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**BECOMING BETTER BUT DIFFERENT:**

**A GROUNDED THEORY OF WOMEN'S  
RECOVERY FROM HYSTERECTOMY  
FOLLOWING EARLY DISCHARGE FROM  
HOSPITAL.**

**A thesis presented in partial fulfilment of the  
requirements for the degree of Master of Philosophy at  
Massey University.**

**Glennis Birks  
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## ABSTRACT

The purpose of this grounded theory study was to identify, describe, and generate a theoretical explanation of the experiences of women following early discharge from hospital, as they recovered from hysterectomy. Ten women participated in the study and provided the major source of data. The women, who had undergone surgery within the previous twelve months and who were discharged within five days of having surgery, were interviewed up to three times at four to eight week intervals.

Constant comparative analysis of the data eventuated in the identification of a core category, 'becoming better but different'. This is the process engaged in by women following early discharge from hospital in order to recover from the surgery and feel improved health and a sense of transformation. To accomplish this, the women actively sought to regain control of their lives and their bodies following early discharge from hospital. They felt personally responsible for their recovery and actively participated in making it happen. It is through becoming better but different that women achieve a sense of closure or recovery from the experience of having a hysterectomy. It is a multifaceted process and includes the intertwined and simultaneously occurring phases of 'assimilation', 'achieving harmony', and 'repaterning'.

The process of becoming better but different is proposed as a possible conceptual model for nursing practice and emphasises the need the women in this study felt to be 'done with' and not 'done to'. Understanding of this process by nurses will enhance the way nurses prepare women for discharge from hospital and provide care following discharge after hysterectomy. Knowledge of the process of becoming better but different may provide the opportunity for creative ways of practising and may provide the means of defining and making nursing practice visible. The consequent implications for practice, education, and research are discussed.

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# CHAPTER ONE

## INTRODUCTION AND OVERVIEW

Is early discharge from hospital a problem for patients and their families? Is recovery from hysterectomy problematic for women when they are discharged early from hospital? This study identifies, describes, and generates a theoretical explanation of the experiences of women recovering from hysterectomy following early discharge from hospital.

### PURPOSE AND CONTEXT OF STUDY

Currently, health care costs are under scrutiny worldwide. Early discharge from hospital following surgery is one strategy being used in the attempt to control costs. It is now crucial that every service offered to a patient, including length of stay (LOS), be medically and economically justified (Lee, 1984). Short hospital stays have advantages and disadvantages in relation to both cost and quality. Advantages could include a potential to decrease iatrogenic problems and to return individuals sooner to their families as well as to reduce institutional health costs. Disadvantages could include the inability of the family/patient to cope with the more acutely ill person at home, family members losing time from employment and a lack of community care being available.

Hysterectomy is a very commonly performed operation in New Zealand and overseas. In 1992 there were approximately 6500 hysterectomies performed in New Zealand hospitals, including both public and private. The mean day stay for women following hysterectomy in 1992 was 5.2 days compared with a mean day stay of 9.6 days in 1984 (MOH, 1994 & 1986). There are reports in the international literature of vaginal hysterectomy being successfully performed as an outpatient procedure when patient screening procedures are used for eligibility (Moore, 1988). There has been much public debate and media attention paid to this policy of discharging patients from hospital early. Whilst it is immediately apparent that hospital stays are decreasing and women are being 'discharged early' following hysterectomy, the nursing and medical literature has contained little or no documentation of women's experiences of recovery from hysterectomy following early discharge from hospital. Much of the media attention has had negative connotations in relation to early discharge. There has been much attention paid to reduced quality of care and families'

inability to cope with sick family members. This study will address these issues from the perspective of the participants.

Although there was considerable research in the 1980's related to women's experience of having hysterectomies which attempted to dispel the myths surrounding the complications and problems which follow this procedure, there is still a body of anecdotal evidence and folklore which suggests that adjustment and recovery may be problematic. The stereotypic image of the post hysterectomy woman as portrayed by the nursing textbooks is of a woman who is likely to be depressed with a poor self-image and decreased sexual functioning. Research establishes that the majority of women do not experience these complications and demonstrates that most of these research studies deal with short-term recovery. This study seeks to avoid an 'a priori' perspective by using grounded theory methodology to generate data deemed pertinent by women experiencing recovery from hysterectomy following early discharge from hospital.

## **AIM OF THE STUDY**

The purpose of this study is to identify, describe and generate a conceptual explanation of the process of recovering from hysterectomy following early discharge from hospital.

## **SIGNIFICANCE OF THE STUDY**

Research has confirmed the significance of surgery in a person's life. As large numbers of women have hysterectomies each year it is almost inevitable that caring for hysterectomy patients becomes routine for many nurses. The decreasing length of stay in hospital for women undergoing hysterectomies decreases both their contact with nurses and the opportunities for discharge education and preparation. This study confirms the importance of accurate information and the importance of experiencing the type of hospitalisation expected as precursors to a more harmonious transition of the recovery period. This study also raises questions about the organisation of the delivery of nursing care to maximise the therapeutic relationship with each woman.

Most of the research to date has focused on the physical and psychological aspects of recovery, making it difficult to see how specific practices relate to overall patterns and

contexts of recovery. In addition, almost without exception, the research relating to recovery from hysterectomy and to early discharge has been conducted by North American and United Kingdom researchers in the context of their own countries. These reports are useful as guidelines for nursing practice but the generalisability of the findings to New Zealand is therefore limited. The present study has a broad focus, utilises a New Zealand setting and population and is particularly timely as funding to the health care sector continues to reduce and length of hospital stays continue to decrease. This study provides findings and information not available from other sources.

The theoretical orientation of grounded theory and symbolic interactionism, chosen for this study adds further significance to this particular research. A basic premise of symbolic interactionism is that for a behaviour to be understood it must be examined in interaction and within its natural setting so that shared meanings held by the participants can be illustrated (Chenitz & Swanson, 1986, p.6). This study explores the thoughts, beliefs, and feelings of women recovering from hysterectomy following early discharge from hospital and includes women who had hysterectomies only and women who had hysterectomies and bilateral salpingo-oophorectomies.

## **STUDY QUESTIONS**

Initially the study was guided by the following questions:

- What are the experiences of the woman recovering from hysterectomy following early discharge?
- What influences a woman's view of her recovery process?
- How does a woman determine her readiness for discharge from hospital?
- What sources of information are important to women in relation to early discharge and recovery?

As is consistent with grounded theory methodology, study questions were altered and new questions generated as data collection and analysis progressed, thus the direction of the study was further refined in process.

## STRUCTURE OF THE THESIS

The account of this research study and its theoretical outcome is divided into nine chapters. Following on from the general overview presented in Chapter One, Chapter Two discusses and critiques literature relevant to this study. Chapter Three begins with a discussion of the relevance of grounded theory methodology in addressing the questions posed, and then describes the use of grounded theory in this particular study by outlining the procedures followed. The ways in which credibility issues of the research were addressed, are then summarised.

Chapters Four to Eight present the theoretical outcome of the research. Chapter Four discusses the environment and background for hysterectomy and early discharge from hospital, thus providing a context within which to view the findings. Chapter Five presents a descriptive account of one woman's recovery from hysterectomy following early discharge from hospital. This chapter provides the reader with a picture of the continuity and connectedness between preadmission, hospitalisation, and recovery following early discharge. Chapters Six to Eight present the phases of the identified conceptual framework. Each chapter describes one phase of the process and includes a definition of the key concept, and excerpts from the data to describe both the phase and the process. Specifically, Chapter Six describes the process of *Assimilation*, Chapter Seven that of *Achieving Harmony*, and Chapter Eight the last phase of the process, *Repatterning*.

Chapter Nine concludes the thesis and provides an integration of the conceptual framework, ie. the process of *Becoming better but different*.

The implications for education and practice are discussed and limitations of the present study, together with directions for further research are identified.

## **CHAPTER TWO**

### **REVIEW OF THE RELEVANT LITERATURE**

This chapter reviews literature related to recovery from hysterectomy and early discharge from hospital. Previous studies have not combined the phenomenon of recovering from hysterectomy and early discharge from hospital nor had participants who included women having vaginal and abdominal hysterectomies and only hysterectomies and hysterectomies with bilateral salpingo-oophorectomies. It is argued that previous research presents one view of various aspects of recovering from hysterectomy or early discharge which, when seen in isolation, are very different to the way they would be recognised as part of the whole.

It is important to also acknowledge that research undertaken in the United Kingdom, North America, and elsewhere reflects not only different cultural and socioeconomic contexts but also different philosophical and clinical orientations. The extent to which findings from different studies may be generalised to the New Zealand situation, is limited by factors that make for different contexts, not always fully acknowledged in research reports. The review will begin with a discussion of the literature related to recovery from hysterectomy. This is followed by a review of the literature relating to early discharge and nursing interventions and therapeutics practised in relation to this. The review concludes with a discussion about the provision of support to patients discharged early and information related to Hormone Replacement Therapy.

### **RECOVERY FROM HYSTERECTOMY**

#### **Sources of Information for Women**

The literature which informs women and professional carers about recovery from hysterectomy is at times similar and at times oppositional. The women in this study often spoke about their doctors telling them that they would feel like "new women" following having a hysterectomy and a recovery period, the length and experience of which was somewhat vague. Six weeks was often mentioned as an appropriate length of recovery time but all the participants were assured that they would be treated as individuals and cared for appropriately according to their individual needs. The women all felt that the information and

care given by medical staff was comprehensive and individualistic, in relation to the surgery and the immediate recovery period, generally the six to eight week post - operative period.

The women in this study felt some ambivalence about the literature they had read. They had almost all read the book written by Coney & Potter (1990). This book about hysterectomy was written specifically as a handbook for women and in relation to the New Zealand context. It was based on a questionnaire the authors published in the *New Zealand Women's Weekly* in 1987 which elicited nine hundred and eighty-seven (987) responses. The purpose of the survey was to find out what women who have had a hysterectomy knew beforehand and what happened to them afterwards. From the results of this survey, the authors wrote the handbook for women which details the reasons hysterectomies are done, advises women on making the decision to have a hysterectomy, describes the surgical procedure, describes the women's responses relating to their feelings about hysterectomy, describes the expected recovery process and provides details of possible complications relating to the surgery and recovery from hysterectomy.

The handbook is well researched, written in language that is easily understood, and provides women with written information not readily available from other sources. Whilst some of the participants found the handbook a useful source of general information, the majority found that the book focused on negative aspects which either did not reflect their own experiences or did not provide enough detail about anything other than physical recovery and depression. Other participants found the handbook a useful resource to have on hand, as a quick reference, to show family and friends the descriptions and sketches relating to the type of hysterectomy they had undergone.

Other literature, like daily newspapers, radio and television programmes and women's magazine articles, whilst often providing useful information, sometimes left the women in this study feeling guilty about choosing to have a hysterectomy and left them feeling that they needed to justify their decision to have surgery. The growing body of literature which offers women alternatives to surgery and describes the medicalisation of menopause and women's health made the participants feel that they were in some way to blame for having surgery and that they hadn't taken sufficiently good care of themselves (Holmes, 1989; Dickson, 1990). The development of self-care notions in nursing and the humanistic and phenomenological philosophies of many nursing theorists (Paterson & Zderad, 1976; Watson, 1985, & Benner, 1984), are products of the individualism which underpin much of the current political thinking about health care in the Western World, including New Zealand (Holmes, 1992).

Essentially, the philosophy that 'you are what you make yourself' underpins the current health care philosophy in New Zealand and has been generally accepted readily by the nursing community. The women in this study blamed other women, particularly nurses, for negative information and perceptions about both the effects of having a hysterectomy and early discharge from hospital following surgery.

Felicity put it this way:

... I think women are unkind to other women..you know, there were certain of my friends that I didn't tell about having a hysterectomy beforehand because they'd have told me about some natural cure for my problems, something someone they knew had used and that someone was bound to be a lot worse off than me. It's as if what they think is the only right way... you know...and that this is somehow my fault and that if I was a better woman I'd be able to heal myself and that I'd have looked after myself better...

(Felicity, Interview One.)

This notion of blaming the victim is a common theme in nursing literature and in the popular press where the public are exhorted to take responsibility for their own health, to eat correctly, to exercise adequately, to avoid excesses of any type, and for women, to have regular cervical smears (Levine, 1989; Williams, 1989). Regular cervical smears are recommended in order to detect abnormal cervical cells which are graded in three levels ranging from Cervical Intraepithelial Neoplasia (CIN) one to three. Much of the popular and medical literature describes sexual activity at an early age and multiple sexual partners as two of the many factors which may contribute to the development of abnormal cervical cells. Most women in this study who were having hysterectomies as a result of abnormal cervical smears felt it necessary to clarify to the researcher that they weren't sexually promiscuous and that they were living in permanent relationships with one partner. This need to rationalise the advent of an abnormal cervical smear or the existence of "sinful cells" is described by Brown (1995). This is a newspaper article which describes the trauma of receiving an abnormal cervical smear result and the author captures the feelings of the women who participated in this study:- that they were somehow responsible for needing to have a hysterectomy.

Pamphlets and information sheets provided by hospitals and generally written by nursing staff were found by the participants to be inadequate and patronising. All participants were given a written sheet of instructions which told them what "not to do" in the immediate post-operative period following discharge from hospital. Most of the participants spoke about this written material as being a useful memento of the occasion but as not useful in relation to their recovery. Conversely, one of the participants found that she followed the instructions "to

the letter so that she couldn't be blamed if anything went wrong afterwards". Generally the participants found that the written literature available to them was inadequate because of its lack of specificity and personal relevance.

The inadequacy of information available for women having hysterectomy has been noted by many authors previously, and the women who participated in this study felt that the inadequacy of this information created dissonance between their expectations and reality. Most felt that this dissonance created a problem for them in their recovery as it took them longer to assimilate the experience, achieve a sense of harmony and repattern following early discharge after surgery. Webb & Wilson-Barnett (1983) published a two part paper which they hoped would assist nurses to develop education programmes which would dispel the pessimistic myths in relation to recovering from hysterectomy. Williams, Valderrama, Gloria, Pascoguin, Saavedra, De La Rama, Ferry, Abaguin, & Zaldivar (1988), describe the effects of preparation on women's post-operative self-care behaviours. They found that structured preoperative and intraoperative preparation improved the performance of self-care tasks in hospital and following discharge. Many authors have published handbooks for women relating to recovery from hysterectomy but these are only available to women if they purchase them or can borrow them from a friend or library. The participants in this study often accessed this type of information on the advice of their doctors and friends. (Morgan, 1980; Hayman, 1986; Dennerstein, Wood, & Burrows, 1989; Coney & Potter, 1990).

### **Other Sources of Information**

The literature available to women about recovery from hysterectomy still has a strong focus on complications likely to arise from having surgery. The most common complications cited are depression or psychologic complications, altered or declining sexuality, feeling older, osteoporosis, weight gain, and urinary disturbances. Whilst it is appropriate that women are given all information about possible complications in order that they may give informed consent for surgery, the women in this study would have preferred a realistic balance in the information they received. Platitudes about feeling like a "new woman" and a list of possible complications was insufficient. Rose said:

...when I look back on it I feel like a great weight has been lifted....I mean I know I was told that those things might not happen to me but I needed to know that they probably wouldn't and if they did they'd only be temporary. I mean I did feel a bit weepy when I was about five days but I did after my

babies too....it wasn't anything to do with mourning my womb. I think it happens after any big episode in your life....

(Rose, Interview 3).

This view is supported by the literature relating to recovery from hysterectomy. A study comparing rates of depression between women who had undergone hysterectomies and menopausal women did not demonstrate any differences in rates of depression between the two groups. The author also noted that depressive symptoms were only observed in recently menopausal women and were short-lived (Kritz-Silverstein, Wingard, Barrett-Connor, & Morton; 1994). Scriven & Chesterton (1994) & Webb (1986) found that women undergoing hysterectomy require sufficient and appropriate information to reduce their anxiety and aid their recovery. They suggested that professionals do not understand the role that appropriate information plays in allaying patient anxiety.

Gould & Wilson-Barnett (1985) compared the recovery of patients following hysterectomy and cardiac surgery in terms of psychological adjustment to the surgery and resumption of a wide range of activities within and outside the home, in addition to physical progress. They found that, on the whole, patients accepted the effects of hysterectomy and their own assessments of progress were favourable in comparison to recovery from cardiac surgery, which was more difficult and proceeded more slowly.

Cohen, Hollingsworth, & Rubin (1989) reviewed the psychological complications of hysterectomy. They found that while the picture of physiological complications has changed markedly over the last forty-five years in response to research findings and medical advances, there seems to have been little change in the perception and treatment of psychological complications. Medical and nursing textbooks remained close to the current research findings when citing physiological complications, their diagnosis and treatment. Those same texts however continued to cite very early studies linking hysterectomy and depression and this link is not supported by current research. The authors believe, as do the participants in this study, that there is a need for wider dissemination of current research findings and the elimination of older work that is no longer relevant. Whilst psychological complications may occur, the current research has established that the majority of women do not experience these complications. This is also supported by a study conducted by Webb & Wilson-Barnett (1983a) who found that the majority of women were glad to have had a hysterectomy and showed no adverse changes in self-concept.

Webb & Wilson-Barnett (1983b) describe how women's pessimistic beliefs in old wives tales and the effects of hysterectomies were modified as they experienced operation and recovery. The majority of their participants made a good recovery in health and activity terms according to their own assessments but found information provided by staff to be low in quality and quantity. The researchers recommend that practising nurses are aware of current research findings and prepare relevant and up to date information for patients and that they receive training in counselling and information giving so that this is done effectively.

The literature therefore conclusively supports that the majority of women, by their own assessment, make a good recovery from hysterectomy and are happy with their decision to have a hysterectomy. The literature also demonstrates that the information given to women regarding their recovery from hysterectomy is inadequate in both quality and quantity. There is no doubt that health services in New Zealand are dealing with issues that are much more complex than those of twenty years ago. Medical technology is advancing rapidly, clients are demanding a greater say in their treatment, and government moves are restricting budgets. One result of these changes is that clients are staying in hospital for decreasing periods following surgery and that these clients require a different type of community support and preparation for discharge from what they did previously.

## **EARLY DISCHARGE**

Length of stay in hospital is a major determinant of the cost of hospital care which, in turn, is the most expensive segment of the health care system. Length of stay is of concern to consumers because it can mean depriving patients of necessary care by premature discharge. In New Zealand patients are admitted to hospital under Diagnostic Related Groups (DRG) and public hospitals are funded according to the pre calculated length of stay per operation. The mean day stay for women following hystectomy was 4.7 days in 1994 in comparison with a mean day stay of 9.6 in 1984 (MOH, 1994). There are currently trials being undertaken for day-stay vaginal hysterectomies. The nursing literature has contained little documentation on the effects of decreasing length of hospital stay for clients. Most of the research documents the cost effectiveness of this as a management strategy and of nursing interventions being trialled with clients who are discharged early from hospital. Very few of these studies relate specifically to early discharge following hysterectomy.

Hackman, (1993) & Taylor, Goodman, & Luesley (1993) have looked at the effect of early discharge on clients and found that the majority of clients would prefer to be at home as soon

as possible but that early discharge places financial and emotional stress on family caregivers at times and results in the need for adequate preparation of family members for care of the family member. The effect of postpartum early discharge programmes have been well documented in the literature as has early discharge of low birth weight babies.

Reiner (1988) reports on a study of 41 women who were discharged within 24 hours of having vaginal hysterectomies. The research was carried out in Texas and the researcher found that the women were comfortable in their own surroundings and none were sorry that they had gone home early. None of the women suffered postoperative complications that could be attributed to early discharge from hospital and all the women were able to return to their work routine or normal activity much sooner than the usually expected four to six weeks. Follow-up on these women lasted for five months to one year and there was no evidence of long-term morbidity. The author notes that not all clients are candidates for this protocol and that they require careful screening and that an individualised follow-up programme needs to be instigated. Moore (1988) also reports on the feasibility and desirability for clients of vaginal hysterectomy as an outpatient procedure. She reports positive outcomes for patients as being able to recover in the comfort and privacy of their own homes. She also describes how extra effort must be made by the health care team to select appropriate clients, and to educate and counsel clients to prepare them for early discharge. Benefits are seen by the clients to be quality care and by the staff to be quality care at a lower cost.

Morgan, Paul, & Devlin (1987) describe the reduction of the mean stay (days) to 3.4 in Ireland following vaginal hysterectomy and notes that the women themselves choose when they leave hospital. In the absence of a domiciliary service, the women still choose to leave hospital early to recover in the comfort of their own homes. This study reflects more accurately the New Zealand situation where there is no domiciliary service for women discharged early following hysterectomy. If hospital costs are to be reduced further, it would seem evident that interventions will need to be put in place to manage the early discharge experience.

### **Managing Early Discharge by Clients**

When clients are admitted to hospital for elective surgery they have time to plan for the time away from home and work and to make arrangements for care following discharge from hospital. They also have time to become knowledgeable and assertive about their perioperative

and postoperative expectations. Consequently, it could be expected that clients would value consultative nursing care, family support and supportive home environments during their recovery.

Wright (1985) has studied women's perceptions of having a hysterectomy and found that the lack of compassion and reassurance from the nurses was a significant factor in the clients feeling out of control and lacking in confidence. Hall & Carty (1992), looked at women's experiences in an early discharge programme. The women managed their early discharge experience by taking control. Taking control of the experience was the key factor and women did this by taking control of all stages of the process - before admission, in hospital, and following discharge. Taking control was influenced by the women's beliefs about family and home; their personalities, eg. ability to accept help; and their available support. The women used a number of strategies to take control. They organised their requirements prior to admission to hospital, they adjusted their expectations to meet the reality of the experience, and they learned to trust their own abilities to manage self-care. Stanhope & Lancaster (1991) and Clinch (1994) also link a healthy recovery with enabling people to increase their own control over their own health transitions.

Schumacher & Meleis (1994) & Chick & Meleis (1986) define transition as a movement from one state, condition or place to another. The concept of transition is therefore a central one in relation to women's recovery from hysterectomy following early discharge from hospital. A prominent concern in the literature has been the transition from hospital to the home environment (Brooten et al., 1988; Chielens & Herrick, 1990; Howard-Glenn, 1992). Other transitions that have been addressed in the literature are home follow-up care for clients and models to increase continuity of care across the health care system. Wide variation occurs among individuals and families in transition and nurses need to be able to capture this variation if they are to understand the transition experience of individual clients. Schumacher & Meleis (1994) have identified meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being as being the most important factors influencing transitions. The authors identify three nursing interventions as being widely applicable to therapeutic intervention during transitions. These are assessment of readiness, preparation for transition, and role supplementation. Programmes designed by nurses to enhance the transition to self-care and control following early discharge could help prevent negative health outcomes.

## **Nursing Interventions for Early Discharge**

When a successful recovery is occurring following early discharge from hospital, it can be expected that clients would express feelings of well-being, would cope effectively and feel a sense of integrity and empowerment. Nursing interventions to assist clients prepare for and assist during recovery should be aimed at promoting feelings of well-being, personal control and integrity.

Preparation for surgery and recovery has been widely discussed in the literature. Education is seen to be the primary modality for creating optimal conditions in preparation for surgery, early discharge and recovery. Approaches to education have been described by many authors including Dulaney, Crawford & Turner (1990); Fleming (1992); Howard-Glenn (1992); Kane (1992); Vezeau & Hallsten (1987) and Wong (1991). Adequate preparation requires that sufficient time is allowed for the assumption and implementation of new skills. Meeting the continuing needs of patients in the era of early discharge practice means that often nurses and clients do not have sufficient time to address specific education requirements of clients and families. Oermann (1994) addresses this issue and believes that trends towards shorter hospital stays mean that nurses need to be more flexible and focused in the delivery of client education programmes.

Brooten et al (1988) designed a model to discharge patients early from the hospital by substituting a portion of hospital care with a comprehensive programme of transitional home follow-up by nurse specialists. The model provides a framework for examining the quality of care as reflected in patient outcomes and the cost of care in providing transitional home follow-up services to specific patient groups. They report that the model is an approach to early discharge and follow-up care that is valued by patients and is cost effective. Similar findings were reported by Haddock (1994) who found that patients who were involved in collaborative discharge planning had shorter hospital stays and felt more satisfied and less anxious about discharge and subsequent recovery.

McIntosh & Worley (1994) found that telephone follow-up and aftercare groups eased the patient's transition from hospital to home and provided a feedback loop to the nursing staff on discharge planning. This model provided consistency of nursing staff and meant that nurses involved in the care of patients in hospital were also involved in their aftercare. This had the added advantage of nurses having currency and relevancy in relation to patients postoperative preparation needs. Burden (1992) believes that post discharge follow-up

telephone contact is an integral part of nursing care. It allows the nurse to assess the patient's level of recuperation and evaluate the care provided. Besides completing the nursing process, there are a number of indicators that this contact is a nursing obligation. These include compliance with standards of care, improvement of quality of care, and reduction of a facility's liability exposure. These calls also demonstrate a sense of caring about patients and help the nurse to develop a sense of professionalism and increased job satisfaction.

Conversely Daly (1992) found that maintaining routine discharge planning for women with hysterectomy for benign reasons was appropriate for maintaining quality of care. This means that this intervention is both cost effective and realistic to complete for patients undergoing a short hospital stay. Despite these conflicting views, it is evident that client and nurse satisfaction with the short stay encounter, is enhanced by consistent and ongoing contact with one another. If demands to further reduce costs and increase efficiency continue, then it will be essential for New Zealand nurses to develop models of postdischarge care along the lines suggested by the previous research findings. The development of these models will need to reflect client needs based on current research and be relevant to the New Zealand context if patients recovery following early discharge from hospital is to be enhanced.

Currently, the routine postdischarge programme in New Zealand for women discharged early from hospital is a visit to their doctor six weeks following surgery. They are told to ring the hospital unit or their own doctors, should problems arise before that visit. Some General Practitioners visit their patients whilst they are in hospital and after they are discharged and others have their Practice Nurses phone to maintain contact and demonstrate caring. Some surgeons telephone women after they are discharged from hospital also to ascertain their progress. These postoperative interventions are haphazard and if all clients are to benefit from appropriate aftercare there is an urgent need for collaborative models of transition care to be developed. There is one group of women who often require more specific aftercare following early discharge after hysterectomy. These are the women who have bilateral oophorectomies with hysterectomy and undergo surgical menopause, often ten to fifteen years earlier than their natural menopause would have occurred. These women then need to decide whether to take Hormone Replacement Therapy.

## **HORMONE REPLACEMENT THERAPY**

Hormone Replacement Therapy (HRT) is usually recommended for premenopausal women who have lost their ovaries, unless there is a contradiction, e.g. endometriosis, ovarian cancer

which are aggravated by oestrogen. Historically, HRT was only oestrogen but because unopposed oestrogen was found to cause increased rates of endometrial cancer, progestin was added. Whilst women who have had hysterectomies cannot get endometrial cancer, some medical research demonstrates that progestin may decrease the risk of breast cancer and other medical research indicates that progestin may increase the risk of breast cancer. HRT is often recommended for premenopausal women because it is believed to help prevent osteoporosis, prevents the symptoms of menopause, which may include hot flushes, sweats, dry vagina and decreased sexuality. It is also believed that HRT may help protect women against cardiovascular disease (Seeley, 1992; Wise Budoff, 1984).

When making a choice as to whether to take HRT, women have to decide between the supposed advantages and the unknown individual risks of the medication. They have to decide whether to prevent the symptoms of menopause with the possible attendant risks of weight gain, headaches, irritability, breast lumps, thrush, and worsening of diabetic conditions. These are some of the documented side effects of HRT for some women and alongside these, women who have had hysterectomies need to decide the length of time they will take HRT, knowing that menopausal symptoms will occur when they cease taking the medication. How do women who have had hysterectomies and are facing early menopause make a decision about HRT when faced with such diametrically opposed perspectives?

The women's and the popular literature essentially takes the view that menopause is a disease and that medical scientists, the drug industry and the media have created a major industry, known as the menopause industry (Coney, 1993; Klein & Dumble, 1994). Voda (1994) states that the definition of menopause as a disease, or an endocrinopathy, has its origins in patriarchal views and beliefs about the normal life processes of women as being imperfect, or being likened to machines that need to be fixed. This view of menopause has overshadowed the concept of menopause as a normal biological event and resulted in increased pressure on healthy women to take steroid hormones. This has legitimated, and thus condoned, the use of risk/benefit criteria normally used to assess risk versus harm in sick people. The use of these criteria assumes that acceptable risks for the sick are acceptable risks for healthy, well women. This research does not however consider the feelings or concerns of women facing a surgical or induced menopause and whilst the process of menopause is a natural biological event, the sudden onset of menopause in a thirty-five year old woman who has had her ovaries removed is not taken into account.

Caldwell (1994) has researched what effect physical activity has as an alternative for women not wishing to take HRT but having symptoms of menopause as a result of hysterectomy. The author reasoned that physical activity, given its beneficial effects on bone density, cardiovascular status, and depressive symptoms, might be a safe alternative to HRT. They found that as leisure activity increased the number of menopausal symptoms decreased. Libov (1995) describes an exercise programme as the 'miracle' replacement for Hormone Replacement Therapy and bases her claims on multi-site research completed at various women's clinics in U.S.A. These programmes need further research in New Zealand to evaluate their acceptability and effectiveness for women but offer exciting alternatives. It is important that nurses are aware of the current research in this area so that they can provide up-to-date information for women to assist them make an informed choice about HRT and in order that they may develop appropriate programmes for women who choose not to take HRT.

## **SUMMARY**

Evidence is mounting that hysterectomy does not create the problems for women that are commonly espoused in the popular literature. Research demonstrates that the majority of women would make the same decision again, given the circumstances that led to their original choice. Despite popular opinion that early discharge from hospital creates stress for families and patients, the research demonstrates that patients would prefer to leave hospital as early as possible to recover in the comfort and privacy of their own homes. There is dissatisfaction though, with the quality and quantity of information provided by nurses to help women and families prepare for their recovery from hysterectomy following early discharge from hospital.

Evidence from the international literature supports the development of programmes for discharge planning and postdischarge interventions, including those in relation to Hormone Replacement Therapy. Limitations evident in the available research include the scarcity of research addressing women's experiences and requirements in their recovery from hysterectomy following early discharge in New Zealand. The present study addresses these gaps and the result is an identification, description, and theoretical explanation of women's recovery from hysterectomy following early discharge from hospital in New Zealand.

## **CHAPTER THREE**

### **RESEARCH DESIGN, METHODOLOGY, AND ANALYSIS**

The purpose of the present study was to identify, describe and generate a theoretical explanation of the process of recovery from hysterectomy following early discharge from hospital. This chapter sets the context and background of the present study by presenting a rationale for the chosen research design, detailing specific methodology and describing the process of data analysis. The relevance of grounded theory for this study will be discussed in the first section and the methodology of grounded theory as used in this study will be addressed next. Data analysis will be described and the chapter concludes with consideration of issues relating to the credibility of grounded theory and the manner in which these were addressed in this study.

#### **RESEARCH DESIGN**

The selection of a research design reflects the researcher's view of the world of nursing practice and the relationship between client and nurse (Moccia, 1988). The qualitative paradigm is consistent with an open system view in which people exist in constant and mutual interaction with their environment and with the belief that the subjective experiences of the participants contributes to scientific knowledge (Leininger, 1985). Researchers with such a world view will frequently ask the type of question(s) which are most appropriately answered by qualitative research designs.

Much of the previous research has been of a quantitative and hypothesis testing nature. While rapidly growing in number, the gaps identified in the literature are related to explication of the way in which clients understand and create meaning from the experience of recovery from surgery following early discharge from hospital. Because social phenomena are complicated they require the complexity of a conceptually dense grounded theory to account for the wide variations of the phenomena being studied (Strauss, 1990).

Grounded theory is derived from symbolic interactionism (Blumer, 1969). It was developed by Glaser and Strauss (1967), as a rigorous and orderly research process for the collection and analysis of qualitative data. Grounded theory is a strategy by which a conceptual

framework, designed to describe and explain a social process, is discovered from data systematically obtained and analysed (Strauss & Corbin, 1990). The strategy, and the theory it generates, identifies concepts which are connected by statements of relationships that describe and interpret events and behaviour in a particular group of people. Without grounding the emerging theory in the data, knowledge remains speculative and ineffective (Strauss, 1990).

The qualitative holistic approach of grounded theory serves as a valuable heuristic tool in understanding and explaining human experience as it is lived, especially those subjective phenomena that can only be interpreted through the eyes of the beholder and those in which the whole is more than the sum of its parts

(Stern & Pyles, 1985, p.3).

Grounded theory is also appropriate for this study because of its commitment to leaving open the definition of the problem and understanding the perspective of the people involved, as well as its propensity to take a "moving picture of processes as they vary under different conditions and interact with other variables" (Mullen & Reynolds, 1978, p. 281). Grounded theory studies what is, works to explain variations in behaviour, and predicts what can occur when conditions change (Wilson, 1985).

Symbolic interactionism, from which grounded theory is derived, is a social theory about human behaviour which focuses on the meaning of events to people in everyday life and makes the assumption that the individual achieves a sense of self through interaction. The human being is viewed as an active participant, not merely a responding one. It is the human being's ability to "hold a concept of self...and for self interaction that is the basis for the formulation meaning and experience in the world" (Chenitz & Swanson, 1986, p.5).

There are several important ways in which grounded theory differs from other research methodologies. Strauss (1990) identifies these as: the conceptual framework is generated from the data rather than from previous studies; the researcher attempts to discover one or more dominant processes in the social scene rather than describing the unit under study; every piece of data is compared with every other piece, rather than comparing totals of indices; and finally, data collection is modified in light of developing theory.

Strauss (1990) says:

So, it is not really a specific method or technique. Rather it is a style of doing qualitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making

of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density.

(Strauss, 1990, p. 5)

In line with these guidelines, the present study was designed as a fieldwork study which used several methods to describe and explain the experience of women as they recover from hysterectomy following early discharge from hospital. A detailed description of the conduct of the study and the specific methods used follows.

## **METHODOLOGY**

In this section the study setting, access to the field, participant selection, ethical considerations, data collection methods, and the profile of study participants will be discussed. The study design is qualitative and adheres to the grounded theory methods of data collection and analysis. Such an approach "studies the phenomena from the perspective of the subjects and within the context in which they occur" (Roberts & Burke, 1989, p.166). Grounded theory was chosen in order to answer the general question "what is happening here?" or more specifically, "what happens for women following hysterectomy when they are discharged early from hospital?" The strength of this inductive method of research lies in the fact that data emerge to generate the theory and not the reverse (Morse, 1989).

### The Setting for the Study

The setting chosen for this study was the community of women in New Zealand who had hysterectomies within the previous twelve months and had been discharged early from hospital. In order not to narrow the sample to one particular context and to provide an opportunity for theoretical sampling of both urban and rural populations, participants were selected for their location within the central North Island. Participants were chosen deliberately in this way as categorical development is much slower on a single terrain and different groups help generate categories by highlighting similarities and differences (Glaser & Strauss, 1967).

## Access to the Field

To ensure, as far as possible, that this study was well understood and the researcher accepted into the setting, a number of steps were taken prior to data collection.

The researcher spoke to several women's groups (formal and informal) in different locations to describe the aims and intent of the study and to invite participation. Notices were placed in Health Clinics and formal letters were sent to other women's organisations describing the study and inviting responses. Women were invited to either telephone or write to the researcher for more detailed information.

## Participant Selection

Participants were selected using the following criteria:

- women who had undergone hysterectomy within the previous twelve months
- women who had been discharged from hospital/health care facility within five days of surgery
- women with no comorbid condition or complication
- women with a good command of the English language.

Of the forty-five women who responded, twenty were eliminated because of geographical location and five were eliminated because they did not meet inclusion criteria. The remaining twenty were visited by the researcher in order to provide further explanation of the study and to obtain informed consent. Seven of these women decided not to participate because of their time commitments. It was felt by the researcher that two of the women would be caused increased stress due to already difficult circumstances so they did not become participants. The final group thus consisted of eleven women who agreed to participate. No attempt was made to control for type of hysterectomy, age, marital status, private or public care or sexual preference.

Written details of the proposed research (Appendix 1) were left with the women, as were copies of the consent forms (Appendix 2). Midway through the data collection, one of the participants went overseas for an extended holiday so only data collected until that time was

used. When the woman returned from overseas, she became one of the group of participants to review the emerging theory. This made a total of ten participants.

### Ethical Considerations

During all interactions with people involved in this study it was made clear that it was the researcher's intention to observe the recovery process of the women and not to interfere with or alter events in any way. In this sense, the study carried no risks for the participants. The presence of the researcher could however have resulted in additional stress for the women. Attempts to minimise this consisted of a familiarisation contact prior to initiation of data collection and supportive discussions during and after contact.

A full explanation of the nature and purpose of the study was given to all potential participants. Informed consent forms were signed by all participants and they were informed that consent to participate was ongoing and that they had the right to postpone or terminate participation at any time. Because qualitative research is a constantly changing process, unforeseen events and consequences are always possible so facilitation, negotiation, and renegotiation are essential to protect the participants' privacy, anonymity, and risk of harm.

In consenting to be part of the study, participants agreed that tape recording was the main means of data collection as it was necessary for accurate recording of information. Participants were assured that the tape recorder could be turned off at any time and that data could be erased at their request. Participants were also assured that:

- All data would be collected, transcribed, and analysed by the researcher.
- Data would be secured in a safe location.
- Identifying names would be removed and pseudonyms used if desired. Two of the participants chose to use their own names.
- Neither identifying details nor participants names would be used in publications or reports.
- Recorded interviews would be erased following the analysis of data.

Interviews were arranged at a time and place that was mutually acceptable to both researcher and participant. The essential concern here was to protect the participant's privacy. During data collection the researcher was aware that increased self-awareness could cause women to question the quality of the care they had received and their personal ability to cope with their

recovery. A debriefing time was therefore built into each session to share any concerns. Where necessary, participants were informed how they could access advocacy services to address their concerns.

### Data Collection Methods

As with accepted views within grounded theory (Conner, 1988), every attempt was made to develop a relationship with participants that was characterised by mutual respect and concern for the participants wellbeing. There was also a concern for power sharing in the research process and the avoidance of the imposition of the researcher's views on the participants. The research was also guided by a view of knowledge as both useful and empowering for both the researcher and the participants.

Although grounded theory research attempts to limit the influence of prior knowledge and experience of the phenomena being studied, Glaser & Strauss (1967) believe that once immersed in the data collection, the researcher cannot remain a passive receiver of impressions. The researcher became engaged in the research process as a whole person, thus experiences as a nurse, educator and woman were shared with the participants and their questions about the researcher's experiences were answered. A context of reciprocity was created by freely sharing information.

Each of the participants was asked to take part in up to three interviews following the one for consent. The first was conducted within two weeks of contact and was for the purpose of exploring the women's knowledge, thoughts, beliefs, expectations, and attitudes about recovering from hysterectomy following early discharge from hospital. Subsequent interviews were conducted at four to eight week intervals. Participants entered the research process at differing times, from two days to eight months following surgery. The recovery period was followed for up to eighteen months following surgery. Interviews ranged from sixty to ninety minutes in length and were conducted until theoretical saturation was achieved and little new information came from the interviews.

The primary aim was to capture information in the participant's own words. For this reason a semi structured interview format was used. The women themselves chose the nature and direction of the discussion for the most part, thus each person provided information in an individual way. This sense of the uniqueness of the experience became apparent when three of the women who had initially requested a group interview subsequently requested

individual interviews so "that I can explain myself properly without offending anyone else" (Paula, Field Notes). Unscheduled and unstructured interviews also took place with most women when they rang the researcher to report on their progress and ask questions about comments they had heard from other people or about their progress. These unscheduled interviews were not recorded on tape but were written in note form by the researcher and served the purpose of maintaining open communication and continued participants involvement in the research process.

All the women had agreed to the researcher's presence during their recovery process and five invited her to be present during the medical review six weeks post operatively. The researcher's role was negotiated individually with each woman and her doctor. In reality, this role varied from a high level of psychological support to the woman, to only providing intermittent support. Some information and clarification of events was provided in all cases. Such participation is in keeping with the grounded theory research design. Neither the researcher nor the women felt that this resulted in any taking over of the post operative care of the women. The result was approximately nine hours of participant observation where the primary focus was on the context of the situation at the time and the woman's experience of the care she received. The original intention of writing field notes throughout the observation periods was abandoned as it was both impractical and interfered with the spontaneity of interaction between the researcher and the study participants. Instead, field notes were recorded immediately after the observation periods and interviews.

Field notes and transcripts were made available to participants prior to subsequent interviews to validate the sequence of events and the context of recovery and care. Participants were offered the opportunity to delete, rephrase or add to any of their own data. During the time of the study, informal discussions with nurses, nursing students, doctors, and women recovering and recovered from hysterectomy were also held and provided contextual and validating information, as did the literature. The researcher's experience as a nurse, nurse educator and woman were considered important in sensitising the researcher to issues in the area of women recovering from hysterectomy following early discharge from hospital. The usefulness of previous experience in a variety of contexts is confirmed by Strauss (1986: 11) when he states that, rather than ignoring personal experience as biasing the research endeavour, it should be mined and serve as an explicit control over the researcher's biases.

## Profile of Study Participants

Of the ten participating women, four had hysterectomies only and six had hysterectomies and bilateral salpingo- oophorectomies. Three of the women had vaginal hysterectomies and the remainder had abdominal hysterectomies. Two of the women self identified as Welsh, three as Maori, and five as New Zealanders. Ages ranged from mid thirties to fifty and eight lived in urban areas and two in rural. All the women lived in permanent relationships and eight had children. Two of the participants had wanted more children prior to having the surgery. All the participants were employed in either full or part-time positions. Two were self-employed and three were health professionals. Six of the participants had their surgery in a public hospital and four in a private hospital. All postoperative checks were completed by the surgeons.

## **DATA ANALYSIS**

This section examines the constant comparative method of data analysis as it was applied in this study. Data collection and analysis occurred simultaneously with the researcher continually checking new data against what was emerging. Whilst data analysis is here presented in a linear fashion, several processes were in operation at the same time. Phases of analysis included:

- coding of two interview transcripts for women who were not participants in the study. This served the purpose of familiarising the researcher with coding methods.
- line by line analysis and coding of first interviews of the women, with the use of the participants words where possible to ensure the theory would be grounded in the data.
- returning to previously coded transcripts whenever a new code emerged.
- categorising the data and coding of field notes as they were generated.
- use of NUDIST (Non-numerical Unstructured Data Indexing, Searching and Theorising) computer programme to compare, contrast and verify codes and categories identified by researcher.
- coding and categorising of data from second and third interviews.
- collapsing of all data into conceptual categories.
- selective sampling of the literature and data.
- concept development and integration of data.

- search for core category.

As ongoing interviews took place in conjunction with this process of analysis, they were also used as a time to validate emerging codes and categories with participants. Interviews were scheduled at four to eight week intervals, and were organised to suit participant availability and to allow the researcher time to reflect on and work with the data.

### Coding

The initial analysis involved line by line examination of the data and the application of a code name that symbolised a process or event in that slice of data. Codes were therefore grounded in the data and named and described the data from which they were derived. This "microscopic analysis" (Cowley, 1991) resulted in forty two codes, some examples of which are:- 'expected length of hospital stay', 'assistants at home', 'freedom', 'control', 'back to normal', 'different'. Data pertinent to each code were transcribed onto sort sheets and a text search was done with the computer programme NUDIST to check that all occurrences within the transcripts had been retrieved.

Coding is recommended as being central to the analysis and may be defined as a "general term for conceptualising data and includes asking questions and giving provisional answers about categories and their relations. It is a term for any product of analysis, whether a category or a relation among two or more categories" (Strauss, 1990, p.20). The substantive codes were grouped together and with further analysis theoretical codes were developed. For example, within the theoretical code 'Assuming control' the original substantive codes were 'managing at home', 'return to work', 'moods', 'Hormone Replacement Therapy', 'sexuality', 'menopause symptoms'. As analysis proceeded, theoretical codes seemed to cluster together naturally into categories.

### Categorising

Category development served to move the analysis a further analytical step. Glaser (1978) commented that categories and their characteristics or properties are conceptual codes that serve as a midpoint between data and theory development. For example, one category, 'Assimilation', incorporated the theoretical codes of 'taking responsibility', 'assuming control', 'being informed', 'attitudes', 'tangible improvement', and 'feeling back to normal'.

As the categories emerged, the data were re examined for the purpose of fully describing the category and to search for any instances of variation within the category. Category was compared with category, participant with participant and groups of participants, and participants with categories in order to establish the relationships between and among them. This process resulted in the categories of 'Assimilation', 'Achieving Harmony', and 'Repatterning'.

Once these categories were identified it became necessary to link them together in order to characterise the process of recovery from hysterectomy for women who are discharged early from hospital. The computer programme NUDIST was used to check for further examples of the codes and the participants scrutinised the categories for meaningfulness to themselves. Whilst the programme, NUDIST, was used to support analytical activities it was not used to provide a graphic representation of the relationships between codes and categories as this was felt to distance the researcher from the data by decontextualising them. Meaning was sacrificed when the data were taken out of context and the frequency of occurrence of concepts was identified and not their meaning. Taft (1993) noted similar concerns when differentiating between mechanical and conceptual activities in qualitative analysis and discussing the interplay between them.

Data analysis was a continuous process and critical reflection and scrutiny of the data was ongoing during the writing phase. Memos were used constantly to record ideas, hunches, recurring themes and questions. Memos were the researcher's record of the analytical process (Corbin, 1986). Methodological memos assisted the researcher to clarify issues related to the research process and theoretical memos were used in relationship to the analytical processes. Categories were also judged according to the two criteria proposed by Catanzaro (1988), ie. the extent to which the data placed in the category fit together in a meaningful way, and the extent to which differences among the categories are clear.

Data reduction inevitably occurs in the process of analysis but this reduction resulted in a more coherent picture and served to eliminate data that was meaningful but only marginally related to the emerging theory. Selective sampling of the literature and a return to the data was necessary at this point to compare and contrast emerging concepts with previously researched concepts. In this way the centrality of the concepts was confirmed. All the women could identify with the emerging theory and some asked questions which helped the researcher clarify those aspects which were unclear. Throughout the analysis, the objective was to discover the core category. This is the term used by Glaser (1978) to refer to the category

which accounts for most of the variation in the pattern of behaviour and which helps to integrate other categories.

### Emergence of Core Category

Glaser (1978) suggests that certain criteria should be used as the basis for judgement of identification of the core category. The category must be central and it must recur frequently in the data. It should relate meaningfully and easily with other categories and account for a large portion of variation in the pattern of behaviour. The core category needs to be completely variable as it has many and diverse relationships with other categories and is also a dimension of the problem and can be any kind of theoretical code. A Basic Social Process (BSP) is one type of core category and is distinguished by its identity as a process. A BSP has clear emergent phases and it changes and moves over time. The phases differentiate and account for the variations in the problematic pattern of behaviour and the BSP is stable and durable over time, but can also account for change over time.

During the process of data collection there was intense reflection, close interaction with the data, conceptual mapping (Artenian, 1982), and continuing attempts to explicate main themes that described the processes occurring in the data. Initially "getting back to normal" was considered as a core category but did not "fit" all the data and did not explain the constantly occurring themes of "better" and "different" in the data. It also implied no change which was inconsistent with the data. Finally the process of **becoming better but different** was identified as the core category. It became apparent that generation of a theoretical framework about women recovering from hysterectomy following early discharge revolved around this process.

## **TRUSTWORTHINESS OF THE STUDY**

Measures which were taken during the research process to ensure what Lincoln & Guba (1985) refer to as the "trustworthiness" of the data will be outlined using the criteria of credibility, transferability, dependability, and fittingness (Catanzaro, 1988; Sandelowski, 1986).

Credibility is achieved when the participants recognise the description or findings as being applicable to themselves, or when another researcher recognises the description or

interpretation as being faithful to the data. Credibility is enhanced when the researcher spends sufficient time in the field to be able to place the 'analysis and interpretation of data in context'. Persistent observation increases the depth of data collected and decreases the possibility of the participants 'putting on a front' (Catanzaro, 1988).

In this study, measures to ensure the criteria of credibility were met, included lengthy periods of observation and the use of multiple sources of data. Participants were asked for similar kinds of information and all interview data were transcribed verbatim. Returning to the participants at intervals throughout the process of data collection and analysis clarified the meaning of emerging codes and categories and ensured that the participants recognised the findings as being applicable to themselves and as being faithful to the data. Followup interviews with a selection of participants, and one participant who had gone overseas midway through the data collection, after the completion of data analysis assisted in the descriptions and interpretations being true to the data. Several women, including a researcher, who had previously had hysterectomies and who were not participants recognised the findings as being applicable to themselves.

Transferability is said to occur when the researcher leaves clear explanations of the strategies which were used in the research process. Explanation is such that a clear 'decision trail' is left which would allow another researcher to follow the research design and arrive at similar conclusions. In this study the processes for data collection and analysis have been described in detail to meet the criterion of transferability.

The criterion of dependability, met through an inquiry audit, was addressed throughout the entire research process. As this study was undertaken as partial fulfilment of a university degree, the researcher met regularly with a supervisor, who, in effect, audited the research process from the beginning to its completion.

The criterion of fittingness was met partially by the methodology chosen as the processes followed in grounded theory ensure that the findings derive from the data. The findings were also presented to a group of women who were not participants and they were able to identify with them. This meets the criterion of fittingness as findings can be applied to an outside situation which is different to the original research setting.

Qualitative research is considered rigorous and "confirmability is achieved when auditability, truth value, and applicability are established" (Sandelowski, 1986, p.33). Truth value and

applicability of the study was enhanced by checking that data were clearly illustrated in the coding categories; by checking that descriptions, explanations, or theories about the data contained the typical and atypical descriptions; by deliberately trying to discount or refute a conclusion drawn about the data; and by obtaining validation from the participants themselves (Miles & Huberman, 1984).

## **CONCLUSION**

This chapter has detailed the specific methodology used in the data collection and analysis in this study. Subsequent chapters present the findings of the study and culminate in the presentation of a grounded theory of women's recovery from hysterectomy following early discharge from hospital.

## CHAPTER FOUR

### THE CONTEXT

This chapter provides a picture of the context and background within which early discharge from hospital following hysterectomy occurred for the women in this study. It thus provides a context within which to view the findings. The chapter describes the period of time from when a woman seeks or receives medical advice related to having a hysterectomy to the point when she is discharged from hospital. Each woman begins this particular experience with a rich personal history of knowledge, experiences, expectations, and hopes that will influence what happens in the ensuing period. The aim of this chapter is to describe the personal and social context of the process of having a hysterectomy followed by early discharge from hospital.

### PERSONAL HISTORY

For many women, having a hysterectomy is their first experience of surgery, and apart from childbirth, their first experience in hospital. All, however, come with feelings of vulnerability and anxiety, along with a picture of what the experience of having a hysterectomy might be like.

Women in this study came to the experience of having a hysterectomy with a long history of menstrual problems and anaemia or a short history of having an abnormal cervical smear. Those with a long history talked about having tried all sorts of treatments to improve the menstrual problems. They had been put on oral contraceptives, hormone treatments, iron tablets, pain relief, and medication to reduce heavy bleeding. The women themselves had tried naturopathic remedies and improving their general fitness and wellness by attending to their diets and their physical fitness in the belief that this might help them. Doctors offered these women the choice of having a hysterectomy quite early in the treatment process but the women themselves made the decision about whether to have the surgery and when to have it. They did not feel "pressured" to have surgery and felt that they were in control of making that decision. They all felt that they had been fully informed by their doctors and were supported by their doctors in whatever decision they made. As Margaret said:

...The gynaecologist put no pressure on me at all and said that if I could live with my problems she could. She told me that I would know if the time was right for me...

(Margaret, Interview One)

The women who had abnormal cervical smears felt that events moved very rapidly for them. They had a routine smear, were telephoned to say that they needed to see their General Practitioners, who told them about the result of their smears and then explained to them in detail about what would happen for them. This group of women speak about their doctors as being "compassionate and caring" and felt that they had been given all the information they needed to make an informed choice about their future treatment. They were then referred to gynaecologists of their own choice who repeated their cervical smears and outlined options about their future treatment. Whilst these women felt that they were fully informed, they all felt that they weren't in control at this point, that events moved too fast for them. As Lois said:

...I felt beforehand that it went too fast..going to see my GP., going to see the specialist..and bang I was on the theatre table. I was only worried that I was having something done that might not really be necessary. I made a point of speaking to the specialist about it....one minute I've got some spotting and an abnormal smear and bang..I'm having a hysterectomy. But a five minute chat and I felt okay about it..in control ..you know...

(Lois, Interview One)

All the women in this study described making the choice to have a hysterectomy as a feeling of not having any other option. They all reached a point of feeling that they had "no choice" about having surgery. Women with severe menorrhagia or menstrual pain felt that they "couldn't stand it any more". Margaret explains it like this:

I was fed up with it. I'd had enough of it. Look, I was sick of trying all these other things to try and get rid of the pain and heavy bleeding..I had really had enough of it. I don't feel guilty at all now because I've never felt better for years...

(Margaret, Interview One)

Other participants, who had abnormal smears, felt that they had no choice either, but not because they were told that by their medical practitioners. This group felt that they were taking a personal risk and jeopardising their families if they didn't have a hysterectomy.

They felt that the other treatments offered them did not provide any "guarantee" that they wouldn't need a hysterectomy at a later date.

Lois explains it thus:

...As far as I was concerned, if there was any question of it being malignant, then out it came so I could get on with my life. I didn't want that hanging over me any more...

(Lois, Interview One)

Katherine describes her feelings of having no personal choice about having a hysterectomy. She felt her whole life was so adversely affected by her symptoms that she couldn't continue like that any more. She said:

...I had no choice. Because endometriosis isn't life-threatening, no-one is saying to you that you've got to have this because you're going to die so it's still a choice thing medically..but..it wasn't a personal choice any more...my life was just a misery and I felt so awful a lot of the time. It was affecting everything, work, family, my husband and mostly I didn't like me any more..I always seemed to be ..I don't know..um..less than whole...

(Katherine, Interview One)

The women all describe a sense of relief and a belief that it was the right thing to do when they had made the decision to have a hysterectomy. Six of the participants said that they had delayed having surgery because they were afraid of having an anaesthetic. The thought of the surgery and of any post-operative pain was accepted as part of the process but the thought of losing control when anaesthetised was frightening for them. As one participant said:

I wasn't afraid of having surgery. I just hated the thought of the lack of control with a general anaesthetic. When my doctor told me I could have an epidural I felt so relieved..

(Felicity, Interview One)

The women all went to considerable effort to prepare themselves for the event of surgery and discharge from hospital. They spoke to women who had had hysterectomies, they read books, and they organised their families, their work lives and their social lives as part of their planning. Many of them went to aerobics and fitness workouts so that they would be "in better shape for surgery". They all expressed the desire that they wanted to do their part and take responsibility for their recovery after surgery. They all had the expectation that the health professionals would "do their bit" and they hoped that they themselves would "do well".

They wanted to do everything "right" so that they would get better and many mentioned that they didn't want to be a nuisance to anyone or to feel dependent on anyone, particularly when they were in hospital. The women all believed that the surgical procedure and care following this would be in the hands of "professionals" and that they themselves would do everything they could to assist, including being physically fit and having the right attitude. As one said:

...Look, they do this all the time..how many operations do they do a year..I just had to make sure that I did my bit...

(Margaret, Interview One)

All the women spoke of this as an intensely personal experience and one which was uniquely their own. They felt supported and cared for by their families, partners and friends but felt it was their own decision and responsibility to organise their own recovery. None of the participants took their partners with them to their medical consultations despite being offered the opportunity. The women talked about this as being their own decision to make and of their wish to make it independently. The doctors prepared them for what they could expect in relation to hospitalisation and discharge and the women prepared themselves and their significant others accordingly. It wasn't that they wanted to exclude their significant others, but that they all felt it was their own decision. As Rose says:

...It's not that it wasn't important to him. It's just that I thought it was more important to me..like I'd put up with absolute misery for years..sure the family had suffered too but it was different for them...it was like...it was my decision to do it and to make it better for me and them. They were all marvellous and supported me...

(Rose, Interview One)

This seemed to be related to the feeling of responsibility the women all felt about their own health. They all spoke about feeling responsible for what happened to them, including making excuses for the care that nurses, doctors or significant others might fail to provide. Felicity spoke about this very succinctly when she talked about it being her responsibility to ensure that she ate properly, exercised and generally "looked after herself". She believed that she couldn't do anything more to improve the gynaecological problems that she had, so that hysterectomy was the best choice but it was her responsibility to ensure that she and the family were physically and emotionally prepared. She said:

...I couldn't do anything more ...I was sick of it all. Deciding to have a hysterectomy is one of the best things I've done. Having decided to have it, it

was up to me to find out everything I could and get myself and the family well prepared...you know physically and mentally, and organised...

(Felicity, Interview One)

The women in this study believed and expected that the professional people, the doctors and nurses, would provide them with the care that they required throughout this event and that the rest was their own responsibility. Having made the decision to have a hysterectomy, the woman will be admitted to a public or private hospital for surgery after a waiting time, and she will then learn to negotiate the social context of having a hysterectomy and being discharged early from hospital.

## THE SOCIAL CONTEXT

Six of the participants in this study had their surgery performed at a public facility and four at a private. There was very little difference between the two in the pre-operative preparation for surgery, some major differences in the perioperative period, and again very little difference in the post-operative period and preparation for discharge from hospital.

When the decision to have surgery in a public hospital is made, prospective patients are put onto a waiting list. The women in this study had a maximum of six weeks wait until they were "called up" for surgery. They then went to a preadmission clinic at the hospital in the week prior to having surgery where they were examined and tested by an anaesthetic team and were admitted to hospital the evening or morning before surgery. Those public hospitals which differed admitted the women twenty four hours prior to surgery to carry out the pre-operative tests. Whichever occurred, the women were "surprised" at having to tell their stories to so many people.

...It's like, you know..the surgeon knew why I was there. Why did everyone, you know, different nurses and doctors, have to ask me the same questions again..I mean he'd [gynaecologist] already examined me and everything. Everyone on different shifts and in different parts of the hospital seem to go over the same thing again and again...

(Bet, Interview One)

Those women who chose private hospitals "chose" a time for surgery that was mutually convenient for themselves and the surgeon. The maximum waiting period was three weeks. They then had an anaesthetist's assessment and were admitted to hospital the evening prior to surgery. These women were not questioned or examined again in relation to the surgery they

were having, only in relation to fitness for anaesthesia. Private hospitals do not have the same medical and nursing hierarchy which public hospitals have so there were no "surprises" for these participants about the number of people who asked them questions or wanted to know their story:

...It was really good. I just made an appointment which suited both of us and he [anaesthetist] told me about what to expect..he took tests first..and then told me when to go in...

( Rose, Interview 1 )

All of the women commented on the fact that when they were admitted to hospital they had only ever previously met the surgeon, and sometimes the anaesthetist, so on admission to hospital, on the day before or the day of their surgery, they had to establish relationships with many different people. The only constant professional person in their experience to date was the surgeon. If they were in a private hospital they had met the anaesthetist already. There had been no opportunity for the nurses or any of the women to share their histories and to learn something about each other before they were admitted to hospital. This is reflective of the hospital system and means that the first time the woman meets the nurse who will care for her, is on admission to the ward. There is also a strong possibility that the nurse's patient load and/or shift will change over the next twenty four hours. This creates less than ideal circumstances to establish a therapeutic relationship. A nurse/ patient relationship is a very intimate one and with shortened hospital stays, both prior to and after surgery, there is only a short time to "get it right". The women who participated in this study did not feel that their relationships with nurses were therapeutic. They saw their doctors as their primary care providers and nurses were not significant in their surgery or their recovery. As Lois said:

...The nurses were like a series of..um.. one night stands. I didn't have a lasting affair with any of them. The relationships didn't develop into anything ..um of depth...You see it was different with the doctors..my GP. and Specialist I mean. We developed a history if you like, we shared the drama, the ups and downs,..the whole thing..the before, the middle, the after. It's hard to explain really. You must think I sound daft...

(Lois, Interview One )

The participants all spoke about this fragmentation of nursing care which currently exists for both clients and nurses within surgical units. They also felt disillusioned by the discrepancies between their expectations and the realities of hospitalisation.

## THE EXPECTATION AND THE REALITY

The reality of the immediate post-operative period was very different from what the women expected in the main. Seven of the participants in this study felt that the experience left them feeling disillusioned with the hospital system generally and with nurses in particular. Whilst these women were unhappy with the nursing care they received, they still made excuses for the nursing staff - "They were so busy" or "She was an agency nurse so you couldn't expect her to know what I expected" -were common comments of those women in public hospitals. Their major complaints related to the administration of pain relief, being understood, and being in control of their own recovery.

Pain relief was a major issue for these women. They thought that the nurses did not believe they were in pain and excused this by detailing how busy they were and describing the number of patients they had to care for. Lois described her expectation of "wonderful" pain relief with an epidural and how the reality was quite different for her. She had asked for the rate of her epidural infusion to be increased:

...I asked and she said no..no, she never said no..she said "I'll come back" and then she would go away and not come back. I finally decided to ring the bell at about 3am and I thought "I've had this"....The bell didn't work so someone else rang for me. When she came in I told her "I want you to turn the infusion rate up and I want you to do it now. "I got a bit stropky but I knew the doctor had said it could go up to 13 and it was on 5. I went back to sleep and then I woke in a sweat and in pain and it was turned down again. I rang the bell, or my neighbour did, again and told her to turn it up again and not to touch me or it until the morning when I could talk to my doctor. I slept again until six o'clock when some goon came in and asked me if I wanted to wash my face. I tell you, I couldn't wait to get out of there...

(Lois, Interview One)

It was a common story that nurses were reluctant or too busy to administer adequate pain relief, despite this having been prescribed by the doctors. One woman described how she had taken a nurse to the hospital pharmacy to check out her own pain relief and another, Katherine, said:

...Nursing staff seem to have an allergy. They seem to think that you'll get hooked on two paracetamol...they would say things like "You

should be off that by now". The doctors didn't though because they had seen my operation and knew what I had been through...

(Katherine, Interview One)

Some of the women believed that pain was to be expected and compared it very favourably with the pain they had experienced in childbirth. Others thought that they were at fault. Felicity described it thus:

...I think perhaps I may have a low pain threshold...

(Felicity, Interview One)

The six women who went into public hospitals also complained that the nurses didn't understand what they were feeling and consequently didn't support them through the surgical experience. Some of these women believed that it would be good if nursing staff could be on the receiving end and then they would understand what it is like to be a patient. Others thought that it was because the nurses were women. Katherine said:

...You need to be understood and I think that women dealing with women aren't very understanding and I can't understand that. On the other hand, I can't speak highly enough of the doctors. I think there is probably a breakdown in the communication between the doctors and nurses. I think that if the nurses listened to the doctors and realised that each patient is a unique person and that they treated them like an individual and not like a number..then I wouldn't have felt like a nuisance because I didn't do it right...you know..I wasn't the same as everyone else...

(Katherine, Interview One)

The women in private hospitals felt that they received very "good" postoperative care. They recall being virtually pain free and feeling like guests in an hotel. Nothing was too much trouble for anyone, they had their own rooms and felt cherished and cared for. The women in public hospitals did not share this feeling of being cared for:

...You need more than just someone coming to you every four hours. You need a relative or someone there to pour you a drink 'cos you can't get to it. You need somebody to comb your hair, those little things that make you feel nice and that's what they don't seem to have time to do...

(Bet, Interview One)

The women generally felt that their major support group within the hospital, apart from the medical staff, was other patients:

...You get about 70% of your support in hospital from the other patients, especially those in the same room. They look out for you, you know...they see things like when your drip has run out and your catheter bag needs emptying..you look after each other like that and support..you know...

(Katherine, Interview One)

All participants felt that it was important to retain control of their own recovery process and so deciding when they were ready to leave hospital was one of the first steps in regaining control of their own lives. This was their own decision following an explanation of what was considered an appropriate length stay. Many women said that the nurses seemed surprised when they told them that they were going home. All the participants were eager to leave hospital as soon as possible so that they could regain control of their lives and make their own decisions. They often asked to go home a day or two before the doctor had suggested their discharge. They all felt confident about going home and thought it was a "move in the right direction."

## CONCLUSION

This chapter has presented some of the historical and interactional issues that provide a context for women who are discharged early from hospital following a hysterectomy. Whilst this information was not strictly part of the research question, the women themselves felt it was necessary to provide this information as a backdrop for the understanding of their subsequent recovery. From this overall context, the next chapter details one woman's experience of her recovery following early discharge after a hysterectomy.

## CHAPTER FIVE

### ONE WOMAN'S STORY

This chapter describes one participant's experience of her experience of having and recovering from hysterectomy following early discharge from hospital. The researcher had the opportunity to be involved with her, in this process, for a year, in a way that is not usual for nurses who are involved in post operative care of clients. The opportunity for follow through does not exist for nurses employed in surgical units. Normally, clients undergoing surgery experience fragmented care from many different nurses and other care givers.

Ruth is a professional woman in her late forties who works in a full-time position. She is married with two adult children. Whilst her preoperative history and her hospitalisation did not occur within the framework of this study and the researcher did not participate in those parts of her experience, Ruth talked about them at length during the first interview. Events which occurred prior to her discharge from hospital had a significant effect on how she managed during the post operative period. These events are therefore discussed in the same detail that she used to describe them.

#### PRE OPERATIVE HISTORY

Ruth felt an abdominal mass four years prior to having surgery. She had begun to experience dysmenorrhoea after many years of "trouble free menstrual periods". Following consultation with her General Practitioner, a negative cervical smear, and an ultrasound which showed a bulky uterus and a mass consistent with a large fibroid, Ruth decided to take no further action. She decided this on the basis that "the period pain and heavier than normal periods were perfectly tolerable". A year later Ruth began to experience shortness of breath after "even moderate" exercise so decided that she needed to "get fit". Her first attempt at running saw her admitted to coronary care unit with a cardiac arrhythmia. She was found to be anaemic with a haemoglobin of ~80 and was prescribed a course of iron tablets. She "felt wonderful" after the course was completed so thereafter she took iron tablets if her haemoglobin fell below 110.

Ruth managed in this manner for another two years even as her periods became heavier and she was experiencing pressure on her bladder at times. She decided her symptoms were tolerable because "the thought of surgery was terrifying". She began to experience mid-cycle spotting so a cervical smear was repeated. It was negative so she again elected to do nothing. Her symptoms became progressively worse over the next six months and she then decided to see a gynaecologist. She agreed to have another ultrasound and a hysteroscopy. The ultrasound showed that the uterus was a little larger than previously but Ruth decided, in consultation with the gynaecologist, that if the hysteroscopy was clear then she would "hold off" with a hysterectomy until she "felt comfortable with the idea".

At this point, Ruth realised that her fear was related to having a general anaesthetic rather than having a hysterectomy. Having a hysteroscopy involved having a general anaesthetic so Ruth elected to have a hysterectomy with epidural anaesthesia. (Hysteroscopy is a very quick procedure so most anaesthetists feel that an epidural is not justified.) She was placed on a semi-urgent waiting list at a public hospital and was given a date for surgery which was three weeks later. At her pre-anaesthetic assessment she was assured by the anaesthetist that she would not be given a general anaesthetic, only a sedative and epidural anaesthesia, and that she would not be intubated. This was important to Ruth. Fear of intubation was a major element in her fear of general anaesthesia. She "hated the thought of losing control". This fear of losing control in relation to general anaesthesia was shared by nine of the ten participants in this study.

Ruth felt that she was well prepared for surgery and that she knew exactly what to expect. She describes her preparation:

...The gynaecologist explained everything. She explained the procedure fully. She mentioned that she occasionally had encountered problems with people suffering from endometriosis when she had been unable to preserve both the ovaries. She said that a patient only rarely lost both. She told me that the chance was remote in my case as I had no obvious signs of endometriosis...

(Interview One).

## HOSPITALISATION

Ruth was admitted to hospital the day prior to having surgery. She was given premedication and says that she felt "very sleepy" when the epidural was inserted in theatre. She remembers feeling relaxed, comfortable and extremely well supported. She says:

...I had total confidence in the team...

( Interview One)

At the end of the procedure Ruth was woken up and recalls that she didn't feel at all drowsy and insisted that she see her uterus. She remembers thinking:

...it seemed enormous...I feel completely comfortable with my decision to have it removed...

( Interview One)

It was at this point that the gynaecologist told Ruth that they had removed both her ovaries because she had severe endometriosis. She describes her feelings:

..it was a bit of a shock but I had been warned. It just didn't occur to me because I didn't think that I had any symptoms of endometriosis...

( Interview One)

She talks about feeling "reasonably philosophical" about it at the time because she knew that the surgeon had done everything possible to save one, if not both her ovaries. A friend of Ruth's was a nurse in theatre during her operation and confirmed that the surgeon had made every effort to save her ovaries and told Ruth how upset the surgeon was that they needed to be removed.

Ruth talks of a pain-free post operative period and believes that this was due to the epidural infusion. She says:

...36 hours later when my infusion ran out, I discovered that no-one on the ward was epidural certificated. I didn't want to lose the fantastic pain relief cover so I took the nurse to the dispensary and checked out my own epidural infusion.....I hate to think about the legality of it but the nurse was relatively junior and didn't dare question me. At the time that infusion was all that mattered...

( Interview One)

Ruth mobilised very early and doesn't recall having any problems during that initial post-operative period. She had refused to have a blood transfusion despite having had a large blood loss in theatre and a very low haemoglobin. She was supported by her surgeon and decided that since she would no longer be having heavy periods that her haemoglobin would soon correct itself. She went home three days after surgery.

## DISCHARGE PLANNING

Ruth felt that her surgeon had prepared her for discharge. She was told not to strain and to be "sensible" and she was told all the usual "prescriptive stuff" that has been written about post-operative activity. For example, the surgeon told her:

...you mustn't carry heavy things. All it really means is that instead of taking out a load of washing this big, you don't strain. Be guided by how you feel...

( Interview One)

Ruth spoke about driving her car quite comfortably within four days of discharge and how the surgeon assured her that she would feel uncomfortable and "pushed" if she overdid things. The surgeon reminded her that she had undergone major surgery and that she needed to rest "and that sort of thing" and checked that she had support at home when she decided to leave hospital early. She describes it thus:

..She asked about the home situation. I said that my husband had annual leave from work. She then asked if he would be good about the place and said that she didn't want me going home to do lots of things...

( Interview One)

Ruth then described feeling a lot better on discharge from hospital than she had after having her first baby and going home after having an episiotomy and feeling really sore still. She felt that there was nothing that she had to do and she didn't have a new baby to care for as she had after discharge with her first baby. Eight of the ten women in this study use having their first babies as a measuring stick for the experience of having a hysterectomy. Ruth talks about feeling really "good":

..I felt so good..you see there was nothing to do. The dust accumulated and I didn't mind at all...

(Interview One)

She also described how the surgeon explained in great detail about when to resume sexual activity and what difference having a hysterectomy might make to having an orgasm. The surgeon explained to Ruth that there was a possibility that she might bleed after ten to twelve days and described for her what quantity was acceptable in terms of how many pads she might use. She also discussed with her the possibility that she might feel tearful and advised her to have a box of tissues on hand. As Ruth says:

...I had good warning about the sort of things that could happen. I was well informed. I didn't anticipate any problems that I couldn't deal with...I knew where to go if I had any problems...

(Interview One)

Ruth knew that she could call her General Practitioner if she had any problems such as a "urinary tract infection" but thought that she would probably have rung the surgeon if it was before six weeks after surgery. The nursing staff didn't discuss her home situation with her or any practicalities related to discharge planning. They provided a booklet for women who had undergone hysterectomies but Ruth felt that it was somewhat "trite" and written by nurses who were obviously in "their twenties". For example:

...some of the things like...if you had a happy sex life before you had the operation there will be no reason for it to be any different. It didn't actually say very much about the things that I think people do want to know...people need to know that it may take a while to stretch back to normal size and things like that...

( Interview One )

Ruth had also prepared her family and organised the household for the period of hospitalisation and the time immediately following discharge. All participants spoke about planning and organising of their households in preparation for their time in hospital and for the time immediately following discharge. This included the women who had young children and those with adult families.

## MANAGING AFTER DISCHARGE

Ruth describes the period immediately following discharge as a time of actively regaining control and independence of the physical aspects of her life. She made decisions about what she should and shouldn't do according to whether she felt physical pain:

...just if it didn't hurt to do something. It was about physical pain....I just kept thinking..no, I've got a cut there and I'm not going to do anything to strain those tummy muscles like lifting boxes of wood or anything silly...

( Interview Two )

Her desire to take control and be independent as quickly as possible led to her incurring the wrath of her family for cleaning cobwebs from the ceiling on her second day at home. Ruth talks about the immediate physical recovery as being "no problem at all". She doesn't recall having any physical pain and only remembers once feeling that she'd "overdone it". She blamed herself for running around too much and believed that she should have "paced" herself better:

... I couldn't see any physiological reason to be that sick anyway. Before I had surgery I was scared I might not have a good pain tolerance and be a wimp so I was delighted when I was up and about and feeling so good...

( Interview One )

The researcher first interviewed Ruth when she was eight weeks post surgery and she was very positive and enthusiastic. She had just returned to full-time work and despite feeling a little tired, she thought that her life was "pretty much back to normal". She recalled that at three weeks after she was discharged she had a "really good hot flush" despite being on Hormone Replacement Therapy and remembers feeling very upset about that. At six weeks post-surgery she began having frequent hot flushes and was waking several times at night bathed in sweat so she went to her General Practitioner feeling:

...this is terrible. This is intolerable...

(Interview One)

Her doctor explained that it was just a matter of adjusting the dosage of her Hormone Replacement Therapy until the symptoms were under control. Ruth was aware of all the advantages and disadvantages of Hormone Replacement Therapy. She had read a lot of the current literature and felt that she had been well informed by her doctors. She believed that

she felt upset about the symptoms of menopause because they were out of her control. Once she had consulted her doctor and could manipulate the dosage of Hormone Replacement herself she felt that she was in control again.

She described a 4 kg weight gain as not being related to "hormones" but as a result of sitting around the house and eating foods that she wouldn't normally eat. She was looking forward to returning to the gym so that she could regain her previous level of physical fitness and weight when she was first interviewed. Ruth also recalled that she had a few days at approximately three weeks and when she had first returned to work when she was "weepy" and felt "a bit down". She describes it:

...I sat and reran all the old movies and felt a bit sad but I believe people do that after any kind of emotional life event anyway....I don't know that it's particularly related to hormone imbalance so much as...but it was not something I was going to indulge and wallow in...

(Interview One)

## RECOVERING

Ruth and the researcher spoke together for the second time when it was approximately fifteen weeks after her surgery. It was very noticeable to the researcher that Ruth appeared less enthusiastic and quieter than she had at the first interview. She talked about having her Hormone Replacement Therapy "sussed", about feeling very well physically but about not feeling the "same" as she had before surgery and she believed that the removal of her ovaries was affecting her a lot more than she had realised it would:

..it's not the same and I think that's something I really wasn't aware of...

(Interview Two)

It was as if Ruth was having a series of good days and bad days and she couldn't relate her moods and feelings to her menstrual cycle any more. She describes it:

...I really like being a cyclic animal and there's something terribly missing and I feel that there's just a sameness now...

( Interview Two)

Ruth did not think that her feeling of "flatness" was related to the loss of her uterus but rather the loss of the cyclic changes related to ovulation and thought that anyone undergoing major surgery probably suffered the same sort of mood changes. She was surprised at the length of time it was taking her to adjust to the changes. She felt that at this stage of the recovery process that she was physically recovered, had an intellectual understanding of the changes but that her emotions had not yet "caught up". Ruth thought that the reason she was having difficulty feeling in control at this stage was that the problems that she was currently experiencing were related to ovarian function and the loss of her ovaries was the one part of the process over which she had no control:

...It's the one part of the whole procedure that I had no control over because it wasn't even part of my decision in the first place to have that done...

(Interview Two)

Ruth talked about post-operative recovery occurring on two levels - "the physical and the other" - and that when these two lines converged that recovery was complete. She saw "surviving" surgery as the first part of the recovery process, then physical recovery with the scar healing and being able to do all the normal activities of daily living as the second step with the final step identified as being psychologically and emotionally recovered. She was very clear that these identified stages in the recovery process were not a linear sequence but rather that they "overlapped and occurred simultaneously, just at different rates". Ruth identified that as a life event that having a hysterectomy ranked as a 7 on a scale of 1 - 10. At this stage it was a major event for her and she now talked about the recovery process taking at least a year. She believed that her recovery would be complete when she had established a new "pattern" and the differences she felt as a result of having had a hysterectomy became her reality and she was no longer comparing her old life pattern with the new one:

...I just want to complete or re-establish a new pattern...

(Interview Two)

Two months elapsed between the second and third interviews and in that time Ruth felt that she achieved harmony and balance in her life again. She appeared cheerful and enthusiastic and now ranked having her hysterectomy as a 3 on a 1-10 scale. She spoke frequently about feeling better but different but that the difference was now her reality and that, for her, was a measure of her recovery. When the researcher contacted Ruth again twelve months after she

had surgery, she believed that her recovery had been complete at the time of the third interview and that the experience:

...was interwoven into the fabric of her life...

(Field Notes)

## CONCLUSION

This case study illustrates the continuity of the experience from diagnosis, surgery, discharge from hospital, and recovery for women undergoing hysterectomy. It should be noted that this was a unique experience for both the researcher and the women who participated in this research. Having a hysterectomy usually involves women in seeing a number of health professionals and following a six weeks check after the surgery, there is no further followup by any of those professionals unless specific problems are identified. The stories told in this research would not normally be heard. It should also be noted, that whilst the other women's stories were different to Ruth's, the concepts that emerge are similar. These conceptual categories are identified and discussed in the following chapters.

## CHAPTER SIX

### ASSIMILATION

The experience of recovery following early discharge after a hysterectomy within the social and personal context described in the previous two chapters, provide the background for the development of a conceptual framework which describes and explains the experience of the women who participated in this study. The three conceptual categories which comprise the framework are presented in the following three chapters. This chapter presents the conceptual category of assimilation which is part of the overall process of becoming better but different.

Assimilation is conceptualised as an active and deliberate process of getting back to normal. During this phase the woman measures everything that is happening to her against her expectations of what should be occurring and against what she was before surgery. She uses this comparison with expectations and before as a means of making sense of what is happening to her now and of measuring her progress. In this phase the woman deliberately and actively attempts to take control of the physical and emotional aspects of her life and reestablish all the patterns in her life which existed prior to surgery ( Figure 1, p 49 ).

For the women who participated in this study assimilation involved the following:

- Taking responsibility for making decisions
- Assuming control
- Sorting all the information
- Having the right attitude to recovery
- Seeing and feeling tangible and ongoing improvement
- Feeling they were back to normal

### **TAKING RESPONSIBILITY FOR MAKING DECISIONS**

As discussed in the previous chapters a woman brings to the experience of early discharge following a hysterectomy, a composite of her own history and an educational and experiential background that provides her and her significant others with a series of expectations about what is involved in the recovery process. The women who participated in this project wished to take responsibility for making decisions about what they could



b e c o m i n g   b e t t e r   b u t   d i f f e r e n t

assimilation

f i g u r e   1

or should do. This often brought them into conflict with their partners and or families who had different expectations, particularly within the first few days of discharge from hospital.

The women had all been given a prescriptive list of activities which they shouldn't undertake or had been spoken to by the medical staff. None of the participants were particularly sure about why specific restrictions had been placed on their activities. Two women describe the reasons as they understood them:

...because I'm the sort of person who asks a lot of questions and I remember asking "Why shouldn't I do these things? What's likely to happen if I do?" There wasn't much in the way of explanations....No, I don't think I ever really understood the implications...

(Katherine, Interview 1.)

...I gathered it was that the stitches might rip apart or..I suppose that's what it was. Mm...

(Hinemoa, Interview 1.)

The participants all talk about the importance of being organised preoperatively as being part of responsibility for making decisions. They all preplanned for their discharge in relation to their work, their family responsibilities and their friends. As Margaret put it:

...it was really important to me when I was in hospital not to have to worry about the kids. You see I had organised them all with lists and things. I felt good about having the operation when I didn't have to worry, you know...

(Margaret, Interview 1.)

Katherine put it this way:

...before they'd go out to school and university and work, they all had set jobs to do. They practised for a week before I went into hospital just to keep me happy really. I kept telling them that I couldn't stand to come home to a mess. They were really good once I got them organised...

(Katherine, Interview 1.)

The women all felt that they had taken responsibility for deciding the length of their hospital stay. Four participants remained in hospital for 72 hours following surgery. This was the generally expected length of hospitalisation and the women all described feelings of wanting to get home as soon as possible.

...I wanted to go home. I was feeling okay and they weren't doing anything for me that my family couldn't do at home...

(Hinemoa, Interview 1.)

...what I wanted to do was to get out of hospital so I could get physically better and then get back into doing what I would normally do...what I used to do before I went into hospital. I knew beforehand that I'd be in about three days but if I hadn't felt ready I would have stayed longer....there was no pressure from my doctor...

(Rose, Interview 1.)

Two other women elected to leave hospital 24-36 hours after surgery. Paula describes it thus:

...My catheter was out and I wanted to go home but I was a bit scared...

(Paula, Interview 1.)

Bet had other reasons for wanting to leave hospital early:

...I really believed that I could manage myself much better at home than in hospital. I mean the nurses were very nice and everything but you see..they don't treat you like an individual. I didn't want pain relief and they kept trying to persuade me. Lots of things like that...

(Bet, Interview 1.)

Taking responsibility for making decisions about discharge planning and timing gave the participants a sense of being in control and of having the power to actively participate in the process of change they were undergoing. This was in direct contrast to the lack of control and feelings of powerlessness they described in relation to the experience of surgery and hospitalisation.

## **ASSUMING CONTROL**

The process of assimilation included taking control of both their immediate post-discharge and long-term recovery. They all described surviving or managing the actual surgery as the first "marker" of the experience and the time in hospital after surgery as the beginning of taking control again. Following discharge from hospital the women,

regardless of the type of hysterectomy they had undergone, described this as a gradual process which began with managing the physical activities of their day to day lives and culminated in getting back to "normal". Things like managing their pain and household tasks were a priority in the period immediately following discharge. They generally described this part of their recovery as physical recovery.

As Lois said:

...I could manage my pain relief by taking Panadol if I really needed to or get my husband to rub my back and things ..you know..I could just decide for myself what I wanted to do about the discomfort ...

(Lois, Interview 2.)

Participants generally made decisions about what they should or shouldn't do according to how painful it was. Bet talks about pacing herself:

...I'd just start off very slowly and do things a little bit at a time and if I felt the slightest twinge I'd slow down a little. The next day I'd try it again until I was able to do it at my normal pace...

(Bet, Interview 1.)

Ruth describes managing the physical activities as:

...it was about physical pain and deciding it was okay just if it didn't hurt to do something...I guess I was proving something to myself that I could do it and it really was important to be independent. I hate not being able to do what I want. I hate losing control as I've already said to you....that part was purely on a physical basis...

(Ruth, Interview 2.)

Other participants talked about feeling that they had to prove to themselves that they could do things as being an important part of feeling that they were taking control. Hinemoa said:

...I hate sitting around doing nothing...when the family was out I'd go and do things like pegging out the washing and I'd manage it fine....if the family were there they'd yell at me not to do it and I'd get angry at them telling me what to do....Once I proved I could do it, they were okay and I felt like I was getting better, you know, back to normal...

(Hinemoa, Interview 1.)

All participants talked about being told by doctors that it would be six weeks before they would be able to return to work or to their normal activities like going to the gym,

playing golf or doing any lifting. It appeared that six weeks was the arbitrary time limit imposed regardless of the occupation or intended activity of the woman. Six weeks was also the time lapse before the final post-operative check with the surgeon. All participants were "offered" further time for recovery if they needed it but it was not suggested that the recovery period might be shorter. Despite the prescribed six weeks all of the participants themselves chose when they did return to work and they made their choices for the following reasons. Lois said:

...like I felt a bit of a fraud at home. I felt that I could have probably come back to work after three or four weeks ...but I'd had no sick leave in twenty something years. I had a huge pile of sick leave...so I figured I'd take my eight weeks and I'm glad I did. It's a very individual thing and it was a nice break...

(Lois, Interview 1.)

Hinemoa, on the other hand, felt that she wasn't fit enough physically to return to work until after six weeks. She says:

...I wasn't fit enough to be back until six weeks. She [the surgeon] said I could have longer if I wanted but I needed to get back even if it was a bit of a struggle so that I would feel like I was getting better...

(Hinemoa, Interview 1)

Felicity felt quite different. She felt that she could return to work the week following her surgery and she worked shortened hours for two days to see how she would cope. As she says:

...I felt so good and I hated just sitting around..besides morally I couldn't be out playing golf and say I was too sick to work, could I...mind you I didn't tell him [the surgeon] that I had gone back to work until he told me that everything was fine when I went for my six week check...we both laughed about it then...

(Felicity, Interview 1.)

Katherine felt that the choice was hers to make about when she went back to work and resumed other activities. She said:

...After all I was responsible for everything else, having the surgery, getting out of hospital etc and I was responsible about this. I just figured that I was doing a lot more physical work at home than I was doing at work so I went back to work after three weeks and to the gym for aerobics after five weeks. As I see it the decision was mine to make, I mean it's me that suffers the consequences good and bad and for me they were all good. I felt

I was well and truly getting back to normal when I went back to work and things...

(Katherine, Interview 1.)

It was as if making the decision to return to work and resume other activities in which the women participated prior to surgery gave them a sense of being in control again and a sense of getting back to normal. No matter whether they had a simple or a radical hysterectomy most participants experienced mood swings and changes which they described as making them feel vulnerable and out of control. Many of them denied that the feeling of vulnerability and depression was specifically related to having a hysterectomy. Being able to rationalise and talk about the mood changes enabled the woman to make decisions about what to do about them and to feel in control again. As Ruth said:

...I had a few days when I was weepy...and when I got back to work and reran all the old movies, I felt a bit sad...but I think that people do that after any kind of emotional life event anyway. ..I remember feeling that way after the children were born and after I'd had surgery on my ankle. I mean I don't think it's hormonal or grieving over a lost womb as popular authors are fond of saying...

(Ruth, Interview 1.)

It was as if by giving themselves reasons for feeling the way they did the participants felt that were taking control. Another way of dealing with the sense of vulnerability related to mood swings was to compare their feelings with how they used to handle mood changes prior to having surgery. For instance, Rose said:

...I think that before I had the hysterectomy I was just as moody and I'd just think that I was premenstrual. My hormones are still the same , it's just that I don't have regular periods anymore so I can't attach my moods to a regular cycle..you know, there's a sense of sameness all the time now..it's like I don't have an excuse for my bad temper anymore...

(Rose, Interview 1.)

This feeling of loss of a pattern or the regular cycle of menstrual periods was common to all participants. For some of the women this gave them a sense of freedom and control which they hadn't considered prior to having surgery and for others the loss of their regular cyclic pattern left them feeling as they didn't have an anchor for a short time. Hinemoa described the absence of her monthly period as being liberating:

...I could just get on with my life and for the first time that I can remember I wouldn't have to stop and wonder when my period was due. It's

wonderful. I can have sex whenever I feel like it now, play tennis, go for hikes and tramp and not wonder if it'll be okay...you know...

(Hinemoa, Interview 1.)

For Margaret, who considered herself a cyclic person, she felt she needed time to adjust to the absence of her period. She assumed control in a different way:

...I marked on the calendar for a few months when my period would be due and then only every two months. It sort of gave me a sense of...um...continuousness..you know, before and after and then gradually, over about five months, I never looked at the calendar so I knew that it was normal for me now...

(Margaret, Interview 3.)

The feeling that everything was back to normal was an important way in which the participants could make sense of what was happening to them and was the way they measured their own progress and recovery. This included feeling in control of menopause symptoms and Hormone Replacement Therapy for the participants who had oophorectomies. This group of participants felt that they had been well prepared by their doctors prior to having surgery about having Hormone Replacement Therapy and about dealing with the symptoms of surgical menopause. Four participants decided to commence Hormone Replacement Therapy and two chose not to have it. The women who chose to have Hormone Replacement Therapy said that they assumed that the taking of the hormones would substitute for the loss of their ovaries and relieve any symptoms of menopause. They all talked of their shock and anger at feeling their first "hot flush" despite taking the medication. As Felicity said:

...I realised what it was straight away and I was really upset about it. I felt sort of..um cheated..it got better then and only happened once in a while until I was about six weeks post-op and then I went back to my doctor and told her that it was intolerable. She explained that the dose needed adjusting and told me how to adjust it for myself. It was much better then...I was in control again...

(Felicity, Interview 2.)

The participants talked about having to adjust to the need to take regular medication and that it served to constantly remind them of having had a hysterectomy. Whilst they appreciated the control of their menopause symptoms they viewed the taking of the regular medication as a form of dependency and the one area of their life which was different to before surgery and the one area over which they felt they had little control. The daily tablet taking made it difficult to completely assimilate the hysterectomy into their lives. As Judith put it:

...You see it's been nine months now and I'm better, really wonderful, but there's a difference you see. I have to remember to take my hormones and sometimes when I do that I remember that I've had a hysterectomy. Mind you that happens less often now so I suppose I'll be better when I just don't think about it...

(Judith, Interview 3.)

The women who chose not to have Hormone Replacement Therapy wanted minimal intervention and they decided to wait for a few months after surgery before deciding whether to take Hormone Replacement Therapy. Margaret put it this way:

...I just wanted to leave my body alone to sort things out so I just said I'd wait a few months to see what I wanted to do...

(Margaret, Interview 1.)

These women decided not to commence Hormone Replacement Therapy after they had waited for two or three months because they felt that they were in control of symptoms like hot flushes, sweats and sleeplessness. They felt that the symptoms were most severe for the first ten weeks approximately and that they gradually abated after that. At times they said that they wondered if they had made the right decision, particularly when they felt that they weren't coping well. They were urged by their doctors to reconsider their decisions, not for the treatment of menopause symptoms but for the prevention of osteoporosis. They decided not to commence any therapy because they felt that they would only be deferring coping with menopause. As Bet put it:

...As far as I could find out I'd go through menopause when I stopped taking the hormones so I decided I wouldn't start. I would be having a natural menopause in ten years or so anyway..it just seemed another unnecessary thing to take hormones and they couldn't guarantee me that there wouldn't be any side effects so...

(Bet, Interview 2.)

The decision to either take or not take Hormone Replacement Therapy was expressed as a specific desire to take conscious control. It was as if the decision to have a hysterectomy was beyond their control and it was seen as necessary and not optional. The decision about Hormone Replacement Therapy they saw as part of the process of regaining control by taking charge of more and more parts of their lives. The participants all expected to feel pain and some physical disability when first discharged from hospital. They made sense and were tangible as did the feeling of fatigue during the early recovery period.

All the participants had expected that once they were capable of performing many of their normal functions and that they no longer had pain, they would be able to return to normal functioning. For almost all participants, fatigue prevented this. The expectation of getting back to normal came not only from the participants themselves but also from family, friends and work associates. The participants found that the ongoing fatigue was unexpected and that it frustrated their desire for control. Bet said:

...I get so angry with myself..you know...I feel so well and I've gone back to work but I just get so tired still, just like when I got out of hospital again. I suppose it's just another one of those processes of getting back to normal, I'll just have to do it gradually. I just get so frustrated though...

(Bet, Interview 2.)

Whilst participants felt frustrated about not being able to control feeling fatigue, they all consciously participated in trying to prevent what they considered to be the negative side effects of having a hysterectomy. They were careful with their diet as they tried to prevent weight gain and for the same reason they all exercised regularly and to an increasing degree over time. They believed that it was their responsibility to do these things to enhance the healing process. Judith said:

...You can't just sit worrying about putting on weight and feeling sorry for yourself...you have to do something..I mean, even if I didn't have the hysterectomy and I just sat around eating chocolates and cakes and not exercising I'd put on weight...

(Judith, Interview 1.)

Progressively taking more control of their own recovery following early discharge was extremely important to all the participants. The immediate focus was the physical aspects which were related to or resulted from the surgery-pain, activities of daily living, housework, returning to work, absence of periods, menopause symptoms, Hormone Replacement Therapy, fatigue and preventing ill-effects. All participants believed that taking control was affected by the quality and relevance of all their sources of information and the way they sorted all the information.

## **SORTING THE INFORMATION**

All the participants felt that they were given appropriate and sufficient information to make an informed choice about having surgery and most believed that they had insufficient or inappropriate information in relation to their post-operative recovery following early discharge. All were given a prescriptive list of things that they shouldn't

do eg. lifting the wet laundry, vacuuming, and a time frame for resuming activities eg. sexual relations, work, sport. Two women felt they were well prepared for discharge and were very eager to leave hospital as soon as possible and begin doing those things which were permitted. Ruth said:

...I had good warning about the sort of things that might happen. The gynaecologist came and sat down and talked to me about everything...when to resume sexual activity, what bleeding and vaginal discharge to expect, what type of pain was acceptable, how I might feel, ...it was good stuff like that. I felt very confident about going home...in control and organised...

(Ruth, Interview 1.)

The other participants felt less than well prepared for early discharge and they believed that this made a difference to the process of recovery. Katherine put it this way:

...I was given a sheet of paper with do's and don'ts by the nurse in the preadmission clinic...I didn't really take it in then...when I was leaving hospital I asked the nurse some questions about it and she said she'd be back later when she wasn't busy...she didn't come back and I left...it was like when you go home they have no further interest or responsibility. I think it is the other women who help most and I rang a friend of mine who'd had the operation. She told me what to do and expect and then I stopped worrying...it was like I had a map again..you know..a direction to aim for...

(Katherine, Interview 1.)

It was usual for the women to have read books on the subject of having a hysterectomy, to have read magazines and to have talked with friends and colleagues about it, particularly people who had had surgery themselves or were health professionals. Not all the information was helpful and the participants believed that the way they sorted all this information had an important effect on their recovery. The women believed that they needed to be selective about the information that they acted upon. They needed to sort the myths and old wives tales from the reality and they felt that they had to know themselves and their own responses to stress.

Judith said:

...I'll tell you one of the things that amazed me was some people told me the most horrendous stories... a midwife told me about terrible complications and if I had believed them I would have been terrified in hospital. I mean I just thought to myself that thousands of women have had this operation and they all seem fine so I just ignored stuff like that. It would have affected my attitude you see...

(Judith, Interview 2.)

Most participants felt that written instructions were useful in the initial post operative period because they served as a ready reference when at home. Two participants, who believed that were well prepared for early discharge received a booklet which had comprehensive information and prior to discharge were spoken to at length by the surgeon. The others felt that they had been sent on a trip without a map. The period following early discharge was often referred to as a trip or uncharted territory. The women all felt the need to draw a sketch plan of this trip so that they could measure their recovery and because they felt it was important for the right attitude. Attitude, particularly a positive one, was seen to be important in this process of assimilation.

## ATTITUDES

All participants described the necessity of a positive attitude for a positive recovery and they actively chose positive attitudes. Rose said:

...It was a matter of forgetting the horror stories and the old wives tales...I believe that what's going on in your head affects what happens to you physically... you need to be positive and optimistic...

(Rose, Interview 2.)

Most participants told stories and remembered examples of people with positive attitudes and successful or uneventful recovery and examples of negative attitudes and slow or complicated recovery. Attitudes that were defined as positive included: optimism, hope, sense of humour, determination, acceptance, and patience. Attitudes that were defined as negative included feeling sorry for oneself, self-pity, blame, depression, resignation, and discouragement. Hinemoa said:

...I could have sat back and wallowed in self-pity but that wouldn't have done me any good. That would just have made all those stories about depression and stuff after a hysterectomy come true...

(Hinemoa, Interview 2.)

Felicity felt that a positive attitude created a sense of harmony between the mind and the body. As she said:

...I think getting better is about being physically and mentally in tune ... about harmony..you know ..mind, body and soul. When you first have the operation you concentrate on getting better physically and then mentally and

spiritually..so they are all in tune again..but you have to have a positive attitude, not get down about it...

(Felicity, Interview 2)

All the women considered themselves to be positive during the first interview and were delighted with the way they were getting better and getting back to normal. Some were actively struggling to regain their "positive" attitude by the second interview. For most they felt that the positive attitude had been lost when they resumed many of their normal activities, eg returning to work, and they felt discouraged when they were tired again or their colleagues and families expected them to just get on with life. As Bet said:

...It wasn't that I wanted sympathy or anything but I'd worked really hard to get well and...you know ...it's like you get no thanks...I shouldn't say that really...I can't expect them to understand..in a few days I'll feel better again...

(Bet, Interview 2.)

Many participants, including Bet actively countered negative statements they heard themselves say. Sometimes the personal pressure that the participants put on themselves to achieve a positive attitude appeared to achieve the opposite. It appeared to create a negative attitude about their negative attitude. For example, Katherine said:

...I just get so angry and discouraged you know..I shouldn't be feeling like this now..I'm getting better and doing well. There are days when I feel heavy..my legs feel heavy, I just don't spark..and I can't put my finger on it ..I'll just have to give myself a stern talking to I think...

(Katherine, Interview 2.)

Having a positive attitude was often related to tangible and concrete evidence of making progress and getting better. This was usually more obvious in the early days and weeks of the recovery process. There was a sense of self-blame by participants when progress seemed to go backwards or not go forward at a steady pace.

## **TANGIBLE AND ONGOING IMPROVEMENT**

All participants found it easier to comprehend that they were getting better and getting back to normal when they could see tangible evidence of change. This was more obvious for those participants who had abdominal hysterectomies than for those who had vaginal hysterectomies. Jane said:

...I didn't have a wound or anything that I could see..I could only go by what I thought was happening inside me and how I felt..I judged getting better by how painful it was when I coughed..suddenly one day I realised it didn't hurt anymore and I didn't think about it...

(Jane, Interview 1.)

Felicity, who had an abdominal hysterectomy measured her progress by the way her wound was healing. It was as if by observing change she felt her progress was more real:

...each morning in the shower I would notice that my wound was healing well and I'd know that I was getting better. Now I only occasionally feel the ridge where the cut was and I remember that I had a hysterectomy...

(Felicity, Interview 3.)

Tangible evidence of improvement also included actively and deliberately remembering how it had felt immediately post-operatively and feeling reassured that things were dramatically improved since then. Some participants talked about feeling that they weren't making rapid enough progress and they would think back to how little they could do when they first got home from hospital and compare that with where they were in the present. Margaret said :

...I remember feeling really excited about getting back to work, that it was a big milestone and then I felt really tired again. But when I look back on it now, four months later I really feel 100% ..I thought I did when I first came back to work because compared to how I felt immediately after the operation I felt fantastic..now I feel that I'm back to normal..no I mean better than before I had the surgery...

(Margaret, Interview 2.)

Participants believed that getting better was being back to normal. To them it meant being able to do all the activities that they did before the surgery. It essentially relates to physical recovery and re establishment of patterns which existed prior to surgery.

## **BACK TO NORMAL**

Participants believed that they were better when they were back to normal. It meant that they had assimilated the experience of having a hysterectomy. This is conceptualised as a conscious and participative process for which the participants feel responsible. This feeling of returning to expected levels of functioning help the women to make sense of

the experience and as a consequence, to achieve a sense of harmony. The phase of achieving harmony will be discussed in the next chapter.

## CHAPTER SEVEN

### ACHIEVING HARMONY

Another conceptual category identified was achieving harmony. This is described by participants as a feeling of being "in-tune" and achieving a feeling of tranquillity. As with assimilation, achieving harmony occurs throughout the recovery process and begins at the time of discharge from hospital. In this phase the women describe moving from having a total absorption in their own process of recovering to not consciously thinking about having had surgery when making decisions. Achieving harmony is about integrating the different parts of the recovery process ( Figure 2, p.64 ).

Participants all spoke about the mind and body healing at a different rate, about achieving balance, deciding what not to do and what to do, moving from dependence to independence, the feeling of being in control/out of control, the difference between expectation and reality. It was as if by integrating all these parts of the recovery process, the women felt that they had achieved harmony and no longer thought about or consciously took the surgery into account when making decisions about what to do or not to do.

#### MIND/BODY

All participants spoke of a connection between their minds and their bodies and of feeling in the days following early discharge that their minds and bodies were out of balance and healing at different rates. As Margaret said:

...it's a mind-body thing ..you know..about them being in harmony and I just don't feel that they're together yet...

(Margaret, Interview 2.)

Participants frequently talked about harmony in relation to physical recovery in the period immediately following early discharge. Hinemoa put it this way:

...you sort of get better on two levels initially, you know, the physical and the other and they don't always both peak at the same time..sort of out of synch...

(Hinemoa, Interview 2.)



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It was important to all the participants that they felt a sense of harmony in relation to their physical and mental recovery. It was their way of making sense of getting better and of the process of recovery. They felt that they were making progress and establishing a pattern with which they felt comfortable when they felt that they were mentally and physically in tune. The women felt that they weren't recovering as they should when they felt a sense of dissonance. Bet described it thus:

... I know in my head I am getting better physically each day but I don't feel any better .it's hard to explain..it's like I want to do a lot of things but I can't do them yet, physically I mean...

(Bet, Interview 3.)

For other participants they felt physically able to do things before they felt emotionally or mentally able. Jane said:

...I was able to do a lot more than I thought I would be able to....I just didn't feel okay about it all the time because I was a bit wary...when I stopped worrying and just did things, I felt like I was on top of it, like my head and body had got it together...

(Jane, Interview 1).

Paula had a different view point. She felt emotions or feelings were part of her spirituality and that her emotions guided what she was thinking. She felt when her mind, body and soul were harmonised that she felt better.

...it's not just about mind and body you know ..it's much more than that. It's about knowing that you're getting better, about doing things without pain or thinking about them and about knowing in your soul that you are better and that you did the right thing..that's what getting better is for me..when they all come together...

(Paula, Interview 2.)

Participants frequently spoke about having a positive attitude and this was seen as important in the recovery process. Lois said:

...I think attitude is all important, the mind-body thing. I try and tell my kids that all the time. Getting and feeling better is about what goes on in your head. I think you've got to be positive because if you're not you'll drag the physical part down...

(Lois, Interview 2.)

In this way, achieving harmony implies active participation as does assimilation discussed in the previous chapter. Katherine said:

...It's up to yourself really. You can wallow in self-pity or choose to have the right attitude...think about other things and there's always someone worse off than you. It's really about what attitude you have about sickness and you can change that...

(Katherine, Interview 1)

In the period immediately following discharge, achieving harmony is closely linked to physical recovery from surgery. As physical recovery occurred, the women spoke about needing to achieve a sense of harmony in relation to other aspects of their recovery. They all spoke about having a sense of loss in relation to their monthly periods. This sense of loss was not a negative feeling for the majority of the women. For most of them, the loss of their periods meant a sense of increased freedom and relief. Most of the women had suffered severe pain and menorrhagia for a long period of time prior to having a hysterectomy and consequently, viewed the loss of their monthly periods positively. Their sense of loss was more related to not having a monthly cycle. Bet said:

...I do recall about eight weeks after the operation I suddenly thought "Oh I haven't had my period yet" and then I remember thinking that I knew I wasn't going to have them anymore. It was just that I'd had them regularly for years and it wasn't a habit not to have them yet...

(Bet, Interview 2.)

The women who had not had oophorectomies talked about having to develop a different awareness of their bodies. They spoke about experiencing the monthly hormonal cycle and of the need to be more "in tune" with what was happening for themselves because they no longer had a monthly demonstration of these hormonal cycles. Felicity put it this way:

...I still have a cycle you see and when I get sore breasts and things I think to myself that my period is due but of course I don't have it anymore. It's like a habit I haven't been able to shake yet. I don't regret not having it at all, it was so painful anyway and now I can do what I like whenever I like without thinking about it. It's funny knowing that your cycle is still going on inside you but nothing happens, it just keeps repeating..you know, round and round...

(Felicity, Interview 2.)

The women who had had oophorectomies talked about having to become accustomed to the loss of their monthly cycle very suddenly. They had all been warned pre operatively about the onset of a surgical menopause but felt that no-one had prepared them for the absence of the cyclic effect of their menstrual cycle. For them, achieving harmony was

related to adjusting to that loss and not consciously thinking about it. Ruth described it like this:

...You get to know your own cycles and there's some degree of predictability living with them and understanding yourself. With this there's not. It's an unplotted course ...so I'm sailing uncharted water here and that I think is what is difficult about it. Instead of having cycles that you can pin anything on it's just sort of good days and bad days...there's just a sameness that's difficult for me to understand yet...I just hadn't thought about that part of it and it's taking me longer than I thought...

(Ruth, Interview 2.)

Most of the women felt that they also had to come to terms with the effects of suddenly becoming aware that they were ageing and that having a hysterectomy and the cyclic changes it caused meant a reassessment of their lives. It was as if they were faced with menopause out of their time and they suddenly found themselves in a new reality. Lois spoke of this feeling very eloquently:

...this has hastened the ageing process , not physically but in the way I now see myself. I feel like it's taken me in a jump over something that I wanted to really take my time..you know..crawl over slowly. It's been a quantum leap over a barrier really and I haven't quite made the mind-body connection with it yet. It is coming..it's not the physical stuff, it's more that I haven't got my head around it yet...

(Lois, Interview 2.)

The two women who didn't mention this as of note to them spoke about their feelings of guilt because they considered that they had an easy time when everyone expected them to be feeling a sense of loss.

...The whole thing was really like going to a dentist and having a tooth pulled. I was a bit sore for a few days and since then I haven't looked back. I think it's about attitude and expectations but I wouldn't want to say that to someone who's suffering after their hysterectomy...I'm pretty ordinary so perhaps you really need to talk to someone who's having problems...

(Jane, Interview 2.)

The other area of their recovery where the women spoke of a mind-body dualism was in coming to terms with taking Hormone Replacement Therapy on an ongoing basis. The four women who elected to commence hormone replacement therapy felt well informed and confident that their decision was appropriate and right for them. What they found most difficult and frustrating was that they had expected to take the medication regularly,

rather like an "aspirin a day", and that would control their symptoms. They were totally unprepared for the feelings of dependence that the regular taking of medication engendered in them. They believed that they had to come to terms with that as well as the sense that they were not quite complete. They described this as knowing and accepting prior to surgery that if your body doesn't produce something that you need then you take the missing thing as a tablet. They all spoke of the need to feel complete as well as know it mentally and that they achieved harmony when they had dealt with that.

... you see, after four months I was fine but every time I took my pills I was reminded that I was lacking something. It took me a long time to adjust to that feeling and to stop feeling inadequate about it. After about eight months I felt that I was on top of it and I was at peace with myself...

(Judith, Interview 3.)

The simplicity of the notion of taking a pill to replace what the body no longer produced denied the complexity of meaning these women had in relation to not needing to take anything prior to surgery. They needed time to adjust to their new reality and they had not initially expected that this adjustment would require time. Apart from the mind-body dualism these women described, they also spoke about achieving balance or harmony between all aspects of their recovery.

## **ACHIEVING BALANCE**

Achieving balance is a process of weighing factors against each other in terms of their significance and relative priorities, and then making choices about one's actions. Achieving a balance commenced for the participants prior to having surgery. They weighed up all the factors and made the decision in the light of what was best for them physically, for their families, for their work/occupation. The women all believed that the decision to have surgery was theirs to make. All but two participants felt strongly that they had decided not to have any more children and so there was no clinical or functional reason to want to keep their uteri. Katherine said:

...We had already made a conscious decision not to have any more children and my husband had had a vasectomy. I felt no emotional attachment to that part of me at all. The anaemia and heavy periods were a problem for me and interfering with family activities and my work commitments so the decision was easy...

(Katherine, Interview 1.)

Felicity had always thought that she wanted more children and had not succeeded in getting pregnant. For her the decision to have a hysterectomy was made by balancing the fact that she felt she was putting herself and her family at risk by delaying any longer. She had been advised that a hysterectomy was the treatment of choice for her abnormal smears several years prior to having the surgery. She said:

...It had got to the point where I couldn't put myself at risk any longer. We decided that if we wanted other children that badly we could adopt. It was more important to be a live mother to the one we already had...

(Felicity, Interview 1 )

Having weighed up the reasons for having surgery the women all believed that the decision to have surgery was theirs to make. Not all of them expressed it as bluntly as Bet when she said:

...It's my body and my choice. My husband wasn't involved in the decision at all. I went and I made the decision and I had it done. He supported my decision by helping organise the kids and things but it was mine to make...

(Bet, Interview 1 )

Having decided to have a hysterectomy the women all undertook a great deal of balancing work in relation to planning and preparing for surgery, in making decisions after surgery, in regaining independence, in remaining in control and in aligning their expectations with reality. In this sense, balancing is a conscious part of the process of achieving harmony.

## DECIDING

Deciding what to do or what not to do in the in the first few days following early discharge from hospital was based on feelings of tiredness, physical pain and a fear of doing themselves harm. The participants were all eager to leave hospital as soon as possible and begin what they saw as their task of getting better. Generally the women were unsure about levels of activity in the initial period and made the decision about what they should be doing themselves. The women all talked about being careful not to "pull anything" in the first few days and feeling afraid that they might "overdo" things. This was balanced for them by the feelings of relief at being home and feeling able to make decisions for themselves again. Hinemoa said:

...the only thing that I felt a bit frightened about was that I might pull something inside so I was really careful. If it hurt I didn't do it you know? But it was just so neat to be back home...um ...it was like feeling I could

stretch out and ..um..nothing seems so bad when you're in your own home. It seems to put things into perspective again...

(Hinemoa, Interview 2.)

The women all thought that deciding what to do /not to do in the first few days was essentially a matter of "common-sense" and of being in-tune with and listening to what their bodies were telling them. Some of them had some difficulty in deciding whether they were actively doing enough to facilitate healing. As Bet said:

...it was easy enough to decide what I shouldn't do in the first few days because of the physical pain. It was more difficult later when I wondered if I could do anything else to help myself get better quicker without overdoing things, you know...

(Bet, Interview 2.)

Three of the women believed that they should do exactly as they had been told and then they were promoting their own recovery. These women believed that if they didn't do as they had been told by their doctors, then if something went wrong they were to blame. As Margaret put it:

...If he [doctor] told me not to do something and I went ahead and did it, I'd be pretty stupid wouldn't I. It's about weighing things up you know, about being balanced and in-tune with your body and what it is that you're supposed to be doing. I listened to what I was told and followed the doctors instructions and consequently I had no problems...

(Margaret, Interview 2.)

This group of women obeyed instructions given to them until they went for the check with their doctor six weeks after surgery. For them, they felt a sense of harmony because they knew that they were doing what was expected of them. They also talk about feeling somewhat adrift and unsure of themselves when one day they were doing as they were told and the next day they could do as they liked and they then needed to learn to make decisions that were synchronous with their physical progress.

Katherine said:

...He examined me and said that everything was fine and I could resume all my normal activities, including sex, if I hadn't already. I felt really confused then because on the sheet of paper he'd given me, it said not to have sex until after the check but then he said that. I didn't want to say anything but it was like...I didn't know what to think...

(Katherine, Interview 2.)

These women went through the dilemma of deciding what to do /not to do after a six week period whereas the women who were guided by how they felt, had dealt with that dilemma within a few days of discharge. The group who obeyed instructions felt that they achieved a sense of feeling in tune with themselves when they felt confident about being guided by how they felt. Lois said:

...I really felt good when I knew that I could be completely independent again...not having to think about what I should or shouldn't do or to have to ask for help. I was my own person again and I felt like I found my soul again...

(Lois, Interview 2.)

Feeling that they achieved independence was important to all participants. It pervaded the data and was seen by all as a critical component in the recovery process.

## **INDEPENDENCE**

Whilst all the women who participated in this study believed that they had made educated and informed decisions to have hysterectomies, they all felt that whilst they were in hospital they were dependent on the organisation for decisions relating to treatments and the way in which these were carried out. Early discharge from hospital represented for them the opportunity to regain this feeling of independence.

They generally agreed that the process of regaining their independence was a gradual one and did not necessarily progress smoothly. They described it as "taking two steps forward and one backwards". Feeling independent and acting independently represented a feeling of being in harmony with the rest of the world.

The time of surgery and the initial period of recovery when these women felt dependent on others for both their physical and emotional needs being met was accompanied by a feeling of being out of the world and distanced from reality. The process of becoming more and more independent as recovery proceeded had a sense of rejoining the world. Initially, the feeling of being dependent on others was difficult for some of the women. Hinemoa said:

...I wanted to be the person I was as quickly as possible. I don't like seeing myself laid up and I don't like people having to do things for me even if it's done in the best of spirits...

(Hinemoa, Interview 2.)

The women felt that it was important to re-establish their physical independence initially. This included learning to trust their own abilities to make the right decision and taking responsibility for that deciding. It was common for the women to relate stories of their own readiness, both psychological and physiological, and of their families and support people not believing in their readiness. For example, Bet said:

...when my family would get home from work and see that I'd done the vacuuming or washed some windows or cooked the meal, they'd yell and scream at me. It was as if having this operation made me like a child to them. I was this different person and whereas I'd been capable of doing what I wanted before they suddenly thought that I shouldn't or couldn't anymore...

(Bet, Interview 2.)

They all spoke about feeling smothered by their family's attentions and having great difficulty persuading them that they didn't need them. They frequently spoke about wanting to do it "my way". Felicity said:

...I know they meant well but they were ..um...stifling is the best word. I hate people fussing over me even though it's my family. I let them do things their way all their lives but they suddenly seemed to think I was too frail. I mean so what if I did something I shouldn't, my body would have let me know, it would have hurt. They couldn't seem to understand that...

(Felicity, Interview 2.)

Whilst the participants appreciated the support and caring intentions of their families and significant others they talked about wanting someone to validate their choices. They felt that more positive support would have given them confidence. Many of the participants felt that the positive interactions with the researcher increased their confidence about regaining their independence. As Judith put it:

...I talk to you [researcher] about it and you don't judge me. We just sort of talk about alternatives and then I decide. We laugh about things too and that makes me feel ordinary again. The family just get so worked up and worried I find it better not to tell them the things that I know will worry them...

(Judith, Interview 3.)

This struggle to regain independence was often frustrating for the women also. There were also times when they felt that they needed assistance and felt that they couldn't ask for it because they had been so adamant about managing on their own. This was particularly related to unexpected things happening when they felt that they were actually

recovered. For Rose it was a sense of overwhelming tiredness when she went back to work. She felt that she couldn't ask for help because she had insisted on going back to work early. She said:

...I was so fed up with myself. I'd gone back to work and I had been feeling better than I had for months and then wham, I just felt bone weary again. I felt like I was back at the beginning again. I didn't want to tell them because they would have started fussing all over again...

(Rose, Interview 3.)

Many of the women felt that their desire to be independent had taught them some new insights. For them it was as if they reevaluated what things were really important to them. They all achieved their accustomed level of independence within three months. Some of the women decided that they were going to increase their levels of independence as compared to their pre operative level. Many decided to take more responsibility for increasing their level of physical fitness, of socialising more and of expecting increasing levels of independence from their families. Margaret said:

...I think they were scared that something might happen to me and you know, when I thought about that I knew that they'd never cope if it did. I decided then that they could all start doing more and being more independent too. That meant that I had to accept them doing things their way too. I just started going out more and left them to it more often...

(Margaret, Interview 3.)

All participants achieved at least original levels of independence and many reviewed and increased their levels of independence. Closely linked with regaining independence was the desire to feel in control of their lives.

## **CONTROL**

Achieving harmony and balance included the need to feel in control and was closely linked to the need to feel independent. All the women expressed the desire they had to be in control during the whole experience. Four of the participants elected to have epidural anaesthesia because they feared losing control and some women described the advantage of having a hysterectomy had been to give them more control of their lives. There were several sub categories related to control.

This desire to feel in control included deciding on discharge timing. The women all commented that whilst they were told that the decision about when to go home was theirs

to make, the nursing staff left them in no doubt about the expected length of stay in hospital. They all wanted to get home as soon as possible, not only to take control of their recovery but to minimise disruption to their families. Bet put it like this:

The family was all prepared for me to be home after 36 hours and so was I. I felt that I was in control when things went according to plan. It gave the family confidence too.

(Bet, Interview 1.)

Feeling in control of what was happening to them was very important to all participants. The women who did not have oophorectomies all felt they could take control once they arrived home and regained their independence. It was not such a straight forward process for the women who had oophorectomies. They often felt that they were not able to control the symptoms of menopause despite taking Hormone Replacement Therapy and they often felt that they had inexplicable mood swings. Judith said:

I was so out of control I felt frightened and desperate. The tablets weren't working properly and I was breaking out in sweats. I'm sure everyone knew and could see and then I'd get so angry that I'd yell at the kids and the family for nothing. It took about three months to sort out the treatment and I felt so much better...in charge again and that's what getting better is for me...

(Judith, Interview 3.)

This feeling of being in control was essential to achieve a sense of tranquillity and harmony. The women all believed it was important for them to get things under control and to feel in control so that they no longer consciously thought about having had a hysterectomy. Not consciously thinking about it was important because then the experience was just part of their everyday life. Lois said:

..It might sound crazy but I know I'm better now because I no longer think about it. I've made it an ordinary event now and it's just there..part of my past and my future. I'm looking outwards now not just focusing inwards...

(Lois, Interview 3.)

An important part of achieving harmony and feeling that their recovery was progressing, was that the women could balance their expectations for the experience and the reality of their experiences.

## EXPECTATION AND REALITY

Women's perceptions of whether they were recovering well were influenced by their expectations and the way they balanced these with reality. Their expectations were informed by a variety of sources. Those women who had been hospitalised for surgical procedures before, felt that they knew what to expect. All the women believed that pain and discomfort were an expected part of having surgery. They all felt that they had been given detailed explanations of what to expect post-operatively by their doctors. Most of the participants knew women who had had hysterectomies and they spoke to them about what to expect. Others had read books or talked to other health professionals they knew personally. They all felt that they were well informed and had realistic expectations of surgery and the recovery process.

The women all felt they knew themselves and their own patterns of healing and they all actively prepared to enhance their healing by eating well, exercising and learning as much as possible about what to expect. It was common for the women to compare having a hysterectomy with their experiences of childbirth. As Rose said:

...I had three Caesareans when I had my kids and I couldn't see that this would be much different. In fact I thought it would be a lot easier because I wouldn't have to look after a little baby as well. You get the hormonal upsets having a baby too you see...

(Rose, Interview 1.)

The participants all expected that recovering from having a hysterectomy would be similar to recovering from childbirth without the addition of having to care for a new infant. They were often surprised when the expected pattern of recovery didn't occur. Ruth had thought that she had everything under control and her recovery was going as planned until she started feeling depressed. She had no prior experience or learning to help her explain why she was feeling so "down". She said:

...I just didn't expect to feel like this now. Everything is fine physically. It's just that I expected to feel weepy immediately afterwards but this is going on a lot longer than I thought...

(Ruth, Interview 3.)

With the exception of two participants all the women felt that their recovery or integration of the experience took longer than they had expected. These women commented that when they discussed this aspect with other women who had hysterectomies they affirmed their feelings. Felicity recalls a friend saying to her that she didn't feel it was appropriate to sound negative when she [Felicity] was going to have surgery and

compared it to telling horror stories about birth to women who were ready to give birth. When the women accepted and adapted to the differences between their expectations and their reality they felt a sense of positive progress. Margaret described it like this:

...it was as if I was stuck there feeling angry and I decided to just take it as it comes. So what if it took me longer than I thought. There was no time limit on this thing. When I let go and listened to my body I felt like I was in control again and in touch with myself, not fighting myself...

(Margaret, Interview 3.)

Two of the participants felt that their recovery was much as they expected. They both felt that they were realistic in their expectations and consequently they weren't disappointed. Bet said:

...I'm a fairly down to earth person and I don't believe that you can predict every eventuality. It's been pretty much what I expected, in fact, a lot better really. I feel better now than I ever have and feel a lot more freedom...

(Bet, Interview 3.)

Whilst the participants all made their own decisions about having surgery they all expected support from their families. They all felt that they received the expected level of support and at times felt that when recovery didn't proceed as planned they were letting themselves and their families down. Judith said:

...I felt bad because I didn't know it would take as long as it did and all my husband wanted was for me to be back to normal. He did everything he could and I was sick of telling the kids that I didn't feel like doing things with them. I expected to be doing everything as normal in a couple of weeks and of course it was too soon...

(Judith, Interview 2.)

Participants believed that when they balanced their expectations and reality they were getting better. They felt this was evidenced by not thinking about having surgery or taking it into account when making decisions.

## **NOT THINKING ABOUT IT**

Achieving harmony is thus both an integrative and balancing process. The process involves finding the most functional place in relation to action and change. There was an undercurrent in relation to this conceptual category which related to both getting back to

normal and not thinking about it. It was as if participants were striving to not think about their own functioning and to be back in the mainstream of life. It was about achieving a balance and sense of harmony when conscious control was no longer necessary. Achieving a sense of harmony enabled these women to incorporate the experience into everyday life and to establish new patterns. The conceptual category of repatterning will be discussed in the next chapter.

## CHAPTER EIGHT

### REPATTERNING

Repatterning is the process of evolving beyond the specific recovery from the surgery and seeking meaning from the experience. Participants describe this as learning from the experience and incorporating that learning into their lives patterns and future plans. There is a sense of a life review and of making spiritual meaning of the event, reviewing past decisions and at times setting new priorities or evaluating existing ones. Repatterning is a participative process which begins prior to surgery when the participants visualise what changes will occur as a result of surgery and plan how to incorporate these into their current life patterns.

Participants describe repatterning as an increased awareness of the life process, an increased sense of freedom, a time to review their lifestyle and values, getting a perspective on the importance of hysterectomy as a life event and of the differences which have resulted from surgery now being their reality. Repatterning is inextricably linked with assimilation and achieving harmony and they all go on simultaneously (Figure 3, p 80 ).

### INCREASED AWARENESS

A consequence of visualising what changes will occur as a result of surgery, is that it enables the participants to continually reframe their picture of what is happening and why it is happening. Each became acutely aware of the physical and emotional changes that were occurring for themselves and reflected on these to make sense of their progress and their altering life patterns. For some of the participants there was a sense of feeling that they were ageing. These women described surgical menopause and the suddenness with which it occurred as taking a leap over a part of their life cycle which they would have preferred to walk through. Ruth describes it thus:

...maybe there's an element of feeling cheated that my cycle didn't quite run its course..I don't have any doubts that it was right to have the surgery but I feel that I've jumped over a barrier rather than having time to come to terms with it gradually...

(Ruth, Interview 2.)

Margaret describes similar feelings:

...I've changed the way I view myself. I used to think of myself as a middle aged career woman and mother and wife and friend and daughter and then I suddenly became a post- menopausal woman. I had to reframe my` image of myself..you know..it's fine now, I don't even think about it...

(Margaret, Interview 2.)

The women did not view surgical menopause as a negative experience, rather as an increased awareness of the progress of the life cycle and the need to redefine their mental pictures of themselves. Their comments related to the suddenness of the changes rather than any regret for the processes which were occurring. The participants all spoke about being mentally prepared for and understanding that surgical menopause would occur post-operatively but believed that their focus was having the surgery and getting home from hospital as soon as possible. It was as if they put further consideration of the effects of surgical menopause to one side whilst they concentrated on their immediate post operative recovery. Lois put it this way:

...I knew what to expect, I just hadn't given much thought to how it would feel or what it would mean to me ...I was more concerned about getting through the anaesthetic and not making a fool of myself in hospital. When I got home I had time to reflect on what the changes would mean for me...

(Lois, Interview 2.)

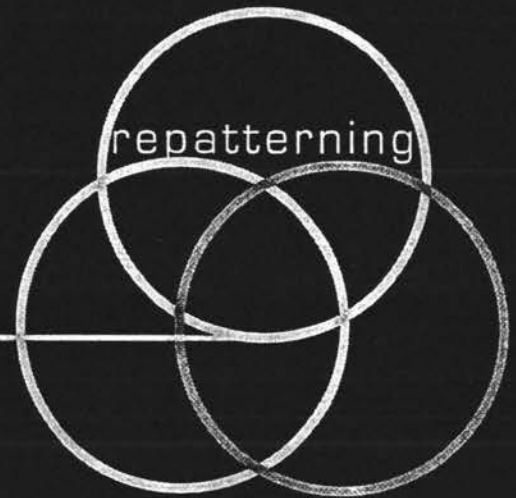
All the participants describe being totally focused on the surgery pre-operatively. They also describe the time after discharge as a time for reflecting on whether the experience was what they had expected and whether they felt they "measured up" as patients. Their image of themselves as good patients was measured in terms of other people's responses to them. They often spoke of their visitors being really surprised at how much they could participate in everyday activities when they were initially discharged from hospital. Paula, in the excerpt below, describes how she and her family and friends expected that she would be convalescent for some weeks post-operatively:

...I felt such a fraud when everyone brought me food and baking and here was I running around cooking and doing everything that I normally did. They kept telling me how marvellous I was but I don't think they give you realistic advice in hospital. They are always talking about major surgery and I really don't think it is....I'd have had it done ages ago if I'd known how easy it would be and how good I'd feel...

(Paula, Interview 2).



b e c o m i n g   b e t t e r   b u t   d i f f e r e n t



f i g u r e   3

There was a feeling of guilt expressed by some of the women in relation to recovering so quickly and easily. They felt that they did not want to deny women who were suffering during their recovery the right to be heard. Jane describes it like this:

...it was so easy for me, just like having a wisdom tooth out. I do feel sorry for women who really suffer though and I wouldn't want all women judged on my experience. I'm just lucky I think but I am a fairly pragmatic person. All the women I've spoken to since have said they had a good experience too ..there seems to be a conspiracy beforehand to have you expecting the worst...like when you have a baby...

(Jane, Interview 2.)

Most participants expressed surprise at both the rapidity and ease of their recovery following discharge. They reframed by merging their expectations with reality as their recovery progressed as part of the process of repatterning. Two participants experienced depression following their surgery; one of whom was prescribed medication and the other worked through the experience herself. Both these women were disappointed and expressed surprise and resentment at feeling depressed because they had not expected that to happen to them. It wasn't that they didn't know this could happen following hysterectomy, rather that they as individuals were affected by depression. Once they too could begin to merge their expectations with their lived experience they began to repattern. Margaret expresses this clearly when she says:

...I had to accept that I was depressed and that was a big thing for me because I thought that was something that happened to other people, not to me. I don't think the depression is totally about the surgery but is a result of everything that has been going on. You know, feeling down and anaemic all the time, then the surgery, then coming to terms with no more pain or cycles that meant living on Ponstan and pills. It's just I'm not used to the new me yet...

(Margaret, Interview 2)

Other participants describe this increased awareness of the life processes in other ways. They talk about being acutely aware of anything that was different to before having the surgery and a tendency to believe that they were ageing. This occurred until they had assimilated the experience, achieved harmony and were successfully repatterning. No specific time period can be put on this as each woman recovered in her own time. For example, Rose said:

...I know my memory is not so sharp now. It used to be really sharp and I could remember things without writing them down. I wouldn't dare do that now. It upsets me because that's something old people do...

(Rose, Interview 1.)

Rose laughed about her statement when interviewed for the second time six weeks later. She said

...I feel a bit stupid when I read the last interview. I think I was so inward looking when I just had the surgery that I lost all sense of proportion. I admit my memory isn't as good as it used to be but I don't think it has anything to do with the surgery. I think I just had the time to notice that it wasn't as sharp as it was when I was twenty. I think it's funny now how important that was to me last time we talked and I don't even think about it now.

(Rose, Interview 2.)

It was as if in the immediate post-operative period the participants viewed everything that was happening to them from the perspective of getting older. It wasn't until they reframed their image of themselves that they no longer viewed having a hysterectomy as a life event of major importance. As the surgery became less significant, repatterning included looking at the advantages they had gained by having the surgery. A feeling of increased freedom was the most common term used to describe the difference the women felt as their recovery progressed.

## **INCREASED FREEDOM**

Increased freedom related to many aspects of recovery. As recovery progressed the participants spoke about feeling increasing freedom over many aspects of their lives. Initially for some, this was a sense of not having menstrual symptoms, particularly pain, any more. There was also a sense of feeling released from something over which they had previously had no control and from something that they felt had at times been almost unendurable. Felicity put it like this:

...For so many years I seemed to be unwell most of the time. I had terrible ovulation pains and then premenstrual pain and then awful period pains. I couldn't have a good go at anything. Having a hysterectomy is a way out of feeling so unwell all the time. It's given me the freedom to make decisions and I don't have to be tentative any more...

(Felicity, Interview 2.)

For Felicity repatterning included the notion of being free to choose and plan to do some different things with her life. Hinemoa also felt that she was now free to do whatever she wanted:

...I have much more freedom now. I can do whatever I like. I feel so good now. I'm free now...I can't think of any other way to say it..it's very liberating...

(Hinemoa, Interview 2.)

Katherine talked about feeling like a prisoner when she was having periods. She felt afraid to leave the house because her periods were so heavy and she was afraid she would flood everywhere.

...they were so heavy that they really restricted my movements. I couldn't leave the house for a couple of days they were so heavy. It's so wonderful now. I can't believe how much freedom I've got. I wish someone had told me I could feel like this and I'd have had it done ages ago...

(Katherine, Interview 1.)

Some women expressed this sense of freedom as no longer having to be careful not to get pregnant. Some of the participants who were living in permanent heterosexual relationships felt a sense of increased freedom at no longer having to remember or feel the need to use contraception. Jane said:

...It has made such a difference, knowing that I won't get pregnant - a hundred percent knowing that is...it's done amazing things for our sex life...

(Jane, Interview 2.)

All the participants spoke about their improved sex lives following surgery. They attributed this to a feeling of freedom, of being able to have sex whenever they wanted. They said that this had come as a surprise to them because they had thought, been told or read that their sex lives would be adversely affected, especially initially.

...I was a bit frightened the first time. I thought the stitches would pop but it was marvellous still. It's got better and better because I can be spontaneous now...you know I don't have to think about it...

(Rose, Interview 2.)

Most of the women felt a sense of freedom about not needing to have cervical smears any more. It was of note that none of the women spoke of a need for continuing to have

regular vaginal vault smears despite some evidence in the literature that this is advisable. These women spoke about not having considered the sense of freedom that they might feel in relation to not needing cervical smears anymore, prior to having the surgery. Bet said:

...You don't realise how intrusive it is to have to have smears all the time until you don't need them anymore. It's hard to describe .. but it's a nice feeling..freedom is how I'd describe it...

(Bet, Interview 2.)

This sense of freedom in relation to not needing cervical smears any more was particularly apparent for those women who had previously had abnormal smears. Those women talked about waiting for the results and then going through this wait every three months and then having other diagnostic procedures performed and finally deciding that a hysterectomy was the best choice. They felt that they had not been given clear information about the likelihood of eventually requiring a hysterectomy and were resentful that they had "put up" with so much before being advised to have surgery. Judith said:

...I can't believe how different I feel...I don't dread the phone call every three months from the doctor, no more biopsies, not even any more smears...I feel whole and free again...it's wonderful. I wish I had known before that it would probably end up with a hysterectomy and I'd have had it done and saved myself all that other stuff.

(Judith, Interview 3.)

This feeling of increased freedom was pervasive throughout the data and as part of repatterning it was often accompanied by a review of lifestyle and values to establish different patterns.

## **LIFE REVIEW**

Participants frequently reviewed past decisions they had made about their lives, including their careers, their relationships and their values. Many contemplated changing goals and priorities as they learned to incorporate their feelings of increased freedom and their increased awareness of their life processes into a different pattern. It was as if the experience expanded beyond recovery from the specific surgery to a process of life review. There was a spiritual sense to this review. For instance Margaret felt that the surgery gave her an opportunity to confront her own mortality. She said:

...it made me realise my own mortality and all of a sudden I realised I wasn't in my twenties any more, I was staring my forties in the face. I wasn't worried about that, more I wanted to take a check and re-evaluate my life - it was as if I suddenly felt okay about making some changes...

(Margaret, Interview 3.)

Margaret decided to learn music. She had thought of doing so for some time and believed that the time of reflection following the surgery enabled her to make a promise and a commitment to herself. Two of the participants found that the surgery and recovery acted as a catalyst to change their careers and retrain. One of these women decided that drama which was her hobby would become her career. She said:

...I've been thinking about it for ages, sort of dreaming about it you know, but now I'm going to do it. I've decided that my life is worth too much just to sit around doing a job that um..I'm bored with. I'm going to get qualified and teach drama...

(Rose, Interview 3.)

Bet felt that as she had raised her children to senior secondary school and university age, and the experience of having a hysterectomy had given her time to contemplate a career as a secondary school teacher. She put it this way:

...I've decided I want to change my life and I don't want to be sitting around in another ten years regretting that I didn't do it. I have always loved maths and science so I'm going to finish my degree and get a teaching job. Call me again in two years and I guarantee I'll have done it...

(Bet, Interview 3.)

Whilst not all participants decided to make revolutionary life changes, there was a sense of review for the others that confirmed their lives were unfolding in an acceptable way and some of them decided that they wished to enrich their relationship with their partners or their children. Felicity and her partner decided that they were going to spend more time alone without other people. She said:

...having this time at home with P has made us realise how busy and involved we get with other people...it's like a treadmill really. We've decided that we're going to go away or at least, be alone together, for a weekend each month. It was wonderful being close again and really talking to one another. We hadn't realised how much we had missed that...

(Felicity, Interview 3.)

Jane on the other hand felt that the whole experience was overrated by women, doctors, and the media and the only thing about her life that she wished was different was that she had had the surgery earlier.

...I can at least swim and dive without thinking about it now and it means we don't have to plan our boating weekends around my menstrual cycle. I'm pleased I'm not the sort of woman who feels she has to go through a grieving process for her womb. I personally feel it has no value except for reproduction...I don't mean to be holier than thou though...I just think that it shouldn't be made to be this huge event. Having a baby was much more important to me..

(Jane, Interview 3.)

For Jane the life review process was more a sense of evaluating and measuring it against previous life events. The evaluation process undertaken by the participants enabled them to attain a balanced perspective about the importance of this experience as a life event.

## **BALANCED PERSPECTIVE**

It seemed important to all the participants that they achieve a balanced perspective about this as a life event in order that they could establish a new pattern. Comparing the experience with other seemingly similar ones was a common way of measuring, and comparing the experience to that of having children, was the most common. This helped the women to make meaning of the experience for themselves.

...it made sense to me and helped me get a sense of proportion about the whole thing when I compared it to having babies. There was a lot that was similar...I had Caesareans so the wound was the same and I remember the feeling of responsibility and feeling really grown up when I brought the baby home. I feel the same sense of this being the next part of the adult cycle...

(Felicity, Interview 3.)

The women who participated in this study all ranked the significance of the experience by comparing having a hysterectomy with other life events. As they made progress and established new patterns they ranked the experience as less significant. Twelve months after surgery the women no longer viewed it as a major event. They believed that as they picked up the threads of their lives and learned from the experience that the new patterns they established became their reality. Rose said:

...I knew I was really better when I didn't think about it any more. The new me was now the real me...it's difficult to explain really but I wasn't comparing the before with the after anymore. The after was me...

(Rose, Interview 3.)

Participants believed that they had recovered completely when the differences or new patterns became an integral part of themselves. Hence, repatterning involves a reframing and review process and occurs as a result of deliberative activities on the part of the woman. The achievement of repatterning is the culmination of assimilating and achieving harmony with regard to each woman's experience of recovery following early discharge after hysterectomy. Together, these three phases constitute the overall process of becoming better but different. In the next chapter this core category of becoming better but different will be examined.

## CHAPTER NINE

### DISCUSSION OF FINDINGS

This chapter concludes the thesis. In the previous five chapters the findings of this study have been presented with a focus on the conceptual categories and codes derived from the research involving ten women. The three conceptual categories generated from the data - assimilation, achieving harmony, and repatterning - tell a particular story. It is a story of women's experiences of recovering from hysterectomy following early discharge from hospital. Within grounded theory the findings need to be interpreted and integrated into a theoretical framework. The processes need to be drawn together into a core category which is broad enough to explain the main idea which has emerged from the research (Strauss & Corbin, 1990).

In the first section of this final chapter the core category, the process of becoming better but different, will be examined. This central category, or basic core variable, recurs frequently in the data, integrates and links the data together and helps to account for the variations that occur in the emerging theoretical framework. In the discussion which follows, the findings of the study are reviewed and integrated with the literature, the implications of the study for practice, education and further research are considered and the limitations of the present study are noted.

#### **THE PROCESS OF BECOMING BETTER BUT DIFFERENT**

Symbolic interactionism, from which grounded theory is derived, is based on the assumption that the relationship between self and society is an ongoing process of symbolic communication, whereby individuals create a social reality. Past personal and professional experience has sensitised the researcher to the significance of the recovery process following surgery in a person's life. Data generated by the present study confirm this significance for women having hysterectomies and being discharged early from hospital. Through interaction with their caregivers and significant others, women make meaning of their recovery from hysterectomy following early discharge from hospital. The process of becoming better but different, grounded in the data and collected through the observation and direct reports of recovering women, is proposed as a conceptual framework for nursing practice and education.

"Becoming" is defined as "to come into being" (The Concise Oxford Dictionary, 1964, p. 104), and involves alteration, transformation, change, and development (The Collins Thesaurus, 1984, p.58). "Better" is defined as completely recovered or well in a greater degree and "different" is defined as change or alteration (The Collins Thesaurus, 1984 ). Becoming better but different in the context of this study denotes a process that is engaged in by women following early discharge from hospital, in order to completely recover from the surgery and feel improved health and transformation. To accomplish this the women actively sought to regain control of their lives and their bodies following discharge from hospital. They felt personally responsible for their recovery process and actively participated in making it happen. It is through becoming better but different that a woman achieves a sense of closure or recovery from the experience of having a hysterectomy.

Becoming better but different is multifaceted and can be seen to involve the three phases of assimilation, achieving harmony, and repatterning. These are not linear steps but rather intertwined, simultaneously occurring phases (Figure 4, p. 92 ). At any particular time the woman may be focusing on any one or a combination of these phases. Becoming better but different occurs over time and at different rates depending on whether the woman has had a hysterectomy only or a hysterectomy and bilateral oophorectomy, or vaginal or abdominal surgery. The women who participated in this study all describe a process of recovery which follows the same pattern. The only difference to emerge from the data was that women who experienced surgical menopause took longer to become better but different and those who had undergone vaginal hysterectomies described a rapid recovery process. All participants believed that they had completed the process of becoming better but different within twelve months. For some the process took six to eight weeks and for others, those women who had hysterectomies and bilateral oophorectomies, up to twelve months. There was a sense that the process was never finished as the women lived with the differences and the differences continued to evolve of themselves.

The first phase of becoming better but different is conceptualised as assimilation. This involves an active and deliberate process of getting back to normal and measuring everything that is currently happening with what happened before surgery and their expectations of what should be happening. When the participants felt that they were back to normal ie. able to do everything that they were doing before surgery, they felt they were better. This phase is essentially a comparison of their expectations with reality. Feeling comfortable and "in-tune" with any differences they now feel results from successful accomplishment of assimilation.

Achieving harmony refers to the process of developing a mental structure that gives shape and support to one's picture of successfully recovering from hysterectomy after early discharge. This is accomplished by fitting many disparate pieces together. Achieving harmony confers an ability to see recovery in new and different ways much like a movie film is a process of moving forward with the events. Achieving harmony requires flexibility and awareness of minor changes and cues, thus providing continual reorientation to the immediate and unfolding situation. Successfully achieving harmony results in the woman not thinking about the differences resulting from surgery when making decisions about what to do or not to do. These two threads of becoming better but different are intertwined, occurring simultaneously and dependent upon each other.

Repatterning, another thread of the process of becoming better but different, refers to the process of evolving beyond the specific recovery from the surgery and seeking meaning from the experience. This phase fuses the thinking, feeling, and action of assimilation and achieving harmony and results in the woman incorporating the learning from this experience into her life pattern and making changes to accommodate the differences. The degree of intensity of involvement is flexible and varies with the needs of the individual woman as she engages in the process of becoming better but different.

## **BECOMING BETTER BUT DIFFERENT**

Whether having a hysterectomy is viewed as a crisis, an opportunity for growth, an evolutionary stage, a significant life event, or all of these, a woman's positive feelings are important in her successful transition of the recovery process. Women report a variety of physical and emotional experiences arising from their experience of recovery from hysterectomy following early discharge. They reflect on and think about their experience and the process of becoming better but different enables them to understand their experience and to put it behind them.

Women having hysterectomies face dilemmas. On the one hand they are expected to temporarily hand over control of their lives and bodies to medical specialists to perform the surgery and on the other, they are expected to take control of their own recovery process following a short stay in hospital. The process of becoming better but different is likely to be easier if a woman has experienced the type of hospitalisation and care that she expected or desired. Although women are grateful for the safe completion of the surgery, they still experience a great need to understand what happened and why, and verification that surgery was really necessary and not just a convenience. Thus, the discrepancy

between their expectations and reality remains problematic until the process of becoming better but different has occurred.

A woman's partner and support network play a vital role in the process of becoming better but different. Being with her, enables the woman's partner, family and friends to participate in discussions and assist her in clarifying events associated with the experience and her understanding of the experience. Her significant others also provide her with physical and emotional support. Her need to become better but different also involves her partner and support people. She needs to understand how they perceive the event, and as well, how they see her part in it. The process is not a linear one and was often described by the women as taking two steps forward and one backwards.

Women begin the process of becoming better but different when they make the decision to have a hysterectomy. They begin the process by visualising the changes and differences the surgery will make for them, and then planning for their recovery. They make a conscious effort to be fully informed about all aspects related to the surgery and recovery. They seek information from their medical practitioners, family, friends, women who have had hysterectomies, and the literature. They do this to both confirm their decision to have the hysterectomy and to develop a mental image of what to expect. Data from this study indicate that the women felt engaged with, and cared for, by their doctors and significant others and this assisted them to assimilate, achieve harmony and repattern successfully. Doctors and significant others were with the women in ways that they expected and hence there was little discrepancy between the expectation and reality.

It was evident in this study that no matter how clear, complete or accurate a woman's knowledge about having a hysterectomy, the very nature of having surgery and the intensity of the fear of anaesthesia and pain and of losing control associated with it, forces a dependency and a vulnerability on women. They must rely on caregivers to assist them to assimilate, achieve harmony and repattern their image of the experience of having a hysterectomy and recovery as it unfolds. This task is difficult when women are in hospital for a very short time and see different nurses for each shift and often, each day. The unfamiliar caregivers, the use of technical language and the reliance on high-technology interventions, rather than the one to one supportive caring all detract from the woman's ability to actively participate in her own recovery. As a result, the women felt that they were not engaged with or cared for by nurses as they had expected. They accommodated to and rationalised this, often assigning fault to themselves but were often left feeling guilty and sad about an experience that did not meet their expectations. The need to participate in decisions about their care and to be "done with" and not "done



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to" was important to the women in this study and they all chose to leave hospital as soon as possible to facilitate the process of becoming better but different. They felt that they regained control of their decision making when they went home and that their partners, families and friends assisted them to actively participate in their own recovery. As Lois said:

...The nurses were really like a series of one night stands. I didn't have a lasting affair with any of them.....you see it was different with the doctors. We developed a history, you know, we shared the drama, the ups and downs, the before, the middle and the after...

(Lois, Interview 1.)

Whilst hospitalisation was not part of this study, the women felt that their recovery was affected by the negative and positive effects of their hospitalisation. Those women in this study who had positive experiences of hospitalisation demonstrated an earlier and more intense focus on assimilating, achieving harmony and repatterning. They did not need to expend so much energy on balancing and reframing their expectations with their reality.

## **INTEGRATION OF FINDINGS WITH THE LITERATURE**

The experience of recovering from hysterectomy after early discharge from hospital as described in this study has many parts that are similar to those described in the existing literature. The way human beings cope with transition and how the environment affects that coping are fundamental questions in nursing (Meleis, 1991). Chick and Meleis (1986) noted that clients in transition share some commonalities. These were defined by them and by Meleis (1986) as a feeling of being disconnected from the usual social network and social support systems, of a temporary loss of familiar reference points or significant objects or subjects, of new needs that may arise, or of old needs that may remain unmet. and of old sets of expectations no longer congruent with changing situations. The authors believe that theories are needed to describe the nature of transitions and to provide guidelines for enhancing a perception of well-being. Becoming better but different offers guidelines for nurses to assist women through the transition of having a hysterectomy and being discharged early from hospital. This theory could also enhance a woman's sense of well-being as she makes the transition through her recovery by providing an explanation of that transition.

A sense of taking and being in control was part of assimilation and achieving harmony in this study. Recovery and control have been linked in previous work. Feeling out of

control increases stress responses, including physiological changes, that potentially could affect recovery (Bandura, Taylor, Williams, Mefford, and Barchas, 1985). Feeling out of control also affects psychological well-being which these women describe as part of their recovery. Johnson, Christman and Stitt (1985) assert that individual control beliefs affect perception of stressful events and therefore influence choices of coping strategies. Seeman and Seeman (1983) found that people who felt a low sense of control felt less optimistic about their health, had more illness episodes and longer bed confinements when they were ill and showed more dependence on their physicians.

A positive attitude or motivation for optimum recovery was frequently mentioned by all participants and was a strong area in the literature. Scheier and Carver (1985) noted a relationship between optimism and positive health outcomes. Taylor (1983) found that her research participants believed that a positive attitude would prevent breast cancer from returning. Allen (1986) and Gottlieb and Rowatt (1987) emphasised the potential that all individuals and families possess in relation to motivation which provides the basis for engaging in the work of healing.

Participants expressed a preference for accurate information. Wright (1985) found that accurate information helps patients to mobilise the required coping energy from their own resources. Many other authors have reported the need for accurate information. (Haslett, 1985; Webb & Wilson-Barnett, 1983a, 1983b; Webb, 1986). Martha Rogers stressed the importance of participating knowingly, which includes being aware of what one can do, and with that knowledge making choices freely and intentionally (Barrett, 1986). Roy (Roy and Andrews, 1991) implies that the person as an informed decision maker is valued.

Some nurse theorists have dealt with the issue of achieving harmony as it is described in this study. Neuman's (1982) Systems Model describes organisms in a process of homeostasis with an ongoing play between balance and imbalance and equilibrium and disequilibrium. Roger's (1970) concept of haemodynamics is similar to these participant's descriptions of achieving harmony. Newman (1986) proposes that the person is identified in terms of pattern and this pattern reflects the person's wholeness. Pattern is characterised by movement, diversity and rhythm, and awareness of these patterns occurs via energy waves.

There is increasing evidence to support the participant's notion that the mind and body are connected. Felton (1991) demonstrated that emotions, neurological responses, and immune responses all have chemical connections. This also supports the participants'

belief that attitude can influence healing. Nurse theorists have also commented on the mind-body connection. Roger (1970), Parse (1981), and Fitzpatrick & Whall(1989), have defined man as an irreducible whole, thus mind-body dualism is non-existent. Newman (1986) described the mind and body as manifestations of some larger reality and therefore one does not cause or control the other.

Repatterning, like the other categories, has strong support from the literature. Finding meaning in illness through values clarification, new learning, life review and continuing evolutionary movement are similar to Moch's (1989) theory of health within illness. She described this as learning about one's self and having the opportunity to reflect on the meaningfulness of life. Many of the nursing theorists have discussed the notion of growing through illness which the participants in this study called a life review. It was a major code within the category of repatterning. Peplau (1952) believes that an illness episode forces patients to reflect on or to evaluate their circumstances, which can lead to greater awareness. Travelbee (1966) identified illness as an opportunity to find meaning and to move to a higher level of functioning. She saw illness as a growth experience. Fitzpatrick & Whall (1989) viewed health as continuously developing, so awareness of the meaningfulness of life is heightened by illness. Newman (1986) considered illness as a manifestation of the total pattern of the individual and health as the expansion of consciousness. Rogers (1970) and Parse (1981) viewed humans as continuously evolving towards greater complexity. The women in this study felt that they had learned and developed a more acute sense of their own life rhythms and patterns when they had successfully repatterned.

Theoretical frameworks consistent with repatterning are plentiful but those relating to difference are limited. Heidegger (1962) and Gadamer (1960/1989), both suggested that all understanding is accompanied by preconceptions, by some pre understanding that mediates new ideas. When something foreign is encountered then the mingling of the familiar and unfamiliar offers opportunities to change one's way of knowing. Choices are difficult to make in light of the struggle inherent in being different. The participants reflected this in their passage through the process of becoming better but different. Once the participants had changed their knowing they believed that there could be no return to the sameness. The women in this study all viewed the difference positively but this does not account for other women who might view the difference negatively.

Although the literature supports the basic core variable of becoming better but different, it is important to appreciate that the emerging Basic Social Process is grounded in the data of the present study and did not come from the existing theory. The data clearly shows

that women assumed the responsibility for and the work of recovering when they were discharged from hospital. At the same time they were keenly aware of the context in which they found themselves changing, developing, altering, and learning how to become better but different. It is an open, ongoing process in which the woman learns to understand the world from encounters and interactions with others and from experiences within that world. These "symbolic interactions" feed back to the woman and act as a reference point which facilitates the achievement of personal integration and healing. As these experiences are assimilated into the person's self-image, new ways of perceiving the self within the environment emerge. Becoming better but different can be seen as a unifying process which gives meaning to the experiences of women recovering from hysterectomy following early discharge from hospital. The ongoing nature of human becoming parallels the experience of these women which they describe as never finished and never ending as they live with the difference.

## CONCLUSION AND RECOMMENDATIONS.

This study has generated data for the systematic development of the process of **becoming better but different**. Derived from the worlds of women recovering from hysterectomy following early discharge from hospital, the process addresses that which is most meaningful to the women. The current context of health care in New Zealand has changed rapidly over the last five years. Early discharge from hospital has placed the responsibility for recovery on the patient and has developed an ethic of self-care. It is not unexpected in this study therefore, that coping was individual and was expressed in personal ways. Early discharge from hospital following hysterectomy was a positive experience for participants in this study. They were anxious to be home from hospital as soon as they felt that they could cope without professional care. Going home was a significant factor in their feeling that they were getting better and making progress and all participants felt that they would recover more rapidly in the comfort and privacy of their own homes where they felt they regained their independence and autonomy.

The women had personal concerns as they considered their places in new situations. They coped in their own special ways and for many the process was frustrating as integration occurred through experiential learning. They had no professional carer with whom to discuss their progress and they all used the researcher as counsellor. Judith said when asked a question about what had been most helpful in her recovery:

...That's exactly what I've been thinking about since last time we talked. It's easy to say that they didn't do things and...um...I want the nurses to do what you've [researcher] done. I don't mean the research and things, I mean just to visit or a telephone call will do. This has been like counselling sessions for me and that has been really helpful. Other women I know wish they had been asked to do this research so they could have someone to talk to about things, to be there for them, you know, to help get things into perspective...

(Judith, Interview 3.)

The sentiments expressed in this excerpt were common to all participants. There was no comparison though with women who had not had a counsellor/ researcher visit them during their recovery. The participants all said that they would make the choice to have a hysterectomy again, given the same circumstances which lead to their decision. They felt that they would have had surgery much sooner had they had access to accurate information about the expected outcome. They all believed that nurses gave little or no information about the expected long-term recovery process or outcomes and that which was given was trite and perpetuated myths about negative outcomes of having a hysterectomy. *Becoming better but different* provides a more wholistic understanding of the experiences of women as they recover from hysterectomies following early discharge from hospital.

The women in this study felt that they emerged from the experience both better but different than they had expected and better but different than they had been prior to surgery. They all viewed the difference positively. Nurses who understand this process could assist women to pass through the passage of their recovery and make the becoming better but different easier. Using this conceptual framework in practice enhances and strengthens the personal resources of women, which is a valued philosophical premise underlying nursing care.

## **LIMITATIONS OF THIS STUDY**

The time constraints and scope of this study limit the findings in terms of generalisability. Findings may be limited by the contextual factors of the time limits of graduate study. If further time had been available, additional theoretical sampling and multiple comparison groups could have added depth to the theory and ensured that it was wide-ranging and broad based. There is clearly a need to research the experience of recovery from surgery following early discharge from hospital with a larger and more diverse population, with a variety of surgical procedures, and in a variety of settings. There is a need to understand whether men, children, elderly people and people from diverse ethnic groups share the

same experiences as the women who participated in this study as they recovered from surgery after being discharged early from hospital.

Being a researcher in one's own cultural context can itself be a limitation (Field, 1989). It is possible that familiarity with a particular group will mean that important pieces of data may be overlooked. Nevertheless, the study findings provide tentative implications for nursing practice, education, and research.

## **IMPLICATIONS FOR PRACTICE**

The aim of nursing research is to improve the quality and relevance of the care offered by nurses. This study proposes the process of becoming better but different as a means to achieve greater quality of care in nursing women who are discharged early following hysterectomy. Each phase of the process discusses issues raised by the women and an understanding of these will enhance the way nurses both prepare women for discharge and provide care following discharge. The level of abstraction encourages application to other situations where patients are discharged early from hospital.

At the very least, awareness of the process of becoming better but different, may sensitise nurses to the impact they can have on the recovery process of women discharged early from hospital. In addition, knowledge of this process has the potential for making the care offered by nurses more congruent for each woman and her family. Thus, although the process of becoming better but different addresses the period following discharge from hospital, knowledge of the process may mean that nursing care in the preadmission and hospitalisation period can be altered to enhance the recovery of women. It could lead to different preoperative, hospital, and discharge care.

This conceptual framework emphasises the need the women felt to be known by the people caring for them. The difficulty for nurses to do this, with the way nursing care is offered in the present fragmented system is acknowledged. Nevertheless, the necessity remains for nurses to be aware of a woman's past experiences, her knowledge about the surgery and her plans and expectations for hospitalisation and recovery. The present way in which nursing care is offered to short stay surgical patients, limits options for practice and detracts from the nurse as an expert practitioner. Knowledge of the process of becoming better but different may provide the opportunity for creative ways of practising and may provide a means of making visible and defining nursing expertise.

The importance of one-to-one care by the nurse and continuity of care from the preoperative through the recovery period are issues which require attention from nurses. This would enhance nursing expertise and ensure that women are given accurate and useful information when they are discharged early from hospital. Most of the problems identified in this study are of an organisational nature and pose challenges for change in the organisation and delivery of care to women who are discharged early from hospital following hysterectomy. Case management or independently run nursing units, staffed by nurse specialists who provide continuity of care are two examples of change that could be considered.

The 'fit' and 'work' of the framework has yet to be tested in actual practice. Discussions held with women and practising nurses provide initial support for the process of becoming better but different, as valid and important. It is recognised however that further research is needed.

## **IMPLICATIONS FOR EDUCATION**

In this study a grounded theory approach has been used to generate a conceptual framework of women's experiences of recovery from hysterectomy following early discharge from hospital. Use of this framework in education would promote a more appropriate, women-centred approach to care, thus women and nurses would be partners in the recovery process. Nursing care partnership (Watson, 1988) is founded on the belief that healing or harmony of body-mind-soul is facilitated through caring. This type of partnership would aid in socialising nurses into the common values of nursing that affirm human dignity, freedom, and wholeness.

In addition to promoting women-centred practice, the process of becoming better but different reestablishes caring as a central concept in nursing, and provides both a conceptual and practical way of addressing caring in relation to women who are discharged early from hospital. It directs educators to focus on the impact that the nurse and women have on one another. There is a need for the educative process to aid in the development of a strong sense of identity in nurses and to surface the critical role they play in the care of short stay hospital patients and their recovery processes. Teaching the process of becoming better but different could aid in the accomplishment of that task.

## **IMPLICATIONS FOR RESEARCH**

The present study represents the process of women recovering from hysterectomy following early discharge from hospital. The conceptual framework, identified as the process of becoming better but different, is grounded in the data and therefore in the worlds of the women. It has not yet been tested in other settings. There is a need for similar studies, in a variety of settings, and with different populations.

The process of becoming better but different offers nurses the opportunity to reflect on their own practice and, in addition, offers tentative support for previously researched constructs such as case management and independent nurse practice. As this research has described the experiences of women recovering from hysterectomy following early discharge, testing of the conceptual framework is necessary, as are studies that address each of the conceptual threads of the process and their dimensions.

An innovative research endeavour would be to test the theory in action by setting up a nursing unit whereby the process of becoming better but different could provide the framework for practice for short stay patients. In addition to providing the opportunity to test the value of the process with regard to a woman's experience of her care, such a unit could provide an opportunity to educate nurses and provide excellent clinical teaching experience. It would also provide an opportunity to assess the expert practice of nurses.

## **CONCLUSION**

The process of becoming better but different derived from the study data is proposed as a possible framework for nursing practice. It is a process that provides a conceptual framework for describing recovery from hysterectomy following early discharge from hospital. Through the interweaving of the threads of assimilation, achieving harmony, and repatterning the process of becoming better but different is completed.

## APPENDIX 1

### Information for Prospective Participants.

My name is Glennis Birks. I am studying for a Masters degree at Massey University, Palmertson North. My particular area of interest is discharge from hospital within five days of undergoing hysterectomy. I am seeking your help in this project by asking you to agree to an initial meeting with me. In this meeting I will give you in-depth information about the study, answer your questions and tell you possible implications of your participation. If you agree to participate I will also ask you to sign a consent form as evidence of your willingness to participate in this study. I anticipate at this stage that your involvement will be for one or two hours of interview, or until such time as you and I feel that you have no more to tell me about your experience.

The interviews will be audio-taped (with your consent), and the tapes will be stopped and started at your discretion. Any subsequent interviews will begin with a re-negotiation of your willingness and consent to participate. The information collected in the course of this research will not be able to be traced back to participants, nor will participants be identifiable in the final thesis.

If you have any questions, please do not hesitate to contact me or my supervisor, Valerie Fleming.

Contact : Glennis Birks,  
Lake Domain Drive,  
Hamilton,  
Ph (07) 8380231 (collect).

Supervisor: Valerie Fleming,  
Ph (06) 3504323.

## APPENDIX 2

### Consent to Participate in Research Project.

I ..... have had a full explanation of this research and its purpose has been explained to me in detail and to my satisfaction. I understand that by giving my initial consent, I may withdraw from the project at any time without this affecting my health care. I also understand that my continued participation will not affect my health care. I understand that the information I choose to share will not be revealed to anyone other than the researcher and her supervisor. The final thesis will be a public document in which I will not be able to be identified.

I hereby give my consent to participate in the project:

#### **Women's Experience of Early Discharge following Hysterectomy.**

Participant; **Name:**.....

**Signature:**.....

**Date:**.....

Researcher; **Name:**.....

**Signature:**.....

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