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RECOVERY:

A JOURNEY AND A DESTINATION

A Phenomenological Study of
Older People Recovering at Home After Surgery

A thesis presented in fulfilment of the requirements
for the degree of

Doctor
of
Philosophy

Massey University
Palmerston North, New Zealand

RAYNA MARGARET WOOTTON

2002



TO WHOM IT MAY CONCERN

This is to state the research carried out for my Doctoral thesis entitled
"Recovery: A Journey and a Destination" in the School of Health Sciences,
Massey University, Palmerston North, New Zealand is all my own work.

This is also to certify that the thesis material has not been used for any other
degree.

Candidate

Rimlvootton

Date


4 December 2002



TO WHOM IT MAY CONCERN

This is to state the research carried out for the Doctoral thesis entitled "Recovery: A Journey and a Destination" was done by Rayna Margaret Wootton in the School of Health Sciences, Massey University, Palmerston North, New Zealand. The thesis material has not been used for any other degree.

Supervisor



Date



DEDICATION

This thesis is dedicated to

my mother

Rayna Jean Wootton

and

my brother

David Keith Wootton

both of whom died in 2001

ABSTRACT

As world populations age there are more older people having surgery. Hospitalisation for surgery is commonly for the day only or short stay, so most of the period of recovery is spent at home where the older person lives either alone or with a spouse / partner.

The purpose of this study was to understand the phenomenon of recovery at home for older people who have had surgery.

Thirteen older people, ten men and three women, were interviewed after they returned home following surgery. Four interviews were conducted over an eight week period. Participants were aged between 69 and 88 years with most being in the 70-80 years age group.

Hermeneutic phenomenology underpinned by the work of Heidegger was used to examine the phenomenon of recovery as experienced by the participants. The essence of recovery was revealed as **enduring my world, caring for and about myself, relating to people and place in my world, and continuing my life**. These arose out of four themes – **disturbance of one's being-in-the-world; being concerned with; being-with others; and recapturing being-in-the-world**. The four lifeworld existentials of **lived time, lived body, lived other and lived space** were used to illustrate the nature of recovery for the older person. Lived time was of particular significance. Age per se was not perceived by participants as a major factor affecting their recovery. Being at home, the effects of surgery on the body and on daily life, being actively involved in their recovery, the support of others, and knowledge and understanding, were significant in the participants' experience of recovery. Recovery was revealed to be both a journey and a destination.

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TEXT CONVENTIONS

The following information explains the meaning of abbreviations and conventions used in the thesis.

Spelling: There are some differences in spelling of particular words, for example, those where alternatives are in common usage. Two such examples are aging / ageing; characterise / characterize. Differences occur in quotations and references from various sources.

Conventions Relating to Excerpts from Participant Interviews

Names: All names used to refer to study participants, are pseudonyms. In the case of family, friends or health professionals the relationship or position rather than a pseudonym are used, for example, [husband] or [surgeon].

Excerpts: Excerpts from participants' interviews are identified by pseudonym, interview number and page reference to the transcription, for example, (Lucy, 2: 5).

Italics: Where sections of interview data are reported, the participants' words are given in italics.

(Italics): In interview excerpts the researcher's words are given in italics inside parentheses.

- (Parentheses):** Included in sections of participant speech indicate such things as the action of a participant, for example, (laughs), or the type rather than name of an institution, for example, (rest home).
- [Square Brackets]:** Are used when a clarifying or explanatory comment has been added or to indicate where a word(s) has been unclear a “best guess” has been provided.
- Bold:** Words in bold in a participant’s speech denote particular emphasis by the participant.
- ...** Indicates a pause made by the participant in speech.

INTRODUCTION

My interest in the recovery of older people was aroused in 1993 when my mother was diagnosed with colon cancer and, at the age of 78, underwent her first “major” operation (her only other experience of surgery was a minor operation 21 years previously). I took a week’s leave from work to care for her after she came home from hospital. Though I lived with my mother and would be at home with her apart from when I was at work, I was concerned how she was managing when I was not there. I remember thinking about older people who lived at home by themselves and wondering how they managed. Who helped them? If they were married, their spouses were most likely of a similar age or older. My experience with my mother and her brothers and sisters meant I knew older people had health concerns, which, though not necessarily interfering significantly with their everyday lives, were present and had to be dealt with.

I considered too the effect on the children when an older parent has surgery, especially when children are working and/or may have other family responsibilities. About this time as a nurse educator of many years I became disillusioned with the changes occurring in the health and education sectors. This, together with my observation of the care my mother received in hospital and the number of older patients in a very busy surgical ward, turned my focus to the experience of the patient. What was it like to experience surgery as an older person? How did they cope when they went home? I was drawn to the patient as a way to refocus and regain a lifelong love of and commitment to nursing.

So began my long journey of writing this thesis during which my mother, in her early 80s, and my aunt, in her late 70s, experienced several operations after unexpected major threats to their health. My topic seemed to develop of its own accord – the older person’s recovery at home after surgery. I became attuned to the topic. Some aspect of it would come to my notice in

a variety of ways. For example, if there was anything in the newspaper about older people it would “jump out” at me, as would a television programme or film about older people. My newspaper file grew rapidly. 1999 was the Year of the Older Person and I seemed to be immersed in the experiences of the older person. As time went on the words I read, pictures I saw, experiences I had, “spoke” to me in that I began to see the connections to the phenomenological philosophy I was using in my inquiry.

My background reading opened up many areas of interest in relation to the older person – aging, socio-political aspects, health services, physiological changes, fitness and health, disability and chronicity, support agencies, carers, nursing, demography. A growing aging population, living healthier, living longer, leads to more older people having surgery and being discharged from hospital on the same day of their operation or after only a short time in hospital. Changes in health services over the past 10 or so years have led to older people going home sooner than previously and not so far advanced in their recovery from their surgery. Support from family members and/or health and social agencies may be required. Family support is most likely to be provided by the spouse, daughter, or daughter-in-law. This was the basis from which my study began. I wanted to know how older people dealt with recovery once home, what their experience of recovery was, what it meant for them.

A review of research on the older person's perception of health and meaningful life provided useful information. Research about the recovery of older people focused on specific types of surgery, for example, hip replacement; problems which arose, for example, limited mobility, dependence in activities of daily living; spousal relationships; support required; or a nursing aspect of some sort, for example, communication and interaction. Much can skew the representation of the older person toward a view of a debilitated chronically ill group and the assumption that aging is a time of decline. Some research of the recovery period covered an age range that included older people but it was not always specified how many older people were included. Other studies identified a small sub-

sample of older people within a larger sample to present information. Uitenbroek (1996) comments:

Many of the medical and health promotion studies are based on small and often unrepresentative groups. It is not uncommon to generalize the findings in younger age groups, particularly the middle-aged, and apply to all older age groups.

(p.24)

Rowe and Kahn (1987) cited in McIntosh (1996) suggest that, "the heterogeneity of older people has been ignored in favour of age-related averages, which ignore the effects of individual behaviours, characteristics and lifestyles" (p.32). McIntosh discusses the difficulties in defining old age for research purposes and the problems inherent in data collection where the instruments used have been standardised in different age groups.

Early in my studies I was directed toward Heideggerian phenomenology as a possible method for my topic. Reading Heidegger's seminal work "*Being and Time*" revealed complex philosophical thought presented in a new language but my understanding was helped by the work of other authors who commented on his work, for example van Manen, Guignon, Spiegelberg. Reading other of Heidegger's works added to my knowledge and understanding. The writing and research of a number of nurses enabled me to see the applicability and usefulness of Heidegger's work in the health field.

Initially my topic was couched in terms of the *experience* of the older person's recovery, but I quickly realised my focus should be the phenomenon of recovery and the experience was the route to find the meaning of recovery for the older person. The phenomenological studies I read revealed insights into the meanings the experience had for the participants. These studies attracted me because I felt I gained greater understanding of how the experience had affected the participants' lives, for

example Walton's 1995 study of the lived experience of schizophrenia, about which my knowledge was scanty.

Phenomenology as a qualitative method of inquiry seemed to me to "fit" my topic. It lay in the everyday experience of the person – I wanted my focus to be the older person. As a nurse and educator who had worked in surgical areas, I knew health professionals had a brief exposure to people having surgery and recognised this lessened their opportunity to understand the day-to-day experience of recovery from an operation in the period beyond hospitalisation. From a nursing viewpoint gaining a better understanding of recovery beyond hospital would help to better prepare the person for recovery at home. From the older person's viewpoint, there would be recognition that there was more involved in their experiences than the medical or nursing stories could tell. The older person "owned" the experience – it was their operation, their recovery – medicine and nursing input contributed only a small part to their story. What the experience meant to the older person was the crux of the story. Cassell (1992) in writing about the nature of suffering states that, "in general we do not act or react because of events but because of their meaning" (p.6). Meaning has two aspects – significance and importance – and it is what it represents to the person that is important.

For Heidegger, phenomenology was primarily a method to uncover the meaning of Being, the object of his philosophical research. Uncovering, taking the hidden out of hiding, implies that what is to be uncovered is already present but not visible. Heidegger's method is used to study the nature or essence of phenomena by uncovering and describing their structures, and interpreting their meaning. Thus the phenomenon I studied was recovery; the context was the lived world of the older person at home; the meaning of recovery for an older person was revealed to me through the older person's sharing of the experiences which were significant / mattered / cared about / concerning. Considering the experiences from the older person's perspective enabled me to gain new insights into an already known phenomenon. What was presented to me was the meaning of

recovery as the older person experienced it, the meaning ascribed to events. Campbell (1994) writes about communicating the experience of illness through the arts. In talking about presenting art he makes three points about presentation: “being ill means that we are present with the experience of illness; art re-presents illness to give meaning to the experience; artists (and patients) call their audiences (and carers) to be present with their experience (of illness)” (p.10). Campbell’s exposition of the act of presenting art mirrors the work of the researcher, that is, “taking an experience and conveying it through a medium to the present – to make present an understanding of an experience of the past. When we represent illness [the phenomenon] in art [text] we are therefore bringing our interpretation of the experience of illness [the phenomenon] into the present” (pp.10-11). He states art [text] is re-present-ational and approximates experience; that we are present with the illness [experience phenomenon] again, but in a new way and in a new context. Art [phenomenology] recontextualises experience.

THESIS STRUCTURE

In the aim of studying the phenomenon of recovery the thesis is structured as follows:

Chapter One considers literature pertaining to the older person, surgery, and recovery.

Chapter Two considers phenomenology and the work of Heidegger and other writers in relation to the philosophical framework in the study.

Chapter Three describes the research process including information about ethical considerations, access to participants, the collection and analysis of data.

Chapter Four describes the contexts in which recovery from surgery occurred, and age in the context of the study.

Chapters Five to Eight are concerned with the interpretation of the data and each is based around a theme and sub-themes:

Chapter Five examines the effect of the disruptions which occurred in the everyday world of the older people.

Chapter Six presents what participants were concerned with and about in their daily lives.

Chapter Seven describes relationships and communications which were of significance to the participants.

Chapter Eight is concerned with the decisions, choices, actions and issues which the older people dealt with as they lived through their recovery.

Chapter Nine discusses the nature of recovery as perceived by the participants and as interpreted by the researcher.

Chapter Ten considers issues arising from the study including the research process, aspects of the data, implications for nurses, the study's effect on the researcher, and possible topics for further research.

Chapter One

THE AGING POPULATION AND ASPECTS RELATING TO SURGERY AND RECOVERY

Chapter One reviews the literature related to the study topic. Literature concerning factors surrounding an older person undergoing surgery and its aftermath is discussed under the following headings: the aging population, surgery, hospitalisation, transition from hospital to home, being at home, and concepts of recovery.

THE AGING POPULATION

McIntosh (1996) states there are difficulties in defining old age for research purposes (p.32). Definitions of how and who is classified as an older person vary. Chronological age has been used to describe levels of age such as the younger old (65-74), middle old (75-84), and oldest old (85 years and over). Brunner and Suddarth (1988) use the term late adulthood to cover the 65-84 age group. More recently the 'first' through to the 'fourth' ages have arisen to describe people according to the activities in each period of life. The 'third' age has been differentiated from the 'fourth' age which is described as the time when a person will need increased assistance / support from others for daily life activities. The 'third' age refers to a time when "conventional work" and child rearing is completed and it is proposed that two or three decades of active living lie ahead (Canterbury Development Corporation, 2002). Terminology used to refer to people in their later years includes older person, the elderly, the aged, elders, geriatrics, the 'olds'. Older person is the term used in this study except where specific writers have used an alternative term.

Worldwide populations are aging. In a number of countries 65 is the age commonly used to determine the parameter of the older person (Brody, 1981; Brunner & Suddarth, 1988; Fletcher & Lynn, 2002; King, Figge & Harman, 1986; Melanson & Downe-Wamboldt, 1987; Statistics New Zealand, 1995). In New Zealand it is projected that by 2051 those aged 65 years and over will comprise 26% of the population; life expectancy is increasing and although people will live longer and experience longer periods of independence they may have more years with a disability (Fletcher & Lynn, 2002). Older people, and especially those who are aged 80 years or more, are high users of hospital services. The number of older persons undergoing surgery is likely to increase, and as they grow older people will require more surgery than those in other age groups (Dean, 1987; Jackson, 1989). The advances in surgical and anaesthetic techniques means surgery poses less risk than previously for older people.

In New Zealand, over the last 10 years hospital admission rates for those people over 65 years have been increasing at a faster rate than for other age groups with the highest increase in people aged 85 years and over. Fletcher and Lynn (2002) comment that the increase is partly due to day treatments and shorter hospital stays which allow more people to be treated.

SURGERY

Reasons for Surgery

In New Zealand the major reasons for hospitalisation of the older person have been identified (according to age) as heart disease, cancer, digestive disorders, hip replacement, cataracts (for the 60-74 age group), and for those aged 75 and over, heart disease, hip problems, cataracts, respiratory illness, senile dementia (National Advisory Committee on Core Health and Disability Support Services for 1993/1994, 1992, p.96). Taking into account the high volume clusters in terms of number of operations and costs, the

major types of surgery carried out are, lens replacement for cataract, major hip replacement, and coronary artery bypass grafts. Not defined in these clusters is surgery for cancer though cancer is the cause of 25% of all deaths. Ministry of Health figures for 2000/2001 indicate that diseases and disorders of the circulatory system are the most common cause of hospitalisation: 65-74 (25%), 75-84 (28%), with musculo-skeletal conditions next most common for these age groups. For people 85 years and over musculo-skeletal conditions are most common, followed by circulatory conditions. This information includes both medical and surgical conditions (Fletcher & Lynn, 2002).

Benefits of Surgery

The benefits of surgery for the older person include increasing longevity, enhancing the quality of life, and being given a "second chance". The degree of benefit is affected by a number of factors, for example the level of overall functioning pre-operatively, reason for surgery, length of hospital stay, type of in-hospital care, and preparation and support for both patient and family after discharge.

Rankin, Gortner, Gilliss, Shinn, and Sparacino (1986) studied over a six month period a small sub-set (11) of people aged 70 and over who had undergone cardiac surgery. Their findings indicated surgery was safe and survival was similar to that of the younger sample. The older group recognised more benefits of surgery and seemed satisfied with less functional improvement than the younger group. Surgery was seen as a means to increase longevity and enhance quality of life. From their findings and a review of other reported surgical outcomes, Rankin et al. considered that the older adult was a good candidate for cardiac surgery. This view is supported in the 1993 Consensus Development Conference Report relating to cardiac surgery. It stated that excellent results had been obtained in treating selected patients over the age of 70 and this indicated it would be wrong to restrict this surgery to patients below an arbitrarily determined chronological age (p.13).

Carroll (1995) studied a group of older patients (65 to 87 years of age) who had cardiac surgery. She found their self-care agency (ability to care for oneself) increased over the 12 week period of the study and was high in comparison to other patient populations. Two possible reasons were given for this – older people recognise healthy outcomes of positive practices and self-care, and the surgery itself acts as a cue to action by giving the older person a second chance so increasing receptivity to changing health practices.

Whereas there are positive outcomes of heart surgery for older people, outcomes for patients having surgery for hip fracture are not so positive. Mossey, Mutran, Knott, and Craik (1989) comment that there is a high incidence of hip fracture in older people, that 70-80% are women over the age of 60 years, with women 85 years or older being the highest risk group. Only 12-23% return to pre-fracture ambulatory status and/or functional independence. Mortality rates for the first 12 months are 12 to 20% higher than age and sex groups in the general population.

HOSPITALISATION

Concurrent Health Problems

The older person is likely to have a number of health problems other than that for which they have been hospitalised (Jackson, 1990; Lorensen, 1995; Marshall-Burnett, 1986; Neville & Alpass, 1999; Statistics New Zealand, 1995). This may be a factor that affects surgery and recovery. Older people are more likely to have multiple risk factors, for example 61% of males and 81% of females have two or more risk factors. In a household health survey carried out in 1992-1993, although 70% of people aged 65 and over reported either a long-term illness or disability, nearly three-quarters reported their health as either “excellent” or “good” (Statistics New Zealand, 1995, p.80). Dealing with health problems but regarding oneself as having “good” health is reported by other writers (Dean, 1987; Hill, 2001; Viverais-

Dresler & Richardson, 1991). Campbell (1993) comments that age is associated with increasing prevalence of chronic disease and that older people have fewer physical and social reserves to deal with acute problems. One of the proposals to improve health care for older people is to design acute care services to meet their needs. According to Brody (1981) while most older people are not sick or dependent the incidence of physical and mental impairments leading to dependency rises with advancing age. Brody suggests that about 8-10% of non-institutionalised elderly are as functionally impaired as those in institutions.

Special Needs of the Older Person Having Surgery

As for any patient undergoing surgery the nature and seriousness of the condition and the person's fitness and general health status will affect the outcome. Hogstel and Taylor-Martof (1994) consider that many older patients, "tolerate elective surgery quite well *if* they have carefully effective pre and post-operative nursing care" (p.288). They suggest it is the time before and after surgery which may be more critical and more dangerous than the surgery itself. Dean (1987) considers, "assessment of the special needs of this population [older patients] is critical to planning care" (p.7). In the pre-operative period several writers support the need for assessment including on-going monitoring of body systems, the older person's response to both psychological and physiological stressors, the effect of medication, and the information the older person has about the operation (Gray-Vickrey, 1987; Hogstel & Taylor-Martof, 1994; Horattas & Haught, 1992; Jackson, 1989).

Particular concerns intraoperatively are hypothermia, positioning, care of limbs and skin, and the effect of anaesthesia (Hogstel & Taylor-Martof, 1994; Jackson, 1988, 1989). Post-operatively, the older person's body systems must be carefully monitored as failure in one system can result in a chain reaction in other systems. The effect of pre-existing conditions must be taken into account as well as the increased risk of infection, sleep problems, delirium and confusion. Some patients may need to spend time

in an intensive care unit (Gray-Vickrey, 1987; Hamner & Lalor, 1983; Hogstel & Taylor-Martof, 1994; Jackson, 1989). Communication, especially touch, was identified as important for patient care (Hamner & Lalor, 1983; Jackson, 1989).

Short-Stay Hospitalisation

Current health policies in several countries provide for short stay hospitalisation including day surgery, and discharge home for recovery. Fletcher and Lynn (2002) report length of time in hospital has reduced for older people although there is evidence of a flattening out in this reduction in more recent years. One possible reason for the flattening out in length of stay is the increase in day treatment. While there are benefits of shorter stays including savings in costs and resources for hospitals (Dean, 1987; Hogstel & Taylor-Martof, 1994), Fletcher and Lynn (2002) comment, "it is not known to what extent shorter lengths of stay in hospital have impacted on demand for disability support services, such as home support and residential care, or on readmission rates" (p.78). The economic advantage of early discharge and the benefits of shorter hospital admissions must be balanced against risks inherent in discharging older patients "quicker and sicker" (Tierney, Worth, Closs, King & Macmillan, 1994). After surgery older people may have a greater incidence of problems and their recovery may be protracted (Hamner & Lalor, 1983; Hogstel & Taylor-Martof, 1994; Horattas & Haught, 1992; Jackson, 1989; Rankin et al., 1986).

Short stay hospitalisation and advances in surgical techniques and treatment contribute to positive outcomes of surgery for older people. In addition meticulous attention must be given to pre-operative, intraoperative, and post-operative assessment and care to take regard of the special needs of older people.

TRANSITION FROM HOSPITAL TO HOME

Discharge Planning

Older people may be discharged home or to a non-acute hospital or a rest home for a period of convalescence. Many older people live alone or with an elderly spouse and may or may not have family support to help care for them. As their period of recovery may be protracted unless there is adequate social support from either or both spouse / partner / family (informal) and health and social services (formal) carers, further health and psycho-social problems may arise. Preparation for discharge is therefore important for the older person (Gray-Vickrey, 1987; Jackson, 1989). A number of studies highlight inadequacies in this area of health care. Inadequacies include lack of documentation and insufficient or poor information provided (King & Macmillan, 1994; Moser et al., 1993; Tierney et al., 1994). Maintaining self care abilities, and assessment prior to discharge are important as some older persons have difficulty with personal and household activities of daily living once home even though they may have appeared to cope while in hospital (Mossey et al., 1989; Waters, 1987; Williams, Oberst, & Bjorklund, 1994).

Information

Providing information to the patient and family is accepted as an integral part of patient care, however, in practice this is not always carried out appropriately.

Gallop, Lancee and Garfinkel (1990) state that, "a review of the empirical literature on nurse-patient communication reveals that nurses tend to offer advice and provide information and pay little attention to the subjective experience of the patient." (p.7). In relation to nurses' communication skills there were, "generally low levels of inquiry with regard to feelings and perceptions of patients" (p.8). Yates (1995) in her study of social support

and short and long-term recovery outcomes in men with coronary heart disease, found that information provided by health care providers (nurses and doctors) was not always satisfactory. She suggested the timing of information and the way in which it is given might be critical in assisting patients in recovery.

In almost all of the studies Moser et al. (1992) included in their review of literature about recovery from cardiac infarction, informational needs were ranked as having the highest priority. Orzeck and Staniloff (cited in Moser et al., 1992) found that postmyocardial infarction patients and their wives had similar needs for information and that for both groups cognitive needs ranked higher than affective needs. The study by Moser et al. identified that informational needs ranked highest among patients recovering from medical and surgical cardiac conditions and second highest among the spouses. Many of the highly ranked informational needs were unmet. Seventy percent of patients and spouses did not receive information about action to take in an emergency.

Tierney et al. (1994) found that two weeks after discharge 47.7% of patients said they had not been given any information in hospital on any topic in preparation for discharge. Their carers supported this, indicating that they and the patient had been inadequately informed. The researchers were aware that, before discharge, information had been given to the patients and carers but it had been forgotten. Three months after discharge 19.1% said they wished they had been given more pre-discharge information. Jackson (1990) found that the patients in her study could not recall being given any information about drugs or their side effects prior to their discharge from hospital.

King and Parrinello (1988) state, "the ability to anticipate possible symptoms can be helpful to patients in making appropriate plans for activities during the recovery period" (p.708). Arising from their study of recovery from coronary artery bypass grafting they identified information which would allow patients to assess their progress, for example the extent

and degree of fatigue after discharge, potential sleep disturbances, and expectations of resuming activities.

Despite discharge planning being considered important it is often inadequate in meeting the older person's needs. How and when the older person and carer are prepared for transition to home highlight the adequacy of the quality and amount of information provided.

BEING AT HOME

In New Zealand the majority of older people aged between 65 and 74 live at home with no assistance. Approximately 50% of those who are 85 years and older live at home with assistance. There is a growing trend for older people to live alone, with women more likely to live alone than men (Fletcher & Lynn, 2002). Many older people prefer to remain in their own homes and wish to return there after hospitalisation (Hanger, Conway, & Sainsbury, 1993; Marshall-Burnett, 1986; Waters, 1987). An older person who has had a period of hospitalisation is likely to be returning to a home where they live alone or with a spouse of similar age (King & Macmillan, 1994; Statistics New Zealand, 1995).

A number of studies indicated that recovery was protracted for the older person (Carroll, 1995; Mossey et al., 1989; Rankin et al., 1986; Williams et al., 1994). Rankin et al. found that the subset of elderly patients who were in hospital for cardiac surgery had greater functional impairment than the larger group but there were no significant differences in the two groups in the operative course and post-operative complications during the hospital stay. Once home, however, they had a greater incidence of problems, recovery was protracted and fatigue persisted longer. Mossey et al. (1989) found that recovery after hip replacement was more limited as age increased.

Williams et al. (1994) also studied convalescence after hip fracture and

looked particularly at women over 60 years of age who were relatively healthy before their fracture. The researchers concluded that recovery can take a substantial time even for a person who functioned at high levels before sustaining the fracture. For example, while 75% of women had been able to walk unaided before their fracture, 14 weeks post-fracture only 27% could walk unassisted. Carroll (1995) found recovery for older patients who had coronary artery bypass surgery was protracted and that while self-care agency increased over the 12 weeks after discharge, only 54% felt back to normal by that time. Carroll comments on the lengthened recovery trajectory in regard to setting unattainable expectations. Her comments relate to both patients and nurses. They are equally applicable to other health professionals and others associated with the older person's recovery.

The lengthened recovery trajectory is compounded by the plateaux, which may occur during the recovery process. It appears that while some aspects of recovery may improve at an even pace others improve for a period of time and then little or no further progress is made over a period of time. This has been a cause of frustration and fatigue for the older patient. For example Williams et al. (1994) found in terms of mobility after repair of hip fracture the most rapid gain was in the period two to eight weeks after discharge while in the eighth to fourteenth week there was a relatively small gain; that while there were still gains they were at a slower rate. Carroll (1995) found that climbing stairs plateaued at six weeks for patients who had coronary artery bypass surgery but she raised the issue that this may have been due to the particular home environment rather than the ability of the older persons concerned.

A British study indicated feeling weak and tired was one of the main reasons 19.7% of older patients gave for not feeling ready for discharge from acute medical and surgical wards (Tierney et al., 1994). Three months after discharge 27.7% were still complaining of fatigue. Williams et al. (1994) point out that factors such as fatigue have the potential for intervention, that fatigue and lack of vigour are common during illnesses

and after surgery and that in the case of hip surgery, having to cope with assistive devices can, in itself, be fatiguing. The degree of fatigue may be compounded for those older patients who may in addition have conditions that are disabling in some way. Rankin et al. (1986) found fatigue persisted longer for older patients in their recovery from heart surgery. The older caregiver spouses in this study reported more fatigue than the younger caregivers. The degree of fatigue can be affected by a number of other factors for the older person; age, type of surgery / illness, functional status, social support, but fatigue is a factor that must be recognised and managed to aid recovery.

A number of writers point to the increasing emphasis on a high turnover of patients in the health services and the implications this has for older people returning home (Bebbington & Charnley, 1990; Jackson, 1990; Tierney et al., 1994; Waters, 1987). Waters (1987) commented about the focus on 'community care' with the increased likelihood of greater numbers of elderly discharged from hospitals before full recovery has taken place and the implications this has for both formal and informal carers. Early discharge from hospital underscores the need for intensive home monitoring for the elderly who have undergone cardiac surgery according to Rankin et al. (1986).

Bebbington and Charnley (1990) express concern about the run down of institutional facilities, which occurred in Britain as a result of changes in health and social policy. Geriatric and residential care places and other in-patient facilities were all reduced. They set this against the population increase in people aged 75 and over who are the major users of the facilities including using two-fifths of all usage of the other in-patient services. They comment that there is no indication that elderly people (in 1990) have fewer health needs than they did a decade before, that hospitals do not see fewer patients but that length of hospital stay has been dramatically reduced. The effect of this policy has the ability to create a new 'boundary group' described as a group of frail and highly vulnerable elderly people living in their own homes (pp.411-412). Bebbington and

Charnley considered this would lead to greater demands on health and social services support and voluntary and informal help at a time when they are not matched by community services. Their study of community care supported this thesis and showed that low priority was given to work with the elderly and the work tended to be given to inexperienced and unqualified workers.

As previously indicated, Tierney et al. (1994) point out that the economic advantage of early discharge and the benefits of shorter hospital admissions must be balanced against risks inherent in discharging older patients "quicker and sicker". This has a consequent burden on community services and informal carers. The average length of stay for the 326 older acute medical and surgical patients in their study was 11.7 days. One third of the patients had less than 24 hours notice of discharge. The surgical patients were significantly more likely to be discharged at short notice and the researchers comment that the reasons for this were not always obvious. The most frequent reason given for early discharge was shortage of beds especially in the surgical area. Fifty-four percent of patients lived alone, 33% with a spouse and 14% with a relative or friend. While 72% of patients felt ready for discharge 30.8% of carers considered the patient was not ready for discharge. Factors affecting discharge were identified as inadequate consultation with patients and carers, insufficient information provided and inadequate assessment of patients' needs. Three months after discharge some patients were still experiencing a greater number of difficulties at home than they did before admission. Over 25% were readmitted during the three month period, 73% of these on an emergency basis. Whether this referred to medical or surgical patients was not identified.

Independence / Self-Care

The degree of independence and level of self-care once people are discharged from hospital are variable. In the study by Mossey et al. (1989), 89% of the women were independent in physical function before their hip

fracture, and 12 months after surgery only 28.1% had returned to their pre-fracture functioning, 18.6% were dependent on a caregiver for most activities of daily living, 7.8% had died, and 7.8% were permanently in a nursing home. Factors of age, pre-fracture physical function and cognitive status were associated with recovery in physical but not psycho-social status. It was found that the older person who is more frail has diminished reserves and is therefore less able to regain losses in functioning following hip fracture.

Similar trends to those identified by Mossey et al. were found in the study undertaken by Williams et al. (1994). The majority of older women were independent in physical functioning before their hip fracture but at 14 weeks post-discharge only 27% could walk unassisted. Predictors of the assistance needed were age, the type of surgery and affective distress but the importance of these varied according to the time at which they were assessed (2, 8, 14 weeks post-operatively). For example, at weeks 8 and 14 the type of operation was no longer important and the age of the patient less important. The problems cited as most important were to do with mobility and especially problems with dressing which persisted across time. Problems related specifically to the surgery itself decreased while the fear of falling became more important at 14 weeks. The authors draw attention to the 'how fell' variable where this was the cause of the fracture and the need to take cognisance of this variable as a possible indicator of other problems which need attention.

King and Parrinello (1988) studied recovery from cardiac surgery. Participants ranged from 39-78 years with the mean age in the 60s. Findings indicated that by six weeks after discharge 76% were carrying out their usual activities. By eight weeks 95% felt good or excellent. Feeling tired was the only symptom reported at all times by the majority of people. Personal care activities were carried out by 91% in the first two weeks at home. During the first three weeks the percentage of people reporting changes in mood ranged from 38% to 53%, levelling off at 24% eight weeks after discharge. Changes in mood for the majority referred to feeling

“down”, a few stated they were depressed. Other researchers have identified changes in mood in older patients during recovery (Mossey et al., 1989; Williams et al., 1994).

Social Support

Social support has been considered by researchers during the last two decades (Callaghan & Morrissey, 1993; Stewart, 1989). The concept of social support has been interpreted in different ways by researchers. Callaghan and Morrissey (1993) in their review of the literature related to the social support concept, point out that two major theories have been used in much of the research, the ‘buffer’ and the ‘attachment’ theories. In the buffer theory social support acts as a buffer to protect people from life’s stresses. In the attachment theory proposed by Bowlby, the adult’s ability to form socially supportive and sustaining relationships is based on the secure attachments formed in childhood, and successful relationships will help in utilising social support. Schwarzer and Leppin (1990) (cited in Callaghan & Morrissey) in a meta analysis of 93 studies which focused on the buffering hypothesis, found that the relationship between social support and illness appeared to be strongest for elderly people. “Support from family and friends appeared to be the strongest variable(s) in reducing the effect of adversity” (p.206). Stewart (1989) identified a lack of intervention studies in her review of 52 studies and proposed strategies for investigation.

The support that people receive from their social network and the primary health care system may affect how well they can take care of themselves and whether they are able to remain in their own home (Lorensen, 1985; Tierney et al., 1994). The ability to carry out personal activities of daily living appears to be a significant factor in an older person’s recovery and health maintenance. Independence in both personal and household activities of daily living may be lost or decreased and an increasing amount of help may be needed (Waters, 1987; Mossey et al., 1989). Social support on a continuing basis is also important (Northouse, 1988; Yates, 1995).

Spouse and Family Support

According to Rowland (1982) in his analysis of the 1976 census data of the elderly in Sydney, living alone was the main census indicator of vulnerability, and aging increased the probability of living alone mainly on account of widowhood. In the case of ill health the presence of a spouse diminishes a person's vulnerability to public dependence. Two factors are important - the mutual assistance of an elderly married couple that enables them to continue to live in their home, and a supportive family network. Rowland's analysis indicated that people living alone or with unrelated persons were most likely to require welfare service support. He compared his figures with those of other countries and this indicated that there were more women living alone. He concluded that women comprise the majority of elderly at risk.

Support of spouse and family was a key factor in Northouse's (1988) study of 50 women who had a mastectomy, and their husbands. The women were aged 25 to 76 years, the husbands 27 to 78 years. Northouse's findings suggest in the immediate post-operative period social support is an important factor for both patients and husbands but on-going support was even more valuable. The latter support appeared to be especially important in maintaining higher levels of adjustment. Spouse and family support were two important and available sources of support to the couples. There appeared to be a degree of reciprocal support between wife and husband. The size of the support networks was not as important as the support provided from a few key sources - spouse, family, and/or friends.

Miller and McFall (1991) studied the degree of stability and change in informal task support networks for people aged 65 years and over. They described informal care networks as providing a range of support functions which included task and emotional support, financial assistance, information, advice, and respite. The family caregivers of the 940 older persons in their study comprised 37% wives, 21.6% husbands, 32.3% daughters, and 8.7% sons. Those cared for by their spouses had smaller

networks and fewer person days of help than those cared for by adult children. Where the degree of burden increased, the intensity of help appeared to increase rather than the number of helpers in the helper network.

Wenger (1990) indicated care provided by a spouse would continue to be the dominant type of care relationship in retirement and it could be assumed that at least one-third of elderly people would be carers at some point during this time (p.207). Most of the elderly carers in her study were looking after their spouse. Often the care was of an intensive nature and was more likely to be provided without help. In her review of literature Wenger found important indicators for the high level of commitment to care demonstrated by elderly carers. Typically the caring relationship (whether spouse or sibling) is central to their lives and based on mutuality and long-term shared residence. In the case of spouses, expectations for care exist. The role of carer may in many cases compensate for the role losses of old age (p.201).

Yates (1995) found the lack of spousal support to be associated with depressive symptoms in males (30 to 80 years) recovering from coronary heart disease. The patients were more satisfied with the informational, emotional, and tangible support they received from spouses than that they received from health care providers. The spouses supplied significantly more emotional support and tangible aid than did the health care providers. The very high level of support supplied by the wives during recovery highlighted for Yates the dangers of overburdening spouses and the over-reliance of spousal support.

Families play an important part in supporting older people. According to Lang and Brody (1983) "family" in this context most often means the women in the family. Elderly wives (helped by daughters) are the caregivers for husbands and adult daughters care for widowed older people. Factors affecting the type of help provided include the older person's functional capacities, living arrangements, age, and marital status.

Jackson (1990) found that after their discharge from hospital 86% of the elderly people who had families had daily or weekly contact with family members. Most of the family carers were either daughters or daughters-in-law but a carer's allowance was paid only to a son and a nephew.

The 117 carers interviewed by Tierney et al. (1994) in their study of elderly patients discharged from hospital were mainly the spouse or the children of the patient (spouse – 33%, children – 55%). Women comprised 69% of carers and 49% of carers were aged 60 or more years. In addition 67% of carers had caring responsibilities other than those for the elderly person. A number of carers were in employment (41%) and 42% had one or more health problems. While almost half of the elderly people had home help they had few other community services and it was left to the informal carers to provide the required care. In New Zealand when a married older person requires assistance most services are provided by the spouse and/or daughter or daughter-in-law (Fletcher & Lynn, 2002). With increased life expectancy and an aging population the support of family could involve a daughter in her 70s caring for a parent aged in the 90s.

Health and Social Services Support

In their study of community care for the elderly, Bebbington & Charnley (1990) observed that many of the elderly approach these services as a result of an acute need, commonly rehabilitation after a period of hospitalisation, rather than, as has been the case in the past, because of a chronic need. They believe the needs of the elderly are far less static than is often assumed and that this is particularly so for the very dependent. The personal social services used included home help and home care services; meals-on-wheels; social work; street wardens; day care services; and short-term (respite) residential care. Nearly one-third of all community nursing visits involved “only basic nursing (personal) care.” (p.425). Included in the group ‘nursing’ were district nursing sisters, state enrolled nurses and auxiliary personnel. Examples given of “basic” nursing care are bathing, lifting, and oral medication with the qualification of “without

technical care”.

Visits by nurses are often very brief (Bebbington & Charnley, 1990; Jackson, 1990; Waters, 1987). Jenkins (2002) comments on the increase in demand for home care services as people are discharged from hospital “sicker and quicker” therefore requiring more acute and complex care. She emphasises the need for a framework of best practice processes for home care. Witham (1996) identifies a dual role for the nurse as a community health worker and an acute care expert.

Hanger et al. (1993) state 50% of a group of 94 older people who were discharged from hospital lived alone. While the reasons for hospitalisation are not specified in the study, most of the group were discharged with some sort of mobility aid, 68% received domestic help, 42.5% meals-on-wheels, 44.7% district nurse services. A wide range of formal community supports was used. Hanger et al. make the point that older people recently discharged from hospital are heavy users of formal and informal community supports, and that the majority want to be in their own homes which is appropriate if needed support is available. They comment that the “receipt of formal community supports is usually indicative of high levels of dependency and supplements, but does not replace, the large amounts (sic) of informal care given by family and friends” (p.399). Flowers (1987) in discussing New Zealand community health services for the elderly commented that the interests of older people are not necessarily best met by having a multiplicity of providers as this does not automatically bring either choice or quality of care.

The needs of recovering cardiac patients and their spouses in the study carried out by Moser et al. (1993) were mainly emotional and informational. Receiving help for household activities was ranked lowest by the spouses. Emotional support was ranked highly by both patients and spouses but each group placed different importance on different types of support. For example while the patients ranked as one of their lowest needs the opportunity to talk with others going through the same experience, their

spouses ranked being able to talk about their fears and feelings as one of their highest needs. The spouses were found to have a high incidence of unmet emotional support needs leading the researchers to suggest that group support may be of more benefit to the spouse than to the patient.

Warren (1986) studied the relationship between husband and wife after the husband had had a myocardial infarction. She found each was concerned about different issues and they disagreed on relative responsibilities for most aspects of the health regimen. This affected communication between the couple and their functioning as a married couple. One of Warren's proposals was the enhancing of the wife's coping capability by improving perceived and actual accessibility to health care providers, for example by twenty-four hour telephone coverage.

Once home, problems may arise, some because of short hospital stay. Support of a family carer and/or health and social services may be required to enable the older person to progress in recovery. Emotional needs of both the older person and carer may require attention. On-going assessment of the older person is important to identify needs and assist with solutions.

CONCEPTS OF RECOVERY

The word 'recover' comes from the Latin, *recuperäre*, "recover, regain" (Ayto, 2001, p.435). Recovery in these terms is the restoration of health. Synonyms include recuperation, healing, mending, convalescence. These words incorporate activity, a progression or process of movement from one state to another. The concept of recovery differs from the concept of rehabilitation, which focuses on the effect of lost functional ability because of accident or disease and how the affected individual can adapt to a new life (Stryker, 1977, pp.13-15). Disease and illness disrupt the pattern of one's life. Much of the literature dealing with health, illness, and disease appears to accept the commonly used meaning of recovery – to recover, to regain or be restored to health, that is one's previous state of health.

Doolittle (1994) points out in her research with stroke patients, "life before the stroke stands out as a point of reference for recovery" (p.213).

Smith (1981) regards recovery as a dynamic process whereby the individual experiences change and looks toward the future. If one thinks of recovery only as a return to a former state, the possibility of change is not adequately recognised. Like Doolittle she stresses that it is what a person does or can learn from the illness / recovery experience that will contribute to personal growth.

Some writers have approached the process of illness and disease and its effect on a person's return to health in wider terms. Frank (1995) discusses illness and disease in terms of bodily breakdown with three underlying narratives of illness:

- 1) A restitution plot where illness is transitory and the story is about health and its restoration. There is a "natural" desire to get and to stay well as the person wants the body's former predictability back again.
- 2) Chaos narrative is the opposite of restitution as its plot imagines life as never getting better.
- 3) In quest narrative illness is a journey and something will be gained through the experience. Recovery is a stepping beyond self-imposed limits and personal growth occurs as a result of the experience.

Dorsett (1991) views recovery as a separate but influential force vis-a-vis the course of illness. The recovery process is described as phasic, in that it comprises a changing pattern of accommodations attuned to a total human response, including illness, that it may have normative standards but each person's recovery is individual and uniquely defined. The outcome of recovery is characterised by renewal and recuperation. It incorporates the strength of the historical self and a new evolving complexity in order to accomplish a major health transformation (p.179). The concept of change

during recovery is also evident in the model of alcoholism recovery developed by Wing (1993). Wing's model explains the natural progression of recovery through four behaviour stages – denial, dependence, behaviour change, life planning. These stages echo the patterns of recovery and the concept of the outcome of recovery identified by Dorsett, who describes the pattern of recovery as informing any professional intervention schema.

Smith (1981) considers that recovery requires time, energy and thoughtful attention, that during the acute phase of an illness this focus is provided by health professionals but once over this stage the patient is given less attention. The priorities of care change but this does not also mean the need for care is diminished nor that less skilled personnel are the most appropriate to provide care. Patients use energy to deal with the crisis of an acute illness and once the crisis is over they may experience anger, sadness and exhaustion. They need time to grieve and to come to terms with a changed reality (p.89). It is Smith's contention that the recovery stage is the very time when the person needs attention such as education and counselling, and when planning involving the family should occur. If this does not happen successful recovery may well be delayed.

According to Waters (1987) the vulnerability of older people discharged from hospital and the inadequacy of their aftercare was first identified 20 years ago. Since that time there have been various studies which indicated continuing difficulties. The period following discharge is one of great vulnerability and anxiety for the older person, which is not helped by "total care" being provided while the person is in hospital. The period of greatest risk for both medical and surgical older patients appears to be immediately post-discharge (Jackson, 1990; Yates, 1995). Hogstel and Taylor-Martof (1994) state that for older people convalescence after surgery is likely to be prolonged and "... is apt to take 4-6 months and will probably require some sort of follow-up care" (p.302).

Yates (1995) cites writers who have provided evidence that "social support is linked with many aspects of health and illness recovery" but goes on to

say that “few investigators have distinguished between different types of support... and different characteristics of recovery” (p.193). She proposed the likelihood that types of support would differ in their recovery outcomes. Kolditz and Naughton (1981) point out that patients have their own criteria for recovery and that these differ greatly from those of the doctor (p.82). In their study of patients who had abdominal surgery the three main areas identified as factors necessary for full recovery were return of strength and energy, spirits returned to normal, and capability to carry out usual activities.

The process of recovery and therefore the outcome may be affected by a number of factors. These factors include preparation for surgery, the state of health pre-operatively, care provided mindful of the age of the patient, for example maintaining existing abilities, effective discharge planning, follow-up, and home / after-care support. Recovery may be protracted and may be more limited as the age of the person increases. While there may be improvements at an even pace there may also be improvement for a time then little or no further progress, thus causing frustration and fatigue for the older person. Problems relating to the surgery itself may decline but other problems may persist or arise (Carroll, 1995; Mossey et al., 1989; Tierney et al., 1994; Williams et al., 1994; Yates, 1995).

Doolittle (1994) presents two levels of recovery, Level I where the aim is functional independence and self-care (she describes this as a common view of recovery in rehabilitation settings); Level II involves personal meanings of recovery, the context of daily life, activities that are important to the individual, their “valued concerns”. “These activities are what matter to the person and which give them identity and continuity to their past, as well as the vision of a livable future” (p.211). Doolittle describes the work of recovery as a conscious mental attempt to regain participation in meaningful activities so the concept of recovery involves recovery of both the physical and the social body.

The dying trajectory described by Glaser and Strauss (1968) is cited by

Lawler (1991) as having similarities to the recovery trajectory arising from her research. The similarities Lawler identifies are time / duration and shape; turning points – for the dying person, critical junctures and for the person recovering, recovery indicators, these occurring for both improvements and setbacks; acceptance or expectation of a particular outcome – dying or recovery; and belief of certainty – death, recovery. Expectations about the particular recovery trajectory for particular patients are based almost exclusively on the patient's medical condition. There are routine recovery patterns for different conditions and surgical procedures. Kleinman (1988) emphasises reflecting on what has happened and making sense of it during the recovery stage; that during sickness one is both the illness and is distanced from it, and there is a need to adopt another perspective. The views of patients and families of the meanings of illness are interpretations of a complex, shifting reality, and the changing contexts of illness and care (pp.181-182). The process of recovery can be separated out and be described in a similar way.

Statements about recovery demonstrate various emphases, for example: illness to wellness (Kolditz & Naughton, 1981, p.71); looking to the future (Smith, 1981, p.3); events and advents (Sacks cited in Benner & Wrubel, 1989, p.65); change in well-being which is assimilated and accommodated (Dorsett, 1991, p.178); becoming independent and regaining control over one's body (Lawler, 1991, p.183); returning to activities and concerns that matter (Doolittle, 1994, p.216).

REVIEW AND SUMMARY

In Chapter One literature relating to the older person having surgery, and recovery, was considered. The increase in the numbers of older people is a worldwide phenomenon. For some countries it is predicted that the aging population may be healthier in the future than is presently the case. As older people live longer there is likely to be an increase in the number who undergo surgery. Older people admitted to hospital for one condition may be dealing concurrently with one or more other conditions. Health and socio-economic policies in a number of countries promote day and short-stay hospitalisation for conditions requiring surgery. The older person is likely to return home to be cared for by an elderly spouse and/or family member during their recovery. The spouse is an important part of the process.

Surgery for older people requires particular needs to be taken into account – concurrent health problems, physiological alterations, preparation for transfer home and support once home. Information to and from the older person is important throughout. To progress in recovery and to become independent in care and activities the older person is likely to require the support of a spouse and/or other family member and may also require health and social services support, such as in personal cares, housework and gardening. Additional emotional support may be required for both the older person and carer.

For recovery to be of most benefit discharge planning is considered an important, even imperative, part of the process. It has shown to be lacking in a number of areas. Collaboration between the older person, family, health professionals and/or home care services is required to plan and provide for a successful recovery.

Nurses can play a key role in contributing to the older person's recovery by the care provided during hospitalisation, discharge planning, and follow-up

care after discharge. Included in these activities is the provision of information to the older person and family members. The short hospital stay is a small part in the process of dealing with and recovering from surgery. Nurses need to take the opportunity to facilitate the best outcomes for the older person during and after hospitalisation. Appropriate professional care can greatly enhance the older person's recovery process. Conversely inappropriate care will hinder recovery. The chapter concludes with the presentation of various views of recovery.

In Chapter Two phenomenology as the philosophical framework for the study is considered.

Chapter Two

PHILOSOPHICAL FRAMEWORK - PHENOMENOLOGY

In Chapter One the framework of the topic was considered. Information about the aging population, and literature about older persons in society, in particular about surgery, hospitalisation, returning home, and recovery, were reviewed. In Chapter Two phenomenology as the philosophical framework is the focus. Phenomenology provides the philosophical basis and the method for the study.

Chapter Two begins with a consideration of the nature of phenomenology with an emphasis on the work of Martin Heidegger, and moves on to provide an overview of phenomenological concepts related to the study. The chapter concludes with a consideration of what the phenomenological perspective offers the topic, and phenomenology's relevance to nursing inquiry. Phenomenology as a method is considered but this is described in more detail in the following chapter, which has as its focus the conduct of the study. Similarly the phenomenological concepts are discussed further in the relevant chapters.

THE NATURE OF PHENOMENOLOGY

Phenomenology is variously described as a philosophical movement, a way of philosophising, an approach, a science and a research method (Beck, 1992; Crotty, 1996; Dreyfus, 1991; Heidegger, 1962; Oiler, 1982; van Manen, 1990; Spiegelberg, 1969).

The German philosopher Edmund Husserl [1859-1938] is regarded as the

founder or father of phenomenology. Phenomenology, as developed by Husserl in the early nineteenth century, had its roots in philosophy. Husserl was influenced in his thinking both by the work of his teacher, Brentano, and that of the nineteenth century philosophers. He was critical of the positivist approach in natural sciences which was apparent at the turn of the century. As Ray (1985) states:

The positivist-empiricist approach in the natural sciences, with its emphasis upon context-free generalisations, influenced scientific thought significantly enough that research in the human sciences was also divorced from influences of the 'reality of the individual in his or her sociocultural context'.

(p.83)

The objectification that was occurring in the human sciences, the scientific position that final truth lay in facts alone, and the denigration of philosophical knowledge, led Husserl to the position that the study of philosophy should have not only rigour, but also a new humanism (Ray, 1985). The work of Husserl and his pupil, Martin Heidegger [1889-1976], had a major influence on phenomenological research.

Husserl had viewed Heidegger as his phenomenological heir but realised his phenomenology was developing in a direction different from his own. Heidegger's work, *Being and Time*, first published in 1927, was a major reinterpretation of phenomenology and its method. Husserl's focus was primarily epistemological, while Heidegger's focus was ontological. Heidegger was critical of abstract theories of human existence because they neglected the actual everyday world, which could not be studied in the same way as the study of objects in the natural sciences.

Heidegger wanted to explore the meaning of Being, not Being itself, so Being, and modes of being, comprised his central theme, with time as a second theme. Being is essentially temporal and time is the possible horizon for an understanding of Being. For Heidegger the essence of

human being lies in its *existence*, existence being used in the sense of its possibility to choose different ways of being, for example, to be oneself or not to be oneself, or in other words to assume one's authentic way of being in the world or to dodge it (Spiegelberg, 1969).

Human being occurs only in the framework of an encompassing world. Human being and the world are what they are, only in being related to one another. Consciousness and knowledge are therefore only modifications of this underlying relationship. The relation of human being in the world Heidegger termed *Da-sein* or "being-there" to convey humanness or the situatedness of human reality in the world. Unlike Husserl he did not accept it was possible to separate or 'bracket' one's being-in-the-world in the process of inquiry, as he considered the observer could not separate the self from the world. Heidegger investigated the world of daily experience in contrast to the derivative world of science. He used human being as a point of departure for analysis of its Being, not as its destination.

According to Heidegger, Being in every case is the Being of some entity. One must first bring forth entities themselves to lay bare Being and must do this in the right way. Phenomena are never anything but what goes to make up Being. Phenomenology is the science of entities, the way of access to what is to be the theme of ontology. The task of ontology is to explain Being itself and to make the Being of entities stand out in full relief. Heidegger proceeds toward the concept of Being by way of an interpretation of the special entity, *Dasein*. His analysis of Being begins by studying the everyday existence of people (Heidegger, 1962, pp.60-62).

One of the major distinctions between Heidegger's phenomenology and critical theory is his notion of background preunderstanding. Humans come with a background, a story and a history so a situation is never without a preunderstanding. "Meaning is shared and handed down culturally through language, skills and practices and directly perceived by the individual", and explanation is making the meaning as apparent as possible (Allen, Benner, & Diekelmann, 1986, p.29).

According to Heidegger the term "phenomenology" referred primarily to a concept of a method, a way of approaching objects of philosophical research. Phenomenology expresses a maxim, "to the things themselves" therefore the method must make what is otherwise concealed, seen, so taking the hidden out of its hiding. For Heidegger, Being is the primary phenomenon which needs to be uncovered and interpreted.

In contrast to Husserl's descriptive phenomenology of pure consciousness, Heidegger's phenomenology was a hermeneutic phenomenology of human being, using methods that go beyond describing what is visible as a means to uncover hidden phenomena and particularly their meanings. Walters (1994b) states that while Heideggerian phenomenology "is described as hermeneutic, some phenomenologists argue that this is a contradiction in terms" (p.138). While Husserl's maxim was, "Let the facts speak for themselves", Heidegger proposed that there were no uninterpreted facts. The only way to bring phenomenology and hermeneutics together is to appreciate that it is not possible to separate facts from meanings; that all interpretation takes place against a background of previous understanding and one can never free oneself from its influence.

Reeder (1988) describes Heidegger's goal as to "think the meaning of Being by way of hermeneutics; he begins with *Dasein* as the place where Being is manifest and uses hermeneutics to interpret *Dasein* for its meaning" (p.212). For Heidegger, "to interpret a text is to come to understand the possibilities of being revealed by the text" (van Manen, 1990, p.180). Hermeneutics therefore implies interpretation and according to Rather (1992) in *Being and Time* Heidegger stated that "everyone exists hermeneutically, finding significance and meaning everywhere in the world. Heidegger saw that hermeneutic methods could, thus, be applied to our understanding of life and other persons, the everyday world of practices, and lived experience" (p.48).

Dreyfus (1991) describes the circular nature of hermeneutic analysis:

In interpreting a text one must move back and forth between an overall interpretation and the details that a given reading lets stand out as significant. Since the new details can modify the overall interpretation, which can in turn reveal new details as significant, the circle is supposed to lead to a richer and richer understanding of the text.

(p.36)

Heidegger repudiated the term "research". He saw 'reflection' as the proper task of philosophy but Spiegelberg (1969) comments Heidegger is unable to describe reflection in terms of a clear and teachable method. Heidegger rejected the special claim of natural sciences to tell us the truth about objective reality. Natural science can tell us the truth about the causal powers of nature but it does not have a special access to ultimate reality and this is what Heidegger attempts to show. Oiler (1982) describes truth as "a composite of realities – the world is grasped in profiles dependent on an individual's perspective" (p.179).

An introduction to those of Heidegger's concepts which are of particular relevance to the study topic is presented. The concepts are discussed further in the relevant chapters.

THE PHENOMENOLOGICAL VIEW OF THE PERSON IN ILLNESS

Being-in-the-world, "refers to the way human beings exist, act, or are involved in the world" (van Manen, 1990, p.175). As previously indicated, human being according to Heidegger does not or cannot occur except in the framework of an encompassing world with which it belongs together, into which it finds itself inserted. He describes this relationship:

Self and world belong together in the single entity Dasein. Self and world are not two beings, like subject and object; ... [instead] self and world are the basic determination of Dasein in the unity of the structure of being-in-the-world.

(Heidegger, 1982, cited in Guignon, 1993, p.13)

The unity of self and world may be fractured in times of illness or disability and events associated with these, such as surgery. Pellegrino (1982) considers the assault of an illness on humanity is not simply physical but also ontological – affecting our very image of ourselves – our being, our circumstance, our world. Illness transforms our being-in-the-world, it is an attack upon it, deforming it because it threatens our integrity which includes the integrity of self and body, and that of self and world.

To understand the experience of an event affecting a person's health it has to be seen in the context of their lifeworld, which includes the "personal and cultural situations that give meaning to the experience. These *situated meanings* must be taken into account, if the essential nature of particular human experiences is to be understood and described" (Madjar, 1991, p.50). This applies to the person to whom the event 'belongs' as well as carers, whether they be family members or health providers.

Lived Body

Lawler (1991) cites Harre (1986) who she says:

... argues that a (human) body is not just another 'thing' because, unlike other things, the person experiences metaphysical ownership of a body in the sense that 'my body' is not 'your body'. And while one 'owns' a body, one also exists in it and experiences it simultaneously. For Harre, an adequate construction of the human body requires integration of the object body-as-thing with the lived body-as-experience.

(p.57)

As Pellegrino (1982) indicates, an illness threatens the integrity of self and body. Rather than body and self working together in harmony and unity as a single entity, the body and self work in opposition with each trying to gain control.

Gadow (1982) in her dialectic of body and self describes four levels of embodiment: primary, disrupted, cultivated, and aesthetic immediacy. In Gadow's first level of the relation between self and body – primary immediacy – the self and body are inseparable as the lived body. The unity of the lived body and its dimensions of agency and vulnerability (“acting upon” the world and being acted upon by the world) define its relationship to the world. When the immediacy is disrupted as in illness or surgery rather than the relation of full mutuality of self and body, the self and body act upon each other rather than the world and the body becomes the object body. The relation between self and body is mutually limiting. In cultivated immediacy the self aims to control the object body to restore harmony and unity.

Gadow's fourth level of the body and self dialectic, – aesthetic immediacy – is exemplified in aging and illness. The body is accepted as valid in its own right and the self recognises the body as another manifestation of selfness. The previous three levels – primary immediacy: the lived body; disrupted immediacy: the object body; cultivated immediacy: harmony of the lived body and object body – allow for a progression which is equally possible in aging, youth, health and illness.

Gadow proposes that there is a prevailing negative view of aging and illness as in disrupted immediacy where the body as object body is regarded as an instrument or oppressor. The body is in the foreground of attention and becomes an object of concern, replacing the lived body, but it is also potentially subject body. Subject and object body can reciprocally affect and develop each other. In aging and illness, “the subject body expresses itself as a reality with its own meanings, values and purposes”, and provides the “possibility for learning to live in aesthetic relation to the

body in anticipation of the sustained relation to the body as aesthetic object that becomes possible with aging" (p.99). The realities of the changes in the body in aging can be seen as "symbols of values and meanings of the experience of the person as a whole" (p.98). (Gadow's work is discussed further in later chapters).

Kleinman (1988) referring to the work of the German phenomenologist Plessner says:

Each of us *is* his or her body and *has* (experiences) a body. In this formulation, the sick person is the sick body and also recognizes that he or she has a sick body that is distinct from self and that the person observes as if it were someone else. As a result, the sick both are their illness and are distanced, even alienated, from the illness.

(p.26)

The disruption of self and body requires a return to unity and as Benner and Wrubel (1989) point out, "feeling 'whole' and recovered must include feeling at home in the body once again" (p.293). The notion of feeling and becoming whole again is expressed by Kondora (1993) in her study of incest survivors when she used the term "reconstituting me". The women in the study, through caring for self were able to reconstitute a sense of self; in their case a new sense of themselves.

The journey to becoming whole again may involve dealing with a body which no longer performs as it should and which affects the person's interaction with their world. Madjar (1991) describes this experience:

In health we experience our embodied selves in an unconscious way, taking for granted and paying little attention to processes such as breathing, or the position of our limbs in relation to the rest of the body. In illness, one's own body can no longer be taken for granted. There is a breakdown, a discontinuity in one's

being in the world, as pain, dyspnoea, nausea or other sensations draw attention to themselves and to the body, and make one's being in the world unpredictable and effortful.

(pp.60-61)

Loss of the habitual skilled body may mean part of the body is altered, is objectified, is no longer to be relied upon to function as it should, has to be consciously thought about rather than taken-for-granted. Surgery can result in any or all of these outcomes. In times of illness, surgery, and recovery, the body can dominate existence. Benner and Wrubel (1989) point out, "Many taken-for-granted aspects of one's body can no longer work smoothly for one... Background meanings, concerns, and bodily understanding all go by the boards." (p.50).

With the loss of the habitual skilled body the person is forced to relate to the world in new ways because the habitual skilled body is "a major coping resource offering flexible fast responses to complex situations. Its loss is a major coping deficit and indeed becomes something to be coped with" (Benner & Wrubel, 1989, p.74). Benner and Wrubel comment that some people, for example, those with chronic illnesses (such as many older people), have developed habitual skilled bodies in response to their illnesses. They point out people's learning about their own illnesses can become a "source of clinical discovery and inquiry in its own right" (p.74).

Kleinman (1988) in writing of the illness experience, talks about the reciprocal relationship between the actual experience as experience and how each of us relates to that experience as an observing self. "We might say that culture fills the space between the immediate embodiment of sickness as physiological process and its mediated (therefore meaning-laden) experience as human phenomenon – for example, as an alienated part of body-self, as a vehicle for transcendence, or as a source of embarrassment or grief" (p.27). Lawler (1991) speaks of the embarrassment and unprecedented nature of an adult's need to ask for assistance with what she labels "privatised" body functions, that this can

also be a time when a person experiences loss of control over the body which can cause embarrassment. The experience of the illness event and its consequences such as surgery can erode “the image we have constructed over the years, often painfully, of ourselves and our world” (Pellegrino, 1982, p.158). Pellegrino further says “illness threatens this carefully wrought self-image. It forces a radical reappraisal; it opens up new, and relights old anxieties” (p.159).

The person faced with an illness related event such as surgery is likely to be concerned about it. It is a situation which matters to them. Concern is one way of being connected to context and it changes across the time of the situation. Because Dasein is always concerned about its being, according to Heidegger (1962), “care is the basic state of Dasein” (p.293). The various structural aspects of Dasein’s way of being are unified by care. “Caring, understood ontologically, is ‘making itself an issue’ ” (Dreyfus, 1991, p.238).

Having surgery, being ill, means the person makes themselves an “issue”. They must cope with their situation. Benner and Wrubel (1989) in writing about coping, state:

In the phenomenological view, coping can never be an unlimited choice from a list of effective and ineffective options. Instead, coping is bounded by the meanings and issues inherent in what counts as stressful.

(p.63)

The context in which the person, who is ill or having surgery, is placed will affect how they cope. In the ordinary course of events a person is ‘thrown’ into a world which with its language, customs and practices helps determine their being and identity. It is a world which is familiar to them and which is shared with others. Heidegger “introduces the idea that the shared everyday skills, concerns, and practices into which we are socialized provide the necessary conditions for people to make sense of the world and

of their lives” (Dreyfus, 1993, p.293).

For most of the time life is lived as “going with the flow” or as inauthentic being. As we go about and become involved in day-to-day life the immediate concerns of handling daily affairs tend to incline us to just “drift along with the taken-for-granted practices of everydayness” (Guignon, 1993, p.227). In Heidegger’s sense the inauthentic self is inauthentic because it is not truly our own. It has lost itself in the public world. A health-related event may threaten the taken-for-granted nature of the person’s world and bring them face-to-face with their mortality (authentic being). Authenticity involves genuine understanding in the sense of being aware of what it means to be and that death is the final outcome of existence. The authentic mode of existence is not one which is continuously sustainable. As Frede (1993) points out, Heidegger repeatedly affirms, “there is no way to live permanently in authenticity, since we have to take the everyday world and its routine for granted in all our practical concerns” (p.57). Depending on the situation, for example, a real possibility of death, the person may be liberated in recognising the possibilities and choices open to them. Zimmerman (1993) expresses this as, “being authentic means being free to invigorate and to transform practices in the light of the realization of their groundlessness” (p.246).

In times when health is threatened a person may be ‘thrown’ into a world of illness and disability where the context, people and language are different and unfamiliar, where there are threats to their control of their body or loss of control over parts of the body. When the person is in the familiar context of home they may be able to cope with the different world of illness and disability (and recovery) because of the nature of home. Home as lived space anchors the person in a familiar environment of objects, rituals and practices and allows the person to *be* themselves (van Manen, 1990; Young, 1997). Treatment of illness or disability, however, may require going away from home. Besides the body appearing alien to the self, if a person needs to be hospitalised, as for surgery:

The context itself can be foreign, causing the person to feel

desituated. Or conversely, if the person is used to the institutional context, the situation could be laden with cues for a sense of dependence, unwellness, security, and so on.

(Benner & Wrubel, 1989, p.50)

The past experience or person's historicity may assist their coping in the different world of the health service. For example, the experience of past operations make some areas less unfamiliar and the person has an understanding of possible effects on the body and their life.

The Self in a Shared World

Benner and Wrubel (1989) stress relationships with others as part of constituting the self and consider, "it is this human connection that gives people the courage to weather illness" (p.52). Part of that courage may arise by the support of family and others at the times of illness. Kleinman (1988) points out that most care for illness is provided by the family which he labels a sector of care and this is where "illness exacerbation is first identified and coped with" (p.259). Understanding of one's altered habitual skilled body and state is necessary to be able to cope with and care for oneself. While the person may wish to be able to care for themselves in order to become well again they may be unable to do so and have to rely on others. As Benner and Wrubel (1989) state, "feeling ill requires seeking help or at least confronting the possibility that one will require help now or in the future" (p.294). When hospitalisation is required, for example, for surgery, this places the person in a particular situation which will contribute to the meaning of the event. How the experience is interpreted by the person will be affected by how their care is delivered.

Frede (1993) comments that the mode of being assigned to different entities is not always fixed. For example, human beings can be treated as scientific objects, or mere tools. Thus, "the context therefore determines their 'being' " (p.59). Rawlinson (1982) indicates that medicine seems to take the body for observation and technological manipulation. She

considers that concepts of health and disease ought to be appropriate to *human* being rather than mere organic or mechanical being. Medicine reads the text of the body in order to discover something about a particular patient's history and prognosis. Rawlinson's contention is the body constitutes a system of possibility rather than a mere physiological entity and that certain states of embodiment are disvalued by defining them as disease states, precisely because they involve specific obstructions of our ordinary embodied capacities. The patient's text of their embodiment is censored and revised by the health professionals to make sense of most if not all of the signifiers, but Rawlinson considers it is not enough to know and explain the physiological facts. Kleinman (1988) supports Rawlinson's (1982) views when he comments, "the practitioner reconfigures the patient's and family's illness problems as narrow technical issues, disease problems" (p.5). Englehardt (1982) describes illnesses, diseases and sicknesses as occurring in "a province of the life-world structured by scientific expectations" (p.142).

Kleinman (1988) discusses illness as having meaning, in several distinctive senses. He includes symptoms as meaning which he says are dependent on the shared understanding of a particular culture; cultural significance as meaning, when "particular symptoms and disorders are marked with cultural salience in different epochs and societies" (p.18); life world as meaning, described as when vital significance is transferred from the person's life to the illness experience. Kleinman uses the examples of a person with chronic illness, and the elderly with chronic illnesses, to illustrate life world as meaning whereby illness is assimilated to the life story of the person.

When speaking of chronic illness Kleinman (1988) describes it as many-sided and differing as our lives, so if we are to understand the meaning of illness, we cannot focus on content.

Instead, we must inquire into the *structure* of illness meanings:

the manner in which illness is made meaningful, the processes of creating meaning, and the social situations and psychological reactions that determine and are determined by meanings.

(p.185)

Kleinman considers the patient's discourse is the primary ground of care and, "hearing the patient's story in his or her own words... is the best way to come to understand the illness experience and take it into account in practice" (p.130).

Frank (1995) views illness as disrupting the coherent sense of one's life sequence. The present is "not what the past was supposed to lead up to, and the future is scarcely thinkable" (p.55). Any health-illness event is going to involve time. From when the person first becomes aware of the problem and the need for help, through the process of receiving help in a variety of forms, to the time when the problem is dealt with and they move on with their life, with or without the problem remedied, time is pervasive.

During an illness or surgical event the person lives through this time in a way different from the usual. For example, in a period of restriction time may seem to have stopped or stretched in an unwelcome way. Once restrictions and limitations are reduced or removed time may "fly by". During the period when people are restricted time controls activities and abilities just as it does when people are feeling under stress and not coping with the pressures of life.

When a person is restricted or limited in any way and for any length of time their usual way of being-in-the-world is affected. A new and different relationship needs to be forged between self and body, and embodied self and world. During the period of recovery this relationship is interim in nature. Once the person has recovered, the form of the relationship forged in the interim may continue, alter, or change completely in order for the person to adapt to a new way of life. The person has to assimilate the experience into their life story and understand their illness and wellness in

terms of what it means for the self. A new way of thinking has to be learned. People learn by telling and sharing stories about their experiences (Frank, 1995). This reflects Heidegger's notion of understanding which is an aspect of being itself. Human beings are special kinds of beings in that their way of being embodies an understanding of what it is to be. These embodied stories have two sides – the personal and the social. They are told about and through the body in particular places and at particular times. "The truth of stories is not what *was* experienced, but equally *becomes* experience in the telling and its reception" (Frank, 1995, p.22). Illness becomes a circulation of stories, both professional and lay, but not all stories are equal. For example, the medical narrative may become the benchmark against which all others are ultimately judged. Kleinman (1988) comments:

Illness narratives edify us about how life problems are created, controlled, made meaningful. They also tell us about the way cultural values and social relations shape how we perceive and monitor our bodies, label and categorize bodily symptoms, interpret complaints in the particular context of our life situation. We express our distress through bodily idioms that are both peculiar to distinctive cultural worlds and constrained by our shared human condition.

(p.xiii)

In introducing the self and world and the disturbances to both in the course of illness and its ramifications, I have endeavoured to relate them to aspects of the study and to provide the basis for the chapters which follow and in which the phenomenological concepts will be discussed further.

PHENOMENOLOGY AS METHOD

Phenomenology is described as a human science because, as a research inquiry, it is concerned with matters which affect people in their lived world. It belongs to the group of research known as qualitative in comparison to quantitative research. Smythe (2000) points out that qualitative research in its different modes is trying to “capture the meanings of life that are often elusive.” (p.18). She sees it as “always a challenge to be able to grasp the nature of human experience through words that seek to retell what happened, what it was like, and what it seemed to mean” (p.18). Astedt-Kurki and Heikkinen (1994) consider the consequence of choosing an interpretive method, in that it:

Implies a commitment to a set of ontological and epistemological premises completely different from those of traditional empiricist research. Most importantly, the research object is defined and understood in different terms, which further implies a different view on the most useful methods of data collection. If the main concern of the research is with the individual's life or with personal experiences of different aspects of life, then the researcher will need to apply such methods that can help to uncover those experiences. The baseline assumption is that the human individual is a conscious agent who is the most knowledgeable expert on his or her life.

(p.418)

Spiegelberg (1969, p.653) makes the point that, “Even if there were as many phenomenologies as phenomenologists, there should be at least a common core in all of them to justify the use of the common label”. He identifies the method as the core which is characteristic of phenomenology.

Van Manen (1990) describes research from a phenomenological point of view as always to question the way people experience the world and to

want to know the world in which people live as human beings. He points out that phenomenological research always begins in the lifeworld, that phenomenology describes how one orients to lived experience and that hermeneutics describes how one interprets the 'texts' of life. He identifies six elements of hermeneutic phenomenological research method:

- turning to the nature of lived experience
- investigating experience as it is lived rather than as it is conceptualised
- reflecting on essential themes characterising the phenomenon
- describing the phenomenon through writing and rewriting
- maintaining a strong and oriented relation to the phenomenon
- balancing the research context by considering parts and whole.

Other researchers have developed, adopted, or modified phenomenological research methods, for example, Colaizzi, Giorgi, van Kaam (one or all three are described by Banonis, 1989; Beck, 1994; Crotty, 1996; Moustakas, 1994); Diekelmann and Allen, 1989; Paterson and Zderad in Oiler, 1982; Spiegelberg, 1969; and van Manen, 1990.

PHENOMENOLOGY'S RELATION TO THE TOPIC

Van Manen (1990) states, "the point of phenomenological research is to "borrow" other people's experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole human experience" (p.62). Several writers comment that phenomenology as a methodology gives acknowledgement, value, and credence to the meanings of people's experiences and their interaction in their worlds (Stuhlmiller, 1994; Taylor, 1994; Walters 1994b). As Stuhlmiller (1994) indicates, this approach is in contrast to other research techniques "that strictly guide what information is elicited and therefore what information has value" (pp.348-349). Madjar (1991) comments, "applying

methods of natural science to the study of human life and activity is not only reductionistic, it also produces results which have limited usefulness" (p.49).

Van Manen (1990) asks the question, "why do we need to collect the "data" of *other* people's experiences?" and answers, "*We gather other people's experiences because they allow us to become more experienced ourselves*" (p.62). The experiences of others allow us to "become 'informed', shaped or enriched by this experience so as to be able to render the full significance of its meaning" (p.62).

The purpose of the research inquiry was to understand the structure and meaning of the phenomenon, recovery, from the perspective of an older person recovering from surgery at home. My aim of gaining a deeper understanding of recovery from the older person's perspective made phenomenology the appropriate choice as the philosophical orientation and method for this research.

Today people are living longer so the number of older people in populations is increasing. It is now more common for surgical intervention to be used to deal with some health problems of older people. Hospital stays are short so that most of the recovery period takes place in the home with little and/or episodic contact with health professionals. This means that many health professionals have little knowledge and understanding of recovery beyond the immediate post-operative period.

Much of previous research on recovery of older people has been related to physical disease, disability or specific illness events where older people are included in a wider age group where a specific age is not the focus. Preparation for going home and the assistance that may be required once home have been other research areas but the experience from the older person's perspective has received little attention.

The prevailing Western attitude is to "hand back" the body to the person to

“take charge” of it for recovery purposes, however, there needs to be a wider view than the body when considering the effect of such an experience on a person. The experience of having surgery and recovering belongs to the person experiencing it. What people share about that experience has value for others as it provides another vantage point of the experience and for a health practitioner enables a deeper understanding.

To use Madjar's (1991) words, recovery “needs to be understood in its lived, embodied context” (p.63). Madjar emphasises that:

In clinical practice it is not enough to attend to the anatomical body or a person's 'psychological needs' alone. It is the lived body in all its dimensions, the incarnate person who needs attention and care. Such care cannot be based on scientific knowledge alone; it must include phenomenological understanding of human experience and its individual and shared meanings. Phenomenological understanding cannot be gained through the methods of traditional science, but through its own methods and procedures.

(pp.63-64)

Inquiry into an older person's recovery at home places a particular focus on an experience which is context-specific and which holds particular significances for that person. It involves understanding and description of the experience as it is lived to enable exploration of the phenomenon of recovery with the aim of deeper understanding.

PHENOMENOLOGY AND NURSING

Nursing throughout its history has seen the need to improve its practices by gaining new knowledge through various means, research being one of these means. The current use of the term “evidence-based practice” demonstrates the recognition of the integral place of research in nursing. The multi-faceted and complex nature of nursing means, “the questions

arising in nursing may be complex and not necessarily answered by a single research method" (Taylor, 1993, p.172). A variety of research methods, both quantitative and qualitative is needed to address the complexities in order to improve practice and develop nursing's body of knowledge.

As a human science phenomenology has a particular attraction for nursing and nurses. Much of the nursing research previously undertaken has focused on such areas as the physical or emotional progress of patients, the effect of particular treatments or activities in relation to care, or the type and amount of help patients require. The methodologies used frequently involve those where quantifiable measures are required.

As a methodology phenomenology acknowledges and values the meanings people ascribe to their own existence (Taylor, 1993). Phenomenology provides for the extension and development of nursing knowledge by presenting another dimension of human experience whereby, "the person's or family's narrative can fill in many gaps in understanding that our traditional empirical science mode of inquiry leaves out" (Plager, 1994, p.68). It is regarded as an approach which is holistic, thereby reinforcing a basic tenet of current nursing practice.

Phenomenology's focus begins in the everyday lived world of an individual. Nursing's focus is a person's health-illness experience. The person's health-illness experience is part of their everyday lived world. Phenomenology offers a way of seeing more completely what the phenomena of health, illness, or recovery consist of for the individual and what is required of the nurse in response. It is a way of "finding knowledge through people's subjective accounts of their experience" (Taylor, 1993, p.5).

Taylor states that "phenomenology as methodology is a perspective applied within nursing, to inform the discipline of nursing about phenomena of concern to it" (p.174). In Taylor's view the practical concerns that people

have in living their day to day lives are those that phenomenology and nursing are both concerned with understanding. Kondora (1993) in her study of survivors of incest states "nurses need phenomenologically based studies to reveal the personal journeys of survivors and help us understand their difficulties, their endurance, and their healing" (p.12).

Kondora's statement is supported by that of Stuhlmiller (1994):

If a goal of nursing science is to uncover not only factors that compromise well-being but also those that facilitate it, then discovering the personal and cultural meanings and strategies that enable individuals to cope with crisis in constructive, self-enhancing ways is essential.

(pp.323-324)

The statements of Kondora and Stuhlmiller reflect nursing's central concern for people, and this is reinforced in the following statement by Taylor (1994), "The value of interpretive research for nurses and other health professionals lies in its assumptions about the value of people as situated humans who have knowledge about their own existence in relation to their health-illness concerns" (p.7). The recognition by the nurse of the person as "owning" the health-illness concern and of being the "knowledge-bearer" in relation to themselves, requires an acceptance of the situatedness of the person in a central place for any activity relating to care and treatment. This implies a need to understand the meanings of the person's concerns in their lifeworld. Phenomenology provides a path to that understanding.

Madjar (1991) points out, "the lived body and the life-world are not the same in health as in illness, crisis, or transition into motherhood. The alteration or loss of one's usual being in the world and the communication of such experiences to others can deepen our understanding of human life, coping and healing" (p.66). Importantly, nursing research has used the phenomenological method to ask "hitherto unasked questions, and produced descriptions, exemplars and paradigm cases that depict the

reality of human experience and nursing practice in a way that statistical manipulation of values assigned to operationally defined variables cannot do" (Madjar, 1991, p.66). Examples of the contribution to nursing's body of knowledge by nurses using a phenomenological method are: the concept of the person (Leonard, 1989); women's inner strength (Rose, 1990); pain as an embodied experience (Madjar, 1991); living with chronic obstructive pulmonary disease (Norris, 2000); schizophrenia as a way of being-in-the-world (Walton, 1995). Studies which specifically include lived experience in the title incorporate: recovering from addiction (Banonis, 1989); postpartum depression (Beck, 1992); chronic leg ulcers (Bland, 1994); and persons with chronic illness (Gullickson, 1993). Two studies specifically related to older persons are: meaningful life experience to the elderly (Trice, 1990); and the lived experience of health in the oldest old (Wondolowski and Davis, 1991). Studies related to nursing practice are: nursing the families of people who die in intensive care (Andrew, 1998); the meaning experienced psychiatric nurses attribute to the term therapeutic interaction (Crowe, 1994); and clinical practice of critical care nurses (Walters, 1994a).

Phenomenology, like any research method has its strengths and weaknesses and the status of phenomenology as a philosophy and a method and as qualitative research has been considered by various writers (Beck, 1994; Carr, 1994; Crotty, 1996; Crowe, 1998; Cushing, 1994; Dreyfus, 1991; Haegert, 1997; Kestenbaum, 1982; Munhall, 1992; Reeder 1988; Sandelowski, 1993; Schutz, 1994; Spiegelberg, 1969; Walters, 1994b). Some of the concerns that have arisen are due to the way the philosophy and method have been interpreted.

Crotty (1996) differentiates between the approaches of some nursing [new] phenomenologists and those who he terms mainstream phenomenologists. For example, he considers the nursing phenomenologists are primarily interested in a particular group of people and others for whom the findings of the research will be relevant. "It is in terms of these specific persons that the research is carried out" (p.107). Conversely, he sees mainstream phenomenologists "engaged with a phenomenon rather than a particular

person or group of people" (p.107). While they may believe that benefits may accrue for people as a result of their research, in the carrying out of research, "any involvement with a particular group of people is for the sake of illuminating the phenomenon, not the other way round" (p.107). In 'new' phenomenology, "the phenomenon must be seen as a construct created by the researcher" (p.56), whereas in contrast with 'mainstream' phenomenology the phenomenon is intuited. In the latter it is the 'subject' who first grasps the phenomenon. The 'new' phenomenology seeks to describe the lived experience of a person or persons in a particular context.

Crotty (1996) considers some nurse researchers have moved too far away from the original concepts of phenomenology and that their research tends to be subjectivistic and individualistic. He believes some nurse researchers seem to focus on the validity measures of their research at the expense of the core of phenomenology, its philosophical *raison d'être*. Husserl stressed the importance of scientific rigour so such issues could be expected in the evolution of phenomenology. Various techniques have been developed to counter criticisms of the method. Beck (1994) reviews philosophical and methodological issues for phenomenology including researchers' responses to deal with these issues. While there appears to be some justification for Crotty's concerns it may be appropriate to remember Spiegelberg's (1969) charge to "do phenomenology" not just talk about it. In this way by the actual application of the method to old and new concrete tasks phenomenology as a philosophy and a methodology will continue to evolve. "Phenomenology has to show its fruitfulness by widening and deepening the range of philosophic insights... [it] can show its mettle only by doing the actual job, not by making fanciful claims, but by offering its services on approval." (Spiegelberg, 1969, pp.644-645).

As for any research method a main issue is whether phenomenology is the most appropriate method for the question being asked, and the way in which the research is carried out. Madjar (1991) provides an answer, "When research questions relate to human experiences and the meanings such experiences have for the people involved (questions which lie at the

heart of nursing), then the phenomenological approach has much to offer" (p.67). In a wider context Dzurec (1989) states, "from the poststructuralist perspective, the use of multiple paradigms for the conduct of nursing research is an evolutionary necessity as well as a necessary stance for a responsible discipline" (p.76). In relation to using the work of Heidegger, Sheehan (1993) suggests, "the task, for those who care to take something from Heidegger, is to learn how to read him critically, both his life and his works, not to swallow his philosophy whole but to sift it for what is still of value and what not" (p.92). Heidegger himself called on thinkers, "to travel along the paths he traversed instead of pondering his words. As a result, the finest scholarly work done on his writings tend to reflect widely divergent readings of what he has to offer" (Guignon, 1993, pp.2-3). Nursing has used divergent ways of conducting phenomenological research.

REVIEW AND SUMMARY

In Chapter Two literature pertaining to phenomenology as a philosophical orientation in particular, and as a method of inquiry, has been presented. The work of Heidegger has underpinned the review. A consideration of why phenomenology is an appropriate approach to study the phenomenon of recovery has been offered. As a human science which is concerned with the lived world of the person, phenomenology offers a pathway to understanding the deeper meaning of the experience and phenomenon of recovery as part of the unfolding event of the older person's life. The focus is not the recovering which occurs in hospital but that which occurs at home, the site of the person's day-to-day life. The context in which a person is situated is important in determining how life is lived, how health-illness events are managed and therefore how recovery occurs. The perspective of the "recoverer" can contribute to the knowledge and understanding of the 'carer'.

In the following chapter phenomenology as a method is discussed in more detail together with the procedures used to implement and to conduct the study.

Chapter Three

STUDY DESIGN AND METHOD

The previous chapter considered the philosophical beginnings of phenomenology. Hermeneutic phenomenology was reviewed through the work of Heidegger and the writings of others. Phenomenology's relation to the study topic and to nursing were discussed. The focus of this chapter is the method and procedures used to carry out the present study.

PHENOMENOLOGY AS A METHOD OF INQUIRY

Phenomenology as a method can be defined as the study of phenomena. The word "phenomenon" derives from the Greek verb, *phantázein*, 'make visible', which is a derivative of *phaînein*, 'show', and *logos*, which, according to Heidegger, is the method of making us see what is otherwise concealed, of taking the hidden out of its hiding, and of detecting it as "unhidden", that is, as truth. Phenomenology for Heidegger is therefore the method of uncovering the hiding, or interpretation. The primary phenomenon that needs uncovering in this sense is Being (Spiegelberg, 1969, p.322).

The central aim of phenomenology is succinctly expressed by van Manen (1990) in his statement, "phenomenology demands of us re-learning to look at the world as we meet it in immediate experience" (p.184). He states that existential phenomenology "aims at describing how phenomena present themselves in lived experience, in human existence" and that Heidegger's professed aim is to let the things of the world speak for themselves, that Heidegger asks, "What is the nature (Being) of this being? What lets this being be what it is?" (p.184). Heidegger differentiated between the 'what'

and 'how' of phenomenology.

The expression 'phenomenology' signifies primarily a *methodological conception*. This expression does not characterize the what of the objects of philosophical research as subject-matter, but rather the *how* of that research.

(Heidegger, 1962, p.50)

Spiegelberg (1969) describes Heidegger's concept of phenomenology as a phenomenon being interpreted as "what shows itself" or more specifically "what shows itself in person, what is manifest". He points out that at times there is the possibility of a phenomenon hiding behind a misleading appearance but that "it is clear it is not the distillate of special reductive operations. It is rather an autonomous entity with powers of its own, independent of and prior to our thinking" (p.321).

Van Manen (1990) emphasises both the explication of human phenomena and the understanding of the lived structures of meanings as the aim of human science. He describes phenomenological research as – the study of lived experience aimed at gaining a deeper understanding of the nature or meaning of our everyday experience; the explication of phenomena as they present themselves to consciousness; the study of essences; the description of experiential meanings we live as we live them; attentive practice of thoughtfulness; a poetizing activity (pp.9-13).

Phenomenological research always begins in the lifeworld, the situation. It involves questioning the way we experience the world, and wanting to know the world in which we live as human beings. Being involved in the everyday world provides a particular vantage point for the researcher. Guignon (1993) comments:

In Heidegger's view, there is no pure, external vantage point to which we can retreat in order to get a disinterested, presuppositionless angle on things. So fundamental ontology

begins with a description of the “phenomena” where this means what “shows itself”, what becomes manifest or “shows forth” *for us*... But this need to start from an insider’s perspective is not a restriction in any sense. On the contrary, as Taylor shows, it is only because we are “always already” in on a way of life, engaged in everyday dealings with things in a familiar life-world, that we have some “pre-understanding” of what things are all about. It is our being as participants in a shared practical world that first gives us a window onto ourselves and reality. The existential analytic therefore starts out from a description of our average everydayness as agents in practical contexts.

(p.6)

Taylor (1993) emphasises the need for nursing to draw on a variety of ways of knowing so as to reflect its uniqueness. Reflecting nursing’s diversity could be added. Taylor views the use of phenomenological methods as “ways of making available to the practice discipline of nursing, that knowledge which is central to the everyday concerns of its nurses and patients” (p.178). The importance of the variety of ways of knowing is reflected in Sandelowski’s (1993) comparison of the validity of the work of two artists. She makes the point that the art of one is no less valid than the other just because they are differently re-presenting common phenomena. From this example she proposes that different qualitative re-presentations of common phenomena may all be valid ones and that the task in a practice-orientated discipline such as nursing “is to find ways to apprehend and re-present these different representations to achieve the “fuller knowledge” that advances knowledge and influences practice” (p.3). In its simplest terms re-presentation is looking at the world from a different vantage point and describing what we see.

My aim in looking at the “world” of recovery for older people was to see it from a different vantage point, to understand what it meant from the perspective of an older person. Phenomenology enables access to that understanding.

AIMS AND ASSUMPTIONS OF PHENOMENOLOGICAL RESEARCH

Guignon (1993) describes the aim of phenomenology inquiry as identifying the essential structures of any Dasein, "to grasp what lets things be what they are, what determines entities as entities in their various ways of being" (p.7). This involves a seeking of what is generally hidden, or does not show itself and Guignon says, "for this reason the phenomenon of everydayness is coupled with a hermeneutic or interpretation designed to bring to light the hidden basis of unity and intelligibility of the practical life-world" (p.7). To allow the phenomenon to speak for itself in order to apprehend its structures and meanings we need to be intuitively receptive. Crotty (1996) uses terms such as opening ourselves to the phenomenon, surrendering to it, contemplating it, and listening to it (p.163). This allows us to open ourselves to new meanings, "to bring new life to the meanings we hold. ...To see the world with fresh eyes is to discover a whole new world" (p.174).

Taylor (1994) points out that, "interpretive methodologies [and therefore phenomenology] are based on the assumption that knowledge that is real and trustworthy is found through qualitative methods, and research interest is invested in finding knowledge through people's subjective accounts of their experiences" (p.5). Thus there is an assumption about both the value of people and their knowledge about their existence in their everyday world, because the person is "thrown" into a community of shared culture, practices and language, which provide a pre-understanding of their world. In addition to the understanding that is present in the shared world, Plager (1994) provides four other assumptions of hermeneutic phenomenology: human beings are social, dialogic beings; we are always already in a hermeneutic circle of understanding; interpretation presupposes a shared understanding and therefore has a three-fold forestructure of understanding; and, interpretation involves the interpreter and the interpreted in a dialogic relationship (p.71).

Leonard (1989) writes of two assumptions that hermeneutics as a methodology derived from Heidegger's phenomenologic view of the person. The first assumption is that the researcher has a preliminary understanding of the human action being studied because of the common background meanings given by culture and language. Secondly, there is no point from which the view of the world can be atemporal and ahistorical so that it is impossible from the phenomenological viewpoint to have objectively valid interpretation (pp.51-52).

Narratives

Part of the research aim is to elicit a narrative which reflects the lifeworld of the person, that is, the context of the phenomenon being studied. Narratives are of benefit to both the person experiencing an event and to the researcher.

Understood as a "happening" that unfolds throughout a lifetime, a person's identity can be grasped only in terms of his or her life story as a whole. The temporal unfolding of life, as Ricoeur has pointed out, has the structure of a narrative. We can understand who a person *is* only in terms of where that person is coming from and where he or she is going.

(Guignon, 1993, p.225)

An older person who has had surgery has a particular story to tell, one which is personally significant. Hydén (1997) reinforces the significance of the narrative in such a situation:

By uncovering a means of interpreting the illness, we become better able to re-establish the relationship between the self, the world and our bodies. Thus, the narrativised reconstruction is concerned with two things: first, with gaining meaning and

import to the illness by placing it within the context of one's own life; and second, with reconstructing the narrative of the self.

(Hydén, 1997, p.57)

According to Hydén (1997) all types of illness affect one of the fundamental aspects of life, that is, its extension of time, as illness ruptures a person's sense of temporal continuity. Hydén sees narrative as offering the opportunity "to knit together the split ends of time, to construct a new context and to fit the illness disruption into a temporal framework. Narratives can provide a context that encompasses both the illness event and surrounding life events and recreates a state of interrelatedness" (p.53).

Kleinman (1988) considers what he terms "illness story making and telling" as particularly prevalent among the elderly. They frequently weave the experience into their life stories and in Kleinman's view this helps them illustrate the high and low points in their life. The telling and re-telling of the story by the affected person and significant others, give "coherence to the distinctive events and long-term course of suffering" (p.49). Frank (1995) considers that stories can heal, that the ill need to become storytellers in order to recover the voices that illness and treatment take away (p.xii). He views telling such stories as giving voice to an "experience that medicine cannot describe" (p.18). As Hutchinson, Wilson and Wilson (1994) point out it is in the telling of the story that the experience takes on meaning (p.162).

Benefits of the Narrative to the Researcher

For the researcher, the use of narrative has a number of benefits, for example:

- The interaction of the features of a story produces a set of meanings which make sense beyond the story itself.
- The story can reveal how the "tellers" explain, that is, understand and find meaning in their situation.

- A health-illness event can be studied from a number of vantage points, including that of the “experiencer’s” point of view. (This includes such aspects as the event itself, it’s effect on the person’s world and on their everyday life, a representation of the experience in daily life, and as an experience apart from that formulated by medicine).
- Participants may be more amenable to sharing their stories of health-illness events than to participating in other more constructed research methods, and therefore a narrative provides access to knowledge which can be a positive experience for both participant and researcher.

(Frank, 1995; Hydén, 1997, Oakley, 1992; Sandelowski, 1991)

Frank (1995) provides a simple statement which conveys the value of narrative. “The content that illness stories offer is valuable for a variety of purposes: for the teller’s reordering of her life story, as guidance to others who will follow, and to provide caregivers with an understanding of what the ill experience” (p.140).

Robertson-Malt (1999) reminds us that, “the essence of the participants’ experience is hidden within the language of the stories that arise once the taped interviews have been transcribed” (p.293). Heidegger (1971) sounds a caution about language:

Language beckons us, at first and then again at the end, toward a thing’s nature. But that is not to say, ever, that in any word-meaning picked up at will language supplies us, straight away and definitively, with the transparent nature of the matter as if it were an object ready for use.

(p.216)

TURNING TO THE PHENOMENON OF RECOVERY

Aim of the Study

The aim of the study is to understand the phenomenon of recovery at home for an older person after surgery. To inquire into the nature of recovery and guided by the work of Crotty (1996) and van Manen (1990) I sought answers to the following questions:

- What is it like for an older person to live through the experience of recovery from surgery?
- What is it that gives meaning to this experience?
- In what way is this recovery?
- What does it mean to experience recovery in the context of home / at this age / in this lifeworld?
- What is the nature of this phenomenon, recovery?

Choice of Method

My initial concern in relation to the topic was how older persons managed on returning home after surgery. From the beginning I was interested in the older person in their lived world and how recovery affected their everyday life. I wanted to know and understand what the experience of recovering at home was like for an older person. This developed to the realisation that the focus of the study was recovery as a phenomenon, as it existed in the life of an older person at home.

My interest was in the older person's perspective rather than from a nursing or biomedical perspective because I considered this would provide the opportunity to "return" to the person undergoing the experience. I wanted to explore recovery as it was lived.

Smythe (2000) states, "the experience following discharge [from hospital] lies hidden from the gaze of the health professional. Advice is given, or not given, based on assumptions" (p.18). Nurses are involved in the initial stages of recovery while the person is in hospital and help "set the person on the road to recovery" but a nurse may or may not be involved in the longer process of recovering. If the initial involvement of the nurse is to be beneficial for both the person and the nurse it is necessary to understand more about the journey and destination of recovery. Taylor (1993) expresses the benefits of exploration of phenomena related to the person, health, environment, and nursing as serving "the immediate ends of relieving human suffering and enhancing patient care generally, as well as generating knowledge to bolster the disciplinary base of nursing itself" (p.175). The philosophical assumptions underlying phenomenology as a method seemed to me to be consistent with the aim of my study.

Research on recovery has tended to focus on areas such as physical progress, preparation for discharge from hospital and the type and amount of help required once the person goes home. The methods often chosen use measurable indicators, tests, and observable behaviour techniques. As Madjar (1991) indicates, such approaches may "fail to capture the complexity and richness" of human experience (p.43). In her study of inflicted pain, Madjar points out that biophysical or behavioural events can answer only a limited range of questions and this applies equally to the phenomenon of recovery. The need is to begin with a phenomenological analysis of the experience of recovery from surgery for the older person, that is, an account of what recovery means. What recovery *means* to the one who is "undergoing it" makes a difference in the course of their recovery.

The phenomenological method was chosen because access to the phenomenology of recovery was considered to be best gained through the lived experience of the "recoverers" (the participants). Their lived experience of recovery provided insights into their daily world and how they inhabited it. In addition, as Plager (1994) emphasises:

What is of concern in hermeneutic phenomenology is this practical engaged activity of our everyday lives and the description and interpretation of what gets disclosed and what might have got covered over in the process of our being-in-the-world.

(Plager, 1994, p.70)

Phenomenology provides another vantage point from which to view the nature of recovery and what it might require of the nurse in response.

Assumptions, Expectations and Preconceptions / “Coming from My World”

According to Dreyfus (1991), in human sciences if the interpreter is to understand what is going on he/she must share the general human background understanding of the person or group being studied. The researcher comes with an already established background of pre-understanding and value positions. My work as a nurse and nurse educator, and the experience of older members of my family undergoing surgery, provided an understanding for this study. My mother's experience of surgery in her 70s spurred my interest in the topic. The topic of research is generated by its emotional significance to the researcher – what is seen as important. The feelings which arise when initially considering a situation or problem will lead to the questions to be asked (Drew, 1989).

Work and family experience has resulted in my having assumptions, preconceptions and expectations about older people, surgery for older people including early discharge from hospital, and their recovery at home. It was important to identify such issues early in the research process to enable the development of non-biased trigger questions and attitudes. During the course of the interviewing process there was need for reflection of assumptions, expectations and preconceptions – I needed to re-examine these as participants shared their experience. Similarly, a review of the study as a whole caused me to reflect on changes in my attitudes.

The experience of older family members was of benefit in that it enabled access to the world of the participants and provided a link between the interviewer and interviewees. For example, two of the participants had the same surgery as my mother and were interested in her progress and how it related to their experience. My experiences of living with an older person recovering from surgery required me to be particularly alert to the necessity to “stand back” from those experiences and to listen to, and regard, each of the participant’s stories with a “fresh ear” and as a new and different narrative. This raises the issue of “bracketing”. Bracketing, whereby all preconceptions and assumptions are put to one side and not allowed to affect the phenomenon being studied, is advocated by some adherents of phenomenology. Van Manen (1990) defines bracketing as the “suspending of one’s various beliefs in the reality of the natural world in order to study the structures of the world” (p.175).

According to Frede (1993), Heidegger considered that use of bracketing in phenomenology was a critical mistake.

For Heidegger, who was concerned with a penetrating analysis of how we are related to the world and to ourselves as beings with a world, all abstraction from the way Dasein actually experiences the world must destroy the phenomenon of “having a world”. For the world is precisely the context in which we encounter beings and *ourselves*, and it is this encounter that determines what they *are* for our understanding.

(p.56)

In other words we can understand something only from within a context that we bring with us already (Hoy, 1993, p.191).

Crotty (1996) points out bracketing, in the sense of what we focus on, what we choose to perceive or ignore, is a normal part of life. The difficulty with bracketing in phenomenology, however, is the differing views of what it means. These range from a “complete” laying aside of beliefs, pre-

understandings, or assumptions to an unnecessary consideration. Oiler (1982) and Crotty (1996) provide an explanation of bracketing which emphasises “focusing in”.

Oiler (1982) says it is possible to control bias in reflection on experience by means of bracketing which she defines as suspending or laying aside what the individual thinks they already know about it. In her examples she conveys the notion of bringing an experience into clearer focus, for example, by the questions asked of the participant and, in interpreting the answers, the researcher’s clarifying their own thinking about the experience. Oiler considers this enables the researcher to bracket the experience more effectively and states that “bracketing does not eliminate perspective, it brings it into view” (p.180). This viewpoint of bracketing includes both researcher and participant focusing on the phenomenon. Crotty (1996) considers bracketing has been misused by a number of nurse researchers (pp.159-160). In his descriptions he conveys a notion of refocusing. For example he speaks of the “need to lay aside familiar understandings and open oneself to the world in fresh ways” (p.71), and “stepping outside the circle of the taken-for-granted” and “be ready to receive being as it is” (p.152). In other words, stepping into the hermeneutic circle and being receptive to what the phenomena have to offer which Crotty describes as “openings to fresh meaning, scope for deeper understanding, possibilities of more authentic and more telling interpretation” (p.152).

As a nurse and as a person with first-hand day-to-day experience of an older person recovering from surgery, I was not able to completely put some aspects to one side during the course of this study. For example I know some participants shared information *because* I am a nurse and because I had an understanding of their daily life – I lived through similar experiences on a daily basis with my parent. This also had the benefit of conveying to them that what they said was of value and was important to me. In the development of the questions, the conduct of the conversations with participants, and in the analysis of the data I attempted to focus in on

the topic, remain alert to bias, and reflect on my assumptions, expectations, and preconceptions.

ETHICAL CONSIDERATIONS

Ethical principles guide any research. Campbell, Charlesworth, Gillet and Jones (1997) identified four areas in which these ethical principles should be applied – scientific validity, risks and benefits, informed consent, and procedures for ensuring the ethical conduct of research. These areas are discussed in relation to my study.

Establishing Rigour

According to Cohen (1987) phenomenology strives to be a rigorous science in the service of humanity. Van Manen (1990) describes phenomenology as a critical theory of the unique. Qualitative research requires unique criteria appropriate to the research approach (Lehr & Marcus, 1994). Concepts such as validity and reliability are not appropriate in phenomenology in that they measure right or wrong, black and white situations. In phenomenology there is no right or wrong answer but there is a need to demonstrate phenomenological research as trustworthy by the rigorousness of the research process and how the findings are able to be evaluated, that is, that good science has been practised. Sandelowski (1993) believes that “rigor is less about adherence to the letter of rules and procedures than it is about fidelity to the spirit of qualitative work” (p.2). Several writers have considered criteria for judging the calibre of phenomenological research (Guba & Lincoln cited in Koch, 1994; van Manen, 1990; Sandelowski, 1993).

The measures I have taken in this study to achieve trustworthiness are considered under the criteria proposed by Guba and Lincoln as identified by Koch (1994), Lehr and Marcus (1994), Morse and Field (1995), and Sandelowski (1993). The criteria are credibility, transferability, and

dependability. (Alternative terms used by some writers are indicated in brackets).

Credibility (Truth Value)

Multiple realities are recognised in phenomenology. The findings are able to be judged as true or credible by the participants and by the researcher's peers. The way in which the participants' data are dealt with in collection, analysis and presentation is important as is the researcher's self-awareness. Participant interviews were taped and transcribed verbatim. Direct quotations and exemplars were used in the data presentation. Participants were offered the transcription of each interview and the opportunity to amend the transcript. (Not all participants took up either opportunity). At the conclusion of the four interviews for each participant the overall themes were presented to check if they reflected the essence of the participant's experience of recovery. The process for collecting data was pre-determined and followed. Any change required was first discussed with the supervisor and was recorded. A journal was kept which was both a log of the research process and a record of my reflections. Orientation and repeated re-orientation to the phenomenon and reflecting on the data facilitated being true to the data. Reflecting on the recovery experiences of older relatives at the conclusion of the findings enabled me to relate their experiences to that of the participants. The credibility of the study will be further judged when it is read by others.

Transferability (Applicability / Fittingness)

Transferability enables readers to relate the data to their own experiences, to perceive data as meaningful and/or to apply the findings in other contexts or with other groups. It determines how well the findings can be transferred outside the study situation.

Sufficient information needs to be provided about the participants, about the context of the study and about the findings to enable transferability. In

this study the age group of participants was provided and the participants' abilities were illustrated in the findings. Age as perceived by the participants was described. All participants underwent surgery and their recovery from different types of surgery was illustrated. The contexts of both hospital and home were presented as perceived by participants with most emphasis on the home. The phenomenon of recovery was discussed from several aspects. The themes and sub-themes which arose from the data, presented a sample of the meaning of recovery for older people and the potential to transfer this understanding to other older people.

Dependability (Auditability / Consistency)

The criterion of dependability requires a clear account of the research process from the study question through to the findings. Providing a decision trail and information about choices made during the research process enables the research to be audited. It may also assist other research to be undertaken for example in a similar context, or with other age groups.

The documentation kept by the researcher as a personal record of the research process allows for a self-audit. The information provided in the text allows the reader to audit the process.

Self-Audit

As mentioned previously a journal was kept to record the research process. After each interview a statement was recorded about the interview itself and the interaction with the participant. Notes were written after each meeting with the supervisor/s. A weekly plan for work was kept throughout the study. Drafts and notes were dated enabling me to see the development in ideas and thinking. Reflections were recorded in the journal and issues were discussed with my supervisor.

Reader Audit

Information throughout the thesis should assist the reader to assess the dependability of the research for example the reasons for choosing both the topic and the design and method of the study, and how the findings were interpreted.

Confirmability (Neutrality)

Confirmability is described by Morse and Field (1995) as freedom from bias in the research process. Leonard (1989) extends this description to emphasise ensuring the maintenance of the integrity of the text. The researcher must be able to stand aside from the text so that what the text is saying is distinguishable from the researcher's responses. Confirmability is also described as what occurs when credibility, transferability and dependability are achieved. The way in which the interpretations have been arrived at demonstrates how the three criteria have been achieved (Koch, 1994; Liehr & Marcus, 1994).

Bias cannot be completely limited because the researcher, like the participants, is a self-reflecting being who shares a common cultural and historical background with the participants. There is therefore a presupposition that the interpreter has some prior understanding of the phenomenon and cannot "bracket" this in order to study the phenomenon.

Steps taken to reduce bias were:

- my personal beliefs and experience were identified before data collection began
- participants were interviewed several times
- care was taken with the language used in interviews
- issues were discussed with my supervisor, for example, ethical situations

- a broad range of resource material was used which provided challenges to thinking and consideration of alternatives
- reflection throughout the research process
- several approaches to the process of data analysis were used to confirm my findings
- my own situatedness in writing up the study was described, for example, my mother's unexpected series of operations.

While the emotional investment the researcher has in the study can be a potential for bias conversely, as I found, it can sharpen one's focus in orientation to the study question.

Ethical Approval

The research proposal which included copies of letters for the surgeons and participants, and the information sheet and consent form, was submitted to and approved by the Massey University Human Ethics Committee and the Canterbury Ethics Committee (see Appendices One, Two, Three and Four).

Autonomy / Informed Consent / Confidentiality

The information sheet and consent form were printed in a font size which would allow for easy reading for participants.

The participant group was a self-selected group. Before any consent form was signed the information sheet and consent form were discussed and the process reiterated. There was one exception, when the person, on initially contacting me had already signed the consent form and was checking where to send it.

My Presence in the Participants' Homes

As the researcher I was mindful that I was in a participant's home at their invitation. I addressed participants as Mr or Mrs unless invited to do otherwise. I sought permission from each participant to use their first name while recording the interviews, to protect their anonymity. I was aware that I was a guest in the participant's home and adjusted my approach according to their response to me. The first visit was crucial in establishing a relationship, which allowed the participant to feel comfortable to have me in their home and to feel able to talk with me on tape. I took care to adapt my dress to fit in with how the participant dressed, for example two of the male participants always wore "collar and tie", another always wore shorts and usually had bare feet so I dressed more casually when meeting with him. Similarly some participants liked to chat, while others did the interview and I left straight after. If participants offered information about themselves that was of interest but not strictly pertinent to the study I accepted this but I was mindful of not asking questions about areas that were not directly related to the study. For example, the type and number of previous operations. Sometimes, what might have first appeared to be information not relevant to the study became very relevant in informing me about a participant's usual way of being-in-the-world.

Interview times were arranged at mutually convenient times and places and in all but one case, interviews took place in the participant's home. A number of participants recorded the time for each interview in their diary or on a calendar, while one participant asked me to contact him the day before the scheduled interview as a reminder.

Participants were told that a pseudonym would be used to ensure their anonymity in the thesis. Several participants stated they were not concerned about the privacy aspect, they did not mind others knowing who they were and what operation they had. A number of participants indicated that by participating in the study they could perhaps be of some help to others who had to undergo surgery. Each participant was offered a copy of

the transcription of the taped interview and/or a copy of each taped interview. Eight participants requested a copy of each transcript and any amendments they requested were made to the original transcripts. Two participants requested a copy of the interview tapes. Five participants indicated they would like a summary of the study on its completion. Participants knew the structure of the interview process, when the recorded interview phase ended, and that the themes discussion completed the process. Several participants invited me to visit them at any time, three participants (including the spouse of one) were specific in their wish to keep in contact.

A transcriber was employed to produce the transcripts of the taped interviews. She signed a confidentiality agreement accepting the information in the tapes and transcripts was confidential, was not to be discussed with or divulged to anyone other than the researcher, and that all interview material, tapes, and computer disks must be returned to the researcher (see Appendix Five). In discussion of issues arising from the interviews with supervisors, the participants were not identified by name. The participants had been told with whom their data might be discussed and under what circumstances as part of the process of obtaining consent.

Security of Interview Data

Copies of tapes, transcripts, computer disks, and field notes were kept in a locked area. Duplicate copies of transcripts, tapes, and disks were kept in separate areas. The transcriber kept disks and transcripts in a locked area. A record was kept of the location of tapes and disks during the transcribing period to keep track of all material. For identification and easy location participants' files and tapes were colour-coded. Files contained notes, records of meetings and a copy of each transcript.

THE STUDY PROCESS

Inclusion Criteria

People were eligible to participate in the study if they:

- were aged 70 years and over
- lived in the Christchurch area
- had returned home to recover after surgery
- were able to understand and respond in English
- were willing to participate

Access to Participants

Recruitment of participants had to meet the requirements of the ethics committees in that participant inducement must be avoided. It was important that potential participants made the approach to the researcher. Advertising was considered and rejected because of the uncertainty of response and timing factors. Two means of access were therefore pursued – primary service access i.e., anyone being admitted to hospital for surgery and fulfilling the specified criteria be invited to participate in the study, and primary surgeon access. In considering the first option it became evident that this could become a prolonged and difficult process in the public sector and gaining approval would be unlikely because of organisational change and privacy issues. Primary service access in the private sector was not pursued on the advice of a private sector manager that the surgeons were the clients of the service and controlled access to the patients.

Surgeons within the Christchurch area were contacted to ask if information about the study could be given to up to five patients who met the criteria (see Appendix One). The number for each surgeon was restricted to cause the least amount of work for the surgeon and his or her staff. Information about the study was provided in writing together with a copy of the

participant information sheet and consent form. A return agreement form was included. Copies of the Ethics Committees approval were offered and provided on request. The approach to surgeons was carried out in two waves. In the first wave nine surgeons were contacted, in the second wave eleven surgeons were contacted. The approach in two waves was done to better manage the number of interviews over a period of time.

Table 1: Number of Surgeons by Specialty

	Eye	Orthopaedic	General Surgery	Gynaecology	Total
Wave 1	2	2	2	3	9
Wave 2	1	5	5	0	11
Total	3	7	7	3	20

Of the 20 surgeons contacted, 12 agreed to assist by arranging for the information sheets to be given to possible participants; two were unable to assist but suggested alternatives for accessing participants; one was on sick leave; three were indefinite and two did not respond. When no response to the initial approach from the surgeon or the designated staff member was received within a two or three week time frame, follow-up contact was made. Once the surgeon had agreed that information would be sent, participant information was provided in a stamped envelope, to be sent to up to four potential participants.

There were three exceptions to access to participants. In two cases I knew the persons and an intermediary made the initial approach, whereupon the persons agreed to my contacting them. In the third case, while interviewing one of the participants he told me of someone he knew who he thought could be interested in talking with me. I indicated if he felt comfortable about approaching him to do so and this he did.

Potential participants contacted me by telephone. The initial contact took several forms - providing further information or reiterating information about the study process, answering questions, checking participants met the

inclusion criteria, and confirming that the participant would be suitable to talk with. I offered to meet with participants before they confirmed their willingness to participate in the study. I suggested they meet me first to decide if they felt comfortable talking with me. There was only one instance where a pre-interview meeting occurred. On the other occasions once the consent form had been discussed and signed, at the participant's suggestion we proceeded with the first interview. Two copies of the consent form were signed and dated, one kept by the participant and the other by me as researcher.

Participant Profiles

A total of 13 people participated in the study. Recruitment via surgeons may have affected the participant group in terms of socioeconomic status and gender but this is impossible to assess. As the surgeons worked in both the private and public sectors the assumption that there would be more participants of a higher socioeconomic status cannot be made and this was not a focus of the study.

Demographic data indicate that the number of women exceeds that of men in the aging population. I had expected there would be more female than male respondents, but this was not the case. Of the 13 participants there were ten men and three women. The need to seek more female participants was discussed with my supervisor about half way through the data collection. This was to be reviewed after the Christmas break but in the meantime several more people wished to participate in the study. Rather than exclude them on the grounds of gender I chose to proceed with the interviews. It is impossible to account with any certainty for the predominance of male participants. One reason could be that participants were approached via surgeons who in the main were males and that they focused on male patients. I am aware, however, that some of the male participants were recruited by a female nurse or administrator who assessed the surgeon's records for people who met the criteria for the study and passed on the study information to them.

Ages ranged from 69 to 88 years with 11 participants ranging through the 70s age group. Eight lived with their spouse and the remaining five lived alone, their spouse having died. Each participant was given a pseudonym. Dulcie (69), Nell (75), Neal (78), Owen (73), and Peter (88) lived alone. Connie (72), Simon (78), Ben (72), Will (71), Matt (74), Colin (75), Frank (73), and Harry (72) lived with their spouses. (Colin and Peter had a birthday during the interviewing phase and their ages at the completion of the process are recorded here). All were “retired” except Frank, a businessman. The description of “retired” is an inadequate one for a group of people who, with one exception, were actively involved in their communities in a variety of ways. The one exception was a participant whose general health precluded such involvement.

In terms of manageability of the study, 13 participants was an appropriate number. Baker, Wuest and Stern (1992) point out, “Phenomenological studies are designed to describe the essence of a given phenomenon and informants are chosen because they have lived the experience being investigated. Sampling is, therefore, purposive. In keeping with its aim of illuminating the richness of individual experience, the sample size is kept deliberately small” (p.1358).

Type of Surgery

The most common surgical procedures carried out for older people are, ophthalmic, for example, lens replacement for cataract, orthopaedic, for example, hip replacement, and surgery related to heart disease. I chose deliberately not to focus on one particular type of surgery as my focus was recovery from surgery per se not from a particular type of operation.

Table 2: Type of Surgery Undergone by Participants

General Surgery	Genito-Urinary	Gynaecology	Orthopaedic
3	1	1	8

Four operations were connected to cancer; of the four, one was to remove part of the colon (large bowel) because of a cancerous growth; two involved complications following previous surgery for bowel cancer, and the fourth was to relieve symptoms of cancer which had affected the prostate gland. Of the orthopaedic surgery there were two hip joint replacements and one shoulder joint replacement; three repairs of shoulders, one spinal and one elbow operation. All participants had undergone previous operations although for one man this was only his second operation, which was required to deal with complications of the first operation.

The surgery had been carried out in both private and public hospitals. The length of stay in hospital ranged from one to 15 days with eight people spending one to five days in hospital, three people spending six to ten days and two spending 11 to 15 days in hospital. Three people had arranged to spend time in a rest home following their discharge from hospital. All three lived alone. Each of the participants shared their reasons for this decision and this is considered in Chapter Three.

Data Collection

Data were collected from a number of sources. Notes were kept of telephone calls, initial and themes meetings, and after each interview. Observations were made about how the participant seemed in terms of their health and in coping with their day-to-day life.

A personal journal was kept as an account of my journey through the process of research. During this time I continued my reading related to the topic. This was assisted by 1999 being the "Year of the Older Person" so that there was extra publicity about and attention to the older person. An article file was maintained and papers such as *Older and Bolder* (a newspaper for Canterbury's over 50s population), and *Keeping On* (produced by Age Concern Canterbury) were read regularly.

In 1996 the Prime Ministerial Task Force on Positive Ageing held

consultation meetings around New Zealand seeking community input on the document, *Facing the Future* and I participated in the meeting held in my city. A number of relevant television programmes were viewed. An unexpected occurrence during the course of the study was that of the first-hand experience of a parent in her 80s having a total of four operations. As her primary carer and her companion I lived on a day-to-day basis with her recovery experience.

Participant Interviews / “Gathering the Stories”

Studies cited in Chapter One used interviews to follow people's progress through recovery. These included interviews while the older person was an inpatient, followed post-discharge by telephone interviews at varying intervals, for example, weekly, two weekly, monthly, and up to 12 months post-operatively. The requirements for completion of the thesis placed limits on the time available for data collection. The interview schedule was planned to capture the richest data possible in a manageable timeframe. It was decided to interview participants over an eight week period with the first interview two weeks after discharge to provide data about the early stages of recovery as the period immediately post-discharge appears to be that of greatest risk for older patients (Jackson, 1990; Yates, 1995). Subsequent interviews at two weekly intervals would provide insight into the progression of recovery.

Interviews were conducted in the participant's home at a mutually agreed time with one exception. One participant, Matt, lived some distance from Christchurch and for this reason did not meet the specified criterion in the research proposal. Matt was eager to participate in the study so I said I would discuss this with my supervisor and get back to him. My Christchurch supervisor suggested the option of taped telephone interviews if Matt had access to a tape recorder. Matt did have a tape recorder as he was learning Japanese by tape. A system was set up whereby I posted the blank tapes to Matt and he returned them in the stamped addressed envelopes I supplied. We each taped our part of the conversation and

during the interviews I kept notes as an added help for the “marrying” of the transcripts by the transcriber. On Matt’s first post-operative visit to his surgeon, his wife delivered the first tape to my home and I was able to go out to meet Matt as he waited in the car. We were able to arrange the fourth interview to coincide with a further visit to his surgeon and this was held in my home.

The interviews were semi-structured taped conversations. As they extended over a period of time, for each two-week period I developed a set of guide questions. Questions asked were modified according to what each participant shared with me at each interview. The question guides were modified after the first two interviews with the first two participants. I realised that I had failed to include anything about being at home for the recovery period, an essential part of the research so I needed to ensure this was in the question guide in case it was not raised spontaneously by the participant (see Appendix Six).

Lawler (1991) comments on the selection of the language used when framing questions and says that “texts often stress the need to use language familiar to the interviewee, and they emphasise the importance of phrasing the questions to fit the interviewer’s frame of reference” (p.17).

A set of question guides was copied for each participant as this enabled me to note any questions or areas to explore specific to a participant, and to record before each interview aspects or issues that had arisen during the previous interview which needed to be followed up, for example, issues I had not picked up on during the interview. During the interviews in addition to listening to what the participant wished to share, I clarified queries, summarised what I thought a participant had said, and explored areas further. After each interview a copy was made of the tape, and during the taping notes were made of the recording. The tape was then transcribed.

At the first interview I began with questions of a general nature to try to put the participant at ease and allow them to become accustomed to having the

tape. General questions covered aspects such as the operation and how they felt about it, how long they spent in hospital and what it was like in hospital. Before the interview started I told them in general terms what sort of things I would ask them about and reiterated there were no right or wrong answers, that I was interested in *their* experience. In following interviews I found a useful conversation starter was to ask how a participant had been over the previous two weeks. This enabled me to assess what had changed for them and what was currently significant for them in their day-to-day life.

Progress through the interview was varied; some participants spoke freely, others needed prompting or time to ponder; some were more comfortable with my "asking my questions", others provided long narratives which often contained significant points and illustrated their way of being-in-the-world. Several participants made it quite clear that if they could help others by talking about their experience they would do so; others did not see what they said would be of any help. I could assure the latter group that what they shared was of value. This was aided when I could share with them that other participants had similar experiences.

The length of the interviews ranged from thirty minutes to an hour. On one occasion I drew an interview to a close because the participant was showing signs of tiredness and pain; and with another participant whose energy levels were not high, I kept his interview sessions as short as possible so as not to overtire him.

For three participants their spouse was present for all or part of the interviews but they were not intrusive. On occasion there were interruptions during interviews by telephone calls, visitors, or meal delivery. These were accepted as part of the participants' lives and were coped with without too much disruption.

After I had completed the set of four interviews with the second participant I asked my supervisor to read them as a check for me to assess my

approach to the participant, to the topic, and to the method. "The art of the researcher in the *hermeneutic interview* is to keep the question (of the meaning of the phenomenon) open, to keep himself or herself and the interviewee oriented to the substance of the thing being questioned" (van Manen, 1990, p.98). Van Manen's proposition of the participants becoming co-investigators in the research holds true for their interest, willingness to participate, their investment in time, desire to be of help to others, and to the researcher, all of which were demonstrated by the participants in this study. The conversations with the participants became as van Manen (1990) stated, "talking together like friends" (p.98).

Adjustments had to be made in timing between interviews depending on the personal circumstances of the participant. For example, Connie postponed her fourth interview because she was unwell, Colin and Will went on holiday so their second and fourth interviews respectively were delayed. Owen came home from hospital for a week then went to a rest home for a week so his first interview was delayed.

Apart from two occasions the second, third, and fourth interviews occurred at two weekly intervals. Where participants contacted me and indicated they had been home from hospital for a period longer than two weeks (e.g. Will, five weeks, and Frank, seven weeks) I consulted my supervisor about accepting them as participants. In Will's case it was decided to proceed with two weekly interviews over an eight week period, in Frank's case which involved a longer time period since discharge from hospital it was decided, if he was agreeable, to undertake a one-off extended interview which would cover the areas for all four interviews. This would provide information about Frank's experience of recovery from a longer time frame and act as a comparison to the experience of other participants. This proved to be a valuable and useful experience for me.

Completing the Interview Process

The final meeting with participants was to present the themes which had come through the four interviews. These were discussed and commented upon by the participants. Participants were asked if they thought the interviews had captured their experience of recovery, if the themes reflected their experience of recovery, and if there was anything they felt had been left out. Simon suggested one aspect that he felt should be included, and this was noted. All participants were aware that once the themes feedback had occurred that this completed the research process.

Participant - Interviewer Relationship

The nature of the relationship established and developed during the interview process reflected those in everyday life. Participants shared aspects of their life and were interested in aspects of mine. Some examples: Connie always insisted on my having afternoon tea after our interview, Nell showed me new clothing she had bought, Dulcie and I sauntered around her garden discussing plants, Simon and I had a common interest in the answers to the *Listener* crossword, Neal had picked a bunch of roses from his garden for my mother, Will showed me the wooden album he had made for his family history and gave me a hydrangea cutting, Ben gave me a video of his home country which I had visited, to look at, Matt invited me to visit his tourist venture, Owen showed me the woodcut pictures he had made, and, Harry and his wife wanted me to "pop in at any time" and have a cup of tea. A number of participants invited me to visit if I was passing. I have made one visit, to the widow of one of the participants who died after a motor vehicle accident.

Some aspects of the participants' lives were probably shared with me because I was a nurse. For example, Connie and Will showed me their shoulder wounds, Ben his elbow, Harry his ostomy hernia, Simon and Nell showed their swollen ankles about which they were concerned, and Owen showed me the chart of blood pressure and pulse recordings he had been

keeping.

In some instances participants sought my advice or reassurance that what was occurring was usual and not untoward. They were looking for affirmation that what they thought or might do was appropriate and/or right. They shared with me what they saw as positive signs of their recovery – my response of “that’s good” was a further way of seeking affirmation especially where, as Simon said, they had no yardstick by which to measure their progress. In responding I had to be careful about the researcher-nurse line and had discussed this dilemma with my supervisors.

I used as an internal audit, the question, “What sort of answer would someone with general knowledge give?”. People appear to be better informed about health and health problems and the participants were no exception. Simon for example, had been reading about some Australian research on recovery after hip replacement and talked with me about it.

Sometimes a simple answer sufficed, at other times I might ask if the participant had discussed the query with their doctor and in some instances suggested they consider doing so. I was able to suggest aids that might help and saw this as appropriate. There was one instance where I acted as a nurse and saw it my responsibility to do so. The participant had unstable health and the symptoms he described to me in the course of the interview concerned me. I checked with him when he was due to go to his General Practitioner and that it would be a good idea to do so. He indicated he would be going to see her in about a week’s time. The interview took place on a Friday and I thought about this over the weekend. On Sunday I rang him to check how he was and reiterated my suggestion that he should see his doctor soon. He thanked me for my concern (and repeated his thanks at our next interview). He made an earlier appointment with his doctor. This was an ethical issue for me. In my assessment he needed to consult his doctor because of the unstable nature of his condition and I needed to strongly encourage him to do so.

Christensen (1990) points out that “entry into the field to collect data does mean that the researcher becomes involved in the everyday life of the people involved” (p.228). The relationship developed between the nurse researcher and the participants will influence the research and needs to be reciprocal in nature.

Data Analysis / “Seeing” the Meaning of the Text

In considering the phenomenon of recovery I needed to “dislocate” myself from my usual perspective in order to view it with fresh eyes, to focus in on it. Oiler (1982) graphically describes this as looking at the experience with wide-open eyes, with astonishment and concentration, becoming absorbed in the phenomenon without being possessed by it.

Phenomenological analysis... sets out to produce its interpretations from within the material itself, the aim being to uncover and understand meanings and to identify important strands and threads. Here the researcher’s own thinking serves as a tool of analysis; the results that flow out of this process are produced in interaction with the material itself.

(Astedt-Kurki & Heikkinen, 1994, p.420).

The process of analysis started early in the data collection.

Part One: Beginning the Analysis / Drawing the Threads Together

From the taped interview as the copy of the tape was being made a written record was kept of the main points. As each interview transcript was received from the transcriber it was reviewed and amended as required. Using van Manen’s (1990) approach, an overall theme or “sense” of the interview data was identified and data were recorded under the four lifeworld existentials of lived body, lived space, lived time and lived relations. Edited transcripts were returned to those participants who requested them for amendment and/or confirmation.

In the review of the transcripts assumptions and areas which required clarification or elaboration were identified, to be followed up at the next interview. Other pertinent areas, which a particular participant mentioned during the course of an interview, were raised with other participants, for example, the concept of hope; or whether other participants who had undergone similar surgery had like experiences, for example, pain.

At the conclusion of each participant's set of interviews, the interviews, the summary notes and the lifeworld existential summary were reread and themes identified. Additions to the original analysis were made. The overall themes were presented to the participants and comment sought. A written record was made of the discussion. I had chosen not to tape the themes meeting to allow for a more informal meeting, but in hindsight it would have been valuable to tape the discussion.

A discussion took place with the transcriber who was not involved with the health field. I asked her what themes had become apparent to her during the course of transcribing and I noted these as we discussed them. This was a valuable exercise with input from someone independent from the study. Part One of the data analysis and interpretation involved continual refining, clarifying, and reflecting.

Part Two: Bringing the Phenomenon of Recovery to Light and Describing It

Throughout the collection of data, reflection and noting of ideas as they appeared took place. This was supported by a framework of material from a variety of sources, which facilitated a consideration of facets of transcript data. In uncovering the phenomenon of recovery for this group of older persons the questions posed by Crotty (1996), Moustakas (1994), and van Manen (1990) were kept in mind viz:

- What is giving itself to us in this moment?
- What is presenting itself to our gaze?

- What is this phenomenon saying to us?
- What does this phenomenon strike us as being?
- How did the experience of the phenomenon come to be what it is?

During the data collection phase similarities between participants had arisen. In embarking on a deeper analysis the themes material previously developed from data recorded under the lifeworld headings were put to one side. One purpose of this was as a self-audit to check that the later interview themes had not been driven by the earlier interview themes - was I just "fitting" later interview data to the earlier themes identified? Before proceeding to the next stage of analysis the initial analysis for each participant's set of interviews was collated for the whole group of participants (Phase One).

All field notes, themes discussion notes, and transcripts were read and reread. Data from each set of transcripts were again recorded according to the four lifeworlds and in such a way to enable overall patterns to be seen for both individual participants and for several participants. Themes and sub-themes were developed and these were compared with the original themes, which comprised the material discussed with the participants. Arising from these two phases a third phase resulted after collation of all the ideas and possible themes and sub-themes recorded during each analysis in Phases One and Two. Phase Three comprised checking, eliminating, building a composite of sub-themes, themes, and essences. The tentative themes discussion with each participant was re-read. During Phase Three pertinent information such as the participants' statements about what recovery would mean for them, was collated.

With each phase new 'ideas' arose as a facet of the phenomenon not previously identified, appeared. These were incorporated into the themes and sub-themes and helped clarify the essence of the phenomenon.

Interpreting the data required a process of going from parts to the whole and vice versa. For example, each set of data for each participant was

studied per individual interview, as part of a whole (one set of four), and then as a whole. Each set of interviews for each participant was studied as part of the whole group and all the data were considered as a whole. This process unfolded themes common to all participants or most of the group, as well as some themes common to a few participants. It should be noted that while themes and sub-themes may be labelled "common" to all or a number of participants at the same time, how the theme / sub-theme is reflected in each participant's everyday life is unique.

Phase Four involved a process of working through variations of themes and sub-themes, considering the wording used to describe them to produce an account of the phenomenon of recovery which would reflect the data and illuminate the phenomenon and which would "speak" to readers / others in a credible and valid way. Throughout the phases there was systematic documentation of pertinent information arising from the analysis, for example, participants whose recovery was longer than they expected; those for whom cancer was of significance in a direct or indirect way. Exemplars were noted and extracts compared.

Interpretive phenomenology (hermeneutic approach) describes things as they appear and interpret what is observed. Van Manen (1990) emphasises that "... no conceptual formulation or single statement can possibly capture the full mystery of [this] experience... a so-called thematic phrase does not do justice to the fullness of the life of a phenomenon. A thematic phrase only serves to point at, to allude to, or to hint at, an aspect of the phenomenon." (p.92).

He variously describes a theme as a means to get at the notion being addressed, as describing an aspect of the structure of lived experience, giving shape to the shapeless, as always a reduction of a notion, as only a fastener, focus, or thread to facilitate the phenomenological description, the fruit of the conversational relation, and as giving control and order to our research and writing.

Van Manen describes the project of phenomenological reflection and explication "is to effect a more direct contact with the experience as lived." (p.78). He points out that the meaning or essence of a phenomenon is not one-dimensional but rather multi-dimensional and multi-layered and can be communicated only textually. The use of meaning units, structures of meaning, or themes can facilitate the textual process and thereby bring to light the phenomenon.

Making something of a text or of a lived experience by interpreting its meaning is more accurately a process of insightful invention, discovery or disclosure – grasping and formulating a thematic understanding is not a rule-bound process but a free act of "seeing" meaning.

(van Manen, 1990, p.79)

Presentation of Findings / "Inviting the Reader to See What I See"

The work and thoughts of van Manen are particularly helpful and insightful when considering the presentation of findings in a study.

A phenomenological description describes the original of which the description is only an example... a phenomenological description is an example composed of examples. If the description is phenomenologically powerful, then it acquires a certain transparency, so to speak; it permits us to "see" the deeper significance, or meaning structures, of the lived experience it describes. ... A description is a powerful one if it reawakens our basic experience of the phenomenon it describes, and in such a manner that we experience the more foundational grounds of the experience.

(van Manen, 1990, p.122)

Van Manen speaks of a good phenomenological description as resonating

with our sense of lived life (p.27), and sums up the essence of phenomenology method:

... a good phenomenological description is collected by lived experience, and recollects lived experience – is validated by lived experience and it validates lived experience.

(van Manen, 1990, p.27)

To paraphrase Oiler (1982) the goal of describing is to communicate and to guide the reader by giving distinctive guideposts to the phenomenon. A successful description directs the reader to his/her own experience of the phenomenon.

In Chapters Four to Eight the context, and the themes arising from the data, are discussed within the framework of hermeneutic concepts and the work of van Manen (1990). In the presentation of findings, themes and sub-themes are used both to give structure to the phenomenon and to the writing. A combination of extracts, follow-through accounts of a particular participant, anecdotes, and literary quotations is used to illustrate the recovery experience for the participants and to illuminate the phenomenon of recovery. The existentials of spatiality, corporeality, temporality, and relationality are used to provide facets of the phenomenon.

Chapter Four deals with the context or lived space in which recovery occurred, with a focus on home.

Chapter Five focuses on the theme “disturbance in one's being-in-the-world”, where the disruption of self and world is considered.

Chapter Six discusses the theme “being-concerned-with”, those aspects of daily life which were of concern to participants.

Chapter Seven considers the theme “being-with others”, relating with others.

Chapter Eight deals with recapturing being-in-the-world and the aspects of moving on with one's life.

Chapter Nine discusses the phenomenon of recovery.

Chapter Ten considers the study as a whole and its implications.

REVIEW AND SUMMARY

In this chapter I have discussed the method and procedures used to carry out the study, provided information about the participants, and considered the ethical aspects of undertaking the study. The information is provided in an endeavour to enable readers to see how I approached the topic and carried out the study in order that they may judge its success in achieving the aim.

I have attempted to show that hermeneutic phenomenology is an appropriate method to study recovery from surgery for the older person. This method provides a way to gain a greater understanding of what recovery means from the perspective of the older person. Robertson-Malt (1999) makes a critical point when she states that "the themes identified are relative to the researcher's context of engagement with the text and therefore accepted as simply one amongst many ways of understanding these experience(s)." (p.294).

The next chapter examines the context participants inhabited during recovery.

Chapter Four

CONTEXT: THE WORLD OF THE PARTICIPANT

In the previous chapter the way in which data were gathered was described. In this chapter the context in which participants dwell is considered. Context as place comprises aspects of the study question – what is the meaning of recovery for older people who have undergone surgery and are recovering at home? Context is considered in the light of being in hospital, and having an operation – **being-out-of-place**; going home from hospital, and being at home – **being-in-place**; and how participants viewed age as a facet of their recovery – **presence of age**.

When we find a certain experience intelligible, what we are attending to, explicitly and expressly, is this experience. The context stands as the unexplained horizon within which – or to vary the image, as the vantage point from out of which – this experience can be understood.

(Taylor, 1993, p.325)

People are beings for whom things have significance and value – a basic characteristic of Dasein is that things show up as mattering. The context reveals what is of value and significance to the person in their connectedness to the world. As the context changes so may what will be revealed. Human experience is described as being context-bound or situated. “The word ‘situated’ is a Heideggerian term that is sometimes used to elaborate upon this contextual nature of human experience for to be ‘situated’ conveys the view of the person as being thrown into a world that circumscribes their choices and creates their possibilities” (Leonard,

1989, cited in Robertson-Malt, 1999, p.293).

Guignon (1993) describes "situation" as that which imparts unity and meaning to the natural flow of life. "It is our being-in-a-situation where things are clearly *at stake*, that gives our lives focus and direction." (p.29). According to Benner and Wrubel (1989) situation implies that one has a place to stand, a place to be. There is an implication of social definition and meaningfulness as well as the influence of the aspects of temporality – past, present, and future. How a person is involved in a situation will determine the coping options available (p.80).

Kluback and Wilde in their foreword to Heidegger (1958) state:

'Place' places man (sic) in the ground of self-consciousness, it confirms him in this world in a unique way. 'Place' reveals our being here, our human reality.

(p.24)

They contend:

To have 'place' is to be free. To have 'place' ontologically and empirically is to have a house in which being can unfold and manifest its Being... 'Place' is the house of Being, the revelation of the freedom of man and of the ground of his Being.

(p.26)

BEING-OUT-OF-PLACE

Being in Hospital

Being in hospital, being-out-of-place, means being displaced from home which is a familiar safe place to a place which is perhaps unknown, feels unsafe, carries risk, and where one is among strangers who speak a different language and have control over one's life. Hospital experience was not unfamiliar to the participants. All participants had experienced surgery before, some on several occasions, others once or twice. Despite this each occasion is a new experience for an individual and there are certain expectations.

Illness or an impairment of some sort (surgery in this case) can "cut into the fabric of everyday life, that is the "taken-for-grantedness' of daily life" (Zaner, 1982, p.48) and fracture one's sense of self, imposing limitations from without and frequently demanding radical adjustments which patients neither seek nor desire.

The time participants spent in hospital was not a major focus of the study but is of interest because it is where recovery begins. Participants were asked if there were any significant or specific things they remembered about their time in hospital. The following extracts illustrate that the specific things remembered often involved dealing with daily life habits and the taken-for-granted. Dulcie's expectations had to be readjusted.

I think the first day, and the second day after surgery, I felt it was a piece of cake but it seemed to get (laughs) worse and in the few days that followed and it was far more painful I thought to move, and to sit around in the days that followed and I think the surgeon explained that the bruising and so forth were coming out but I (laughs) I felt I was better the first two days. Perhaps I was a little more drugged those two days. (laughs)

...//.. It was very it was quite painful to be mobile, to walk and to sit in a chair, ah, that was quite painful whereas if I was lying down on the bed I was more comfortable but I certainly did get up and do my walking and you have to make yourself do that. I think they just leave you to please yourself but I'm a person that, I don't know, likes to get around and move and I knew it was better for me to get up and to exercise and walk around [than] give in and lie down again (laughs) so I do that.

(Dulcie, 1: 6, 7)

Dulcie was afflicted by a rash while in hospital and this was a source of great discomfort for her. This was significant for her and she also commented about her feelings.

Just the thought, after the operation that it was over and that I really wanted to get back to normal health and the surgeons telling me that that things were OK the operation went OK so I knew that I was quite, you know, I wasn't worried at all about the aftermath because I'd known that the operation went the way they wanted it and I think I just was looking ahead to getting home and getting back to normal (laughs). I can't really ah I think that sidetracked was the fact that I had this rash and that was a worry to me because I felt I had enough to get over (laughs) without having to put up with this rash... I think you just look forward to better health and, you know, recover completely from it.

(Dulcie, 1: 8, 9)

Pain and discomfort affected Dulcie's mobility initially while the surgeon's reassurance enabled her to look forward to when she could go home.

Neal's operation was to deal with a complication following previous major surgery. He referred often to the previous surgery throughout the interviews:

Oh no no. I found it, in fact sometimes I'd feel not as comfortable as I was after the big operation. I don't know whether that was because I didn't remember too well after the first operation.

(What sort of things made you feel uncomfortable?)

Well, I'm not sure about that really. Well, sometimes I think to myself you anticipate things that just doesn't happen, you know.

(Neal, 1: 6, 7)

As for Dulcie, Neal's expectations had to be readjusted, and he was left with a feeling of "discomfort".

When Simon who was recovering from a hip replacement was asked if there were particular things that he remembered while in hospital there was an immediate response.

(laughs) Sure are! I developed severe muscular cramps. I'd go into these muscular spasms in my leg just like normal cramp. I occasionally had cramp [previously] you know. Strangely enough, when I, in my bridge-playing days and sitting around the bridge table occasionally I'd get cramp but it was just very very occasionally. But this was very severe and of course it made movement, you know, getting out of bed and that sort of thing, very difficult because I'd go into these muscular spasms particularly going to the toilet. (laughs)

(Simon, 1: 2)

Along with the cramp, Simon had a further problem to cope with in hospital.

Well I completely missed out telling you that I've got prostate cancer which was diagnosed about three years ago. I had drug therapy and radiation therapy, and that's left me with a bowel

control problem. The radiation from the therapy, in the mornings when I go to the toilet I have to go. Straight away. (laughs) And I have to go probably three times, and so that was a further problem in hospital. But I was so grateful to the nurses. They were always immediately available. ... But these were just sort of added difficulties.

(Simon, 1:3)

Adjusting daily habits to a different context can create additional problems for the person in hospital. Another participant, Nell, had suffered severe pain for some time and welcomed her surgery.

The aftercare, I was in for a whole day afterwards, in that special room, they were very very attentive, absolutely marvellous. I felt very very confident. When I got into my room, I had the bedpan once, I rang the bell once for the bedpan. That was OK, two women came in, two nurses, and then from then on the nurse said to me, "Well you can get up now and go to the toilet yourself". But I did feel a wee bit weak, and a wee bit woozy, and the only complaint I did have was if I had fallen, with a back operation as such, it would have been disastrous. And I do feel that someone should have been with me, to just wait for me, to get me back to bed or to see that I was O.K. and had got back into my bed again. I did feel that.

(So the first time that you got up yourself, there was no-one actually there to help you and see that you got there safely?)

No, oh I beg your pardon. I got up myself and went to the toilet and then I sat on the toilet and I pressed the button because I felt I couldn't get back. I pressed the button and they came in and got me back into bed again, but I went from the bed to the toilet all the time on my own. Which I sort of felt was a wee bit quick, the day after. (laughs) ... I kept thinking, "If I fall, I've

had it". Because you know this back's, won't hold me, you know. And it was, I just didn't have confidence at all in myself at that time, but after I'd done it three or four times I was much better. The food was good, the nursing was good, didn't see much of them because all they needed to do was just to look at the wound once a day. And I showered myself, and they washed my back and then I got back into bed, and that was all for the day again.

(Nell, 1: 5, 6, 7)

Simon and Nell each describe a sense of vulnerability while in hospital. Van Manen (1990) comments, "the space in which we find ourselves affects the way we feel" (p.102).

Matt, who, like Simon, had undergone a hip replacement had mobility problems. For Matt, having a hydraulic bed enabled him to get in and out of bed.

And I wished I had the bed at home (laughs) when I got home, because I had difficulty, well the wife had to help me in and out of bed. ...//..

(And you were all right about getting out of bed?)

Yes. I got a wee bit fainty, one time in the bathroom, I think it was the first day, and rang the bell, but I'm a bit like that. I have a history of that.

(Matt, 1: 2)

Matt's comments emphasise the differences in being able to cope with problems when in hospital and at home. He had his own explanation for feeling "fainty" just as Frank, in the following extract, explains his feeling ill. Frank's shoulder operation caused some problems for him.

After the first day, it was painful of course, and they had given me a lot of injections and things like that, quite a few tablets and morphine, which ultimately I found the second night, ... I was quite ill, and I put it down myself to the injections and tablets and things. ... But I had settled down there. It was difficult to sleep at night time because I couldn't get comfortable, but by the time the Saturday morning came, and I'd had the operation on the Thursday night, I was you know, reasonably comfortable, with the exception of the pain, which could be attended to at home I felt just as easily as in the hospital.

(Frank, 1:5)

The site of, and pain caused by the operation affected Frank's sleeping. He conveys that life would be more manageable at home.

Owen's whole approach to his operation for bowel cancer was affected by his heart condition which was such that his surgery would involve extra risk. Owen's son had taken time off work to spend time with his father before the operation

Well he stayed all day with me in the ward or in the room at the hospital, and I can recall quite clearly that particularly that last day of the operation, I was totally relaxed, and I'm sure that had a lot to do with how I, how quickly I made a recovery following the thing. I'm convinced of that now. I had been quite relaxed in previous occasions in the hospital, ...but I was more so this time. I had a feeling that I only had a 50:50 chance of making the grade, that there'd be problems from the heart point of view, and I really had little knowledge about the implications of the colectomy operation itself. And I really wasn't worried about that. I felt as long as I survived the thing I could cope with it and that has been my tendency right through especially since I've

been on my own, after my wife died and I've had all these health problems. My primary thing has been to get on top of the problem, mentally as well as physically.

(Owen, 1: 4, 5)

Owen's attitude was affected by his past, which determined how he faced his future.

These extracts reflect the participants' response to the context in which each was placed and how they coped with the situation.

The Operation

There were various attitudes towards the operation each participant had undergone.

Harry's attitude to his surgery was typical of his way of being in the world.

I don't think there was anything significant. I was just glad that it was all done, and I felt as though I was regaining a bit of strength every day, you know, I just felt, kept feeling all right. Moved around, and everybody was very good, and I suppose you see a lot worse patients coming and going (laughs) and you think, "well, I'm damned lucky".

(Harry, 1: 4)

For Harry his operation was a means to an end as he had a complication, which needed attention before further surgery could take place. A series of delays meant that to have the surgery was a relief. Connie hoped further surgery would provide relief from pain, though unexpectedly having a different surgeon caused some concerns for her. The new surgeon thought he could relieve the pain in her shoulder. The operation was the third on this particular shoulder joint so she was able to compare it with previous operations.

I'm just pleased that this time it is different, it's a different way, he's done it a different way and just hope it's going to be a better outcome and I'll just say that the nurses were all very good, you know and I think I had good care and the night nurses are nice.

(Connie, 1: 30)

Having hope was important for Connie.

Matt was also able to compare his current operation with previous surgery. He thought the previous surgery on his knee, was more difficult than the current hip replacement operation.

Well, I think I'm feeling better probably than I thought I would. This is probably due to the fact that I had a horrendous time with the knee pain, when I had the knee done. Very painful thing, and then I had to go back in and Mr [surgeon] had to take me in for a night and a day and stretch the knee because the physiotherapist wouldn't come, couldn't get it straight, and so because of that, this hip is quite a lot less stressful than I thought.

(Matt, 1: 6, 7)

Certain of Matt's expectations did not eventuate and a similar situation occurred for Owen. Owen had what could be described as a fatalistic attitude to his operation because of his heart condition. Following his surgery for bowel cancer he expressed surprise at how he felt.

I think that when I came to in the cardiac ward following the operation, which would probably have been in the early hours of the next morning, I couldn't, the first thing I thought about when I came to was realising where I was, because there was a lot of activity in that ward all the time, and I remember saying to

myself, "Oh, I made it". And then I didn't seem to be noticing any great discomfort.

Later in the morning, mid-morning, I was taken back up to the room ... where I'd been initially, the hospital room, and I seemed quite comfortable. Surprisingly so. ... I couldn't believe how little discomfort I had. And in a way I suppose, this might sound a bit pretentious maybe, but I have had a lot of discomfort with illnesses over the years and I guess I tend to accept a lot of that. And because this wasn't what I expected as far as the degree of discomfort, post-operation I 'm meaning, I was able to cope with it quite easily.

(Owen, 1: 6, 7)

When outcomes were better than expected, coping abilities appeared to be enhanced. Like Matt and Owen, Nell's experience was compared to previous surgery. She had undergone heart surgery some years before and the operation on her back paled into insignificance when compared with that. Neal's repair of an ostomy hernia made life easier for him in managing his ostomy but his narratives focussed more on the initial major surgery he had undergone for cancer. Harry whose initial surgery was similar to but not as extensive as that of Neal's surgery kept in contact with people who had been in hospital with him and "compared notes". Like Neal, the operation, which resulted in his having an ostomy, was of greater significance in his life than the current one, which dealt with a complication arising from the previous surgery. As Benner and Wrubel (1989) state:

Health and illness are always situated in the person's life. When an illness is extreme, it temporarily becomes the whole situation, and the other aspects of the person's life may fade into the background. In contrast the illness may be defined totally in response to another situation such as a major performance or other life event.

(p.80)

Dulcie's rash is another example where, for a period of time, it superseded the operation itself as her focus.

Moving Forward – Recovery Signposts

Whether participants were in hospital for a day or for longer periods they recognised that they were making progress in their recovery. Connie was connected to a machine that, by pressing a button, enabled her to administer pain relief as she required it.

So we got over that and then in the end the silly old thing [machine] was beeping as soon as I pressed the vein thing, (laughs) it beep-beep-beep, so I had a male nurse [name] and after a few days of that he said, "I think we'll get rid of that, it's done it's day". (laughs) So he took it off and every time you had one other thing it's nice, you know take the things away, your oxygen away ...//..

(Connie, 1: 10, 11)

Connie described the taking away of each "thing" as a relief. These were signs of progress.

Owen was pleased about the signs of his progress, which included lack of physical weakness and earlier mobility than in previous surgery. Unlike Owen, Peter was in hospital for just a few days - he went into hospital on the day of his surgery, Tuesday, and came home the following Friday. He considered he had got over the operation very well.

While Peter agreed that things had gone smoothly for him in hospital his later conversation suggested otherwise.

Well, what happened was they took, on the Thursday, see the operation was a Tuesday, on the Thursday they took the catheter out in the morning and left me 'til the afternoon, and I

couldn't pee. I couldn't use the usual function, which was a bit depressing so they put the catheter back on Thursday evening and left me 'til the following morning when they took it out again. They said I could go home on the Friday and I was quite happy to do so.

(Peter, 1: 5)

The difficulties with Peter's catheter and his feeling of depression were signs of what was to come on his return home.

Harry's recovery signposts involved both a feeling and physical aspects.

I felt as though I was regaining a bit of strength every day, you know, I just felt, kept feeling all right. ... Well, after three or four days I was showering you see. Before that, prior to that, because I've got a slight heart condition, they were a bit worried about the old ticker a bit, and the nurse was coming with me into the shower for the first time. The first operation I had I collapsed in the shower one day and just sort of fainted, but I think it was the heat more than anything, but they had the nurses come in, nurse used to come in and I said, "OK I'm right, you just come back just in case". "But", I said, "I can do it, I can shower myself". [Harry was becoming more independent]

Oh yes, I was independent there, after about four days, yes and I used to go for walks up to the lounge room, and talk around to different guys that come in and that. And I felt, you know, good, mm. Oh yes, yes, I could manage [in the shower], that was no trouble at all. Of course, they had to unhook the drip feed while I went and had my shower, it was unhooked and... no, everything was managed pretty comfortably I think, and I just kept on improving until they said I could go home.

(Harry, 1: 4, 5)

Harry's increasing ability to care for himself enhanced his feeling about himself.

The operation and the time in hospital went smoothly and as expected for some participants, while others were surprised when things happened or did not happen as expected. Van Manen (1990) comments, "we become the space we are in" (p.102), and gives the analogy of walking in a foreign city and experiencing a sense of lostness, strangeness, and vulnerability. While some participants experienced such feelings in hospital all had the experience of having previous surgery which provided some familiarity, although, apart from Connie, for each person the current operation had not been experienced before.

BEING-IN-PLACE

Young (1997) considers Heidegger's notion of dwelling in relation to home and notes Heidegger's equation of dwelling with the way of being that is human. According to Heidegger habitual human activity reveals things as meaningful and through dwelling among the meaningful things people have a place for themselves. We dwell by making the places and things that structure and house our activities. These places and things establish relations among each other, between themselves and dwellers and the surrounding environment. Young considers the arrangement and preservation of things give meaning to individual lives and are an intrinsically valuable and irreplaceable aspect of home-making. She sees a home:

is personal in a visible, spatial sense... displays the things among which a person lives, that supports his or her life activities and reflect in matter the events and values of his or her life. There are two levels in the process of the materialisation of identity in the home, (1) my belongings are arranged as an extension of my bodily habits and as a support

for my routines and, (2) many of the things in the home, as well as the space itself, carry sedimented personal meaning as retainers of personal narrative.

(Young, 1997, p.149-150)

For a person, home encompasses a building, it's contents, the environment in which it is placed, and the meanings and activities attached to it. The discussion of being-in-place includes going home, and being-at-home as well as the data from the three participants who went to a rest home for a short period after discharge from hospital.

Leaving Hospital for Home

Participants were ready to go home no matter how short or how long their stay in hospital. As Dulcie stated:

I was in hospital for five days. I perhaps may have stayed a day or two longer but I developed a terrible allergy, a rash over my body and I think my specialist thought the environment (laughs) there wasn't the best place for me so he thought it better that I went home to my own home... but it was good to get home just the same.

(Dulcie, 1: 3)

She later expressed how she felt when told she could go home.

Well I was really pleased because I did want to go home. I felt that it is hard to fill in time in hospital even although it's a busy place and particularly in private rooms because there's not a lot going on in your own room. I'm always wanting to get home and I feel I can fill in time better at home even although you haven't

the same reassurance perhaps at home on your own that you have, you miss that bit of perhaps backup in case something does go wrong but, no I was pleased to go home.

(Dulcie, 1: 9)

Dulcie appreciated the benefits of hospital but her preference was to go home. Connie, while ready to go home, had concerns about managing with her shoulder out of action and her arm in a sling.

Well its, can you manage? Can you cope? But then when Father [husband] came in the morning (laughs) to fetch me he'd fallen over [broken some ribs], and he was sore, so I thought, "Oh Lord", but anyway you're so, it's lovely to get home because I was sort of spoiled, and came home and then so I just made an appointment straight away for him to go to the doctor, which he did but they can't do anything about the ribs so he's just had to suffer. But no it's lovely to be home and of course he couldn't get me home quick enough because he was visiting me twice a day and three times sometimes. (laughs)

(Connie, 1: 15)

Connie's husband was several years older and not in the best of health. Simon, like Connie, had concerns about his spouse. When asked if he felt all right about coming home, Simon responded:

Yes. Oh yes. Mr [surgeon] said originally, you know, that it would be six, possibly seven days, but because of the cramps I had I stayed an extra two. And I wouldn't have been comfortable coming home before then. Particularly as we had no assistance at home. It was a lot for my wife to cope. I don't know how people get on when you need constant attention, and the little things that you can't do, getting undressed, can't tie your shoes, and socks.

(Simon, 1: 5, 6)

Simon's stay in hospital was extended for a short time and this suited him both for physical and home reasons. When Matt was asked if he had any qualms about going home he responded:.

No. Mr [surgeon] never told me until the last minute really, that I could go. Oh, he told me the day before but he never indicated prior to that. But I was ready. The Sister asked me, "Are you ready to go home?" on the fifth day, and I said, "Yes, I think I could go home". And anyhow, the next morning Mr [surgeon] said I could go home... It depends how, he struck me in the bathroom and I was having a shave, and I seemed to have everything under control, and if they strike you like that where you're in control of yourself, they're favourably impressed.

(Matt, 1: 3)

When asked if he felt ready to go home Matt agreed and offered an explanation for the surgeon indicating he could go home.

Harry tried to get home earlier than planned.

He [surgeon] said Thursday or Friday, I said, "Thursday". (laughs) In fact, Wednesday I said. He said, "We'll see". But I went out on the Thursday. Oh I wasn't as fit as I thought I was, but by the time I got home I'd had enough, you know.

(Harry, 1: 5, 6)

Harry was eager to go home, but once home found he was not as ready as he thought. Frank also wanted to get home after two nights in hospital and explained:

I was to stay a third one, well, they were talking about it but when the doctor came in on the Saturday morning which was two mornings after the operation, I was sort of at the stage where there wasn't much point and I may as well have been at

home as just lying there. There was nothing to be done, only take a few painkillers and that was all that was happening so I came home.

(Frank, 1: 4)

When little appeared to be happening in hospital Frank felt there was no need to stay. Participants might have felt ready to go home but once there found they did not feel as well as expected. Despite this, home was where they wished to be.

“Home is Life” / Being at Home

Young (1997) comments that home is an extension of and mirror for the living body in its everyday activity and is the materialisation of identity. The materialisation of identity does not fix identity but anchors it in physical being that makes a continuity between past and present. “Without such anchoring of ourselves in things, we are, literally, lost” (Young, 1997, p.151). Ben encapsulates this in his simple statement, “Home is life”. Home is both a representation of life and a re-presentation of life. Van Manen (1990) comments that it appears that lived space is a category for inquiring into the ways people experience the affairs of their day to day existence and in addition it helps people uncover more fundamental meaning dimensions of lived life. He talks about home reserving a very special space experience, which has something to do with the fundamental sense of people’s being as it is the place where people can be what they are. Lived space is not something upon which people usually reflect despite their knowing that the space in which they find themselves affects the way they feel. Van Manen describes lived space as the existential theme that refers people to the world or landscape in which they move and find themselves at home (pp.102-103).

Van Manen (1990) proposes that to understand a particular experience, “it is helpful to inquire into the nature of the lived space that renders that particular experience its quality of meaning” (p.103). In considering the

phenomenon of recovery the nature of “home” was significant for participants. While the qualities and aspects of each participant’s home varied, the importance of home as the preferred place to recover was universal. For the participants home encompassed the familiar. It included the physical environment of a house and garden, belongings, people, pets, and for some participants the extended boundaries of countryside and community. It included memories, love, affection, comfort, relaxation, and freedom.

Connie described her feelings about home.

You’re definitely more relaxed, and in your own atmosphere, you’re all much better in your own atmosphere, and I think the only place you can recover is in your own home, four walls, and your partner. So I think that’s a big ‘A’.

(Connie, 4: 5, 6)

When asked about coming home after being in a rest home on discharge from hospital, Neal replied:

Oh that was a bonus. You know that was a bonus because I mean I can sit and relax in my own home as I said amongst things we’ve acquired together, and from my friend. As I said everything to me at home is good.

(Neal, 1: 16)

Neal had cared for his terminally ill wife and during our conversations he commented about continuing the routines he and his wife had in their daily life and the pleasure he received from the memories their belongings provided.

Another participant, Nell, had also gone to a rest home for a short while on her discharge from hospital. When asked if there was any particular thing that stood out for her over the previous two weeks (in that time she had

been discharged from hospital and been in a rest home), Nell responded:

I've got (laughs) I've got a very very comfortable easy chair on the terrace in the sun, and it's so sheltered I can sit out there and just sing away and look at the birds, and the insects crawling round, and the flowers, and I sit there with the hose in my hand, and I hose all round the garden from the chair. And those are the pleasurable things I like. And nicer surroundings than in a nursing home, (laughs)... or hospital, yes. And my own lovely bed, and everything's just so nice, yes.

(Nell, 1: 16)

Home contained the familiar and the pleasurable for Nell, as it did for Matt. Matt's description of what being at home meant for him included an expansion beyond the boundaries of four walls.

Well, it's the family atmosphere, it's like when I was in the army for a short time during the war, and if you were given home leave (laughs) there was a feeling of, kind of excitement, kind of sort of steadfastness or something about getting home. So it's really almost the same. ...//.. Now, I have never mentioned this before, but I thought of it the other night. You see, we have a very small, low-key tourism business with pet animals, and a museum with our own and other people's things in it. And to go out and the sheep come running up, and hold the pot out, and then they, the cheeky ones give you a nudge, and the goat comes up looking for attention and food, and the rabbit's there, he gets excited-looking and knows he'll get a carrot, and this kind of thing. All that atmosphere, particularly with these pet animals, has also helped.

(Matt, 4: 7, 8)

Atmosphere, as described by Matt, illustrated the nature of his lived space and the meanings it had for him. Participants with a spouse were

particularly appreciative of their being in the home. Colin expressed this when he said, "A great appreciation for the wealth I have in my wife, and for the help and assistance that she's given, and the patience she's exercised" (Colin, 4: 8), and Will's succinct statement about being home, "being with your partner, being with your family" (Will, 1:18).

As well, being at home meant a sense of freedom and control over one's situation. As Simon expressed:

I'm the master of my own destiny (laughs) at home. You know, you're just much more comfortable in your own surroundings. I can sit and listen to cricket or whatever, whenever it pleases me, and if I want to get up and move around I can. There's no constraints on me at home.

(Simon, 4: 4)

Once home the person regains control of actions and activities and responsibility for decisions, as Owen describes:

Well, I suppose the primary thing is that I'm making my decisions for myself. And I'm not governed by what somebody else's routine is, or that kind of thing. And I'm totally independent, I can, I guess these are obvious things of course, but I can go to bed when I want to. [Owen explained why his independence was important to him] It's primary, yes. I think I might have said early on in these interviews that I had the experience, five years ago almost, when I came out of hospital, where I found people were making decisions for me which I didn't want, I wouldn't have made, and I didn't want made. And I felt I was losing control of my life. And I was starting to get inwardly a little panicky.

(Owen, 4: 8)

Owen's past experience affected his present attitude. When Nell compared the independence provided by being at home with being in a rest home, home was the place where she wanted to be. Home provided independence and a return to 'normal' life for Dulcie.

Yes well there's always something you can do in your own home, small and all as it is, that you're allowed to do. And I think that's important. Even if you're just moving a duster around or something like that, you're doing it to your particular home, and yes I think it was important to be in my home... And besides, the normal things happen, like the telephone rings and you answer it, and it's your usual friends calling, so those things are normal. Yes. And I have my cat here, that's (laughs) normal to have her here, and she'd always show the affection that she shows, so yes, it was really important.

(Dulcie, 4: 5, 6)

Carrying out usual activities, and her cat, helped Dulcie re-establish her patterns of everyday life.

When Ben had talked about being a home to recover he stated, "home is life". When asked what he meant by that, he started by commenting about nurses being younger and not having the experience of:

A person who has seen life go away in small or big steps, one after another, and then their home becomes the representation of what that life has brought. And take the person away from home, you have taken life away from the person, and that is how I see it... I like home, I like to come home, I like to be home, and if ever we go away it is nice to come home. But already, I can sit in our house, and look at things, and I am pleased that these things can bring back memories... so eventually, for me too, definitely, home will be the – what should I say – the representation of my life, and it is excellent. My

home is so important. .../. And as you know, I refer to Curnow's poem [Allen Curnow's poem, House and Land] where the immigrant woman, by herself, said that her life was represented in the silver teapot and the picture on the wall. That is what I mean by that. .../. So all these comforting things are associated with home. And they eventually become part of thinking, I think. I hope that I can still say that I have a few years to go but I certainly find home important. And it does become one association, a oneness, a unity, home and life therefore becomes important. .../. I do not know anything about medicine or medical problems... They say there is a psychological connection between recovery and yes, between, so much so that it is a psychological link between body and mind. I don't know whether I express this correctly but if that is so and I find that to be true, really, then your peace of mind helps you I think, to recover faster than if you were in a foreign bed. A hospital is, no matter how good the nurses are, not really a congenial place to recover from, I don't think, from any illness.

(Ben, 4: 2, 3, 4)

For Ben peace of mind helped recovery and home was where there was peace of mind. Ben conveyed sentiments expressed by other participants. As well for the participants home provided independence, freedom, privacy, the ability to maintain social contacts, as well as a familiar space which represented each participant's life. Home encapsulated not just a building with four walls but an environment of garden and community which provided the context in which to recover.

Rest Home Experience – Being Away From Home

For three participants a rest home was a temporary 'home' for a period after their discharge from hospital. Neal had gone to the same rest home after his first operation for a period of five months; Nell's husband had been in the rest home she went to; Owen had not stayed in a rest home before

but he had the experience of his mother's being in a rest home.

Neal lived alone and decided to go into the rest home to convalesce.

And strangely enough I spoke very, very highly of (rest home) after a five month stint but the second time I went in the atmosphere was entirely different, for two reasons. One, the room I had previously the first time I went in there, the room I had was facing the street and it was at ground level and near the door, the entrance door. And also at the table, I was sitting with four other men and so there was always something being said. This time that room wasn't as congenial at all, wasn't congenial at all, and also the company at the table, I was sitting with another two couples and I mean there was no conversation. And I found I wasn't as relaxed as I was the previous time. So I decided I would come home. And since then I'm coping very well indeed. [Neal explained what made him feel more relaxed at home] Well, I look around the house and see all the things that both my wife and I acquired, so when I look around and see them I can relate to all the things in the house, you know, and that's the whole feeling so I mean I did carry on the routine as though my wife was still here. And I find that I've never ever felt lonely. Even though I'm alone I never feel lonely because I'm drawing on past experiences.

(Neal, 1: 7, 8)

Neal decided to come home after a week in the rest home because, as he described it, he didn't feel comfortable. He said he found that he had done the right thing.

For Neal the space he was in and the people with whom he associated were of paramount importance. Heidegger (1971) states, "spaces receive their being from locations and not from 'space' " (p.154). Van Manen (1990) comments, "There are cultural and social conventions associated with

space that give the experience of space a certain qualitative dimension" (p.103). Van Manen gives the example of the space people feel they need around themselves to feel comfortable or intimate. Neal's comparison of his experiences in the rest home illustrates this where the site of his room, and the social interactions with others affected the quality of his experience. In his first experience he felt "at home". With his second experience he wanted to "go home".

Nell also spent a week in a rest home, and when asked if she made the decision to go to a rest home she replied:

Yes. I decided that, well, no I didn't decide it. Because I didn't quite know what to do, and Dr. [surgeon] said, "Well," he said, "when you come out of hospital," he said, "you'll have to have twenty-four hour care," he said, "you can't do anything for a week". So I thought, well if I can't do anything for a week I can't come home here on my own. So that was then. My husband had been in (rest home) for four months before he died and I knew the place, I knew the nurses, so I decided that that's where I would go. And it was just for care, and they made my meals and made my bed, and I showered myself and dressed myself except for socks. And they put my socks on and that was the care, but I didn't have to do any housework or anything like that. And consequently I just lay, sat, and walked. Walked, sat and lay. For a week. And then I came home and I was fine. [Nell was asked if she had felt the benefits of the week]

Oh yes. Oh very much so. I don't think I could've come home and stood and made a hot dinner for myself at night.

(And did you decide when you felt you were ready to come home?)

I said that I thought that I would be in there a fortnight. Of course I didn't know how I was going or anything, but oh no, a week was plenty, plenty. Came home in a week.

(Nell, 1: 7, 8)

Nell considered her options and made the decision about going into the rest home and when to come home.

Owen was the third participant who went to a rest home for a period and, like Neal and Nell, lived alone. He explained how going to the rest home eventuated.

Well, there was a suggestion that if I felt like it, I could have gone home [from hospital] on the eighth or ninth day. But the reason I stayed the rest of the time, was that my daughter had at short notice, decided to come down ... from the States and spend time with me when I came out of the hospital with me here in my own place. And I really felt that, well initially, what I planned in my own mind was, when I came out of hospital, was to go into a rest home instead of coming home by myself here, on my own. As on previous, at least two previous occasions when I had been in hospital and had come straight home and looked after myself straight away, more or less. Within a week, ten days, I was back into the hospital in the cardiology ward with problems because of that, coming out, trying to look after myself too soon. So, as I said, I decided I'd have at least a couple of weeks in a rest home before coming home. Well, my daughter, as I said, decided that she would come down and fill part of that time in, and she spent nine days with me. And then I still decided I would go into a rest home after that, for at least another week, and give myself a really good chance to make a proper, really good recovery from this. Because I felt so good I didn't want to set myself back, just because I felt good I could overdo it I felt. So the answer really, (laughs) in a roundabout

way, is why I stayed there [in hospital] was that I figured for what it was costing me to stay in the hospital for another three days, I was getting the best of care, and the meals, and it was more economical for me to stay there than getting out and going into a rest home until my daughter arrived. So that's what I'd worked out in my mind lying in bed in the hospital. So that's how it worked and as I said, I came home and I felt relatively good when I walked out of the hospital on the eleventh or twelfth day, whatever it was.

(Owen, 1: 10, 11)

Owen had planned to spend 10 to 14 days in the rest home but after a week considered he had improved so much that he felt sure he could cope on his own at home

Neal, Nell, and Owen lived alone and had made the decision that a period of convalescence in a rest home would be of benefit. Each had gone to the rest home thinking they would stay for a particular period but each had decided that they could come home earlier as they felt they could manage their recovery at home. They regarded the time in the rest home to be of benefit but they were each ready to move on.

Participants recognised signs of recovery while in hospital, which enabled them to feel ready to go home. Once home they were in a place which provided familiar surroundings redolent of meanings and memories as well as an environment which provided freedom and restored control of their lives. The participants who went to a rest home for a short time considered their options and chose the one which suited their situation.

PRESENCE OF AGE

The participants comprised a group of older persons whose ages ranged from 69 to 88 years with the majority in the 70 to 80 years age group. Whether the age of the participant was perceived by them to be a facet of their recovery was considered as part of the phenomenon of recovery.

Lack of Presence

The term 'lack of presence' is used in the sense that their age did not make a conscious appearance in the day-to-day life of the participants. When asked what they felt about their age, participants gave similar responses. Connie did not like to think about age.

Well wouldn't we all like to be younger. (laughs) I'd love to be younger. Well we can't do anything about it Ray, it just goes on. But I don't try and think about age. That's one thing I've never liked to think about age, it just sort of goes on. It's like a brook, it just goes on.

(Connie, 4 :9)

Connie conveys the inevitability of age, while Dulcie did not really think about age.

Yes, well I don't really think about the age, its funny isn't it. I know we're getting older but I tend not to, in the mind I don't think (laughs) I'm older but I know what you mean. I do perhaps think, as I said before, that I am getting older and naturally, if I look back on operations past, yes I think it's been a bit harder to pick up and after the operation each time, so I think age does come into it a little bit, yes.

(Dulcie, 4: 7, 8)

Dulcie had an active, busy life, which she felt meant she did not have time to think about her age. Reflecting on her age in relation to past operations, Dulcie concluded age could affect recovery.

Harry's focus was on being alive rather than his age:

There again, I still don't think about my age really. I'm just glad to be alive. (laughs) [When asked if he was enjoying the time he had, he responded:]

Yes, that's right. Yes... That's what life's all about. I don't think anything, think oh, I'm 71, 72 now, I'd better start sort of pulling up.

(Harry, 4: 8)

Harry did not associate his chronological age with a need to change his lifestyle, Neal was of like mind.

I was very, very fortunate because I've always been very very fit, and also I've never ever been on any medication. And age doesn't, it's not relative [relevant] to me. You know I don't think of myself as an old man of 78 you see, I feel good. No. No. ...//.. No, I never think about it [age] at all. You see, in fact, I think myself now, I think, "78, well that's a very good age, isn't it?" (laughs) And yet, even though after that operation, I mean the first operation, it's remarkable how well I've coped with it. You know, it is, it's remarkable to me how well I'm coping with it and always have, and also I'm very, very fortunate, I don't seem to have a great problem with pain.

(Neal, 4: 4, 5)

Neal's first operation, which was the first operation he had ever experienced, left him with a permanent ostomy and an in-dwelling catheter. He lived alone and as he said it was remarkable how well he was coping.

Two participants, Nell and Ben, did think about their age. Nell's past experience affected her attitude to her age.

Yes, I do often think about my age because I'll be 76 this month, next month, January, and I quite frankly, I thought that when you've had a by-pass [heart operation] it lasted six years and that you had to have an upgrade and that sort of thing. Well, mine's '86, thirteen years, and nothing has happened to me, and nothing, angina, nothing as far as my heart is concerned so I think that I'm living on borrowed time. And whatever I enjoy now I enjoy to the full, but when things start to slip, I think I've had enough. (laughs)

(Nell, 4: 6)

In Nell's situation she regarded her age as a bonus.

Ben who was handicapped by the operation on his elbow, wanted to be fair when considering the effect of his age on how he was managing.

Well, I have to be sure that I don't now all blame everything I can't do on this operation. (laughs) I have to be fair in saying that if I had had no operation whatever, perhaps I would also have slowed down or not been able to do this or that sort of activity. ... But getting up from the floor normally without any operation is harder than it used to be. And although I don't feel old, that reminds me that I am actually older than I used to be.

(Ben, 2: 8, 9)

Ben realised his age might be affecting some activities.

Nell and Ben reflect Gadow's (1982) notion of aging in the self-body relationship. As indicated previously, Gadow, in her analysis of the self-body relationship, regards aging as an essential stage of the self-body relationship. She proposes the completion of her dialectic may occur not

only in aging but also in illness. Her fourth level of knowing is titled as "aesthetic immediacy: the subject body, exemplified in aging and illness". Aging is an essential stage of the dialectic, illness is regarded as a sub category. In aesthetic immediacy there is a difference in the form in which the self-body distinction arises and is incorporated into a new unity. The subject body is of greater importance in aging and illness, than in Gadow's first three levels of knowing.

Aging and illness are regarded as extreme situations of the breakdown in self-body unity and the only remedy is disengagement. In aesthetic immediacy Gadow's thesis is the body in aging and illness insists that its own reality, complexity and values be supported and acceptance of the insistence as valid is recognition of the subject body, the subject body as part of the self.

The slowing of the aging body can have negative or positive meaning, for example, not being able to move as quickly as before or as a new capacity for "opening time" (p.94). Positive meaning is a consideration of the particular phenomenon as the body's expression of its own determination, aim or purpose. A phenomenon has a positive meaning when it is regarded as a symbol of value. There is a new relation between self and subject – one of intrasubjectivity in that the self recognises the body as another manifestation of selfness. Gadow contends a process of mutual learning is required. The self must learn to attend, to perceive and interpret the body's symbols and acquire complex ways of responding (p.96).

In the aesthetic relation between self and body there is a complex balance between form and freedom. The subject and object body reciprocally affect and develop one another. There must be aesthetic regard for the body as a being in itself and for itself in order for self to engage body in a relation of intrasubjectivity. The opportunity for concentration on the body, and thus for aesthetic regard toward it, is pronounced in aging and illness because the body establishes itself in the foreground of attention as an object of concern so replacing the lived body. This occurs inexorably in aging, and

intermittently in illness. The body also becomes potentially subject body – the body as the object of aesthetic regard. Gadow suggests, “the ‘facts’ of the body in aging can be seen as symbols rather than finalities – symbols of values and meanings of the experience of the person as a whole” (p.98). “The aesthetic model can extend the commonplace understandings of aging to more fully appreciate the unique way in which individuals shape themselves in aging.” (pp.98-99). Gadow’s premises are reflected in the participant comments in the following section when age comes to the foreground of their existence.

Age as a Presence / Age to the Fore

While age lacked presence for participants, at times it came to the fore as a reminder or a reason for being able or not able to carry on with everyday life activities and how participants regarded the future. Participants commented on how they thought their age had affected their attitude to their operation and/or to their recovery. Simon, for example, weighed up whether he would have a hip replacement. He had taken his age into account and commented what recovery would mean for him.

Well I would say hopefully getting back to where I was, with the proviso, of course, that I'm not getting any younger. (laughs) At this stage of life you become very aware of how rapidly everything is deteriorating. I've spent the last... 12 or 18 months having little bits taken out, you know, skin cancers, things like that, and it all sort of adds up to this general pattern of deterioration. ... one of the things that weigh [ed] heavily in making the decision to have the hip done was my other complaints, whether it was worthwhile to go through all this. I tossed up, you know and just got to take it the way it comes out.

(Simon, 4: 8)

At the time of this interview Simon indicated he was not at the stage where he could say if his operation had been worthwhile. Dulcie, while not being

overly concerned with age, did have some concerns about her operation beforehand.

Well I think, as I get older I think (laughs) I was a bit more worried about it than I would've been, when I think of the anaesthetic and think "Oh my goodness as long as you wake up you'll be O.K.". But I think you've got to realise that as you get older the thing is not to put it off and to have it done instead of waiting, you know, I could've put it off perhaps for longer if I'd wanted to, but I say that you're better to have it, and not wait 'til you're older.

(Dulcie, 1: 4, 5)

About a month before the current operation Dulcie had required surgery for another health problem and this may have made her consider the implications of having further surgery in such a short period. She recognised the need to attend to health problems and her particular problem was distressing for her. While Dulcie recognised the need to attend to health problems promptly as one got older, other participants accepted that they might not "get over" things as quickly and that it required extra effort on their part. Will provided an example of this.

Oh I think if you're younger you'd probably... recover quicker. I think so... had I been 40 and I'd had the operation on my arm and I did the exercises on my arm I'm sure my back would still be O.K. (laughs) So that's something that when you get old as you make an effort to recover in one direction something goes somewhere else. [There were other areas Will had to contend with as he explained] It's a lot harder going out there and having to put a, it doesn't sound much but every time you go out there [Will used his garage to carry out his arm exercises] you have to, I put a sheet down on the floor in the garage, that's for... my back, so OK, that goes down, then you go around and you start looking for your stick and because of your age you never

remember where you put it. (laughs) And then when you get down there and you do your exercises then you have the problem of getting up again. And that's not easy. Not at 70. So the floor exercises, there's a series of exercises. You start on your feet, then you go on your back, then you go on your feet, then you go on your back again. Now, I'm not sure, but I learnt to do all of the floor ones (laughs) so I only had to get up once. I'm sure if you're 40 you wouldn't worry about that sort of thing. Your legs would still be in good condition and you'd be getting up and down without any trouble at all, but I'm having to sort of hang on to the handle of the door to... (laughs) [get himself up] Kind of. (laughs) So yes, there are a lot of reasons why I think it's a lot harder as you get older, I'm sure. Mm.

(Will, 4: 10, 11)

Will demonstrated the problems of carrying out exercises when mobility and agility have been affected by aging.

Colin recognised the effects of age on his recovery.

I can no longer at my age do the things I did with impunity before. Now it takes a long while for the body to recuperate and adjust.

(So you're saying that you feel your age has a definite bearing on maybe the future for you in terms of your health?)

Well having reached 75 now I just know that that's the case. I can no longer take a fall and expect to get up without any bother. It takes longer, I notice older people, bruises take longer to heal, and pain to disappear.

(Colin, 3: 5, 6)

Colin realised his expectations of his body had changed and he recognised certain actions had consequences.

Peter, though he slept well, still felt tired and this was a continuing problem. He felt feeling tired was, "partly me age. At 88 you do sleep a lot" (Peter, 2: 8).

Some participants did not see their age as a major factor in their recovery. Matt's response when asked how he thought his age had affected his recovery was:

Well, that's difficult to answer because I probably would've recovered more quickly had I been 40. I presume I would have done, but as I see it I'm very pleased with my recovery at my age. [74] I have no complaint.

(Matt, 4: 9)

Matt's response suggested he had recovered better than he had expected.

Connie considered it was pain rather than her age that affected her recovery.

Oh I don't know. I suppose that you take a bit longer to bounce back. That's the only thing. I mean when you're younger you're more resilient aren't you and you can go, things but I don't know. I don't know if the age is knocking me back at all really. Because I mean I've always been a mover. I've always been a mover, I've never been one to sit around and mope. It's very rare do I get down to it and that's when it's bad.

(Yes, so you think is that more the pain that has affected you rather than what you'd say your age had?)

Oh yes. Oh yes, oh yes, it's not my age I don't think. I might be a bit slower.

(Connie, 4: 8)

Connie conceded age may have slowed her down but this was not significant for her.

Harry professed to not thinking about his age but while reflecting that age may have had some effect on his recovery did not view this as major.

I think you're having an operation and that pulls you up a bit because you can't do things that normally that you used to do easily, easily. You might when you've fully recouped but it's not easy at the moment. If I walk round the block a couple of times, I could walk all day years ago you know, it wouldn't worry me two hoots. But I think if I walk around the block a couple of times, I think I'd be crawling the last quarter. (laughs)

[When asked if this could be due to his age or the series of operations he had had, Harry replied:]

Oh, I suppose it would be partly because of the age, yes. And mostly because I'm recouping, I suppose. And I'm not just fully recouped yet. I'm 75% of the way, but no, I think it's probably, yes I suppose everybody slows up a wee bit... but I don't think about that. It's not on my mind at all, about being old, I can't do this and I can't do that, ..//.. Oh, everybody says I don't look as old as I am so I suppose that gives you a bit of a thrill too. But I mean, everybody might have a different opinion on that too you know. "You don't look quite your age". They all say that. That's good. I say, "You're just saying that". (laughs) ..//.. No, it's something I don't really worry about, my age, at all.

(Harry, 4: 8, 9)

Age was a reason to decide whether to have surgery and for not delaying it; affected how quickly one healed, might mean extra effort to aid recovery, acted as a reminder to look after oneself (as an investment in the future); and was displaced by physical symptoms such as pain and lack of mobility as an aspect that was to the fore.

REVIEW AND SUMMARY

Home was the familiar space, full of the belongings and memories that represented the participant's life, providing peace of mind enabling the person to pick up the threads of life, to return to their way of being-in-the-world. Being in hospital and having the operation formed an interruption in the person's day-to-day life and removed them from a place that offered peace of mind. For some participants the operation was a means to an end, for others it meant the hope of relief of pain, discomfort and disability in the short or long term. Aspects that were significant for participants while they were in hospital centred mainly around physical comfort or discomfort. The three participants who went to a rest home for a period of time made the decision when to go and when to come home, the latter when they felt ready and able to manage their recovery themselves.

Coming home was significant for participants as home was the place where people felt comfortable and could have the freedom to make choices in their own environment, whether they be interacting with others, enjoying belongings, pets, garden and other activities. Going home and being at home enabled the participants to integrate the experience of having an operation and being in hospital into the narrative of their lives. Home was the space where participants wanted to be.

Young (1997) sees home as a concept and desire that expresses a bounded and secure identity; where one can be "oneself", and that the longing for home is just the longing for a settled, safe, affirmative, and bounded identity (p.157). To paraphrase van Manen (1990)

phenomenologically it appears that the structure of the recovery experience asks for a certain space experience (p.103). For this group of participants home was the certain space experience. The New Zealand Positive Ageing Strategy (Ministry of Social Policy, 2001) considers being able to “age-in-place” is a determinant to making growing older a positive experience. To “age-in-place” is being able to make choices in later life about where to live and having the support to do so (p.10).

Age per se did not come to the fore in the daily life of most participants. Consideration was given to recovery possibly being delayed or not as rapid than if one were younger but participants were not overly concerned with this as a factor in their recovery.

In the following chapter consideration is given to the disturbance of the participants' being-in-the-world; what factors made an appearance to create difficulties in their everyday life and which thus formed aspects of recovery.

Chapter Five

DISTURBANCE OF ONE'S BEING-IN-THE-WORLD

In the previous chapter the context in which participants dwelt was considered, the primary context being home as a place that provided peace of mind and identity. While home enabled a space which provided comfort and familiarity, the unity of home and life was disrupted after surgery. The disruption to the participants' Being-in-the-world is the focus of this chapter and is considered under four themes identified in the data: **difficulties of the everyday; difficulties of the altered body; pain-presence / lack of presence; and difficulties of 'my' world.**

Zaner (1982) speaks of the vulnerability which occurs as a result of illness, injury, or impairment where the sense of oneself is fractured, and where limitations are imposed from without; these limitations frequently demanding radical adjustments which the person neither sought nor desired (p.56). Experiences such as surgery and recovery impact on space, time, possibilities, and the intersubjective world, and cause obstruction to the person's usual taken-for-granted capacities and possibilities, so disrupting their autonomy and self control (Rawlinson, 1982). According to Rawlinson, the person's ordinary access to the world is obstructed and "presents the body as a signifier for the way in which we are limited and can be impeded in our encounter with the world" (p.74).

Leonard (1989) describes the effects of disruption thus:

Our everyday lived experience, in which the embodied self is taken for granted, breaks down in illness [and in surgery and

recovery]], and our ready-to-hand understanding of ourselves as embodied doesn't work for us any more. Thus it is in the state of "breakdown" that we develop insight into the taken-for-granted understanding of health: the unity of self and healthy body.

(p.48)

The options a person has in dealing with such disruptions will depend on their involvement in the situation. A severe illness is likely to become the whole situation for the person and other aspects of their life consequently may fade into the background. Alternatively, the health-illness event may be defined totally in response to another situation in the person's life (Benner & Wrubel, 1989). The experiences of participants Owen, Neal and Harry provide an example of the latter as current surgery was overlaid by previous surgery or an already present illness. Their experiences are also an example of Heidegger's (1962) way of involvement in the world, what matters to us, which he called "concern". Particularly in the case of surgery the body is primarily what matters to the person; the body causes concern, it is of concern.

DIFFICULTIES OF THE EVERYDAY

In health-illness events the physical and ontological assault affects our image of ourselves, our being, our circumstances, our world. It transforms our being-in-the-world, and threatens our integrity; integrity which includes that of self and body and that of self and world. This loss of integrity results in loss of freedom (Pellegrino, 1982). Limitations may occur and radical adjustments may be required. The person's taken-for-granted fabric of daily life is breached and a special kind of reliance on other persons is brought into play (Zaner, 1982). Surgery and its aftermath, for example, pain or an unexpected limitation in mobility cause an interruption in the taken-for-granted actions or activities. "Things, particularly objects which may be used toward some end, are ready-to-hand when they are employed smoothly in practical activity" (Walton, 1995, p.113), but when the smooth

functioning breaks down it may create uncertainty and frustration. The changes which occur mean that “the old self-understandings are no longer completely relevant” (Benner & Wrubel, 1989, p.49), and the altered circumstances give the current situation an unfamiliarity. Not only is one’s daily routine interrupted but also plans for the future may be disrupted. For example, Colin’s plans for overseas church work had to be delayed because of the extent of his recovery time.

“It All Falls On the Shoulders of My Wife”

Frustrations and limitations may be experienced in dependence on others, waiting, and the personal and household activities of daily living.

For some participants, frustration increased as they felt better but were disabled in some way, which meant dependence on others and not being able to participate in their usual activities. For married participants it meant being unable to participate in their usual shared household responsibilities. For example Ben was retired and his wife worked. There were certain jobs for which he was responsible.

But this is the time of year that a lot needs to be done in gardens and I can’t plant and [press in the] plants, I can’t do anything. And it all falls then on the shoulders of my wife who has enough to do. I don’t work any more, she does, and then on top of that she has to do these things as well. So that frustrates me.

(Ben, 1: 16)

As did Ben, Colin had to depend on his wife to do things he would normally do. He expressed frustration that the limitations of his shoulder meant that he could not make his usual contribution to family life.

About the only thing I've been able to do is write Christmas cards. I've sort of got a thumb on one side and just write [demonstrates] and I can't dry the dishes, can't do anything that's really I'd say is practical to help which makes frustration.

(Colin, 1: 5, 6)

Colin was frustrated about not being able to carry out the jobs he usually did at home.

I want to get these windows all fixed up. I've done the bulk of it but there's a lot of things still to be done. I can't do them. Just to go out in the garden, I can't do it. I want to do something, can't do it. Stick a shovel in, dig up some potatoes. Hey, that's one arm, and it's things like that, that you know you cannot do or you undo all the good work that has been done. And that's the area of frustration, and a sense, emotion.

(Colin, 1: 10)

Limitations imposed by periods of incapacity cause frustration because the limitations affect not only the physical body but also interactions with, and responsibility toward, others. As physical capabilities change over time during recovery on-going renegotiation of social obligations and personal identity is required (Frank, 1995).

“I Felt it was Like a Sentence”

For some participants there was a sense of waiting, which caused frustration. Dulcie likened the six weeks she had to wait before being “allowed” to do certain things to a sentence (Dulcie, 3:18). Waiting might be waiting to be able to move more, to have less pain, to be able to have a bath or shower, to be able to play bowls, or to be able to drive safely. Dulcie felt so restricted in having to wait before she could do certain activities that she did not want to have surgery of any type in the future. Her experience with the current surgery had changed her outlook.

It has changed the outlook. I didn't mind so much the thought of it, I knew I had to have it and the sooner it was done and I'd be fine, but I did notice the convalescing time that I went through, particularly at the beginning. I was impatient to get it over with. That's because I'm used to getting up and around all the time. (laughs)... I think I was so frustrated at the beginning, I couldn't believe that I had to watch what I was doing for six weeks, but I also knew that my body wasn't letting me do the things I wanted to do, and I wanted it to heal too. So being active, and a very busy person, I think, you know, it was natural for me to be impatient and want to get back to the life that, and be more independent perhaps. (laughs)

(Dulcie, 4: 10, 11)

Dulcie, like Colin, while frustrated by her situation recognised time and limitations were needed for healing. Connie had to wear a cumbersome sling day and night six weeks after her shoulder surgery. She sighed as she indicated the time and described it as “a real drag”. Having to wear an apparatus which emphasised one’s incapacity seemed to compound the extension of time.

“Lived time (temporality) is subjective time as opposed to clock time or objective time” (van Manen, 1990, p.104). For participants, lived time slowed down during periods of incapacity and sped up as their condition improved. Incapacity affected the ability to carry out usual everyday activities.

“What’s a Bugbear is Trying to Clean Your Teeth”

The taken-for-granted no longer held true for participants. Limitations imposed by the surgery brought the taken-for-granted to the fore. Participants had to adapt to limits set by their surgeon and their body. Peter described the difficulty he faced when he forgot to turn his light out.

*They sent me out of hospital with a catheter and that was a bit of a bore, because they put on the night bag. The day bag's all right, it's strapped to the leg, and you emptied it about every two or three hours. That's not a problem. But at night they put on, or I had to put on myself ../.. I found I could do it very easily myself, put on the night bag for the night. That was all right once I was **in** bed, but the trouble is I'd connected it up and I'd get into bed and found I hadn't turned the light off. So I had to, clasping two plastic bags and about a yard of tubing, wander round the house doing the odd jobs that I'd forgotten to do.*

(Peter, 1: 6)

Personal activities of daily living such as cleaning teeth, combing hair, dressing, shaving, bathing/showering, and getting in and out of bed limited the participants' way of being-in-the-world. One example of this which caused difficulties was the position in bed – not being able or allowed to sleep in one's usual position in bed. This caused discomfort and affected the sleep pattern of the participant. Matt had a hip replacement and was required to sleep in a particular position. Matt had arthritis and suffered from stiffness when lying in bed.

The problem I've had at home is the same I had in hospital only a bit more exaggerated at home. You see in hospital ../.. I had to sleep on my back, flat on my back. Now.... well I had my head up a bit of course with a couple of pillows, but I could work this hydraulic bed up and down, which gave me some relief from aching bones and that, on my back because I'd always slept on one of my sides. And when I got home, I've still got to sleep on my back ../.. so this means getting up, every two hours. I've got to get up and have a walk round, so my wife has got to help me out of bed and back in.

(Matt, 1: 4)

The sleeping patterns of both Matt and his wife were disrupted.

Connie described the difficulties of trying to be comfortable in bed while wearing a sling. The sling was padded and quite heavy.

*And **bed**, you've got to be careful, you can't turn you know and I've sort of got to get in a right position ../... It's awkward in bed (laughs) and I can't turn, I go to turn round (husband's) side, I can't do that, I've got to go back again. So it's awkward, I have had a pillow under me, but I found as though that was pushing me and that was worse so I, throw that out.*

(Connie, 1: 25, 26)

Wearing a sling meant simple activities of daily living were affected for Connie.

What's a bugbear is trying to clean your teeth, false teeth it, it's hard because you're jarring everything, so [her husband] invariably ends up cleaning my teeth.

(Yes, so what are the things that you find particularly hard?)

Going to the toilet I cannot, I cannot pull up my knickers and certainly can't pull up trousers. (laughs)

(Connie, 1: 20, 21)

Colin was a person who looked for the positive in life as a matter of course but the limitations which beset him with his shoulder were a cause for concern.

Instinctively, you go to shave and you can't lift up, hold, when you're trying to use a blade razor or even an electric razor... Which is just one of the little difficulties, and I've been very careful getting in and out of bed, or doing it, I have to

*concentrate on the right arm to lift myself up, do things like that.
Just, yes, I find I miss the use of that arm.*

(Colin, 1: 7)

A part of Colin's body was no longer available to him so activities had to be adapted to deal with this. Eight weeks after surgery Matt was still limited in being able to dress himself. When he tried to put on his sock or tie his shoelaces, "it's inclined to twinge me a bit in the hip, so I just back off." (Matt, 3: 2).

Matt, like other participants, was particularly concerned about taking care not to do anything which would delay or harm the healing process. There was also the realisation that it would take time for recovery to occur. Sometimes this was accepted readily, at other times particularly if the person was feeling well, the waiting time caused frustration. Will had to use his left hand to comb his hair and clean his teeth for several weeks after surgery but decided, "left hand's not much help" (Will, 1:10).

Will illustrates both the aspect of time in the recovery process and the disruption in the everyday activities which are performed without thinking about them. These necessitated the help of others and this situation occurred with household and other activities as well.

Household activities were affected, for example, drying dishes, winding the clock, using a knife and fork, cutting food, feeding the dog, turning keys and knobs. These may be regarded as "minor and little things" but are an integral part of the fabric of the participant's life. Ben describes the difficulty of carrying out home activities.

I could not hold a loaf. If I wanted to slice bread, I could not butter my bread, or toast or whatever... I couldn't open doors before. I could not lift, I'm not allowed to lift anyway. I could lift things but sometimes you lift something and your other hand comes with it, and I had to cut that out, and now I can do that

without feeling any untoward pain or untoward feeling... you become aware of them [those automatic things]. Turning the knob on appliances was impossible, now I do it. But at first, I'm aware of that, and then I try, and if it resists, I don't, and if it goes easily, I have made another victory. (laughs)

(Ben, 1: 14, 15)

Ben was faced with new limits for his activities. Activities such as driving, bowling, swimming, and gardening were affected limiting the participants' horizons and their interaction in the social world. The unity of self and world was disrupted. Driving the car was a concern to some participants both as a concern for their own safety and the possibility of injuring themselves and others. Will had difficulties with driving. Just after he came home from hospital his wife was admitted to hospital unexpectedly and for the few days she was in hospital Will was on his own. He was incapacitated with a sling on one arm.

I have only one eye (laughs) but I don't drive when I can help it, my wife always drives... but I do drive if I'm on my own and... so I had to go backwards and forwards to the hospital, [driving the car] I found quite difficult. The most difficult part was getting the key, putting the key in the lock, and turning the key on. And turning it off, and take it out of the lock again was almost impossible. And it was a really painful feeling, to have... but I had to do it to drive the car. But once I had the key turned on, I had no problem. A funny little thing like that...

(Will, 1: 12)

Will illustrates how in incapacity the minutiae of life are affected. Participants were willing to try to continue with activities of the everyday but were often thwarted. It was often the minor things which caused most difficulty and activities both within the home and beyond. The physical, emotional and social worlds of the participants were affected and their landscape restricted. Being bound in this way by the limits imposed by the

body caused frustration.

DIFFICULTIES OF THE ALTERED BODY

Pellegrino (1982) describes illness as attacking the fundamental unity of being and as an ontological assault on the person's unity of being. An aspect of the assault is the rupture of the unity between self and body. "Illness interposes the body – or the mind – between the self and reality of our perception of reality." (p.158). This means that the "body impedes choices and actions; it is no longer the willing servant of transbodily purposes – work, amusement, pleasure. The body stands opposite to the self; it demands to be served – to take center stage. It stands in opposition to the self while still partially inseparable from self." (p.158).

The aftermath of surgery may mean one's body is no longer able to be taken for granted. There is a breakdown or discontinuity in one's being-in-the-world which makes it unpredictable and effortful (Madjar, 1991, p.60). Madjar comments:

There is an inherent uniqueness in how people experience their own bodies for themselves which is different from how they experience external objects. It is this sense of personal integrity, of knowing oneself as uniquely self, which may be disturbed in situations of illness, disability, or unrelieved pain.

(p.56)

"Heidegger labels the ordinary way that objects are for us in the midst of practical activity 'ready-to-hand' " (Hall, 1993, p.127). Being ready-to-hand is tied to specific familiarities and skills for coping in specific practical environments – there is implicit familiarity and competence which are the hallmarks of everyday practical activity. When breakdowns occur Heidegger used the term "unready-to-hand".

Heidegger's (1962) *ready-to-hand* describes the body / self engaged in smooth everyday action. When there is a breakdown in action which has previously been taken-for-granted the activity itself and its components come to our "notice", in other words become conspicuous. To illustrate the breakdown of the taken-for-granted Heidegger used the example of a hammer as a piece of equipment. When the activity of using a hammer is smooth and without incident we concentrate on the work being done not the hammer per se, but when something goes wrong we are aware of the hammer as separate from ourselves rather than as an extension of our actions (Heidegger, 1962, p.103; Walton, 1995, p.115).

There was a breakdown of the taken-for-granted for participants in their difficulty in carrying out their everyday tasks and because of incapacity this became a difficulty. Doolittle (1994) expresses this as a breakdown in skilled know-how and that when this occurs skilled practices and activities show up differently. For example when a limb is affected there is no longer automatic movement, the nature of the lived body has changed, there is a loss of sense of body wholeness, and the person must think about limbs reflectively (p.219).

"One False Move"

The lived body was altered to a greater or lesser extent; alterations were both visible and invisible for the participants. As well participants were made aware that there was a breakdown in the previously taken-for-granted abilities and activities. Simon found instinctual response could result in harm.

The greatest danger I find, is you know like, with the crutch there, and it suddenly starts to fall. Your instinct of course is to grab it, before it falls over, and you can't pick it up off the floor.

(laughs) *And you've got to try and restrain yourself, you know, in that **instant** of time, because one false move like that might be very harmful.*

(Simon, 1: 8, 9)

Simon illustrates that the previously taken-for-granted actions which would have protected him now could possibly do harm to his altered body. Ben described a similar situation when out in the garden he slipped on the wet petal of a rhododendron and involuntarily tried to grip something for support. He is right-handed, it was his right arm which has been operated on and it is his right hand which he uses to steady himself. He uses humour to illustrate the dangers.

And that is the danger that I still have, that I might slip on a banana skin and the wall or lamp post is on my right hand side, and it should be on my left hand side, for safety. (laughs)

(Ben, 1:15)

Besides dealing with the involuntary responses to situations the other aspect which affected participants was that of forgetting – forgetting that they were not to do certain things because of their altered body. Frank and Dulcie provide examples of this. Frank commented:

I'm finding that you sort of tend to forget when you are working in the garden you go to do something and get a bit of a shock and a bit of a jolt in the shoulder which quickly reminds you that you've got to keep it quiet and do it carefully.

(Frank, 1: 11, 12)

Forgetting gave reminders usually in the form of pain or discomfort. Dulcie, being normally a very active person, found it hard to remember not to do things.

Well I'm not allowed to do anything, not even make a bed which seems ridiculous or, not to pick up anything that would be any heavier than a couple of toilet rolls, (laughs) and you are inclined to forget that and reach out for something and think, "well, I'm not supposed to do that," and I really want to obey these people that've told me not (laughs) to do those things this time, but it is quite frustrating and the half of it is, you, you automatically do, try to do these things, you've got to tell yourself you can't... even picking up the cat, the cat and the basket to put it out in the evening, I think, "Oh I can't do that" because it's quite heavy but (laughs) you think you can especially when you're feeling a wee bit better. Yes, but the hurt sometimes warns you that you can't do it in any case.

(Dulcie, 1: 10, 11)

Dulcie's experience is an illustration of Benner and Wrubel's (1989) statement, "The loss of the habitual, skilled body makes the body feel foreign and objective, like a thing... Without a habitual, skilled body, people find all activity effortful and deliberate" (p.73).

One false move for the participants meant consequences previously not experienced when carrying out particular activities. The altered body affected the taken-for-granted.

"The Arm Tells Me Plainly"

When the taken-for-granted activities of the body break down the self becomes aware of the body; the body becomes the objective body. Bennett (1998) when writing of his toothache said, "Right now, I am a tooth" (p.6), and that when we are sick the world shrinks to the part of us that is sick. "Nothing else is." The focus for the self is the body, the horizon of the self is limited to the body.

Gadow (1982) labels the body and self acting upon one another as disrupted immediacy. In her dialectic of the levels of relation between self and body the self is experienced as free subjectivity, while the body is its vehicle and instrument. When immediacy is disrupted, for example in incapacity or pain, the body is seen as the source of impediment or origin of constraint of the self. The body and the self are at odds with each other. The body therefore needs to be controlled and becomes "the object" body or existential otherness of the self. Unless the self can control the body it will remain limited by the given capacities of the lived body (pp.88-90).

The alienation between self and body may mean the person objectifies parts of the body. The loss of the skilled body means the person is forced to relate to the world in new ways (Doolittle, 1994, p.212). Lawler (1991) states that "in the context of living through illness, some people cope with their bodies by objectifying or disowning the part which is affected." (p.155). The object body may dominate. Some participants expressed the concept of the objective body in the body "telling" them while others "told" their body, in other words the body was controlling what was happening to them and in the latter situation the participant was trying to regain some control over what was happening to them.

The participants' experiences illustrated how the body "directed" the self. For example, Matt considered his hip twinge warned him to go no further in putting his sock on his left foot. Colin said that his arm would tell him plainly that it was painful (Colin, 1: 4). The affected area of the body becomes a focus and preoccupation for the person especially in the earlier part of recovery. Simon was definite about his hip being a prime focus in our second conversation (about four weeks after he had come home from hospital). It controlled his life.

Yes, because that governs the whole of my activities, and going out and that sort of thing... it's getting in cars is the worst thing for me.

(Simon, 2: 6)

Ben perceived his tingling fingers were a reminder – telling him about his exercises, "you have to do a bit more" (Ben, 3:2); indicating where he was in his recovery, "it just tells me, 'I'm still there'. And so I'm not yet there" (Ben, 3:4).

I do more things than I did before and therefore I think the hand and the arm will become stronger. But it tells me now, "don't, don't skite about it, don't overdo it now", and then I do not do that extra bit.

(Ben, 3: 5)

It could be said Ben's tingling fingers demanded he attend to the signals they were sending.

Dulcie's body also sent her signals. Dulcie regarded "normal health" as having no restrictions. Her body made it clear that she had not reached the stage of normal health in her terms. She knew her body was not letting her do the things she wanted to do.

My body is still telling me that I can't reach up and I can't go out and garden. I know I can't because if I try to do some of those things, the operation is still reminding me that it's not right yet to do that...

(Dulcie, 2: 10)

Signals of constraint, warning, and urging were given to participants. The body provided signposts for the participants about their progress in recovery, but while the object body was a central focus the capacities of the lived body were limited.

"Behave Yourself"

Indications of the self's attempts to regain control over the object body in order to restore unity were illustrated by the participants. Connie provided

an example of trying to have some control over her body.

I put the beanbag on there [painful shoulder], because it was so naughty I just say it's naughty and I think give it a hit and say "behave yourself", but oh no there's nothing you really can do.

(Connie, 2: 5)

Pain which continued caused Connie to "attack" her body to try to bring it under control. Nell had experienced severe back pain for some time and had sought help from a number of health professionals in finding the cause and dealing with the pain but without success until the surgery. To Nell her mind had become attuned to never being without pain.

I've got no pain left in the backs of my legs now, and I can do anything and even my head tells me that when I get up now, I don't have to think, "I've got to get up, I'm going to have pain when I get up". That is all gone from my head and gone from my brain now. I don't think about it at all, I just get up, and I know it's not there. It's wonderful.

(Nell, 4: 2)

Nell's words, "even my head tells me that", suggests self and body are in harmony. The return to harmony often had hurdles to overcome.

"I Regret Doing Them Afterwards"

As participants coped with the difficulties of their altered body for some there was a sense of "paying for" actions and activities, that is, that they did or would suffer the consequences of such things as unwise or automatic movement of the affected area or overextending themselves in some way. Owen overextended himself:

I have had one or two days the past fortnight where I've suddenly thought, "Oh, I'm starting to feel right this morning"

and I'm feeling much like I would normally expect to feel. But only odd mornings I've felt like that. And of course the trouble is that what happens then, when I start feeling like that I can start seeing things that I would like to do and then I go and do them. And then I regret doing them afterwards, because I know I've tired myself out again, putting myself back where I was.

(Owen, 2: 5)

A month later Owen was again in the same situation. After half an hour of pottering around the garden he was “**extremely** tired”, and said, “I seemed to pay for it for the rest of the day” (Owen, 4: 14).

Owen had been tempted beyond his limits and had “paid” for it. Pain and discomfort could be the penalty for overdoing things as in the case of Will, and Nell. It is interesting to note that the word pain derives from the Latin *poena*, meaning penalty. “I went swimming, I went to [pool] but I did far too much, and I haven’t been back, I was too sore.” (Will, 2: 16).

While in a rest home for the first week of her recovery Nell started walking along the road every day.

When I did too much, at night my legs ached from hips to my toes. And they ached the whole night, and I knew then that I'd done too much.

(Nell, 1: 11)

The consequences of doing too much meant for Owen, Will, and Nell their activities were curtailed. One explanation of “paying for” could be related to Gadow’s (1982) disrupted immediacy where self is trying to gain control of the body. Here the body is exerting its “will” to undertake activities which are beyond it. The self as the body’s monitor must bring the body “back into line”.

The self either controls the body, through discipline, habituation, and training, or is controlled by it through illness, awkwardness, disability. In either case, the relation is one of implicit struggle: ... I *will not* give in to this pain. Body and self are inevitably at odds with one another.

(Gadow, 1982, p.89)

The implicit struggle may result in shame and distress.

“You Feel Ashamed of Yourself”

Shame and distress were other consequences in coping with the difficulties of the altered body, where difficulties left behind in childhood occurred, for example, needing help to pull up clothing after going to the toilet, or wetting the bed. For example, when Connie attended a meeting of a group to which she belonged she needed help to pull up her clothes after going to the toilet. The person who helped her had been a nurse and she felt that lessened the difficulty of the situation. The dependence on others for basic human needs proved frustrating for many of the participants.

Peter was distressed about his situation and had a sense of shame, “I’d peed in the night on the bed again which I **hate**. It really upsets me” (Peter, 3: 2). Peter later talked about wetting his bed as a very small child. He had never had any further trouble with bedwetting, until now.

You feel ashamed of yourself. Although I know I can’t help it, there’s no reason to be ashamed of myself, we’re not all rational are we? We’re guided by our emotions quite a lot. ... I know it’s not my fault. It’s the result of the operation or the disease or what-have-you. But I just can’t help it, I’m asleep.

(Peter, 3: 4)

Wetting the bed was described by Peter as “terribly depressing”. Shame, which includes in its meaning something which shocks the sense of

modesty and propriety, is a synonym for embarrassment. Embarrass implies some influence which impedes freedom, causing uneasiness or constraint. In Peter's situation his feeling of shame was present but he knew nothing done by the self was the origin of the shame – it was rather the body out of control.

Using Gadow's disrupted immediacy as an explanation shame could arise during the struggle between self and body to gain control. Peter's feeling of shame could also be likened, in phenomenological terms, to Sartre's description of the experience of a shy man who blushes. According to Sartre a term such as to "feel oneself blushing" is inaccurate.

What he really means is that he is vividly and constantly conscious of his body not as it is for him but as it is *for* the *Other*... We often say that the shy man is "embarrassed by his own body". Actually this expression is incorrect; I cannot be embarrassed by my own body as I exist it. It is my body as it is for the Other which may embarrass me.

(Sartre, 1956, cited in van Manen, 1990, p.25)

For both Connie and Peter shame / embarrassment arose because events occurred which should have been left behind in childhood.

The altered body resulted in the loss of the habitual skilled body which meant taken-for-granted actions were impaired and had to be consciously thought about. The body as object appeared and self and body struggled for supremacy. Shame, embarrassment, and paying the consequences were outcomes of the struggle between self and body.

PAIN - PRESENCE / LACK OF PRESENCE

Pain and/or discomfort featured in the participants' being-in-the-world to a greater or lesser degree. For example, those participants who were recovering from orthopaedic surgery often experienced a marked degree of pain and discomfort, while those who had abdominal surgery reported little or no discomfort rather than pain. Pain is considered under the headings presence and lack of presence in relation to the participants' perceptions.

Schrag (1982) describes pain as a mode of being-in-the-world which is manifest within copresent fields of consciousness and embodiment (p.119). Experiencing pain means a person is dwelling within a time span of concern. As lived experience pain is a configuration of sensation, feeling, imagination, memory, conception, and other forms of human intentionality – making and experiencing meaning. Schrag emphasises the place of pain in the everyday world of the person when he says pain “is a mode of existing in the world against a background of attitudes to be assumed, projects to be undertaken, tasks to be performed, and goals to be realized” (p.120). Madjar (1991) writing about clinically inflicted pain says this pain:

is regarded as an embodied human experience which needs to be understood in terms of both its lived, context-specific manifestations, and its meaning as a phenomenon – an abstraction of the essential and the universal qualities, which help us to attain a richer and deeper appreciation of human experience.
(p.68).

Pain or its lack added meaning to the participants' recovery experience.

“It Goes On and On”

For a number of participants pain was present as a feature of their recovery. To some extent this occurred because the nature of the operation

they underwent was usually accompanied by a degree of pain or discomfort. For some participants the pain they were experiencing before surgery continued after surgery though may not have been as severe, or may have been of a different nature, or as a result of another problem. For example, the operation site, mobility, a rash, were causes of a degree of pain or discomfort. Pain was described in a variety of ways and in a variety of degrees.

The language used to describe pain was graphic: pain, strain, discomfort, sore, soreness, painful, aching, throbbing, constant, uncomfortable, unpleasant, sharp, jolts, jarring, gnawing, grating, tender. Language informs us about the nature of a thing. Words bring to light the nature of entities. The words participants used when talking about pain illustrate the meanings that pain had for them. The words and the bodily effects of pain, "let that which shows itself be seen from itself in the very way which it shows itself from itself" (Heidegger, 1962, p.58).

Connie experienced prolonged pain both before and after her surgery. While Connie had not really wanted a third operation on her shoulder the pain she continued to experience made the decision for her. Following surgery, the brace she had to wear, while it provided support and protection, caused discomfort as, because of its bulk, it pulled on her neck and was hot. Connie required drugs for pain. Six weeks after surgery she stated the pain was, "even sort of a bit worse than what it was when I first had the operation" (Connie, 2:8). By the eighth week the brace was removed which meant for Connie that her arm was all right as long as she kept it to her side, as sudden movement caused problems. She commented, "let's hope some of the ache'll go, you know, it goes on and on" (Connie, 3:4). Our fourth conversation was delayed for a week as Connie was not feeling well enough to meet with me. When we met we talked about the pain. Connie said, "I think you expect it really. You can't get away without the pain, but things are going like they tell me. There's tissues, there's so many things inside there that've got to heal, and move" (Connie, 4: 16).

Connie's past experience of both arthritis and surgery did not lessen her pain but enabled her to understand it and accept the reality of it while coping with its relentlessness at times.

Nell's experience of pain had both similarities to and differences from that of Connie. Nell had pain affecting the back of her legs for at least three years before finding someone who could offer her some hope and help in relieving this. The surgeon said, " 'Right, I'll fix that for you', and so I've got **no more** pain" (Nell, 1: 3). No longer having the pain meant improvement both physically and mentally for Nell.

I can get round so much quicker, and I think mentally, I'm much more alert because I am not having to fight through that pain all the time, you know. I can speak to people much more easily, because I'm not speaking through pain. It's a big difference. It's a very big difference.

(Nell, 1: 13)

Nell compared how she felt after the operation with what affected her decision to have surgery.

*But a pain that is continual, is I think one of the worst things you can put up with. I really do. I **had** to have this operation. Because I knew that I couldn't live with that pain and even if I'd lived for another five years, my heart was good, everything, my lungs and everything but I knew that if I lived I would have that pain. And so I just **had** to have the operation... Because I couldn't have lived with it. I couldn't have lived with it. I think I'd have changed my nature, my, the whole of my living and everything, if I'd had to live with that pain.*

(Nell, 2: 5, 6)

Nell talked about how the effect of the lack of pain was noticed by others. She had gone to play bridge with some friends for the first time since her

surgery and she played exceedingly well much to the delight of her partner. Nell put this down to her not having any pain to contend with “because ../.. you’re not yourself if you’re coping with something down there all the time” (Nell, 2: 8). Nell’s friends noticed a difference in her in that the pain was no longer showing on her face.

It’s right off the face. Yes, they noticed it on my face. And my movements, they say, are quickening up all the time. (laughs)

(Nell, 2: 8, 9)

Nell’s experience reflects the comments made by Sontag (1991) about the privileged status of the face, “Our very notion of the person, of dignity, depends on the separation of face from body, on the possibility that the face may be exempt, or exempt itself, from what is happening to the body.” (p.125).

Even though Nell knew her pain had gone in a physical sense she had to adjust to this mentally, by relearning that she could rise from a bed or chair without pain. While surgery remedied the pain which had affected her legs, Nell had hip and back pain owing to other causes. She accepted this saying, “it’s better than that terrible pain down the backs of the legs, and I don’t mind that at all” (Nell, 3:1).

Nell had to learn to live without the presence of pain from one cause while still coping with the presence of pain from other causes. Colin, experienced pain consistently throughout our conversations. Colin had tripped over while shifting the garden hose and injured his shoulder. He described his pain two weeks after surgery.

The area where the tendons were torn out, at times it can be very painful. ../.. every now and then I’d find if I move unwisely, I’d get a shaft of pain go through those muscle areas where the tendons were damaged in the shoulder and elbow.

(Colin, 1: 4, 5)

Colin was given exercises to do. While he saw the benefits in doing the exercises the pain of his shoulder and that caused by the exercises was a disincentive, "So I have to concentrate on those exercises, regardless of the pain" (Colin, 2: 6). About seven weeks after surgery pain continued to affect Colin's everyday activities.

Well, you see, the strength in the left arm, you see, to do things, just to hold other things, it's painful if I hold up a book, if I hold it too long, or depending on the weight, or if it's a heavy dish. And I know the discomfort's saying, "listen, ease off".

(Colin, 3: 2)

Despite the pain and discomfort Colin was able to do more things around the home than previously. Two weeks later pain was still present. Colin had been to see his surgeon the previous week.

Oh he was very pleased. He could see me reading a newspaper and he said, "Why, you're looking so well". What I didn't tell him was the pain I had, because I just have to drop my arm, I couldn't keep holding the paper up, and it's the same with a book. I find that the muscles really protest, and yet I recognise that that is part of the growing healing move, and I've got to keep on with the discipline and exercise, and that's part of the price, but I never realised that a wound could take so long to be restored.

(Colin, 4: 1)

Pain affected many of Colin's everyday activities – helping in the home, gardening, reading, studying, responsibilities he had for his church. Some participants did not regard their operation as particularly painful. This depended on their perception and previous experience of pain. For example Matt had the previous experience of a very painful knee operation to compare the pain of his hip replacement.

Well, there's not much pain with this hip. It gets a little, the wound seems to get a little painful when I'm just back from a walk but otherwise it's generally pretty comfortable.

(Matt, 1: 5)

“There's a Lot of Discomfort”

Some participants experienced a degree of pain or discomfort only when exercising. Twinges of pain might come and go to remind them that they had experienced an operation. Pain as a reminder acted as a safeguard for Ben.

Sometimes I have to tell myself not to lean on the elbow as I had been advised early in the beginning, but I go back to old habits, and I lean on my elbow, and then I remember and put it away so remembering that, because I feel less pain, of course, I become a little bit more neglectful about the rules of the game. (laughs) That is one. I feel some twitches of pain, twinges of pain, as I do some gardening, then it disappears again, so I just have to wait my time.

(Ben, 4: 1)

The lack of pain meant Ben forgot the rules while the presence of pain meant he was reminded of them. As for other participants, his pain or a degree of pain came and went.

Simon used the term “discomfort” rather than pain and talked about its effects.

There's a lot of discomfort and so on when you come home.... and sitting in the chair, all that sort of thing, you stiffen up and you've got to unwind yourself and move around.

(Simon, 1: 12)

Dulcie talked about the relief required. Dulcie's previous operations enabled her to compare the degree of pain she was experiencing. Her pain was worse and lasted longer than she had anticipated.

[The surgeon] did say that I would have pain and the nurses said to me it'll be quite painful and I really didn't take much notice of that. (laughs) I thought that oh yes it'll be quite painful but it really has been very painful to move but I am moving much easier now so it just proves that the pain isn't as bad. As it was restricting I didn't want to move around very much in the beginning.

(Dulcie, 1: 14)

By our second conversation Dulcie's situation had improved to some extent. She used the term soreness rather than pain.

Participants compared different types of pain as well as the pain related to different operations they had experienced. Heidegger (1971) states, "A comparison places different things in an identical setting to make a difference visible" (p.100). Comparisons enabled the participants to incorporate pain experiences into their life stories. Past experience provided knowledge to help deal with new experiences of pain.

"I've Got No Pain"

Several participants experienced little or no pain after coming home. For example, for the three participants who had undergone surgery connected with their large bowel, pain was not significant. Some discomfort was commented upon while their alimentary system was returning to normal functioning. Neal was one of the three participants and compares his lack of pain with that of a friend.

See, I've got a person, another friend I ring up, ... and he's got a lot of problems again, with pain. And it's interesting because he asks me how I am, and I tell him I've got no pain. So you see, with health, who's the better off, because there's a terrific amount of stress with pain, and I don't have that stress.

(Neal, 4: 16)

Neal viewed having no pain as a bonus.

Participants dealt with pain with fortitude. A degree of pain or discomfort was accepted as part of their condition. Benner and Wrubel (1989) in talking about cancer patients comment that "acute distress and pain can make the present moment seem interminable and can foreclose the past and the future" (p.296). This statement applies equally to those participants who experienced pain and distress of some kind. For example, Dulcie's rash and imposed limitations made time seem interminable.

Those participants who were required to exercise the affected area of their body did so with doggedness and determination knowing they were likely to suffer pain and/or discomfort in the process. Participants were also particular about the amount of analgesia they took and for how long. For some participants pain was of lesser importance than other concerns and the type of pain they experienced might or might not lead them to take notice of it as in Owen's case. The length of time pain was experienced varied. The degree of pain was used as one of the signposts for recovery as part of the passage of time. Pain acted as a safeguard by reminding participants when they moved unwisely or overextended themselves. As Heidegger said, pain separates yet at the same time draws everything to itself (Heidegger, 1971, p.204). Pain separates the affected part of the body from the rest of the body but acts as a reminder for the body to protect and draw together again the separated to the whole.

For participants to have some control over their pain they needed information and preparation. Is the pain or discomfort being experienced to

be expected? What does this pain mean? Should I ask someone about it? Should it last this long? As will be discussed later the amount and type of information participants wanted and needed about pain and other issues was sometimes not forthcoming.

DIFFICULTIES OF “MY” WORLD

When a person experiences surgery and its aftermath there are a number of possible ways of coping. Both the surgical events and ways of coping are “understood in the light of personal background meanings, the situation, and the ongoing concerns” in the person’s life (Benner & Wrubel, 1989, p.88). Benner and Wrubel propose that as well as the social world a person inhabits once they become ill they automatically become part of a new community, for example, that of a cancer patient, that is, membership of a community of shared diagnosis (p.139). When a person has had surgery they are already members of a shared diagnosis community; now they are members of a shared surgery community. For the participants who also were members of an “other health problem” community “surgery and recovery” was something else that had to be accommodated in their everyday life.

The difficulties of “my” world for the participants encompass the concerns and problems they faced as part of recovery such as coping with an altered and unreliable body. Attention is also given to cancer, which touched the lives of several participants and affected their view of the world in particular ways.

Proximally and for the most part, Dasein *is* in terms of *what* it is concerned with (BT 181).

(Heidegger, cited in Hall, 1993, p.126)

Concerns centred mainly around the physical body, for example unexpected symptoms arising and persisting such as Simon’s swollen feet

(oedema); weakness, tiredness, and sleeplessness; a “lacklustre” feeling; and for those participants who had experienced cancer, fear of the cancer’s returning.

Heidegger used the term “falling” to describe the tendency to be absorbed in day-to-day preoccupations and to “drift along with the crowd”. This tendency is a tying to the present, and to temporality. “In everydayness Dasein becomes blind to its possibilities and tranquilizes itself with that which is merely actual” (Guignon, 1993, p.6). While participants were dealing with concerns and problems their focus was on the present and the actual in terms of what was happening at the time. Coping with a body which may be altered in some way as well as being unreliable in its performance meant participants had to focus on themselves. The relation to and concern for our own selves that we are and have to be is what Heidegger called “in-each-case-mineness” (Guignon, 1993). As previously mentioned coping can never be an unlimited choice but rather is bounded by meanings and issues inherent in what counts as stressful (Benner & Wrubel, 1989, p.63).

There were problems directly related to the operation, such as pain; previous problems not related to the operation; displaced problems in that they were caused by having the operation but were not specific to the operation such as a stiff back due to being less mobile; and predominant problems which overlaid the operation and captured the participant’s focus of attention.

“I’m Not Joking When I Say Both Mentally and Physically”

Changes in mood ranged from lacking motivation to “feeling depressed”. What might be a concern for one participant could be a problem for another and vice versa. Peter was most concerned about his weakness and it was a problem for him in aspects of his daily life.

All my limbs seemed to have, all my muscles seemed to have atrophied. I am very weak and I'm not joking when I say both mentally and physically. I find it difficult to get up from the chair and that sort of thing. Difficult to get dressed in the morning and undressed at night.

(Peter, 1: 2)

Peter's physical weakness affected him emotionally. He was also affected by the problems with his "waterworks". He stated, "I haven't been really very happy. A couple of times I've felt desperately depressed, because of my physical weakness" (Peter, 2: 1).

Physical concerns and problems caused "downers" for Connie and Dulcie. Dulcie had felt a "bit down to it" when she first came home. She shed tears but did not tell her family how she felt. I asked her why she had not told her family.

*Well I don't know **why** I didn't, but I just felt that I was a bit sorry for myself, and perhaps I just should pull up and I think it was the thought that I had all those weeks ahead, when I thought I'd have to fill in time because I wasn't feeling I could do anything, and I expected to be, you know, I expected to feel a lot better than I did. And of course the rash that I had at that stage, I think was the worst thing. I think that made me very depressed because I could cope with the pain, with the Paracetamol, but you just can't do anything with, when you have a rash like that that was all the time itchiness, there's really nothing you can do to sort of stop it. You can, you know, apply what they gave me, for the rash but it didn't stop it, (laughs) really. And I think that was really the reason why I gave way to tears, not so much the operation. I was just feeling too sorry for myself, I think.*

(Dulcie, 3: 16)

Dulcie prided herself in coping with life as a widow and it was important to her to be seen as doing so. Dulcie's not telling her family how she felt is an example of what Dreyfus (1991) means when he says in special situations of breakdown we hold back or disguise our activities. In other words, our relating to others becomes unavailable. Connie was another participant who felt "a bit depressed".

The nurse, when she came on Monday morning, I didn't have a good day, Sunday, and she said, "I think [it would] be a good idea, it's a cold frosty day, ... if you went back into your bed" so she just put the nightie back on and I went back to bed, and that's where I sort of stayed for the day, because I was a bit depressed and she wanted to know had I had tears and I said yes. "Well," she said, "you will". I said, "I haven't cried very much at all through this one" [operation] and she said, "Well, they don't hurt you, they're good for you, to have a weep" so I did, but just for no reason it sort of bubbled, just feel a bit bubbly and depressed.

(Connie, 2: 9, 10)

Lack of sleep and continuing pain undermined Connie's ability to cope with daily life. King and Parrinello (1998) found in their study of recovery after coronary artery bypass grafts that for the first three weeks after discharge from hospital mood changes fluctuated. Most of the participants reported feeling "down" rather than feeling depressed.

While some participants did not feel depressed they spoke of a lacklustre feeling or a feeling suggesting a lack of motivation. Matt, Will, and Nell were three such participants. Matt described his lack of motivation.

I've had letters which are due to be written. For example filling out my hospital form to get the cash discount, it lay here and I just couldn't be bothered filling in the form. Well, now, I filled it in about a week ago, and now I could write a letter and pay

accounts, and that sort of thing, whereas I just couldn't be bothered to do it a month ago.

(Matt, 3: 3, 4)

Will's lack of enthusiasm extended to his playing bowls.

I haven't the enthusiasm to get back to bowls as I thought I might have. We're supposed to be playing this afternoon, but I didn't put my name down, did I? And that would never have happened, once.

(Will, 4: 5)

Will gave as his reason for not returning to bowls, being too comfortable at home but playing bowls was an important part of Will's life and for him not to put his name down to play was significant. Nell required frequent rests between exercise or activities because of the pain and she became frustrated. "I'm really getting very cross with myself because I should be really better than this". She goes on to say:

Do one little job, and then I think, "Oh golly, where's a chair?" and I have to sit down for a while, and I'm feeling (sighs) got a can't-be-bothered attitude, that is not me.

(Nell, 2: 1, 2)

Sometimes reasons for changes of mood were obvious, for example, the physical problems Peter had, or there were a combination of factors including expecting to be feeling better than one was. The fracturing of one's sense of self required a period of time to restore stability and changes in mood may be one sign of this period.

"I Do Get Very Tired"

Physical responses to the difficulties of the participants' world occurred and tiredness and sleep problems were common.

Colin found that he needed a lot of sleep, that he became sleepy quite easily. The combination of his feeling of weakness, tiredness and need for sleep made him realise and wonder about “how long it will take before I’ll be back to fitness. Considering all the fitness I had before” (Colin, 1: 4). Colin was reassessing his progress in the light of his concerns.

Tiredness was a concern for all participants. Some were surprised about the degree of tiredness and how long it lasted. Visitors sometimes contributed to the participants’ tiredness.

I do get very tired. People out of their kindness, come and visit me and they’re apt to stay a bit long. I like them to drop in but some will stay a couple of hours and it’s much too long for a chap.

(Peter, 1: 11)

Peter had to resort to asking visitors to go. Connie, like Peter, had a number of visitors.

Today you see I’ve had five [visitors] (laughs) but, no it doesn’t really matter ... it’s just that I get a bit tired and then I think, “Oh good I’ll have a good sleep,” and I don’t.

(Connie, 2: 3, 4)

In the initial stages of Matt’s recovery tiredness was a feature of his day. After breakfast he returned to bed, got up mid-morning for his shower and shave, and had a walk before lunch. “And then, after lunch I seem to feel tired again, and have another hour just resting on top of the bed with the duvet over me” (Matt, 1: 4). The feeling of tiredness is woven through Matt’s day. At a similar period of time post-operatively, Dulcie too felt the need for a rest during the day, usually in the late morning. Eight weeks after discharge from hospital tiredness was still a presence for Dulcie, “I feel I need a rest in the afternoon. Perhaps that’s habit now, I don’t know, but I still do get very tired” (Dulcie, 3: 8).

Will's third interview occurred about nine weeks after he was discharged from hospital. He said he was very tired and thought the breathlessness, which he thought was due to problems he had while in hospital, had contributed to this.

I've heard it does affect people. And I am, I am very tired with it. The other problem, well, normally I've been able to go up there in the afternoon and play bowls and I'm jumping up and down, but yesterday I played, we played for three hours, after about two hours I'd had enough, and I was ready to go home. And the rest of it was just hard work, which is not very pleasant.

(Will, 3: 4)

Concurrent health problems contributed to Will's tiredness. The degree and amount of tiredness participants experienced was to them inexplicable. They could not understand why it should occur and last so long. It interfered in their everyday life as they sought to restore their usual pattern of life. Nell illustrates this as she attempted to maintain her fitness.

*And I've been trying to go for a walk every day. That is I found sort of the hardest thing of all, because I'm terribly terribly tired. ... I just sort of feel **tired** all the time. I'm sleeping well, I'm eating well, and nothing's wrong with me except that as soon as I start to walk or anything like that I look for a chair to sit down afterwards... I think it's just the tiredness that's upsetting me more than anything.*

(Nell, 2: 1, 2)

Nell considered the possible reasons for her tiredness but could not identify a specific cause.

For some, there were poor and erratic sleep patterns. Nell, in her second interview, was concerned about tiredness but said she was sleeping well. Two weeks later the situation had changed.

I have improved, but my sleeping is ghastly. I can't keep my sleep for very long at night, I get terribly terribly stiff, all over, (laughs), and I think it wakes me because I'm awake about every hour and then from five o'clock on I just lie there and I take deep breaths and I do everything I'm supposed to do to get myself off to sleep but the sleep won't come. And I'm not making it up during the day. Sometimes I fall asleep. At seven o'clock is my worst time, I can sit on the sofa and go to sleep for an hour, at seven o'clock at night, which spoils the night routine if I do that. But I wish I could sleep a bit better than I'm doing, but I'm not half as tired as I was, nowhere near as tired.

(Nell, 3: 3)

While Nell's tiredness had improved, sleep became a problem. In King and Parrinello's (1998) study, feeling tired was the only symptom reported at all times of measurement by the majority of subjects. In the first week post discharge 94% of subjects reported feeling tired; by the eighth week this had dropped to 50% of subjects. Sleep disturbances were also reported throughout the period of the study, ranging from 50% reporting problems in the first three weeks, dropping to 21% by the eighth week. A particular problem was trouble staying asleep rather than not being able to fall asleep. Tiredness and sleep problems affected the other activities for participants in this study and created difficulties for them.

“And All This is Sort of Just Added Stress”

There were many examples of factors which added to the stress faced by participants coping with an altered body after surgery.

Home help was both a concern and a problem for Simon and his wife. Simon talked about this in three of the four interviews. As Simon said, “if there's one thing that we would've done, you know, with hindsight, was to have the home help all set up before I had the operation so that the day that I came out it would've been available” (Simon, 3: 10). Simon and his

wife thought the hospital would arrange home help for them but this did not happen and arrangements to set up home help after Simon came home did not go smoothly.

Well, one of the things, you know I think I mentioned this last time, the problem has been that getting help in the home. Because there's a lot of extra work for my wife. Unfortunately we thought that the hospital were going to sort of steer us into the right path, and we approached (community nursing and home help service) and they took so long to produce somebody and then they didn't turn up, and we've got problems there. And I think, you know, in the particular circumstance that I'm in, where I've got a wife to look after me, she's like me, she's (laughs) not getting any younger. [Simon was 78] And, you know, you very much need assistance. We have a woman comes twice a week, two hours, cleaning... vacuuming and clean the floors and that sort of thing, the more robust parts of the housework and this I think is very much part of the recovery process and it doesn't affect me directly in a sense, but I mean it does, and in an indirect way.

(Simon, 2: 9)

Simon explained the process of trying to get help, and after getting help, the person came, then a different person came, twice, then did not turn up the next week. "And all this is sort of just added stress" (Simon, 2: 9). For Simon, having adequate help in the home "is rather a vital part to the recovery at home" (Simon, 1: 11), and his story illustrated the importance of effective home help.

For a number of participants, particularly those who had orthopaedic surgery, there was the need to remember to avoid unwise movement as this could give sharp reminders in the form of pain. Simon talked about the stress of remembering.

I suppose there's the mental stress of having to remember all the time, what to do and what not to do. Because I've always been one to cross my legs. ... And I've only done it once. I'd been putting my foot up on the chair there, or the stool, because I've had a lot of oedema in the last few days, and they swelled up, particularly the one with the operation and some in both of them. I was taking my feet down, I suddenly found myself stuck because I'd put one leg over the other, (laughs) and hastily retrieved. That's why I keep the cushion there, to remind me.

(Simon, 1: 8)

Remembering that certain actions need to be thought about before being carried out in order to reduce harm may create added stress during recovery.

“But I Still Have This”

During recovery participants had to cope with lost or impaired control of the body. Sometimes the body is subject to events that cannot be controlled. The predictability that provided a “past that leads into a present that sets in place a foreseeable future” (Frank, 1995, p.55) is threatened. Some participants found they could no longer rely on their body to function as it normally would.

Some participants had to cope with difficulties which arose because of their surgery. Simon was concerned about his thigh muscles after his hip surgery.

But I still have this. ... it's a sort of.... it's hard to describe, a sort of a muscular tension, you know, and sometimes the muscles don't seem to operate, and I just sort of lurch a bit to one side, as if, you know, there's something not quite, not the full stretch. (laughs)

(Simon, 2: 3)

Simon thought some physiotherapy might help the problem but his surgeon

did not agree and the hoped for answers did not eventuate. The problem with the thigh muscles was raised again during the fourth conversation with Simon.

The thing is I've still got this discomfort, if you like, in the hip and round the thigh, as a result of the muscular constriction if you like, and.... I still find that when I'm walking along, I'll suddenly sort of, it's almost as if the leg gives way, you know, and then I just veer a little bit to one side, and it leaves, you feel you haven't got complete control over your movement. ... I'm just hoping I'll be able to walk in a straight line. Changing direction is something you've got to be pretty careful of. Like going through the house, you come down the passage and turn into a doorway, you've got to be a little careful how you guide your new hip round the corner.

(Simon, 4: 4, 5)

Simon's mobility was affected by the danger of his leg's being unreliable. Dulcie was another participant whose body "let her down" when an untoward outcome from her surgery occurred.

Yes I noticed that my bladder was letting me down and I was very disappointed. And I said to [surgeon] "I don't know whether this is your fault (laughs) or not, or whether it was the previous operation just giving way", and he explained and I didn't understand his explanation of the body.

(Dulcie, 3: 4)

Problems sometimes arose after surgery which the participant did not expect.

“It’s All Clouded By This Other Problem Now”

Problems affected other parts of the body as a result of the particular operation. For example both Will and Simon suffered back problems. Will thought his problems arose from the stretching exercises he was doing for his shoulder and which caused quite a strain on his back muscles. Simon's stiff back was due to his initially having to lie on his back when in bed and this was later compounded by longer periods of sitting in a chair. Ten weeks after coming home from hospital Simon's stiffness was still a problem, “I’m not worried about the hip so much, but the other, the stiffening up doesn't seem to have got any better” (Simon, 4: 2).

Simon felt the problems affected his recovery in a particular way.

Well, putting it in percentage terms, I suppose I’m about three quarters of the way [to being recovered]. No, I’m nowhere near there yet. But.... it’s all these other things that are sort of overlaying this which rather obscure whether it’s, you know, how much better I am as far as the hip is concerned.

(Simon, 4: 3)

Problems other than those directly related to the operation acted to distract or divert the participant. The recovery period was one of shifting ground as different problems took a central place for the participant, for example, Owen's heart condition. A major problem was his angina. Owen had various problems including severe backache which started in hospital and took two to three weeks after he came home, to diminish. By the sixth week after Owen came home from hospital he reported his back problem had “mostly cleared up” but “this nausea and fainting thing’s come back, and it’s the lack of energy. I’m quite exhausted most of the time.” (Owen, 3: 13) Owen had started to feel “quite good” about a month before. He started to do some light jobs around the home but he found this coupled with the warmer weather had depleted his energy. Owen felt his other health problems obscured his recovery. When asked what would make him feel he

had recovered from his operation he responded:

Well it's all clouded by this other problem now. And if I had, I guess, see because the energy is, the lack of energy is not directly attributable to this operation. At least I don't think it is now. I don't know how I can answer that accurately. I think that, I don't think I can expect any more from it than I'm having. It seems to be if I didn't have this other problem I'd be O.K. That's the way I feel.

(Owen, 3: 11)

Owen's low energy levels and angina had come quickly to the forefront, focused his attention elsewhere and pushed his operation to the background. All participants had other health problems they were dealing with as well as recovering from their operation. For example, Harry had a heart problem and an ostomy which had herniated.

I had a shower and got back into bed and put the bag [ostomy bag] on and... everything was cleaned up, all of a sudden the bag just started erupting and I thought it was never going to stop. You know, and of course I had paper towels all round (laughs) it just poured out, it's quite amazing. And it's only done that about a couple of times, all the times I've had showers and got on to the bed to put a new bag on, and it's only done that a couple of times. Yesterday I couldn't believe it.

(Harry, 1: 7)

Harry's hernia was not painful but he regarded it as a "nuisance" and found it to be uncomfortable. Caring for his ostomy predominated over his operation.

Dulcie's rash (thought to be an allergic reaction) was predominant in the earlier stages of her recovery.

*When I think back about that I think it [rash] was worse than the pain from moving because that rash was, it was a dreadful thing... I had to go back and have the medication changed twice and it wasn't working and I had to have some sleeping pills to get over it but, thank goodness, it has cleared... there was nothing worse than an itch, it was **so** itchy, and you know I just couldn't, well couldn't go out or anything (laughs) because you would be scratching all over the place and at least when you're at home you could do that or put on some of the cream that I was given.*

(Dulcie, 2: 6, 7)

Dulcie's rash caused her stress and interfered with social interaction. It was an unpleasant and unexpected consequence of her surgery.

Coping with the unreliable body involved coping with health problems already present, new problems arising as a result of the surgery or for other reasons. Any of these problems might take precedence in the participant's daily life and divert attention from recovery from the operation.

“They Told Me I Had Cancer”

In New Zealand 20% of people over the age of 65 die as a result of cancer (Statistics New Zealand, 1995, p.76). The lives of several of the participants had been touched by cancer. Five of the 13 participants had spouses who had died of cancer, and five participants had previously received treatment for cancer; for three of the five their current surgery was not related to the cancer. One participant, Peter, whose cancer was in remission required surgery to relieve symptoms caused by his cancer. Owen's surgery was for cancer of the colon, while the operations for Neal and for Harry were directly related to their previous surgery for bowel cancer. Peter, Owen, Neal and Harry had wives who had died of cancer and at least two had cared for their wife during her terminal illness. Cancer can be regarded as a disease befalling a person – unasked for, unanticipated, falling outside the

person's range of possible choices and plans (Zaner, 1982, p.50). The body is no longer reliable nor trustworthy, the "person's embodied sense of self may change as a result of internal and external physical alterations in the body" (Benner & Wrubel, 1989, p.293).

Owen was surprised when told he had cancer. He thought his health problem was due to another cause. He had followed a diet which supposedly reduced the risk of bowel cancer so a diagnosis of cancer was unexpected.

I wasn't despondent about it. I thought it was a bit, oh perhaps a bit fatalistic about it, I just accepted it and thought, "well, that's another thing we've got to go through", as I have done over the past few years.

(Owen, 1: 3)

In Owen's case other health problems overlaid his operation for cancer and affected his attitude to cancer and the surgery.

Neal's previous surgery for cancer had resulted in his having a permanent ostomy and an indwelling urinary catheter. His current surgery was for a hernia involving the ostomy area. Neal stated he did not fear cancer but each time we met the topic of cancer arose. "I've just always treated it as an illness, it never entered my mind that it could be shortening my life span. Never think of it now" (Neal, 1: 1).

Neal felt that he had recovered from the cancer because, "I don't feel any ill effects, anything that I feel is not normal" (Neal, 3: 6). He had been a volunteer driver taking people for radiotherapy treatment. He felt that experience had helped him when he was diagnosed with cancer and had to have radiotherapy. Having had cancer Neal said, "I think the important thing is to know where you're going and to know what you're confronted with" (Neal, 4: 6).

In our conversations Neal talked about people being unaware of his condition and therefore not being able to appreciate his situation. He told me he belonged to Probus (a social and educational group). Several members had died of cancer in recent years but, "it's a thing that's never ever discussed" (Neal, 4: 8).

Neal later took it upon himself to give a talk at his group about cancer. Benner and Wrubel (1989) point out that cancer is not considered a suitable topic of conversation. The language associated with cancer and its metaphorical usage in social discourse brings both stigma and social burden for a person with cancer and therefore adds to what the person has to cope with (p.270). While Neal's cancer had been removed and treated it continued to be *present* emotionally and physically. The physical presence of his catheter and ostomy bag was an ever present reminder and his operation for cancer took precedence in his world over the surgery for the hernia affecting his ostomy. The latter operation was a means to an end in that it enabled Neal to better cope with his ostomy.

Peter had cancer of the prostate gland and cancer had spread to his bones and injured some of his vertebrae. Peter told me at our first meeting that the cancer was in remission.

When they told me I had cancer I wasn't a bit upset. I'm 87, I've had a very happy life, happy and fulfilled, and I thought, "well, we've all got to go sometime". So I wasn't a bit upset about that but I was upset when I found I was wetting the bed.

(Peter, 1: 1)

A diagnosis of cancer forces a person to confront mortality and temporality. Peter experienced back pain from the cancer in his bones. Untoward pain in another area of the body raised the spectre of a recurrence of the cancer.

Wednesday morning ../.. my left knee was very stiff and sore. I wonder whether the cancer had come back because it's supposed to be in remission, and had got into my knee. I don't know, I'm waiting to hear about that.

(Peter, 3: 2)

Pain takes on new meaning for the person who has experienced cancer as "the person is not radically free to 'reinterpret' pain in just any fashion" (Benner & Wrubel, 1989, p.78).

As well as the bone pains the difficulties Peter was having with his bladder raised concerns about the return of the cancer. He had been treated for a urinary infection but then began to have similar problems again. He expressed his concern about whether the cancer had become active again because it was supposed to be in remission. Benner and Wrubel comment, "Many patients experience remission as a period of uncertainty and limbo. Their cure is ambiguous consequently, any illness, symptom, pain, weakness, fatigue, even headaches may be a source of distress or worry. The illness continues, although the disease may be cured" (pp.284-285). Peter was aware that the cancer might return.

I'm now 88, and we've all got to go some time, and I'm not afraid of going. No. If it comes back, as long as they can keep the pain under and I'm assured they can, I'm not worried about it.

(Peter, 4: 4)

Peter's religious faith, the experience of losing two wives to cancer, and the knowledge of the support of his family and friends were some of the facets of his life which helped him face the stringencies of his cancer. While there was an acceptance of cancer there was also always present, overtly or covertly, the fear of the cancer's return and a seeking of reassurance that it was and would be being "controlled".

Harry, who had a temporary ostomy, had been waiting for several months for the rejoining of his colon after his operation for bowel cancer. Complications had required two trips to hospital, the most recent for a repair following adhesions in the lower section of his bowel. For Harry, like Peter, there was an element of doubt – had the cancer returned, was it all gone? He needed the safety net of reassurance that the adhesions were just that and that there was no cancer.

And there's no sign of any more cancer or anything like that, because the doctor told me that, that there was no sign of any more. It was just an adhesion, so that was, you know, I was quite happy with that.

(Harry, 2: 5)

For Harry his cancer had been physically removed but it was emotionally present. He spoke about being near at hand to the experience of cancer when he was in hospital, talking about a particular patient and the effect this had on him.

He just, after the operation, I knew there was something wrong because all the family were there, and he was quite bright before the operation. And they give him the word, and told him that, you know, he couldn't do anything, just close him up and that was it. And they shifted him out of the ward [six-bedded room] into one of those rooms across, [single room across the corridor] and I always thought, (laughs) in fact I didn't want to be shifted up to where he was, he had a window seat, and I thought, "I'm not going to ask for the window thing". (laughs) It's funny isn't it?... and you've got the same thing, and you're thinking, "Oh, I've been told I'm O.K.", and then it makes you think, "Oh well, am I O.K.?" (laughs) But you've got to have faith in your specialist, and whoever is handling your case, and doing their best for you, because they're obviously trying to do the best for you. That's life. I'm pretty, you know, realistic. Well,

*having had a wife with cancer, and she was never ill in her life,
and within eight months she was dead.*

(Harry, 3: 4, 5)

Despite the reassurance of both his surgeon and his G.P. Harry's close experience with death from cancer created uncertainty.

Harry, Neal, and Owen had all talked about their diet, with the implication that it should have provided protection against getting cancer. As with the experiences of other participants there was an element of betrayal in that they had tried to live their lives according to "expert" advice yet they had still been affected by an illness or condition which they neither wanted nor expected. Despite this the four participants had a positive attitude toward and an acceptance of cancer but from time to time cancer in a negative sense, that is, the threat of presence, would come to the fore. For example, Harry's experience of the death of people near-at-hand brought him face-to-face with his own mortality.

Benner and Wrubel (1989) comment we cannot step outside our own history, that we constitute and are constituted by our experience. A person may be judged as cured of cancer but the experience of having had cancer "will inform the rest of that person's life" (p.61).

REVIEW AND SUMMARY

Pellegrino (1982) points out, "Even when one is 'cured' the experience of illness leaves its imprint. Body and self are never again quite so comfortably united, for the person who has been ill recognizes that at any time his body or mind may again come into opposition with the self" (pp.159-160).

The disturbance of the everyday; the difficulties of the altered body; pain and the difficulties facing participants in their everyday world acted as an assault on their being-in-the-world, disrupting the harmony and the unity of their Being. The physical, social, and emotional components of their world were threatened as they sought to carry on with their day-to-day activities and in the process of recovery unite the separated part of their body to the whole. For a sub-group of participants cancer was both present and lacked presence; it might be physically removed but came to the fore in a variety of ways.

The aspects with which participants were concerned as part of their recovery and how participants moved beyond the disruptions of everyday life to look ahead are discussed in the next chapter.

Chapter Six

BEING CONCERNED WITH

In the previous chapters the context in which participants experienced surgery and their recovery, and the disturbance in the participants' being-in-the-world, were discussed. In this chapter consideration is given to those aspects of everyday life which had special meaning / came to the fore during the participants' recovery and which were both of concern and/or necessitated being concerned with. Heidegger (1962) calls the particular way of being involved in the world where things and people matter to us "concern". The world is apprehended in how it affects the self, how it has meaning for the self. Concern, along with solicitude, is integral to Heidegger's notion of care and "care is the basic state of Dasein" (p.293). For Heidegger "Dasein finds 'itself' proximally in *what* it does, uses, expects, avoids – in those things environmentally ready-to-hand with which it is proximally *concerned*" (p.155). Concerns differ and change depending on the situation, while also changing across time. These shifts in concerns create a new understanding or a reinterpretation of one's experience (Benner & Wrubel, 1989). Benner and Wrubel comment that "concern is not just an understanding that allows a person to define the situation in a certain way. The situation itself defines the person because of the way concern involves the person in it" (p.115). Furthermore, concern attunes the person to cues and signs that relate to or affect that concern, the experience of pain for a number of participants being an example. Each participant who experienced pain interpreted it differently depending on past experiences of pain, on what was happening in the present, and expectations for the future.

The focus of this chapter extends from the physical body and its safety, care, healing and keeping healthy, to a broader horizon encompassing knowledge and meaning, and the responsibilities and requirements to achieve health. The data are discussed under the themes: the **lived body**, which includes being aware, taking care, and healing and keeping healthy; **lived time**, which considers aspects of making progress in recovery and being in control; and **finding meaning**, that is, participants wanting information and wanting to know about the experience they were going through to achieve understanding, and their ways of being, reflected in attitudes and feelings.

LIVED BODY

"One's body is one's point of view upon the world. Man's [sic] body is his natural access to the world." (Merleau-Ponty, 1962, cited in Robertson-Malt, 1999, p.293). The lived body (unity of self and body) is a way of being in the world, the consciousness of being able to affect the world and of being vulnerable to the world's impact (agency and vulnerability) (Gadow, 1982). In everyday lived experience we take our embodied self for granted. Illness and associated events cause disruption to the embodied self so that our ready-to-hand understanding of ourselves as embodied is impaired or breaks down. The previous unity of self and body is impaired and the "body" is to the fore (Leonard, 1989).

The physical body was a central focus for participants who were both more aware of their bodies because of their surgery, and were made more aware of their bodies, for example, when pain or discomfort were experienced. As part of the heightened awareness was a desire to know about their body and to undertake certain actions to enhance healing and comfort.

“I’m Consciously Aware of the Problem All the Time”

Participants had a heightened awareness of the lived body, either or both the affected part of the body and the whole body. For example, Colin was aware of his shoulder all the time.

At the moment, it's consciously, I'm consciously aware of the problem all the time and if I do things unwisely I'm suddenly reminded.

(Colin, 4: 5)

Colin talked about how trying to protect his shoulder made it more vulnerable.

The strange thing was that I was more in danger of damaging the limb by the overprotectiveness... in a sense while trying to protect the limb, it's like if you got a damaged foot, invariably you'll kick it or hit something with it. And you're aware of it. It's always sort of before you.

(Colin, 2: 11)

Colin emphasised how one part of the body becomes the focus of concern and care. Like Colin, Will also had shoulder surgery. Several weeks after being home Will said, “it's still the part of the body that concerns me. It doesn't worry me, but it's one that concerns me and restricts me at the moment.” (Will, 2: 14). The restrictions imposed by his shoulder surgery increased the awareness of this part of his body.

While Dulcie was not restricted in the same way as Will she was well aware of her operation.

Because it's uncomfortable when I do go to the toilet still and that is reminding me of the particular operation that I've had, but

still uncomfortable, so until that goes away, I'll always be reminded of the operation.

(Dulcie, 2: 11)

For as long as participants were aware of and concerned about their bodies, and restricted in activities, their daily patterns of life were affected. Certain embodied states cause obstruction to the usual taken-for-granted embodied capacities and possibilities. Phenomenologically the effects of the events associated with illness and disease affect space and time and impact on one's intersubjective world (Rawlinson, 1982).

Colin, Will, and Dulcie illustrated awareness of a particular part of the body. Simon, Ben, and Matt indicated how an operation, which affected one part of the body, had a wider effect in their lives.

Ben talked about the effect on the whole body of a cut in the elbow (which he regarded as minor in comparison to other surgery).

There are not very many things that you do without using your hands, or needing your hands, so it is a completely involved process. The whole of your body seems to be involved, and you are handicapped by having a cut in your elbow... So the effects are much more than I thought of before, it affects the whole of your demeanour, your whole attitude, because it is frustrating not to be able to bend over and pick up a weed because it will hurt. Anything small that you cannot do is quite difficult.

(Ben, 3: 7)

Difficulties were also recognised by Simon. Simon's hip was a prime focus for him, but he described it as also governing "the whole of my activities, and going out and that sort of thing" (Simon, 2: 6). Difficulties in getting in and out of the car (Simon was a tall man) and walking distances affected Simon's social activities.

The need to be aware of his hip was a focus for Matt but it also made him more aware of the rest of his body.

So at each point in time I'm careful not to twist around, to bend too far, very careful going up and down steps, so it seems to take priority, your hip. But as I said before, it, the fact that one part of your body has had to be replaced tends to make you look after the rest of it. I put on my big sunhat when I go out. I put, walking down the street, I put on cotton gardening gloves to keep the, I used to be ginger and I'll burn, and so I keep the sun off my body. And the people look at me walking down the street with these gloves but that doesn't worry me.

(Matt, 2: 8, 9)

Participants were made aware of the part of the body which had required surgery and the effect on the physical and social body. They were concerned about a variety of aspects which arose from the increased awareness.

Participants were concerned with things which were directly related to their operation, such as pain or discomfort, or a feeling of an incomplete body where an arm was unable to be used for a time; aspects of healing, such as sleep, rest, energy; activities of everyday life, for example, dressing, mobility; and other health problems, such as angina, bronchitis. These aspects made participants more aware of their bodies and might enhance or hinder the healing. An example of this was the feeling of tiredness which was a difficulty experienced by all participants. Where tiredness persisted beyond a time where a participant considered it should not have, it became an issue of concern and/or one which needed to be dealt with.

A focus of concern for Connie was the cumbersome sling, which was a constant reminder of her shoulder operation.

I mean you can't help but know that it [operated shoulder] is there, you know you know it's there, and of course I know that I'm all the time moving this, this block thing, [sling] and then when I move it that grabs. The shoulder grabs, but you see this one, this [points to the left shoulder]. The left shoulder has been, being a bit bangified too, so so it's been the both of them, and I suppose I think that's when I get a wee bit more, down, when both of them are going at me.

(Connie, 2: 24, 25)

Connie had two painful shoulders, one in a heavy sling, which concerned her and affected her physical and emotional ability to cope.

Harry had been concerned about his tiredness. A question asked of him about his tiredness led him to reveal other concerns.

Yes, I think that's improving, yes. I don't think I feel quite as tired. I don't get those periods when I do feel sort of lifeless as much as I was before. In fact, I haven't had any since I seen you last time, and I feel you know, more myself, but I don't do anything, any strenuous exercise or anything like that. [When asked what he meant by "feeling more himself" Harry responded:] Well, I feel as though, at stages prior to this that I felt sometimes that there was a bit, I was still in a bit of trouble somewhere, you know. I couldn't pinpoint or anything. I just felt as though, I wondered if everything is all right. But now, I feel confident that everything's O.K.

(Harry, 4: 2)

Harry's concern that there might still be something wrong could be linked to his previous attempts to convey to his G.P. that there was something wrong. This was not followed up, with the result that he was admitted to hospital for emergency surgery. Harry's experience with cancer had made him very aware of his body and its workings. Participants "knew" their body

in all its nuances and expressions of health and ill-health. Past experiences had contributed to their knowing. With the added experience of their surgery participants wanted to add to their knowledge in order to achieve the best outcome.

“All I Wanted to Know”

When the body lacked harmony participants wanted to know what might be causing the disharmony and what they could do about it. Will found that if he did not do his exercises his arm would become sore and uncomfortable by late afternoon, “and you go out and you do your strenuous exercises, and it would feel better again” (Will, 4: 6). Will’s body made him aware that the exercises could lessen the pain and discomfort in his arm.

Wanting to know and do contributed to the ability to cope with the experience of surgery and recovering and to move on. Coping, as one of the three types of Heidegger’s understanding (coping, interpreting, asserting), was important. Coping strategies were therefore essential both in the process of understanding and the necessity of dealing in a practical way with everyday life.

Matt had confidence in his surgeon and he felt that confidence helped him to cope. His surgeon had shown him how to bend down safely. The increased knowledge gained from his surgeon enabled Matt to cope with his altered body more satisfactorily, including having a better night’s sleep. Matt had difficulty coping with sleeping on his back which he was required to do after his hip surgery. He was much relieved when his surgeon said he could sleep on his side provided he kept a pillow between his knees. “So that’s been a big help, being able to get on either side. I get a better sleep” (Matt, 2: 2). Another concern for Matt was coping with tying his shoelaces. He checked this out with his surgeon.

Well I have difficulty in tying up my shoelaces on my left foot. It was the left hip that was replaced, and all I wanted to know from [surgeon] was, that when I got near to the shoelace it caught my hip here, a little pain, was it O.K. to make a further lunge? See, would I damage anything and he said, "No, that's O.K., make the lunge, do it". (laughs)

(Matt, 4: 1)

Knowing what he could do to make life more manageable and to lessen any harm, enabled Matt to increase his ability to cope with everyday life. Participants were concerned to do the right thing and reduce the possibility of harm and at the same time carry out the instructions given by the surgeon. Knowing helped participants prepare for future possibilities as well.

Harry described the re-joining of his colon, which was his next operation. He told me about trying to explain about his ostomy to a member of his family and showed me how he had done this with two small pieces of hose pipe, then said, "And she wanted to know what they were going to do. And I said, 'Well, they just pull it out, and stitch it up, and then pop it back in'. Isn't that what they do? I would think." (Harry, 4: 5). His demonstration was his interpretation of what would happen and is an example of Heidegger's notion of understanding. This is also an example that life does not "stop" during recovery. People continue to deal with on-going and new concerns as with Harry who was waiting for further surgery.

Learning to cope with the altered body was helped by the participants' knowing about their condition. They actively sought knowledge and had a desire to be actively involved in promoting their well-being. Benner and Wrubel (1989) remind us that when people experience an illness related event they do not relinquish their concerns but rather their concerns lead them to take up the event in a particular way (p.294). Boykin and Schoenhofer (1991) state that "personal knowing is essential to 'being' in a nursing situation" (p.247). Personal knowing was essential for these

participants recovering from surgery. They wanted to understand what was happening, and how it happened, in order to respond appropriately in terms of their “known” world. Knowing helps the person recover the freedom lost through the surgical event. Knowing allows the person choices, and to consider ways of coping and therefore enables a sense of control to be regained.

“I Also Had to be Careful”

In the previous section the increased awareness of the lived body was considered. The unity of the body was impaired or threatened in some way and necessitated closer attention to minimise and overcome this situation. This was demonstrated by participants “taking care” in a variety of ways.

Heidegger’s notion of care (*sorge*) is revealed in his statements, “care is the basic state of Dasein” (Heidegger, 1962, p.293) and “Dasein’s Being reveals itself as care” (p.227). Heidegger’s unifying term “care” is used to designate the basic feature in us that constitutes all our involvements with the world.

It is the analysis of the structure of care that allows him [Heidegger] to claim that our being is at the same time “being-in-the-world” as an organic whole. This holistic conception of “care” must take account of the overall *sense* we give to our existence as being-in-the-world by virtue of which it is an integrated whole.

(Frede, 1993, p.63)

Walton (1995) explains why Heidegger viewed care as being fundamental to our existence. “It is *care* which makes human life meaningful, denoting as it does the way things matter to us, our involvement in the world and the sense we give to existence. It is in our being careful (*besorgt*) that our Being-in-the-world is made significant. In our everyday actions *care* is demonstrated by what we are concerned for and concerned with, and by

our solicitude toward others" (p.212).

Participants carefully followed the surgeons' instructions, were careful about movement, rest, and exercise, were alert to potential and actual problems and ways to protect themselves. The participants had all had the experience of previous surgery and conveyed that they realised the significance of "obeying the rules". For example, Nell said:

*Certainly, you wouldn't **dream** of doing anything that, if he [surgeon] told me not to do a certain thing, which he didn't, but if he had, I'd never dream of doing it, in case it mucked things up for a while.*

(Nell, 4: 10)

Sometimes it was difficult to remember the rules to obey. Dulcie felt some of the problems that had necessitated her surgery had arisen because she had not "obeyed the rules" in the past, and she was determined to do her best to do so this time. In Smith's (1981) study of survivors of serious illness, when participants were asked what they did to help themselves recover 89% responded "doing what they were told" and 11% spoke of self-care and participating in therapies and activities.

Taking care involved a balance of rest and exercise or activity. Participants were mindful of the need for rest. Owen, whose general health was not good, followed activity with rest. For example, after clearing up after his main meal at midday he would sit with his feet up and read. Like Owen, Nell, while freer in terms of her mobility, needed to balance activity with rest. "I can do more heavier things, but I have to sit down in-between because of the ache in my back. And I get tired" (Nell, 4: 2). Nell's need for rest depended on the type of activity she did.

Rest and exercise went hand in hand for participants, as indicated by Owen and Simon.

But I have tried to walk to the local park which is only a matter of a quarter of a mile away. I have been there twice. The first time I went I had to sit down in the park, and I was concerned about whether I'd get back by myself. The second time I, it was O.K., I did go there and have a seat, and then I came back and I was O.K.

(Owen, 1: 17)

Owen learned from his first experience that he would need to allow for a rest part way through his walk. Simon, on the other hand, recognised the need for motion after a period of immobility.

What I find, although I do a fair bit of sitting, I always make a point of getting up periodically and just moving round. That stops the hip from not working. All I can think of is "casts".
(laughs) *Like an old ewe.*

(Simon, 2: 7)

Simon found with sitting he became very stiff and to maintain his mobility he needed to move around. Because of the stiffness he found, "standing up and the initial walking takes a sort of few minutes to get adjusted (laughs)" (Simon, 3: 1). Simon took care to use his crutch when he first stood up.

As Simon illustrates, keeping safe and reducing harm involved the recognition of potential or actual problems and taking steps to avoid or deal with these. For example, simple everyday tasks required thought in their execution. Colin realised the problem of trying to dig potatoes with one hand and that it was unwise. This task, along with mowing the lawn and drying the dishes, caused his arm to throb and ache. Colin commented, "I have to recognise, well, I've got to be a bit more careful" (Colin, 4: 2).

Like Colin, Ben realised the need to take care with simple tasks, as he explained when discussing the grip of his hand.

I feel that the grip is better, so, and I can do more than I could before, but I also had to be careful that I didn't try something, like that lopping, which was too much, and therefore I never really, I don't think, tried to get near the limit. Whereas, now I can go a bit further and we have a cuckoo clock here, as you can perhaps hear, and to get the weights up, and the chain down, I was in a quandary, but I have decided that surely that weight, as I hold the other chain down, is, can be taken, is O.K.

(Ben, 2: 2)

Ben had worked out a way to deal with his clock which would not harm his hand. Ben proceeded with care and that included not driving his car until he felt it was safe to do so, "Just in case, when I have to suddenly make a move which I can not really execute" (Ben, 1: 8). Matt, with his hip replacement, was, like Ben, concerned about driving and was not going to drive his car until he had seen his surgeon.

You see, if you've got to suddenly lift your foot and push it on the clutch, you know, you could do some damage there and if you're not properly healed up.

(Matt, 3: 8)

Matt wanted to prevent any problem arising from unwise actions. Ben and Matt wanted to protect themselves from harm

Wearing a sling or brace helped remind participants to take care and avoid unwise actions. While the slings / braces were regarded as a nuisance at times their protective function was recognised by the participants. Frank described the use of his sling, which the surgeon had told him was optional.

He said it was optional, just put it on when I felt I needed it. And I wore it off and on, I suppose for two or three weeks, but not very much. When I went out in the garden I had the habit of putting it on because that stopped me from trying to do things

with my arm, because I automatically, I'd go to pick something up. And I did find that my arm got tired, when I was standing about, my sling was helpful then.

(Frank, 1: 22)

Frank's sling acted both as a reminder and as a source of support when his arm became tired. Like Frank, Ben made use of his sling in particular situations.

Yes, I had a sling, and I wore that for a few days, perhaps for more than a week. And then I take it off at home, but I put it back on again when I am going to be in a place where there are quite a few people, such as a supermarket, then they at least know there's something wrong with my arm, and the collisions will be avoided.

(Ben, 1: 4)

Ben used his sling as a reminder to others to take care.

Part of keeping safe and reducing harm was remembering to take care. Remembering to be careful demonstrated the participants' increased awareness of the physical body's needs, recognition of potential threats to safety and measures to avoid them. Connie provided an example of remembering. Connie felt some progress had been made when she no longer had to wear her cumbersome sling, however, the absence of the sling required a greater need to take care and remember her arm was not fully operational.

So now it's just, times that I have to remember not to do things with that, but it's a very hard thing not to move that hand when you want to do something because you're relying on that right one all the time.

(Connie, 3: 26, 27)

Sometimes, taking care required compromise in the way day-to-day activities were performed. For example, Dulcie had worked out a way to take out her rubbish bags for collection so that the risk of harm to her from lifting was reduced. Colin learned the lesson of the need for compromise when trying to be independent, that there are some situations where the assistance of others has to be accepted. With his arm in a brace he tried to get into a boat without assistance.

I was trying to get up into the boat which was rocking in a fairly lively sea. In the end I landed on my right shoulder. I fell into the boat. ... my son's a good strong fellow, so he said, "Now Dad, we are going to help you". So one on each side, [they] made sure I got in, and got out. I was grateful, I really needed help. And I was trying to be independent, but that's a danger.

(Colin, 2: 8)

Colin had to compromise his desire to be independent to ensure his safety. **Taking care** included steps to keep safe and reduce harm by a variety of measures: following instructions, balancing rest and exercise, being alert to problems, protecting oneself and making compromises.

"I Think That's Good for Me"

The process of healing is exemplified by level 3 of Gadow's (1982) body and self dialectic Cultivated Immediacy: Harmony of the Lived Body and Object Body. Reuniting of self and body takes place by the transcending of the struggle between self and body from a mutually limiting to a mutually enabling position. Self and body are experienced as still distinct but no longer opposed, rather, they are mutually determining and enabling, as occurs during recovery and learning to live with a disability or a chronic condition. Also "the additional learned capacities that have been acquired through the struggle of mastery and submission... are now exercised as immediately as if they were originally given" (Gadow, 1982, pp.91-92).

Gadow's notion of the reuniting of self and body is reflected in Pellegrino's (1982) description of healing as to "make whole again" which he says entails ameliorating the ways illness can wound the ill person's humanity (p.160). To feel "whole" and recovered necessitates "feeling at home in the body once again", according to Benner and Wrubel (1989, p.293).

The greater awareness of the lived body revealed a need to create the circumstances for healing to occur and continue. Integral to this was the need to keep healthy. Keeping healthy had a number of aspects. All participants were aware of and took action to keep fit and well as part of the aging process - this pattern was already established as part of their lives. As they lived through the healing process they meshed together the patterns of healing and health. Diet, rest, sleep, dealing with symptoms, following doctor's orders, exercise, social activities, goals were all aspects of this enmeshment. Participants were therefore active in the healing/keeping healthy process in both a figurative and a literal sense. There was recognition of a responsibility to help themselves get better, the need to take active measures to aid healing and to keep healthy.

Taking responsibility for healing is described by Will. Will expressed the belief that he was in partnership with his doctor. The doctor had done his part in operating on his shoulder and now it was his responsibility to aid healing by activities such as the required exercises. This sentiment was echoed by Colin who said, "and my part, the doctor's done his and now my part is to do what I can to get it right again" (Colin, 2: 7). "And healing requires a lot of participation from the person" (Colin, 3: 8).

The participants had to confront the realities of their particular situations and fashion their lives accordingly to work toward "wholeness" and equilibrium. Pellegrino (1982) expresses this in regard to healing when he says, "healing is the attempt to find a new balance, to move back in the direction of our personal project" (p.159).

Even when dealing with quite major problems participants still tried to take action to keep fit and healthy. The statement Banonis (1989) makes about healing encapsulates the approach of the study participants – “healing is a deliberate, self-initiated, creative choice of the person” (p.37). Healing and keeping healthy went hand-in-hand. Peter, whose cancer had spread to his spine was concerned about his physical weakness and how to overcome it. He undertook activities such as walking.

I only do a very short walk, because both my dog and I are pretty ancient and lame. So I just do a short walk of 20 minutes, and I think that's good for me, and I do 500 strides on my walking machine, which I think is important.

(Peter, 3: 5)

Peter exercised within the reality of his situation. Maintaining fitness and exercising were very much part of the pattern of each participant's life, as was the need for a good diet. Participants were concerned about their diet to ensure they were eating the “right” foods. Connie, like other participants, was conscious of the need to have a good diet. She commented about her blood test which showed she had a lack of iron.

But it's probably made itself up, by having an orange and I had a kiwifruit today. I mean I try to have things, you know, like the silverbeet to give me iron and everything, and broccoli, that's what I mean, I, we try to do things, you know... We're taking our bee pollen, that too.

(Connie, 4: 4)

Connie, when “feeling down” ate some chocolate. “I thought it would sort of give me a bit of a boost I thought, that's only my thinking, whether it does” (Connie, 3: 15). Besides chocolate to give her a boost, Connie was a great believer in laughter. Laughter and humour featured in the experiences shared by all the participants. Connie described laughter as healing. Peter's comments reinforced this belief. He said, “I like making people laugh...

Well, laughter's good, it's therapeutic, both for me and for them" (Peter, 3: 10). Joking was part of Peter's life and helped him deal with the more serious side of his condition. Dulcie saw laughter as a measure of her improvement, "perhaps I'm laughing at you know a little more of the things that people say whereas we tend to be sort of really serious before that and I think that's a sign of, you know, that you're getting better" (Dulcie, 1: 17).

Humour, in the form of quips, was expressed during the participants' sharing of their experiences and in some cases it was used to lighten a serious statement. Harry had described how in his job he had been able to vent his feelings by yelling at the sheep in the sale yards. As he described it, "you don't hurt them, [the animals] but you can get rid of a lot of steam like that" (Harry, 4: 10). Harry had led an active life and the length of his condition where he had undergone several operations and was facing another made him feel frustrated at times. He had therefore not had the same opportunities to vent his feelings as before, "Only the odd times when I see a strange cat around, then I'd say to Mac, [dog] 'Come on, sic it' (laughs)" (Harry, 4: 10).

In being concerned with the lived body the participants were more aware of their bodies, and learned ways of coping. They were concerned to take care of themselves by measures to keep safe and reduce harm. Activities and actions to aid healing and keep healthy were performed. Healing was marked by small steps in independence, the lessening of pain, the beginning of new activities, extending boundaries care-fully, trying to deal with life positively (and for the participants this included laughter and humour), while at the same time continuing with the activities which ensured them as good a standard of health as possible, for example, good diet, rest and sleep, and exercise.

Genuine healing must be based on an authentic perception of the experience of illness in *this* person. It must aim at a repair of the particular assaults which illness makes on the humanity of the one who is ill.

(Pellegrino, 1982, p.160)

LIVED TIME

During recovery:

The human being is diverted by the world of their present, yet tied to their past, while still primarily reaching out into the future, into which they find themselves “thrown”. This “thrown-ness”... represents an intimate part of our way of being, even though it usually is pushed into the background.

(Cohen & Omery, 1994, p.145).

“I Feel a Lot, 200 Percent, Better”

Making progress incorporated the past and the present, while at the same time participants moved at varying rates toward the future. Movement across time gave meaning to the lived world of participants. Past illnesses give meaning to our ways of being in the world and come into play in what Robertson-Malt (1999) describes as “this moment’s becoming: a history of past experiences [of surgery, of illness, of pain, of good health] that all roll into one and influence the interpretation of the present moment” (p.293).

Some of the aspects about which participants talked as affecting their healing were their previous good health, the food they ate, their age, time, and how well they healed. For example, Neal considered his past activity of running had affected how well he had recovered from his operations and he described it as a real bonus because it kept him really active. His past voluntary work with the Cancer Society and Aged Concern had informed

him about people who had cancer and their treatment, so that when he was in the same position it was not a foreign land for him. His past had informed his present.

Participants accepted that time was an important factor in the healing process. Owen said, "It's always just a matter of time, just a matter of time" (Owen, 3: 5), and Colin felt both time and age were important in order to recover.

Regardless of what one feels, one has to be disciplined, to allow time for the body to be restored. And the fact that you're older, you don't get restored as quickly.

(Colin, 2: 5)

While participants, like Colin, would sometimes be frustrated by lack of progress, they were realistic about the need to allow time for healing to take place. Being able to see improvement in abilities, health and activities was beneficial for participants, as illustrated by Harry.

I'm pleased, just in the last week I'm feeling as though improvements are going ahead in leaps and bounds, you know. Last time you were here, I don't think I was. I was sort of a wee bit worried that I wasn't improving, but yes, I am, I feel a lot, 200 per cent, better.

(Harry, 2: 18)

Harry felt he improved over the previous few days and reflected on why he had thought he was not improving as quickly as he expected. He felt he should have had more strength and exercising had not seemed to help. As well he had what he described as a "lacklustre feeling". He commented:

Initially I felt as though I wasn't improving. I suppose that sort of makes you feel a bit, takes the edge off you a bit, you think, "Oh, why the devil aren't I improving?" But now, I feel that I am

improving, and that sort of eggs me on, now. I keep thinking, "Well, I can do something, I can do this, I can do that".

(Harry, 2: 3)

Seeing indications of "coming right" enabled Harry to feel more positive.

Colin felt very positive about an improvement with his shoulder when he was able to lie on his left side, after three months, "without undue discomfort and pain" (Colin, 4: 3). He described this as "wonderful". Matt felt he was improving because his appetite was improving, he had lost some weight, he was doing more things himself instead of needing his wife's help, and he was feeling better, stronger and brighter, and more positive.

While participants noticed signs of progress, progress varied. For example, Frank's progress was slower initially. He was unable to move his shoulder for six weeks so he regarded his recovery as stationary, or on hold, for that time. Once he was able to move his arm he gained more independence and said, "I'm sure the recovery's going [quicker] because I've been moving practically all the time, and things like that" (Frank, 1: 13). For the first six weeks Frank had no signs of progress so time seemed to stop. While Neal felt he had progressed in his recovery, six weeks after his discharge from hospital he found there were indications that he had not recovered completely.

I feel exceptionally good, and also exceptionally well. But I realise my limitations because I know very well if I overdo it, I can tell that I'm tired, you know and I'm just not as good as I think I am. But nevertheless I feel really good.

(Neal, 3: 5)

Connie judged her progress by the amount of pain she experienced and the amount of pain relief she required each day. On the day she did not require pain relief she said, "So I think I must be coming right" (Connie, 4: 1). Both

Neal and Connie felt much better but were also aware of the need to take care and be alert for anything that might be a setback in their healing.

Participants described the rate of recovery in various ways, for example, gradual, "There's been no sort of no dramatic breakthrough" (Frank, 1: 17). Will's progress was described as very gradual even though each day he found he was able to do something more. This meant actions which he thought he would never be able to do he succeeded in achieving. "So, all those little things, they all help, and you notice it every day" (Will, 2: 12). Matt described his progress as steady. He had said he was gaining strength day-by-day initially and when asked if that was continuing or were there longer gaps in his progress he commented, "Probably no, I think the steady progress" (Matt, 2: 5). Dulcie recounted her progress from a life with restrictions, low energy, feeling tired, not wanting to go out at times, through a six week period where each week she noticed a difference, her pain and discomfort lessened, and she was able to return to "normal life with no restrictions" (Dulcie, 3:12).

As the recovery from surgery progressed participants felt more positive about their well-being and the future. Colin and Harry each provided an example of wanting to "get on with life". Colin said:

I'm feeling keen. I told the people on Sunday that I'm rearing to go, I'm feeling a health and strength that I haven't felt for a while. It's a good sign.

(Colin, 3: 9)

Colin was looking forward to the challenges and travel ahead. Harry wanted to participate more in the activities he had previously enjoyed when helping on a friend's farm, and when asked if he felt he would get back to doing that he responded, "Yes, I'm quite confident that things are on the move" (Harry, 4: 3).

During the long process of a series of operations Harry found the visits to the farm helped him to retain some normality in his life and to enjoy the friendships he had made as part of his previous job. This gave him pleasure and something to look forward to. "Our everyday know-how involves an understanding of what it is to be a person" (Dreyfus, 1993, p.295). Helping on the farm enabled Harry to express what was previously important in his life. It was important to him in his present because it was part of his being, and it provided a possibility for his future.

The time to heal was paramount. Some participants were surprised about the length of time it took for them to feel better, others were accepting that their particular surgery would take a length of time before they would see much progress. All were accepting of the responsibility to be active participants in the healing process and were adept at assessing their progress. Small gains accumulated to move them forward and provided encouragement to persist with what were sometimes painful or discomforting exercises or activities.

"I'll do Something About it"

Frank (1995) is referring to chronic illness when he says, "Illness is learning to live with lost control" (p.30). This statement applies equally to recovery from surgery except that the time span for, and nature of, loss of control differs. Engelhardt (1982) elaborates on the effect of being ill:

To be ill is typically to be unable to have immediate control over some of the circumstances of one's life, to be in need of some special care, and depending on the severity of the illness, to be unable to discharge some of one's usual social duties.

(p.148)

Dreyfus (1991) reminds us that Dasein is constantly making sense of itself, and everything else, in its activities (p.29). Being in control is a way of making sense of one's circumstances.

Pellegrino (1982) refers to the work of Ortega y Gasset in writing of the engagement of each of us in a personal project – “to fashion a life of our own out of circumstances in which we find ourselves” (p.159). As previously mentioned, Pellegrino describes illness as a situation where a person is absorbed by circumstance and healing as, “the attempt to find a new balance, to move back in the direction of our personal project” (p.159). He describes these as ontological crises which must be confronted when the person is in a vulnerable existential state because of the loss of the freedoms which are ordinarily available to us. Loss of control, to one degree or another, affects our situated freedom, that is, the “freedom to actualize and choose options for a particular situation and a particular history” (Benner & Wrubel, 1989, p.275).

It was important for participants that they be in control of their bodies and their lives. As discussed in the previous chapter when the body could not be “controlled” in some way this caused concern and created problems. Being in control also contributed to healing, being healthy and returning to health and fitness. In an effort to progress their recovery participants took responsibility and action for their situation; they made judgements about actions and they tested limits. Sometimes testing limits met with success and resulted in a feeling of progress. At other times testing limits resulted in failure or discomfort and so acted as a warning that perhaps action was premature or too vigorous.

The importance of taking responsibility for one's recovery was stressed. Part of taking responsibility for Will meant that he would contact his surgeon if he had a problem. As he said, “If you don't ask the questions, you're not going to get any answers, are you?” (Will, 3: 10). He later said:

*Yes, well I do enquire, and I do get the answers. I think I do,
and if I don't get the answers, I kind of do something about it.*

(Will, 3: 10)

Will indicated he would take action if he had a problem. Connie and Nell described the action they took to deal with sleep problems, which were common for participants. Connie had trouble going to sleep. Often she would get up at 12 o'clock, eat a piece of fruit, sit out in the conservatory, have a walk about, or look out the windows and then go back to bed. She said, "it seems though if I just have that, and go back to bed I can go to sleep" (Connie, 1: 17). Connie worked out the action which helped her go to sleep as did Nell. Nell woke every hour from midnight so at 4am decided to take two Codeine which enabled her to sleep until 7am. She felt it was important to sleep at night rather than during the day, "So I'll try and keep awake during the day, but obviously I can't sleep after four without a wee bit of help" (Nell, 4: 7).

Participants made judgements about aspects of their recovery as they assessed their progress and the outcome of their operation. This enabled them to make decisions about action, for example, safety when exercising. Matt related a decision he made after assessing his safety. His surgeon had told him to use his walking stick in place of the crutch when he was out walking. Some parts of the street were uneven and Matt felt the crutch was more appropriate.

But the point is if I drop the walking stick, if it happens to fall out of my hand, I cannot pick it up. ... But with the crutch, it's got this, clasps round your wrist, and you can't drop it. ... If he, he told me, you see, to use a walking stick. Now when I go back, if he scolds me I'll tell him just what I've told you, if I happen to drop it, I can't pick it up. ... [Matt proceeded to consider possible ways around his problem including a strap arrangement and carrying the "pick-up thing" which his wife had suggested.]

(Matt, 2: 3, 4)

After considering options, Matt judged that his personal safety over-rode his commitment to follow the surgeon's instructions to the letter.

Will assessed how well he was coping with his exercises and activities. He had been swimming but thought he must have done far too much because his shoulder was sore, so he reduced the frequency of his exercises for a few days. He had also tested out his ability to play bowls but decided his arm was too sore, "So I'll leave it for a while" (Will, 1: 8). In Connie's assessment she was lacking in energy and thought she needed in her words, "a bit of oomph". "I was wondering if perhaps I could do with a bit of iron again" (Connie, 2: 20). Connie's assessment proved to be accurate as a blood test indicated she did require iron. Walton (1995) comments that it is because of past experiences incorporated into their way of Being-in-the-world, that the participants in her study understood what actions they needed to take in order to achieve the ends they desired for themselves. "It is in this way that temporality is an integral part of *care*" (p.181). Connie provides an example of the participants' self-knowledge and their cognisance of their bodies' nuances.

Participants tested their limits and actively sought to extend themselves in an attempt to return to their everyday activities. If something untoward resulted they stopped but tried again at a later time. Extending oneself was considered a positive thing to do as Neal indicated, "And I feel myself, sometimes it's a good thing to extend yourself, without overdoing it of course" (Neal, 2: 5). Participants worked out ways of doing things that would not cause them harm.

Being in control required being actively engaged in the recovery process. Participants took responsibility and action for their well-being. This often required self-discipline for example, to carry out painful or uncomfortable exercises. Participants **made** themselves do things because they believed this would help them "get better". Because participants were actively involved in their recovery this enabled them to make judgements about the rate of their progress and to make decisions about the actions to take and aspects of care. It enabled them to assess the benefit of the operation in terms of improving their health status. Testing limits imposed by the operation itself, the surgeon, and the participants themselves was integral

to their recovery. Participants were concerned with testing limits carefully, stopping when and where appropriate but trying again and again to enhance progress and to extend their range of activities. They put their bodies on trial as it were, in their attempts to regain function and the ability to both return to a state of health and progress to a better state of well-being.

Lawler (1991) views recovery as essentially being about becoming independent and regaining control over one's body functions and body care (p.183). There is a progressive "handing back" of body functions, and control of them, to the person [in hospital or at home] as the person moves toward recovery. Lawler describes the shifts in control as "recovery markers". For the person recovering at home the regaining control of the physical and social body redefines their level of dependence and interaction with others and their world. By taking care of themselves after surgery, the participants were reconstituting a sense of "self" and regaining their personal empowerment (Kondora, 1993).

FINDING MEANING

Robertson-Malt (1999) states:

Heidegger understood that to be-in-the-world is to be consumed by a constant state of striving to understand and attach meaning to our own (and others) numerous *ways-of-being*. This premise is an understanding that respects and works with the context bound nature of human experience rather than trying to separate past experience(s) from present and in doing so alienating an integral component of human nature.

(p.293)

For the participants, finding meaning meant understanding their altered worlds by interpreting the events related to their surgery. For Heidegger,

understanding is not a way of knowing but a mode of being, a fundamental characteristic of our “being” in the world. Understanding means understanding not only the world but also Dasein’s way of being-in-the-world, therefore it is always self understanding — a disclosure of possibilities. Hoy (1993) points out possibilities are not simply subjective or inner phenomena, in that they are always tied to worldly situations. The projection of possibilities opened by understanding is realised and made concrete in interpretation which is our way of explicitly appropriating the world in our familiar activities within ordinary contexts (Guignon, 1993).

Koch (1995) states that according to Heidegger:

Nothing can be encountered without reference to the person’s background understanding, and every encounter entails an interpretation based on the person’s background, in its ‘historicality’. The framework of interpretation that we use is the fore-conception in which we grasp something in advance.

(p.831)

“My Mind Was Telling Me”

For the participants meaning was derived from their own history, from reflecting on and comparing their current experiences, and from gaining information from other sources. Information was sought about the operation, the body, symptoms, progress, outcomes, and the future. The participants’ wanting to know encompassed getting answers, being reassured, seeking advice, sorting out conflicting information, overcoming a perceived lack of information and wanting more information, and finding explanations or developing their own explanations to enable them to deal with concerns. Finding meaning was enabled by participants’ affirming their opinions and/or beliefs, reasoning out potential problems, and increasing their knowledge about their operation and their health and well-being. It enabled participants to gain understanding about their present situation using their experience from the past and to prepare for the future.

For Heidegger "meaning" involves "the holistic way in which something becomes intelligible as something in a web of relations (BT 193)" (Hoy, 1993, p.183). According to Heidegger, strictly speaking it is not meaning that is understood but the entity, and we grasp entities as entities in their webs of relations with other entities. The context of meaningfulness is what makes interpretation possible. This context, while not always explicit, forms the background of understanding Heidegger calls the "fore-structure" of understanding, which comprises three levels – "fore-having", having a general grasp of the whole situation; "fore-sight", *seeing* in advance how things can appear; and "fore-conception", grasping conceptually in advance the appropriate way to interpret something. Hoy points out that none of these levels is fully explicit, that all are in play in any given act of interpretation (pp.183-184).

In the examples which follow, the participants demonstrated their attempts to make something intelligible in a web of relations and the levels of fore-structure of understanding. Hoy (1993) points out, "An interpretation is precisely not a heap of facts but an account of how these facts are possible" (p.178). The reason for their tiredness was of interest to the participants. Dulcie, who had experienced a number of operations, was unsure why she was more tired after her recent surgery than she had been for previous operations. She felt her age was not the reason.

I think the warnings that I had this time, I did take a lot of notice of them, because I felt I'd had enough and that I should do as I was told. So perhaps my mind was telling me that I should be resting more and perhaps I gave in to the tiredness more so.

(Dulcie, 4: 2)

Dulcie was concerned about her tiredness and concerned with understanding the reason for it. Matt thought, "maybe it was the effect of the anaesthetic and the operation" (Matt, 4: 6), that was the cause of his tiredness. Colin wondered if, "that injury and that healing, or that operation took more out of the muscle area than I had realised" (Colin, 3: 3).

These three participants provide examples of trying to work out why, trying to understand and to provide explanations for a situation which concerned them, in other words how to account for the fact of their tiredness. Participants were also aware that some problems or areas they were concerned with might not necessarily directly result from their operation. Nell, for example, found she became puffed when doing certain activities.

There's no concern, because I've got no pain in the chest with it or anything, no pain at all. And no headaches, no nothing. I think it's just that I am just unfit, I really do. And overweight.

(Nell, 3: 2)

Harry found his exercise tolerance was low, and, like Nell, felt he knew the reason for his being "puffed out".

This morning I've cleaned up, and walked around a bit, and done a couple of little jobs and, I'd sort of, I wanted to come and sit down, you know. I thought, "Oh, I'm puffed out", you know. But probably that's more to do with the ticker [heart] than anything, I think.

(Harry, 1: 11)

Harry's explanation for his getting puffed was his heart condition rather than as a result of the operation even though it was just a fortnight since he had been discharged from hospital. Will experienced soreness in an area not on his shoulder which had been repaired but on his upper arm. His belief was:

Must be some tendons in there, possibly some tendons in there, you know, that are getting exercise now that they've never had. Because I'm doing, I am doing things that I've never done before. Well, I guess, the tendons that are working now they've never worked for years, (laughs) and they're a bit sore.

(Will, 2: 6)

Later Will developed a sore back. He thought this was due to the stretching exercises he was required to do to strengthen his shoulder but which he found to be quite a strain on his back.

*Quite strange. I think it's muscular, I'm pretty sure it's muscular.
And I think it's from the working, that's something that's
happened I'm not, you know, I wish that hadn't happened.*

(Will, 3: 3)

Participants interpreted symptoms to give meaning to why something was happening to them. When their interpretation was unsatisfactory they sought reassurance and advice. Owen discussed with his G.P. the possible reasons for his fainting spells. With her he reviewed test results but the G.P. was of the opinion that his lack of energy and dropping blood pressure could not be accounted for by the test results.

*And I'm still of the opinion a lot of it's to do with the drugs I'm
taking, coupled with, I think it's a combination of two or three
things.*

(Owen, 3: 2)

Owen's familiarity with his body in ill-health meant he had his own interpretation of events.

Seeking reassurance was part of finding meaning for participants. In an attempt to understand what they were experiencing participants sought reassurance from a variety of sources including themselves when they would compare their present with previous surgical experience, for example, in comparing the amount of pain. Connie, despite continuing to experience much pain, tried to reassure herself that this time there would be a better result from the surgery.

*I'm sure this time it'll be better, I'm sure it will, because, I sort of
have confidence that, he was so careful with it, and he got all*

those bits out, and I don't think he broke any bones (laughs) he broke any bones this time, because I mean I think that cracked bone had a bearing, on that last one.

(Connie, 2: 26)

The surgeon was one of the sources of information for participants. The surgeon and other sources of support and information are discussed in Chapter Seven. When participants had concerns they wanted to understand what they meant regardless of whether the concern was of a minor or major nature. Understanding something of concern depends on knowing who might be able to provide answers, and on their availability to do so. In some instances the participant may not know whether their concern is of a major or minor nature, so ready accessibility to a source of information is important.

Sometimes conflicting advice or information was received. Owen provided an example of being given conflicting advice when he talked about his diet after bowel surgery.

And it's interesting really, because in the hospital I was given this diet list. And it's interesting from the point of view that I asked four different nurses how long this would apply for and I was given four different answers from two to three weeks, to six weeks. And when I visited the surgeon on the 23rd December, I said, "What's the story with the diet?". And he said, "Oh, don't worry about that, just carry on as normal". He said, "That causes a lot of confusion, that". So I'm still confused actually. But out of just sheer caution I'm holding myself to this for at least eight weeks because I asked the surgeon how long it took, approximately, for the join of the whatever it is, of the colon, to heal. And he said about eight weeks. So I have decided that I'm going to stick to this diet for eight weeks.

(Owen, 1: 15)

Owen sought advice, sought clarification, was not reassured by the answers so took matters into his own hands and decided what he would do.

While participants did not want to know every last detail of what was involved with their surgery and its aftermath they did want to know enough to understand what was happening. Nell had seemed quite cross when talking about the lack of information about her operation. While she did not want detailed information about all aspects of the operation she did want to know what the surgeon was going to do to her spine. The brief explanation she received clearly failed to satisfy her. It was not helped by someone telling her about the danger of damage to the spinal cord during surgery and that she could become a paraplegic.

And the first thing I did when I came out of the operation was to move everything as quickly as I could, to see if I was all moving. And that was, and once I knew that I knew I was O.K.

(Nell, 2: 4)

When participants did not receive enough information from their doctors they found it elsewhere. This could lead to speculation which might be erroneous. Pellegrino (1982) views closing the information gap as an essential first step "in enhancing the patient's capacity to act as a human person in the healing relationship" (p.161). From the point of view of the recipient of health care the known is far less fearful than the unknown.

Self-knowledge aided finding meaning. The experience of previous surgery and illness provided a source of information to help the participants' understanding of the current situation in which they found themselves. Nell, from her past experience described degrees of pain.

Yes, well, there's three different kinds. There's pain and there's aching, and there's soreness. And pain is the worst, and that pain down the back of my legs was excruciatingly sore and almost unbearable. But where he cut me was sore, it wasn't

pain. There was no pain there, it was just sore, and I knew it was getting fixed, I knew it was mending. And that is, an ache or a soreness, is nothing like a pain. A pain is the worst thing. A bad pain is the worst thing of all. And then just an ache is an ache. (laughs) Well, like you have when you get old you ache everywhere until you get moving in the morning after being in bed. You ache everywhere. (laughs)

(Nell, 2: 5)

Nell's description clarified the meaning of the pain she had experienced.

Participants reasoned out concerns or problems. Matt described how with the help of his wife, he managed to sit down in the bath and more importantly get out of the bath. He was concerned about "putting out" his cemented hip.

I'm not sure that I can put out a cemented hip. You might know about this. I thought all I could do was perhaps hurt it, or injure it. You see my hip is cemented. If I'd been ten years younger, [surgeon] would've put in a ball and the muscles would've grown round it... But see, I think if you, if you over-reached you could hurt your hip.

(Matt, 3: 5, 6)

Matt had identified a possible problem and was reasoning out a possible answer.

Kleinman (1988) states that "the long-term strategies for assessing the deeper, more powerful currents that influence the chronic course of disorder also require continuous surveillance and information gathering" (p.48). Participants wanted to know and understand about their surgery and their recovery as part of both their current and future general health and well-being. Harry reflected this in his comments about his cancer.

I never have a fear of it, because it's no use getting frightened of it, because that's it. If you get it, you get it. Oh, you think of different things – what have I been eating? Why should I have cancer? I've always had the best, eaten the best, as I thought.

(Harry, 3: 5, 6)

Harry wanted to understand why he had cancer and how the risk of cancer might be reduced. Simon's wife had brought home a library book about research concerning people recovering from hip replacement which Simon described as "fascinating". He talked about the range of satisfaction or otherwise that the patients had with their surgeons. "You know, some gave them all sorts of guidance and advice, and others just left them to it" (Simon, 3: 2). This was of particular interest to Simon who felt his surgeon could have given more advice than he did. From his past experience Simon knew the importance of receiving adequate information and the implications when this was not provided. His experience with a reaction to radiation therapy led him to emphasise the need to know and to comment:

Yes, and I think that it would probably protect you. I mean, if you had one of these treatments and one of the things that goes wrong goes wrong, if you knew about that possibility you'd be much better able to accept it, than if it was totally unknown to you.

(Simon, 3: 3)

It was important for Simon to be informed and to be listened to. It was his way of keeping safe. Knowledge was a form of protection for him and enabled him to have some control over his day-to-day life.

In support of their statement that the shape that the meaning of an illness will take depends in part on the nature of the situation, Benner and Wrubel (1989, p.136) provide examples for illness situations which interrupt ongoing life. For example, when an illness situation is acute but brief (such as in some types of surgery) the person can put their usual life on hold for a

short period. When a person is faced with an extended illness / recovery, regrouping and reorganisation of usual life may be required. Both Colin and Harry provided examples of this. Colin's recovery was longer than he expected and disrupted overseas commitment plans. Harry was affected by complications of surgery which extended his recovery period and postponed planned surgical intervention. Where illness / recovery is long-term, as Benner and Wrubel (1989) point out:

A person... does not simply take a temporary leave-of-absence from life. One is forced to let go of the life as it was lived. The person is left with the need to find an ongoing way of maintaining meaning during a long recovery. The illness becomes both one's occupation and preoccupation.

(p.136)

The attempts of the participants to know and to understand reflect Hoy's (1993) statement, "Understanding is holistic and includes a dense pattern of interlocking beliefs and skilful know-how" (pp.185-186). Beliefs and skilful know-how develop with age and experience. For the older person with a health problem(s) who experiences surgery there is the opportunity to develop considerable knowledge. Each person is active in constructing and making sense of the realities faced. Older people, like the chronically ill, about whom Kleinman (1988) is writing, become "interpreters of good and bad omens... archivists researching a disorganized file of past experience... diarists recording the minute ingredients of current difficulties and triumphs... cartographers mapping old and new territories, – critics of the artifacts of disease. ... There is in this persistent re-examination the opportunity for considerable self-knowledge" (p.48). Kleinman comments further that "interpreting what has happened and why and prognosticating what might happen make of the present a constant, self-reflective grappling with illness meanings" (p.48). Interpreting meanings helped the participants to give coherence to and gain control of the surgical event and its aftermath.

“You’ve Got to Understand That it’s Going to Happen”

Hall (1993) describes general skilled comportment as the general being at home or “dwelling” in everyday environments. Comportment is knowing, for example, how to position and move oneself and what to do and say, that is knowing in the sense of possessing the skill or competence, not in the sense of having the right sort of beliefs.

The temporal dimensions of past, present, and future constitute the horizons of a person's temporal landscape. Whatever I have encountered in my past now sticks to me as memories or as (near) forgotten experiences that somehow leave their traces on my being – the way I carry myself (hopeful or confident, defeated or worn-out), the gestures I have adopted and made my own (from my mother, father...), the words I speak and the language that ties me to my past (family, school, ethnicity), and so forth. And yet, it is true too that the past changes under the pressures and influences of the present.

(van Manen, 1990, p.104)

The ways in which participants dealt with life were reflected in the ways they dealt with their recovery. As each participant attempted to understand their world of recovering, their ways of comportment demonstrated their commitment to future fitness and health. A positive attitude, the way they faced problems, motivation, discipline, fortitude, hope and optimism, illustrated ways in which participants faced the future.

Participants demonstrated the importance of concern with both the mental and physical aspects of recovery. For example, Dulcie, despite her six weeks of restriction, and feeling tired and miserable said:

I always wanted to, I always looked ahead and thought I'll be glad when these weeks are over and, so as I could be just my normal self... I think having the positive attitude that I was going

to be right in those weeks, helps, I think, everybody must have that otherwise you wouldn't care if you felt better or not, would you?

(Dulcie, 4: 2)

Neal also felt having a positive attitude helped. He described his attitude and response to his situation.

Oh mine is absolutely positive. You know as I said, I have no fear of the disease [cancer] I've got no fear at all, and I just, I keep trying to push myself and as I said, I think I am getting the reward from doing that.

(Neal, 1: 22)

Progress in recovery engendered a more positive outlook.

Motivation and discipline were aspects of recovery. For example, Will's desire to play bowls again provided the motivation to be disciplined to do his exercises.

You've got to be enthusiastic about it. ... when I first went to him [surgeon] I said how long will it be before I could play bowls again because that's a very important part of my life. "Oh" he said, eight weeks if everything goes right". And I said, "Well look I'll be able to play with my left hand in the meantime, wouldn't I?" "Oh", he said, "you're going to have no trouble". Meaning that, O.K., you know, I wasn't just going to just sit down and give bowls away.

(Will, 2: 5)

Participants faced their situation with fortitude and expressed this through their general approach to life. For example, Connie had much that she could have cried about but laughter was a constant in her life. She described laughter as her tonic for the day. Owen described his approach

to health problems. He said, "my primary thing has been to get on top of the problem [any health problem], mentally as well as physically" (Owen, 1: 5). Owen had a number of health problems and his general health status was not very good. When asked how he felt about his quality of life he responded:

Very mixed really. Very mixed. I'm sure that I can feel better. I'm always feeling that it's just a matter of time, but then I used to say to myself 30 years ago, "I'll be better tomorrow, I'll feel better next week, next month, next year". And I know that I've said that to the family. I've deluded myself for 40 years but I guess it's allowed me to survive shall we say.

(Owen, 2: 12)

Kleinman (1988) points out that we all use denial and illusion to "assure that life events are not so threatening and supports seem more durable" (p.48). Self deception allows for events which may overwhelm or threaten us to be more tolerable and may help in maintaining optimism. Owen's attitude facilitated his survival through years of ill-health.

Hope was a term used by almost all participants. While hope for the participants was looking toward a better future it was also firmly situated in the present and the past. The possibilities of the future were before the participants but the situation they were in was anchoring them to the past. Hope was a peg to hang on to. As His Holiness the Dalai Lama (2001) states, "our day-to-day existence is very much alive with hope, although there is no guarantee of our future. There is no guarantee that tomorrow at this time we will be here. But still we are working for that purely on the basis of hope" (p.26).

Steiner (1978) cited in Walton (1995) explains, in Heidegger's analysis "Desires and hope are the reaching-forward of care" (p.193). Walton goes on to say:

In "Being and Time" Heidegger is clear that hope is not simply a forward looking expectation. Rather, hope is intensely bound to past experiences. Hope, he suggests, is related to our "having-been", to past hurts, disappointments and pain. As the opposite of "depressing misgivings" hope is possible only when the past is acknowledged and taken on board. Hope is related to what we wish and look forward to for ourselves. In order to look forward in this way we must acknowledge what has already been and accept our thrownness, the way we are in-the-world. It is only from this acceptance that we can move forward to what we hope for. Hope, as futural, is thus also tied to the past and to the nature of Dasein as aware of itself.

(p.193)

Participants expressed their hope and optimism in a variety of ways. Nell hoped for relief from pain through surgery and this had eventuated. She was able to look forward with optimism.

Well, it's given me a new life, because I didn't think that I would be able to, I thought that I would be in a nursing home now, if he hadn't operated.

(Nell, 4: 4)

Nell had kept her husband's motorised chair in anticipation that this would be her only means of mobility. The surgery changed this, and the chair was no longer required.

Simon indicated how he felt about the future in relation to the outcome of his surgery.

Oh well, I'm optimistic. (laughs) You know, I hope I'll get back a lot more mobility than I had, and there's every indication that that's going to happen.

(Simon, 4: 7)

Simon was not at the point in his recovery where he wanted to be but he felt he would get there.

The importance of looking to the future is illustrated by Will.

I think you've got to understand that's it's going to happen, that one day the pain'll go. Otherwise it would be too hard to handle, wouldn't it?

(Will, 1: 17)

Will conveyed that one must believe a future of possibilities in order to get through the present.

The fortitude displayed by participants enabled them to cope with the low times and to accept the reality of their situation. Simon conveys his approach to his particular situation. In talking about recovery, he said:

I think it all comes down to the fact that, you know, it's just so much an individual thing as to how your own particular body reacts to it, and the mental approach you've got to it... I'm going to give it the best shot I can to get through it and get the most benefit out of it. It's the only sensible attitude I think that a person can have. (laughs)

(Simon, 4: 10)

A positive attitude and feelings of hope and optimism, were features of the participants' ways of being-in-the-world. Participants demonstrated attitudes such as acceptance, perseverance, fortitude, discipline, accountability and independence. They took account of other health problems and found ways round the problems they faced in their everyday life. Feelings of hope and optimism were demonstrated by the belief in the outcome of surgery, recovery and improvement, trust, faith, and confidence in the surgeon, belief in a better future, and in setting goals. Optimism was tempered by a recognition and acceptance of the reality of their situation. At

any given time confidence was raised or lowered by factors, such as the degree of pain or the surgeons' responses to their progress. Optimism and a positive outlook and approach took participants onwards, looking to the future. Self-discipline, taking care, and compromise assisted participants in their efforts to participate as fully as possible in this life experience of recovery.

REVIEW AND SUMMARY

Being concerned with included the sub-themes of **the lived body, lived time** and **finding meaning**.

During recovery participants were concerned with or by aspects of their lives which their surgery had affected. The surgical intervention brought an altered meaning to the physical body which resulted in participants being more aware of or being made aware of the physical body's needs. Participants wanted to know how to keep their bodies safe and the actions to take to reduce harm and to aid healing. They were concerned with making progress in their recovery and being in control of their situations. Wanting to know and to understand what was happening to their bodies was important. The ways in which they dealt with recovery helped them find meaning in their situation and supported the way they looked toward the future. The participants demonstrated their awareness of the physical, mental, emotional, and social aspects of recovering and their importance to recovery.

In the next chapter the significance and nature of the network of relationships for participants are discussed.

Chapter Seven

BEING-WITH OTHERS

In the previous chapters the focus of discussion was the context in which participants experienced surgery and recovery, the disturbance in the participants' being-in-the-world, and the aspects of their everyday life that they were concerned with as they dwelt in their recovery. In this chapter the nature of relationships is discussed. Heidegger (1962) states, "the world of Dasein is a *with-world*. Being-in is *Being-with* others. Their Being-in-themselves within-the-world is *Dasein-with*" (p.155). One of Heidegger's modes of being is "being-with" other people. This means not only being 'face-to-face' with others but also that others are "there" for us even though they are not present. An expression of being-with is van Manen's (1990) existential lifeworld – lived other or relationality, the lived relation maintained with others in the interpersonal space shared with them (van Manen, p.104). Each of us constitutes our own world but we also have aspects in common with others (Leonard, 1989, p.44). We are embedded in the co-happening of a community of others. Being-with involves being with self, with others, both known and unknown and being within a world. This means, "in a larger existential sense human beings have searched in this experience of the other, the communal, the social for a sense of purpose in life, meaningfulness, grounds for living" (van Manen, 1990, p.105). This search is interrelated with the notion of care (*sorge*) the basic state of Dasein, because to be human is to be concerned about things and to be solicitous toward other people (Zimmerman, 1993, p.247). Other people have significance and importance to us and valuing others shows concern and involvement in the historical, cultural, and social contexts that make up our world.

Events such as surgery can be included in the field of affliction when Zaner (1982) speaks of how affliction breaches a person's taken-for-granted fabric of daily life and so brings into play a special kind of reliance on other persons (p.48). Who those persons are and what type of support they provide vary. In this chapter the participants' reliance on others and what this meant for them are considered. In order to heal one has to seek the help of another and the freedom to act as a person is severely compromised (Pellegrino, 1982). The healing relationship may be inherently unequal as in the case of the "professed healer" (doctor or nurse), "for the healer professes to possess precisely what the patient lacks – the knowledge and power to heal" (Pellegrino, 1982, p.159). Pellegrino goes on to say, "genuine healing must be based on an authentic perception of the experience of illness in *this* person. It must aim at a repair of the particular assaults which illness makes on the humanity of the one who is ill" (p.160). People undergoing recovery after surgery may not regard themselves as ill but they are healing and their interactions with others can enhance or hinder this process.

Maintaining ties, human connectedness, and human concerns become not just ends but are understood as constituting what it means to be a person. The self is understood as a member / participant in part constituted by relationships with others... And it is this human connection that gives people the courage to weather illness.

(Benner & Wrubel, 1989, p.52)

The relating to and with others, whether they be spouse, family, friends, or people in a wider network, was an integral part of recovery for the participants. Relationships extended from those who were significant others such as spouse and family, through to the surgeon and/or general practitioner, helping agencies, to others, both known and unknown, who had experienced the same or similar surgery.

Being-with others is discussed under the themes of **everyday relationships**, the people with whom participants were likely to relate in their everyday life; **the wider network**, which encompasses those people who formed the net of support for the participants during recovery; and **relating**, the nature of interaction.

EVERYDAY RELATIONSHIPS

There was a variety of relationships which were significant for participants. Each participant had a spouse, significant friend, or family members whom they regarded as key factors in their recovery. Other family members, friends, neighbours, and acquaintances in organisations to which participants belonged contributed to their recovery in particular ways. People visited or telephoned. Relationships extended beyond people to pets, which provided comfort and belonging. The importance of support of others was stressed.

“I Don’t Know How People Who are On Their Own Get By”

For married participants the balance in the relationships with their spouses was displaced for a period of time as they were more dependent on their spouses for help. One outcome of this was the concern of participants that they were unable to carry out their usual set of responsibilities in the relationships. Significant friends provided support and practical help. Participants like Colin, Simon, and Matt needed extensive help with day-to-day activities particularly in the initial stages of recovery. Colin spoke of his wife's help.

My wife has to do so many extra things, for which I'm truly grateful, for all the help that she is... she always comes up to help shower me and dry me, and put the brace on, and help me dress. Because, that is not because I couldn't do anything, but working the brace, I have to have her help. ... I can get most

of the clothes on but when it comes to, and I can even put socks on, but I can't do up laces on shoes. So I'm grateful for her help.

(Colin, 1: 6)

Colin and his wife each contributed to his showering and dressing as was the case for Simon.

Apart from my wife, looking after me and tending to my various needs and doing up my shoes and putting on my socks which I can't do, helping me in the shower and drying my feet, you know, these are all the little things that you do have to have help with. I don't know how people who are on their own can possibly get by.

(Simon, 2: 6)

Matt had initially needed his wife's help to get in and out of bed. Once he managed to do this for himself there was one job he relied on his wife for.

I doubt if the wife'll need to help me much more, except she's got to tuck my feet in, because I'm inclined to get cold feet at night, so at half-past-ten she'll tuck my feet in and put a hottie there, and I'll be off to sleep.

(Matt, 1: 7)

Though Matt's dependence on his wife had decreased there were still occasions when her help was needed.

Connie was in no doubt that it was her husband who had been most help to her since she had been home from hospital. She stated that without her husband she would probably be in a home or need to have somebody with her all the time. Connie later described how she and her husband worked together as she tried to help herself to recover. Within her limitations she carried out her usual household activities such as the dishes, dusting, and

making the bed. Connie had difficulty lifting anything with weight, especially up to a cupboard, so her husband assisted with this as he did with the laundry, "I put the wash on but I'm not any good at hanging out. I try to, I just hand him the pegs (laughs) (Connie, 2: 22). For Connie and her husband it was a co-operative effort but Connie, while describing her husband as wonderful, commented, "but he gets tired too" (Connie, 2: 23).

Wenger (1990) comments that care provided by an older person's spouse is associated with intimacy and companionship. For the spouse it involves looking after the most significant other and is part of the marital relationship. Caring thus may become the focus of their lives. Wenger suggests that it seems likely that in sound relationships the long history of intimacy in the married relationship results in positive attitudes to caring (p.199). Health problems which often accompany aging can increase the risk of public dependency. According to Rowland (1982), "the presence of a spouse diminishes vulnerability to public dependency; mutual assistance enables most of the married elderly to remain in their own homes and live independently of outside help" (p.230). Research by Yates (1995) found that spouses provided significantly more emotional support and tangible aid than health care providers during recovery and that patients were more satisfied with their spouses' support.

Significant friends and family provided support and practical help for participants. Peter was definite in how important people were in his recovery. His son lived in another part of the country and had come to stay with his father on his discharge from hospital.

It's been a great help having my son down of course. He's a nice, gentle fellow. As I said, [significant friend] has been a great help to me encouraging me. People are terribly nice to me, very kind.

(Peter, 1: 12)

Surgery affecting a member of a family or friendship group can be a catalyst for closer or more frequent contact as for Peter. Owen's surgery helped bring him and his son closer together.

When he was younger we were very close, and of course things change when children marry as people know well enough. And we haven't been as close as we might have been over recent years. But this was a period where we just seemed to slip back to 30, 40 years back and things hadn't changed.

(Owen, 1: 5)

A supportive family network helps decrease the older person's vulnerability to the exigencies of their situation.

Owen was very grateful for the support of his family in keeping in touch with him and following things up. He had a married son in the same city and two daughters who lived overseas. His daughters kept in regular telephone contact including by fax and one of his daughters sent him compact disks of music she knew he would enjoy. Owen's son, daughter-in-law and grandchild telephoned and visited on a regular basis. Owen described his daughter-in-law as being "as good as a daughter in lots of ways to me" (Owen, 1:18). Owen had only one close male friend from school days as the others were dead. In recent years he had made friends with a woman who, in Owen's words, had been good company and very attentive. Owen felt she had made it easier for his son and daughter-in-law.

And she has been extremely supportive. Like she visited me in hospital every day and it made it easier for the family, when they couldn't come in and see me, perhaps some days. And she is also doing things that I don't need to ask the family to do, that's my son and daughter-in-law to do, and she's quite happy to do these things and she's been able to drive me around everywhere, .../. Taking me wherever's necessary prior to the

operation this time, and following it, and even yesterday to the doctor and chemist, and so on and so forth. And that's been very, very pleasing.

(Owen, 2: 15)

Owen's friend was able to share with his family the support he required. Like Owen, Neal had a woman friend whom he regarded highly and as the person who had been most help to him since he had been home from hospital. His friendship with his friend was important to him particularly in dealing with his surgery and recovery.

She won't accept this is a great part of the healing process. "No" she said, "you've got a strong will". And I said, "It's nothing to do with that". I said, "You are the one, I mean it's, gave me something worth living for". And that's how I see it anyway.

(Neal, 2: 15)

Neal was in no doubt what would have happened without her support.

If it wasn't for my friend, I think I've mentioned this, I'd be a prisoner of circumstances. No doubt about it, in fact, I would have to have sold up and gone into a rest home, because I couldn't have coped, you see.

(Neal, 4: 9)

Neal echoed Connie's sentiments. Without the help of Neal's close friend and Connie's husband each would have been faced with, in their contexts, less desirable options.

The support that family provided was both emotional and physical in nature. Dulcie illustrates the importance of her family's support to her.

I automatically rely on the family. I can just 'phone them up and ask about something and that relieves any tension or any particular thing I might be worrying about.

(Dulcie, 1: 27)

Matt was in no doubt about the importance of his wife and family to his health and recovery. He described his wife as the “key factor”, the person who was always there and caring and attentive. He gave an example of the way in which family members were supportive. His son, busy at harvest time, had come to have breakfast with his parents and afterwards chatted with them for half an hour. Matt commented, “this is most uplifting, you know” (Matt, 3: 4).

Beside his sons calling in regularly other people also visited. “We've had quite a few visitors over the Christmas period. Brother, and nieces and nephews, and lots of good friends” (Matt, 2: 7).

And there was very good neighbours, and the neighbours were always wanting to help, because one of them has just had his hip done too, you see, so he was sympathetic. (laughs) And he was calling in and, but of course we didn't need help from him actually but it was there. The backup was there.

(Matt, 4: 2, 3)

Like the others, Matt had the assurance of a safety net of people that provided a secure and supportive environment in which to recover. Family, friends, and neighbours are labelled “informal” carers because they do not originate from any formal organisations (Garrett, 1991). “Informal” carers often play the major role in care and support.

“The Lady Over the Road came with a Casserole”

People other than family members or significant others were an integral part of recovery. Harry enjoyed the company of friends coming in and

having a “yarn”. He said he had a good band of friends that had been very good in coming to visit and say hello. This group extended from the farming community to “chaps I used to work with”. Neal also had a band of people who kept in contact with him. He felt the company was good for him and he appreciated it. One friend visited regularly on a Friday, another visited and rang him up. Peter’s friends brought food and had “got the message now not to stay” (Peter, 2:5). Peter’s neighbour was of particular help, by making his bed, stacking / unstacking the dishwasher, and tidying the kitchen, “She comes in every morning to do that and that’s made a lot of difference to my back, made quite a bit” (Peter, 2:4). Everyday tasks which cause pain and distress can sap the person’s energy and hinder healing and recovery.

Maintaining social contacts with others contributed to the participants’ well-being. Peter and Connie were appreciative of the practical support provided by friends and neighbours. Connie had several people who visited or telephoned every day and this was the case each time I met with her. In our first interview she said her husband was getting no rest with the telephone calls.

*I’ve got muffins in the freezer and cakes given to me (laughs)
and somebody came with soup, the lady over the road came
with a casserole, so it’s been very good.*

(Connie, 1: 22)

Practical support and friendship values the person’s place in their world. Research by Melanson and Downe-Wamboldt (1987) led them to conclude that the older person’s perceived health status was the primary reason for variance in their perceived feelings about the future. The researchers commented on the importance of maintaining friendships in the community and of the family as a support system. In a four year New Zealand study being undertaken “Preliminary findings have shown that most older people are not isolated from their families and that the difficulty of growing older is reduced by good relationships.” (“Kiwis”, 2000, p.3).

Nell identified the stimulation of visitors as being the most help since she had been home from hospital and the rest home. Nell enjoyed the company of others, they were important to her as part of her everyday life.

What has been most helpful?... I think it's the stimulation of visitors, I think. Really. I really do think that it's a terrific help to you getting better. If I sat here day after day, thinking, "Oh, I think I'm getting stronger", but when you're talking to people, you just get stronger and stronger, and I have had a lot of people helping me. Ringing up, and we have long chats. It's all great. Wonderful.

(Nell, 1: 15)

Having friends to visit, even for a short time, was important for Dulcie. She commented, "your friends that you know very well you can tell them if you're tired and they can go home, leave you to yourself (Dulcie, 1: 28).

The telephone was an important means for participants to keep in touch with others. For Owen, who tired easily with visitors, telephone calls had been the main means of interaction. Dulcie had not had time to catch up with all her friends but, "I'm always in touch with them on the 'phone" (Dulcie, 4: 4). The telephone was also the means to return to the "normality" of everyday life.

And besides the normal things happen, like telephone rings and you answer it, and it's your usual friends calling, so those things are normal. Yes. And I have my cat here, that's (laughs) normal to have her here... she'd always show the affection that she shows so yes, it was really important.

(Dulcie, 4: 6)

Like Dulcie several other participants had pets, which were mentioned either during the interviews or during casual conversations and which were held in affection.

The unexpected kindness and actions of others as mentioned above by Connie were appreciated by participants. An example of this was provided by Colin who had a problem with a tree which was affecting the sewerage system. He asked one of the men belonging to his church if he could help when he had time.

Two hours later, he had it done. I wondered where the tree had gone. He'd come without my knowledge, while I went to the shops, and he'd removed the tree. And I couldn't do that. But he's done it, which means that may save me having to get some outside help to check the drains.

(Colin, 3: 8)

This was particularly significant for Colin who regarded himself as a self-sufficient person, doing things himself, standing on his own feet instead of asking others to do a job. During the problem with his shoulder he had found the men in the church, "getting alongside and they're doing things with thought, they'll look ahead, and the moment I say something they'll jump in to do it" (Colin, 3: 8).

While the spouse / significant other played the most important part in everyday relationships, participants gathered strength and practical and emotional support from family members, friends, and neighbours. Contact by visits and telephone enabled participants to maintain social relationships.

THE WIDER NETWORK

The network of people beyond those of the everyday varied in presence. Some people were present in the lives of participants on a short-term basis, others were present for longer periods.

“That Was an Excellent Service and Absolutely Vital”

The people from the helping agencies were in general present on a short-term basis. Nurses, housecleaners, gardeners, and the deliverers of hot meals were the most usual. Peter received help from the district nursing service as well as help in the home and garden. Simon had help in the house and garden and felt the help provided by the occupational therapist was something that had stood out for him during recovery.

Oh well the occupational therapist was very good. She came round and had a look at our facilities, and gave us all the recommendations. That was excellent service and absolutely vital... Yes. The modifications, the toilet seat, the blocks on the chair, the pick-up stick, (laughs) picking up things I've dropped, and she was the one who suggested we put a towel under the heels, and that was highly effective in preventing them getting painful.

(Simon, 1: 11, 12)

This was practical advice and support which Simon needed for the everyday problems he was dealing with.

A similar situation occurred for Connie as both she and her husband were incapacitated when she came out of hospital. Connie had home help and a nurse to help her shower.

I am having once-a-week help because my husband has broken his ribs (laughs) so it's at the wrong time so, he is wonderful because he has done everything, but he can't do the ironing or the hoovering, so we have to have help and I have the nurse three times a week to shower me as I'm very incapacitated, because even in personal things it's, you can't do it.

(Connie, 1: 2)

In her third interview Connie told me the cleaner had felt she needed help for a longer period so Connie arranged for the home help to be extended. Connie commented on the difference in care provided by the district nurses.

We had a different nurse this week, and she doesn't sort of do as much as the other nurse does, and well I find... the problem is to get that arm up to wash under it, you know... and the other nurse is very good with it. She sort of puts the flannel underneath it that way [demonstrates]. But this sort of other nurse she sort of stands and lets me do it, which I find very hard.

(Connie, 3: 19, 20)

In this example Connie's specific needs in relation to her shoulder surgery were not met by the nurse.

Poole and Rowat (1994) studied elderly clients' perceptions of the caring of a home-care nurse. Three major themes arose in the perceptions of caring and in order of emphasis these were – the attributes of the nurse, giving emotional support, and physical support. The authors concluded it is not so much what the nurse does but how it is done that is important. Yates (1995) found that the main type of social support provided during recovery by health care practitioners was informational, followed by emotional and then tangible aid. She cites research by Winefield and Katsikitis (1987) who found that, "support from family and friends was described more often with

empathy words (cheerful, warm, caring) whereas support from doctors was described more often with expertise words (businesslike, expert, capable)" (p.200). Smith (1981) states that, "For many patients, care following discharge is limited largely to periodic visits to the physician or clinic, where attention often is focused on objective data and little attention is given to their human responses to the illness and their reentry into work and family life." (p.92). Despite much of the recovery process taking place after the person leaves hospital Smith comments that the adequacy of their support system often remains unexplored when they leave hospital.

Dulcie's surgery meant she was restricted in lifting and other activities for a period. She had help with her garden and in the home which, because it was important to her to have her home looking tidy, she felt was wonderful. She also enjoyed the company of the young woman who came to clean her house. "I have a bright young girl comes in and it's very nice to talk to her too." (Dulcie, 1: 24).

Agencies provided help with home help, gardening, meal service, occupational therapy services and nursing care. While help provided to participants was of a practical nature it also provided contact with others, emotional support, and companionship, especially for those participants who lived alone. Agency help acknowledged the need in the life of the participant and confirmed the legitimacy of their situation. A particular form of contact was provided by compatriots.

"Practically Everybody You Talk to Has Either Had it or Knows Somebody..."

There were always people in the participant's landscape who had experienced the same or a similar operation. Sometimes these people were known to the participant, sometimes they were unknown. There was mutual benefit in the relationship with compatriots – the sharing of one's own stories, comparing one's experience with that of another person, which enabled one to assess such aspects as progress, treatment, and what to

expect, and to enable the participant to help others.

The significance of sharing one's experience of illness, surgery, or recovery, is illustrated by Frank (1995) who says that stories can heal, that the ill can become healers and by sharing stories they can bond with others. By becoming a storyteller a person is able to recover the voice that illness and its treatment often takes away. New stories are needed to make the body familiar again. Embodied stories are those told about and through the body and these embodied stories have both a personal and a social side. The social context affects which stories are told and why, as well as when or at what times.

Serious illness is a loss of the "destination and map" that had previously guided the ill person's life: ill people have to learn "to think differently". They learn by hearing themselves tell their stories, absorbing others' reactions, and experiencing their stories being shared.

(Frank, 1995, p.1)

Participants used others to compare or measure progress or to assess their progress or treatment. One group used as a yardstick was sportspeople. Frank, who was a tennis player and bowler had obviously thought about this group of people when considering the progress of his shoulder surgery. He compared himself with golfers, footballers, and tennis players who had recovered from injuries similar to his and, regardless of their age, the recovery time of some months appeared to be the same as his. When I asked him if what he was saying was that age was not a major factor as far as he was concerned he responded:

No, well, you know, I've got no way of measuring that. I suppose if you're young and fit, all these things would heal up

quicker, if you exert more pressure on them to get them back into action.

(Frank, 1: 20)

Participants sought guidelines for their progress and rate of healing, and a group which had experienced similar injury or surgery provided a useful source of information as they saw it

Connie had a reference group to source information. In the course of the interviews with Connie she mentioned a number of people, both known and unknown, of whom she was interested in knowing how they had fared with their operation. The replacement of a shoulder joint was relatively uncommon in her experience even though she herself had had both shoulders operated on more than once. A woman who was with the Arthritis Society to which Connie belonged had rung Connie three times to see how she was, "as she's had it done too, not as much as mine, and she's fit as a fiddle, mind you hers is ten weeks [since her surgery] I think she said, so we had a chat. It's very nice that she even rings me" (Connie, 2: 16). Connie had recently been visited by a member of an organisation to which she belonged and the person's next-door neighbour was about to have a shoulder replacement. She knew also of another person in similar circumstances.

In her third interview Connie talked about a magazine article in which there was an account of a young woman who had had several joints replaced including her shoulder joints. She compared the young woman's fortitude in coping with the surgery, to her own. Connie also spoke of a person who used to be her neighbour and who had decided to have a shoulder replacement. Connie had recently met someone of a similar age who had shoulder surgery.

She said hers was a real success. What she actually had done I don't know, I know that [Connie's surgeon] did it, she was thrilled so when I see him on Monday I don't know if he will say

anything, I will ask or tell him that I met one of his patients. You sort of don't hear much about the old shoulder replacement.

(Connie, 4: 12)

Connie had a network of people which she used to measure the success of her operation and her progress and provide access to information. Connie's avenues of information are reflected in Will's account of how an operation and/or the people who have the operation come to the fore at the time of one's own experience.

It's amazing, immediately you have something like this happen to you, practically everybody you talk to has either had it or knows somebody that has had the same problem. And most of them are doomsdayers, mostly there's very little success with these things, they all say, you know, you're very brave, but it doesn't work very often. But I've found that one lady in particular, she was, she went to [the same surgeon as Will], "Oh," she said, "Will, you're crazy". She said, "I wish you'd seen me before you'd gone". And she was three years before hers came right. But she cheated, she didn't do her exercises. That's what her husband told me later. He said she'd do them one day and he said you'd talk to her a week later and she hadn't done them.

(Will, 2: 3)

Will made special effort to carry out his exercises, as has been illustrated previously. Simon was another participant who was responsible about his exercises but he also showed concern about not having any physiotherapy following his hip replacement, particularly as he was having a problem with his leg. Another member of a group to which he belonged shared her experience with him.

And she'd had a big operation and I was speaking to her today, and she said her specialist had given her a series of exercises

to do, you know, to strengthen the muscles. She found it very beneficial. But everybody whom I speak to, seem to think I'm doing very well as far as mobility is concerned. But I don't have a yard-stick to judge it by. (laughs)

(Simon, 2: 4)

Simon needed affirmation that the measures he was taking were sufficient to show progress and overcome the problem he was experiencing. He was left uncertain after meeting with his surgeon and needed to gain reassurance from others. Sometimes the issues about which participants needed reassurance were not specific to their operation, for example the actual hip replacement, but symptoms that arose in conjunction with the operation. Matt had experienced a sickly feeling which he could not account for.

I was talking to a lady down the street today when I was walking and she said she knows two other people, slightly younger than me that had this sickly feeling after the anaesthetic.

(Matt, 2: 3)

Hearing about other people having the same experience reassured him. In the surgeon's waiting room Colin met up with several other men who had had shoulder operations. He had not realised how many people had the same problems as he did.

I didn't know that either, but I understand it's very common with footballers and people like that. They land on their shoulders, or do something else, and so they go and have these operations. I read of one of our New Zealand Black Caps, cricketers... been six months to get himself back into fitness after a shoulder "op". And so it's something that's taken

longer than I thought, must be close to three months now, and I thought it'd take another couple of months before there'll be a full restoration.

(Colin, 2: 2)

By comparing himself with others, both known and unknown, Colin developed more realistic expectations of his progress and how he would have to manage his plans for the future. Colin had shared the experience of his operation with a stranger with beneficial effect.

Well, I went into a hire firm to get some equipment to cut a hedge. A man at the church came to do it, but I was getting the equipment. And the man there had the same problem. Now facing an operation or a specialist, so I was able to share what happened to me. He was quite encouraged to know, you know, the positive sides about it... He seemed very appreciative of it, and I told him what next steps to take and what to do and so on, and what the costs would be, and so he was happy.

(Colin, 3: 4)

Colin's behaviour in this situation was a reflection of his way of being-in-the-world. He was a person who helped others and would do what he could to benefit others. Harry was a "people" person in the sense that he enjoyed the company of and camaraderie with others. The way in which he related to others helped him deal with his past and current surgery and prospect of future surgery. Harry had talked to a number of men who had an ostomy. He kept in touch with people who had been in hospital with him. One man who had a permanent ostomy had visited Harry who had shown him his herniated ostomy. They compared notes.

While Harry expected to have his colon reconnected, he had prepared himself for the possibility of a permanent ostomy. Part of this preparation for his further surgery involved talking with others who were in a similar situation.

I keep in contact with Jack that had the same thing as I'm going to have, you know. He said he has recovered, he said he's all right, good as gold, and he said it's still not like it was before. He said it's sort of different. I don't know what he meant by that. I've never sort of questioned him on that, but [surgeon] told me, he said, "It won't be just the same as it was before", but he said, "it won't be far away, but it won't be just quite so, you know, just expect a wee bit of change". That's what he said. But I don't know just, I must ask him what he means but obviously, this other chap is, he's O.K.

(Harry, 3: 11)

Compatriots provided knowledge, reassurance and support for Harry. They clarified the expectations he had.

Just hope it all, when they've put it together [reconnected colon] I think I know what to expect, and seeing this other guy, he was right opposite me, in the opposite bed. I seen him go through the operation, and the recovery stage, until he went out. He was about four days in there, thereabouts. I've spoken to him since. He's getting on good.

(Harry, 3: 12)

On reflection I think that I became a compatriot of sorts. For example, I was shown healed wounds on an elbow and shoulders, swollen feet, Harry's herniated ostomy, and was asked to feel Connie's knobbly shoulder scar. In our conversations I was asked my opinion about aspects and concerns which I had to deal with carefully and mindfully of my position as researcher. The showing and telling that occurred was in all likelihood because I was a nurse, and as a nurse and a researcher, interested in what had happened and was happening to the participants.

Compatriots came from a variety of sources providing an avenue for participants to assess the success of their operation and their progress in

recovery as well as to provide information. They also enabled participants to belong to a community of 'like' people with similar experiences and understandings. Doctors provided another reference source.

“I Had Faith in Him”

Pellegrino (1982) wrote of the relationship between the patient and the professed healer with the patient being in a vulnerable position and the healer having a moral obligation to heal (“to make whole again”). Pellegrino expresses the nature of the relationship the doctor has with the patient as one in which there needs to be a balance struck between competence and compassion – “interpreted here as the capacity to *feel* something of the experience of illness *with* the patient” (p.161). The competency of the doctor (and nurse) is a necessary but not sufficient condition. The patient’s bodily good, concepts of health, value system, sense of the kind and quality of life considered worthwhile must all shape the healing relationship if it is to be authentic in Pellegrino’s terms. “The patient must be assisted, to the extent he wishes, to make conscious choices and thus act as a human person rather than become the object of technical manipulation” (p.161).

While not all participants spoke of their general practitioner, all spoke of their surgeon, who featured significantly in their lives in a variety of ways. Having faith and confidence in the surgeon affected the participants’ attitudes to their surgery. Connie had been referred to another surgeon by her previous surgeon who had carried out a number of her operations. Initially she thought her shoulder was to be “tidied up” in an attempt to relieve the pain but she had another shoulder replacement. In the following extract there is a sense of wanting to benefit from the new surgeon and to have faith in him that there will be benefit. This statement was made in the last interview with Connie when I asked her if there was anything else she wanted to say. At this time Connie had not yet experienced any benefit from her surgery.

Just that a younger person doing it and has more modern ideas perhaps and he has studied the shoulder replacement. Which is a good thing too. So I just hope that it, other people benefit from his experience... I had faith in him. I did have faith in him. When he said to me, "I will do this surgery", and I thought, "Oh"... So that was that. I'm quite pleased but I was always happy with the professor. Of course I'd known him for so many years, but I was just a bit disappointed.

(Connie, 4: 18, 19)

Connie was pleased with her new surgeon but also loyal to her previous surgeon who had carried out all the surgery on her arthritic joints. There is her sense of disappointment that he did not continue as her surgeon. Why participants had faith and confidence in their surgeon is illustrated by Matt, Will, Ben, and Harry. Matt had confidence in his surgeon from the first time he met him and said, "I think that helps quite a lot" (Matt, 2: 1).

Well, I think the first thing is I've got confidence in [surgeon]. He's a disciplinarian, he looks you straight in the eye when he gives you instructions about how far to walk and not to bend and all this kind of thing.

(Matt, 1: 9)

Will said he had always had the utmost confidence in his surgeon and, like Matt, thought that helped. When I asked him what it was about his surgeon that gave him confidence he replied that he had the impression that his surgeon seemed to know what he was doing, that he explained things very well and answered every one of Will's questions.

Matt, Will and Ben had the same surgeon and appreciated the way in which he dealt with them. A positive response from the surgeon increased the confidence of the participant. Ben's surgeon engendered confidence and a positive feeling about his progress. Ben had been told it could be six months before his arm returned to normal and the time seemed to stretch

ahead for Ben. After a visit to his surgeon Ben said:

*I'm not worried about that time now, I can do more things ../..
So I think things are going along the way he expects them to go
along. And I am quite, it has given me more confidence that
things are O.K. And I feel much better about it.*

(Ben, 2: 6)

Following a further visit to his surgeon Ben reported:

*And he doesn't want to see me now since last time, for two
months, so that is February, so he is quite confident that things
are going the right way. And therefore why should I be not
confident if he is confident?*

(Ben, 3: 3)

Ben used his visits to his surgeon as a way of judging his progress. The fact that he did not need to see his surgeon for another two months, "I felt therefore that that was good, and perhaps that helps me feel better about it" (Ben, 3: 5). The competence of their surgeon, and the way in which he dealt with each of them, created a trust relationship with Matt, Will, and Ben.

Nell had faith in her surgeon though it was blind faith. Despite being frustrated by the lack of information from her surgeon, Nell was nevertheless pleased that he would operate.

*I'm just absolutely thrilled that he said, "Yes, I'll operate",
because sometimes I know, two of my friends who both went to
him with backs, and he said, "No, I can't do it". But he did me,
and I was just so pleased that I had something that he could fix
for me, and let me go on for a bit longer without pain. (laughs)
../.. And when I heard him say, "Yes, I'll fix that for you", I was
just so pleased, but he wouldn't tell me what he was going to do*

or anything, you know, but I just sort of had such great faith in him but I just went in completely blind really. I really didn't know what he was going to do. And these lovely friends that say, "Ooh, backs", you know, "paraplegic", and blah-blah-blah, but I thought, "Oh well, it's either that or wheelchair, so it's got to be that, hasn't it?"

(Nell, 4: 8, 9)

Nell's comments reflect the length of time she had sought help for relief of her painful back. The surgeon was the first person who offered some certainty of pain relief and hope. For Nell it was her last hope of treatment that would allow her to continue her life in a way that was meaningful for her.

"I Feel You Could Get More Guidance"

Aspects of care, treatment, or worrying symptoms sometimes received a response from the surgeon which left the participant dissatisfied or confused about what they should do for the best. Owen had experienced some sharp severe pain which concerned him.

I mentioned that to the surgeon when I visited him on the 23rd December, and I mentioned the backache, and he really didn't offer any specific reasons or explanations for that. Except, I think he said something like, "Oh, you'll get a lot of these odd pains for a while until your system settles down".

(Owen, 1: 13)

Owen, who had experienced pain of varying types and severity throughout his life, knew when pain was different in any way and when he needed to take notice of it. Nell was frustrated by the lack of information she was given about her back surgery. When asked what instructions her surgeon had given about the length of time she would be restricted in movement, she responded:

*Oh, he was hopeless. Absolutely hopeless. I said to him, "When can I drive the car?" And he said, "When you feel you are able". I said, "Do you think an exercycle would help? I've got an exercycle to get fit again". "If you've got an exerciser, and you want to ride it, you can ride it. If you want to go for a walk". "How far can I walk?" "As far as you feel you want to walk". He wouldn't give me any instructions whatsoever. It was all up to me. As he said, "You'll know how far you can go". And that was it. [Nell was told she was not allowed to do anything for a week] But he didn't tell me what **anything** was, you know. I mean he didn't say, "Well, look, don't stand at the bench and peel a potato", he didn't tell me what, but he said, "Just do nothing, for a week". And that's that.*

(Nell, 1: 10)

Nell's seeking of advice was an attempt to do what was appropriate to aid healing and to prevent harm to her back. She had to make decisions about how she would manage once home based on the advice given by the surgeon.

Simon was another participant who was left dissatisfied with the response from his surgeon. After a visit to his surgeon he was:

Not terribly enthralled... I feel that these people are so busy that you have the feeling all the time that they just want to be shot of you as quickly as possible. And it's very hard to sort of bring up all the points you want to, and they just seemed to be brushed aside. It was like the oedema I had in my feet. When I saw him the previous time, he just said, "Oh well, we'll just leave it as it is", you know. And I feel that you could get more guidance on whether it was just to be expected or, it's normal, a part of the process, or, you know, what's causing it.

(Simon, 3: 2)

Simon wanted to take an active part in his recovery and do the best for himself but did not have all the information he felt he should have to be able to do this.

I felt that there was possibly more I could be doing to hasten my recovery. Well that may not be so but, you know, I just would like to be more assured of that. ../.. He just completely brushed aside physiotherapy, that seemed a bit one-eyed to me.

(Simon, 3: 5)

Simon was the major participant in his recovery and provided several examples, such as the above, which indicated he felt he was not being heard. Will had no difficulty finding out information from his surgeon but he commented upon the need to talk about problems.

When you're under, in an operation or anything like that, I think you've got to be able to, I know their time's important, but they're well paid for it. And you've got to be able to talk to them, if you have problems. It's, you know, O.K., it might not be terribly serious, but when you've had a serious operation ../.. and some surgeons won't talk, and if they don't talk to you, and explain to you, it would be pretty hard to take, I think.

(Will, 2: 6, 7)

The surgeon was the primary source of information about the operation. When the quality of information provided to participants was lacking, dissatisfaction resulted.

Connie was another participant who, while she liked her surgeon, would have welcomed some more information. She was experiencing much pain with her shoulder surgery and had not been given any indication about the amount or duration of pain that might be expected. "No they don't tell you really ../.. no they don't tell you anything" (Connie, 2: 6). Despite Connie's response she did confirm if she was concerned enough about the pain she

would ring her surgeon.

Neal's lack of response from the surgeon was of a different nature. There was the suggestion of abandonment and a need for reassurance.

I have to see [the surgeon] after six weeks. Well it's eight weeks now and I still haven't heard from him. I'm not worried about it. Because I mean there's nothing, no reason why I should have to see him, only he, I thought he would've wanted to see me, more than I wanted to see him.

(Neal, 4: 11)

Reiser's (1992) concept of the medical navigator would avoid the abandonment Neal conveys.

When we are sick, we are like a traveler on a voyage with an uncertain destination. Each new symptom felt, each new opinion voiced, may change our course and take us where we do not wish to go. Medical navigators to explain these diversions in our voyage would do much to relieve the anxiety and fear, which perhaps constitute the main burdens of illness. The diversion away from persons and the stories of their lives to special sites in the body depicted objectively with numbers or images prevents health care personnel from assuaging this dimension of illness.

(Reiser, 1992, p.48)

Yates (1995) points out that patients typically receive most information while hospitalised – but this may be too early in the recovery process to have lasting consequences especially as findings suggest the need for information is highest several weeks post discharge. To be effective, information must be provided in an emotionally supportive manner, so how information is given is possibly more important than what information is given (p.201).

Despite concerns about aspects of their progress participants received some comfort and/or accepted that if the surgeon was satisfied with their progress they should be also. In the latter case this was sometimes reluctantly.

Well, yes, that was it, that he seemed completely satisfied with my progress, and therefore there was no need to worry about anything else. Well, perhaps I should just be grateful. (laughs)

(Simon, 3: 6)

Simon had been unhappy about aspects of his surgeon's response to some of his problems hence his qualified response. Sometimes participants relied on hope to carry them forward as in Connie's case. She talked about her visit to the surgeon. He was pleased with the wound healing and checked the movement of her shoulder joint. Connie observed, "but they don't comment much, you know they don't give you anything really, so ah, that was that, but I just hope it improves" (Connie, 3: 3).

A surgeon's satisfied response sometimes resulted in a similar response from a participant. As Ben laughingly expressed it, "if he is happy about it, then I withdraw my objections" (Ben, 2:3). How the surgeon conveyed the management of recovery determined the approach the participants took. Aspects of recovery involved doing what the surgeon advised. Following instructions, obeying orders, taking note, doing what one was told, being good, were all elements of how participants interpreted what the surgeon had conveyed. Colin realised the importance of the advice from his surgeon.

And also because I'd be unwise to try and move the arm more than the doctor said that I should do. And I want to be cooperative to the fullest extent with the instructions from the surgeon.

(Colin, 1: 6)

Colin was one of the participants who conveyed during the interviews that he was in partnership with the surgeon to heal his shoulder. Dulcie had not followed the advice of surgeons on previous occasions and her past experience provided an incentive to “obey the rules” this time.

I did not mention that I did have a big operation two years ago for a repair and the previous big one was a way back for a hysterectomy but I, both times I felt so well that I didn't obey the rules and when I felt well I just did the things that I normally did and that's why I think people often are troubled with adhesions and things like that and, at my age the surgeon said, it is most important that I follow every rule, and not to do any of the things that I did so, I'll have to try because I don't want to go back into hospital again and I believe you would soon land back again with all the repairs that I've had done, to undo them would be longer recovery next time, so I think it is important I will have to try and keep thinking about that. (laughs)

(Dulcie, 1: 26, 27)

Dulcie took heed of the warnings she had had this time because she wanted to make sure that she would recover properly. She said, “I felt I'd had enough and that I should do as I was told” (Dulcie, 4: 2). This was the first time Dulcie had had home help after surgery. For previous operations she felt she could manage things herself. With the latest operation having help meant she could rest more and not worry too much that work was not done. “Having help in the home was great really. And I think that was a great help too, in the recovery part” (Dulcie, 4: 3). Dulcie saw the benefits of following the doctor's orders and this had a beneficial effect on other aspects in her recovery.

Ben was very particular about not doing more than the surgeon advised in regard to the use of his hand. In our second interview he had recently seen his surgeon who had indicated he could use his hand more extensively, “So I am using, because of the say-so, my hand a bit more freely than before

and I am quite happy" (Ben, 2: 3, 4). The visit to the surgeon had given Ben the confidence to try more and test the limits within which he had been living. Participants realised the importance of the advice and instructions given by surgeons and if the benefits could be seen this was reinforced and gave participants confidence in the surgeons.

Participants were satisfied, dissatisfied, uncertain or more confident as a result of the surgeons' responses. Following instructions and obeying orders, acknowledged the importance of the surgeon in the life of the participant. Participants such as Ben, Colin, Matt, and Will viewed the relationship with the surgeon as a partnership. Having faith and confidence in one's surgeon engendered a situation where the participant gained confidence and trust. Several participants mentioned the surgeon's nurse, who was often the first point of contact, and who offered advice, information, and support.

Some participants spoke of their general practitioner when talking about the diagnosis of the condition that required the surgery and the follow-up after surgery. Both positive and negative comments were made. Will found it easy to talk with his G.P. because he said he did not treat him like an old person. Will's comment is of interest in the light of Taylor's (1992) research cited in McIntosh (1996). Taylor considered how elderly identity is established through talk. His findings were that the older person "tended to yield rights of definition to the other by following the textual flow established by the other, 'even as it applied to their own identity' " (McIntosh, 1996, p.34). This reflects Heidegger's notions of *das Man*, or fitting in with the anonymous 'they'. In Will's situation the reverse was the case. Will was not treated as a stereotypical "old person". Ben said his doctor had been really good with his elbow and knee problems and, "I like to feel a doctor is on your side, and he seems to be, which is good", (Ben, 4: 9). The G.Ps of both Owen and Harry had apologised to them for not recognising the seriousness of their symptoms and for not taking the appropriate action.

The wider network of relationships encompassed agencies providing care and support, compatriots, and doctors. Each group contributed to the participants' recovery in particular ways which were both positive and negative.

RELATING

Relating to others enables the search for a meaningfulness of experiences, and their communal nature. Heidegger (1962) talked of empathy becoming possible only on the basis of Being-with. As Cassell (1992) describes it, "we live in a sea of others without whom existence is literally unthinkable" (pp.6-7). Recovering from an operation may disrupt those aspects of the person's lived world which involve social contact and interaction.

Participants spoke of the importance to them of keeping in touch with others and with the wider world, the social community in which they lived. Going on outings, continuing their involvement in, for example, organisational or church activities, or just driving round their community, enabled participants to feel part of their usual day-to-day world and to restore balance in their lives. Participants interacted on a variety of levels and the nature of the interaction was important for different reasons.

Participants used a variety of means to keep in contact with others. Throughout his interviews Neal spoke of the importance of keeping in contact with others but this contact took different forms. For Neal it was important to be **among** people but not necessarily **with** them. He did have his one significant friend as well as a small group of close friends. He saw his significant friend every day.

In fact, as I've said, I mean I've used that term before, I'd be a prisoner of circumstance if I didn't have this support. [support of significant friend] Also one or two people come in to see me, and also a person that I know I ring up, and two other men that I

ring up or they ring me up. Also yesterday for example, I went along to Probus in the afternoon. And again, meeting up with people from the district. So that's another thing that I do.

(Neal, 3: 4, 5)

Participants welcomed an interest in what was happening to them but not necessarily to dwell upon it. As Will said if someone walked in and asked about his shoulder and said they had the same problem, he would talk about it, but unless people showed some interest and an indication that they really wanted to know his response would be, "Yes, it's all right", or "It's coming on well" (Will, 3: 9). Will's response is an example of Heidegger's inauthentic discourse or "idle talk". In Will's example he judges whether people really want to know about his situation or whether it is a superficial doing-what's-expected inquiry similar to that of the check-out person's "how are you today?" Lawler (1991) states, "in effect, the body is associated with, and a source of, things which one does not make public. It is not a topic for legitimate 'normal' social discourse." (p.225). In everyday communication with others there is usually no place for Heidegger's authentic discourse. Rather, conversation is at a superficial level but, despite this, provides a means by which one "keeps in touch" with others, is connected to a communal world, and is responded to. Will did want some interest in his welfare.

It would be dreadful, wouldn't it, to find that something had happened to you and nobody interested, nobody concerned. That would be true, wouldn't it? Yes. But yes, I think it's very, very important. This is why when you get home, you tend to see more people in your home than you do in hospital, people like friends I mean. And it's terribly important that they come in and say hello and wander off again.

(Will, 1: 21)

This feeling was reiterated by Matt who said, "In life if you have contact with someone who is interested in your life and your problems, I claim it makes

you feel better" (Matt, 2: 8).

Matt enjoyed contact with people in his community. He maintained contact by watching the world go by as he sat at his window, on his daily walks, his drives around the countryside in which he lived, and other activities in which he participated. Peter, when he was fit enough, returned to his weekly church service for older people. This was important to him for his faith as well as providing social interaction. Most of the participants had groups to which they belonged and which they began to re-attend as they felt able. Keeping in contact involved an interaction of some sort ranging from idle talk to participating in a group activity. It enabled participants to take up or continue their usual social activities.

One aspect of recovery was that of mutual benefit. Neal and Colin provided examples of this. Neal spoke of two friends in terms of mutual benefit. One was his significant friend who had provided support in a number of ways.

Because as I said, I've got this friend and I mean that she's a remarkable person to me. But I've got no-one else I could rely on. Full stop. And I mean I know I'm good for her also because although she has a grown-up family, she's lonely, you know. More so than I am.

(Neal, 4: 17)

Neal's friend was the one person he knew he could rely on for help. His other friend lived in another part of the country and they kept in contact by telephone.

This person's absolutely marvellous (laughs) person that I know, she's 93 ../.. she rings me up here and she wants to know how I am coping, and she always asks me questions, and although I find it difficult with her hearing and my accent, to get across, I've got to keep repeating myself. You know what I mean, it's no problem, but as I said,

(It's giving help to each other, isn't it?)

Definitely, no doubt about it.

(Neal, 4: 17)

From Neal's point of view his keeping in contact with his older friend and helping his significant friend with various issues were ways in which he could contribute to each relationship so that the benefit was mutual. Neal's relationships with these two women were meaningful for him on a one-to-one basis. Colin provided an example of meaningful communal relationships. He found mutual benefit in his circumstances. He was used to being independent in his activities and found his degree of pain and incapacity required him to accept the help of others. Colin's experience enabled him to convey to people in his church community that he had an understanding of what they were going through in times of stress and difficulty.

I think this has been one of the most, well I would say most, fulfilling times I've had in my life outside of the seeing people's need and trying to help them, there's the reality that I know a bit more about pain, and there's a level of pain that people can't handle. [Colin talked about a woman who had similar surgery and how his experience had given him a compassion he never fully had before] ../.. and I notice when I come into church, people gather, "How are you?" they ask, and, "We've been praying for you". And these are folk that I've prayed for, and now they're turning around and asking how it's all going. To me, that's a mutual benefit.

(Colin, 1: 11, 12)

As a retired pastor who was still very much involved in his church, Colin was on the receiving end of the kindness and compassion that he was used to imparting.

The aspect of mutual benefit extended to the interviewer, as commented upon by some participants such as Neal, Will, and Colin. For Neal I was another “contact”, and contact with others he regarded as important.

I hope this is helpful to you, I mean this is important you're here, see, well that's another contact. And this is the important thing isn't it?

(Neal, 2: 18)

While Neal's benefit from our interaction was related to the contact with someone new, Will's focus was more specific to a health problem and means of communication. The following comment from Will was in our fourth and final interview when I asked him if there was anything else he wanted to say.

You've done me a lot of good coming down and talking to me because it's interesting, people don't want to listen to your aches and pains, and that's true too, but O.K. I might make a comment to you, and your reply always could indicate that yes, this is quite natural, others have the same problem. And that's good. You know that it's not just something going wrong with you, you know that other people are going through the same things. You don't have many channels of communication, very few... if something goes wrong, who do I ring? I ring [surgeon] and, because he's who he is, it's like getting through to the Kremlin ../.. but I was very lucky in that [surgeon], he's one of the few specialists I found did this [returned Will's call] ../.. So lines of communication are important, but... we're very reluctant to use them.

(Will, 4: 11)

While Will felt he received some benefit from our interaction his comments convey other important points. Will, like the other participants wanted to know about what was happening to him; he wanted to know there was a

means of finding answers if there was something concerning him, and he was concerned about how people are reluctant to use the lines of communication that they do know about. These are aspects that affect a person's recovery and need consideration. Colin's comments which follow focus on what the patient conveys to the doctor.

I hope this could be helpful to you. But it's also helpful to me in retrospect, because so often [I think] "What am I going to say today? What can I say positively?" Even when I went to see the surgeon, I wondered. And I thought, "Well you can't see in there. He doesn't know how I feel because he's not been through it himself". Doing the operation is a different thing from having the problem. And yes I thought, "Well, he can make some of these decisions by what I say". And evaluate whether what he's done is helpful to me.

(Colin, 4: 9)

Relating with others on a variety of levels and in a variety of ways were important aspects of recovery for participants.

REVIEW AND SUMMARY

Being-with others included the sub-themes of everyday relationships, the wider network and relating with others.

People and relationships were significant in the lives of participants. In the time of recovery, support, caring, kindness, concern, sympathy, companionship, comfort, help, assistance, partnership, service, information and advice were aspects of the relationships experienced by participants. The participants in a compatriot role experienced the mutual benefit of learning and teaching, and giving and receiving advice and information.

In the next chapter the focus of discussion is that of recapturing Being-in-the-world, where participants picked up the threads of everyday life, faced the reality of their world, took a stand, while at the same time extended the boundaries imposed by their surgery.

Chapter Eight

RECAPTURING BEING-IN-THE-WORLD

In the previous chapter discussion focused on how the “presence” of others affected the everyday life of the participants during recovery from their surgery. Pellegrino (1982) states:

We feel healthy when we are in a state of equilibrium between our already experienced shortcomings and our aspirations and thus have adjusted our goals to the gap between them. Health is a state of accommodation defined in different terms by each person.

(p.158)

Surgery upsets the person’s equilibrium. The experience of continuity and inner coherence is called into question. Coping with the disruption and how it affects one’s life in a changing situation also involves incorporating new meanings and thus personal change (Benner & Wrubel, 1989, p.125). A temporal context can be recreated. Experiencing recovery involves a passage of time. It implies a progression through time. Though it involves looking ahead from the present, recovery also involves looking to the past to a place where one was in terms of one’s being-in-the-world. This chapter deals with the aspect of recovery where participants are in the process of recapturing their previous way of being-in-the-world.

The sub-themes under which the data are presented are: **picking up the threads of everyday life**, returning to the usual activities of daily life; **facing reality**, accepting the situation as it is and might be; **taking a stand**, considering possibilities, making choices, taking action; **extending**

boundaries / looking toward horizons, moving beyond limits imposed by surgery; and, for a sub-group of participants, **death coming to the fore**, facing authentic being.

PICKING UP THE THREADS OF EVERYDAY LIFE

There was a desire by participants to take up the pattern of their being-in-the-world as and when they were able. Picking up the threads of everyday life for participants meant re-establishing the fabric of their life. It involved returning to their usual routines of life, becoming involved again with the usual household and other activities such as shopping, gardening, mowing the lawn, participating in home life for example by taking responsibility for household tasks, or returning to their joint responsibilities in the managing of the home. This range of aspects was described by participants as "returning to normal". Reinvolvement in social activities such as playing bowls, and outings contributed to restoring balance in the life of participants.

"I Feel Myself I'm Just Carrying On Normally"

While Doolittle (1994) is writing about people recovering from a stroke, the comments which follow could apply equally to older people recovering from surgery.

Although clinicians mark recovery in terms of functional ability and movement, people who have had a stroke measure recovery in terms of how well and to what extent they can take up activities of concern. These activities are what matter to them and give them identity and continuity with their past, as well as the vision of a livable future.

(p.211)

Being able to drive his own car rather than being driven by his wife pleased Frank and enabled him to go into his business premises. Frank was able to go out in his garden and pull out weeds, albeit one at a time and with his left hand, but these activities provided evidence of “normality” returning.

Life before an illness event stands as a point of reference for recovery which involves not only recovery of the physical body but also of the social body – a reconnection to concerns and social practices and restoration of the member – participant self in the community (Doolittle, 1994). Nell, became re-involved in a variety of activities such as going out to a friend's place for dinner, playing bridge, and later becoming involved in Christmas activities.

Well, Ray, I've been quite social. I don't know whether I've been a naughty girl, but I've, in between each social event, I've done a lot of lying around and getting over it and that sort of thing, but with all the things I belong to, they've all decided this year to have Christmas parties and dinners out and lunches out and so forth, and I have been to them. I haven't driven to all of them, people have been picking me up, or I have driven myself to a lot of them.

(Nell, 2: 1)

Nell gained pleasure from the company of others. At the same time she was doing more about her home.

By our third interview Nell's enthusiasm for doing things was returning.

That's right. I am, especially round the house. I'm looking in cupboards and having little cleanouts, here and there, and especially when I had this big haul, you know, that week [Nell had won prizes at a pre-Christmas customer buying night] I thought, “Well if I'm going to get all this into the house, I'll have to clean some cupboards out” and away I went. And sat down

in between times (laughs) when I got tired, but I've got the enthusiasm to do things round the place, no mistake about it.

(Nell, 3: 4)

Despite her enthusiasm for her activities Nell took care in looking after her self. She knew her limits and tried to avoid pain and discomfort.

Returning to "normal" life involved returning to the routines of daily life. Routines gave a framework to the lives of participants. This was particularly the case for Neal. His day followed a similar pattern through the week, "and again as I've said to you before, the routine I carry on is the routine my wife and I carried on together, so I just carry on" (Neal, 3: 3). Neal did his own housework but had a hot meal delivered each day although he was thinking of reducing the number of meals, because he said, "I do like to just fiddle about making my own food (Neal, 3: 2).

"Weaning himself off" the delivered meals (as he described it) was a step toward returning to his usual routine. Neal carried on his usual pattern of life saying he had not found his latest operation a major disruption in his life.

I feel myself I'm just carrying on normally, as though I haven't been in an operation, so I just fiddled about in the garden or in the house, and then the odd person would come to see me, and so I just carried on.

(Neal, 1: 17)

Carrying on with usual home routines and patterns helps re-establish a sense of order in one's life.

Homemaking consists in the activities endowing things with living meaning, arranging them in space in order to facilitate the life activities of those to whom they belong, and preserving them, along with their meaning. Dwelling in the world means we

are located among objects, artifacts, rituals and practices that configure who we are in our particularity.

(Young, 1997, pp.152-153).

Participating in household tasks and/or taking up responsibility for them again affected all participants to a greater or lesser degree. Dulcie described the sorts of things she had been doing within her limits of no stretching or reaching – tidying cupboards, ironing, dusting, as well as doing messages, visiting, or being visited.

By her fourth interview Dulcie was feeling she was back to “normal”.

Oh I think my recovery is really, well I feel I've completely recovered, that's how I feel. I seem to be back to doing all the chores, household chores, that I was doing beforehand.

(Dulcie, 4: 1)

Functional independence measured by the physical signs of self-care is not the only measure of recovery as it does not take into consideration the personal meanings of the illness event, and the context of daily life and activities which are important to the person (Doolittle, 1994).

While Connie continued to experience pain throughout the interviewing period, she endeavoured to participate in home responsibilities, either by herself or in partnership with her husband. Her activities included trying to scrub the kitchen vinyl, dusting, painfully making the bed with her husband's help, and making a big pot of soup (again with her husband's help). She was very pleased to tell me at our fourth interview that she had done some gardening (which was primarily her responsibility).

Mm, and I've done some gardening. Which is an A+ because I think that's marvellous because that's what's worried me – get the garden started. I just put some blood and bone on, around

the ground, so that's good. I think all those little things, I'm pleased about.

(Connie, 4: 3)

Connie was also pleased about managing to do some ironing. She was feeling more confident but got very tired.

Home activities gave the participants pleasure and a sense of achievement, for example, Colin split some wood, Will mowed his lawns and budded his roses, Owen swept the path. These were simple tasks which previously these participants had been unable to perform so they were also measures of progress. In Owen's case even though he was not in good health he wanted to do what he could within his limits as part of his usual way of being-in-the world. The older person with an underlying health problem(s) incorporates this within the everyday lifeworld. Surgery breaks into everyday life and therefore during the period of recovery there is the need to transform this experience into an aspect of one's life. Harry described his activity in the garden as "mucking around" and that he had never been a great gardener. His day was made up of what he described as "little things" – reading the paper, helping with the dishes, pottering round doing odd jobs, watering the garden, taking his wife to the supermarket, having a rest. He commented:

*Oh no, my day's pretty empty as far as that goes, just moving around, you know. ... I've seen the mint's grown up quite high, so I'll bring some in and make some mint sauce to put away, and those sort of things. They're just little things, but they're not important really, but they **are** just something to do. ... Oh yes, I've bottled about 20 bottles of apricots and I've done all that you know over the last week, yes.*

(Harry, 2: 14, 15)

Harry illustrates filling in time as an aspect of recovery as well as the need for rest following activity. He recognised the little things that occupied his

day but at the same time he was carrying out activities that were a usual part of his life such as bottling apricots. By our third interview Harry felt he could do most things for himself. He had mowed the lawns with the motor mower that week but when I spoke with him he was not feeling quite so well. His wife felt mowing the lawns could have contributed to his feeling of unwellness and had told Harry he should not be doing it. Harry's response was, "No, but it's something I've always done you know. It's been O.K. But ah..." (Harry, 3: 3).

Participants felt it was important to be able to carry on with their usual way of life as it gave structure to their days. There were tasks that needed to be done and being able to do them meant participants were regaining their place within that context. Particular activities were important in restoring balance in the participants' lives.

[Dasein] *finds itself* primarily and constantly *in things* because, tending them, distressed by them, it always in some way or other rests in things. Each one of us is what he pursues and cares for. In everyday terms we understand ourselves and our existence by way of the activities we pursue and the things we take care of.

(Heidegger, 1982, cited in Leonard, 1989, p.45).

Guignon (1993), in discussing quality of life, describes the constituent-ends way of living, that is, actions taken as central to constituting a particular way of life – one that is good because it consists of certain activities. One's actions are an integral part of being a person of a certain sort. "When life is lived as an on-going process of self-building or self-composing, it has the kind of cumulativeness and continuity that makes up authentic temporality" (p.231). In contrast to the constituent-ends way of living, in the means-end way of living the actions taken are in order to get something. Life is experienced as an episodic sequence of calculative strategies lacking any cumulative significance or overriding purpose. Eighty-eight year old Peter provides an example of "picking up" a previous activity which was important

to him.

I had 40 years in the ministry, and then I continued after I'd retired, visiting elderly. I'm still visiting the elderly. There's a lady across the road who's very sick. I went across the road the other day to see her, and chat with her, cheer her up.

(Peter, 3: 10)

Peter illustrated the notion that one's actions are an integral part of being a person of a certain sort.

Matt's environment helped restore balance in his life. He had given some thought to how it had helped his recovery.

It seems stimulation from the family, to see the farm operations going, and to have them calling in and to have friends calling in, and I feel sure that the fine, warm, bright weather has helped us too. The mornings and the sunrises and the sunsets are beautiful, and to breathe in the air, and see the mountains, and then, on top of this, the constant attention of the wife.

(Matt, 3: 4, 5)

People and the land were essential for Matt's well-being and interacting with both brought harmony in his life. These were the things he cared about. The friendliness of the small community in which Matt lived contributed to this.

Dulcie described the activities that were important to her.

Yes, I'm back to being so busy that I don't have enough time to do the tasks (laughs) inside the house. Because I'm going to bowls, and the garden needs attention at this time of the year and I like to do that, and visiting people I haven't, I think I'm making the excuse that I have been sick (laughs) and I haven't

had the time, and I still haven't caught up with friends, but I'm always in touch with them on the 'phone.

(Dulcie, 4: 3, 4)

Dulcie had entered fully into the everyday life she experienced before her surgery.

Connie was used to working in partnership with her husband in the sharing of household tasks. Her progress was slow and at times seemed not to move forward at all. At our last interview aspects of a return to her everyday life were apparent.

No, we've been doing lots of things, extra actually because we've been doing bits of tidying up out in the sheds, and that's quite an effort, you know? So yes, I'm improving.

(Connie, 4: 5)

Being able to do "extra things" was a sign that Connie was moving forwards as extra things were those beyond the essential tasks. Leonard (1989) notes, "Another aspect of Heidegger's account of significance is the way in which our activity is directed in a transparent, taken-for-granted, nonmental way toward the future (the 'for-the-sake-of')" (p.45).

The participants' re-involvement in household and social activities helped re-establish taken-for-granted patterns and routines of everyday life and to move toward restoring balance. Patterns and routines may have required adaptation to take account of altered abilities or physical limitations.

FACING REALITY

Facing reality is reflected in Gadow's (1982) fourth level of body and self dialectic. Gadow posits that the body in aging and illness insists that its own reality, complexity, and values be supported and that acceptance of that insistence as valid is recognition of the subject body. The self's recognition of the subject body as another manifestation of selfness provides a new relationship – intrasubjectivity.

The difference between the subject and object body is the concern directed toward the *experience* rather than the concept and image of one's body.

The opportunity for concentration upon the body, and thus for aesthetic regard toward it, is pronounced in aging and illness. The body establishes itself in the foreground of attention, insistently reappearing out of the background of mute immediacy until it engages our full concentration. Thus the body as object of concern replaces the lived body – inexorably in aging, intermittently in illness.

(Gadow, 1982, p.98)

Gadow continues that to the same degree that the body becomes an object of concern it can also become an object of aesthetic regard; that the "facts" of the aging body can be seen as symbols rather than finalities. In aging and in illness "the subject body expresses itself as a reality with its own meanings, values, and purposes" (p.99).

Gadow counters a negative view of aging and illness by demonstrating that situations which arise in aging and illness can be seen as having positive meanings. For example, in aging, the particular phenomenon could be considered to be "the body's expression of its own determination, aim, or purpose... when it is regarded as the symbol for a value" (p.95). Illness, Gadow proposes, is an "experience essential in human existence" (p.99) as

it allows one to experience the aesthetic relation to the body which in aging may be sustained.

“I Just Have to Accept it”

Walton (1995) reminds us that, “the recognition of our need to face up to our lives as they are is part of the challenge of authenticity” (p.203). Both Matt and Nell provided an example of this in their desire to make the most of what was left of their lives. As Heidegger (1962) states, “Dasein is authentically itself only to the extent that, as concerned Being-alongside and solicitous Being-with, it projects itself upon its ownmost potentiality-for-Being rather than upon the possibility of the they-self” (p.308).

Authenticity is characterized by a distinctive temporal structure. Where inauthentic existence is lost in the dispersal of making-present, an authentic life is lived as a unified flow characterized by cumulativeness and direction. It involves taking over the possibilities made accessible by the past and acting in the present in order to accomplish something in the future.

(Guignon, 1993, pp.229-230).

Acceptance might mean the participants coming to terms with the restrictions of their situation. Harry who had always been an active person had to deal with relative inactivity after his surgery, “Well, I suppose that’s part and parcel of it” (Harry, 2: 9). Participants had to accept following surgery, that they might be as or more limited in movement than they were before surgery. As Simon pointed out:

Well, of course, you’re balancing one set of limitations with another. I mean, the new hip, there are so many things that I couldn’t do, was told not to do, you know, that in itself was much more restricting in a way than the pain in the hip had

been previously. (laughs) But, you know, you expect that is only a temporary phase.

(Simon, 3: 8)

Surgery sets up the expectation that there will be an improvement in the condition but this is not always the outcome. Participants had to accept a continuing state of illness, discomfort or pain, or the possible return of the health problem. Sometimes it might mean the possibility of settling for less as in Will's case in the use of his arm.

*Prior to the operation, it was working 70, 75%, it was only 25% disability, and this is what you hope to retain, this is what you **hope** to gain from having the operation. And yes, you know, 24 of that 25% is back. And the other one per cent really doesn't matter. You can live without it.*

(Will, 4: 7)

A degree of pain and/or discomfort was expected and accepted by participants following surgery. Colin accepted the pain affecting his arm even though exercising the arm or holding up a book or newspaper caused more pain.

I find that the muscles really protest, and yet I recognise that that is part of the growing healing move, and I've got to keep on with discipline and exercise, and that's part of the price, but I never realised that a wound could take so long to be restored.

(Colin, 4: 1)

Colin accepted the need to carry out the exercises and recognised the discipline required. Like Colin, Will at times had to push himself to do his exercises.

Yes, it's just something you have to do, yes, it's not essentially a challenge. It's something that, yes, I was told I'd have to do

exercises and that was it, I did them. It's just reality, and we do them, a fact of life. It's no good dodging things. (laughs)

(Will, 3: 7)

Accepting the reality of the discipline of exercise meant participants realised this was necessary to make gains in their recovery. Accepting that one may need the help of others in achieving improvement was a difficulty for Colin. Colin found it hard having to accept the help of others because of his incapacity.

In fact I've never been so non-productive, and so almost useless, in my whole life. I've always been active, always been insistent at doing things. Now I have to sit back, and let others do things. That's been the hardest battle for me to face.

(Colin, 2: 9)

Participants were realistic about accepting restricted activities, pain, the discipline of exercise, and the possibility that the outcome of surgery might not mean full recovery.

Facing reality also meant accepting things as they were and that some things were not going to change. For at least three of the participants other health problems were of such a nature that they overbore and intruded upon their recovery from the current surgery. In our conversations Neal talked often of "feeling relaxed" and I asked him what he meant by that. "Well, feeling relaxed to me is accepting things as they are" (Neal, 2: 16). He later explained further.

Accepting the lot, accepting the fact that well, I mean, you've got an illness, you accept that fact and that's it, and accept that everything's going well. And I do feel that. I do feel that, everything is going well for me.

(Neal, 2: 17)

Neal had been healthy all his life until his first operation and he saw no reason that he should not continue on living his life as he did before. He accepted what had happened to him and got on with the job of living.

Nell accepted that back pain would continue for her for the rest of her life. Her recent surgery had dealt with the pain down the back of her legs but the other pain would remain, "And I just have to accept it" (Nell, 4: 2). Owen accepted that he had made a good recovery from his surgery but that the benefit of the recovery was affected by his heart problem.

To me it was rather disappointing that in view of the fact that... I seemingly had made a good recovery from this problem, and that this other thing had come back to spoil things, and limit the amount of pleasure that I could still obtain from whatever amount of time I have left.

(Owen, 4: 10)

These three participants had accepted the reality of living with previous health alterations and assimilated the current operations into the pattern of their lives.

"It Takes Time"

Participants had to accept that the time they might be incapacitated or had to allow for recovery was longer than expected. This involved waiting or marking time.

Ben felt his operation was relatively minor but there was a considerable time to wait before his arm would regain full mobility.

I go entirely by what the surgeon tells me. And he tells me it could be six months all told, as much as six months, for it to be

quite normal, and I had hoped that it was earlier but, we all expect that, I think.

(Ben, 1: 11)

Accepting the time needed for healing allowed Ben to have realistic expectations of his recovery as was the case for Colin. Colin did not initially realise how long his shoulder would take to heal but the continuing pain and discomfort reinforced the need to accept this was so. "But I recognise the fact that it takes time, and one has to be very careful and patient" (Colin, 2: 3). As the time Colin thought it would take for his shoulder to heal became extended he had to readjust plans. Dulcie expressed her feelings when faced with a six week period of restrictions.

Yes, yes I think I was so frustrated at the beginning, I couldn't believe that I had to watch what I was doing for six weeks, but I also knew that my body wasn't letting me do the things that I wanted to do, and I wanted it to heal too.

(Dulcie, 4: 11)

Despite finding the limitations frustrating Dulcie accepted they were necessary and knew from past experience it was unwise not to do as advised. Like Dulcie, Connie accepted the time for recovery and the presence of pain. Her hope for recovery was that there would be no more pain from her shoulder but the reality could be something different.

Oh well I don't think I'll ever be out of pain. I mean he's taken out the cement, and the chips of bone, perhaps and, I'm hoping that with that positioning he did different, might make a difference when it's better. You see, it does take months doesn't it? But then they say it takes six months to get anaesthetic out of your system. So, it's going to be a long journey I guess and all I need's patience.

(Connie, 3: 28, 29)

Connie accepted that recovery was “going to be a slow process”. Simon, also, had expected his recovery would be slower but, “a number of people have said that I’m doing very well, and I think I’m just grateful for that. I’ve still got sufficient recuperative powers to get over it” (Simon, 4: 9). Earlier he had said:

It’s a matter of waiting and seeing, I think, how quickly I get back to that mythical stage [recovery] that I have to arrive at.

(laughs)

(Simon, 3: 13)

Recovery for Simon meant enjoyment of those things that his immobility had prevented him from doing for some time and he was looking forward to returning to or picking up those activities.

The surgical experience has to be integrated into the personal meanings of the person in a temporal sense. As the person moves through recovery they have to understand how the changing nature of wellness has meaning for the self, such as in the habitual body and bodily ways of being in the world. During recovery, periods of inactivity may cause frustration especially when there is a gap between what the person expects their body to do and what it is actually able to do (Benner & Wrubel, 1989). Recovery enables the person to reclaim, “a sense of embodiment that allows for taken-for-granted unselfconscious transaction with the world” (Leonard, 1989, p.48).

Facing reality meant incorporating into everyday life a situation not previously experienced, for example that one’s arm might not return to 100% mobility. It meant also foregoing or postponing planned activities. Both accepting it was just a matter of time before they would “get better” and accepting their health was not likely to get any better were in the spectrum of reality for participants and had to be incorporated into everyday life. For some of the participants aspects such as pain, discomfort and limitation had to be incorporated into their day-to-day life: for example, the

pain and limitation of their shoulders for both Connie and Colin, the incomplete mobility of their arms for both Will and Ben. Harry provided an example of incorporation when while he was waiting to have his large bowel rejoined he had become accustomed to the temporary ostomy.

*No, I could live with a bag [ostomy bag] it wouldn't worry me two hoots, provided that [ostomy hernia] is fixed up. You know, I've got used to it, and as I say I could live with that, if it had to be, if he can't connect it up well it wouldn't worry me two hoots. If he [has] trouble, you know, trying to connect it up, I just say, "Don't bother, just fix that up so the hole's in, and I can live with that. Because I know jokers that've had, well I've spoken to a lot of guys that've had bags for **years**, and you wouldn't know.*

(Harry, 1: 9, 10)

Because of complications after Harry's original surgery for cancer he had been waiting for some time for his surgery for the rejoining of his bowel.

The recovery from the operation about which Harry was interviewed was regarded as one operation in a series and one part of a process. "It's something I've got to live with, you know" (Harry, 2: 13). Harry had "learned to live with" and to manage his herniated ostomy and described in detail how he dealt with applying his ostomy bag. This was a daily situation he had to deal with whereas his operation for adhesions was "obscured" or hidden from him. Neal was in a similar situation to Harry in that his operation for a hernia around his ostomy site was over and dealt with whereas dealing on a daily basis with his ostomy and urinary catheter was always with him. As Neal said, "I got used to the catheter, and it's now, that's been since February, you see, I've got used to that now and it's just part of normal life now." (Neal, 4: 2). Earlier he had stated, "I accept my situation, as just part of life" (Neal, 3: 8).

“But”

Part of facing reality was recognising there were gains and losses.

For participants the gains of their operation were often accompanied by hurdles or barriers to progress or in reaching goals. Along with this there were periods of time when losing ground, standing still or plateauing, and having to wait for a change or progression in health, occurred. Progress was sometimes aligned with a “but”. For example, Connie began to carry out activities **but** experienced tiredness, she might have a good night’s sleep **but** her arms became stiff as a result; Dulcie was pleased with her progress **but** she was left with a bladder problem.

Colin and Will provided examples of gains during recovery. One gain for Colin was the recovery time provided him with the opportunity to do the study he had been putting off. His accident had created the opportunity.

And this has been very beneficial, and in fact, I’m continually thankful for the whole thing. There are times I wince a bit, I’m thankful for it. It just makes me think why I would’ve done what I did, allowed this to happen, but it was an accident.

(Colin, 2: 14)

Will’s gain was related to his exercise programme. He was found to have a small tear in his left shoulder (the right shoulder had been operated on) and the exercises he was doing had helped.

And, if anything, the left shoulder’s getting better. (laughs) It’s a wee bit of a blessing... I feel good from doing the exercises, yes. I have to do one where I bend over and swing my arms around, I could almost touch my toes again. (laughs)

(Will, 2: 15)

Will had begun swimming again as part of his exercises. At first he could only swim two lengths with much “huffing and puffing”:

After I'd been there a little while, and did two lengths I never puffed. So, O.K., yes, if it got me back to swimming again more seriously, I think it would be great. All these little benefits you get sometimes, from a misfortune.

(Will, 2: 15)

Will enjoyed his time in the pool and gained from the exercise that swimming provided. He regarded these as pluses.

Will had been told it could be twelve months before the aches and restriction of movement could disappear. His application to his exercises meant he was ahead of the expected level of movement, but had faced and accepted the reality that it could be a year before his shoulder movement was 100%.

As mentioned previously progress was often aligned with a “but”. Participants were aware of the reality of their situation and appreciated the positive and negative aspects of their situation. In the following examples the “but” has been emphasised in bold [my emphasis]. Connie expected and accepted pain, “**But** I think I've had my share” (Connie, 4: 15). Harry considered how the operation affected him.

*I think you're having an operation and that pulls you up a bit because you can't do things that normally that you used to do easily, easily. You might when you've fully recouped **but** it's not easy at the moment. If I walk round the block a couple of times, I could walk all day years ago you know it wouldn't worry me two hoots. **But** I think if I walk around the block a couple of times, I think I'd be crawling the last quarter. (laughs)*

(Harry, 4: 8)

Harry shows the acceptance of a period of time when usual activities are affected and are carried out with a degree of difficulty. As an active person the length of time Harry had been unwell affected activities he enjoyed.

*I want to get moving around. I don't like just sitting around. It's been, I've had enough of that for a long time. I go down to the farm, my friend's farm, and say, "I would like to be out and doing something, driving the tractor or something like that". Which I do do the odd one, **but** not like I used to do. I couldn't spend a day on it, like I used to do.*

(Harry, 4: 3)

While unable to participate in farm activities Harry saw this as a temporary situation and he was sure he would be back doing the things he had done before. Frank had a similar expectation to Harry. However he accepted reality even though he wished his situation was otherwise. He was going overseas and on his return would be seeing his surgeon.

*And that's when I'm hoping you know there'll be all sorts of magic words and say, "Well, you're 99% recovered. Go straight round to the tennis court". (laughs) **But** in my own mind I think it's going to take a bit longer than that.*

(Frank, 1: 22)

The inability to do the things one usually did was also coupled with things one planned to do. The period of recovery produced a hurdle or barrier to undertaking planned activities and so resulted in a loss for the participant.

Suddenly I faced the fact I cannot do all the things that I was programmed to do. Like finish off a building and all that kind of thing, I've got to sit back, until I'm totally restored, so that's a factor, whether I like it or not, has to be considered in a length of time.

(Colin, 4: 7)

Colin had also to alter travel plans. When I first spoke with Colin he expected to be going overseas at the planned time. As time went on the date for travel moved further away.

I was being too hasty, yes I am. [in terms of time periods] I've had to cancel an overseas ministry in the Philippines because I couldn't carry the bags. And that would be most uncomfortable. One arm is not enough, you usually have something else. So I just have to wait until everything's right again.

(Colin, 2: 4)

Colin provides an example of all the aspects of facing reality - acceptance, incorporation, and gains and losses. Connie exhibited these aspects in her interviews though gains were not primarily evident during the period of the interviews because of the expected length of time of recovery. There was a sense of betrayal or broken promises in that expectations for relieving pain had not yet been realised by the time my association with Connie ended.

The sense of being "let down" is conveyed in Connie's comment.

You sort of don't hear much about the old shoulder replacement. There you are you see and when I had it done first they said it, well, at first they said at least you won't have to have it redone like they do the hips, that come out all the time. They were the good words, weren't they? (laughs)

(Connie, 4: 13)

Connie's "let down" feeling was conveyed also by Neal, Owen, and Harry who developed bowel cancer despite following what they considered were good dietary practices which should have protected them according to the publicity.

Facing reality meant accepting an interim situation (e.g. pain and limited movement); accepting things as they were in everyday life; accepting the healing and recovery would take time and would require adaptations in expectations; incorporating meanings of surgery and recovery into everyday life, and accepting the gains and losses which arose during recovery.

TAKING A STAND

Hall (1993) comments:

We take a stand on our own being whenever we choose a particular possibility or project. Every purposive, future-directed choice made from among the culturally determined alternative possibilities expresses an understanding, in Heidegger's sense, of what is to be a human being (BT 185-6).

(p.137)

In referring to Heidegger's special use of the term "understanding", Guignon (1993) expresses it as Dasein having:

always taken some stand on its life insofar as it has undertaken (or drifted into) the vocations, roles, life-styles, personal relationships, and so on that give content to its life. Because our familiar skilled activities embody a generally tacit "knowhow", a sense of what things are all about in relation to our practical concerns, taking a stand is to be a "projection" of possibilities of meaningfulness for things and ourselves.

(p.9)

For the participants taking a stand included making choices, for example, choosing a particular course of action, setting goals and deciding on or working on projects, and taking stock of one's life.

"They're the Choices You Make"

"The world of Dasein is the milieu not just of presence but of possibility as well and, more specifically, of the possibilities that correspond to the choices a particular Dasein can make and to the actions it can perform" (Olafson, 1993, p.101). In making choices participants sought knowledge

and answers so that they could make decisions and set goals. It involved participants taking responsibility for their health for example by planning for follow-up medical checks.

Peter had to consider whether to give up his home and go into a rest home. In making a decision he considered his elderly dog. He had thought he would wait until the time when the dog would need to be put down and then go into a rest home where he would have his independence but also have the care and help he now needed. At our first interview Peter had his son staying with him but he was about to return home which was some distance away. Peter was planning to have someone come in each morning to make his bed and clean up the kitchen. At our second interview Peter told me of a family conference about his future where alternatives had been considered.

And the third alternative was that I get a bit more domestic help.

And that is what I've done. I got a bit of domestic help because it's stooping over the dishes which makes my back hurt.

(Peter, 2: 3)

Peter was very fond of his home which he had lived in for many years and with a variety of help in dealing with the effects of his increased health problems he planned to continue living there for as long as he was able. His freedom of choice of the possibilities available to him was circumscribed by his situation hence according to Heidegger's notion his freedom was situated freedom (Leonard, 1989, p.44).

Participants chose particular courses of action in relation to their health. For example, Owen had not thought much about the future in terms of his cancer but had decided he would ask his surgeon about having another colonoscopy "at some future time, perhaps in the next twelve months or whatever" (Owen, 4: 10). Owen monitored his health carefully and this was an aspect of his taking care. He had initiated the original investigations for his bowel cancer after a prolonged period of symptoms. Will had made a choice about continuing his arm exercises.

He [surgeon] has suggested that I do these exercises for the rest of my days. Not the lot but the ones I feel are helping. And particularly perhaps to concentrate on the more difficult ones for a little while, then just to do just a few simple exercises every morning for the rest of my days. But I don't think I'll do that.

(Will, 3: 1)

Will had decided with his bowling and swimming that this should be sufficient to keep his shoulder mobile without continuing with the exercises. He enjoyed both bowling and swimming whereas he had had to really discipline himself to regularly do the exercises. He had made a choice which fitted into his everyday life seamlessly. Several participants made choices about “getting off drugs”, in the case of analgesics. Analgesics were reduced or participants stopped taking them as soon as they felt they no longer needed them.

In the process of making choices and deciding on the best course of action participants sometimes had to weigh up the best option. Colin made a choice about not wearing his brace because it interfered with his way-of-being-in-the world. While Colin welcomed the brace as a means to rest and protect his arm he felt there was another aspect to wearing the brace in his situation.

Yes, and there's a psychological side to all this. You put a brace on, go in to church, I was ministering yesterday, and I deliberately did not have the brace on. Someone said, “You should be wearing the brace”. No, I'm not going to. That immediately draws people's sympathy and attention. It's a focal point, and that wasn't to be the focal point. The focal point was meant to be what I was saying, and doing with the people.

(Colin, 2: 11, 12)

An authentic stance toward life makes us face up to the fact that to the extent that we are building our own lives in all we do, we are “answerable”

for the choices we make. At the same time, to be authentic is to recognise circumstances may arise to force us to take back our basic decisions.

Thus, authentic Dasein “resolves to keep repeating itself” (BT 355); that is, it keeps renewing its commitments to knowing that it might have to change its course. Repetition imparts “constancy” to one’s life, making it clear that, in the end, we *are* what we *do*.

(Guignon, 1993, pp.232-233).

Colin had a clear intent not to draw attention to his surgery but at the same time was ever mindful of taking care and preventing harm to the healing part. He had also to make choices about his future plans, for example, he chose to cancel his planned overseas ministry.

I still feel right about that. And that’s very definite. I, besides that I have commitments, selling a home up north, and having to go up there at the same time, so I had to sacrifice one thing or the other. And see, I’m not quite physically right yet, and shifting things is better than going overseas, that’s why I notified them.

(Colin, 3: 4)

Colin felt comfortable about making this decision and his reasons for doing so are reflected in Heidegger’s statement below.

The options that I take shed light on what was important to me all along, on the endurance and the strength of my commitments (or lack thereof), and so on... as long as Dasein is, it can choose its possibilities; hence, as long as this “ahead-of-itself” item in the structure of Dasein is not extinguished, Dasein will be characterized by a “lack of totality” (BT 279).

(Heidegger, cited in Hoffman, 1993, p.196)

Choices made reflect the type of person we are. Gullickson (1993) talks of a future that is one of possibilities where new possibilities emerge that provide meaningful insight into how one chooses to be. "Creating and re-creating a future of possibilities requires reciprocity. As individuals we shape and are shaped by our concern and caring." (p.1390).

Three participants spoke specifically of making the choice of having the operation in the first place. Nell, who had suffered pain with her problem for the previous three years, knew the probable outcome if she did not have the surgery.

Oh no, I knew that the game was up as far as going out, and this house was concerned, everything, everything was concerned, because I got to the stage where I couldn't walk from the chair to the sofa.

(Nell, 4: 9)

Nell was prepared to take the risk of surgery to better the quality of her life. Simon's decision about having his hip replacement rested on a number of factors, including his age (78 years).

At this stage of life you become very aware of how rapidly everything is deteriorating. You know I've spent the last... 12 or 18 months having little bits taken out, you know, skin cancers, things like that, and it all sort of adds up to this general pattern of deterioration. //.. one of the things that weighed heavily in making the decision to have the hip done was my other complaints, whether it was worthwhile to go through all this. I tossed up, you know, and just got to take it the way it comes out... The last four and a half years [I've been] through a lot of problems.

(Simon, 4: 8)

Simon made his choice about having surgery but his recovery was not yet at the point where he was assured that he had made the right decision. Will is the third participant who spoke about the choice of whether to have an operation or not. While Will felt the operation had fulfilled his expectations, he went on to say that if he had not had medical insurance he doubted if he would have had the surgery, "I'd have had to think very seriously about it, mm" (Will, 4: 8). He commented that a lot depended on one's financial circumstances, for example, whether one was a millionaire or on a reasonably average income. In the latter case it could be a choice between having the operation or going on a trip to Australia. "And they're the choices you make. So I think I'd have gone to Aussie with a bad shoulder. (laughs) (Will, 4: 9). (Will had family, including grandchildren, in Australia). He was one of several participants who had medical insurance and who expressed similar sentiments.

For each person, the assessment of progress and recovery is based on possibilities within a context or within a situation. For each individual the social context may differ, yet the return to activities that matter marks recovery. Through involved recovery, people begin to understand themselves in terms of their possibilities instead of their deficits.

(Doolittle, 1994, p.216).

Making choices involved considering the possibilities available to participants in their particular situations. They considered alternatives, made decisions about the future, and weighed up options to choose the one best suited to their circumstances.

"I've Got Plenty to do Once I Get Better"

Possibilities may come to fruition through goals and projects. In Heidegger's terms a goal is expressed as "toward-which" while purpose is "for-the-sake-of-which". Our projects and goals are linked to the past because they arise out of the past while at the same time they are tied to

the present because of our absorption in and with our everyday world – yet they are future oriented. Recovery was both the present and the future in that participants were experiencing recovery in the here and now and at the same time working toward it. They had goals to reach along the way and signposts by which they measured progress. These goals and signposts were related to both their health and to their everyday life.

Matt's goals, which would enable him to return to everyday activities, provided something to work toward as well as acting as a measure of his progress.

The blackcurrants are ripe to pick, and I could do a little picking, but if I, you know, in another fortnight I'm looking forward to say picking, bending down, and picking, and this sort of thing, and going round the sheep. We've got this small farmlet, and I can do the sheep and that. More easy I can get over gates and that sort of thing later on. And I'm not quite up to hoeing the garden yet. You know, I don't think that is, I'm just not fit to do that yet but maybe in another week I might be able to do a bit of that.

(Matt, 2: 10)

Matt had his goals but at the same time he was realistic about his abilities. Harry, like Matt, had projects in mind once he was feeling better.

I've always liked mucking round with machinery, and doing odd things, you know. I've got plenty to do once I get better, a bit better, I've got, you know, jobs lined up, yes. Different things to do.

(Harry, 2: 9, 10)

Harry serviced his own vehicles and described himself as “mechanically-minded”. He was determined to be able to return to working with his vehicles. Harry was very proud of his motors and showed me both his “Bronco” and his sedan car.

“I’ve Got to Make Use of Every Day”

Authentic self-focussing is said to require such traits as resoluteness, steadiness, courage, and, above all, clear-sightedness about one’s life as a finite thrown projection. It calls for integrity and a lucid openness about what is relevant to one’s actions. The authentic stance toward life makes us face up to the fact that to the extent we are building our own lives in all we do, we are “answerable” for the choices we make.

(Guignon, 1993, p.232).

As considered in Chapter Six, the attitude displayed by participants was indicative of their commitment to their chosen course of action. Determination, optimism, faith, and having a purpose in life were features of this. Attitude and commitment involved getting on with life despite distressing health problems. Hope also played a part – hope that the operation would be successful, hope that symptoms would improve, that pain would lessen, that the area of the body would function better.

Frank (1995) believes patients display heroism in the face of bodily breakdown. “They live out illness as a matter of doing their jobs as patients, preparing for the future after illness, and getting through their own days” (p.93). They want their body’s former predictability back again. Frank points out this is not just the mechanical functioning of the body but that what needs to be staved off is the deeper contingency which illness represents, the contingency of mortality (p.85).

Doolittle (1994) comments, “Individuals have a bodily set that responds to the environment in terms of a sense of its own goals. Bodies recognize complex patterns in precognitive ways, thus allowing transparent access to the environment.” (p.218). A change in Colin’s bodily set affected his stance in his world. Colin felt his operation had, “taught me quite a lot of things” (Colin, 4: 8). He talked about growing older, and having physical defects and that these changed one’s whole outlook, that you either slowed up or

you saw things differently. "Whether we like it or not, all of us have to go through that part of life" (Colin, 4: 9). The combination of his recent retirement, his accident and the resulting surgery had caused Colin to reflect on / take stock of his life.

And whether I like it or not, and nobody really wants to get old, and told, "Oh you're looking old", it's not a bad time. It's a good time. It just means reassessing values and goals, and working accordingly to get the best out of life, in the time that's available, and the things that we could do. And I think it's a very important time. It has to come.

(Colin, 4: 7, 8)

Colin went on to talk about the contribution older people could make, that there were still things to do in one's 70s and 80s, and said, "So it's not a negative, it's a positive" (Colin, 4:8).

Owen, Matt, and Nell had also reflected on their lives after the surgery and they had come to a decision as to how to approach life. Owen's attitude was, "I guess, now, that I can see I've got to make use of every day" (Owen, 4: 14). Matt commented, "But the other thing that dawns on you after surgery at this age, is that you must make the most of what's left of life" (Matt, 4: 9). The other aspect for Matt was:

The effect of this operation has tended to be on me, that I'm going to look after, I'm going to make a better job of looking after each of my body parts from now on. (laughs)

(Matt, 2: 5)

Nell considered she was living on borrowed time anyway as it was well over six years since she had a heart bypass operation. Her back operation had given her a new lease on life both figuratively and literally, "And whatever I enjoy now I enjoy to the full, but when things start to slip, I think I've had enough" (Nell, 4: 6). Nell was optimistic about her future and her attitude

was one of taking life full on but at the same time she was realistic about her health problems and their outcome. The stand taken by participants in their recovery demonstrated what was of significance and value in their lives.

EXTENDING BOUNDARIES / LOOKING TOWARD HORIZONS

Heidegger (1971) describes the concepts of boundary and horizon in relation to space. He said that space is:

Something that has been made room for, something that is cleared and free, namely within a boundary, Greek *peras*. A boundary is not at which something stops but as the Greeks recognized, the boundary is that from which something *begins its presencing*. That is why the concept is that of *horismos*, that is, the horizon, the boundary. Space is an essence that for which room has been made, that which is let into its bounds.

(p.154)

This notion is reflected in the way participants tested their limits in order to move beyond them. For example, the close-at-hand boundary of physical limitation could be regarded either as a temporary or false horizon, as the participants sought to go beyond it, or something that was a beginning for a new pattern in life. Extending boundaries meant reaching beyond the life circumscribed by surgery.

“I’m Going to Live Life to the Full”

Simon extended his boundaries through exercise, increasing the time and distance until he was walking a mile without having to use a stick. He decided on his walks to take his crutch with him, “and then if I get a bit tired I can take the weight off (Simon, 4: 1). Even though Simon extended his

boundaries he was taking care of himself and being careful. Nell was of similar mind. She was participating in the social activities she used to before her surgery but at the same time thinking about managing the particular activity to reduce tiredness and pain.

But I'm going out tonight to [name of shop] and they've opened it up to customers only and I'm going to do all my Christmas shopping there tonight. Well, I'll be walking round there for quite a while and I'll be very exhausted when I get home. I'll drive there and drive back and pop into bed. And that's it. But I think that if you rest like that you're right.

(Nell, 2: 13)

Like Nell, Neal prepared for extending his boundaries. He had not driven his car for about nine months because of his operations, and had taken it to be serviced in readiness for his use.

But now, I feel, myself, I'm back to more or less normal routine now. And now I've got the car, I've got the car ready, I just have to go out and get my test now, and I shall, I don't know what I'll do but I mean I'll be doing all right. (laughs)

(Neal, 4: 7)

Part of recovery involves testing limits including stepping beyond self-imposed limits. Participants tested their limits carefully. They decided when it was safe to step beyond the limits, for example, those imposed by physical incapacity, and when to extend social horizons beyond home and community.

Participants tried activities as they felt able. Sometimes these were successful, sometimes not. Connie, with her restricted shoulder movement tried to tong her hair, "I couldn't, I gave it up" (Connie, 4: 9). Dulcie had a six week moratorium on a number of activities she enjoyed, one of which was gardening which she was looking forward to picking up again. Soon

after her surgeon said she could recommence activities she was in her garden and trying to follow his instructions not to lift anything.

He said wait 'til your family comes round. But as I said to you before, that's hard to do because if they're busy you might wait for a few days, (laughs) and you get impatient to do that, and I think you've got to learn to wait, but I'll try.

(Dulcie, 3: 5)

Looking toward horizons meant looking forward, looking to the future. The following statement was made in the 13th and final episode of a 1993 television programme entitled "Growing Old in a New Age":

It is not so much what the future will be but how we want the future to be. The future is the arena of possibilities. There are no future facts, there are no past possibilities, the future is the arena of possibilities, of hope, of invention.

This presents a positive view of the future as one grows older. Crotty (1996) states, "human being emerges as primarily a projection towards possibilities and, as Heidegger sees it, our possibilities are a gift of the future, not the past" (p.87). Making plans provided something to look forward to in the form of a goal or a hope. In having a plan the person has made a choice, selected an option. According to Heidegger, the future has priority over both the past and the present in defining the being of the self – what the person is aiming for in life determines both how the past can be encountered as providing assets for the present and how the present can show up as a situation demanding action. The future, however, also has priority because, insofar as a person's actions commit them to a range of possible ways of being in the future, their future-directedness defines what their life – that is, their "being" – is adding up to as a totality, "right up to the end" (Guignon, 1993, p.9).

Participants made plans for activities, travel, a holiday, painting a house. Colin used his time of inactivity to read and study in preparation for, "the rest of the ministry this year and I know there's a lot of things coming out of overseas work" (Colin, 2: 13). For Colin his recovery engendered, "Very, very real positive feelings to me personally, that I can approach overseas work, as well as in New Zealand, without any real anxiety (Colin, 3: 7). Fitness for Colin meant, "I can achieve the goals I set before me. For me, it's travel back overseas" (Colin, 4: 6). He was reassessing his goals for the future but at the same time had to keep in mind the selling of his home and buying a new home, "so I've got to keep those plans, you know before me. That's why it's wise not to go overseas [at] this time (Colin, 4: 7).

Frank was looking forward to playing tennis and doing his garden. He thought his recovery would not take long and talked to his surgeon about it.

I was sort of thinking that it wouldn't take long and I asked him silly questions like, "Will I be able to play tennis before the end of the year?", and things like that, (laughs) and he, I think he was kind. He didn't say, "No, you can't", but he said, "I think it might take a little longer than that". (laughs)... No reason why I can't get back but he didn't say specifically, "You'll be there".

(Frank, 1: 9, 10)

Peter was planning to see the new millennium in. He was proud of being 88 years of age which he attributed to his family, "I come from a long-lived family," (Peter, 4: 6). He was mindful however of the threat of his cancer's returning and qualified his statement:

Well, if the disease doesn't come back. If it doesn't, I could go on for, I don't think I'll make the second millennium, but I hope to meet this one.

(Peter, 4: 7)

Peter had a goal but balanced it with reality as did Matt. At our third interview Matt was thinking ahead about jobs to do. He had assessed his progress after his hip replacement and did not consider he was ready to tackle one particular job.

For example, there's parts of our house need a coat of paint. The house is half brick and half boards, but I wouldn't be game to stand on a stepladder yet, with some paint and put it on, but I think I could in another month.

(Matt, 3: 9)

Matt had other smaller tasks planned such as fencing, helping his wife with the garden, picking the blackcurrants. He was more confident about undertaking jobs but illustrates a common feature of the participants in their desire to take care not to do anything which might impede their recovery. Nell planned to return to the exercise sessions run by the Arthritis Society as soon as she was able. She enjoyed them immensely and was looking forward to attending them twice a week. Her operation had given her a new lease on life which encouraged her to think of travelling again. She had travelled widely with her husband and had continued after his death until her physical condition prevented this. By our second interview she was already making plans for possible travel and by our third interview the plans had come to fruition.

I've arranged a couple of days ago to go to Wellington for Christmas which I didn't think I ever would, and I had a ring from my niece in [Australia] and she has said, "Now you're better, what about coming to see me?", so I've booked for May. And I'm going over to see her and I'm just trying to do everything I possibly can because I've got no pain, and until the next thing arrives, I'm going to live life to the full.

(Nell, 3: 7)

Nell's statement, "until the next thing arrives" reflects the experience of other participants, when they are dealing with more than one health problem at a time or new problems develop. The older person with other health concerns accepts these as part of a permanent background and their coming to the foreground intermittently. Health status may vary from day to day so that in some senses every day is a new beginning in terms of health. During recovery from surgery the reason for the surgery took precedence but at the same time other problems arose which were unconnected with the surgery. For some participants these problems were already present; in some cases new problems came to the fore which pushed the operation to the background and hastened its departure to the past. The placement of the surgery in the past was evidenced by **forgetting**.

"I Don't Even Know I've Had an Operation"

Heidegger (1958) states, "for the ordinary conception, forgetting easily takes on the appearance of mere neglect, of a lack, of something disagreeable" (p.89). Through habit forgetting and forgetfulness are taken as an omission. Forgetting is a concealment of the present while remembering is unconcealedness of what has been concealed. According to Hoffman (1993):

The overall attitude of "expecting" one's future and of "forgetting" one's past shapes one's inauthentic stance toward the present, the stance of "making present". The inauthentic Dasein's search for security is reflected in a collection of entities – of persons, things, goods, and so on – with which this sort of Dasein surrounds itself (and thus "makes present" these entities) in order to gain a sense of having a place within the reassuring world of the 'they' ".
(p.207)

For the participants forgetting or not remembering was an element of the past and it was also a facet of looking forward toward horizons. Forgetting occurred on several different levels. For example, forgetting an operation had taken place; forgetting about aspects of the outcome of the operation such as exercises or symptoms; or viewing the act of forgetting as a sign of progress.

The experience of surgery was put in the past and because participants had moved on they *forgot* they had had an operation. The experience had been removed from their conscious/current state of being-in-the-world. Participants made comments to the effect that they had forgotten their operation had ever happened.

I still seem to just forget that it has happened. I don't even think about it. As far as my body is concerned, no, which I find quite amazing.

(Owen, 4: 6)

Owen was surprised at the minimal after effects of his surgery in comparison to previous surgery, while Nell experienced a release from pain and incapacity.

Well quite frankly (laughs) I don't even know that I've had an operation. I can't feel anything in my back at all, I can bend right down and pick things up off the floor, and I am not being careful in any shape or form because I feel so well that I don't have to be careful any more, that's how I feel.

(Nell, 4: 1)

Not having to be careful was indicative of recovery for Nell as she had been so used to thinking about movement before she stood. "I don't ever sit there and think, "Oh I've got to get up, but oh it's going to hurt". I just get up now, and all that's gone out of my mind now. So that's great." (Nell, 3: 3). Sometimes participants forgot about their operation until some thing or

someone reminded them about it, such as, when I asked Dulcie about the allergic rash that had severely troubled her. It's presence had dominated her life yet, while she expressed again how difficult it had been for her, she said, "oh yes, I'd forgotten about that. So that's good isn't it?" (Dulcie, 2: 7). Dulcie had moved on and "forgotten" the disagreeable experience of the rash.

At our last interview when I asked Connie if there was anything looking back over her recovery that really stood out for her, her response was, "No, no, I really don't think so. Just it's gone, it's past, past." (Connie, 4: 10). Connie's operation had been concealed from the present. The perspective a participant had of the surgery changed as time passed. Dulcie illustrates this.

I just think it's over, and even two weeks ago I suppose, I thought well I still had to wait. I felt it was like a sentence, (laughs) in a way, six weeks and that's it and I had to deal with it, and now looking back I think, you know, it was a mere nothing. It just is wonderful, you know, I don't think about it at all. I think well, I'm over it and I'm back to normal... I feel as though now it was a piece of cake. (laughs) But I didn't think that at the time.

(Dulcie, 3: 18, 19)

Dulcie felt that if there was nothing to remind her of the operation, as in her case, no soreness or pain, she would completely forget about it as she had with other operations (Dulcie, 2: 11). Dulcie was deliberate about not having to think any longer about aspects of her surgery and the operation per se. She made several statements like, "And I don't have to think about it any more" (Dulcie, 4: 11). She also intended to tear up a photograph that her children had taken when she was in hospital. She described the photograph as a "shocker" and said that, "I really was sick-looking", and, "I think that's not me, so I don't need to look at that photo any longer, do I?" (Dulcie, 4: 12).

Since successes and failures on the road of the inauthentic future are defined by the trends and pressures of the public world, an inauthentic Dasein's past will be disclosed through "forgetting". An individual will repress and relegate into oblivion such parts of his past as may prove detrimental to his search for success in the rapidly changing world of the "they" with all of the world's trends, fashions, and cliches. Conversely, whatever it is that this type of individual will remember will be remembered on the basis of forgetting (BT 389).

(Hoffman, 1993, p.207)

Participants considered forgetting about the operation was a sign of progress. As Ben said, "But no, it is out of my mind. That is the main thing, I will say, a sign of progress, it's not on my mind all the time" (Ben, 3: 5). Will asked his surgeon, "How long will it be before I've forgotten it's ever happened?" (Will, 3: 11). There was an expectation for participants that the operation would be "forgotten" but this was in the sense that it would not be in the conscious mind, that it would be forgotten but not gone; it could be returned to the foreground by an unexpected twinge, an unwise movement, another health problem, a reflecting on experiences.

Extending boundaries included the participants moving beyond physical and social limits of their lived world. It included making plans for the future and removing the experience of the surgery to the past by forgetting.

DEATH COMING TO THE FORE

Walters (1995) comments:

The possibility of death, for all human beings, demonstrates the temporality of our existence. Death is the common end of all life and, as such, is part of the ontology of being-in-the-world. Death gives an importance to our being by creating an awareness of what it means to-be.

(p.496)

For the main Dasein lives out its temporality as inauthentic, caught up in the present and cut off from its authentic future (its "ownmost possibility") but in the authentic moment, our mortality is recognised and accepted (Dostal, 1993, p.156).

"I Just Had a Feeling it was the Last Round Up"

A sub-group of participants spoke about death during the course of the interviews. In various ways each was faced with their authentic being. Death was prepared for, expected, observed close-at-hand, and self-focusing.

Owen spoke about his feeling about his surgery.

I just had a feeling that it was the last round up. And I was as I said, more relaxed than usual. I did not think I would survive it. And, in a way, because... my health had been blighted by a lot of illnesses, seeming to follow one another over 50 years at least of my lifetime, that I was thinking that, well, if I died, it'll be a relief. It's a sort of a relief. I'm prepared for it. I can accept it.

(Owen, 2: 9)

Owen said he considered he had a 50:50 chance of surviving his surgery and prepared for his death by putting his affairs in order, spending time with his son, and writing to the people who were important to him.

I've sat down and wrote cards to my daughters, and my daughter-in-law, and this lady friend of mine, ... as if I might not see them, thanking them for what they had done for me. Although not alluding to the fact, that, you know, I was feeling that way, but so that just in case it did eventuate I had sort of done what I had wanted to do.

(Owen, 2: 16)

Owen had taken the step of writing because of his experience when his wife died. He had not had the chance to talk to her and, "tell her the things that I wanted to talk to her about and she never talked to me the way I wanted her to" (Owen, 2: 16).

Heidegger (1962) stated:

Once one has grasped the finitude of one's existence, it snatches one back from the endless multiplicity of possibilities which offer themselves as closest to one – those of comfortableness, shirking, and taking things lightly – and brings Dasein into the simplicity of its *fate*.

(p.435)

Owen was liberated by accepting the real chance of death as a result of undergoing surgery. He used the opportunity to prepare his family and friends for that possibility.

Because of his age (88 years) and his prognosis, Peter expected his life to be nearing its end and, helped by his strong religious belief, was ready to face death while at the same time hoping that the pain which was likely to return would be able to be controlled when the time came.

I think I've probably told you, when they first told me I had cancer it didn't upset me at all. I thought, "Well, I've got to go some time", and I was, as a priest, I've spent my life, my chief subject of my sermons was the resurrection of the dead and the life of the world to come. And if I find I'm a bit near the end of the road, so what? I'm not worried about it, not depressed about it.

(Peter, 3: 8)

Hunt (1985) talked with 19 New Zealand men and women born in the late nineteenth century. All spoke of aspects of health and at least half spoke of death and/or dying. Peter reflected the thoughts of some of Hunt's participants. For example, in facing death, Peter said, "Well, I've got to go sometime" (3: 8). "But it's the one thing you can't shirk, death. It comes; that's all there is about it. You can shirk everything else, not death" (Stan, in Hunt, p.59). It was not death itself that was a fear for Peter but the possibility of pain. For Kenny, in Hunt, "I accept death but not senility... But when you're old you've the time to think it out, and I'd say the fear of my old age isn't death but senility" (p.89). Peter's belief in the resurrection and life of the world to come is mirrored in Charlotte's statement. "No, death's nothing to me now. I know we're all under a death sentence, and I firmly believe in life after death. But also I look on death as a great friend, not something to be feared." (Charlotte, in Hunt, p.144). The following statement by 49 year old Tim Finn, reflects those of Peter and these older people.

Somebody once said that one of the great wonders of the world is that we can all live our lives as if we're not going to die, and that doesn't mean you have to be obsessed with your death, but it's there on your shoulder the whole time. The failure of the flesh. You best be prepared if you can. There are some people who can ignore it until they're actually going through it. I don't want to be one of those. Ultimately, it's at the bottom of everything. Extinction is a vast conundrum. But it's not being

morbid. In fact, it actually enhances the pleasures of life to allow that thought into your mind.

(Tim Finn, cited in Steel, 2002, p.50)

Simon accepted his lifespan was possibly nearing its end.

Yes, you've got to look at things in a realistic light, I mean I'm 78 and I'm living... and I'm over the average age and that sort of thing, and as I said before, you become more and more aware of your limitations, and you've got to accept it. And I'm certainly not a person who would want to go on, extending my life to the point where it's no longer enjoyable for me.

(Simon, 4: 9)

Simon was realistic in his appraisal of the quality of his life and had weighed up the points for and against having his hip surgery. His statement reflected his response to events in his life.

Harry, dealing with his own cancer, and while in hospital, observed close-at-hand others who died or could not be offered hope. This raised conflicting thoughts for Harry – relief, “I’m damned lucky”, versus uncertainty about whether the cancer had been removed and whether his emergency operation was for just adhesions. Walters (1995) in speaking of confronting death as an everyday experience stated, “death cannot escape conscious awareness. Its impact is experienced as part of our immediate being” (p.496). Harry stated more than once that he lived his life by the day and he had a matter-of-fact attitude to life.

I lived all my life by the day, and you know, if you're going to get something, you'll get it, that's all about it.

(Harry, 3: 3, 4)

After discussing the importance of what you eat in reducing the risk of cancer Harry commented:

But that still doesn't stop things but O.K., no. I don't, we've all got to die some time and die of some thing. (laughs)

(Harry, 3: 7)

Harry did not dwell on his death. He thought one could just as likely be killed on the roads of his home town as be killed by cancer. Harry's past experiences with his wife's death accounted for his attitude – death was a matter of fact therefore you got on with your life in the best way you could until it came.

Nell felt she was living on borrowed time anyway as she had exceeded her projected span of life following heart surgery 13 years before. Her current operation reduced her pain and she felt she had nothing to lose. She intended to live life to the full, for example, go travelling again and enjoy socialising with her friends.

And whatever I enjoy now I enjoy to the full, but when things start to slip, I think I've had enough. (laughs)

(Nell, 4: 6)

"It is through the act of understanding the nearness of the possibility of one's own death that new possibilities for being emerge." (Gullickson, 1993, p.1388). Nell had faced death, had chosen the way she wanted to-be, "living life to the full", living life in a positive and meaningful way. Guignon (1993) writes that if we take a stand on our being-toward-death our lives will be transformed. "Facing death, one is pulled back from the dispersal, distraction, and forgetfulness of everydayness. The result is the ability to live with a clear-sighted grasp of the temporal continuity and future-directedness of one's own life-happening." (p.229). This lucidity leads to self-focusing and the recognition that not everything is possible and so our focus is drawn into a range of possibilities which Heidegger expresses as being determined by the end and so understood as finite. The directedness into a coherent range of possibilities brings a change in the way we relate to thrownness and our being as projections toward the future. We take over

our situatedness with resoluteness expressed by Guignon as a decisive dedication to what we want to accomplish for our lives. The resulting stance toward the future is one of unwavering commitment to those overriding aims taken as definitive of one's existence as a whole.

Nell talked about some older friends who were very fit but whom she felt had not worked as hard as she had. She felt the hard work in her younger life had contributed to her health problems.

But so what? I enjoyed it. And I think that every, I always say every year over 70 years is a bonus. And I don't want to live forever anyway. (laughs)

(Nell, 4:5)

The above typified Nell's attitude to life. Despite health problems she carried on with her life in a positive way, enjoying the company of others and doing the things which were important to her.

Age and/or situation instigated the participants' reflections on their mortality. Their thoughts about their future reflected their feelings about death.

REVIEW AND SUMMARY

The sub-themes of picking up the threads of everyday life, facing reality, taking a stand, extending boundaries and, for some participants, death coming to the fore were encompassed in the theme recapturing being-in-the-world.

Recapturing being-in-the-world suggests re-establishment of harmony and balance in the participants' lives. It involved a return to activities, routines, and tasks that made up the fabric of participants' lives. In the process of re-establishment it required participants to face the reality of their particular health status and situation and that this reality might involve both positive and negative aspects. Re-establishment required participants to also make choices, to achieve goals, to test their limits, to move past their operation and to look toward the future and what it might hold for them. For some participants their authentic being came to the fore in the *presencing* of death in one form or another.

In the next chapter the threads of the data are drawn together to present a picture of the meaning of recovery as perceived by the participants and as revealed in their stories.

Chapter Nine

RECOVERY:

A JOURNEY AND A DESTINATION

The aim of this study was to gain a deeper understanding of what recovery meant for older people once they had returned home after having an operation. This chapter considers the nature of recovery as experienced by the study participants. The process of recovery is discussed under the headings **journey and destination; essence of recovery - enduring my world, caring for and about myself, relating to people and place in my world, continuing my life; significant aspects of recovery - lived time, lived body, lived other, lived space; the effect of age on recovery; concepts of recovery.**

JOURNEY AND DESTINATION

Recovery for the participants can be expressed both as a journey and a destination. The journey involves a passage of time, a moving towards. Surgery, regarded in Pellegrino's (1982) terms, is an assault on the body, a fracturing of self and body. To recover, the individual moves from a state of disharmony and disunity to one of harmony and unity. The disharmony and disunity involves self and body, and self and world. The body must be incorporated once again as part of the self, and the person must be incorporated once again in their place in the family and their wider world. This then is the destination, or becoming, in recovery - to become "whole" again, and to become again a participant in one's world.

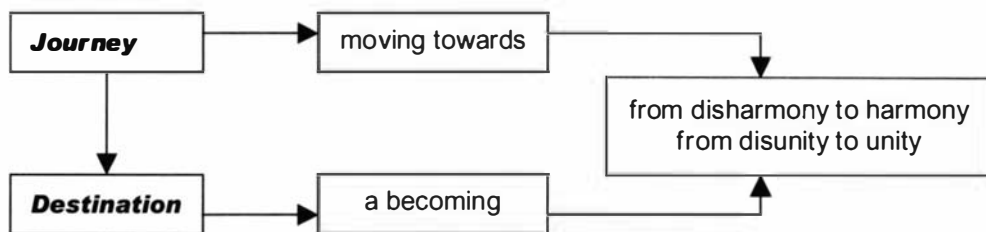


Figure 1: Recovery – A Journey and a Destination

The journey or passage of recovery commenced in hospital where participants experienced **being-out-of-place**. Returning home provided participants with **being-in-place**. Home provided a constant of security and familiarity and a centre in the fabric of each participant's life (Chapter Four). This was important in a time of dis-harmony and dis-unity when participants travelled through the **disturbance of one's-being-in-the-world**, dealing with the difficulties of their everyday lives, of their altered bodies, perhaps with pain and/or discomfort, and with the particular concerns and problems which faced them (Chapter Five). Their situation required their **being concerned with** various issues: the lived body, lived time, and finding meaning in their experience (Chapter Six). Contributing to this was **being-with others**, the nature of relationships with others (Chapter Seven). The passage of recovery moved toward an ending in the process of **recapturing being-in-the-world** with participants picking up the threads of their everyday lives, facing the reality of their situations, taking stands, extending their boundaries and looking toward horizons. For some participants death appeared as a "presence" in their lives (Chapter Eight).

Participants verbalised what recovery would mean and when they would consider it had occurred. This ranged from 'getting on with life', 'carrying out plans', 'getting back to normal life', 'getting back to everything one loves doing', 'getting back to where one was before', 'no more symptoms' to continuing life without restrictions or limitations. These expressions demonstrated both a moving forward and a going back and emphasised the significance of time throughout the shared stories of the participants. Participants were dealing with the present and at the same time looking to

the future as a means of “returning” to better physical states of the past. They accepted that healing would “take time”.

ESSENCE OF RECOVERY

Attempting to illuminate the essence of recovery involved mining the meaning revealed by the participants as they shared their experiences. The essence of recovery needed to convey movement and ‘becoming’ as well as a sense of coming full circle. (See Figure 1)

The four themes arising from the data were **disturbance of one’s being-in-the-world, being concerned with, being-with others, and recapturing being-in-the-world**. From these four themes the essence or nature of recovery as a journey and a destination was revealed as **enduring my world, caring for and about myself, relating to people and place in my world, and continuing my life**.

Enduring My World

Etymologically ‘enduring’ derives from the Latin adjective *dûrus* – hard. It is thought it could be from ‘oakwood’ hence the notion of continuing in existence and lasting. Enduring conveys the notions of continuance, strength and perseverance. While synonyms depict suffering, coping, bearing with fortitude, pain, and staunchness, they also convey making the best of an experience, and “getting through” the situation all of which reflect the participants’ experiences. Enduring has the element of time in lasting and persisting.¹

Participants endured waiting for healing to occur and the restrictions required to allow healing. Restrictions affected the body in that there was a breakdown in the usual taken-for-granted responses of the body. These

¹ References for word meanings of the elements of the essence: Ayto, 2001; Bloomsbury Books, 1992; Wyld & Partridge, 1968.

might result in the inability to carry out personal care and household responsibilities, and to participate in social activities. Unwise movement or forgetting the habitual body was not performing in its usual way called upon a participant's staunchness and perseverance to cope, especially when faced with pain or discomfort. Feelings of shame, low spirits, tiredness, and concerns about coping with an altered and/or unreliable body, as well as other health problems, required strength to persist through these difficulties. For those participants dealing with cancer, facing their mortality also required strength to cope with the diagnosis and prognosis. The participant's world was disrupted, as well as the link between self and world and self and body. The outcome of this disruption was disharmony and disunity. The elements of endurance were required to sustain participants through this time and to enable them to care for and about themselves.

Caring For and About Myself

Understood ontologically 'caring' is "making itself an issue" (Dreyfus, 1991, p.238). Etymologically 'care' derives from the Germanic *Karo* and Old English *caru* meaning anxiety, grief, trouble, care. Aspects of care depict attention, pain, or custody. These in turn convey watchfulness, solicitude, protection, taking precautions, heeding, responsibly managing, looking after, taking charge of, providing for, and feeling strongly about. The synonyms for caring provide the elements present in the theme "being concerned with" where the main focus for the participants was the body, its care, protection, healing, and health.¹

The disruption of the embodied self caused an increased awareness of the body and its needs. Time was important to allow for healing to occur and thus recovery to progress. Caring for and about one's self involved wanting to know and understand the experience of surgery and its aftermath, and its effects on the body and on everyday life. The participants also wanted to

¹ References for word meanings of the elements of the essence: Ayto, 2001; Bloomsbury Books, 1992; Wyld & Partridge, 1968.

know how they could be active in their own healing, care, safety and comfort and be in control. Knowledge and understanding enabled the participants to find meaning in their experience in order to assimilate and to accommodate it in their life story, and to learn and grow in the process. This was necessary as part of the moving toward harmony and balance. Participants were aware of the physical, emotional and social aspects of recovery and the significance of the contributions of others to their recovery.

Relating to People and Place in My World

In an etymological sense 'relate', from the Latin *relatus*, means to carry back, refer to, bring back in terms of bringing back into relation with, to connect, associate with. Aspects of affinity and association, regard, and concern are conveyed by the term relating. Participants linked with a variety of people and their day-to-day relationships had to be brought back into relation when disrupted by their situation, for example, resuming home tasks normally shared with their spouse.¹

Relationships with others were continuing (spouse, family, friends) and short-term and/or episodic (doctors, help agencies, others who had experienced the same or similar surgery). The nature of the relationships was important in the meanings they had for participants, for example the physical and emotional support provided by family members; the practical assistance for household activities; the competence, knowledge and reassurance a doctor might provide, and the affirmation of the similar experiences of others.

Keeping in touch with those people who were part of the participant's wider world was also important. The social interaction allowed reconnection with the participant's everyday world and contributed to restoring balance in their

¹ References for word meanings of the elements of the essence: Ayto, 2001; Bloomsbury Books, 1992; Wyld & Partridge, 1968.

life. As well, being able to assist others, for example sharing experiences, enabled a context of mutual benefit. This enhanced the participant's journey toward the unity of self and world.

The world of the participants encompassed people and place and the place of significance was home. Home provided security, freedom, control, privacy, memories, belongings, identity. It involved a family, a garden, being part of a community, and invoked a special relationship or affinity with the environment in which the participant dwelt. Being at home was a step nearer to one's usual way of being-in-the-world and assisted participants in their ability to continue their lives in their usual way.

Continuing My Life

'Continuing' derives from the Latin – *continére* or hold together, contain, and the Latin *continuáre* – to make continuous, to join, to connect. As for enduring, continuing includes to last, and persist, as well as perseverance, repetition, extending, to go on, maintain a course of action, keep up, to carry on doing or resume something which has been interrupted, and to remain at or in place or in a frame of mind or state of body. Continuing conveys the re-uniting of the participant's self and body and self and world, reconnecting with the social world, regaining participation in meaningful activities, reflecting on experience and thus continuing previous patterns of past life, continuing on into the future, and continuing on with life on a day-to-day basis.¹

For the participants part of the continuing on with life involved reconnecting and regaining previous relationships, abilities, activities and life patterns. The experience of surgery and recovery implies change. It required participants to persevere, to face their reality, for example accepting that pain might continue, that full use of an arm might not be possible, that while

¹ References for word meanings of the elements of the essence: Ayto, 2001; Bloomsbury Books, 1992; Wyld & Partridge, 1968.

there might be some gains there could also be losses because of the surgery. Participants also needed to take a stand, to consider the possibilities they were faced with, to make choices, to have goals or projects and by taking stock, so fashion their life out of the circumstances in which they found themselves. In order to do this they needed to look ahead, extending the boundaries imposed by the surgery by testing their limits and making plans. Life would continue but perhaps in a different form because of the experience through which they had journeyed. For some participants continuing on in life meant incorporating the experience of having faced the prospect of death in the near or distant future. For all participants the experience of surgery and its aftermath had to be assimilated into their life story in the process of re-establishing harmony and balance in their life.

SIGNIFICANT ASPECTS OF RECOVERY

Recovery as both a journey or *moving towards* and a destination or *a becoming* involved moving from a situation of dis-harmony and dis-unity to one of harmony and unity. Throughout, and of significance, were the aspects of time, the effect of surgery on the physical and social body, the contribution of others and the environment where healing occurred, thus lived time, lived body, lived other, lived space.

Lived Time

Recovery as a becoming has elements of the past, a transforming of the present and a continuing on into the future. Lived time was a central thread in the pattern of the lives of the participants. Time was in a state of flux. Sometimes participants were reflecting on past experiences for example when comparing their present situation with past surgery. Previous good health was regarded as a plus by some, while previous and existing health problems came to the fore for others and overlaid or obscured their current operation. At other times participants expressed hope for improvement

some time in the future. Sometimes participants felt they were marking time when no appreciable progress was being made or they felt they were “going backwards”. Terms such as ‘spending’, ‘filling’ and ‘passing time’, and waiting were used. For example waiting involved waiting for improvement or change or, as in Harry’s case, also waiting to be fit enough for further surgery. A six week restricted activity time was described as a “sentence” by Dulcie (3: 18) while she described recovery as “freedom from restrictions” (3: 11). When progress took longer than expected the time stretched. For example, at each interview Colin extended the time when he thought his condition would improve. Conversely as recovery progressed time contracted when participants were able to do more things or reached a specified point in time and passed it.

In her study of people with chronic illness Gullickson (1993) found that, “each individual living with a chronic illness brought with them a wealth of past experiences that shaped and moulded their present being as well as affected their future” (p.1388). The same could be said of this group of older people – each of them had experienced surgery before and each had one or more continuing health problems. Each had taken measures to keep healthy and maintain fitness within their capabilities. These experiences shaped and moulded their present – how they lived their lives, dealt with recovery, and how they viewed the future. As Hoffman (1993) states:

My past is nothing other than my “thrownness” – that is, my rootedness in a culture, my already established preferences, skills, habits, and so on – and it is precisely in terms of this thrownness that my present experiences get to be organized and endowed with meaning.

(p.208)

The present involved coping with pain and restrictions, and dealing with problems and concerns. For participants in this study the present was, for the most part, a time of active involvement when action and responsibility were taken to aid healing, to keep healthy, and to take care. It included also

activities which would help recovery and help fill in the time or the day. Participants assessed their progress and made judgements about action and activities. Progress was measured by how well the activities of daily living and other activities and responsibilities were managed, by their visits to, and response from, their surgeon, and by their own assessment of their abilities and how they were feeling.

People are future-orientated. The future involved a looking forward to recovery. "This sense of forward movement, along with astute descriptions of progress in concrete detail, allows the patient to gain a sense of progress and projection into the future. The patient's world expands to include future capabilities" (Benner & Wrubel, 1989, p.65). For some participants hope featured strongly. Van Manen (1990) states that, "through hopes and expectations we have a perspective on life to come" (p.104). Participants in this study expressed their desire to move forward by testing their limits and extending their boundaries though always mindful of reducing or preventing harm. They spoke of activities or travel they planned to undertake as they looked ahead to what they hoped would be a better place than they were at present. This was balanced by the acceptance of the reality of their situation, whether it be their physical condition, usual state of health, age, likely outcome due to their current or past surgery or future expectations related to their health. Participants saw it as a responsibility to take care / better care of themselves in the future. This included plans to have check-ups and request tests to monitor their health.

Participants accepted that the reality of their everyday life, the past and the present would determine their future reality. Their being-in-the-world required the unity of the self and their world. Time contracted and expanded depending on the rate of progress of recovery. Participants regarded recovery as progressing week-by-week rather than improvements occurring daily. Participants moved backwards and forwards in time as part of this process. The period of recovery unfolded as a reflection of everyday life in that each participant's story contained experiences / elements which were consistent with their way of being-in-the-world. The way the

participants lived through the 'present' of recovery reflected the way they lived through the past and how they would face the future.

Lived Body

The lived body is our bodily presence in the world. "My lived body is the base of operations from which my world is perceived; it defines the lived and oriented space from which I project my action; it is where I encounter the other in the communicative act" (Schrag, 1982, p.120). The physical body is thrown to the fore in illness and surgery. It becomes a focus for the person rather than a taken-for-granted aspect of their being. Having an operation is a hurdle or a barrier, which may stop or prevent the person from doing what they want to do. This may be the everyday activities and responsibilities in which they are usually involved, for example, feeding the dog, doing the housework, playing tennis.

Participants regarded their operations in several ways: 'minor', 'not drastic', 'not as major as previous operations', or, as in Owen's case, in a fatalistic way. It was hoped the outcomes of surgery would enable the retention of previous abilities. Surgery also had a hidden nature in that the face the participant might present to the world hid what was really going on, such as Dulcie's not sharing her distress with her family. Added to this, other health problems might obscure how a participant was progressing. The operation was an assault on the body which, for several participants, resulted in pain and/or discomfort, affected the positioning of their bodies and therefore the quality of their rest and sleep, and required compromises to be made in their everyday lives. A situation was created which had to be endured.

Participants objectified the body in that they regarded the affected part as an entity in its own right, apart from the self, and they personalised it. They "talked to" the body part – Connie told her shoulder to behave when it was causing her pain. Conversely they conveyed that their body "talked to" them, for example, told them when they overextended the affected area, telling them to be careful, to not undertake a particular activity, conveying to

them by pain or discomfort that their actions were unwise or premature. When a part of the body was unable to be used for a period of time an incomplete body was experienced. This was of most significance for those participants who had surgery affecting an arm. After their hip replacements, Simon and Matt found positioning, walking, and mobility in general, required specific attention to the functions of their affected legs and their relationship to the rest of their bodies.

The automatic response of the body or body part, previously unconscious, was now an action which required conscious effort and care. For example, Colin stated, " I'm consciously aware of the problem all the time " (Colin, 1: 4, 5). Will said, "It's still *the* part of the body that concerns me" (Will, 1: 14). As healing progressed this situation diminished. As Ben stated, "But no, it is out of my mind. That is the main thing, I will say, a sign of progress, it's not on my mind all the time." (Ben, 3: 5). Participants viewed it as a sign of progress when the body part was no longer "on their mind" all the time. During the healing process as the participants' awareness of or focus on the affected part diminished they were sometimes reminded by their bodies that healing was not yet complete. Doolittle (1994) talking about recovery from a stroke, speaks of certain parts of the body taking it in turn in being the focus of attention and this being a sequential focus on the body part.

The presence or not of certain aspects had an effect on the passage of recovery for participants, for example, pain, other health problems, cancer, crises, motivation, knowledge, outcomes, and other people. Dealing with the body sometimes resulted in qualification. For example, Connie was able to undertake more activities **but** experienced tiredness; Dulcie was pleased with her progress **but** was left with a bladder problem.

A participant's own action and attitude affected their recovery. All participants were active in their recovery within their limitations, for example following doctors' "orders", taking exercise, resting, monitoring diet, and participating in activities as able. Participants actively sought knowledge about their operations and their conditions. They needed and wanted

information to manage and cope with the assault on their body in their efforts to heal, and to keep fit and healthy. As previous research has indicated (Chapter One) the quality of discharge planning and support varied as did the information provided, especially post-discharge. Information about the operation, what to expect once out of hospital, possible problems or symptoms and what to do about them, as well as how one would know if progress was being made are examples of issues raised by participants. The need for information was often linked to their past experience of surgery. Wanting to know and understand were paramount in their desire to improve their physical condition and to return to, and continue with, their usual everyday lives. Added to this was the need to recreate interrelatedness of the surgical event and surrounding life events and assimilate the experience into their lives. Verbal repetition of events or concerns and including comparisons, were two ways for participants to achieve this.

Hydén (1997) points out that researchers concerned with narratives and narration are interested not only in *what* participants talk about but also *how* they talk about and present events (p.50). For some participants verbal repetition indicated a degree of anxiety or concern about events which had either not been resolved satisfactorily or which were continuing. Heidegger (1971) reminds us that, "It is language that tells us about the nature of a thing" (p.146). Repetition illustrated by the participants conveyed what was of concern to them and what was affecting their lives. For example, pain was a significant feature in recovery. For those participants who experienced pain before and/or after surgery, recovery appeared more difficult, progress took longer, and required more effort. Those participants who experienced little pain or discomfort returned more readily and quickly to everyday life activities. When symptoms return or problems recur, this affects the safety of a person. The success of the operation is questioned and anxiety occurs. Where symptoms which may be associated with cancer arise after surgery related to cancer this poses a threat to a person's well-being and future.

While the physical body took primacy during recovery the social body gained more prominence as recovery progressed. Participants undertook activities which they felt would help their recovery and to help fill in the day, or fill in time while they waited for recovery. Participants' being-in-the-world involved self and world. The social body was placed in a network of relationships with others and the participants' community and environment – lived other and lived space.

Lived Other

Having contact with other people was important to participants. The degree of involvement with others and their environment was affected by their particular situations and abilities.

In a larger existential sense human beings have searched in this experience of the other, the communal, the social for a sense of purpose in life, meaningfulness, grounds for living, as in the religious experience of the absolute Other, God.

(van Manen, 1990, p.105)

Lived relations with others enhanced the participants' efforts to restore harmony and balance in their lives. For those participants who had a spouse this meant taking up again the tasks and responsibilities of their relationship. The lived relation to the other that the older person had with their spouse and/or family enabled a sense of security and support and facilitated independence after a period of vulnerability and reliance on others. Contact with family, friends, and others was maintained and contact and social activities increased as each participant felt able to deal with these. In the earlier stages of recovery such aspects as tiredness, pain, and an inability to cope with visitors, restricted interactions with others. Keeping in touch was considered important. Participants interacted with others through a variety of groups such as church, social, educational and sporting groups.

To recover was seen as a responsibility and involved partnerships, such as between the participant and the surgeon, the participant and the spouse or significant other, the self and the body. It was a time when a participant was able to focus on the self. The spouse, significant other, and family members contributed to the recovery of participants in varying ways and at varying times. They provided support, comfort, help, care, a sounding board.

There was variation in the relationships participants had with their doctors – in the main with their surgeons but also with the general practitioners. Relations with their surgeons ranged from complete trust and confidence to frustration and feelings of not being listened to and/or heard. Some participants saw themselves as in partnership with their surgeons to aid their recovery, with the major role shifting to themselves once they returned home from hospital. Not all participants spoke of their G.Ps but for those who did the feelings expressed were mostly of a positive nature - they felt supported and listened to.

Relations with others during recovery were reciprocal. While the participants were more dependent on others during this time and were recipients of care, support, advice, service, and assistance, they also reciprocated. As each participant lived the experience of recovering from their particular surgery they were both learner and teacher, received advice and gave advice. They learned about their condition by both their own experiences and those of others. For example, Harry actively sought information from others and kept in touch with people he had met in hospital. Knowledge gained through experience was able to be shared with others in a helpful and supportive way, Colin shared his experience with someone facing similar surgery and tried to provide reassurance. The participants as a group of older people provided examples to others by dealing with their experience with fortitude, responsibility, and humour. They regarded relations with others as paramount in their day-to-day lives.

Lived Space

Home was the focus of the participants' lived space. Young (1997) describes home as the site of identity and this was borne out by the participants. Home served a number of functions for participants during their recovery. It was described both as "home is life" and a representation of life because it contained memories, familiar belongings, and evidence of achievements. Home was where family was or came to. It provided a place in which socialising with others occurred and where pastimes could be enjoyed. Van Manen (1990) states, "There are cultural and social conventions associated with space that give the experience of space a certain qualitative dimension" (p.103). As a space home allowed privacy, freedom, comfort, choice, and independence. It enabled routines to be carried out which gave structure to the participants' day and which facilitated their return to their usual pattern of life. Most importantly participants regarded their home as the environment and atmosphere in which they could best recover – a therapeutic milieu. Home was a safe place to experiment with what participants could and could not do in their attempts to re-establish their usual ways of functioning.

Leonard (1989) emphasises understanding 'the significant' for a person - the background of significance, in their context (p. 46). For this group of older people their homes were 'the significant' and this reflects the notion of home as a critical value described by Young (1997). Young proposes at least four normative values of home that should be thought of as minimally accessible to all people – safety, individuation, privacy, and preservation. Safety means a safe place where a person can retreat from the dangers and hassles of a collective life. In individuation home is described as an extension of the person's body, the space the person takes up and where the basic activities of life are performed. It is also the space where one's belongings are which "reflect their particular identity back to them in a material mirror" (p.162). Privacy means the person has autonomy over who will be admitted to the space and its contents, while in preservation the home is the site of the construction and reconstruction of the self. In

addition is the safeguarding of meaningful things in which are seen the stories of one's self embodied and which are reiterated by the rituals of remembrance (pp.162-163).

"In a general sense too, lived space is the existential theme that refers us to the world or landscape in which human beings move and find themselves at home" (van Manen, 1990, p.102). Home included not only a house but also the land attached. All participants had a garden of some sort from which they gained enjoyment. Will had a workspace in his garage for his hobbies, Harry had a space in which he could work on his vehicles, and Peter could enjoy the sea which was a few metres outside the window where he ate his meals. Matt was able to 'watch the world go by' from his window which allowed him to still feel part of his community while he was incapacitated. He lived in a farming area which enabled him to enjoy the countryside as he expanded his horizons. Home provided the environment which made recovering more endurable, a safe place to care for oneself and to relate to others, as well as enabling the participant to pick up the threads of their life by continuing the everyday practices and routines.

THE EFFECT OF AGE ON RECOVERY

From a physiological / biomedical point of view there is concern with the age of the person who undergoes and recovers from surgery. This is particularly so in regard to the older person. Age in itself was not perceived by the participants as of major significance to their recovery from surgery. While chronological age may not have been significant the accumulated life experiences through time did have a bearing on how participants coped with recovery.

Some participants thought age could *possibly* slow down recovery but they did not necessarily relate this to their own situation. Age did not come to the fore unless there were reminders of some aspect of aging. Simon felt that his other health problems had more bearing on his recovery than his age.

He had expected his recovery would be slower because of his age [78] and was grateful that he still had sufficient recuperative powers to get over his operation. Colin felt as one grew older age affected the progress of recovery, limited activities, one was not restored as quickly, and healing took longer.

Age had brought the participants to a time in their lives when each had several health problems other than their current surgery. Each participant lived life within their body's context which they had assimilated into the pattern of their daily life. The Prime Ministerial Task Force on Positive Ageing (1997) comments that one of the common myths is that most older people are in poor health but, "while older people may have chronic, controlled health problems as they age, they are not necessarily bothered or limited by them" (p.13). For some participants the body context was there but not to the fore, while for others such as Owen, body context had supremacy in everyday life. For Peter, life was nearing death as both his age and condition determined life's progress. Nell felt she had faced death at the time of her previous heart surgery hence her belief that any time over the age of 70 was a bonus for her and she would enjoy whatever time she had left.

Gadow's (1982) notion of the greater importance of the subject body in aging (Chapter Two) when the body insists that its own reality, complexity and values be supported and has positive meaning, is inherent in the lives of the participants. The acts involved in being concerned with and caring for their bodies besides promoting healing, indicated a valuing and nurturing of the body in its role through the aging process. Participants were alert, interested in the world around them, maintained health and fitness in ways appropriate to their situation, enjoyed the company of others, and dealt with adversity. They sought knowledge and understanding. For example Colin viewed aging as a good time to reassess one's values and goals. He believed being an older person changed one's outlook, and one saw things differently and operated differently (Colin, 3: 5).

Do you think I pretend not to notice he's old? I notice. But Sobran is so familiar to me that his age isn't an otherness, a mist gradually obscuring the body I know, or something that stands in opposition to my "youth" like some vulgar emblem. His age is as much himself as his youth.

(Knox, 1998, p.221)

Heidegger's concept of general skilled comportment or the general being at home or 'dwelling' in everyday environments can be enhanced in considering chronological age and dealing with an event such as surgery. As Hall (1993) states, "things show up for us or are encountered as what they are only against a background of familiarity, competence, and concern that carves out a system of related roles into which things fit" (p.132). All the participants had experienced previous surgery, all had other health problems, all had been made aware of their bodies as requiring attention and specific care. This occurred over time and because of illness / injury events. They were familiar with their bodies' foibles on a day-to-day basis and had incorporated the bodies' needs into the pattern of their lives. Hall (1993) points out that:

Human being is skilful coping all the way down, and this broadest level of familiarity, competence, and involvement is rock bottom. We do not even consciously acquire such things. We grow up into them through socialization and enculturation. They are what we are, not what we are aware of.

(p.133)

Through the passage of time and so aging, participants grew in their particular ways of being-in-the-world. Neal talked of the wisdom of older age, which incorporates how one lives one's life at this time of life and how one deals with expected and unexpected events, which was demonstrated in how the participants dealt with recovery.

CONCEPTS OF RECOVERY

Aspects of recovery as experienced by the study participants are reflected in the concepts of recovery discussed in Chapter One. For example recovery was dynamic in that it was a complex shifting reality as the contexts of 'illness' and of care changed (Kleinman, 1988). It was phasic in that changing patterns occurred and were shaped by time/duration and marked by turning points/recovery indicators. These included the movement from dependence to independence, to full responsibility for personal care, and changes in well-being and in the physical body (Dorsett, 1991; Lawler, 1991; Doolittle, 1994). Changes occurred also in the number and type of social interactions and as participants were able to focus again on valued concerns and activities which were the context of their daily life. Changes did not necessarily proceed in an orderly and direct fashion and required a changing pattern of accommodations.

Recovery was dynamic also in the sense of moving forward and looking to the future and in an acceptance or expectation of a particular outcome, for example the recovery of the familiar physical and social body and a return to the activities and concerns that mattered to the participants (Smith, 1981; Lawler, 1991). According to Dorsett (1991) renewal and recuperation characterise recovery. On the journey the participants had to accommodate and to assimilate the experience of recovery from surgery by way of reflecting on the personal meanings of the experience and making sense of it (Kleinman, 1988; Dorsett, 1991). What is learned and the actions taken contribute to personal growth (Smith, 1981; Doolittle, 1994). Doolittle conveyed these elements in her presentation of recovery as having two levels - functional independence and self care, and the personal meanings that recovery has. Participants had to pick up the threads of daily life and reconnect to concerns and social practices. The experience of recovery involves change - in behaviour, the body, relations with others, and in one's social world, all of which were experienced/exhibited by the participants. The journey of movement through time toward a destination implies a place

in time where change has occurred and which is not the same as the place from which participants began. It is not a return to the past.

REVIEW AND SUMMARY

This chapter draws the threads of the data together to present my interpretation of the nature of recovery as perceived by the participants. In this study participants moved from a place of disharmony and disunity toward one of harmony and unity of self and world. Madjar (1991) describes this as losing, then regaining, the habitual body and becoming oneself again. Movement occurred from **being-out-of-place** to **being-in-place**; from **disturbance of one's-being-in-the-world, being concerned with, being-with others**, to **recapturing being-in-the-world**. These themes expressed the experience of recovery for this group of participants. The essence of recovery was revealed as **enduring my world, caring for and about myself, relating to people and place in my world, and continuing my life**.

Recovery was further illustrated by using the lifeworlds – lived time, lived body, lived other, and lived space. The life worlds emphasised the significance of the part time played in recovery, the effect of surgery on the lived body, the people who had an effect on the participants' recovery, and home. As well, participants wanted information in order to understand what was happening to them, and were actively involved in their recovery. They did not perceive age as specifically affecting recovery in any major way.

The progress toward harmony and unity varied for each participant. While some participants believed they had recovered and returned to their usual way of life, other participants were still journeying toward the becoming or destination of recovery from surgery. Participants looked to the future while dealing with the present and reflecting on past experiences. Their hopes for the future might incorporate a past when they had been able to live their lives within parameters that provided a safe, enjoyable, pleasurable,

beneficial environment.

I think it all comes down to the fact that it's just so much an individual thing as to how your own particular body reacts to it and the mental approach you've got to it.

(Simon 4: 10)

Enduring, caring, relating, and continuing, reflecting the nature of recovery, formed the pattern of recovery. While recovery was in one way a process whereby there was a moving toward it can also be likened to a kaleidoscope in that the patterns of the participants' lives continually changed – sometimes a new pattern or picture emerging, sometimes a similar or the same pattern. Aspects merged, changed, re-emerged, and/or continued but regardless combined to form the unity of the participants' world for both the present and for the future.

In the final chapter the study is reviewed and issues which arose are discussed.

Chapter Ten

CONCLUSION

In this final chapter of the thesis a brief review of the study is provided. In the previous chapter the focus of discussion was the phenomenon of recovery. In this chapter the areas of discussion include aspects of the research process, issues relating to older people, issues and implications for nurses, and possible areas for further research.

My aim in undertaking the research was to understand what it was like for older people who had surgery to recover at home. People are now living longer so there is an increasing number of older people undergoing surgery. This, combined with shorter hospital stays post-operatively, raises issues for care and recovery. While the literature provided information about discharge planning and care and support of debilitated elderly at home there was little to be found in relation to how older people coped at home following surgery. Older people have been included in studies of recovery after surgery but often only within the age range of the sample, and not as the focus of the research.

The method chosen to investigate the topic was hermeneutic phenomenology because of its focus on illuminating a phenomenon by gaining a deeper understanding from the perspective of the person experiencing the phenomenon, that is arising from the everyday life of the person. What is significant in our everydayness is what shows up as counting or mattering to us. In terms of knowledge, in gaining understanding from the perspective of the participants themselves, the researcher recognises "truth is not absolute but exists in multiple forms" (Benoliel, 1984, p.4). Health and illness are what the person experiencing

them perceives them to be. As the focus of the nursing profession is the health / wellness of people nurses will be enabled if they gain a greater understanding of the meaning of the experience of health and illness from the person's point of view. This will enhance nursing's contribution to the health and welfare of older people.

The use of Heidegger's earlier and later writing and the work of other writers provided a way of looking at the data which revealed the nature of recovery. It provided guidelines to delve deeper into meaning in an attempt to understand and gain new insights into what recovery was like for each participant. Access, reflection, organisation, and discussion of data were guided by the work of Heidegger and that of other writers. The existential lifeworlds – temporality, corporeality, relationality, and spatiality – revealed the phenomenon with specificity.

In the course of sharing their stories, the participants reveal what is significant to them. What is significant is how recovery is realised in the life of the person, what recovery carries into consciousness for the experiencing person. The researcher then reflects on what appears and interprets during analysis, what seems significant to the essence of the phenomenon thus gaining new insights into the phenomenon. Using the analogy of a tapestry where individual threads with their own colour and texture are represented in the interweaving to provide a new pattern or picture, can provide a picture of what happens in phenomenology. The philosophy, the narratives of the participants, and the reflections and analysis of the researcher are interwoven to provide a picture of the phenomenon.

In Chapter Four the contexts in which recovery began and continued were considered. Chapters Five to Eight presented and analysed the data under four themes respectively – disturbance of one's being-in-the-world, being concerned with, being-with others, and recapturing being-in-the-world. Disturbance of one's being-in-the-world considered the difficulties of the participant's altered body and world. Being concerned with related to taking

care of the lived body in a variety of ways. Being-with others reflected the need for contact with others as part of the healing and continuing of recovery. Recapturing being-in-the-world considered the steps taken by participants to restore balance in their lives.

ASPECTS RELATING TO THE RESEARCH PROCESS

Reflecting On My Understanding of Recovery

I asked myself what had altered in my understanding of recovery. I realised my initial view of recovery was superficial – people “got better”. Recovery involves more than this, and the term “recovery” may not be the best one to describe what happens. The word recovery is commonly used to describe recovering and the end result of recovering – recovery. Recovery in an ontological sense can be described as recovering the unity of self and world. It is not recovery in the sense of necessarily recovering or regaining former health and well-being. “Returning” is not appropriate because of the sense of moving on into a future with different possibilities from a present which has changed from the past. Returning is to the past, recovering is the present, recovery is the future. My research has made me look at “recovery” anew, to move from a taken-for-granted meaning which, when looked at, did not stand up to scrutiny. I asked myself is the term “recovery” a medical–scientific term? It is a common usage term – we all “know what it means” – but it has many meanings and is unique to the individual’s being-in-the-world. Nursing and medicine may more commonly operate from the “getting better” base and this may mean the assistance an older person receives during recovery may be inadequate.

My journey in coming to realise a deeper meaning of recovery is what Crotty (1996) terms transcending the natural attitude. The natural attitude is the way in which we make sense of things being taken to be the way things really are. Phenomenology enables the transcendence of the natural attitude. It involves contemplating the invisible in the obvious and stepping

outside the circle of the taken for granted to grasp the new meanings and deeper understanding of the phenomenon (pp.151-152).

Reflecting On My Understanding of the Older Person

As for recovery my preconceptions about older people were uncovered, shaken, and changed. I knew there were many active older people – I had only to look around my own extended family – but my perception was distorted by those who were sick, or had health problems and then had difficulties in coping with life.

The study participants did not categorise themselves as “old” – their chronological age did not signify “their world”. To paraphrase van Manen (1990, p.77) I discovered there was a difference between my pre-reflective lived understanding of older people and of recovery and my reflective grasp of age and the phenomenological structure of the lived meaning of recovery. Despite there being increasing numbers of active older persons living productive and fulfilling lives, there still appears to be a strong social myth about the aged, as being disabled and dependent, as somehow being essentially “other” than the rest of society. This is conveyed in the language used by those in younger age groups when referring to older persons. There are, however, social paradoxes where, on the one hand, the aging person is encouraged to be active socially, physically and mentally, yet on the other hand, newspapers and articles specifically targeted at the older age group include “over 50s” and advertise rest homes and disability aids. It seems active old age is being extended one way and middle age is being contracted. A project concerning the portrayal of older people in the media aims to challenge the stereotypes and depict the realities of being an older person. There is a case for a change in focus from chronological to biological age – “you are only as old as you feel”. In the New Zealand Positive Ageing Strategy the comment is made that “people are not just living longer; they are also living healthier and can contribute many more years to society” (Ministry of Social Policy, 2001, p.9).

The study participants appeared to be living fulfilled lives, occupied, content with their place in life, participating in a social world, taking responsibility for their health and well-being, living in a world of health problems which were assimilated into their daily lives.

The Term “Illness”

Use of the word “illness” is common in the literature yet seemed inappropriate in relation to the participants’ situations. Their surgery was planned in that they had a problem, sought medical advice, and surgery was arranged. Participants were dis-abled in some way in that their usual functioning was disrupted but they did not appear to consider themselves to be “ill”. Descriptions of surgery in this situation seemed inadequate and though I used terms such as health-illness event or health-related event for this purpose I found this not entirely satisfactory. This was exacerbated by quotations from sources commonly referring to illness despite reflecting an aspect of a participant’s experience. Etymologically the word ‘ill’ means ‘bad’ and its meaning “sick” did not arise until the 15th century. “Sick” is thought to have arisen from Old Norse usage, “it is bad to me” (Ayto, 1990, p.294) so in this sense using the term “illness” could be appropriate.

A journal entry reflects my grappling with illness terminology.

It has struck me on more than one occasion in my reading about a suitable term to describe planned surgery. The person isn’t “ill” in the usual sense of the term so you can’t talk about the person’s experiencing illness; they aren’t having acute surgery for an acute, unexpected illness or disease yet where an author speaks of the disruption of illness all you can say is, surgery, whether planned or unplanned, is also a disruption.

(Journal Entry, 08-04-02)

Benefits to Participants

Hutchinson, Wilson, and Wilson (1994) considered the personal benefits for participants in qualitative health research interviews and provided the following which were voluntarily described by participants: catharsis, self-acknowledgement, sense of purpose, self-awareness, empowerment, healing, and providing a voice for the disenfranchised. These can be related to the participants in the current study.

Catharsis – the participants whose lives had been touched by cancer appeared to have a need to talk about cancer because it continued to have meaning and significance for them. The same applied to those participants experiencing pain.

Self-acknowledgement – the interviews provided a voice for participants. Hutchinson et al. include the elderly as members of discredited groups for whom having a voice through interviews may be particularly meaningful. Neal and Will were two participants who commented about the opportunity (or lack of same) to talk about their recovery. The interviews gave legitimacy to speak.

Sense of Purpose – “How one makes meaning of an illness often involves helping others” (Hutchinson et al., p.163). A prevailing attitude of the participants was that sharing their experiences might be of help to others. The desire of older people to help others is supported in research by Trice (1990).

Self-awareness – talking about their recovery experience to another enabled participants to reflect and gain new perspectives on their recovery experience, for example, verbalising possible reasons for a problem and considering options to deal with it.

Empowerment – telling one’s story and really feeling heard can be empowering which can result in movement and change.

Healing – sharing one’s story can have a therapeutic effect. Several participants made comments to the effect that it had “done them good” talking to me.

Providing a voice for the disenfranchised – those who have not been able to tell their story for one reason or another. Some participants shared information which they had chosen not to share with family members

For both interviewee and interviewer the stories have value and meaning, can enhance their understanding and may help to more effectively achieve their purposes.

Management of the Research Process

In a self-selection process the number of participants and timing of their availability is not completely manageable. In one two week period five new participants contacted me and I was already part way through the interviewing process for three other participants. It is important to be well organised, have a process for keeping track of each participant's material, and prepare for each interview so that the researcher is focused on the particular participant. While the timing of the interviews worked out over time so that there was a manageable number in a week the number of interviews per week is an aspect for the researcher to consider.

Taping each interview requires good equipment. I had sought advice about equipment before buying a recorder but found sometimes recordings were not as clear as I had hoped. Further consultation with technical people gave me more helpful information and a change in the type of speaker helped. The positioning of the speaker was important and practice runs as well as checking the taping near the beginning of each interview provided me with reassurance. I found that the tone of the voice contributed to the clarity and that women's voices were clearer and taped more successfully. I noted in a journal entry about a male participant with a quiet voice – "my own voice is quiet – if I speak louder it seems to encourage the other person to speak louder and this happens anyway once their conversation begins to flow" (Journal Entry, 11-11-98).

ISSUES RELATING TO THE OLDER PERSON

Health, Fitness and Well-Being

As previously indicated many older people have one or more chronic conditions affecting their health and this was the situation for each participant. Brunner and Suddarth (1988) state that, "studies have shown that the elderly are very health conscious and that many of them are willing to adopt practices that will improve their health and well-being" (pp.45-46). The positive effect of the emphasis in New Zealand on encouraging older people to keep fit and healthy by means such as exercise, diet, activities and interests was evident in the participants.

Viverais-Dresler and Richardson (1991) cite a 1988 study by van Mannen who found that as age increased health, as defined by the elderly, was more a "state of mind" than the absence of disease. In Viverais-Dresler and Richardson's study, despite 93% of participants having one or more chronic illnesses the majority rated their perceived health status as excellent or good. Exercise, diet, relationships with others, activities, religious beliefs, and coping mechanisms formed the health-promoting patterns. Almost half of the participants perceived health as a bio-psycho-social construct.

A four year study in Britain found that people in their 70s reported an overall life satisfaction far higher than anyone else of any age despite such factors as increasing health problems, reduced income, and encroaching mortality (Hill, 2001). New Zealand's "positive ageing strategy" embraces factors such as health, financial security, independence, self-fulfilment, community attitudes, personal safety and security, and the physical environment (Ministry of Social Policy, 2001, p.9).

Positive ageing is about “ageing with attitude”. In fact, many older people tell me that they never feel old, that “old” is always someone 10-15 years older than yourself.

(Dalziel, 2001)

Surgery

A number of factors may impact on the services for older people requiring surgery and their recovery from surgery. Those factors include the increase in the population of older people, their need for surgery, life expectancy, one-person households, day and short-stay hospitalisation for surgery, and recovery at home.

One aspect arising in the study was the “obscured” nature of the operation for some participants. The operation itself was obscured / of lesser significance because of other factors, for example, poor health (Owen), previous more major surgery (Neal), a step to further surgery (Harry). This obscuring emphasises the importance of how the person perceives surgery as part of their life and the need for carers to be aware of this.

Another aspect was the site of the surgery and its effect on the day-to-day life of the person, for example, those participants who underwent surgery for an orthopaedic condition were incapacitated for varying lengths of time (Connie, Colin, Frank, Will, Matt, Simon). Dulcie was reminded of her surgery every time she went to the toilet because of the site of her surgery.

The pain, discomfort, restrictions and limitations experienced by participants were not always expected and prepared for, which suggests a need for a greater focus on pre-operative preparation, discharge planning, and support and contact at home. Consideration needs to be given to what the operation will *mean* for the older person once home and recognition of how life will be affected in the simplest ways, such as the ability to carry out activities of daily living. What is required to enable the older person to manage their life effectively?

Swindale (1989) emphasises the importance of providing information pre-operatively in that it lowers anxiety levels, reduces stress and pain, and promotes a better and quicker recovery. This supports the research of Thongkrajai (1986). Zetterlund's (1986) research relating to patients recovering from a myocardial infarction found a major factor in the recovery process at home was the clarity and consistency of information and instructions provided pre-discharge to patients and their families. Owen and Simon were given conflicting information from health professionals about diet and crutch-walking respectively. Such instances create uncertainty and anxiety and could be harmful.

The effect of impaired or loss of bodily function control should not be underestimated by carers. The shame felt by Peter when he wet his pyjamas; Connie's embarrassment when needing someone to pull up her "knickers" and trousers after going to the toilet; the need to rely on others to put on shoes, tie shoelaces, or cut up food, were all examples of the physical problems which caused varying degrees of emotional distress to participants.

Information and Knowledge

Knowing about one's operation and its aftermath and being able to access information were important to participants. As Will expressed it, "it's important to have someone you can talk to and that you felt you had confidence in, and they can reassure you" (Will, 4: 12).

The type and amount of information provided by doctors was variable, consequently the satisfaction of the participants in this respect was variable. Even when participants considered they had a good level of knowledge there were still instances when something was of concern and they were unsure whether they should contact someone about it. The significance of some issues is not always apparent to participants so access to or contact with a carer such as a nurse would be helpful. Added to this is that the need for information may be highest several weeks *after*

discharge (Yates, 1995).

Conversely participants did not always share information, for example, Dulcie did not tell her family when she was feeling low in spirits, Connie did not tell the relieving nurse she needed assistance to wash under her arm, and concerns were not always shared with the doctor. The attitude and behaviour of health professionals and family members toward the older person recovering from surgery will encourage or discourage the sharing of information thus enhancing or impeding recovery. Smith and Birrell (1991) in writing about encouraging patient compliance indicate compliance is likely to be higher if the health professional has a warm friendly manner, heeds the patient's need for information and provides specific information (p.254). In a study of medical-surgical patients Smith (1981) found 95% of the patients stated that the cheerfulness and good humour of nurses and other staff helped them to recover. The next most frequent responses involved caring, and knowledge and skill.

ISSUES AND IMPLICATIONS FOR NURSES

The nursing input to the older persons' recovery was not solicited as part of the study but nurses were mentioned by participants. Positive statements about nurses and/or nursing care were made by Ben, Connie, Simon, and Will. Owen and Simon received conflicting advice from nurses. Nell was concerned about the care and support she received when getting up for the first time after back surgery, and her safety when walking. Simon had concerns about sufficient information being provided. A previous severe drug reaction had made him particularly aware of the need to be alert for problems. He commented:

When you tell somebody, a medical person, be it a doctor or a nurse, that something is happening, and they pooh-pooh it, you

know, they've got no right (laughs) to do that, because it may well be real. I mean it's real enough for you.

(Simon, 3: 5)

Being heard is important for older persons. The nurse has the ability to judge the nature of the communication from the person and to determine if action is required. The above examples occurred while the participants were in hospital though Will also spoke positively of the nurse at his specialist's rooms. Connie was the only participant who received care from nurses once home. She was positive about the care received and the friendliness and manner of the nurses. (The two participants who had ostomies from previous surgery were visited by a specialist ostomy nurse).

Lawler (1991) uses the term an *environment of permission* which, she says, nurses create by structuring environments and defining situations so as to make it possible for patients to live through difficult illness experiences. The environment of permission helps the patients reconcile what has happened to their bodies. While the strategies used by nurses are not always successful a climate is created "in which reconciliation and integration of the object body and lived experience of the body is possible" (p.176).

Smith (1981) is particularly concerned about how nurses view the recovery process. She asks:

Is recovery viewed primarily as a period of diminishing needs for physical care, or as a dynamic period that presents particular challenges different from but no less important than the acute phase?

(p.91)

Smith considers the recovery period is a time when education, counselling, and planning with the family are especially important. If a person is discharged from hospital before they are physically and emotionally ready or if there has been a failure to plan adequately for the period following

discharge, this may result in their readmission. Carroll (1995) believes the nurse is in a pivotal position to influence the self-efficacy expectations of the elderly. The nurse provides coaching, assistance, and guidance while the person is in hospital, while after discharge frequent telephone contacts "can continue the supportive-educative nursing care that was initiated in the hospital" (p.57). Carroll's proposal refers to older patients recovering from coronary artery bypass surgery. She comments about the need to provide these patients with information which reflects the longer recovery trajectory. Some of the study participants with orthopaedic conditions did not realise how long their recovery period might be.

With day-only and shorter hospital stays after surgery the opportunities during hospitalisation for coaching, assistance and guidance are diminished though the need is not. One solution is nursing input following discharge. This could include both telephone contact, as Carroll suggests, and face-to-face contact. For example, home visits allow a physical assessment, time to observe the nuances of verbal and facial expression, and for the person to raise items of concern that might be considered too trivial for a visit to the doctor, observation of self-care activities and social interaction, advice about managing symptoms, and time for the older person to share their perception of their experience. The comprehensive knowledge, skills, competence and qualities of nurses make them the most appropriate health professionals to provide the support for older people and their families to manage the recovery period. Spouses of older people are often the main support person during recovery. Acting as a support when they themselves may have health problems can affect the health and well-being of both partners. This issue arose during the study when the spouse of one of the participants showed signs of stress. I reflected on this in my journal.

While visiting a new potential participant this morning I found I was confided in (because I was a nurse) and I felt comfort and reassurance was being sought by the person's spouse who appeared to be in some stress. I think I established rapport with this couple but it was hard to refrain from reassurance and

comfort where there appeared need. Thinking about this I see this as basic human interaction – not one just because I was a nurse. ...//... Is it ethical for me to gently ask what supports the spouse might have? A nurse does visit – is she recognising the spouse's situation?

(Journal Entry, 06-10-98)

Essentially the partner's story runs alongside and intertwines with the participant's story. Each is part of the other's lifeworld. This was illustrated for me in a further journal entry relating to the stressed spouse and the effect on the participant.

When I rang the fourth person today and spoke with his wife it was a distressing experience. The nurse-researcher dilemma arose – or rather the researcher was put in the background. Out of human compassion I spoke with this woman who sounded even more stressed than when I originally met her. I listened, made suggestions for help and encouraged her to talk with her G.P. I tried to leave her with a positive and reassuring thought. The comments made me wonder how well her husband was really coping and how well she was going to cope for very much longer.

(Journal Entry, 22-10-98)

Another aspect of the benefit of home visits by a nurse is that of establishing a trust relationship. The following journal entry illustrates trust and also the privileged position of the nurse-researcher. The entry was written after my first interview with a participant.

This man shared some personal (family) comments about family relationships after the interview. I was surprised because he had stated during the interview he was a very private person. He was affected emotionally by what he was telling me and I tried to be supportive in my comments and affirming. He

epitomised for me the trust the participants place in me which is sometimes unexpected but heartwarming. I think being a nurse helps induce that trust and is an inescapable part of the participant-researcher relationship. It places me in a very privileged position.

(Journal Entry, 08-01-99)

This participant lived alone and his general health placed severe restrictions on his life. The opportunity to unburden oneself about concerns affecting one's health is not always available partly because only some people are interested (e.g. nurses) and only some people can offer support, information, and reassurance (e.g. nurses). Another participant who also lived alone rang me about five months after I had completed my interviews with him. He had been for a check-up with his surgeon and decided to ring me up to tell me about this. My comment in my journal entry was, "I think he may have wanted some reassurance" (28-04-99). He always rang his friends to find out how they had fared in similar situations so this sort of contact was important to him. My surprise was that I had had no contact with him since completing the interviews, but I think it reflects a need for access to someone to share this particular type of information. My study has confirmed my strong belief in the value of and need for the presence of a nurse during the recovery of the older person at home. The nurse's role must extend beyond assessing and meeting the physical needs of the older person. The presence of a nurse after hospitalisation is supported in the work of Carroll (1995), Jackson (1989), Landsberger (1986), Ryan (1994), Stevens (1986) and Witham (1996).

LIMITS OF THE STUDY

The nature of phenomenology means this study and these particular participants have provided a particular meaning of the phenomenon of recovery. While some aspects are common for the group they are not necessarily able to be generalised to a larger population. Conversely, while aspects may be common to the group each participant's experience of recovery and the meanings it held are unique to the individual. Phenomenology enables one way of looking at the world and is therefore no different from any other type of research.

Phenomenology entails the interpretation of interpretations, as the researcher interprets the interpretations of the participants. This requires intense application on the researcher's part and a process of orientation and continual re-orientation to the study question being asked. Kondora (1993) considers nurses must maintain a place in their practice for listening to stories, that this type of listening is a complex and engaged hearing which does not seek to guide or direct. She describes the engaged listener as accompanying the storyteller on the journey and walking alongside. "Perhaps engaged listening can best be described as a type of presence in which the listener actually becomes a part of the story" (p.15). Kondora's exposition describes the researcher in phenomenology – the engaged listener accompanying the participants as they tell their stories and becoming part of the stories in the analysis and interpretation. Use of the participants' own words and my interpretation of their meaning enable the reader to judge my attempts to remain true to the essence of the participants' experience of the phenomenon.

The study's age inclusion criterion was 70 years and older. Apart from two participants, all were in the 70s decade. While the outcome of the study suggested chronological age was not of significance a wider range which included more participants over 80 years may have provided other aspects of meaning. Similarly a balance between male and female participants, and

one-person and two-person households may have provided other data. Regarding the number of participants, access and the time demands of the study meant the number of 13 participants was manageable for the time available. Alternative ways of access could be considered.

The decision to not specify a particular type of surgery was deliberate and made for two reasons – firstly, I was interested in recovery not the type of surgery, and secondly, the research I located in the literature invariably focused on recovery from one particular type of surgery. For access to participants I approached surgeons whose specialty related to the more common conditions which affected older people. Either a meta-analysis or comparisons of clusters of recovery from several types of surgery could extend understanding of recovery for older people.

POSSIBLE TOPICS FOR FUTURE RESEARCH

Given the projections of an increasing population of older people worldwide, research relating to the health and well-being of older people is of critical importance. My background reading about the physiological changes which occur as we age and what happens physiologically during and after surgery emphasises for me the need to increase knowledge and understanding in this area. During hospitalisation older people having surgery are commonly in areas with a wide age range of patients. In this situation the type of operation may be a primary focus rather than the effect of the operation on the older person. The physiological changes in the older person can occur rapidly and/or in different ways from those in a younger person, and nurses caring for older patients need to be aware of this. Content of basic and continuing education for nurses needs to include this information to raise the awareness and increase the knowledge of nurses. Research in this area will determine how well nurses are meeting the older person's needs.

The New Zealand Positive Ageing Strategy (Ministry of Social Policy, 2001)

includes as a goal that “people of all ages have positive attitudes to ageing and older people” (p.22). Research in the area of stereotyping and the development of appropriate attitudes toward older people could contribute to the goal, including nurses’ attitudes to the principle of older people having surgery, and to their recovery. McIntosh (1996) suggests the use of discourse analysis for researching communication between older people and health professionals. He states, “recognition that ageism is reproduced through interacting with older people as stereotypical representations would be a positive step” (p.37).

Research relating to the on-going presence of a nurse in an older person’s recovery period at home / after discharge from hospital would enable an indication of the benefits or otherwise. Similarly, investigating the situation of the significant other in the older person’s life and how this affects recovery could be helpful in terms of what contribution they make and how they are affected and other aspects such as support required in the home – how much, what sort, who requires it and for how long. Considering the role and contribution of individuals and groups the older person regards as supportive to their recovery could provide useful information about persons often overlooked as part of recovery. The effects/benefits of the place where recovery occurs, for example, the home in comparison to a convalescence facility could be investigated.

The participants in this study had planned surgery. Research on recovery for older people after acute unplanned surgery would add to the knowledge of this area and broaden the applicability to nursing practice. Research about the benefits or otherwise of their surgery as perceived by the older people and in terms of improved quality of life could provide useful data for health services. Particular health and disability issues affecting older people in rural and smaller urban areas were raised by Fletcher and Lynn (2002). For example, the effect on the spouse if the health of one partner deteriorates, access to services, and transport difficulties could impact on recovery from surgery and are worthy of investigation. Another impact on recovery from surgery could be the socioeconomic status of the older

person if personal resources are scarce or limited.

Other issues which warrant further inquiry include the perceived contribution to recovery of various categories of health workers and differences in experiences of recovery in terms of:

- age, gender and ethnicity
- type of surgery and previous or repeat surgery
- length of recovery
- recovery other than from surgery for example after an acute exacerbation of a chronic illness.

Pain was of particular concern to participants in this study and led me to ask questions like – what does pain mean for the experiencing person?, how is the person prepared for the amount and type of pain they will experience during recovery at home?, how does the presence or absence of pain affect recovery?, how is pain managed for the older person post surgery? Pain and how it affects recovery is another topic which requires further research

Older people have much to teach us. It would be foolhardy not to take advantage of the knowledge and experience they are willing to share with us. The experiences of recovery the participants shared with me enabled me to gain a greater understanding of what recovery meant for them – enduring, caring, relating, and continuing. Frank (1995) states:

The first lesson of thinking with stories is not to move on once the story has been heard, but to continue to live in the story, *becoming* in it, reflecting on who one is becoming, and gradually modifying the story. The problem is truly to *listen* to one's own story, just as the problem is truly to listen to others' stories.

(p.159)

The participants' stories made me "listen" to my story which includes two older close relatives, my mother and my aunt, who both had several operations over the duration of the study. I could see the essence of the participants' recovery reflected in their stories. The participants' stories are part of my story now. As a researcher one is open to self-change during research inquiry (Koch, 1994). I have tried to show how I have changed in my thinking, and how my awareness and understanding of older people and recovery have changed. As a method, hermeneutic phenomenology "holds the participant as the expert from whom we can all learn" (Robertson-Malt, 1999, p.296). Uncovering new stories in established patterns is one way to gain new insights and expand understanding of the person's experience in health and illness.

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APPENDICES

- Appendix One:** Information to Surgeons
- (a) Letter
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APPENDIX ONE

Information to Surgeons

(a) Letter

Dear Mr/Dr

My name is Ray Wootton. I am writing to ask your help in gaining access to participants for my research.

I am a registered nurse who has been involved in nursing education for 30 years at both Christchurch Hospital and Christchurch Polytechnic. I am currently a PhD student with the School of Health Sciences at Massey University. My research topic concerns what recovery means for older people who have surgery. The focus of the research is recovery, not any specific surgery or treatment.

I am writing to several surgeons with my request. I want to talk with people aged 70 and over after they have been discharged from hospital. Research participants would need to live in Christchurch and be able to understand and speak English. I would need to conduct the first interview about two weeks after the person's discharge from hospital.

Would you be agreeable to your receptionist posting the enclosed information sheet to about five patients over the period October to December? Neither you nor your staff would be involved in the research other than to make the information sheets available to patients who are to have surgery and who are over 70.

If you are able to help me I would provide the information sheets and stamped envelopes for potential participants. Research approval has been received from the Canterbury Ethics and Massey University Human Ethics Committees. I can supply a written copy of the approval if you wish. Once the study is completed I would provide you with a summary if you wanted.

If you have any queries I may be contacted by telephone (3518-003). My supervisors are Dr. Judith Christensen (telephone: 09-443-9700) and Marie Crowe (telephone: 03-372-0400). It would be helpful if you could confirm your assistance or otherwise either by telephoning me or completing the enclosed form.

Thank you for considering my request.

Yours sincerely

Ray Wootton

(b) Notice for Staff Dealing with Postage

Title of Study: **The Older Person's Experience of Recovery After Surgery**

Researcher: Ray Wootton, Contact No: (03) 351-8003

Attached are five postage-paid envelopes containing an information sheet and copy of a consent form.

_____ [surgeon] _____ who has the information about my study, has agreed to these envelopes being posted to up to five patients aged 70 years or over who will be having surgery between now and the end of October (this date may need to be extended).

If there are any queries please do not hesitate to contact me at the above number.

Your assistance is much appreciated.

Ray Wootton
Doctoral Student

APPENDIX TWO

Information to Participants

Title of Study: The Older Person's Experience of Recovery After Surgery

Researcher: Ray Wootton

Telephone: 351-8003

Supervisors: Dr Judith Christensen, Massey University at Albany
Marie Crowe, Christchurch School of Medicine

Introduction

My name is Ray Wootton. I am a registered nurse who has been involved in nursing education for 30 years. I am a doctoral student with the School of Health Sciences at Massey University. As part of my work for my degree I am undertaking a study to understand more about what it is like for older people going home to recover after an operation, and how they get on once they are at home.

Speaking with you about your recovery will allow me to learn from your experiences. Knowing more about recovery after an operation from the older person's point of view will help nurses to better understand what the experience is like and how care and services might be better planned and provided.

Invitation

You are invited to take part in this study. On my behalf your surgeon has arranged for this information sheet to be sent to you. I do not know any details about you. If you are willing to help me with my research or if you want more information before you decide please contact me. My telephone number is 3518-003.

About the Study

There will be up to 20 participants in the study. If you agree to take part through your participation I hope to understand what your experience of recovery is like. I will ask you how you feel you are progressing, and to tell me about specific episodes, situations, events, or experiences that come to mind and what these are like for you.

If you agree to take part in the study:

- a) I would arrange with you a suitable time and place for us to meet and talk together.

- b) I would meet with you about 2, 4, 6, and 8 weeks after you come out of hospital. We would talk about how you are getting on in your recovery and what the experience is like for you.
- c) There are no expected risks or discomfort for you. The length of each meeting will depend on how you are feeling and what you want to say but is likely to be about an hour. At any time if you feel uncomfortable or not well enough to continue our talk we can stop. In total there would be 4 to 5 interviews and the time involved for you would be from 5 to 10 hours.
- d) I would like to tape record our conversations so that I have an accurate record of what we say. The taped conversations will be typed up. You will be able to read the transcripts and we can discuss them and make any changes you want. I will keep the tapes and transcripts locked up.
- e) When I have completed the interviews with all the participants I will contact you to discuss any common themes that have arisen and ask your opinion about whether they describe your experiences.

Participation

Your participation is entirely voluntary (your choice). You do not have to take part in this study and this will not affect any future care or treatment. Please feel free to take your time in thinking about taking part in the study and discuss it with others, for example your family, before deciding. I would like to meet with you to discuss what is involved in the study and to answer any questions you might have.

If you agree to take part in the study you have the right to:

1. Ask any questions at any time.
2. Withdraw from the study at any time without having to give a reason.
3. Decide not to answer all the questions.
4. Stop the interview at any time.
5. Have the tape turned off at any time.

If you have any queries or concerns about your rights as a participant in this study you may wish to contact a Health and Disability Services Consumer Advocate, telephone 03 377 7501.

Confidentiality

The information you provide is confidential

No material which could personally identify you will be used in any reports on this study or in any publications arising from the research.

The tapes and typed material will be kept in a secure place accessible only to me. The only people dealing with this material will be me, my supervisors, and the person who types up the tapes. The typist will be required to sign a confidentiality agreement

If you wish you can have a copy of your tapes and transcript.

At the completion of the study if you decide you do not want your tapes or transcript, with your consent the tapes will be erased and the typed copy will be destroyed.

Results

When the study is written up in its final form for the doctorate a copy will be held in the library at Massey University. I will have a copy you can borrow and I will send you a summary of the study. Material from the study may be published in professional journals.

Thank you for reading this information and considering if you will take part in my research.

If you agree to participate in the study you will be asked to sign a consent form - see attached copy.

Please feel free to contact me if you have any questions. My contact number is at the top of page 1 and my supervisors' numbers are:

Dr Judith Christensen
Massey University, Albany Campus
Phone: (09) 443 9700

Marie Crowe
Christchurch School of Medicine
Phone: 372 0400

This study has received ethical approval from the Canterbury Ethics Committee and the Massey University Human Ethics Committee.

APPENDIX THREE

Participant Consent Form

Title of Study: **The Older Person's Experience of Recovery After Surgery**

Researcher: Ray Wootton, Telephone: 351-8003

I have been invited to take part in a study to find out about the experience of recovery at home after an operation.

I have read the information provided by Ray Wootton and she has explained the details of the study to me. I have been given the opportunity to discuss it with her and ask questions about it. I am satisfied with the answers I have been given. I understand that I may ask further questions at any time.

I have had enough time to consider whether to take part and to discuss my decision with a person of my choice.

I understand that:

- my taking part in this study is voluntary (my choice)
- I am free to withdraw from the study at any time and for any reason
- I am free to stop the interview at any time, and to decide not to answer any questions I don't want to answer
- I have the right to ask for the tape to be turned off at any time during an interview
- my participation in this study is confidential, and no information that could identify me will be used in any reports on this study

Title of Study: **The Older Person's Experience of Recovery After Surgery**

Researcher: Ray Wootton, Telephone: 351-8003

I have read and I understand the Information Sheet. I will be given a copy of this consent form.

I understand that this study has received ethical approval from the Canterbury Ethics Committee and Massey University Human Ethics Committee.

I consent to take part in this study under the conditions set out.

I agree / do not agree to the interviews being audiotaped.

I wish / do not wish to receive a copy of the transcript and taped interviews

I wish to receive a copy of the summary of this study - Yes/No

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date:

Copy to: 1. Participant
 2. Researcher - Ray Wootton

APPENDIX FOUR

The following two pages:

- Approval letter from Canterbury Ethics Committee
- Approval letter from Massey University Human Ethics Committee

CANTERBURY ETHICS COMMITTEE

South Office
4th Floor, 144 Kilmore Street
PO Box 3877
CHRISTCHURCH
New Zealand
Telephone 03 372 1000
Facsimile 03 372 1015

26 June 1998

Ray Wootton
84B Memorial Avenue
Christchurch 5

Dear Ray

The Older Person's Experience of Recovery After Surgery: A phenomenological study

Investigator: Ray Wootton; Supervisors: Dr J Christensen (Massey)

Protocol Number: 98/05/048

Thank you for your response to the Committee's comments and the amended information sheet and consent forms. Ethical approval is now confirmed for the above study.

Approvals granted to protocols are for 12 months. If, after 12 months the study is not completed, it will be necessary to forward to the Committee a request for an extension. A form to assist with this is available from the Administrator. Please quote the above protocol number in all correspondence relating to this study.

It is also a requirement of the Committee that researchers submit a report upon completion of their studies. I look forward to receiving your report in due course.

Yours sincerely



Sally Cook
Ethics Committee Administrator



**MASSEY
UNIVERSITY**

Private Bag 11222
Palmerston North
New Zealand
Telephone +64-6-356 9000
Facsimile +64-6-350 5000

**FACULTY OF
BUSINESS STUDIES**

**DEPARTMENT OF
HUMAN
RESOURCE
MANAGEMENT**

30th June 1998

Ray Wootton
84B Memorial Avenue
CHRISTCHURCH 5

Dear Ray

Re: Human Ethics Application HEC 98/93
The Older Person's Experience of Recovery after Surgery: A Phenomenological Study

Thank you for your letter of 23rd June and the amended information sheets and letters.

The amendments you have made now meet the requirements of the Human Ethics Committee and the ethics of your proposal are approved.

It is my understanding that the Human Ethics Committee do not want you to go ahead with the offer of \$50 for participation and they believe that the best way to deal with this is, as you say, by thanking participants both verbally and in writing.

Yours sincerely

Professor Philip Dewe
Chairperson
Human Ethics Committee

c.c. Dr J Christensen
Department of Nursing and Midwifery
Albany Campus

APPENDIX FIVE

Transcriber Confidentiality Agreement Form

Title of Study: **The Older Person’s Experience of Recovery After Surgery**

Researcher: Ray Wootton, Contact No: (03) 351-8003

I understand that this study has received ethical approval from the Canterbury Ethics Committee and Massey University Human Ethics Committee.

I accept that the information transcribed from the audiotapes of participant interviews arising from the research is confidential.

I understand that no such information is to be discussed with or divulged to any person other than the researcher.

All interview printed material, tapes, and computer disks relating to the interviews carried out as part of the research must be returned to the researcher.

I have discussed these requirements with the researcher and I accept the conditions stated.

Transcriber: _____ **Date:** _____

Signed in the presence of the Researcher: _____

APPENDIX SIX

Interview Prompts

(a) Interview 1

I am interested in how you felt about your operation and how you have been since you came home / out of hospital.

Tell me about the operation and being in hospital

- what you had done, how you felt about it
- significant things remembered - what sticks in your mind?
- how long were you in hospital?
- recovery points
- effect of condition on health and wellness

Tell me about being at home

- what has it been like for you?
- how has it been for you since you have been at home?
- how did you feel about coming home / out of hospital?

Tell me about your experience of recovery. What is the experience like for you? What are the things that have made you think / feel you are improving, getting better, recovering?

- how are you feeling?
- what changes do you associate with recovery ?
- what are the things that give you hope / encouragement?
- what are the things that have / do worry you, cause concern, are holding you back?
- are you feeling better / worse than you expected?
- how are you managing?
- what has been most help? What have you needed help with?
- are the things that have been / are significant for you since you've been home, physical / emotional etc?

What stands out for you?

- are there specific instances, situations, people, that come to mind which illustrate for you the experience you have gone / are going through as a result of the operation?
- what incidents, events, people connected with your recovery stand out for you?

Is there anything else you want to say (about the experience)?

.....

(b) Interview 2

It is now about two weeks since I last saw / spoke with you.

What has been happening for you in the last two weeks?

Are you feeling any better?

- what is making you feel better, that you are improving?
- why do you feel that you haven't made much / any progress?
- what makes you feel you are not feeling any better?

Last time we talked you mentioned:

.....

.....

.....

[seek feedback on above issues]

What do you do to help yourself recover / can you give me an example of...?

What do other people do to help you recover / can you give me an example of ...?

**How does what is happening to your
affect what you feel about the rest of your body (i.e. focus /
preoccupation)?**

Is there anything else you want to say (about the experience)?

.....

.....

.....

(c) Interview 3

It is now about six weeks since you came home.

What are the things you can do for yourself now?

Last time we talked you mentioned:

.....

.....

.....

[seek feedback on above issues]

In what way do you feel better as a result of your operation?

Have you any continuing problems as a result of your operation?

How do you think your recovery is proceeding / getting on?

What will make you feel you've recovered?

What will recovery mean for you? [looking to the future?]

Is there anything else you want to say (about the experience)?

.....

.....

.....

(d) Interview 4

It is now about 8 weeks since you came home and the last time for me to talk with you about your recovery.

How do you think your recovery is proceeding / progressing?

What are the things about your recovery that stand out for you at this time?

How far do you think you will have to go before you consider you are “recovered”?

- what else will have to happen for you to feel you have recovered?
- what does / will it feel like for you to consider yourself recovered?

[Earlier you said you were glad to be home]

What do you feel about being at home for this period of recovery?

What does being at home to recover, mean for you? (rather than elsewhere)

How has the operation fulfilled / met your expectations?

- how do you think your life has changed as a result of the operation?
- how do you feel about the future (in relation to surgery)?

How do you think your age has affected your recovery?

How do you feel about being the age you are at?

[Issues to follow up as required – from previous interview/s]

.....

.....

.....

Is there anything else you want to say (about the experience)?

.....

.....

We have now finished all the interviews and I will be contacting you about any queries, about what might arise out of all the interviews, the tapes and transcripts, and the summary of the results.