the qualitative research methods, the participants are introduced and a brief description of their circumstances is included. Table 10.4 displays their underlying pathology, demographic details, current surgery and number of previous surgical episodes surgery. This table shows that six of the nine participants had no previous experience of eye surgery, while the remaining three participants had experience of multiple episodes. All of the participants enjoyed family support on the night of the surgery, an important factor in the day surgery experience.

Consistent with the principles of ethical conduct in human research as described in chapter 6 section 6.3, each participant's confidentiality was protected through the use of pseudonyms. Following the production of the transcripts of the interviews and completion of the thesis recorded tapings were destroyed.

The following section further develops this brief description by introducing each participant and providing an opportunity for insight into their unique situations.

**Table 10.4 Demographics, pathology, episodes of previous surgery and social supports of the nine participants of Step 5 evaluation**

<b>Participant</b>	<b>Age</b>	<b>Gender</b>	<b>Pathology – elective/emergency</b>	<b>Surgical event</b>	<b>Previous eye surgery</b>	<b>Social supports</b>
Marion	34	Female	Diabetic retinopathy – elective	Vitrectomy	1st	Husband and family, two small children
Tyrone	57	Male	Traumatic retinal detachment – emergency	Vitrectomy	4th	Wife
Sally	78	Female	Epi retinal membrane – elective	Vitrectomy	1st	Sons
Ivan	68	Male	Retinal detachment – emergency	Vitrectomy	1st	Wife
Beth	54	Female	Retinal detachment – emergency	Vitrectomy	1st	Husband
Deb	44	Female	Recurrent retinal detachment – emergency	Vitrectomy + scleral buckle	5th	Family
Bob	66	Male	Recurrent retinal detachment – emergency	Vitrectomy + scleral buckle	4th	Good neighbours and friends
Evica	68	Female	Recurrent retinal detachment – emergency	Vitrectomy	1st	Husband and daughter
Jim	54	Male	Emergency retinal detachment	Cryotherapy	1st	Wife

### **Marion**

Marion (34 years of age) was a young mother of two children who had recently experienced a vitreous haemorrhage as a complication of her Type 1 diabetes.

Marion’s surgery was elective and she waited until after her second child was born before agreeing to the procedure. Her supportive partner and close family ensured that Marion was closely supported through the convalescence period. Marion’s visual recovery had been excellent.

### **Tyrone**

Tyrone, aged 57, sustained significant head and facial injuries following an unprovoked assault. After treatment of his facial injuries, Tyrone experienced four episodes of V-R surgery to repair his retinal detachment. A supportive partner helped

Tyrone deal with the multiple surgical episodes, the psychological issues that resulted from the assault and a complete loss of vision in one eye.

### **Sally**

Sally had greatly valued her gardening interests and an active social life. She sought expert advice when her vision began to deteriorate and discovered that, without surgery, the degradation would continue rapidly. At 78 years of age, Sally chose to have elective surgery, which she managed well with close family supporting her during convalescence. Sally's elective surgery was successful and her vision had improved.

### **Ivan**

Whilst holidaying at a local destination, Ivan's vision began to deteriorate quickly due to a retinal detachment. Following advice from a local GP, Ivan sought emergency care where he underwent a repair of retinal detachment. Being elderly (68 years of age) yet still active, Ivan was very anxious regarding the surgery outcome and the impact that loss of vision might have on his independence. Ivan's final visual outcome was not established as he was still in the convalescent phase during his interview.

### **Beth**

As a school teacher, Beth placed great importance on her visual capacity. When her sight suddenly deteriorated, Beth sought care and experienced one occasion of V-R surgery to repair her detached retina. A recent shoulder operation made convalescence a little more difficult, particularly when positioning following eye

surgery was required. Beth was also still convalescing and her visual outcome is yet to be determined.

### **Deb**

A repeat retinal detachment prompted Deb to seek assistance, resulting in emergency eye surgery. A supportive husband and children helped Deb recover quickly from unexpected surgery. At 44 years of age, Deb had experienced four previous episodes of retinal surgery and her visual prognosis caused significant anxiety. Multiple treatment episodes compounded the complexity of Deb's surgery and she was advised that her visual outcome would take several months to establish.

### **Bob**

Independence and travel had been substantial components of Bob's life. At age 66, a retinal detachment threatened this lifestyle and left Bob anxious, as this was a second occurrence. With no family close by, he relied on friends and neighbours for help through the long convalescence. At the time of the interview, Bob's vision was gradually improving as the intraocular gas inserted was being absorbed and no longer obstructed his vision.

### **Evica**

Part of the "grey nomad" migration, Evica was in the Northern Territory when her vision suddenly diminished. Upon discovery of a retinal detachment, she flew to Adelaide and had surgery the day after arrival. Evica was very anxious as she was 68 years old, English was her second language and she had no family to support her until her daughter's arrival a day later. In the short time between her surgery and the



interview, Evica's retina remained attached and she was hopeful of a full visual recovery.

### **Jim**

Surgery for a retinal detachment was the consequence of an injury to Jim's eye. At 54 years of age, Jim was a full time employee and breadwinner for his family; hence, he found it difficult to manage time off for surgery. This was Jim's first surgical episode, with his wife and family standing by him on the night of the procedure and during convalescence. At the time of the interview, Jim was some months through convalescence and his vision had recovered soundly.

### **10.3.2 Data collection**

In-depth interviews transpired between October and December 2010, either in the participants' homes or in a quiet room within the clinical setting. In accordance with interviews conducted in Step 3 of this study, all interviews were unstructured and each interview began with the phrase "Tell me about your experience of V-R day surgery". The interviews lasted between 60–120 minutes and were audio-recorded with the participant's permission. The tapes were transcribed verbatim and the resulting text became the data for this qualitative step of the study.

### **10.3.3 Data analysis**

The following steps are adapted from Polit and Beck's (2006) methods of editing analysis and immersion crystallisation, and Flemming's (2003) method of data analysis. These steps are consistent with the previously described qualitative data analysis methods. They were utilised in developing an understanding of the second

group of participants who had experienced V-R day surgery. The four domains of the *self* are evident (see Figure 10.1) and no new themes are identified; however, the themes emerging from the participants' narratives retain a different strength. A clear example is the *physical self* – this theme dominated the experiences of Step 3 participants, but was much less evident amongst Step 5 participants. The following section presents an analysis of Step 5 narratives, framed by a previous thematic understanding of the V-R day surgery experience.

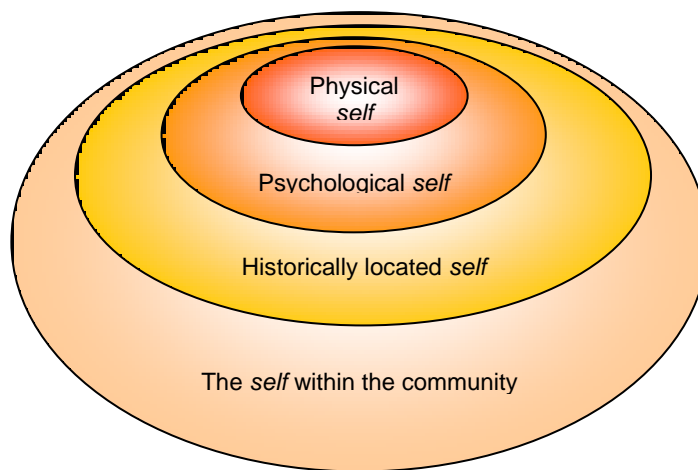


Figure 10.1 **Domains of the human self, as influenced by the experience of V-R day surgery**

### **The physical self**

Amongst participants' of Step 3 experiences, the *physical self* emerges as issues with pain, nausea and vomiting. For numerous participants, the described intensity of pain was overwhelming and was one of the dominant features of their experience. In the current participants' experiences, the *physical self* is much less evident, with fewer and less vivid reports of pain or nausea.

In this second research phase, the instillation of the anaesthetic (the eye block), which had terrorised first phase participants, was much less problematic:

Jim: *It was just a sting [the eye block], you feel a sting and a bit of a push* [Participant 27; Line 42].

Sally: *It was alright [the eye block] although; I wouldn't like to go through it again [no sedation]* [Participant 21; Line 102].

Beth: *The eye block didn't hurt* [Participant 23; Line 23]

Ivan: *I didn't have any problems [with the eye block]* [Participant 22; Line 110]

Marion: *A small pinch and that's all I felt [with the eye block]* [Participant 19; Line 18].

The diminished pain experiences could be attributed to the use of sedation, as six of the nine participants had either received sedation prior to the instillation of anaesthetic or received a complete general anaesthetic. Tyrone and Deb requested and received a general anaesthetic, as they had difficult past experiences and felt they could not cope with the eye block or the awake surgery. These requests were identified during the pre-operative interviews with the liaison nurse and the surgeon.

Post-operative pain was a marked issue for participants of Step 3, with numerous reports of severe pain on the night of the surgery. All of the current participants received pre-emptive and multimodal analgesia, resulting in less dramatic experiences.

Jim: *In regards to the pain, it was all manageable, definitely manageable* [Participant 27; Line 58].

- Ivan: *The first night was a bit sore ... the tablets were good* [Participant 22; Line 24].
- Beth: *It was just a headache* [the night of the surgery] [Participant 23; Line 48].
- Sally: *There was a little bit of discomfort, not really pain* [Participant 21; Line 92].
- Marion: *I didn't have any pain at all.* [Participant 19; Line 76]
- Bob: *I didn't have much pain* [on the night of the surgery] [Participant 25; Line 80].

However, Tyrone had considerable issues with post-operative pain, due to significant previous problems combined with facial fractures from the assault and a desire not to take analgesic medications:

- Tyrone: *It was very painful; I didn't want to take the medications* [Participant 20; Line 60].

No participants reported nausea and vomiting on the night of the surgery. None needed to contact the on-call specialist, nor required emergency readmission. Experiences previously reported as extremely negative were, for this group of participants, pain free at best or manageable with prescribed pre-emptive and proactive interventions. A deeper immersion in the stories of these participants establishes that, while the physical aspects were fulfilled, the psychological issues dominated.

### **The psychological self**

With the physical aspects under control, the psychological issues of fear and anxiety became prominent during the experience. Participants Sarah and Marion were

anxious – both required elective surgery for slowly progressing pathology, including epi-retinal membrane (Sally) and diabetic retinopathy (Marion). They were pragmatic about the need for surgery while voicing concerns over the procedure and the possible outcomes:

Sally: *I knew it had to be done [the surgery] ... you can only put up with so much [diminishing vision] [Participant 21; Line 52].*

Marion: *I freaked ... [about the surgery] absolutely freaked because your eyes are sort of like you know it's going to hurt ... and if they botch it I won't be able to see but we talked it through ... I trusted my doctor ... he knows what he is talking about ... so yeah we booked the surgery ... I needed to have my full vision [Participant 19; Line 26-32].*

Participants Bob, Jim, Tyrone, Deb, Ivan, Evica and Beth required emergency care. They had all experienced an unexpected sight-threatening event that would lead to visual disability if left untreated. Their narratives show evidence of psychological angst regarding their pathology, the need for surgery and potential visual disability.

Bob: *It really gets me down sometime ... my visions is really poor ... it could go on and on and on [the need for surgery] [Participant 25; Line 98].*

Jim: *I panicked I was really stressed [about the surgery and the loss of vision], but then you know you have no option [Participant 27; Lines 19-20].*

Tyrone: *I had no vision ... I was pretty anxious [Participant 20; Line 15].*

Deb: *I didn't really know what was happening ... it was a bit scary [Participant 24; Lines 9-11].*

Ivan: *I couldn't see anything out of this eye ... that wasn't very funny ... I was anxious about how it was all going to work out [Participant 22; Lines 31-2].*

Evica: *You never know what will happen [with the eye] ... maybe next time I will go blind [Participant 26; Lines 58-9].*

Beth: *I could go blind ... it all happened so quickly I think I was in shock*  
[Participant 23; Line 9].

The professional literature embraces the use of information as a strategy to reduce pre-operative anxiety. However, this study produced a varied response from participants regarding the need for detailed information about the surgery and the pathology; this response is described by Phase 1 participants and is evident in the audit results. The provision of detailed information did not necessarily decrease anxiety. This finding is consolidated by Phase 2 interview participants; it supports the constructs of Mishel's (1988) theory of Uncertainty in Illness and the ameliorating effects exerted on appraisal of uncertainty by the credible authority (in this case, the surgeon and nurses).

Beth, Sally and Evica specified that they did not want too much information. Deb and Sally's comments expressed that the most important thing was trust in the healthcare providers and that detailed information did not reduce anxiety:

Deb: *If I trust in them [healthcare providers] then that puts me at ease rather than knowing all the information because I would probably get a bit squeamish ... I think just knowing Dr ... and everyone here was just great ... made you feel at ease* [Participant 24; Lines 86-87].

Sally: *I'm a bit of an ostrich ... I didn't want to know too much ... it was available ... I trusted Dr ...* [Participant 21; Lines 18-19].

Participants who required detailed information also felt the need for a strong trusting relationship with the healthcare providers. Marion's thoughts exemplify the importance of this trust:

Marion: *He put me at ease [the surgeon] ... I trusted him ... he knows what he is talking about [Participant 19; Lines 7-9].*

Marion, Jim, Ivan and Tyrone requested detailed facts regarding the procedure.

Marion: *It did help me to know exactly what was going on ... I'm one of those people who wants to know every detail beforehand [Participant 19; Lines 27-28].*

Jim: *What they say and how they explain it takes away all the myth ... and you know where you stand [Participant 27; Line 86].*

Ivan: *It does help [the information provided] because it makes you understand ... when you haven't experienced this in the past [Participant 22; Line 82-84].*

Tyrone: *I had a lot of information [Participant 22; Lines 82-84].*

The findings from this group of participants are congruent with findings from Step 3 and with the audit data. They show that the need for information is a subjective individualised need and that information does not always reduce anxiety. These findings are congruent with the role of credible authority as described by Mishel (1988b). The newly developed role of the liaison nurse within the clinical context was able to address the individual need for information and provide the required level of information. However, the expanding trust-based relationship was encouraged by the development of a credible authority through constructs of event familiarity.

An ongoing fear of blindness or visual disability, as described in the previous findings, was evident in the experiences of the participants in the Phase 2 group.

- Ivan: *I didn't worry about anything else [surgery] it was the unknown ... are you going to end up with no sight [Participant 22; Line 81].*
- Tyrone: *I had no vision, I was pretty anxious [Participant 20; Line 15]*
- Beth: *If someone could say to me, your sight will be as good as it was in August eventually, and promise me that ... I would be fine, but I know they can't do that [Participant 23; Line 82].*
- Bob: *My vision is really poor ... at least it's better than being blind [Participant 25; Line 90].*

Anxiety regarding surgery and its outcome was influenced by past experiences, both positive and negative. In this study, such experiences are understood to be within the domain of the historically located *self*.

### **The historically located self**

Past incidents exert obvious influence on the participants' current experiences.

Where participants had difficulties with previous eye surgery, as was the case for Tyrone, Deb and Bob, their needs regarding pain management and anaesthetic type required thoughtful assessment. Deb recounted negative past procedures and how a general anaesthetic improved the experience.

- Deb: *The experience with the local anaesthetic [first time] I didn't want to have that anxiety again ... I had a general anaesthetic the second time ... and that was just great, I just went to sleep and woke up ... it was all absolutely fine [Participant 24; Lines 37-39].*

Participants who were anxious about the surgery and anaesthetic but had no previous experience, reported positive experiences aided by the use of sedation. Ivan and Beth had no previous eye surgery experience; as a result both were tense and anxious on the day of the procedure.



Ivan: *Because I was a bit tense they gave me some medications [sedation] ... I didn't have any problems [with the eye block] ... the sedation really helped [Participant 22; Lines 110-111].*

Beth: *I was really anxious ... [given sedation] the surgery and the eye block didn't hurt [Participant 23; Line 86].*

Positive experience of the eye block had the potential to improve future experiences, as Jim stated:

Jim: *I think it's better now [anxiety regarding the eye block] I know what's coming up and that would make it easier [Participant 27; Line 82].*

The use of sedation or general anaesthetic evidently improves the participants' surgical experiences by providing a positive incident that would help assuage anxieties in the case of future surgery. The final domain identified by Step 3 participants was the *self* within the community.

### **The self within the community**

This study's participants of Step 3 reported significant difficulties when discharged from the day surgery centre and during the post-operative convalescent period. The Step 5 participants recounted few difficulties during convalescence and immediate post-operative self-care.

Step 3 participants encountered numerous physical management issues. The participants of step 5 described comfortable self-care period immediately following the surgery, as pain management was improved due to pre-emptive interventions. An interview prior to the surgery between the liaison nurse and the participant facilitated

management of potential self-care problems. During the interview, the participants' self-care needs were discussed and arrangements were made to have a friend or relative care for them on the night of the surgery. All participants, with the exception of Bob, were cared for on the night of the surgery, while Bob was able to stay with supportive friends. The combined effect of successful pain management and supported post-operative care resulted in positive experiences during a time that was known to be difficult.

All participants of step 5 were in the early convalescent phase of recovery when interviewed and had not considered a need for wider community support. However, the liaison nurse provided a point of call for a number of participants who needed extra advice concerning medications, appointment scheduling and information regarding previous surgery. All participants were grateful for help with their problems; they were hopeful that their vision would improve and their lives would return to normal.

Jim: *I was just so lucky to get it fixed* [Participant 27; Line 161].

Deb: *I think I have been very lucky ... it's an unfortunate thing to have happened but I really think I have had the best care* [Participant 24; Line 106].

Marion: *I can't think of anything else that could have made it better* [Participant 19; Line 122].

Ivan: *I've been very lucky; my eye sight is virtually back to 90%* [Participant 22; Line 153].

The problems experienced by participants of Phase 5 of this study were significantly alleviated by the provision of a named liaison nurse and successful pre-emptive pain management strategies.

## 10.4 Discussion

Many participants of the initial research (Step 3) of this study reported issues across a range of human domains, with some descriptions of very difficult V-R day surgery experiences. This knowledge resulted in new interventions that include a new pain management protocol and the use of adjunct anaesthetic techniques, as well as the development and implementation of the liaison nurse role. The intervention successfully meets the participants' broader needs, as demonstrated by the step 5 audit results and interviews of patients who experienced V-R day surgery following implementation of new interventions. The success of the new interventions is evident in the domain of the physical *self*.

The findings identify that patients, who were allocated to an appropriate pain protocol group and had received specific pre-emptive and pro-active self-managed analgesia, had their pain managed in a manner consistent with the standard of care established by the Australian and New Zealand College of Anaesthetists (ANZCA 2010). One of the strengths of this multilevel pain management protocol is its flexibility, which facilitates allocation to a group based on the needs and history of individual patients. An example of this flexibility is seen in the allocation of patients, who were having relatively minor procedures and who would normally be allocated to group A or B, allocated to group C where more intensive pain management

strategy occurred. Such patients had described significant difficulties with past pain management and were allocated to a group with a higher level of intervention and analgesic support based on the given information.

The flexible nature of the protocol is also evident among patients who had co-morbidities that precluded pre-emptive COX II. These patients could be allocated above the group that would normally be appropriate for their specific surgical complexity; their pain management needs would still be met without undue use of rescue medications. Flexibility is also evident in the capacity to accommodate specific anaesthetist and patient preferences. Despite these successes, further work needs to be done in increasing the use of pro-active paracetamol, as only 67% of patients administered the analgesia as directed. Pro-active and multimodal pain management is identified as successful pain management strategies after discharge from day surgery (Older, Carr & Layzell 2009).

The qualitative understanding emerging from this final data collection step identifies psychological issues as the dominant aspect of the V-R day surgery experience. This is congruent with knowledge gained from the profession literature in step 3, where fear of blindness has been well documented. The judicious use of analgesia, sedation and general anaesthesia ameliorates some of the more difficult physical aspects, as identified in Step 3 of this study. These techniques also relieve the psychological issues of fearing the anaesthetic and fearing the surgery. However a fear of blindness persists. The development of the liaison nurse role provides a named person that participants may contact with issues and concerns, thus augmenting the psychological support offered by the healthcare providers.

The liaison nurse interviewed the participants pre-operatively and identified any potential issues. During this interview, the nurse had the opportunity to assess their previous experiences and the potential for further problems. Based on this knowledge, individualised care plans were developed that addressed many of the previously identified patient issues, including negative past experiences, difficulties with pain management and specific anxieties.

What these evaluation activities display is that V-R surgery as *day surgery* can be a positive experience. However, to accomplish this there is a need for innovative and supportive care that meets not only the community need for access to services but also the individual's need for care that addresses the multiple aspects of the human domain influence by such an experience. Reliance on a biomedical-acute model of care is no longer acceptable, particularly when many of the caring function of health care have now been devolved to patients and families.

The need for cost containment within the acute health care setting will be an ongoing and potentially escalating issue, thus development of effective strategies that meet the needs of individuals is of paramount importance. Success of such strategies will rely on the underlying knowledge that is brought to the care planning and decision table. This knowledge must be broad based as suggested by Newhouse (2007), Rycroft-Maloney (2009) and Earl-Foley (2011) and needs to incorporate not only research knowledge but also experiential knowledge that is gathered from qualitative research such as that described in this study.

## 10.5 Summary

Step 5 of this EBNP activity has provided confirmation of the need to address the multiple aspect of the human domain when providing care that meets the needs of individuals. The success of the interventions developed in step 4 has been explored and measured and a significant increase in positive experiences occurred. The information developed through these evaluation research activities adds to our understanding of these patients' needs and provides a strong knowledge platform from which care can be further developed. The following chapter discusses the limitations and conclusions of this study, and provides further recommendations for the care of patients requiring V-R day surgery.

## CHAPTER 11

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# CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THIS STUDY

### 11.1 Conclusions

This study is a research-in-practice activity and successfully bridges the widely discussed research-practice gap. Closing this gap requires the use of a synthesised EBNP model that meets the study's purpose and includes a qualitative methodology to guide the knowledge-generating activities. The understanding of research findings and subsequent development of new nursing interventions are aided by Rutter's (1998) theory of resilience and resource depletion and Mishel's (1988) theory of Uncertainty in Illness.

The synthesised EBNP model uses various aspects of EBNP from the JBI (Pearson, Weichula et al. 2007), JHNEBP (Newhouse 2005) and Fain (2009) models. The synthesised model is a five-step process that leads the research-in-practice activity through: identifying a clinical problem (Step 1), tracking down current knowledge (Step 2), the processes of qualitative research evidence development (Step 3), integrating evidence into clinical practice (Step 4) and, finally, evaluating the care provided (Step 5). A report on each of these activities forms the substance of the present thesis.

The conduct of this study has led to the recognition and understanding (at a micro level) of the effects and shortcomings of a healthcare model that focuses on the

invasive and highly technical aspects of care provided. At a macro level, an ongoing evolution of healthcare is shown with the devolution of the non-technical, non-invasive convalescent care back to patients and the community.

This devolution is a response to the economic fallout of expensive modern health technology and treatments. Cost containment strategies, developed as a result of fiscal constraints, include the move to day surgery where treatment is limited to invasive interventions and lower cost “convalescent care” is devolved to the individual. This devolution of care is supported by a system that is described as an acute model of care. This model focuses on highly technical episodic physical interventions and provides minimal ongoing community-based support.

The experiences of this study’s participants in Step 3 provide evidence that using an acute model of care for patients undergoing surgery for complex V-R conditions results in inadequately met needs and negative experiences. These findings concur with research evidence from other specialties, which shows that a system of care focussed on acute episodic interventions does not effectively meet patients’ needs. The episodic nature of care is further amplified by the adoption of a day surgery model of care.

The success of cataract surgery as a cost containment strategy caused the precipitous adoption of a day surgery mode of care for these patients. Day-case surgical care is fostered by financially driven outcomes and the success of day surgery for cataract extraction suggests that this model of care would be appropriate for V-R surgery. Patients requiring cataract extraction and those with V-R pathology have similar



needs for access to services; however, there are significant differences that extend well beyond the physical. It is known that all people greatly fear blindness and those who experienced a sight-threatening event displayed psychological distress. The experiences of the participants of this study consolidate this understanding. This study highlights the complex needs of individuals when experiencing a sight-threatening event and displays the inadequacies of the current model of care. These findings concur with the professional literature, which contains abundant evidence of unmet patient needs following day surgery across a broad range of surgical specialties.

Step 3 illuminates the complex nature of V-R disease in participants' life histories, extending valuable insight and understanding into this experience. The incorporation of the past into the understanding of the present is consistent with Gadamer's (1975) belief that cultivating the history within brings new possibilities of meaning.

Gadamer's (1975) belief in an unfolding understanding centres on the hermeneutic circle, where understanding occurs through dynamic movements between the parts and the whole. Within this study, a co-constructed understanding of participants' experiences emerges, as reflection on the text requires a deconstruction of aspects of *self*, an identification of the unfamiliar, and an oscillation from these aspects to the individual and cohort as a unified whole. The identified subthemes are the "parts" leading to a comprehensive theme of "The inadequacy of an acute model of care to meet the complex needs of people experiencing V-R day surgery".

Each identified level of the deconstructed *self* supplies evidence of inadequate care and conveys an understanding of participants' complex needs. To begin with, day

surgery was believed to encompass “simple surgery”, which addressed the patients’ needs in the short pre-operative time available. The present study shows that patients with V-R pathology have complex needs, which are inadequately addressed in a busy outpatient environment. Day surgery for V-R pathology can be successful; however, a fundamental change is required in the care providers’ understanding of patient needs.

Step 4 combines new qualitative knowledge with other research knowledge, patient preferences and local contextual information, to inform and modify patient care in the clinical context of this study. New strategies are developed with the aid of all evidence sources; they address adequate pain and nausea management (pre-emptive pain management protocol, promotion of adjunct anaesthetic techniques), pre-operative preparation that is cognisant of past experiences (liaison nurse role of pre-operative patient interviewing), and feelings of isolation and abandonment. The strategies also provide a connection with community-based supports, with the liaison nurse acting as a conduit between patients and further services. The development of these interventions and strategies is followed by their implementation into the clinical environment. In this manner, the findings of research evidence are translated into practice, a requirement of the fourth step of this EBNP model. The fifth and final step measures the success of these strategies and interventions.

The evaluation of new interventions is an essential component of the synthesised EBNP model. The final step requires a conduct of evaluation activities that gauged the success of new interventions in meeting the needs of the patient population. An audit of 100 successive patients, who experienced V-R day surgery, found that the

newly developed pain management protocol appeared to have improved patients' experiences of post-operative pain. A successful feature of the protocol is its inherent flexibility to meet patient needs depending on past experiences, underlying pathology and patient co-morbidities. An aspect of the protocol that needs further refinement is the education of patients to comply with taking pre-emptive paracetamol as directed. The barriers to compliance are unknown, although there is some evidence to suggest that lack of patient understanding plays a part.

Qualitative evaluation occurred through interviewing a further nine participants about their experiences of V-R day surgery. The findings from these interviews were analysed in a manner consistent with the Step 3 understanding of the domain of *self* influenced by the V-R day surgery experience. These findings show that the physical aspects of the experience play a less prominent role. This is evident in the minimal accounts of pain with either post-operative self-care or with aspects of anaesthetic instillation. The recession of these aspects may be viewed as evidence that successful strategies of psychological and physical support enhance the individuals' protective resources and their resilience to adversity. Figure 11.1 provides an overview of the resource depletion sites, interventions designed to enhance protective resources and potential outcomes as results of a new model of care. The next section (11.2) provides recommendations for future care of people who require V-R day surgery and justifies each recommendation with the findings of this study.

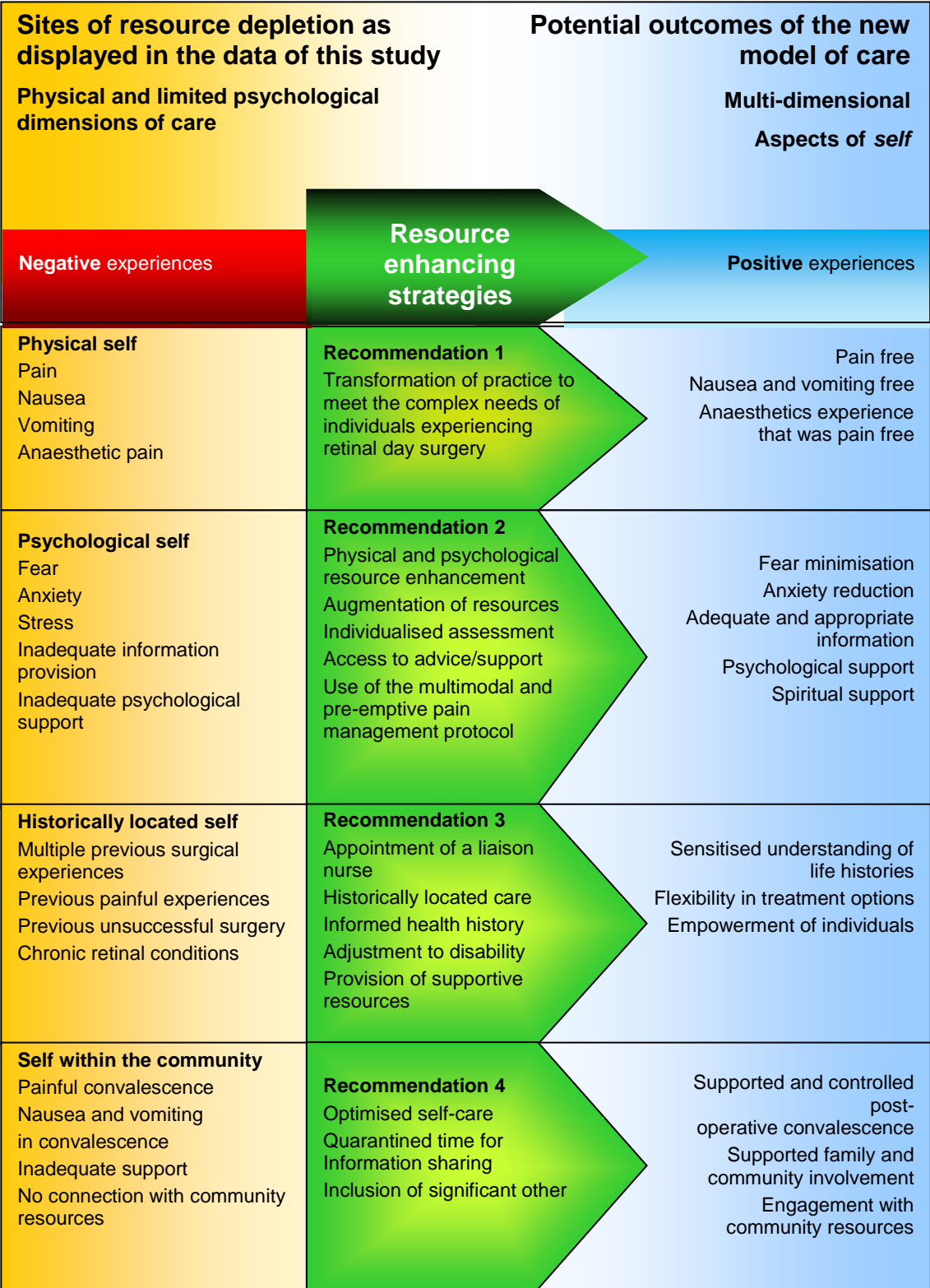


Figure 11.1 Recommendations for transformation of clinical practice

## 11.2 Recommendations

Figure 11.1 (above) displays the essence of the participants' current experiences and the recommendations to practice changes that may improve future experiences of patients with V-R conditions. It provides both a static view of current care and a dynamic model for future care. The left-hand side features the current inadequacies of care within the identified aspects of *self* that emerged from the data in Step 3 of this study. A shift in care is proposed through the recommendations (in line with the interventions evaluated in Step 5), which are located in this figure as the central arrows. This shift would move future patient experiences away from inadequate care and support (negative experiences), towards care that meets their complex needs (positive support). The following sections discuss the aim of each of the recommendations.

### 11.2.1 Recommendation 1: Transforming current care from an acute model to an ocular model of care

The difficulties experienced by participants are largely a result of an inherited utilisation of an *acute* model of care, which bases care provided on physical interventions for disease management and anatomical normalisation. This study conveys a new understanding of the needs of people undergoing V-R day surgery, which must be brought to the attention of all health professionals who are involved with the care of future patients.

There is an urgent need to provide care that responds to the wider and more complex needs of patients experiencing V-R pathology, which requires surgical interventions. New care pathways are developed to meet their complex needs and facilitate positive patient experiences. These care pathways need to be incorporated in the care of all future V-R day surgical patients. The broader patient needs must be qualitatively and quantitatively evaluated on a regular basis, to ensure the appropriateness and success of changed models of care.

### **11.2.2 Recommendation 2: Physical and psychological resource enhancement**

Patients' protective resources are finite and negative experiences transpire when their capabilities are overwhelmed by challenges to their resources (physical, emotional or psychosocial). Patients' protective resources need to be actively augmented by the responsible healthcare professionals. Physical enhancement should include adequate pain and anti-emetic medication provision, through supplying pre-emptive and multimodal pain management strategies, as described in the pain management protocol evaluated in this study.

Preparation for surgery needs to be consistent with the patient's individual information requirements, as assessed in a pre-operative meeting between patient, carer and liaison nurse. Psychological resources need to be protected by improved access and the opportunity for patients to discuss issues with healthcare professionals outside of their scheduled appointments.

Both psychological and physical support are augmented by the creation of a liaison nurse, who is available for informal contact, advice, information dissemination and

who is able to facilitate referral to other support organisations, such as the RSB, the LVC or psychological counselling. The psychological angst that accompanies urgent day-case surgery needs to be anticipated in view of the minimal time available for professional support and advice.

Pain, fear and anxiety regarding local anaesthetic application are frequent features of participants' experiences, and are compounded when repeat surgery is required. In order to minimise the pain and anxiety of anaesthetic administration, alternative management strategies need to be utilised. These strategies may include the use of sedation, music or other activities that help minimise anxiety. All measures of resource augmentation need to be regularly audited for efficacy and appropriateness, with amendments made that reflect the audit findings.

### **11.2.3 Recommendation 3: Recognition of the historicity of V-R ocular illnesses**

Participants' ability to cope is significantly influenced by the length of time that they experience an ocular condition and the number of surgical interventions. Thus, the history of the patient's condition, including the number of previous surgical interventions, must be recognised and incorporated in the planning of care.

For patients who had experienced multiple surgical interventions, previous failed procedures bring the prospect of visual disability closer to reality. The accompanying fear of blindness that these patients contribute to the surgical event must be recognised and understood. A shared understanding of the potential for blindness provides healthcare professionals with the opportunity to assess needs and provide support that assists patients in adjusting to a visual disability.

A salient feature of successful care is the empowerment of individuals through the availability of supportive resources. Engagement with community resources, such as the RSB, the LVC and local support groups, offers the opportunity for the patient to develop supportive networks that assist in the adjustment phase through sharing information and experiences.

Adjustment to visual disability features fear, depression, anger and anxiety regarding quality of life, social activities, independence and financial security. Patients must have the opportunity to deal effectively with such issues through referral to counsellors and social workers. The lack of access to professional staff due to clinic overcrowding causes feelings of abandonment and helplessness when participants require advice and assistance. The gap between patients' needs and the inaccessibility of medical staff can be bridged by creating a liaison nurse, who is available for assistance, advice and ongoing referral.

In order to succeed, all changes to healthcare delivery require ongoing evaluation and assessment. In the past, success was determined by medical and economic criteria, which caused inadequate care and patient dissatisfaction. The changes to care provided proposed here require ongoing evaluation based on patient-generated criteria that emerge from knowledge of patient experiences.

#### **11.2.4 Recommendation 4: Optimised self-care**

The acceptance of self-care following surgery is an implicit aspect of day-case surgery from the healthcare professionals' perspective. However, the needs of self-care are not suitably understood by participants, which cause difficulties during



convalescence. The opportunities to discuss convalescent self-care are restricted by time constraints, which are imposed by day-case modality. These constraints are particularly evident for emergency surgery. In recognising such time constraints, every effort needs to be taken to ensure that participants and their families are provided with the knowledge, support and utilities (medications, etc.) for successful self-care.

Time needs to be set aside for sharing information between the patient and the healthcare professionals. This time would be utilised to support self-care and to assess the need for additional community resources, ensuring that patients are not discharged to unsupported self-care. The value of a supportive partner/friend/family is well established. The sharing of information and knowledge regarding self-care need to be inclusive of the carer nominated by the patient.

Healthcare professionals are often unaware of the difficulties experienced by the participants. The knowledge manifested through this study of participants' difficulties and requirements needs to be disseminated to healthcare professionals. Pain and nausea are frequent features of convalescent experiences. Inadequate medications fail to support a pain and nausea-free convalescence. The results of the audit demonstrate that a multimodal and pre-emptive pain management protocol significantly assists with acute pain and nausea during self-care periods.

### **11.3 Dissemination of research knowledge and skills**

It is essential that the knowledge developed in a clinically based research thesis be disseminated throughout the clinical setting of the study. This dissemination was achieved through various purposive strategies. At all stages of the research journey the researcher was supported and encouraged by the staff of the clinical unit where the Universities ongoing designation of a centre of Clinical Research Excellence (CRE) had been awarded in 2004. This support was evident as making time for progress of the research to be discussed regularly at the multi discipline departmental meetings. These meeting were of long standing and had the aim to bring together the research and clinical arms of the departmental activities for dissemination of findings. All researchers within the ophthalmology unit were provided time for display of their progress and critique by all members of the staff. The research progress was reported on at regular intervals as well as many ad hoc discussions with clinicians. As most research conducted within the unit was quantitative in design, the staff were keen to understand the processes of qualitative research. At the completion of this thesis, a final presentation was conducted not only within the university setting (June 2011) but also duplicated at the request of the ophthalmologist in one of the regular meetings (September 2012). The nursing staff of the clinical unit were encouraged to attend the weekly meeting where research was discussed. A close relationship with the nursing staff and researcher fostered informal inquiry about the progress and findings of the study. When the research reached important milestones such as the completion of the data analysis, the nursing staff were very keen to hear the findings and to contribute to the development of the nursing interventions. In 2012 a paper detailing the initial research findings of this study was published in the *Journal of Advanced Nursing* (McCloud et al.2012). The researcher was invited to

speak of the research findings at a number of Nursing forums including: the Australian Ophthalmology Nurses conference, Sydney, 2012, Melbourne 2012, Adelaide 2011. In June 2010 the research findings were presented at the Joann Briggs Institute Evidence based practice conference. In September 2008 the early results of the first phase of the research was presented at the International Ophthalmic Nurses Conference, London UK. Thus the findings of this research have been disseminated at a local, national and international level. Despite the researcher leaving the clinical unit in 2010, she has maintained a close relationship with both the medical and nursing staff and the pain management protocol and Liaison nurse role developed through this research continues to be utilised.

A criticism of the research journey could be that much of the processes were conducted as an individual and whilst the findings were shared with the clinical staff, the research skill development journey was a singular one. This was not a conscious decision but was a result of the strictly limited time available to other nurses and the researcher being the only fulltime nurse within the day surgery unit. The lack of involvement of other nurses in the research process was regrettable and future research projects will endeavour to encompass non research based nursing staff.

#### **11.4 Limitations of this study**

The research aspects of this EBNP activity provide a rich understanding of the V-R day surgery experience. However, the present study contains limitations to its findings. In terms of the study's sample population, it is limited to one specific healthcare institution and is of a relatively small size. Moreover, the inclusion criteria

exclude people living in rural or remote areas and people who do not speak English. A further limitation is the diversity of underlying pathology, which accounts for variations in the experiences. Whilst these aspects of the study are considered to be limitations, an in-depth and rich understanding of the experience is developed, which would not have been possible with a quantitative methodology. Healthcare professionals can use the knowledge gained through this study to share the patient perspective of the experience, and to develop policies, protocols and care pathways that facilitate effective and improved outcomes, specific to this clinical context.

#### **11.4.1 The limitations of the dual role of clinician-researcher**

The dual roles of clinician and researcher have many significant advantages as described in Chapter 7, The following areas of potential conflict were identified:

Potential for participants to be reticent in regard to the information that they disclosed for fear of repercussions to their future care; Potential for participants to be reticent about issues that were meaningful to them but which they perceived to have the potential to offend or embarrass the clinician researcher; Potential for participants to feel coerced into participation in this research for fear of repercussions on their future treatment; Potential for the researcher to interpret the findings in a manner that was biased toward particular clinical outcomes.

The advantages of being a clinician researcher are numerous and include the following: a deep engagement and understanding of the norms and tacit knowledge specific to the context of the study; Ready access to patients who were identified as potential participants; Potential to use the findings of the study to improve clinical practice; An ongoing commitment to the clinical context of this patient population.

The role of clinician-research is not an easy one to navigate and there are many potential pitfalls of such a position. However, research that is driven from clinical need has the potential to illuminate inadequate practices and bring about transformation of care.

#### **11.4.2 Limitations of the design of this study**

At conception of this research study it was proposed to understand people's experience of V-R day surgery. Furthermore as a clinically sited research it was intended to base changes to practice on issues identified in the research in collaboration with the various stakeholders embedded within this experience. The researcher's beliefs at the time of the study were underpinned by a clinical environment that was deeply immersed in the scientific and technical world of peri-operative care. As such it was expected that most patient problems identified would be physical and to a lesser degree psychological in nature. This was based on the researcher's acute care outlook that was underpinned by a biomedical model.

What was surprising during the conduct of the early interviews was the depth and breadth of influence of this experience on the lives of the participants. It was here that the strength of using a qualitative research methodology to understand this experience was most evident given the unexpected breadth and nature of the experiences described. From these interviews, it was learnt what was important and meaningful to the participants of this study. However, having delved deeply into the lives of these participants the questions that needed to be asked, were did the EBNP framework facilitate exploration and were appropriate new interventions developed for all issues raised by participants?

On reflection it could be said that in the areas of physical distress the new management policies appear to have contributed to a more satisfactory experience. Likewise the raised awareness of the influence of past experiences also appears to have contributed to improved experiences. Furthermore the supportive role of the Liaison nurse appears to have provided an avenue for close and supportive care following discharge. Despite these apparent improvements there were a number of issues.

The design of this study illuminated the complexity of the experience, it was this complexity that outgrew the scope of the study design overall design and led to significant limitations. These limitations included: Limited ability to deeply explore issues of psychological stress. The fear of blindness was clearly evident and a further study that focussed on this issue and its impact on the lives of individuals who experienced a sight threatening V-R condition would add to the body of ophthalmic nursing knowledge and had the potential to lead to new situation Given the new understanding of the experience of pain on the night of the surgery, the qualitative / audit design of this study has limited the capacity to transfer this knowledge to other ophthalmic settings.

A study that was based on these qualitative findings but which utilised quantitative methodology would add strength to the findings and facilitate generalisation. A Grounded theory approach to this phenomenon would provide an opportunity for theory development in an area that has a paucity of theory on which to base care. Alternatively the cyclical nature of an Action Research framed study would provide opportunity for a collaborative, ongoing and outcome specific application of study findings to practice.

The conduct of the audit could also have been improved. The use of 100 participants in the audit was designed to capture the experience of a broad range of participants however this could be increased to a much larger number and have included a preliminary baseline observation. Likewise the number of participants interviewed qualitatively could have been increased to mirror the first phase of the study. In this manner the conclusions drawn from the findings of the evaluation would have added strength.

The disability participants experienced during long term recover was a aspect that would benefit from further examination. A longitudinal study that tracked the experiences of participants over years would contribute to the understanding of this condition from a lifelong perspective and could have led to further situation specific theory development.

The role of spirituality was not addressed in this study and is an avenue of the human experience that could be understood through a methodology that sought how spirituality assisted patients in dealing with uncertain health care situations. There is burgeoning evidence in the literature that links an intact sense of spirituality with positive health outcomes (Brennan & Heissler 2012).

There were a number of aspects of the participant's experience that could have led to the uncovering evidence of oppression. One such as aspect was the constraint of an almost exclusive day surgery model of care. Whilst some authors have described day surgery as empowering for patients (Korc & Moreland 1998; Gilmartin 2008) empowerment assumes an alternative choice and for many participants of this there were very limited choices available. Thus a study design from the critical paradigm that examined the social structure of the day surgery world and patients experience of

this world may uncover hidden power inequalities and constraints and lead to more equitable care. The role of the nurse patient relationship in this study was explored briefly through the liaison nurse role. Whilst the role appeared to add to the care provided the role of the therapeutic nurse patient relationship in day surgery needs to be further explored.

Thus there were many aspects of the experience of VR day surgery that were not accommodated by the design this study utilised. However, EBNP frameworks have met many of the needs of the clinical environment for research based intervention development and the framework used in this study has identified opportunities for a deeper understanding of this very complex issue.

The complexities of the now identified domains of self could be further explored through further study utilising a variety of methodologies. Perhaps using a theoretical framework that encompasses all aspects such as Rogers' science of unitary Human beings (Alligood & Tomey 2010). A grand theory that would guide development of a broad understanding, but not lead to development of specific interventions.

Conversely each of the identified domains of self would lend itself to focussed exploration, using a site specific middle range theory suited to each domain. The changes to practice described in this thesis were not based on qualitative evidence alone, as such a narrow evidence base would limit the strength underpinning the developed interventions.

The strength of an EBNP model lies in the incorporation of multiple sources of evidence in the practice improvement processes. As previously described in the changes to care section, all new interventions were based on a number of sources of evidence that included, patient and carer experiences, expert opinions from nurses,



ophthalmologists, anaesthetists, pharmacists and industry personnel. Furthermore information regarding various aspects such as liaison nurse role, pre-emptive medications and multimodal pain management strategies were supported by evidence from the literature.

The accumulation of all sources of evidence occurred over a long period of time that was in excess of 12 months and each source was carefully scrutinised and synthesised with the qualitative research knowledge to develop situation specific interventions. Thus the evidence source for the intervention was not the qualitative evidence from 18 participants alone but was broad based and inclusive of a variety of sources. These interventions were site specific and as such may not apply to other clinical contexts.

A further specific limitation of this study that needs to be reflected upon was the conflict in the role of the clinician-researcher. Whilst this dual role brought with it many advantages as previous described, it was this dual role that had the potential to challenge the rigour, ethical conduct and the veracity of the findings. The dual role had the potential for the analysis of the data to be question as to the influences of biases. The use of Gadamer's principles of 'fusion of horizon' in the moment of understanding has overcome many of the potentials for such biases. However, collaboration with other researchers, wider use of a reflexive journal and field notes may add to the credibility of the findings and assured the reader of truth of the analysis. . During the phases of data collection the stories of participant's difficulties brought to the forefront the conflict in the role of clinician researcher. It was here that the researcher recognised evidence of inadequate care and felt a compelling need

to make changes to. The clinical care. Such actions may have influenced the findings of the study; however there was an ethical imperative to do no harm.

The role of clinician- researcher also presented the potential for coercion of participants and for participants to say what they thought the researcher wanted to hear. The actions of the researcher reflected the great care taken not to pressure patients into participation and to establish with participants that she really did want to know the truth of the experience from their perspective without limitation, repercussions or consequences. However the potential for aspects of this to seep into to this study cannot be ignored and the reader needed to be alerted to this situation so that their understanding of the findings can be seen with this in mind.

In light of the illumination and understanding of the complexity of the experience of V-R day surgery that this study developed, coupled with the reflected limitations in the design of this study, this research project is just the beginning of an ongoing research journey with this patient population. The opportunity to continue exploring the many aspects of the experiences identified, using a variety of research designs, with increasing knowledge and critical reflection on past issues is an exciting and challenging future prospect.

## **11.5 Summary**

This EBNP activity has resulted in a rich understanding of the V-R day surgery experience, which leads to changes to care that appeared to have improved patient care. A strength of this study is the clinical location of the research activity and the capacity to make a difference to patients' lives. Whilst the fear of blindness after a sight-threatening event persists, nurses now have knowledge of this fear.

Interventions are in place that can lead to much less physiological and psychological trauma when a need for eye surgery is identified. Removing the adversity of the surgery and post-operative self-care through patients' enhanced resilience to the trauma of this procedure is a positive step towards patient-centred care. Repeat surgery may be required due to the inherent ongoing nature of the underlying pathology, which includes diabetes, high myopia and the aging process. Hence, a painless first event lessens fear and increases the capacity to cope with further surgery. Furthermore, this study's conduct and presentation to clinical care workers has encouraged peri-operative nurses to look beyond the technical mastery of equipment and interventions, and to relocate the anxious patient to the centre of the care-planning continuum.

# APPENDIX 1

## LITERATURE SEARCH RESULTS

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Akçay, Uyar, Akkan, & Eltutar, 2011)	Prospective quantitative descriptive study of 350 surgical procedures	Described the outcomes of surgical procedure of vitrectomy using 23 g system	86% reported anatomical success following surgery, 72% reported functional success. 31% required further surgery 23 of 98 RD cases required repeat surgery					No discussion of the experience of this procedure or psychological issues with repeat surgery
(Auquier et al., 2005)	Development and validation of questionnaire of satisfaction with anesthetic services	874 sample population from clinical contexts, inpatient population					Questionnaire was developed from qualitative data thus provided patient orientated views and perceptions	Power of the sample size was not established, cultural sensitivity of the questionnaire was not established
(Avis, Bond, & Arthur, 1995)	Literature review of the concept of satisfaction						Found unresolved issues in relation to the concept, not grounded in patient values or experiences	Descriptions of explore used frequently yet study used pre-structured questionnaire with no room for qualitative data associated with exploratory studies

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
Aylin, P., Williams, S., Jarman, B., & Bottle, A. (2005) UK	Descriptive epidemiological study	Compared data from 1996–7 to 2003–4 rates of days surgery by procedure		Day surgery rates have continued to rise steadily over the past eight years				Specific to the UK
(Bell, 2005)	Literature review	Analysis not stated		Broad range of specialties including ophthalmology	Post-operative pain management problematic. Effective pain management can be achieved with multi modal medications			Literature analysis not clear, inclusion and exclusion criteria not stated
(Benz et al., 2004)	RCT, sample of 50 patients, including control group. IOP was checked at completion of surgery and 5 hours later	Power of sample size not determined, inferential statistical analysis used	Examined use of topical medication to prevent raised IOP following V-R surgery	IOP was associated with increased complication rates				Limited to physiological aspect of the experience
(Bernier, Sanares, Owen, & Newhouse, 2003, USA)	Quantitative, interventional convenience sample of 116 people undergoing day surgery	Structured interviews. Analysed using correlation statistics	Cataract but not V-R	Need for effective communication in a reduced time frame	Displayed inconsistencies between information about an management wanted and nurses perception of need	Examined the congruence between information received and what was valued		Single centre study, small sample size and deductive methodology. Examined across specialties including ophthalmology but limited to elective cataract surgery

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Bhatt, Elena Gregory, Benskin, & Banerjee, 2010)	Prospective study	68 participants surveyed visual experiences during surgery	88% had visual experience but did not find it frightening	Concluded that V-R surgery appropriate as day case, pain was an issue but considered as a need for better management strategies	Pain during procedure related to length of surgery	Anaesthesia either GA or LA + sedation	Absence of pain and desire to be home on night of surgery used as measure of satisfaction	Variation with previous studies attributed increased pre operative counseling
(Blaxter, et al., 2006)	Convenience sample of 55 patients quantitative descriptive study	Descriptive and correlation statistical analysis	V-R patient population studied	Concluded that V-R surgery appropriate as day case, pain was an issue but considered as a need for better management strategies		Anaesthesia either GA or LA + sedation	Absence of pain and desire to be home on night of surgery used as measure of satisfaction	Limited to only physical aspects of the experience. No discussion of psychological issues or influence on experience
(Clarke, Robertson, & Plummer, 2006)	Descriptive quantitative	100+ participants, analysed using descriptive statistics	Described anesthetic techniques for V-R surgery			Examined the learning curve of anaesthetists performing sub-tenon eye anaesthetics. Compared subtenon with peribulbar anaesthesia		Methodology not clear, sample size not well established, success of anaesthesia graded according to researcher defined parameters
(Coll, Ameen, & moseley, 2004a)	Literature review	24 papers on pain experiences following day surgery examined			Inconsistencies in the reporting of post-operative pain following days surgery			Described a need for a standardised pain assessment tool. Questioned the validity of many papers



Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Cooper, 1999) UK	Discussion paper Theories of education, teaching and learning in relation to patient care	Ophthalmology pre-operative education	V-R specific requirements not addressed	Day surgery will continue to increase learning and education to reduce anxiety, for patients to assume responsibility for care	Described a need for increased pre operative education, for the prevention of conflicting advice, described the increase in day surgery rates			Clear description of the need for increased pre-operative education given the rise of day surgery Not original research, assumed education reduced anxiety, recognised that the time limitation of day surgery will cont
(Costa, 2001, USA)	Hermeneutic phenomenology Convenience sample 16 who had undergone abdominal day surgery	Semi structured interviews		Inadequately prepared for self care	Inadequate pain management			Context specific, assumption that successful pain management was based on information and education Examined the political and ethical conduct of nursing research
(Coyle & Williams, 2000)	Descriptive paper of the experience of developing an instrument to measure person centeredness							Person centeredness in patient dissatisfaction with care

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Desai, Rubinstein, Reginald, Parulekar, & Tanner, 2008)	Longitudinal observational study of 100 patient experiences of V-R surgery	Descriptive statistical analysis, sample size of 100 patients, prospective and retrospective	Established that patients as in patients required minimal interventions and concluded that this patient population could be successfully managed as day surgery this	Established a criteria for transition to day surgery that was based on interventions required				Used only physical aspects of care as a basis for relocation of care to day surgery.
(Fekrat et al., 2001)	Quantitative prospective study	185 participant sample, quantitatively evaluated at 2 and 5 hours post surgery Descriptive statistical analysis	56% of V-R surgical patients experience pain, all were in patients		56 % of patients required rescue pain medications, use of opioids increases incidence of PONV			Studies inpatients, only quantitative data collected
(Fraczyk & Godfrey, 2010)	Cross sectional survey of patients satisfaction with day surgery	275 patients surveyed, descriptive statistical analysis		Patient satisfaction with preparation for day surgery				Limited to specialties of urology and general surgery preoperative information, supportive attitude, anxiety and fearfulness, and aftercare considered important to satisfaction with care



Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Frezza, et al., 2000)	Mixed methods study, 105 participants using survey tool Semi-structured interviews followed	Descriptive and bivariate statistics used for analysis Qualitative data analysed using thematic coding					Anomalies between survey data and descriptive data identified. Measurement of satisfaction as indicator of quality of care is flawed	Qualitative data methodology and analysis strategy not well described
(Frezza, Girnys, Slich, & Coppa, 2000)	Commentary discussion on cost containment and quality improvement strategies in ambulatory surgery	Mixed methods study survey and interview, descriptive statistical analysis and thematic qualitative analysis 105 participants		Number of cases of day surgery will continue to rise, cost containment is achievable and quality of care is high				In-patient population only
(Fung, Cohen, Stewart, & Davies, 2005)	Comparison of two satisfaction rating instruments Sample of 306	Multivariate regression analysis conducted		Non specific speciality population			Health care providers are unable to predict priorities and perceptions of patients	Whilst both tools were validated, they were not sensitive to the needs of cataract patients
(Ghosh & Sallam, 1994)	Quantitative survey of patient satisfaction following day surgery	557 survey's returned Likert scales used to rate levels of satisfaction	No responses received from ophthalmic patients		Only 60% of patients were satisfied with pain management		Acknowledged that patients will rate satisfaction as high despite when asked experiencing difficulties	Development of the survey instrument not described or evidence of validation

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Jenkinson, Coulter, Bruster, Richards, & Chandola, 2002)	Descriptive survey of satisfaction with care, 2249 respondents	Correlation statistical analysis						Information was the issues not adequacy of medications and effect of information pre operatively
(Kamming, Chung, Williams, McGrath, & Curti, 2004)	Literature review and descriptive study	Descriptive of experiences in one clinical setting	Pain management following day surgery is important factor in successful self care	Pain protocols need to be pre emptive, multi modal and structured				Qualitative evidence would strengthen the findings Physical comfort, emotional support and respect were major determinates of satisfaction. Patient satisfaction limited and optimistic evidence Study was descriptive of a protocol, evidence of evaluation would enhance the findings
(Kang, 2009)	Descriptive correlation study	81 participants, descriptive statistical analysis						Qualitative data would have enhanced this study and provided patient perspective

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Kiecott-Glaser, Page, Marucha, Maccllum, & Glaser, 1998,UK)	Discussion Paper Discussion of the influence of psychological states of stress and anxiety on post operative recovery		Experience of pain influences recovery	Stress and anxiety influenced length of recovery time and complications experienced. Psychological issues seldom dealt with pre operatively	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Answered the "why" question of the relationship between anxiety and post-operative experiences, but offered little insight into the "how"
(Kitz, Susaiz Ladden, & Lecky, 1988)	RCT, day surgery or inpatient surgery for emergency surgery	Inferential statistical analysis performed, sample size power determined at 80%	Multiple specialities, Cost compared	No difference in satisfaction measured between groups				Very low response rate to questionnaires, measure of satisfaction not clearly described, cost containment considered justification, limitation of pre operative care not discussed
(Kleiman, 2004)	Discussion paper on the value and process of using descriptive phenomenology to underpin research		Experiential knowledge but not specific to V-R day surgery					Provided clear steps for the conduct of study, but issues with how to bracket or the possibility of bracketing continue

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Lau and van Niekerk 2012)	Qualitative, social constructivism	Narrative analysis Explanatory meaning of burns experience 2 participants		Minimal pain reported				small sample size
(Law, 1997,UK)	Quantitative, Descriptive 45 adult patients interviewed following eye surgery	Structured questionnaire, analysed using descriptive statistics	Relevant to ophthalmology, V-r not included				Long waiting times pre operatively, difficulty remembering advice, and unsatisfactory journeys to and from OT Described 55% satisfaction with current care	Findings could have been enhanced with qualitative data Randomisation of the study population failed to provide procedure specific patient needs. Small sample size for study, unit specific
(Leinonen, Leino-Kilpi, Stahlberg, & Lertola, 2003)	Development of a structured questionnaire based on patient perceptions	1200 participant sample, instrument pretested, analysis using statistical analysis			Pain management as inpatient was well managed			Results conflict with other studies that demonstrated that pain was not always well managed in hospitals
(Lesnoni, Rossi, & Nistri, 2005)	Retrospective survey of 62 patients following V-R surgery	Correlation statistics used, variables of satisfaction visual function and fellow eye	52% of patient believed they had improve vision				Satisfaction levels were described as high	Criteria for satisfaction not well described and appeared to be based on functional



Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
vision assessed								
outcome								
(Majasaari, Sarajarvi, Koskinen, Autere, & Paavilainen, 2005, Finland)	Quantitative, descriptive 60 day surgery patients survey for information needs and family member requirements	Structured survey analysed using descriptive statistics	More than 50 % of patient felt they needed more information on self care following discharge and side effects of medications	Predetermined questions may have missed aspects considered important to this patient population				
(McDonald, Jackson, Wilkes and Vickers 2012)	Interventional descriptive study of work place resilience	Interventions aimed at promoting workplace resilience 14 beginner nurses, evaluation through interview						Evaluation of the intervention would be enhanced with structured methods
(McHugh & Thoms, 2002, UK)	Quantitative – Descriptive 102 post day surgery patients surveyed regarding pain management following discharge	10 centre survey	Patients needed continuing support and information after discharge	21% reported pain after discharge	Reports of satisfaction with care was not consistent with actual experiences			Influence of non medication interventions on experience of pain not explored

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Mitchell 2004)	Literature review / discussion paper	Examined the reasons for inadequate post operative pain management		Inadequate information regarding pain management	High levels of pain were experienced post day surgery			Analysis methods of the review not evident
(Mitchell 2010)	Discussion paper with clinical guideline developed			Day surgery rates will continue to rise		Psychological support of patient need to be addressed		Evaluation of the protocol would enhance the findings
(Mitchell, 2010)	Quantitative descriptive 460 patient sample following surgery as day case	Structured questionnaire, analysis using descriptive statistics		General anaesthesia provoked high levels of anxiety				
(Mlangeni et al., 2005)	Mixed methods qualitative interviews 22 participants, survey questionnaire of 355 participants	Qualitative information used to inform the survey questionnaire. descriptive statistics used to describe findings of the survey		Pain was an important issue to day surgery patients		Described the insensitivity of satisfaction surveys to detect deficient areas of care		Context of the study not well described.
(Mottram, 2011a)	Qualitative grounded theory study of peoples experience of day surgery	145 participants and 100 careers, line by line coded analysis of text		People welcomed the speed, efficiency and predictability of day surgery				Minimal exploration of the aspect of satisfaction and variance with satisfaction
(Mottram, 2011b, UK)	Qualitative Grounded theory 145 patients interviewed following day surgery	Semi structured interviews, thematic analysis		More information needs to be provided in regard to community services. Discharge planning should commence pre operatively and more information was required		Perceived lack of support during self care		Self care seen as empowering, but often not a choice, not specific to surgical specialty

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Mozaffarieh, Krepler, Heinzl, Sachl, & Wedrich, 2004)	Prospective trial of instrument to measure satisfaction, and gain in quality of life between patients presenting with varied ophthalmic conditions	100 patient experiences measured, included V-R surgical patients	People who experienced V-R surgery took longer to recover, and had the highest HOQOL gain due to sudden and sever ocular conditions		Pain management correlated to satisfaction with care	Satisfaction did not correlate with vision improvement		Satisfaction was related to improved visual function, self care and inpatient modality as not delineated
(Newhouse, 2007)	Book section describing the sources of evidence							Book section describing sources of evidence and critical thinking skills in nurses
(Newsom, Wainright, & Canning, 2001)	Prospective study of La for V-r surgery.	1497 patient data examined, non and parametric analysis conducted	LA suitable for V-R surgery,	Patients with repeat surgery had increased experiences of pain			La considered acceptable for V-R surgery. Considered well tolerated	The use of sedation as a confounding factor was not well explored.
(Older, Carr, & Layzell, 2009)	Qualitative exploratory study on peoples use of analgesia	28 participants who had experienced day surgery Developed and explanatory framework with three themes		Self managed pain is based on complex decision making steps	Participants held erroneous belief about pain management, interventions needed to provide more than just information			Specific to the context of the setting
(Pager & McCluskey, 2004)	Quantitative Descriptive survey specific to cataract surgery	81 patient and 77 MD completed the survey		Discordance between day surgery patients priorities and surgeons perceptions demonstrated				Validity of the questionnaire not established

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Pager, 2005)	Descriptive study using validated instruments	132 patient sample, power analysis indicated >106,			Pain management exerted significant effect on satisfaction with care	Age, gender, culture, pain management and communication affect satisfaction with care		Single setting context, validation of instruments not established in this setting
(Pager, 2005)	RCT education interventions effect on anxiety and psychological adjustment	141 participants assigned to an intervention, correlation and descriptive statistical analysis		Psychological adjustment and decreased anxiety as a result of pre operative preparation and information				No inductive qualitative evidence to support the validation of the questionnaire
(Pavlin, Chen, Penaloza, Polissar, & Buckley, 2002)	Quantitative prospective study of pain as a complicating factor in day surgery	175 participants, multivariate regression analysis of statistical data		High level so pain influenced recovery and discharge following day surgery	Pain experience was improved with use of NSAID and La techniques			Did not include V-R cases in study population
(Peters, Jackson and Rudge 2011) Aust	Qualitative study of experience of childlessness	10 participants, data qualitatively analysed					Resilience in couples relationship help to survive the psychological trauma of childlessness	
(Polder, Bonneux, Meerding, & van der Maas, 2002 Netherlands)	Quantitative, Descriptive Data collected of cost of heal care in the Dutch population in 1988 and 1994	Comparison of data using descriptive statistical analysis		Ageing will result in increasing health care demands and costs				survey data, site specific to Netherlands
(Rawal, Allvin, Amilon, Ohlsson, & Hallen, 2001)	Quantitative study comparing the efficacy of analgesics	120 sample, intervention of three various analgesics, analysis of variance and distribution		Pain following day surgery was problematic and delayed recovery				Supported the point that pain following surgery has been problematic



Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Ray, 2004)	Book section	Explored the relationship between the mind and the somatic body. Described the influence both positive and negative of mind behaviour and the physical						Secondary source
(Rosen, Bergh, Lundman, & Maartensson, 2010)	Qualitative mixed methods	298 patients experiences explored open ended and structures questionnaire			Pain following day surgery continues to be problematic			Qualitative thematic analysis only explored people one aspect of pain Limited in context
(Rosique, Prez-Creles, Romero-Martin, Osuna, & Luna, 2006)	Quantitative prospective descriptive study	159 sample, questionnaire data collected, descriptive statistical analysis						Concluded that information provided to patients prior to surgery 67% had little or no recall, improved pre operative information required
(Rycroft-Malone, et al., 2003)UK	Discussion paper as to the nature of evidence in Nursing practice	Described four sources of evidence						Did not recognise the power relationship within evidence and evidence based practice
(Sakalya, 2000)	Qualitative study using Cultural criticism	Describe the political role of autobiographical patient accounts of illness	Aimed to restore cultural pluralism in nursing and patient agency					Discussion paper with specific point of view
(Sandali et al., 2011)	Quantitative retrospective comparative study on 20 23 and 25	555 participants, analysis conducted using descriptive and covariance	23 and 25 gauge vitrectomy safe and effective					Outcome measures were limited to physical and anatomical aspects

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
gauge Vitrectomy measures								
(Schwartz & Flynn, 2006)	Literature review / discussion paper	Number of papers reviewed not stated	The choice of surgical approach continues to be dependent on surgeon and patient preferences					How patient preference influence decision was not made clear
(Shaha, Cox, Talman, & Kelly, 2008)								
(Shannon & Mitchell, 2002)	Descriptive participative , 489 participants from multiple sites	Correlation analysis performed				Nurses, physicians and patients viewed quality of care and satisfaction differently		Limited by geographical region and context
(Shelswell, 2002)	Discussion paper		Urgent nature of the surgery and inability to absorb information	Described education /information to maximise compliance and outcomes	Limited discussion			Previous theories of knowledge as anxiety reduction strategy, not original research
(Suonen, Lävonen, & Vähimäki, 2007, Finland)	Quantitative, descriptive 126 day surgery patients surveyed in regard to HQoL	Structured survey, descriptive statistical analysis		Day surgery patients demonstrated distress with sleep, energy and pain following discharge	Inadequate pain management			Only 126 participants were day case surgery, context specific, HQoL instrument specific to Finland
(Tan et al., 2005)	Quantitative prospective study	65 participants, descriptive statistical analysis	Visual experience during awake V-R surgery was frightening for 13% of participants 58% experienced visual stimuli					Quantitative study would have been enhanced with some qualitative data

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Tyson & Padgham, 2006)	Cross sectional survey of patients satisfaction with day surgery	158 participants , postal questionnaire Descriptive analysis of the data			with surgery			Validity of measurement tool questioned
(Vowles, McNeil, Sorrell, & Lawrence, 2006, USA)	Quantitative-Quasi Experimental 48 undergraduate students exposed to an intervention of pain and fear inducing	MONOVA statistical analysis conducted		Fear and pain	Fear took precedent over pain when object of fear was worst possible		When more than one adverse state experienced . Is dependent on current and past environmental factors	?? the value of participant motive with financial inducement
(Waterman, Harker, MacDonald, McLaughlan, & Waterman, 2005, UK)	Action Research Interviews with 17 staff members of an Ophthalmic unit	Semi structured interviews, Thematic analysis	Elective V-R surgical patients. Posturing following V-R surgery was problematic particularly following urgent surgery, psychological care an issue	Patients requiring urgent surgery were more difficult to prepare for post operative activities				Limited understanding of post surgery psychological issues, single context.
(Watt-Watson, Chung, Chan, & McGillion, 2004)	Quantitative– Descriptive 180 post day surgery patients interviewed for information on pain management analgesic up take and education needs	Structured survey analysed using descriptive statistics		need for more information regarding analgesia and pain management	High levels of pain reported, improved pain management strategies required			Understanding of pain experiences would have been enhanced with mixed method study

Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialities	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(West, Usher and Foster 2011)	Development of a model of care based on resilience theory	Review of the literature on resilience and family stress					Described resilience as a valuable theoretical underpinning for the development of new interventions to support families	Validation of the model the of evaluation would have strengthened the evidence
(White, 2002)	RCT of NSAID in improving patient pain experiences	Inferential statistics utilised		Non specific population, no v-r surgery included, pain has a major impact on recovery	Multi modal pain management can improve patient experiences following day surgery	Analgesia type not described	Successful pain management influences patient satisfaction with day surgery	Not specific to specially, did not consider psychological and historical influence on pain experiences
(Wickham, Bunce, Kwan, Bainbridge, & Aylward, 2010)	Pilot RCT of pain experiences comparison between two surgical techniques	Sample of 40 participants inferential statistics	Concluded that no difference between 20 or 25g vitrectomy technique in regards to pain		Concluded that neither group experienced pain despite 50% of patient in one group reporting pain			Pilot study only, no qualitative evidence of pain collected
(Wildlund, Lindholm, & Lindstrom, 2002)								
(Wilcock, Brown, Bateson, Carver, & Machin, 2003)	Exploration of the use of patient narratives to inform care	Examined various studies where patient narratives were the knowledge source for the improvement of care					Described the inadequacies of satisfaction surveys	direct patient narratives provided energy and patient focus, to improvement activities
(Wimpfissinger et al., 2008)	RCT comparison of 20-23g vitrectomy	60 participant sample, non parametric statistical analysis applied	23g less painful than 20g vitrectomy					Significant difference to Wickham study, no qualitative data collected



Authors, year and location	Study paradigm and research framework	Analysis method and sample	Relevance to question 1: Experience of V-R day surgery	Relevance to question 2: Day surgery across specialties	Relevance to question 3: Pain management during self care	Relevance to question 4: Ocular anaesthesia	Relevance to question 5: Satisfaction surveys	Limitations of findings
(Yellen & Davis, 2001)	Descriptive correlation study	130 patient participants, STAI instrument to measure anxiety, patient satisfaction survey instrument, VAS for measurement of pain experiences		Two site collection of data from patients who had experienced day surgery,	Pain management correlated to patient satisfaction	Pain management correlated to patient satisfaction		The need to understand the relationship between nurses collecting electronic data and satisfaction with care was not well established

## APPENDIX 2

### ETHICS APPROVAL DOCUMENTS

**Flinders Medical Centre**  
Bedford Park South Australia 5042

Telephone (08) 8204 5511  
International 618 8204 5511

**Flinders Clinical Research Ethics Committee**  
FWA00001785

Telephone (08) 8204 4507  
Facsimile (08) 8204 5834  
email: Carol.Hakof@fmc.sa.gov.au

30 April 2004

#### MEMORANDUM

TO: Ms. C. McCloud, Clinical Nurse Manager, Flinders Eye Centre  
FROM: Ms. C. Hakof, Executive Officer, Flinders Clinical Research Ethics Committee  
TOPIC: **Research Application 130/034**

I am pleased to advise that the Flinders Clinical Research Ethics Committee (FCREC) has approved your research 19 April 2004.

5877 RESEARCH APPLICATION 130/034 – MS. C. McCLOUD  
Understanding the experience of ambulatory eye surgery.  
Reviewer: Prof. D. Watson

This application was approved subject to the following:

1. Clarify whether this has been submitted to the DHS Insurance Services Section for review and indemnity.
2. Information sheet requires amendments which have been conveyed to the investigator. Also, explain what the interview involves, how long it will be and who will be conducting it.
3. Consent form – fill in the 'procedures', eg, take part in an interview, questionnaires, etc.

A progress report must be provided annually. Approval is given for a period of three (3) years only and, if the study is more prolonged than this, an updated submission will be required.

**If conditional ('subject to' or 'in principle')** approval is granted, research involving human subjects **may proceed only after written acceptance of the conditions of approval** (including a copy of the modifications) has been received by the Committee.

If patients are involved the chief investigator is responsible for the process of notification, seeking approval or permission of Departments, Divisions or individual consultants. **A copy of the signed consent form is to be filed in the participant's medical record.** Please note that if this trial involves normal volunteers it will be necessary for you to keep a record of their names and you may be required to supply this list with your annual report.

You are reminded that the FCREC must approve the content and placement of advertisements for the recruitment of volunteers.

**The Committee must be notified and approve any changes** (e.g. additional procedures, modification of drug dosage, changes to inclusion or withdrawal criteria, changes in mode and content of advertising) in the investigational plan particularly if these changes involve human subjects.

The safe and ethical conduct of a trial is entirely the responsibility of the investigators. While the FCREC takes care to review and give advice on the conduct of trials, approval by the Committee is not an absolute confirmation of safety, nor does approval alter in any way the obligations and responsibilities of investigators.

It is the duty of the chief investigator to give prompt notification to the FCREC of matters which might affect continued ethical acceptability of the project, including:

1. Adverse effects of the project on participants, including the total number of participants recruited, and of steps taken to deal with these adverse effects.
2. Other unforeseen events.
3. A change in the base for a decision made by the Committee, e.g. new scientific information that may invalidate the ethical integrity of the study.



The Flinders Clinical Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Research Involving Humans (June 1999).



15 November 2007

Bedford Park 5042  
South Australia

## MEMORANDUM

TO: Ms. Christine McLeod, Clinical Nurse Manager, Flinders Eye Centre  
FROM: Ms. C. Hakof, Executive Officer, Flinders Clinical Research Ethics Committee  
TOPIC: **Review of Research Application 114/07** (re-registered, previously 130/034)

Level 2  
Room 2A221  
Telephone  
08 8204 6453  
Facsimile  
08 8204 4586

Letter dated 12 November 2007 regarding extension of this study, was received and noted. The Flinders Clinical Research Ethics Committee (FCREC) Executive considered and re-approved your application on 14 November 2007.

This approval will be ratified at the next meeting of the Flinders Clinical Research Ethics Committee. You will only be notified if there are any further queries.

**Period of Approval: 14 November 2007 to 14 November 2010**

**Please note the terms under which ethical approval is granted**

1. **If conditional** (*'subject to'* or *'in principle'*) approval is granted, research involving human subjects **may proceed only after written acceptance of the conditions of approval** (including a copy of the modifications) has been received by the Committee.
2. Researchers are required to immediately report to the FCREC anything which might warrant review of ethical approval of the project, including:
  - a. Adverse effects of the project on participants, including the total number of participants recruited, and of steps taken to deal with these adverse effects.
  - b. Proposed changes in the project.
  - c. A change in the base for a decision made by the Committee, e.g. new scientific information that may invalidate the ethical integrity of the project.
  - d. Other unforeseen events which might affect continued ethical acceptability of the project.
3. Projects are approved for up to 3 years only and a progress report must be provided annually. Extensions after 3 years will not be granted without a report to the Committee and the provision of an updated submission.
4. Confidentiality of the research participants shall be maintained at all times as required by law.
5. All research participants shall be provided with a Patient Information Sheet and Consent Form, unless otherwise approved by the Committee.
6. The Patient Information Sheet and Consent Form shall be printed on the relevant site letterhead, stating the contact details for the researchers and must also state that the Executive Officer can be contacted for information concerning policies, rights as a participant, or should the participant wish to make a confidential complaint.
7. A copy of the signed consent form is to be filed in the participant's medical record.
8. A report and a copy of any published material should be forwarded to the Committee at the completion of the project.
9. **For conditional approval or deferred approval, a response must be received within 8 weeks. Failure to do so will result in non-approval of the project.**

**McCloud, Christine (Health)**

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**From:** Randhawa, Harry (Health)  
**Sent:** Monday, 18 May 2009 13:28  
**To:** McCloud, Christine (Health)  
**Subject:** RE: 114/07 Protocol amendment approved by ethics  
**Importance:** High

Dear Christine

I can confirm that the FCREC approves your use of the data generated for the study 195/034 (called an assessment of the effectiveness of piroxicam for pain following retinal surgery) by Dr Jon Clarke for use in your study – 114/07 - Understanding the experience of ambulatory eye surgery.

Please keep this email as evidence that ethics has reviewed and approved the amendments below.

Cheers Harry

Dr Harry Randhawa MB BS, LLB/LP  
Acting Executive Officer for the Flinders Clinical Research Ethics Committee and Clinical Drug Trials Committee  
Manager - Human Research and Ethics Department  
Southern Adelaide Health Service  
Room 2A 221  
Flinders Medical Centre Bedford Park SA 5042  
T: 08 8204 6453 or M: 0422 687 087 or Fax: 8204 4586  
Harry.Randhawa@health.sa.gov.au  
<http://www.flinders.sa.gov.au/research/pages/ethics>

The information contained in this email may be confidential and may also be the subject of legal professional privilege or public interest immunity. If you are not the intended recipient, use, disclosure or copying of this email and / or its attachments is unauthorised. If you have received this email in error, please email or telephone the above signatory.

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**From:** McCloud, Christine (Health)  
**Sent:** Friday, 15 May 2009 15:22  
**To:** Randhawa, Harry (Health)  
**Cc:** Clarke, Jon (Health)  
**Subject:** Eye study

Hello Harry,  
Following our discussion to day regarding my currently approved research 114/07, I request advice / approval for the following.

- I wish to make reference to data collected by Drs Jon Clarke and Gail Robertson (research approval number 195/034), in my current qualitative research project 114/07.
- The data collected has not been analysed, reported on or published, and the study at this point is incomplete and discontinued.
- I have had discussions with Dr Clarke regarding my intentions and I believe that he has provided approval for me to refer to the data collected
- Dr Jon Clarke is a current employee of FMC, however Dr Gail Robertson is no longer employed by FMC.
- I would not need to revisit any of the patients.
- I will reference all included data to Drs Clarke and Robertson.

Thank you for your advice in this matter.  
Kind regards

*Christine McCloud*  
*Clinical Services Coordinator*  
*Flinders Eye centre*  
*8204 5355*  
*christine.mccloud@health.sa.gov.au*



**McCloud, Christine (Health)**

**From:** Rusby, Tamara (Health)  
**Sent:** Tuesday, 16 February 2010 11:55  
**To:** McCloud, Christine (Health)  
**Subject:** RE: 013/09 Final Ethical Approval Granted  
**Importance:** High

Dear Christine McCloud

*This is a formal correspondence from the Flinders Clinical Research Ethics Committee, which is a properly constituted HREC under AHEC requirements with the registration number EC00188. This committee operates in accordance with the "National Statement on Ethical Conduct in Human Research (2007)." This department only uses email correspondence for all documents unless prior arrangements have been made with the manager. No hard copy correspondence will be issued.*

**Application Number:** 013/10

**Title:** Peri-Operative Care of Patients Undergoing Ambulatory Vitreo-retinal Surgery: A Clinical Audit.

**Chief Investigator:** Ms. Christine McCloud

**The Issue:** The Flinders Clinical Research Ethics Committee (FCREC) have reviewed and approved the above application under the expedited review program. Your project may now commence. The approval extends to the following documents:

- Clinical Audit Application, dated 13 January 2010

**Approval Period:** 16 February 2010 to 16 February 2013

Please retain a copy of this approval for your records.

**TERMS AND CONDITIONS OF ETHICAL APPROVAL**

**Final ethical approval is granted subject to the researcher agreeing to meet the following terms and conditions:**

1. Compliance with the *National Statement on Ethical Conduct in Human Research (2007)* & the *Australian Code for the Responsible Conduct of Research (2007)*
2. To immediately report to FCREC anything that may change the ethical or scientific integrity of the project.
3. To regularly review the FCREC website and comply with all submission requirements as they change from time to time.
4. Submit an annual report on each anniversary of the date of final approval and in the correct template from the FCREC website
5. Confidentiality of research participants MUST be maintained at all times.
6. A copy of the signed consent form must be given to the participant unless the project is an audit
7. Any reports or publications derived from the research should be submitted to the Committee at the completion of the project.
8. Report Significant Adverse events (SAE's) as per SAE requirements available at our website.
9. The researchers agree to use electronic format for all correspondence with this department.

Kind Regards

**Tamara Rusby**

24/01/2011

## APPENDIX 3

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# PATIENT INFORMATION SHEET

### Flinders Eye Centre Flinders Medical Centre

#### Participant Information Sheet

##### *Understanding the Experience of Ambulatory Eye Surgery*

**This is a research project, and you do not have to be involved. If you do not wish to participate, your medical care will not be affected in any way.**

You are invited to take part in a study exploring your experiences of eye surgery as a day case (ie;not being admitted to the hospital following the surgery).We are hoping to increase our understanding of the problems and experiences of patients and their families following discharge from the hospital. We are interested in your post-operative management of pain, and visual disability, and how these factors affected you in the time immediately after the surgery and following discharge. By increasing our understanding of your experiences, this study may be able to guide policy development for improved care and support to post operative eye surgery patients.

If you choose to participate, you will be asked to

- participate in either a short questionnaire about your recent surgical experiences
- OR
- participate in an interview about your experiences of eye surgery. Open ended questions which explore your thoughts, experiences and feelings about the surgery will be asked during the interviews. The interview may take up to one hour in length and will be audio taped for later transcription. The interviews will be conducted by the researcher

There are no direct benefits to you associated with this study, however the information and knowledge gained through this research will assist with the planning and implementation of care for future eye surgery patients.

There are no physical risks involved with this research, however the reliving of experiences may have psychological and or emotional consequences. If at any time you feel overwhelmed or distressed by the research interviews, you are free to withdraw from the study and support services offered will be offered

If you, as a participant of this research, suffer injury, compensation may, at the discretion of Flinders Medical Centre or Flinders University of South Australia be paid without litigation. However, compensation is not automatic and you may have to take legal action in order to receive payment.

Your participation in the study is entirely voluntary and you have the right to withdraw from the study at any time. If you decide not to participate in this study or if you withdraw from the study, you may do this freely without prejudice to any treatment at Flinders Medical Centre.[.

The research team receives no financial benefit from your participation in this study.

All records containing personal information will remain confidential and no information that could lead to your identification will be released.

The findings of this study may be published in the Nursing Literature.

Should you require further details about the project, either before, during or after the study, you may contact Christine McCloud Clinical Nurse Manager at the Flinders Eye Centre, Flinders Medical Centre on 8204 5355.

This study has been reviewed by the Flinders Clinical Research Ethics Committee. Should you wish to discuss the project with someone not directly involved, in particular in relation to matters concerning policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact the Administrative Officer - Research, Ms. Carol Hakof, on 8204 4507.

May-04

Page 1



# APPENDIX 5

## PAIN PROTOCOL

### Flinders Eye Centre Pain Protocol for V-R Patients

All Adult patients discharged from Flinders Eye Centre (FEC) will be assessed by the Surgical and/or Anaesthetic Consultant for self administered pain management and allocation into one of the following three groups;

Group A, self purchased paracetamol as required

Group B, provision of mild pain relieving medications and protocol required.

Group C provision of strong pain relieving medications and protocol required.

The inclusion criteria of each group is as follows (not exclusive)

#### **Group A type procedures:** (as determined by the surgeon)

e.g.

- Lid procedures
- Minor conjunctival procedures
- Minor ocular surface procedures
- Uncomplicated Cataract extraction
- Corneal graft

Following these procedures patients are advised;

1. to take (self purchased) paracetamol 6/24 as required.
2. If pain is not adequately controlled they are advised to contact the oncall ophthalmic Registrar who can advise them regarding management of eye pain.

#### **Group B type procedures** (as determined by the surgeon)

e.g

- Extensive lid procedures
- Complex conjunctival/limbal/corneal procedures i.e.
  - Pterygium + conjunctival graft
  - Limbal lesion removal
  - 25g. and 23g vitrectomy

Following these procedures patients will receive Ibuproffen or IV Paracoxib(Dynastat) (unless contra indicated) prior to discharge. Patients will be provided with paracetamol and a protocol that commences with ;

1. Take two tablets six (6) hours from the time of regional anaesthetic instillation.
2. There after they will be advised to take two (2) paracetamol 6/24.
3. If pain relief is inadequate they may take paracetamol/codeine 6/24 as required.
4. If pain is still not adequately controlled they are advised to contact the on call ophthalmic Registrar who can advise them regarding management of eye pain.

**Group C type procedures**(as determined by the surgeon)

e.g

- Patient with significant pre operative pain
- Complex 23g or 20g Vitrectomy with operating time of > 2 hours
- Scleral buckle procedures
- Adult Squint procedures involving 2 or more muscles
- Cyclodiode laser

Following these procedures patients will receive Ibuproffen or IV Paracoxib(Dynastat) (unless contra indicated) prior to discharge. Patients will be provided with analgesia medications and a protocol that commences with;

1. to take two paracetamol tablets six (6) hours from the time of regional anaesthetic instillation.
2. There after they will be advised to take 2 paracetamol 6/24. If pain relief is inadequate they may take oxycodone 4/24 as required.
3. Patients mayl be given IV tropisetron prior to discharge to prevent side effects of nausea and vomiting
4. If pain is still not adequately controlled they are advised to contact the on call ophthalmic Registrar who can advise them regarding management of eye pain.

**Contraindications**

Group A protocol

- Known allergy to paracetamol
- Hepatic Failure

Group B protocol

- Known allergy to paracetamol or codeine
- Allergy to NSAID
- Concurrent use of NSAID
- Concurrent use of corticosteroids
- Concurrent use of anti coagulants
- History of previous GI bleed
- Chronic debilitating disorders eg. advanced cardiac disease, renal failure, hepatic failure. .

Group C protocol

- Known allergy to paracetamol or codeine
- Allergy to NSAID
- Con-current use of NSAID
- Concurrent use of corticosteroids
- Concurrent use of anti coagulants
- History of previous GI Bleeding
- Chronic debilitating disorders eg advanced cardiac disease, renal failure hepatic failure. .
- Known allergy to oxycodone
- Known allergy to tropisetron

## APPENDIX 6

### STRUCTURED PRE-OPERATIVE QUESTIONNAIRE

#### V-R Surgery Check list Flinders Ex

2 Paula Avenue  
Windsor Gardens, 5087



#### Physical preparation

1. Appointment time and Place.....
2. Pain management
  - a. Pain medication taken in the past.....
  - b. Medications available at home.....
  - c. What non- pharmaceutical activities have helped in the past  
.....
  - d. Previous painful experiences with Eye block / surgery  
.....
3. Nausea and Vomiting ( PONV).
  - a. Past problems with PONV.....
  - b. Medications that have helped.....
  - c. Other actions that have helped.....
4. Fasting requirement.....No.....Yes.....
  - a. Time.....
  - b. Diabetic.....First on List.....
  - c. Sedation required.....
5. Transport to and from FEC arrangements.....
6. Post operative Self care arrangements  
.....

#### Psychological preparation.

1. Proposed surgery.....
2. Information required
  - a. High Detail information needs.
    - i. High detail Information Sheet provided.....
    - ii. Discussion with staff regarding procedure.....
    - iii. View of DOU area.....
    - iv. Meeting with DOU staff.....
  - b. Low Detail information needs
    - i. Meeting with DOU Staff.....
    - ii. Discussion with staff regarding procedure.....
    - iii. View of DOU area
    - iv. Low detail information sheet provided.....
3. Availability of family / friend support on the day.....
4. Other psychological support required .....  
.....
5. Anxiety level ( self assessed).....
  - a. Actions that have worked in the past to reduce anxiety / stress.  
.....
  - b. Other actions that may assist;
    - i. intra operative music ..... own CD
    - ii. pre operative sedation

---

## **Historically Located Care plan**

1. Past eye surgery experiences.....  
.....
2. Past negative experiences  
a. Anaesthetic / Eye Block  
.....  
b. Surgery  
.....  
c. Immediate convalescence  
.....  
d. Psychological adjustment  
.....
3. Past positive experiences  
.....  
.....
4. Patient stated expectations of the surgery  
.....  
.....

## **Community Located care.**

1. Convalescent- family / community situation.  
a. Who will be your carer  
.....  
b. Who will care for any dependants  
.....  
c. How will you meet your need for support during immediate convalescence  
i. Meals – night of surgery and during convalescence  
ii. Transport to shops / appointments / other  
.....  
iii. Care for pets.  
iv. Will you be safe in your place of residence  
.....  
v. Do you need supported accommodation following the surgery  
.....
2. Community based support  
a. Do you want / need community supports  
.....  
b. Do you want / need referral to Low Vision centre, vision impaired support groups  
.....  
c. Do you know what to expect in terms of visual disability following the surgery  
(monocular vision)  
.....  
d. Do you need the services of a councillor  
.....  
e. is there anything else that we can do to help you with your surgery and convalescence?  
.....  
.....  
.....

# APPENDIX 7

## AUDIT TOOL

### Vitreo- Retinal Audit Sheet

Contact Nurse.....

Pre operative Data collection phase.

Operation Date..... 9/6/10

Discharge time..... 1100

Surgery... Vitrectomy... 20g... 23g... 25g

Las<sup>er</sup> / Gas Oil

Scleral Buckle..... 1300

Cataract.....

Other... CMO

Reason for surgery..... (R) RD

Anaesthetic... Sub Tenon Block... Peri Bulbar Block ... Sedation  GA R30

Pre Operative VA... 10m... Fellow eye... (R) 10/20

Post operative NSAID / COXib...

Pre operative information given...

Pre operative face to face interview/ Pre operative telephone interview

Questions / problems identified

No problems identified previous bilateral surgery  
Mention provided to Registrar

### Within 48 hours Follow up

Date of follow up... 11/6/10... Hours since surgery... 48... OPD/Phone.....

Post operative Problems

Good exercise } Return to work Wednesday

Pain anaesthetic no pain 1 2.3.4.5.6.7.8.9.10 extreme pain

Pain during surgery no pain 1 2.3.4.5.6.7.8.9.10 extreme pain

Pain during self care no pain 1 2.3.4.5.6.7.8.9.10 extreme pain

Medications Taken

Paracetamol...

Oxycodone .....

Other.....

6 hour post Eye block paracetamol medications taken Yes (No)



# APPENDIX 8

## PUBLICATION

JAN

JOURNAL OF ADVANCED NURSING

### ORIGINAL RESEARCH

## Understanding people's experience of vitreo-retinal day surgery: a Gadamerian-guided study

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### Abstract

**Aim.** This paper is a report of a study that aimed to understand the individual's experience of day surgery for repair of vitreo-retinal pathology.

**Background.** Day surgery evolved as a global phenomenon in response to tensions existing between community demand for health-care services and fiscal limitations. Since then vitreo-retinal surgery has been routinely performed as day surgery. Whilst studies have reported on patients' experience's following *inpatient* surgery, there has been limited investigation of vitreo-retinal day surgery from the patient's perspective.

**Methods.** In-depth unstructured interviews with 18 people were conducted between July 2006 and December 2007. Data analysis using philosophical hermeneutic techniques enabled a co-constructed understanding, where, the 'conditions of understanding' as described by Gadamer were established.

**Findings.** Guided by a Gadamerian approach to analysis, four constitutive themes were identified: 'the physical Self', 'the psychological Self', 'the historically located Self' and 'the Self located in the community'. Within each theme the participant's positive and negative experiences were understood in the context of human need, and gaps in nursing care became illuminated. These experiences included: pain, nausea, problematic self-care and psychological angst.

**Conclusion.** Insights into the experience of vitreo-retinal day surgery, gained from this study can be used to inform nurses planning care for people with vitreo-retinal pathology. Nursing care must address broader patient needs that span multiple human domains, particularly when vision has been threatened by complex pathology.

**Keywords:** blindness, day surgery, experience, Gadamer, philosophical hermeneutics, vitreo-retinal pathology

### Introduction

Day surgery, defined as admission, surgery and discharge within one day (Sangermano 1991, Stein *et al.* 2006) has been a rapidly expanding care phenomena (Aylin *et al.* 2005,

Chanthong *et al.* 2009). Embraced by a wide diversity of surgical specialties, day surgery has seen an extensive international uptake (Twersky 1995, Gilmartin 2007). Researchers from diverse global contexts have estimated that day surgery will be 75% of all surgery performed (Twersky

1995, Coll *et al.* 2004, Aylin *et al.* 2005). Political and economic pressures, including an increasing demand for services amidst fiscal constraint, have been the driving forces behind this widespread and international transformation of surgical services (Rose *et al.* 1999, Little 2000, Stein *et al.* 2006). Cataract surgery, one of the earliest and most successful day surgery transitions (Panchapakesan *et al.* 2003, Dhillon & Gerassimos 2009) provided a successful ophthalmic surgical pathway that has been extended to encompass vitreo-retinal (VR) surgery (Bhatt *et al.* 2010). VR surgery for sight threatening pathology is now routinely performed as day surgery.

### Background

Vision loss, a frequent cause of disability, has emerged as one of the most feared health conditions world wide (Taylor 2002, Stein *et al.* 2006). This fear has been largely due to the important impact vision loss has on quality of life, independence, social interactions and financial stability (De Leo *et al.* 1999, Chia *et al.* 2003, Lau *et al.* 2004). In 2004 there were 480,000 visually disabled Australians, of whom 12% have attributed their disability to VR pathology, most commonly from complications of diabetes (Spaeth 2003, Australia 2004). Sight threatening VR disease has been known to cause vitreous haemorrhage, tractional vitreous detachment, retinal detachment or development of metaplastic membranes (Vaughan *et al.* 1999).

Surgical interventions for the management of VR pathology have included: vitrectomy, scleral buckling, cryotherapy, endolaser and epi-retinal membrane peeling (Stein *et al.* 2006). Success rates following VR surgery have significantly improved with modern techniques; however, complications may occur which limit functional and anatomical success and may result in visual disability or blindness (Quillen *et al.* 2003, Kawahara *et al.* 2008, Goezinne *et al.* 2010). Whilst recent advances in VR surgical techniques have contributed to reduced surgical trauma and successful outcomes (Wimpissinger *et al.* 2008, Wickham *et al.* 2010), advanced pathology has continued to require complex surgery that has been associated with a painful and problematic recovery (Stein *et al.* 2006).

Surgical inpatient care has provided opportunities for nurses to manage immediate postoperative problems, usually through provision of: analgesia, anti-emetics and supportive professional care. Despite these opportunities, recent studies have found that pain and postoperative nausea and vomiting (PONV) management has not always been successful (Waterman *et al.* 1999, Fekrat *et al.* 2001, Mozaffarieh *et al.* 2004, Morel *et al.* 2006, Hashemi *et al.* 2009, Ghali & El

Btarny 2010, Wickham *et al.* 2010). For example, Fekrat *et al.* (2001) found that 56% of patients experienced pain post VR surgery and 27% required narcotic analgesia. Morel *et al.* (2006) also confirmed the high incidence of postoperative pain following VR surgery. Both Morel *et al.* (2006) and Fekrat *et al.* (2001) report PONV following VR surgery. Clearly recovery from VR surgery was known to be problematic even when supported by acute care staff and facilities. The transference of recovery following surgery to patients and families as *self-care* was a salient feature of day surgery. The known difficulties patients may experience during self-care, needed to be addressed during the outpatient visit when the need for surgery had been identified and planned.

Physical and psychological preparations for surgery and self-care have been core nursing activities prior to day surgery. Time available for these activities was limited to the brief interaction between patients and staff during the preoperative outpatient visit and prior to discharge. Costa (2001) described difficulties patients had experienced following day surgery and attributed them to inadequate preparation for postoperative care, a finding that studies across a broad range of surgical specialties have also reported (Costa 2001, Pavlin *et al.* 2002, Lellan 2004). A lack of preoperative preparation has been reported as influencing: non-routine visits to healthcare centres, management of pain, wound care, preoperative anxiety and satisfaction with surgical outcome (Waterman *et al.* 1999, Henderson & Zernike 2001, Coll *et al.* 2004, Lesnoni *et al.* 2005, Mitchell 2010). Clearly inadequate care planning, can impact significantly on patient experiences of day surgery.

The study reported in this paper examined the experience of 18 people who underwent day surgery for VR pathology. This study originated from a clinical practice setting where the murmurs of patient difficulties following VR day surgery had become increasingly audible, and where knowledge in the professional literature was limited.

### The study

#### Aim

The aim of the study was to co-create an understanding between the researchers and the participants of the experience of vitreo-retinal day surgery.

#### Design

This study utilized a research design underpinned by Gadamer's philosophical assumption that people experience the world through language, and language was the conduit

for understanding and knowledge development (Gadamer 1975). Gadamer emphasized the importance of language as text, noting that interpretation of text required an understanding of the possibilities that can be revealed (Gadamer 1975). In the creation of the text of this study, the conditions for understanding, essential to Gadamer's philosophy were established. These conditions included: engagement of the 'horizons' of the researchers, locating the participant within their historical context, language as the conduit of understanding and a circularity of movement between the parts and the whole to create the 'fusion of Horizons' necessary to the moment of understanding. The creation of text in which the participant's experiences, beliefs, cultural situatedness and historical circumstances was central to the methods of this study.

The context of this study was an Australian public hospital day surgery unit, an environment that Benner (1994) believed de-contextualized patients from their unique life-world, and where there has often been a systematic blindness to an embodied lived experience. An interpretive research design that sought understanding of experience was appropriate to underpin this study. The articulated practices and meanings of a participants' life-world enabled encounters with the variant and multiple essences of being human, and informs practice to become effectively and humanely engaged (Benner 1994, Adams *et al.* 2007).

### Participants

A purposive sample of eleven men and seven women, aged between 45 and 87 years of age was recruited between July 2006 and December 2007. Participants who met the following criteria were invited to join the research: experienced at least one episode of VR day surgery in the previous 3 months, over 18 years of age, able to speak English and lived within a 50 km radius of the healthcare facility. Information about the study was provided and interested participants were confirmed by a follow-up phone call from the first researcher (CM). The desire for rich in-depth data limited the sample to 18 participants, and participant selection ended when no new information arose satisfying the criteria for sample saturation (Munhall 2007).

### Data collection

The data collection method was a single unstructured face-to-face interview that uniformly commenced with the dialogue 'tell me about your experience of VR day surgery'. Interviews were conducted at the homes of participants in all but two instances, where it was more convenient for the participant to

be interviewed in the health-care facility. Interviews lasted from 40 minutes to 2 hours and were tape recorded and later transcribed. All interviews were conducted by CM who was responsible for the management and planning of care provided to patients of the eye department where participants underwent surgery. This close connection between the researcher and the participants influenced the choice of Gadamer's Philosophical Hermeneutics as the methodology for this study. Participants were encouraged to disclose aspects of the experience that were important and meaningful to them and this disclosure became the participants' 'horizon' reported in the text of the study. Interviews were taped with participants' consent and later transcribed verbatim to create the text for this research.

### Ethical issues

This research was approved by the University and Hospital Ethics committee and all participants were issued an information sheet, asked to sign a consent form and were advised that they had the right to withdraw at any time. Participants were informed that the findings of this research would be published in the professional literature.

### Data analysis

Consistent with Gadamer's philosophical hermeneutics, resonances and dissonances between revealed experiences and articulated researcher 'horizons' were explored, examined and then re-examined in light of the whole text. This dialectical process facilitated a 'fusion of horizons' between the researcher and participant experiences that Gadamer believed was essential to the development of new understanding (Gadamer 1975). All transcripts were initially read to develop an overall impression of the experience. An in-depth re-reading of the text that followed enabled the identification of experiences and statements that resonated with the researchers' preunderstandings or presented unique and unexpected knowledge. Shared patterns of experience were clustered into conceptual units of meaning that developed into themes. The identification of emerging commonalities and themes was assisted by the soft ware program NVivo 7.

### Rigour

Guba and Lincoln's (1985) seminal work on trustworthiness in qualitative research was the reference framework for rigour in this study. The classic criteria of credibility, transferability, dependability and confirmability, considered by Guba and Lincoln to be essential for establishing

trustworthiness have been addressed in the following manner (Guba & Lincoln 1985).

Prolonged engagement with participants led to the development of a trusting relationship between one of the researchers (CM) and the participants, a relationship considered by Guba and Lincoln necessary for the credibility of the findings. The context of a day surgery unit became 'thoroughly understood and appreciated' in the process of prolonged engagement (Guba & Lincoln 1985) further enhancing credibility, as the researchers were able to recognize salient and distorted elements in the findings.

Peer review of the study occurred at a conference for Ophthalmic Nurses, London, United Kingdom 2008, where searching questions by experienced ophthalmic nurses led to corroboration of the findings. Provision of 'thick description' of participant experiences provided conference delegates and readers of this study sufficient information to judge the transferability to other contexts.

The conduct of interviews over an 18-month time frame reduced the possibility of early closure of data collection and thus limited researcher *a priori* distortions. Dependability and confirmability were satisfied through an audit trail that existed in the layered nodal analysis achieved through the use of NVivo 7 for the thematic coding and coupling of data. Verbatim participant excerpts were used to illustrate the constitutive elements of a reported theme and provided a direct link between the findings and the interview transcripts.

**Results**

**The continuum of experience**

Participants of this study described variable experiences of VR day surgery. The number of their previous VR surgical events ranged from first episodes to more than six previous procedures. The length of time participants had endured VR

disease spanned a few days to more than 31 years. Underlying eye pathology included, slowly evolving macular hole, sudden retinal detachment and complex end stage pathology. A broad understanding of the data revealed both positive and negative participant experiences. Positive experiences were more frequent in participants who had elective and generally curative surgery. Negative experiences illuminated inadequacies of care and unmet needs when complex and ongoing pathology was present. The continuum of pathology from simple to complex was closely aligned with increasing negative experiences (See Figure 1).

The understanding of the described positive and negative participant experiences has been developed from an existential theoretical framework. Within an existential framework the phenomenon under scrutiny has been contextualized into the existential 'life world' of researchers and the researched, a process that Munhall viewed as essential to interpretive inquiry (Munhall 2007).

**An existential framework**

According to Gadamer (1975), the primal reality for human beings is their historically situated 'life-world'. Understanding of the life-world of the participants was the aim of the study reported in this paper. Munhall (2007) has described four existential constituents of a 'life world' as: temporal, spatial, corporeal and relational. In this study, Munhall's constitutive concepts of the 'life world' have been modified to reflect the interconnected human domains of 'Self'. Whitehead (2003) has argued that there are many facets of 'Self' in an existential understanding of health, and these facets are closely intertwined and influenced perception and attitudes of the lived world. The concept of 'Self', is presented here as themes and includes: 'the physical Self', 'the psychological Self', 'the historically located Self' and 'the Self located in the community'.

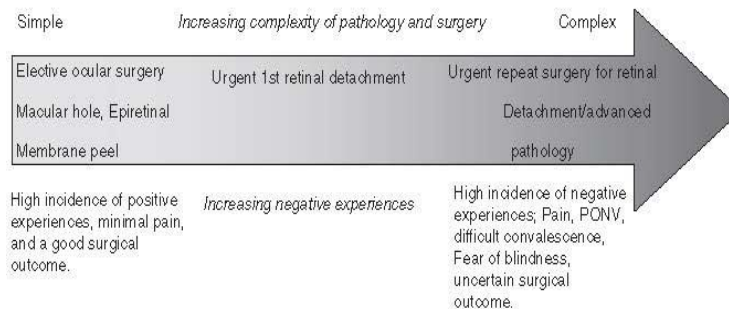


Figure 1 Relationship of negative experiences and complex disease pathology and treatment.



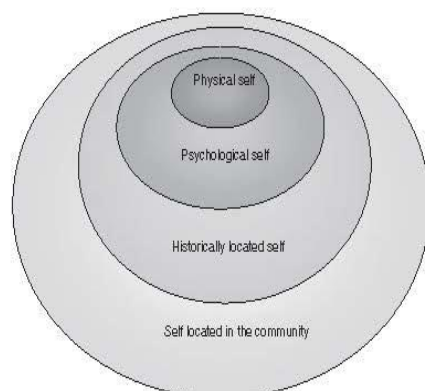


Figure 2 The identified layers of *Self* influenced by a V-R day surgical event.

Each theme was examined in light of the researchers' preunderstandings using the 'hermeneutic circle' considered necessary by Gadamer to 'understand in a different way' (Gadamer 1975). The interconnected domains of 'Self' that gave a greater understanding of the experience of VR surgery represented in Figure 2, will be presented in this paper.

### The physical Self

'The pain behind the eye was just unbearable': 'I went blind in that eye completely blind'

These heartfelt comments illustrated the participants' physical experiences of the phenomena of VR day surgery. Throughout their narratives, physical experiences were readily and vividly described, often dominating early sections of the interview. These experiences included: visual disturbances, pain, nausea and vomiting. At the commencement of each interview participants frequently described their visual symptoms: 'I saw... fireworks in the eye'; 'I was having all these lights and all flashing going on'. These frightening but painless physical symptoms were their prompts to seek medical help and it was from here that participants entered the world of day surgery care.

Whilst day surgery was most commonly performed for elective surgery, many of the participants of this study required urgent surgery, usually due to a pressing need to re-attach the retina: 'They got me in [for surgery] that day'. This urgency limited time for preoperative preparation, and resulted in participants arriving for surgery unsure of what was happening to them: 'it was explained it to us to a certain degree but I don't really understand these things'; 'I didn't know that [the eye block] was going to happen'. When time

allowed physical preparation included: description of the anaesthetic, instructions about medications, arrival time in the unit, the need to have an escort home and self-care. However, these preparations were often inadequate or incomplete and a number of participants described harrowing experiences that included: the anaesthetic, 'Gee those injections were nasty... that much pain'; 'the anaesthesia was probably the worst part for me'; postoperative pain during self-care 'The pain relief [during self-care] was not effective... wasn't adequate'. Participants were not routinely sedated for the anaesthetic or surgery, a strategy that aimed for a reduction in complications due to diabetes or other co-morbidities. Whilst this strategy worked well for prevention of complications it resulted in painful experiences of the eye 'block' that became increasingly evident when repeat surgery for complex pathology was required.

At the less complex end of the VR pathology spectrum were participants whose surgery was elective and curative. Whilst their experience was generally positive, they also reported pain during the instillation of the eye 'block': 'Yes it [the block] was well... painful'. As complexity of pathology increased, pain became more evident: 'I didn't think any of them have ever had an anaesthetic in your eye... I nearly squeezed the nurse's hand off'; 'the anaesthesia was probably the worst part for me'. The eye 'block' was well-known to cause pain and the use of sedation could have significantly ameliorated the pain experience. A participant who did receive sedation described: 'Yeah you don't know what's going on [with the eye block]. You're awake apparently but don't know. That's good. [the sedation]'

Pain during self-managed convalescence was also vividly described, and the following excerpt clearly illustrated the experience and influence of pain during recovery at home: 'I think that because of the pain in the eye it took longer for me to recover'; 'it is so sore and painful that most of the time my eyes are closed'.

Following discharge from the day surgery unit participants were supplied with combined paracetamol and codeine tablets or oral oxycodone, a narcotic-based analgesia. These medications were part of the standard postoperative pain management strategies. However, these strategies were clearly inadequate, as a number of participants reported, intense and debilitating pain during self-care: 'I was in a fair bit of pain and I was taking some fairly heavy pain killers'; 'The pain relief was not effective.. it wasn't adequate'. Postoperative pain was for some participants compounded by PONV after discharge: 'My level of nausea could not have been any worse'; 'I was very nauseous ... I had to go back to casualty...because the pain and the nausea were really over the top...'; 'I was sick for five days'. Experiences of pain and

PONV were abundantly evident, and these difficulties were compounded by psychological distress, evident as fear, anxiety and angst. These difficulties became the basis of the second theme of this study, the psychological Self.

### The psychological Self

'I was absolutely terrified'

Similar excerpts displayed the psychological distress that was evident in the narratives of all participants. Angst was intrinsically related to the perceived threat to not only the physical aspects of surgery but also to the consequences of vision loss. The emergence of this theme was related to the high value people have attached to vision, as participants explained: 'I really did have the fear that I would go blind'; 'once they're gone [eyesight] you realize how much you miss them how precious they are'; 'its pretty traumatic [the experience] but I could go through it all and this wouldn't matter if you had some certainty... that you're sight was going to be ok'. Psychological angst was not unique to participants with end stage pathology but was evident in the narratives of participants who required elective and curative surgery. This statement was representative of their thoughts and displayed the underlying fear of blindness: 'if anything happened to my eyes you are in a dark world and I just couldn't imagine myself doing that'. Participants who had urgent or previous unsuccessful surgery expressed a greater fear of blindness, evident in the following exemplar: 'it [surgical failure]... was devastating to me because I really thought you know it's going to work....'

The failure to address psychological issues left a number of participants struggling to cope and they displayed feelings of depression, anxiety and loneliness, exemplified in the following statement: 'I cried and cried: that's the sort of effect it had on me'. Repeat eye surgery was the experience of almost all of the participants of this study. Whilst the success or failure of previous surgery significantly contributed to their anxiety, it was often the nature of the previous experience (either good or bad) that played a crucial role in participant's ability to cope when further surgery was indicated. It was these previous events and the influence they exerted (both positively and negatively) that became the basis of the third theme 'the historically located Self'.

### The historically located Self

'That's the scary bit ... I know what's coming'

The 'scary bit' in this context was related to previous difficult experiences of VR day surgery. Whilst participants were

asked to identify their previous health and eye surgery experiences via a health questionnaire, the care provided rarely displayed sensitivity to an individual's health histories. The need to locate individuals in the context of their unique health history became evident as the study progressed. Participants with previous positive experiences described how past experiences helped to assuage anxieties and facilitated individual coping as one participant stated: 'I had no issues at all... I knew what to expect'. Negative past events, however, compounded fears and anxieties and contributed to an undermining of coping ability, as clearly articulated by these participants: 'I did find it harder... as I went along because what happened the first time...it erodes your self confidence and I guess your ability to cope a bit'; 'the second episode it was more traumatic because I knew what was coming'; 'I knew what to expect ...it probably increases the anxiety because I knew what was coming'. The effects of past experiences, compounded by psychological distress and physical difficulties all coalesced at the time of the surgical intervention and flowed into postoperative self-care. Consistent with day surgery care, support provided by the healthcare facility was transferred at the time of discharge to the participant in the community. The participants' self-care experiences in the community was the subject of the fourth and final theme, 'the Self located within the community'.

### The Self located within the community

'A terrible time when I got home, I could have done with nursing help'

Discharged to self-care following an episode of surgery, meant that individuals relied on family or community accepting the burden of convalescent care. It was assumed that care provided by the healthcare facility would facilitate a transition to the community through careful planning and supportive strategies. The experiences of many of the participants included physical and psychological difficulties during convalescence and rehabilitation. The following statements from participants displayed the difficulties encountered during self-care convalescence: 'I had to go back to casualty... because the pain and the nausea was really over the top'; 'we rang a doctor and emergency...'; 'I went home and was quite ill to the point where I was almost ringing for an ambulance to be brought back'. Difficulties during convalescence extended beyond the immediate recovery to include ongoing anxiety and problems adjusting to a visual disability. Participants found it difficult to get help when their immediate surgical interventions had been completed. Ongoing counselling whilst not necessary for all participants was sadly lacking for the people who faced an

uncertain visual future. 'all I wanted really was just sort of to have someone there who could answer questions who I wouldn't feel that I was putting upon on you know ... everybody out in the clinic area was in one almighty rush'.

**The interconnected domains of Self**

'how difficult it is [the surgery and loss of vision]... it affects your whole life'

The interconnected domains of *Self* that were influenced by the experience of VR day surgery became clearer after close examination of the four themes. Each layer of the *Self* was intimately connected and influenced by the phenomena of VR day surgery. When the human need associated with each theme was met, positive experiences resulted. However, when needs were un-met, negative experiences occurred, as Figure 3

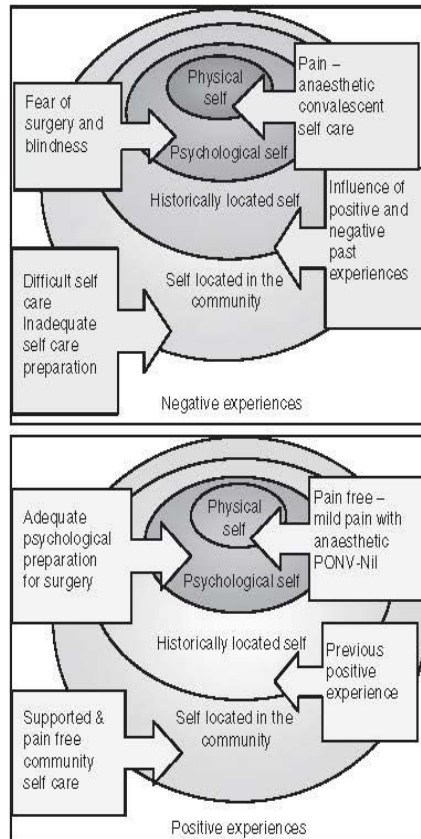


Figure 3 Positive and negative experiences and the interrelated human domains of *Self*.

displays. The *physical Self* was found to be a central construct because of the influence this aspect exerted across the spectrum of the experience. The early identification and location of this theme was consistent with the researchers' prior understanding which was deeply influenced by the physical context of a surgical and medicalized environment. As trust between the participant and researcher developed, emotional responses to VR disease and surgery, represented as the *psychological Self*, emerged. This theme also displayed an influence across all aspects of the experience. The *historically located Self* was a theme that challenged the researchers' preunderstandings. Whilst previous experiences were known to influence new experiences it was the depth of this influence that was unknown by the researchers, prior to the study, and provided valuable insight from the participants perspective. Finally the fourth theme, *the Self located in the community* had been alluded to by clinical experience. It was however, the depth and ongoing difficulties participants experienced, and identified in this study that displayed important unmet needs.

**Discussion**

**Limitations of the study**

The findings of this group of participants with diverse VR disease pathology were grounded in their lived experience of day surgery. The small sample size could be considered a limitation as the findings would not be deemed generalizable to wider populations where context, culture and interpretations differ. However, the depth, and rich descriptions within the findings have provided the opportunity for transferability to other contexts where similarities of setting, anaesthetic and analgesic regimes exist. The findings of this study offer recognition of the needs of ophthalmic patients undergoing day surgery, and an understanding of the experience when needs are unmet. These findings resonated with anecdotal clinical reports and published research around specific aspects of the experience, and found support within the Ophthalmic Nursing community, evident in the interest displayed when presented at a professional conference.

the life-world is...an intuitively given world...has the universal structure of a finite, subjective-relative world with indeterminately open horizons. (Gadamer 1977, p. 193)

In the findings of this study the subjective and relative life-worlds of the participants, described by Gadamer (1977), and classified by Munhall (2007) were interpreted as the interconnected human domains of *Self*, during an experience of VR day surgery. These domains were titled as: The *physical Self*, the *psychological Self*, the *historically located Self*, and



**What is already known about this topic**

- Recovery following vitreo-retinal surgery has been reported as problematic with high levels of postoperative pain and nausea reported in *inpatient* populations.
- Preparation of patients for day surgery has been a challenging nursing issue with many studies identifying problems in elective patients' experiences due to inadequate preparation for transition from the day surgery unit to community self-care.
- Potential blindness provoked fear and anxiety across many populations, and was strongly associated with loss of quality of life.

**What this paper adds**

- This study that employed Gadamer's notion of the 'Hermeneutic circle' has revealed participants' needs as constructs of self that spanned multiple human domains.
- Identified needs were grouped into four themes of: physical self, psychological self, historically located Self and the self located in the community.
- This paper identified gaps in nursing care that led to participant experiences of pain, nausea, problematic self-care and psychological angst.

**Implications for practice and/or policy**

- The identified complex needs of individuals should inform nurses planning vitreo-retinal day surgery care with the potential to improve patient experiences.
- Pain management strategies should be improved for community based self-care following vitreo-retinal day surgery.
- Research aimed to explore interventions to meet the psychological needs of individuals experiencing vitreo-retinal day surgery should be made a priority.

the *Self located in the community*. Within the *physical Self* participants experiences of VR surgery concurred with published knowledge about pain and PONV (Sahasivam *et al.* 2000, Fekrat *et al.* 2001, Mozaffarieh *et al.* 2004, Morel *et al.* 2006). However, knowledge in the literature was limited to the postoperative time only. The findings of this study have highlighted physical experiences across the whole experience, from participants' first visual disturbance through to their difficulties during self-care. Importantly the difficult experience of the eye 'block' has been identified and nurses

planning care for future patients need to be cognisant of these difficulties and modify care. Postoperative pain management has been problematic and alternative pain management strategies that participants can self administer continue to be urgently required.

Participants' anxiety about the eye block, possible blindness and potential pain following surgery has been explicated in the domain of the *psychological Self*. The finding of anxiety about possible blindness concurred with the published knowledge (Taylor 2002, Coyne *et al.* 2004, Brennan & Bally 2007). However, this study has added a broader understanding of participants multiple sources of fear and anxiety. The eye block was a particularly anxiety provoking event. The ameliorating influence of sedation during the instillation of the eye block was the experience of one participant and this strategy needs to be further explored for incorporation into routine care, particularly necessary when previous experiences have been difficult.

The *historically located Self*, is a domain of the life world that was rarely addressed in the current published literature. This domain displayed its importance in the experience of participants who had undergone multiple episodes of surgery. When previous experiences had been good participants were less fearful when further surgery was required. However, when past experiences had been painful or problematic participants brought the memory of the experience to each episode of care. These memories exerted an important negative influence. Whilst nurses cannot change past experiences they can give an understanding of patients' heightened anxieties. The day surgery environment that Benner (1994) identified as decontextualizing patients from their individual life world, offered very limited time for the preparation of people for surgery. The available time must address multiple patient needs to facilitate the transfer of care from the healthcare institution to the patient and family for self-care.

Self-care in the community had been known to be problematic across a range of surgical specialties (Costa 2001, Pavlin *et al.* 2002, Chanthong *et al.* 2009). The *Self located in the community* developed from identified participant difficulties following discharge from the day surgery unit. Difficulties included pain, PONV and psychological angst and were rarely addressed by the healthcare facility. Identification of specific deficits of care has become important in today's healthcare environment of day surgery.

The transition of many specialties to day surgery care has paradoxically both limited and expanded the sphere of healthcare responsibility. On one hand care it has been limited to the few short hours of the surgical event, and on the other hand a much broader implicit responsibility exists



that includes care well beyond discharge. The challenge to nurses will be to develop strategies that successfully prepare patients for surgery and self-care that are effective and easy to implement in the short available time frame. Failure to meet these responsibilities results in unmet patient needs and negative experiences.

### Conclusion

This research has laid an important foundation to the understanding of the needs of patients experiencing V-R day surgery. The identified complex needs of individuals should inform nurses planning V-R day surgery care with the potential to improve patient experiences. Pain management strategies that are successful and easy for patients to self-manage need to be urgently developed. Research aimed to explore interventions to meet the psychological needs of individuals experiencing V-R day surgery should become a priority.

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### Conflict of interest

No conflict of interest has been declared by the authors.

### Author contributions

CM was not only responsible for the study conception and design but also performed the data collection and data analysis. CM, AH and LK were responsible for the drafting of the manuscript. CM, AH and LK made critical revisions to the paper for important intellectual content. AH and LK supervised the study.

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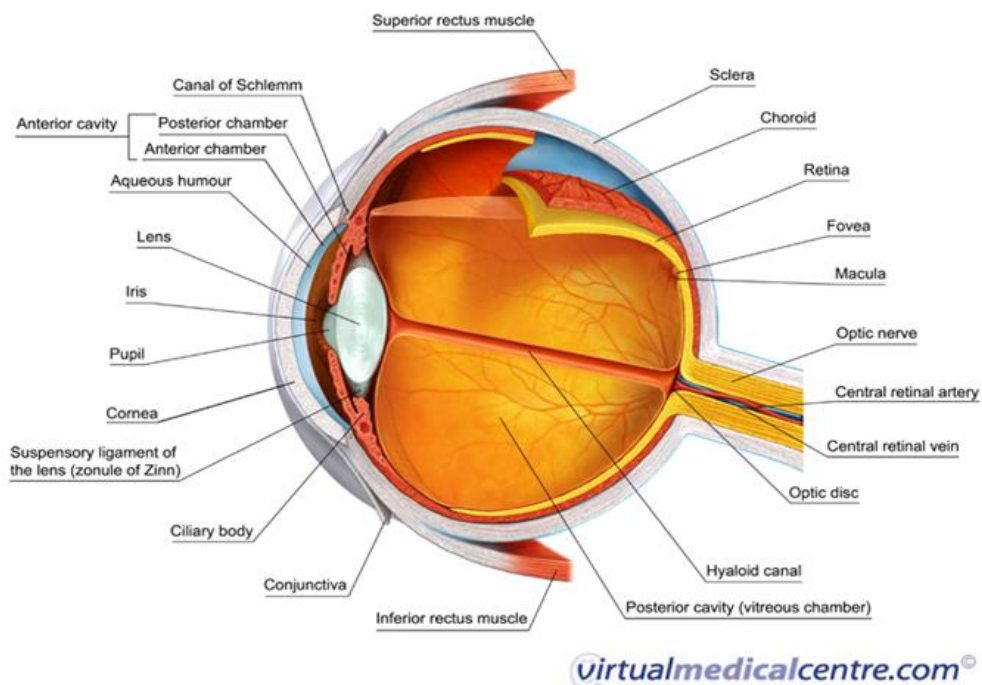
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## APPENDIX 9

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Ophthalmic Care is densely populated with terminology and procedures that are unfamiliar to many health care workers. With this in mind the following short definitions and descriptive diagrams will assist the reader to understand some of the most common conditions and treatment encountered within this study.

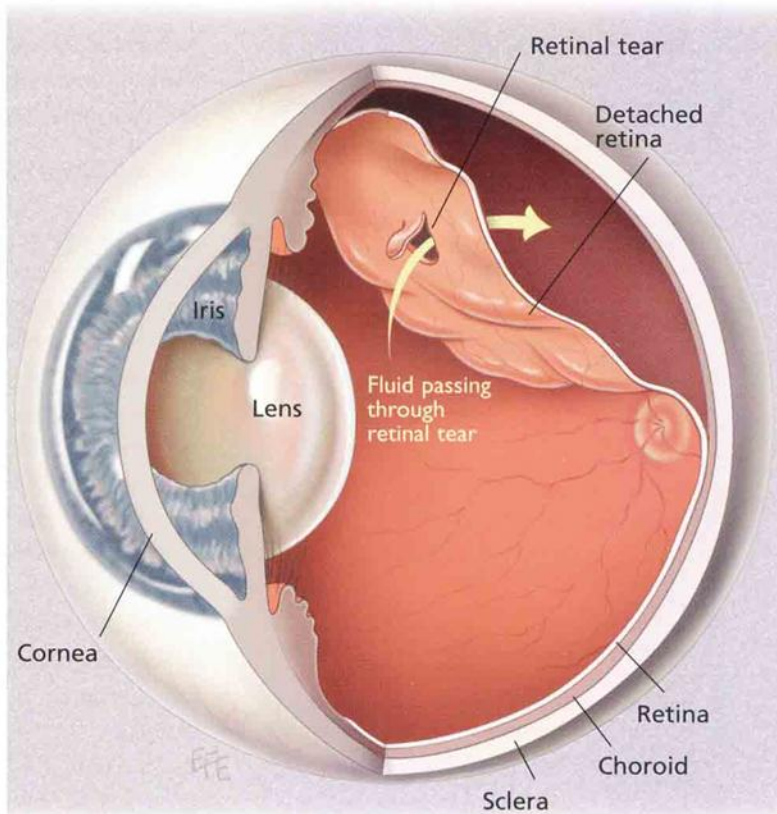
### Basic anatomy of the Human Eye



[HTTP://WWW.VIRTUALMEDICALCENTRE.COM/UPLOADS/VMC/DISEASEIMAGES/2133\\_EYE\\_ANATOMY\\_LABEL\\_V2\\_700.JPG](http://www.virtualmedicalcentre.com/uploads/vmc/diseaseimages/2133_eye_anatomy_label_v2_700.jpg)&IMGREFURL 31/01.13

### Retinal Detachment

Retinal detachment is a condition where the epithelial layer of the retina separates from the neural layers of the retina, as a result of either disease, ageing processes or trauma (Shaw et al. 2010). Retinal detachment may occur when the vitreous gel, a clear gel that fills two-thirds of the inside of the posterior segment of the eye, pulls loose or separates from its attachment to the retina, usually in the peripheral parts of the retina. Retinal detachment repair is an emergency procedure requiring either vitrectomy or scleral buckle or both.

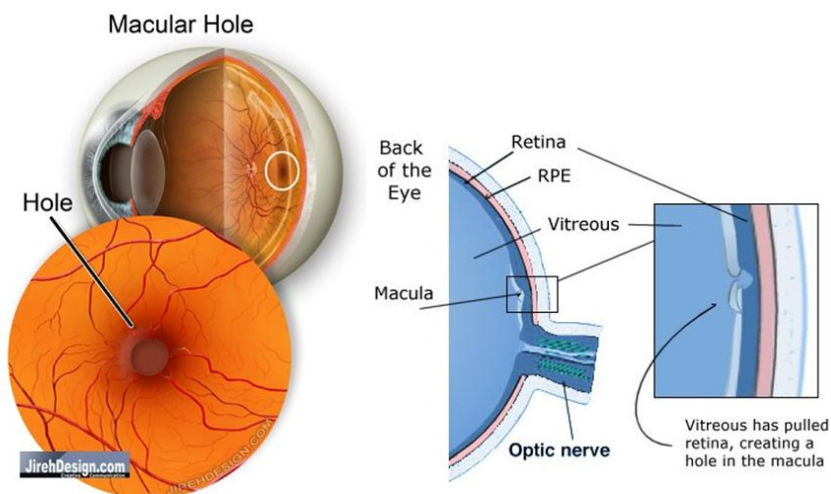


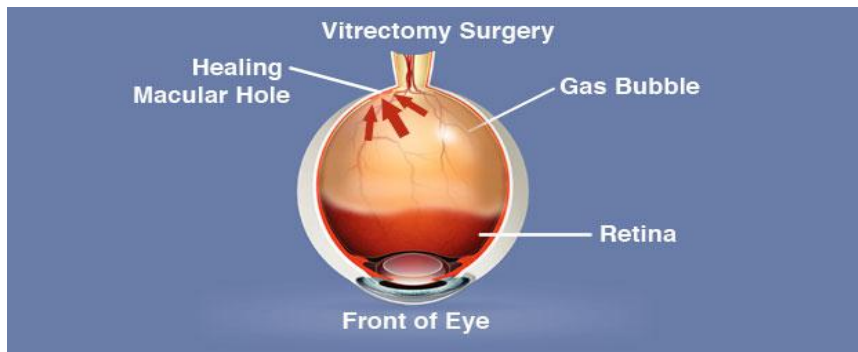
A retinal tear is a common cause of retinal detachment.

[HTTPS://WWW.RETINAL+DETACHMENT+OF+THE+EYE&BIW=1680&BIH=949&BAV=ON.2,OR.R\\_GC.R\\_PW.R\\_QF.&UM=1&IE=UTF-](https://www.retinadetachmentoftheeye.com/biw=1680&bih=949&ba=ON.2,OR.R_GC.R_PW.R_QF.&um=1&ie=utf-)

### Macular Hole

Macular Hole is a small break in the macula, located in the centre of the eye's light-sensitive tissue. A repair of Macular Hole consists of a vitrectomy followed by intra ocular tamponade with either an expansile gas or silicone oil. Macular hole repair is an elective procedure.



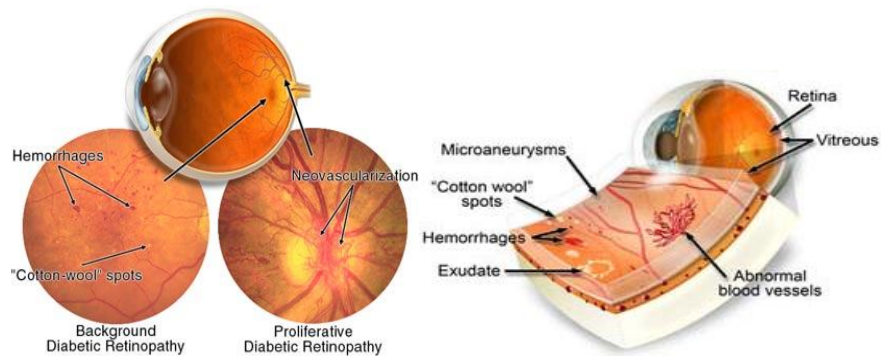


[HTTP://VIRGINIAOPHTHALMOLOGIST.COM/MACULAR-HOLE.HTML](http://virginiaophthalmologist.com/macular-hole.html)

[HTTP://CHICAGORETINAVITREOUS.COM/MACULAR-HOLE/TREATMENT](http://chicagoretinavitreous.com/macular-hole/treatment)

### Diabetic Retinopathy

Growth of abnormal vessels and fibrous tissues in the retina associated with Diabetes mellitus. Diabetic retinopathy frequently leads to hemorrhage and traction detachments that require vitrectomy for repair



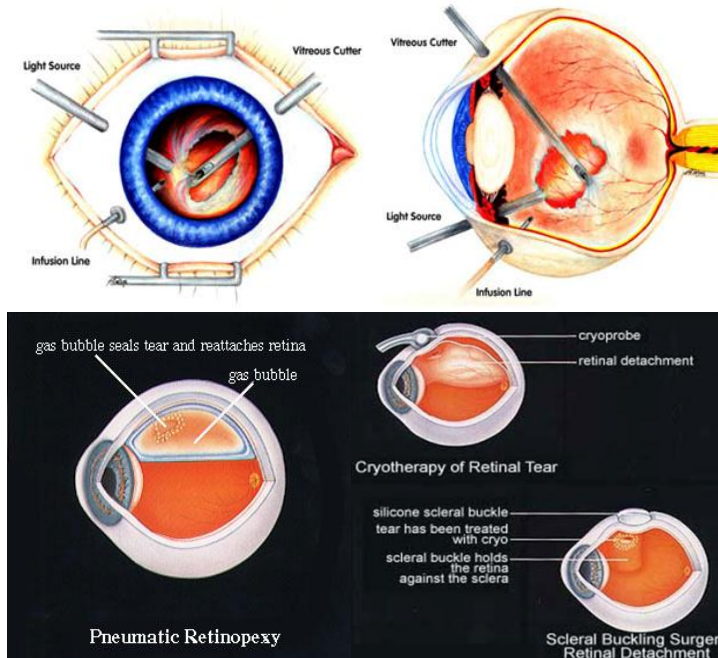
[HTTP://WWW.DRPETERMACKEN.COM/DIABETIC.HTML](http://www.drpetermacken.com/diabetic.html)



## Surgical procedures to treat vitreo-retinal conditions

### Vitrectomy

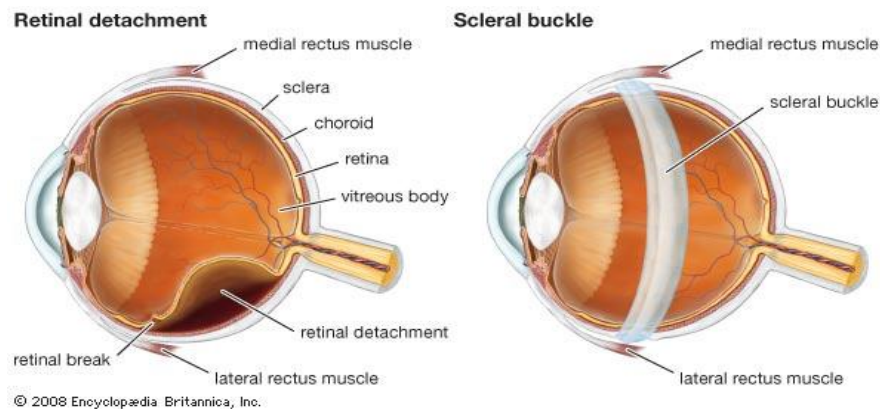
A Surgical procedure for the removal of vitreous, blood or membranes via small ports at the par planar site. An infusion line maintains the shape and pressure within the eye, whilst a fiber optic light facilitates view of the structures which are manipulated by instruments such as a vitrector.



[HTTP://WWW.EYECENTEROFTEXAS.COM/RETINAL-TEARS-DETACHMENT](http://www.eyecenteroftexas.com/retinal-tears-detachment)

### Scleral Buckle

Surgical procedure to repair a retinal detachment by indenting or 'buckling' the sclera inwards facilitating reattachment of the retina with the choroid.



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[HTTP://WWW.EYEMDLINK.COM/EYEPROCEDURE.ASP?EYEPROCEDUREID=52](http://www.eyemlink.com/eyeprocure.asp?eyeprocureid=52)

## APPENDIX 10

Theory	Internal criteria	External criteria	Summary
Acute pain management (Good 1998).	<p><b>Clarity:</b> There is clarity in terms used, and definition of the major concept that of a 'balance between analgesia and side effects' (Moore 2013)</p> <p><b>Consistency:</b> there is consistency between propositions and concepts and definitions such as pain management strategies.</p> <p><b>Adequacy:</b> Whilst this theory is comprehensive for inpatient pain management it fails to address issues of self-care and self-managed pain for day case patients.</p> <p><b>Logical development:</b> The theory systematically develops from established knowledge relating to effects of analgesia and pathophysiological responses.</p> <p><b>Level of theory development:</b> This theory has been tested using high level quantitative methods. There are limitations to the development in that aspects such as culture, gender, and patient decision making are not well developed</p>	<p><b>Reality convergence:</b> This theory is based on the reality as identified by nurses caring for people in acute pain. It does not explicate the reality of people in acute pain in the self-care recovery period.</p> <p><b>Utility: Pain</b> is a common phenomenon in nursing care. Whilst this tested theory has clear application in the acute care inpatient setting, its utility in the outpatient self-care patient group has not been established</p> <p><b>Significance:</b> Significance of this theory is relative to the sphere of clinical practice.</p> <p><b>Discrimination:</b> clearly identified the relationship between analgesia and side effect. However is limited in application to settings where, children, self-care or chronic pain management strategies are required.</p> <p><b>Scope of theory:</b> satisfies the criteria of middle level theory, but as such is not applicable in all aspects of pain management</p> <p><b>Complexity:</b> whilst the theory adds clarity to the balance between analgesia and side effects it does not take into consideration the many other variables of pain perception and management. Such variable include non-pharmacological activities and issues that influence perception of pain such as culture and gender.</p>	<p>This is a clear and well supported theory for the management of acute pain in the inpatient setting of adult patients. However it is limited in application and does not address the needs of people during the self-care period following day surgery.</p>
Lenz et al's (Lenz et al. 1997). Unpleasant symptoms theory	<p><b>Clarity:</b> The constructs of this theory are clearly described and include Physiological, psychological and situation factor that influence the experience of unpleasant symptoms</p> <p><b>Consistency:</b> The key concepts are used consistently throughout theory making this theory readily testable.</p> <p><b>Adequacy:</b> intent of this theory was to enable nurses to understand all unpleasant symptoms and how to manage them. As such it exhibits a broad level of abstraction consistent with high level middle range theory. As such its specificity is diminished.</p> <p><b>Logical development:</b> this theory builds upon previous work on symptom management and understanding and leads to a wider understanding of the factors that influence the experience of unpleasant symptoms.</p> <p><b>Level of theory development:</b> whilst not addressing all the issues in nursing, this theory provides clear constructs for research and practice that are testable.</p>	<p><b>Reality convergence:</b> The complex and comprehensive nature of this theory resonates and provides insight into real experiences.</p> <p><b>Utility:</b> Whilst this theory has been considered as useful for explain both chronic and acute unpleasant symptoms, there is an underlying illness assumption rather than a wellness one. As such there is an underlying belief in the nurse manager and rescuer role rather than an empowered patient who is both controller and arbitrator of their condition and management.</p> <p><b>Significance:</b> This theory adds to the dimensions of unpleasant symptom which can be researched which leads to deeper understanding.</p> <p><b>Discrimination:</b> Has been considered as less discriminatory due to the broadness of the concepts addressed.</p> <p><b>Scope of theory:</b> This theory provides a framework for the study of symptoms either singularly or within a multifaceted experience. However the emphasis is on researcher choice of examination not what is important and meaningful to patients.</p> <p><b>Complexity:</b> The theory has the capacity to encompass very complex situations, however, specificity is lost when using less sensitive theories to understand and manage individual issues.</p>	<p>This is a complex and reasonably comprehensive theory in the understanding and management of unpleasant symptoms. However, the broader abstraction of the theory limits the sensitivity to individual symptom issues particularly when the holistic experience is complex and multifaceted.</p>

<p>Resilience (Rutter 1985).</p>	<p><b>Clarity:</b> There is complexity and divergence in the concepts of this theory. Protective factors and outcome factors are clearly described.  <b>Consistency:</b> Whilst there has been some inconsistency in the display of the constructs of this theory, recent analysis of the theory has provided conceptual clarity in this evolving theory.  <b>Adequacy:</b> this theory is grounded in contextual experiences from a wide variety of clinical sources  <b>Logical development:</b> Through cyclical research processes that included quantitative and qualitative methods the constructs and model of this theory continue to evolve  <b>Level of theory development:</b> This is an emerging middle range nursing theory</p>	<p><b>Reality convergence:</b> the real world of participants can be clearly viewed through the concepts of resilience.  <b>Utility:</b> generally used to describe the psychological adaptation of children or adolescence it is now being used for wider purposes including studies of physiological adversity  <b>Significance:</b> this theory offers an opportunity for nurses to develop strength based interventions as opposed to deficit models of understanding  <b>Discrimination:</b> The boundaries of this model are expanding  <b>Scope of theory:</b> whilst most applications of this theory have been limited to psychosocial aspects, there are wider physiological applications being increasingly reported.  <b>Complexity:</b> the complexity of this theory lends itself to a deeper understanding of nursing interventions beyond cause and effect.</p>	<p>This emerging theory has much to offer nurse researchers who wish to look beyond the deficit of care model of understanding to one which provides insight into the enhancement of individual strengths and potential for empowerment.</p>
<p>Uncertainty in illness (Mishel 1988).</p>	<p><b>Clarity:</b> two concepts of this theory are clearly defined, depending on the phase and trajectory of an illness.  <b>Consistency:</b> there is consistency in the display of the constructs of this theory and in the discussion of such constructs  <b>Adequacy:</b> This theory is based in the experiences and behaviours of patients when faced with uncertain health situations.  <b>Logical development:</b> This theory developed from early explorations of uncertainty to a useful model for understanding the needs of individuals in uncertain situations  <b>Level of theory development:</b> This theory has been widely utilised by clinicians to understand patient's families and illness situations.</p>	<p><b>Reality convergence:</b> This theory is based on the real life experiences of patients and resonates with clinical insights.  <b>Utility:</b> This theory has been used in many research activities that investigate a wide range of patient illness and situations)  <b>Significance:</b> Use of this theory to underpin interventions may facilitate positive patient adaptation to an illness (Mishel and Clayton 2008)  <b>Discrimination:</b> This theory is not clearly discriminatory as it has been successfully utilised to understand patient experiences from a broad range of clinical setting  <b>Scope of theory:</b> This theory has the capacity to provide insight in to singular heat events or to widely complex health situations  <b>Complexity:</b> Whilst relatively complex in the theoretical constructs, the clearly described major themes assists with applicability of this theory to patient experiences.</p>	<p>This theory has been successfully utilised across a broad range of clinical situations. It offers opportunity to look beyond the obvious aspects of an illness situation and develop a deeper insight into the decision making process or support patients utilise when faced with an illness of uncertain consequences or duration.</p>

**Table 8.1. Summary critique of four middle range nursing theories ( Moore 2013; Richardson 2002; Smith & Liehr 2008; Peterson & Bredow 2013) Moore, S 2013, 'Analysis of Theories: Pain: A balance between analgesia and side effects', in S Peterson & T Bredow (eds), *Middle Range Theories: Application to Nursing Research*, Third edn, Wolters Kluwer, Lippincott Williams & Wilkins, Philadelphia, pp. 306-7.**



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