SELF PERCEIVED NEEDS OF THE FAMILY MEMBERS OF THE ELDERLY SURGICAL PATIENT

by

Lynne Parsons

a thesis
presented to the University of Manitoba
in partial fulfillment of the
requirements for the degree of
Master of Nursing
in
School of Nursing, University of Manitoba

Winnipeg, Manitoba 1991

National Library of Canada
Acquisitions and Bibliographic Services Branch
395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale du Canada
Direction des acquisitions et des services bibliographiques
395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

ISBN 0-315-77733-8

Canada

SELF PERCEIVED NEEDS OF THE FAMILY MEMBERS OF THE ELDERLY SURGICAL PATIENT

BY

LYNNE PARSONS

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

TABLE OF CONTENTS

Abstract

This descriptive study investigated 18 family members who were each involved in supporting an elderly relative when s/he had surgery. The focus was on self-perceived needs of family members, as well as the supports, both formal or informal, that families found helpful while the elderly relative was hospitalized and then discharged. Family systems theory and the double ABCX model of family stress (McCubbin & Patterson, 1983) provided the sensitizing framework for the study.

Data gathered via semistructured personal interviews revealed that the surgical experience did create stress for most families but did not precipitate a crisis situation even when the diagnosis was cancer. Spouses and adult offspring provided major social supports to the patient. Physicians were perceived as being helpful and informative. Nurses were perceived as being technically competent but this was not necessarily perceived as conveying caring. In the hospital nurses were not seen as having a major teaching or information-giving role.

Implications for nursing practise and administration and suggestions for future research are made based on the study findings.

Acknowledgements

I wish to extend a sincere thank you to Dr. Erna Schilder, Dr. Eleanor Adaskin, and Dr Carol Harvey. Their support and guidance throughout the project were much appreciated. This was no easy task given the distance. I was truly fortunate in having them for my committee. I also want to thank Dr. T'ien and the families who participated in the study and so willingly shared their time and experience. To my husband Ian and my son Adam go my heartfelt thanks. Their love, support and patience helped me persevere and complete the project. Thanks for believing in me fellows.

I wish to dedicate this work to my mother. She saw me start this course of study but died before it was completed. Thanks Mom for giving me the encouragement to start and for passing on to me the value of finishing what one starts.

CHAPTER 1

Statement of the Problem

Nursing care of elderly surgical patients and their families is an area scarcely researched to date. There is every indication that the elderly population will continue to grow in numbers creating an ever broadening range of demands for health care services. The health care system is going to be increasingly challenged to develop comprehensive yet economical approaches that will meet the unique needs and problems of this particular patient group and their families.

In 1986 10.6% of the Canadian population was sixty-five years or older. Projections indicate that by the year 2001 this group could comprise as much as 14% of the population (Kamenir, 1989) and by 2036 this could be as high as 25% as the post war baby boom children reach 65 years of age (Mimoto, 1989).

The marked increase in the population over the age of 65 presents the health care system with the dilemma of meeting increased need for services with limited resources. Dimond (1989) reports that in 1984 the United States population over 65 years of age made up 12% of the total population but they accounted for 31% of the nation's total health expenditure. The older age group has the greatest prevalence of chronic disease and recent estimates indicate that 80% of health care resources in the United States are used to treat chronic diseases (Reigle, 1990). In a Canadian study Lapierre (1990) also reports that a small proportion of the elderly population uses the majority of health services.

In Canada we spend approximately $60 billion a year on health care (Ramsey, 1991). In 1990 approximately one third of all provincial budgets was directed to health care services while at the same time federal financial input to these services was decreasing (Banning, 1991). It is inevitable that if Canadians wish to maintain quality universal health care, they will soon have to make some difficult choices between the two opposing goals of maintaining quality and containing costs (Nyberg, 1990: Ramsey, 1991).

The elderly population use more health services than the rest of the population, seeing physicians 50% more frequently and incurring four times the cost of health services of other age groups combined (Kamenir, 1989). Mullens (1991) reports that presently almost 50 cents of every dollar spent on health care in Canada goes to someone over 65 years of age.

Statistics collected by Health and Welfare Canada between 1985-86 revealed that the average length of hospital stay increased with age and the discharge rate for the group over 64 years increased by 13% (Riley, 1989). In the 65 years and older age group the hospital separation or discharge rate increased by 47.9% since 1971, while rates per 100,000 population for surgical procedures decreased for all other age groups (Riley & Kanagan, 1989). Between 1987-88 the average length of hospital stay for surgical procedures for the entire population was 11.2 days for men and 9.5 days for women with the longest being 17.1 days for men and 20.9 days for women in the 65 and older age group (Statistics Canada, 1990). Hospital care is costly and given the current financial reality of shrinking budgets, length of hospital stay for the elderly surgical patient is likely to come under close scrutiny.

Health care professionals will be compelled to strive for earlier discharge or possibly even ambulatory surgery services for this particular patient group as a means of cost containment. As a consequence the work of postoperative recovery is shared, if not totally transferred, to those at home, and many home care issues will need to be addressed (Alderman & Cruise, 1989; Firsch, Groom, Sequin, Edgar & Peplar, 1990; Given & Given, 1989; Naylor, 1990). While expecting families to assume the supporter or helper role, it is important to recognize that this expectation may create strain. Families themselves have needs and their ability to provide ongoing support appears to be directly related to the level of support they receive (Blythe, 1983; Bouman, 1984; DiMatteo & Hays, 1986; Gaglione, 1984; Gardner & Stewart, 1978; Haggmark, 1990; Robinson, 1988; Tringali, 1986; Welch, 1981; Wilson, 1982). Indeed in the case of ambulatory surgery patients, families' acceptance of the caregiver role is critical to the safe recovery of the patient (Firsch et al., 1990).

Jackson (1990) reports that the main source of support for elderly discharged patients continues to be the family. The elderly patient tends to need more assistance and for a longer time post discharge than most other age groups and yet often theirs is the smallest support group upon which to rely (Given & Given, 1989; Hawe, Gebski & Andrews, 1986; Naylor, 1990; Woods, Yates & Primomo, 1989). It becomes increasingly important that those existing resources are reinforced if the family are to play an active role in the recovery and convalescence of the elderly surgical patient. This can only come about by identifying the needs of the elderly surgical patient and their families and applying this understanding to improved home focused health care that enhances the coping and family functions of the caregivers. A study to explore the needs of these family members and identify how best to meet their needs is vital and timely.

Recognizing that nurses will be dealing with elderly surgical patients and their families in ever increasing numbers, this exploratory study will examine the post surgical experience from the family members' perspective to identify the support or helper role they are expected to perform. The purpose of this study is to explore 1) the family members' perceived needs during the post operative period of their elderly family member, and 2) those activities by health care workers or others that helped them assist their family member to cope after discharge from the hospital.

Research Questions:

1. What are the perceived needs of the family members of the elderly surgical patient during hospitalization and

after discharge from hospital?

2. What activities by health care professionals or others are seen as helpful in coping with the family member at home?

It is also important to acknowledge several underlying assumptions held by the author which have guided the study. First, nurses should be committed to provide total patient care to the patient and the family. Second, family members' perceptions of their needs are considered valid, as they are the actual co-participants in the experience. Third, the family is defined as anyone, related by birth or not, who is significant to the patient; i.e., family members are who the patient says they are (Wright & Bell, 1989). Fourth, need is defined as a requirement, which if supplied, relieves or diminishes an individual's distress or improves his/her sense of adequacy or ability to carry out a function or activity.

The issue of elderly surgical patients with their unique set of needs and problems is one that health professionals are going to confront on an ongoing basis and most likely in increasing numbers. This study will explore the family as one of the major resources available to help the patient cope and it is hoped that its results will help health professionals identify strategies that will help them in their struggle to contain costs while providing high quality care. The perspective family members have about the surgical experience of an elderly family member and the roles they feel prepared to assume in the post operative period is the focus of this exploratory study. The next chapter will review the findings of a relevant literature review.

CHAPTER 2

Literature Review

While an extensive review of the literature revealed increased attention directed toward the family and the role it can play in the illness experience, this review will be confined to literature which helped guide the development of this study. Included will be a brief discussion of illness and the family, and the concept of family centered care. This will be followed by a more extensive delineation of those studies which dealt with family needs in specific clinical settings.

Any illness, regardless of severity, can produce stress in the family (Craven & Sharp, 1972; Brandt, 1984; Leavitt, 1984). It "affects the family as a whole, and the family affects the individual's response to the illness" (Hanson, 1987, p. 5). In some instances spouses have actually reported higher levels of anxiety than the patient both during hospitalization and upon discharge (Gilliss, 1984). Silva (1987) points out that there is increasing evidence that surgery may be more stressful for individual family members than it is for the patient. Surgery on the elderly patient may create a potential crisis for patients and their family as a result of the disruption of what has been an otherwise steady state since it necessitates reorganization to re-establish a sense of equilibrium for everyone involved.

Providing care to both the patient and the family is an essential aspect of quality nursing care (Hymovich, 1974). "The need for the family to be the target of nursing care is especially true if the staff expects the family unit to pull itself together, mobilize resources, and carry on nursing responsibilities in the home setting" (Welch, 1981, p. 366). Care is being provided to the patient; but the question remains unanswered whether it is family centered or whether this even is an expectation of the recipients of health care.

While there has been considerable research on the family related to their mental health, nursing studies of how the family manages with physical health problems are scarce. Wright and Leahey (1990) reported a trend toward increased nursing research on the family and physical illness. They suggested that this research will profoundly expand the knowledge of the impact and long term consequences serious illness has on the family member and on the family unit, and they postulate that more effective and comprehensive care will ensue. Moriarity (1990) concurred that identification of family variables related to the individual and family management of stressors will enhance nursing assessment and the development of interventions appropriate for families with specific health problems.

Community health nurses and nurses in some specialized areas such as pediatric, oncology and intensive care areas have recently become more family focused. However in other clinical areas, such as medical-surgical nursing, the importance of the patient/family relationship is often ignored or overlooked (Brandt, 1984; Daley, 1984). Care in these areas tends to be focused solely on the individual despite nurses professing that they advocate family focused care.

The current nursing shortage prompted Hendrickson and Doddato (1989) to study the perceptions nurses have about the choices they make among competing activities, contrasting these perceptions with their opinions of what tasks they would like to spend time on. Nurses identified giving psychosocial care to patients and families as a professional nursing function, and yet this function was given inadequate attention when time was lacking. This inability to meet their own expectations of their nursing role and to provide the care they believe their patients and families deserve can lead to dissatisfaction and frustration. Yet another study suggested that some nurses feel inadequately prepared to provide the psychological care needed by patients and families and opt to pass this responsibility on to those they feel are better qualified to provide the support (Wilson-Barnett, 1988). These two quite different findings raise two questions. The first of these is whether nurses are consistently prepared to care for families. Second, in a time of financial constraint, is whether administrations truly do value family focused care and whether they convey this commitment to the nurses at the bedside.

The belief that illness has an impact on the whole family, and that the determination of relative needs would help ensure that the energy of health care professionals was not misdirected, have prompted a number of studies focusing on the needs and nursing care of family members. The review of these will be outlined according to the clinical area along with specific studies done to develop useful assessment tools or to compare perceptions of family members and nurses in the various clinical settings.

Needs of Grieving Families

Grieving spouses were one of the first groups of family members to be studied. Hampe (1975) found that spouses whose mates were terminally ill could identify their own needs although that did not necessarily mean those needs were met. Spouses felt that nurses' primary responsibility was to the patient, and they did not expect nurses or doctors to be concerned about the needs of the family members. Nursing behaviours directed toward supporting the patient rather than the relative were most valued by family members of the terminally ill in another study (Friehofer and Felton, 1976).

Dracup and Breu (1978) interviewed 26 spouses of acutely ill terminal patients. Thirteen who received no consistent nursing interventions were the control group and 13 who received interventions according to a standardized nursing care plan based on Hampe's findings were in the experimental group. The needs of the spouses in the experimental group were met more consistently and completely. The researchers attributed the difference to the utilization of the standardized nursing care plan.

Needs of Families of Critically Ill Patients

The needs of family members with a relative who is critically ill has been the focus of considerable research. Studies have focused on identifying the needs of family members, ranking the importance of the needs, and in some studies on an exploration of whether the needs were met and by whom. The research covers a variety of settings, including medical and surgical Intensive Care Units (ICU) and patients with a range of diagnoses such as cardiac surgery, trauma, head injuries and myocardial infarctions. Data collection occurred while the patient was in ICU or shortly after the patient was discharged to the ward. Needs of family members have been researched from the families' perspectives as well as that of health care workers.

Identifying needs. Molter (1975) interviewed 40 family members after their relative was transferred to a general ward from ICU and found that family members could identify and rank their needs. They ranked the need for honesty as the highest priority. A caring attitude toward the patient, information concerning the patients' prognosis and being kept informed of the patient's condition were ranked, in descending order. No description of diagnosis was given.

In exploring Molter's findings further Daley (1984) interviewed 40 family members within 72 hours of their relative's admission to ICU and found the needs for relief of anxiety and information ranked highest and were perceived as best being met by the physician. Bouman (1984) utilized a Q sort methodology which involved 45 need statements adapted from Molter's study and covered cognitive, emotional and physical needs. She interviewed families within 36 hours of patient admission to ICU and again 96 hours after admission to the ICU. She found that family members of the critically ill patients ranked their cognitive needs higher than emotional or physical needs but all needs were rated lower the longer the patient had been in I.C.U.

Mathis (1984) utilized Molter's interview guide in an attempt to determine if family members of critically ill patients, who had sustained an acute brain injury, had personal needs that differed from family members of other critically ill patients. There were marked similarities in the needs identified, but there was a significant difference in the perception of the degree of importance of personal needs which emphasized the need for individualized nursing care for family members of critically ill patients.

<u>The Critical Care Needs Inventory</u>. Leske (1986), in

co-operation with Molter, developed the Critical Care Family Needs Inventory (CCFNI). This 45 item questionnaire utilized the need statements developed by Molter (1979) and was administered to relatives within 72 hours of the patient's admission to the ICU. No new needs were identified by the families and no statistically significant differences were found in the 10 most important needs between Molter and Leske's data. However the needs about the environment and visiting hours were ranked significantly differently than in Molter's study. The fact that Leske had families answer the questionnaire while the patient was in ICU rather than on the ward may account for this later variation.

Norheim (1989) administered the CCFNI to families while patients were undergoing coronary artery bypass surgery. The need for obtaining honest information once again ranked highest, while a variation in the ranking of a need for a telephone, the need to be alone or being encouraged to cry led her to conclude that the timing of assessment of needs has an impact upon the ranking of needs. Spouses and relatives ranking of importance of needs varied slightly, but both groups felt that the nurses were the greatest resource in meeting their needs.

The CCFNI or other adaptations of Molter's original 45 need statements have been used in a number of different studies. Price, Forrester, Murphy, and Monaghan (1991) suggested that the CCFNI does not discriminate between the relative importance of needs and that this is a possible limitation of the tool. This concern regarding discrimination of items arose also when the CCFNI was translated into French. The result was a 33 item French translation of the CCFNI which was tested in a Surgical Intensive Care Unit in Sherbrooke, Quebec. Once again family members ranked having questions answered honestly and being assured that the patient is getting the best possible care most highly (Coutu-Wakulcyzk & Chartier, 1990).

<u>Family members' perception of the support role of health care workers</u>. Family members while perceiving that nurses helped meet their needs in most instances, believed that staff were responsible only for the care and support of the patient and not the family (Molter, 1974). Stansfield (1989) found that family members of brain injured patients could identify caring behaviours, but they did not expect support from the health care team for themselves. The focus of family members is on those needs pertaining to the welfare of the patient, not their own, and this appears to

extend to the need for emotional support (Price et al., 1991).

Since most patients are a member of a family, the family and staff need to recognize that caring for relatives is an integral part of total patient care. The finding that relatives perceive the role of the health care workers to be patient centered only points to the need for further study of this aspect of total patient care (Molter, 1979; Price et al., 1991; Stansfield, 1989).

Comparing families' perception of their needs with nurses' perceptions of family needs. Studies comparing families' self perceived needs with ICU nurses' perception of family needs found similarity in family needs identified but a difference in the ranking accorded to needs (Lust, 1984; Norris & Grove, 1986). Honest information, effective communication, a caring attitude, hope, flexible visiting hours, a support system and a comfortable environment were rated most highly by family members. Lynn-McHale and Bellinger (1988) reported that critical care nurses are moderately accurate at identifying the extent to which family members perceive their needs as being met. They also identified the need to study the importance of the need in relationship to the level of need satisfaction.

Jacano, Hicks, Antonioni, O'Brien, and Rasi (1990) studied two groups of registered nurses, one from an adult ICU and the other from a neonatal ICU setting, and compared their assessment with those of family members who had a critically ill member on one of those units. While nurses' perceptions were congruent with each other regardless of the type of unit, family members consistently ranked their own needs higher and in some cases differently than did the registered nurses. Nurses valued information but seemed to underestimate the need of the family for specific information and did not recognize family members needs to feel accepted by the staff.

Meanwhile Forrester, Murphy, Price and Monaghan (1990) compared the perception of critical care family needs between family members and ICU nurses providing direct care to their family member and found a significant difference between what nurses and family members perceive as the most and least important needs of the family members. Indeed nurses were accurate only 50% of the time. O'Malley et al. (1991) found nurses from different critical care areas ranked needs significantly differently and attributed this to patient acuity and length of stay in the unit. They also concluded that nurses' perception of family needs is influenced by length of time practising in critical care, educational background, and length of time in nursing.

The importance of communication is apparent as is emphasized by Lust's (1984) findings that communication or lack of it greatly influenced how the family with a relative in ICU rated the stress of the experience. Indeed Gardner and Stewart (1978) found that nurses' failure to interact appropriately with family members lead to increased anxiety, fear in the family, misunderstanding, mistrust, hostility and failure to obtain important information. Arkley (1990) found ICU bedside nurses to be the health care professionals most available to give information to relatives, but she also reported that these same nurses found this activity stressful and frequently passed the task to those they considered more qualified or experienced.

A summary of the findings. The needs of family members with a relative who is a patient in the ICU setting have been assessed quite extensively. Hickey (1990) summarized eight research articles on the needs of families of critically ill and concluded that while the studies had relatively small sample sizes, the findings were similar.

Information needs were frequently identified by families as being among their most important. The need for reassurance that their family member was receiving the best possible care ranked highly as did the need to feel hope and to feel accepted by personnel. The difference lies in the ranking of importance of needs and has been related to patient diagnosis, timing of assessment, and/or relationship to the patient.

Nurses were identified as meeting most of the needs, but there was some evidence that the most important needs for families were satisfied by physicians (Hickey, 1990). Dracup (1987) indicated that while the needs of these families have been well explored, interventions have not been developed or tested and that this should become a research priority.

The research on the needs of the family members of the critically ill patient indicates that family members have specific identifiable needs which are very individualized. Nurses' awareness and concern for families of the critically ill patient are also apparent, but their perception of the priority of those needs is quite different from those of families. Nurses can assist families meet their needs only when they are made aware of the discrepancy between their views and what family members would prefer.

Needs of Families of Surgical Patients

Silva (1987) examined the needs of spouses of patients undergoing major general surgery with an expected benign outcome, using a questionnaire adapted from Molter's work. The most important spousal needs identified were for reassurance about the quality of care, availability of hospital staff and understandable information about the patient's hospitalization and surgery. Although the general type of surgery was identified the average age of the patient was not stated.

Needs of Families of Cancer Patients

Other studies have focused on families of cancer patients. Bullough's study (1981) of the support role nurses play for the breast cancer patient lead her to suggest that there is a gap between the support role nursing proclaims and the reality of that role in the clinical setting. Oberest and James (1985) reported that spouses of cancer patients experienced distress, anger and frustration about the lack of support from professionals. They also recognized that the post discharge period could be extremely distressing, as much of the internalization and adjustment to the cancer diagnosis takes place once the patient has gone home. In a further study the need for supportive interventions for spouses was apparent but the optimal timing for them was not (Oberest & Scott, 1988).

Vess, Moreland, Schwebel and Kraut (1988) stated that "effective communication between staff and family may alleviate the patient's and family's anxiety and result in improved medical care for the patient" (p. 48). They suggested that the current structure of hospital based health care delivery is in many ways inadequate to meet the psychosocial needs of cancer patients and their families.

Research investigating the need of family members of cancer patients revealed the importance placed on the cognitive need for honest information regardless of the stage of the cancer. Physical needs of family members were consistently reported as least important and the percentage of important cognitive and emotional family needs decreased after the initial diagnosis (O'Brien, 1983; Tringali, 1986; Vess et al., 1988). In a study by Lovejoy (1986) preparation for the unknown, validation of worth and provision of assurance were identified as nursing activities helping families during a relative's hospitalization with cancer.

Elderly Patients and their Families

Thompson (1989) suggested that recent research identifies a positive relationship between a supportive network, largely composed of relatives, and an elderly person's ability to cope with stressful problems. Many patients 75 years and older needed the help of family or friends immediately after discharge but within three months of discharge most had resumed their prehospital living pattern (Hawe, Gebski, & Andrews, 1986). Conndis (1989) stated that the interdependence characteristic of most older marriages enables couples to adapt when one of the spouses needs care, particularly when it is a physical illness with the possibility of recovery. In the absence of a spouse, the key person in the supportive role is usually a daughter who in many instances is middle aged and has other family responsibilities as well.

While family members assume the largest responsibility for posthospital care of the elderly patient, it is often at cost to their own well being. Burden created for the caregiver of the elderly needing assistance with more than one activity of daily living is well documented, and it is important to recognize strengths of these caregivers if we are to truly assess their needs and develop interventive strategies (Fletcher & Winslow, 1991). Support services, particularly for the patient, may be available but there has been some reluctance to utilize these services. The nature of these attitudes and the services themselves need further research (Wolock, Schlesinger, Dinerman, & Seaton, 1987).

The elderly tend to have a number of readmissions but Naylor (1990) discovered fewer readmissions in a group of elderly patients who had received comprehensive discharge planning. Family support appeared to be the most important factor in determining patient outcomes in a study in France involving 75 elderly patients with medical problems (Roudot-Thorval, Boubert, Fourestie, & Lejonc, 1987).

From these later studies it is apparent that the posthospital needs of both the elderly patient and their caregivers must be assessed upon admission to the hospital to plan for community services well in advance of discharge. Meeting the needs of family members will help them provide the support the elderly patient needs to return to his/her prehospital status. Everyone, including the patient, family, nurse and ultimately society, benefits when the family is nursed as a unit (Stanik, 1990).

The ability of family members to identify their own needs has been well researched in both critical care and oncology settings. There is a marked similarity in the needs identified by both families and nurses regardless of the clinical setting. There are, however, marked differences in the ranking between nurses and families and between families of patients with different diagnosis and at different points on the illness trajectory. Perception of personal needs is quite subjective and should be individualized for families in a variety of settings. "In deciding on the most appropriate style and types of support for anyone it is vital to explore their needs" (Wilson-Barnett, 1988, p. 218). From the review of the literature it is evident that the needs of family members of the elderly surgical patient have not been explored. It is important that nurses understand the needs of family members in order to facilitate their support as a resource for the patient (Rasie, 1980).

There is a decided lack of documentation about the needs of relatives of elderly surgical patients, although there is an increasing trend to utilize them for a support resource for this patient group. The next chapter will outline a sensitizing framework that guided the assessment of the postoperative surgical experience and the needs it created for families of the elderly surgical patients.

CHAPTER 3

Conceptual Framework

There are divergent points of view as to how structured qualitative research design should be. "The theoretical structure in a qualitative study is developed inductively and is expected to emerge from the data" (Burns, 1989, p.45). Miles and Huberman (1984) suggested that "researchers come to the fieldwork with some orienting ideas, foci, and tools" (p.27). The researcher's thinking is influenced by the metatheory of his/her discipline as is the choice of terminology, methods of analysis and articulation of findings (Burns, 1989). Miles and Huberman (1984) suggested that these theories provide a focusing function. It is incumbent upon the researcher to be explicit in the identification of what theories shaped the study in order to facilitate review and replication of the study. "Theory directs research and research findings shape the development of theory" (Fawcett, 1986, p. 569). Qualitative research is informed but not limited by theory (Moon, Dillon & Sprenkle, 1990). Theory provides a sensitizing framework which guides the initial design of the study but the framework continues to evolve and develop throughout the research process.

A basic premise of this study was that all individuals have needs. This is a requirement within the individual which stimulates a response to maintain integrity. Roy (1976) suggested that Maslow's hierarchy of classifying needs according to their importance for survival is frequently applied to discussions of needs. A belief that needs take on greater immediacy and importance in different sets of circumstances is inherent to the present study.

The overall goal of the study was to explore the surgical experience of the elderly surgical patient from family members' perspectives. The research questions are directed at identifying the self perceived needs of family members and the activities of health care workers or others that helped families cope with the post operative and discharge period.

The theories guiding this study were family systems theory as discussed by Friedman (1986) and family stress theory as outlined in McCubbin and Patterson's (1983) Double ABCX model of adaptation and adjustment to stress. These theories guided the initial study design, but as Lincoln and Guba (1985) suggested, with a study of this nature, the elements of the design evolved and became more clear and explicable as the study progressed through data collection and analysis.

Family Systems Theory

Family systems theory has evolved from systems theory. "A system is defined as a goal directed unit made up of interdependent, interacting parts which endure over a period of time" (Friedman, 1986, p.81). An open system is one that is in constant interaction with its environment both receiving input and sending output. The universe is made up of smaller open systems functioning within larger open systems.

The family is a "small group of closely interrelated and interdependent individuals organized into a single unit so as to attain specific purposes" (Friedman, 1986, p.83). Families are open systems in constant interaction with their physical, social, and cultural environment (Friedman, 1986). The nature of these relationships is so intricate that a change in any one member of the family will have an impact on each member and the family as a whole. The family is self regulating, containing homeostatic mechanisms to restore balance and is capable of transformation (Turk & Kerns, 1985). Family in this study was defined as anyone, related by birth or not, who is significant to the patient. In other words family members are who the patient says they are (Wright & Bell, 1989).

Individual family members and the family unit itself are constantly responding to internal and external input. The responses to these stimuli result in maintenance, repair, growth or possibly deterioration or destruction of the status quo of the system. The major goal however is to maintain a steady state. These responses are the result of complex interactions of many variables interacting in a circular rather than linear form of cause and effect (Adaskin, 1987; Turk & Kerns, 1985).

Illness is a change that places demands on both individuals and families. Families have an impact on illness and can promote responses conducive to recovery and a healthy condition or can conversely foster maladaptive responses resulting in increased stress. Family systems help determine the course and outcome of illness.

The patient and family are both open systems with psychosocial, physical and emotional needs, which when met have a positive effect on the health of the patient and the family. Unmet needs in turn have a negative impact on the health of the patient and the family (O'Malley et al.,1991). Recognizing the impact that illness has on the family system and the well being of the family, care should be directed to the total family system (O'Connell, 1989).

Family Stress Theory

Having recognized that illness has an impact upon the total family system, stress theory evolved as a model for examining this process. An early model was proposed by Hill (1949, 1958) and emphasized that the disorganizing potential of stress is related to the nature of the stressor event (A),the resources of the family (B) and the family definition of the event (C). McCubbin and Patterson (1983) expanded Hill's model to include post crisis variables (see Appendix A). This later model has helped guide the present study.

Mccubbin and Patterson (1983) suggested that over time Hill's ABCX model should be expanded to a double ABCX model. Their "aA" factor is viewed as a pile-up of demands over time. The source of these may be from the original stressor and its accompanying hardships, normative transitions, prior strains, the family's efforts to cope or from the ambiguity within the family and/or society. Family resources, the "bB" factor, were defined as personal resources, the family system's internal resources and social support. The "cC" factor is the definition the family makes of the seriousness of the experienced stressor and also the meaning or purpose the family attributes to the situation.

"Family adaptation becomes the central concept in the Double ABCX model used to describe the outcome of family efforts to achieve a new level of balance after a family crisis" (McCubbin & Patterson, 1983, p. 13). The model helps determine what specific dimensions of family life are likely to shape the course of family adjustment and adaptation over time. Units of analysis include individual family members, the family unit, and the community to which they belong. The balance among these three units is dependent upon a relationship of demands of one unit and the capabilities of another.

Five types of demands can compose factor "aA" (McCubbin & Patterson, 1983). First, the stressor can be a life event having an impact upon the family, together with other demands which create additional hardships for the family. For example an elderly cancer patient may require hospitalization for surgery or treatment in a city some distance from home. The illness is the stressor but the distance from home, the travelling required, the fatigue this causes and perhaps cost of travel are some of the accompanying hardships that may confront the family.

Second, normative transitions, while predictable and expected, can also create strain. Often there are several changes going on at the same time which can mean an increased degree of overall change and consequently place additional demands on the family to adjust and adapt. Family units may find themselves dealing with the illness and death of grandparents and at the same time the birth of grandchildren as their children establish their own family units.

Third, family systems carry with them the residue of prior strain; therefore, when a new stressor is experienced "these prior strains are exacerbated and families become aware of them as demands in and of themselves" (McCubbin & Patterson, 1983, p. 15). They may emerge quite insidiously rather than as discrete events and contribute to a sense of pile-up of demands. Previous experiences with illness or hospitals may be long forgotten but will surface again when a family member becomes ill.

A fourth source of stressors and strains appear as a result of specific behaviours used by the family to cope with the crisis. For example, a couple may relocate a frail elderly parent so that the person may be closer to them but soon thereafter the couple may have to move due to work transfers. The dilemma is whether to leave the parent behind in this relatively new setting or relocate him/her once again.

Fifth, a source of pile-up can be intrafamily and social ambiguity. Change may bring about confusion as to who belongs to the system and how to delineate roles. A system needs to be aware of its components and boundaries and any ambiguity in this area can be a major stressor (McCubbin & Patterson, 1983). Remarriage is a situation where there may be ambiguity for the family and society. Adult children may have difficulty accepting an elderly parent's new spouse.

The "bB" factor is the family resources or capabilities for meeting demands and needs arising as a result of the crisis. Personal resources refer to the characteristics of the individual family members and include financial, education, health and psychosocial resources. Family integration or cohesion and adaptability appear to be two of the most important internal family resources in the management of crises (McCubbin & Patterson, 1983).

Social support is defined "as the existence or availability of people on whom we can rely, people who let us know that they care about, value and love us" (Sarason, Levine, Basham, & Sarason, 1983, p. 127). Social support offers families information at an interpersonal level. This may take the form of emotional support that leads family members to believe they are loved and cared for. Esteem support encourages the member to feel valued. Network support means the family feels they belong to a network involving mutual obligations and understanding. This social support may be reflected in the form of instrumental support or counselling, active support or material support (Cobb, 1982). The elderly are likely to have less social support as a result of diminished finances, loss of family and friends and decreased access to transportation (McCubbin & Patterson, 1983; Woods et al., 1989).

The "cC" factor in the Double ABCX model is family definition and meaning. In the face of crises and the demand for change in the family unit, families attempt to give new meaning to the situation (McCubbin & Patterson, 1983). This helps the family clarify issues, hardships and tasks, making them more manageable and decreasing the emotional burden of the situation. Family adaptation is facilitated by redefining the situation as a challenge rather than a threat. Viewing the situation in a positive but realistic manner impacts greatly on how the family responds and adapts as a unit.

The family may indeed be able to balance the stressor event and its hardships with adequate resources and by redefining the situation in a positive light. They may be able to adjust with minimal change or disruption in the family's usual pattern of behaviour. "Adjustment can be viewed as a short term response by families, adequate to manage many family life changes, transitions and demands" (McCubbin & Patterson, 1983, p. 21). However there are situations where the demands outstrip the efficacy of the adjustment strategies. If this imbalance persists or increases the family moves toward crisis. "Crisis involves disorganization and the demand in the family unit to restore stability at its prior level or another (higher or lower)level of family functioning" (p.22).

The movement to initiate change marks the beginning of adaptation. The "xX" factor in the Double ABCX model refers to this phase in which the "processes of reconstruction and consolidation evolve over time as families work towards adaptation" (McCubbin & Patterson, 1983, p.23). McCubbin and

Patterson (1983) view this phase as a continuum. At the positive end is bonadaptation where the family is able to change and develop coping skills and acquire new resources. On the other end of the continuum is maladaptation, where instability and disruption persist, resulting in a dysfunctional family or perhaps disintegration of the family system.

The Double ABCX model of family stress presents a vehicle for examining the many variables,the complex interactions of these variables and the responses of families as they address stressor events which could develop into crisis states. It provided a framework for examining how families cope with the surgery of an older family member, a potentially stressful event.

The behaviour of any one member can only be understood in the context of the entire family system. The role of the family is crucial during every facet of health care (Friedman, 1986). Surgery on the elderly family member can certainly create stress and instability for the entire family system. The ability of the family unit to adjust to this change is dependent upon its experiences with past and present stressors, the adaptive resources available to it and how members define the situation. The next chapter will outline the various aspects of the methodology including ethical considerations for this study.

CHAPTER 4

Methodology

Research Design

The usefulness and the application of qualitative research for nursing has been the subject of considerable debate (Benner, 1985; Field & Morse, 1985; Leininger, 1985; Munhall & Oiler 1986). Although its acceptance is growing the criteria which apply to qualitative nursing research remain an area of controversy (Burns, 1989; Duffy, 1985; Goodwin & Goodwin, 1984; Sandewlowski, 1986).

Qualitative research involves "methods and techniques of observing, documenting, analyzing, and interpreting attributes, patterns, characteristics and meanings of specific contextual and gestaltic features of phenomena under study" (Leininger, 1985, p. 5). "Qualitative research methods help researchers obtain in-depth knowledge of human realities and meanings, participant expressions, relevant contexts, and intrinsic and extrinsic attributes of human experience" (Leininger, 1985, p.12). Qualitative research can generate a richness of data that expands nursing knowledge and can advance nursing practice.

This study was an exploratory-descriptive study to explore a phenomenon about which little is known. The aim was to describe human experience as it is lived (Munhall & Oiler, 1986; Omery, 1983). "The meaning of the client's reality through the phenomenological approach will reveal to the nurse the qualities of each individual's existence, which subsequently will provide a more comprehensive understanding of the nature of nursing itself" (Ray, 1985, p.85). It is the study of human experience from the actor's particular perspective (Knacck, 1984). Family systems theory and the Double ABCX model provided a sensitizing framework from which the self perceived needs of the family members of the elderly surgical patient were explored.

In depth informal interviews, guided by a tentative interview guide (see Appendix D), were conducted with participants. The guide was designed to elicit both definitive and unexpected kinds of information from the interviewee (Leininger, 1985). Its flexibility encouraged the participants to completely describe what the experience meant for them (Field & Morse, 1985; Swanson-Kauffman & Schonwold, 1988). The interviews were scheduled around the participants' availability and were conducted anywhere from four days to two months after the patient was discharged from the hospital. Interviews lasted between 30 to 60 minutes and were tape recorded. This freed the researcher to be attentive to the participants' words and gestures and to concentrate efforts on assisting the informant to reflect on the meaning of the events as they were discussed (Swanson-Kauffman & Schonweld, 1988).

Sandelowski's framework for assessing the rigor of qualitative research was applied to the study. The first criterion is the truth value or credibility, which refers to how well the study measures the phenomenon under scrutiny. A study is credible when "it presents such faithful interpretation of human experience that the people having the experience would immediately recognize those descriptions or interpretations of the experience as their own: (Sandelowski, 1986, p. 30). The discussion was summarized upon terminating the interview and arrangements were made to contact the participants for clarification, verification or correction of the data collected and the conclusions drawn.

The researcher has considerable experience working with surgical patients of all ages and their families. This experience, along with a review of the literature, helped reconfirm this author's belief that families can play a significant role in supporting patients and that nurses are in a position to enhance families' ability to do so. Having acknowledged these preconceptions, it was necessary for the researcher to set them aside both prior to and during the actual data gathering. This process of bracketing is an attempt to more fully understand the phenomenon and accurately portray the reality of the informants (Knacck, 1984; Munhall, 1982; Swanson-Kauffman & Schonwold, 1988).

Duffy (1984) postulated that in qualitative research the researcher is so immersed in the data that they are representative of the phenomenon being studied. This also carries with it the risk of "going native" since the researcher may have difficulty discriminating between his/her own experiences and those of the informants. This researcher kept a journal in which she outlined her perceptions during the data gathering phase, which provided another source of data for analysis.

Applicability of the study is the second criterion and refers to the fittingness of the study "to contexts outside the study situation and occurs when the audience views the findings as meaningful and applicable to their own experiences" (Sandelowski, 1986, p. 32). Participants were chosen because they represented the human experience under study, but there was the risk of "elite bias" since those who volunteered may have been more articulate and accessible than non-volunteers. The assumption of this study that perceptions of all family members are valid addressed this concern, but generalizability of the study is limited by a small sample size and its nonrepresentative nature. Sandelowski also cautions against "holistic fallacy" which stems from making data more homogeneous or patterned than they really are.

Consistency, the third criterion, is measured by auditability. A clearly delineated decision trail throughout the study can enable another researcher to arrive at the same or similar conclusions given the same data. Since the study reflects a unique natural setting and was done by the researcher alone, auditability was not easy even though the researcher collected the data in a consistent reliable manner as suggested by Lecompte and Goetz (1982). The investigator's interpretations and conclusions were compared with those of the informants at the conclusion of the interviews and thesis committee members were consulted with any concerns about validation or tentative conclusions.

Freedom from bias in the research process and product or neutrality is the fourth criterion against which the rigor of qualitative studies can be measured. This is achieved when "auditability, truth value and applicability are established" (Sandelowski, 1986, p. 33).

Data Collection and Analysis

Congruent with the qualitative approach, data collection and analysis occurred concurrently and helped shape one another in the process.

Recruitment and Sample Selection

The population from which the study was drawn were the family members who had a relative over 65 years of age undergoing surgery by a selected general surgeon, on North Vancouver Island. A non-probability convenience sample was selected. The patients were asked to identify their support persons who comprised the sample for the study. Eighteen family members were interviewed.

Participant inclusion criteria that were used are as follows:

1. The respondent was identified by the patient as a major support person.
2. The respondent was available and willing to be interviewed at some point in time during the patients' recovery period at home.

3. All respondents were at least 18 years of age.

4. Respondents had to be able to understand English verbally and in written form.

5. Respondents were mentally competent to answer open ended questions and to recollect their experience.

Instrumentation

In qualitative research the researcher is often the primary instrument. The outcome of the enquiry depends on the researcher's ability to engage with the informants' reality.

The person is the instrument of choice in much qualitative research for a number of reasons. The researcher is able to respond to personal and environmental cues and seek clarification or explore responses on the spot. This human instrument must be flexible and willing to adapt to unexpected circumstances in the quest for answers to the research questions. The ultimate credibility of outcomes depends upon the extent to which trust has been established (Lincoln & Guba, 1985).

The researcher developed an interview guide with questions geared to helping informants talk about their own experiences. This interview guide coupled with well developed interview skills allowed the researcher to move back and forth between encouraging exploration of the experience and verifying with the informant as the informants experience unfolded as suggested by Lincoln and Guba (1985). The need for the researcher to bracket her own preconceptions has already been discussed.

Data Analysis

A constant comparative method of analysis was utilized. The tape recorded interviews were transcribed verbatim as soon after the interview as possible. The journal was read concurrently with the transcripts, compared and contrasted for new insights. The transcripts were read while reviewing the tapes. This was a time consuming task but allowed the researcher to relive the interview, listen for and note any significant pauses or voice changes and to correct any errors in the transcription (Swanson-Kauffman, 1986).

The transcript was then read more slowly and hand coded to identify categories and themes. Coding is the method whereby the raw data is transformed and grouped into categories that permit precise description of relevant content characteristics (Glaser & Strauss, 1967). Care was taken that code words were derived as directly as possible from the data. Reviewing passages or paragraphs within the context of the whole interview permits the intent of the information to be coded in addition to allowing analysis of underlying meanings in the communication (Field & Morse, 1985). Transcripts were reviewed on a continuous basis for the purpose of relabelling categories and identifying possible omissions or redundancies. The computer program Qualpro was utilized to help with the sorting and searching process of codes necessary to defining categories. Once the researcher was satisfied that her analysis had identified the categories and had arrived at tentative conclusions, which she validated as discussed earlier, the final report of the findings was developed (Lynch-Sauer, 1985; Omery, 1983; Ray, 1985).

Ethical Issues

The study proceeded after approval by the Ethical Review Committee of the University of Manitoba School of Nursing. The researcher approached one of the general surgeons regarding the identification of elderly surgical patients and families for the study. The surgeon identified elderly patients whom he had slated for surgery. Both the surgeon and the researcher reiterated the point that participation in the study was entirely voluntary and free of coercion.

Verbal and written explanations of the study (see Appendix B) were given to the patients, and they were asked to identify their main support persons after discharge from the hospital. Once the patient had given permission to approach the informants the researcher did so and explained the study and asked if they were willing to volunteer for the study. An appointment for the interview, at a time and place of their convenience, was made and reconfirmed by phone just prior to the interview. Questions and concerns were clarified to the satisfaction of the patient and informants. The researcher was alert to any indication that the participant was becoming tired or uninterested and was prepared to interrupt and reschedule the interview as necessary. Family members were free to withdraw from the study at any time without consequence to them or the patient. The right and roles of the participants were carefully outlined in the verbal and written explanation and disclaimer given to the participant (see Appendix C).

The ethical principles of autonomy, non-maleficence and beneficence as set forth by Ford and Reutter (1990) guided the development of the explanation and disclaimer. In this study autonomy was assured by participation which was informed, voluntary and free of coercion. The voluntary aspect was stressed throughout the study. Potential participants were given as much information as possible prior to commencement (Archbold, 1986).

The principle of non-maleficence requires that the researcher "does no harm" (Ford & Reutter, 1990). Physical and psychological comfort of the participant was observed during the interview. Confidentiality was maintained by assigning a number code known only to the researcher to all transcribed material. All tapes, field notes and transcribed materials were kept in a locked drawer accessible only to the researcher and were destroyed upon completion of the study. Permission for publication was explained to the informants in the disclaimer. Only the researcher and her thesis committee had access to the code numbered transcripts. The interviews occurred in the informants homes, making the researcher a visitor with the responsibility of respecting privacy and minimizing intrusiveness.

The principle of beneficence relates to the benefits of the study. Subjects were made aware that participation in the study would not result in any direct benefit to themselves or to the patient. However the benefit lies in the generation of knowledge that may enhance future nursing practise. As the researcher was not involved in the caregiver role, subjects may have tended to be more forthcoming with information as no benefit or detriment to care was apparent.

The therapeutic imperative took precedence over the research mandate throughout the data collection. Nurses are patient advocates believing that trust, compassion and empathy encompass all endeavors including research (Munhall, 1988). The researcher wholeheartedly subscribes to this belief.

In summary this qualitative study was exploratory-descriptive in nature and involved informal interviews with eighteen family members of various elderly surgical patients. Participants were asked to describe their perception of the post operative experience and the needs it created for them as they helped their family member return to their optimum health status. Sandelowski's (1986) framework for assessing the rigor of qualitative research was applied throughout the study. Ethical issues were considered by carefully adhering to Ford and Reutter's (1990) principles of autonomy, non-maleficence and beneficence. The subsequent chapter will be an analysis of the data.

CHAPTER 5

Analysis of Findings

The findings generated by the study will be the focus in this chapter. This presentation will begin with a descriptive profile of the patients and participants comprising the study sample. The double ABCX Model of family stress (McCubbin & Patterson, 1983), which served as a sensitizing framework for the study, will be used to outline and discuss a substantial portion of the findings. The remaining findings will be discussed according to the categories that emerged as the researcher attempted to answer the research questions posed.

Study Sample

Of the 12 patients approached about the study only one woman declined to participate because she was being readmitted to another health centre for further treatment. All support persons identified by the patients also agreed to participate.

The sample was comprised of 11 patients and their identified 18 support persons. The age of the patients ranged from 65 to 96 years of age with a mean age of 75 years. The group included 4 women ranging in age from 65 to 85 years of age ($\underline{x}$= 72) and 7 men ranging in age from 65 to

96 years of age ($\underline{x}$= 77) (see Appendix E).

Of the 11 patients one had multiple medical problems, four admitted to two health problems and the other five patients stated they were being treated for one medical problem. Illnesses included heart disease, stroke, emphysema, hypertension, arthritis, urinary tract disorders, diabetes, "nervous" stomach, eye conditions and severe allergies. All patients took some form of medication and saw a physician regularly regarding the management of the identified health problems.

The surgical procedures included cholecystectomies, bowel resections, mastectomies and hernia repairs. The patients spent anywhere from 3 to 18 days in hospital with an average stay of 8.5 days. Patients were discharged on the average of 6.5 days after surgery. The earliest discharge after surgery was 24 hours following a laparoscopic cholecystectomy. Twelve days was the longest time spent in hospital after surgery and included one patient with a gangrenous bowel and another with a perforated bowel from diverticular disease (see Appendix E). Both these patients required admission to the ICU unit for a period of time either during their pre or post-operative period.

Of the eleven patients, nine of the patients were married, one was a widow and one a widower. Marital relationships were long standing. Only one marriage was a second marriage, and that couple had now been together close to 50 years. The two patients who had lost their spouses had been on their own a long time and had adjusted to living alone.

Nine of the patients lived in their own homes, one lived in a seniors' apartment and one was living with his son and daughter-in-law although he too planned to return to his own home. All couples were retired.

All patients and their spouses had raised children and maintained contact them, although in many instances the children did not live in the immediate area. Six patients had at least one child living nearby but only three of these identified their offspring as major supports through this surgical experience. Six children arranged to come to the area and spend some time with their parent during hospitalization. The amount of time ranged from several days to three weeks.

The individuals identified by the patient as their main support person(s) and the ones to be approached for interviews were related in some way. The 18 participants included five wives, three husbands, one daughter, two sons, two step sons, four daughter-in-laws and one patient (see Table 2). One patient, who was included as a participant, identified himself as his main support since his wife has Alzheimer's disease and he and his daughter had become "estranged". Of the adult children interviewed six were 40 to 65 years of age and two were 20 to 40 years old.

The interviews occurred any time from 4 days to 2 months post discharge and lasted from 20 to 60 minutes. Ten patients chose to participate in a portion of the interview when the interview took place in their home.

All of the families had some form of exposure to hospitals or surgical experience although the nature of this exposure varied considerably. Some felt their past experience helped them define their expectations of the current situation but for others the experience was too remote to have much impact in the present.

All of the patients and participants were able to read and write English. One patient and his wife had been born in the Ukraine and had come to Canada in their early 20's. They had learned to read and write English at night school many years ago although they still spoke with a noticeable accent and occasionally still used their native language at home.

TABLE 2

Characteristics of Main Support Persons

Patient	Relationship to Patient	Age	Domicile
A	Wife	85	S
	Stepson/daughter-in-law	60/57	L
	Stepson/daughter-in-law	58/56	L
* B		75	S
C	Husband	70	S
D	Son/daughter-in-law	59/36	S
E	Wife	67	S
F	Husband	67	S
G	Daughter	42	G
H	Wife	78	S
I	Husband	69	S
	Son/daughter-in-law	41/38	L
J	Wife	67	S
K	Wife	63	S

* One patient considered himself his main support.

Key Domicile:
S = same house/apartment
L = same locality
G = geographically distant

Double ABCX Model of Family Stress

The central concept of the double ABCX model is that when a crisis occurs the family attempts to reestablish a balance within the existing system. The family's vulnerability and adaptation to the crisis (xX factor) depends upon the interactions of the stressor event and its accompanying hardships (aA factor), existing and new resources (bB factor) and the family's perception of the event (cC factor). "If existing internal and external resources are sufficient and/or the perception is that the stressor can be met within the existing system, no crisis occurs" (Hare, Skinner & Kliewer, 1989).

These components and their interactions were well demonstrated by a number of the families in the study as they coped with an elderly family member who had undergone surgery. These study findings will be outlined utilizing the framework of this model.

Family Demands: Pileup (aA factor)

Family demands are never static but change over time. McCubbin and Patterson (1983) identified at least five broad types of stressors that contribute to pile-up of demands for families in crisis situations. These included the stressor and its accompanying hardships, normative transitions, prior strains, consequences of family efforts to cope, and intrafamily and social ambiguity. Study findings for each of these will be discussed separately.

Stressor and its hardships. Patients and families face a stressor and a potential crisis when a family member undergoes surgery. When the family member is also elderly there are other considerations that have an impact on the crisis potential of the situation. The elderly surgical patient is commonly regarded as being a greater surgical risk than his or her younger counterpart given the variables of physiological changes that occur with aging and the various health problems that many elderly have acquired (Dellefield, 1986).

Six of the eleven patients in the study had surgery for cancer and two other patients required admission to ICU for a period of time. All of these patients and their families referred to the surgical experience as stressful. Families of patients requiring admission to ICU also experienced considerable stress related to the instability and unpredictable outcome of the patient's condition. One woman, whose husband required several admissions to ICU, stated that when the doctor suggested she come in and see her husband before his surgery she knew that his condition was indeed very serious. She went on to say "I just decided to dig in my heels and make the best of it." The other wife, whose husband spent a total of eight days in the ICU, commented that "there's so much you don't understand about surgery".

The patient who had a hernia repair perceived this surgical experience as much less stressful than having his pacemaker inserted eight months earlier. His wife commented, "Everybody says it is routine. It is anything but routine. It does hurt." The remaining two patients and their families did not perceive the actual surgical experience as being particularly stressful. One patient was admitted through emergency because of the pain she was experiencing at home. She then had a four day wait until her surgeon was available and found this delay stressful. Another patient was unsure whether she would have a laparoscopic cholecystectomy or the more conventional approach, which created some stress for her.

In the pre-operative period, patients and family members found that the required tests and accompanying preparation was often quite unpleasant. Post-operatively, in hospital, patients experienced a number of problems that caused concern for themselves and/or their family members.

Three patients experienced confusion post-operatively. One patient's confusion cleared the day following her surgery. Another had little recall of the first three days, or of resisting care as it was given. His wife found his altered mental state quite "frightening" although she realized it was most likely attributable to his pain medication. Another man suffering post operative confusion clearly recalled telling everyone to "look out for water everywhere" and everyone appearing "white". His family was upset by the change in their father although they recognized that age and drugs contributed to his behaviour. They were much relieved when his mental state cleared.

Two patients experienced urinary urgency and found it distressing to lose control of this bodily function. One patient was extremely nauseated after the anaesthetic and commented that this was worse than any pain she experienced.

Families also encountered some surgery related problems once the patient went home. These included problems with incisions, fatigue, bowel function and drug reactions.

One patient returned home with a minor wound infection which cleared up shortly after discharge while another had his incision line separate. Another patient developed an infection at home and had to take a course of antibiotics. One woman suffered a rash from surgical tape used.

Patients who had breast surgery found that, while their incision did not bother them much, the arm on the operative side ached especially at night. One woman, with a history of drug allergies, experienced a drug reaction to her discharge pain medication. She vividly described the nightmares she had after only one pill and refused to take any further pain medication.

Both patients with hernia repairs had some problems with their bowel functions post discharge, as did three others who had bowel surgery. All problems were resolved with diet and adequate fluid intake.

Two patients experienced considerable fatigue at home. One woman attributed this to having two surgeries within a week, although one required only a local anaesthetic. Her fatigue resolved within two weeks. The other patient attributed her fatigue to the fact that she had company as soon as she came home. She also was not sleeping well because of worry over future treatment. She started taking anti-anxiety medication which both she and her husband felt helped. Several other patients referred to a decreased energy level, but within six weeks they felt this had been resolved.

One man had lost considerable weight since his illness and his food allergies limited his diet selections. Six weeks post-operative he had not gained much weight, but he perceived his appetite and energy level to be improved.

Another man experienced severe muscle spasms approximately two weeks after discharge. He saw his family doctor and received medication which made him feel more comfortable.

Several patients and family members coping with the diagnosis of cancer commented on the stress of waiting for results. In one instance the patient had phoned the office in an attempt to learn her biopsy results and was told would have to wait until she saw her doctor some 48 hours later to learn the outcome. Both she and her daughter found it difficult to cope with the delay. They assumed the worst, as no one had phoned to advise them otherwise. They tried to imagine how they would manage chemotherapy with the mother living alone and the daughter residing at a great distance. They said they relaxed immediately upon seeing the doctor and learning that a one time visit would be required to see a specialist in Victoria.

Another patient and her husband had gone to the doctor's office on a Friday, expecting to learn the surgical results. They were told to re-contact the doctor on Monday, as he had some concerns about her pathology report and the preferred course of further treatment. This couple found dealing with the unknown very stressful and anxiety provoking. The patient readily admitted she was a "worry wart", which intensified the acute anxiety she experienced. The husband's comment was, "This waiting----I don't know if he (referring to the doctor) realizes it, but this waiting is worse than anything".

Adult children observed that this couple seemed immobilized by the uncertainty. The parents never left the house and the patient, normally well groomed, was not nearly as interested as usual in her appearance. Once they spoke to the doctor again the couple were better able to resume a semblance of their normal activities and get on with their lives. Cassileth et al. (1985) reported that patients and families in active treatment show greater emotional distress than do patients and relatives under follow-up care but less than those facing palliative care.

In addition to being concerned about the need for further treatment, this woman had the added strain of recognizing that travelling to and in Victoria would be stressful for her husband. As a result, they made arrangements to stay in the city for the course of her treatments.

The need for surgery made several of the patients and their family members look carefully at the current home situation in an effort to anticipate changes that might be in the offing. All patients had been in their own homes but several questioned how much longer this could continue.

The surgery had prompted one elderly couple to start discussing what changes they might be compelled to make in their living situation although they admitted that they had not discussed the matter with their sons. Their daughter-in-law said that the patient had done really well, but they realized that this was just a "breathing spell", given the age of the parents and the many health problems they had. The parents were very resistant to moving into a senior citizen's center. Both they and the family felt there was no facility in the community that met the parents' needs as they currently existed. Consequently, the most suitable arrangement appeared to be leaving the couple in their home and having structural changes done to make the existing residence safer and more convenient.

Another patient recognized that he might have to make some major changes in his living situation. Along with some home-maker support he had been looking after his wife who suffered from Alzheimer's Disease. His intent was to keep her at home as long as she was continent and slept through the night. He realized that his recent surgery for cancer, along with is wife's doctor's report that her condition was deteriorating steadily, meant he would have to make some very serious decisions in the near future.

The 96 year old man, who had been living in his own bungalow-style home in Los Angeles, California, had managed well with a housekeeper and gardening services. Both he and his family questioned whether he would be able to care for his own colostomy because of his diminished vision and difficulties he had in handling the equipment, but they hoped that with additional support services coming into his home he would be able to manage.

Three patients owned large properties. One thought she and her husband would be able to continue to manage their home and yard, hiring help as needed. An elderly woman recognized she would have to hire help for her yard work and she would be getting a homemaker to assist her in the house. Another couple was considering selling their two and a half acre property as they were finding it too difficult to manage with the husband's numerous health problems.

For most patients and families, the surgery created a degree of stress, but they managed to mobilize their resources and adapt to the situation. The diagnosis of cancer, uncertainty of having to wait for results and anticipation of the need for further treatment were particular strains identified as intensifying the stress. In most cases the surgery did not necessitate immediate changes but it did act as a signal that change might be forthcoming. Consequently, families were beginning to examine viable options now rather than waiting for them to become absolute necessities.

Normative transitions. Families go through various stages of growth and development. While these bring about anticipated changes they can none the less create stress, particularly if they occur as the family is undergoing a number of other changes.

The patients and their spouses were within the stage of life frequently referred to as late adulthood. "Development continues during the years after 65, as adults in the last phase of life face challenges, both old and new, in highly individual ways" (Papalia & Olds, 1989, p.531).

The physical changes in sensory and psychomotor abilities that occur at varying rates amongst the aging population were apparent in many of the patients and their spouses. Hearing and vision abilities had declined most noticeably in those interviewed. Many had developed other physical health problems but remained mentally alert and capable of independent decision making.

Attitudes toward aging surfaced in several interviews. One 78 year old woman had heard herself referred to as an old, old lady. She did not appreciate the description, but was able to joke and say at least they had called her a lady. Another patient said she did not feel old until she looked in the mirror.

Another patient indicated that the young today did not want to be bothered with the elderly. He and his wife had cared for his mother-in-law and thought nothing of it. The patient wondered if his daughter's unwillingness to assume any responsibility for him or his wife might account for the estrangement that had occurred between him and his daughter since his surgery.

In another family, a son commented that the elderly are put into institutions and often forgotten. Both he and his brother and their wives agreed that their elderly parents should not be pushed into a senior citizen's facility against their wills. "They feel like you are just trying to get rid of them". Both children had accepted this, but they questioned their parents' wisdom in not making changes to their home or making application to a seniors' residence.

Another patient aged 67 commented on how interesting old people are. Her husband acts as the major support person for a man who is 103 years old and still lives in his own home. This couple did not perceive themselves as elderly.

Participants who were 65 years and older recognized that they were aging and entering another stage of their lives. One son indicated that he had talked with his parents about the fact that they were getting older, and that death was inevitable. He felt that his mother in particular had thought of death and dying and was prepared for this eventuality. Another patient referred to the fact that he had his will prepared should it be needed.

The children interviewed represented the young and middle adulthood stages of human development. The family in young adulthood did allude to a need to alter family roles. The families in middle adulthood experienced little if any disruption in their family routines.

The family involved in the tasks of young adulthood had two young children, the oldest had just started kindergarten. The daughter-in-law was concerned about being able to meet the needs of her young family and still provide the support she wanted to give her mother-in-law. Their five year old child asked if his grandmother was going to die like their other friend had. The mother took him up to the hospital to assure him that his grandmother was all right. She found friends and other family members willing to care for the children at the times she felt she needed to be with her mother-in-law. Her husband rearranged his schedule so that he was more available to be with the children. This freed her time when she needed to consult the doctor regarding treatment or help with dressing changes, grooming needs or household tasks. They also recognized that this restructuring of roles and responsibilities was going to be short lived and was consequently perceived as being minimally disruptive.

Two of the couples in the middle adulthood group had no children, and none of these participants felt that their parent's surgery had created any unusual change for them. Two other couples in this group did have grown children with children of their own. One daughter-in-law referred to herself as a "sandwich child". She said she felt caught between meeting the needs of aging parents and those of her own children who, while grown and raising their own families, still required some assistance.

The other son and daughter-in-law in this family had several children coping with major health problems of their own. They said they were there for any of their own children but "they have to live their own lives too. We can't mix in." This son was the sibling who did the most to help the elderly parents and yet he and his wife clearly stated that they did not feel trapped. They attributed the difference being more relaxed in their attitude to life, encouraging and supporting independence in family members.

The surgical experience and normative transitions families were experiencing were not perceived as creating undue stress for the families in the study. For those patients with the diagnosis of cancer or who had been acutely ill requiring care in ICU, the issue of mortality and change was more of a reality, but not one perceived surgery as having precipitated a crisis.

Prior strains. McCubbin and Patterson (1983) identified prior strain as contributing to a pile-up of demands in a family system. This strain may be the result of unresolved hardships from earlier stressors or transitions or inherent in the ongoing roles of the family members.

Only one patient had no previous surgery experience. The seriousness and recency of the surgeries ranged from a 96 year old man who had his tonsils removed at the age of 20 to a patient who underwent a heart bypass operation in 1981.

Three patients had undergone surgery recently, one for the insertion of a pacemaker, another for an incisional hernia repair, and the third for a cataract removal under local anaesthetic only one week prior to her mastectomy.

None of the patients had previously undergone surgery for cancer. One individual had major surgery some ten years ago for suspected cancer which turned out benign. He and his wife observed that the first surgical experience was more stressful than the second although the recent surgery was for cancer. The wife of one of the patients had a bowel resection for cancer in 1983 and had experienced no recurrence but had required surgery approximately one year prior to the study for a strangulated bowel thought to be caused by adhesions developed as a consequence of the surgery in 1983.

Three of the participants had friends or family members die due to cancer within the past year. They admitted that this influenced their responses to the present situation. One patient and his wife noted that their friend's cancer had been in a very different site,and, consequently they felt their situation was not comparable. Another patient had family members and friends who had undergone radiotherapy and chemotherapy and she felt that their reactions to treatment had an impact upon her own anxiety regarding the need for further treatment. A son and his wife found that friends, who had recently lost their mother to cancer served as a great source of support as they dealt with their own mother's surgery for cancer.

All but one of the patients had health problems aside from the one requiring surgery. The patient with no additional health problems felt his optimal state of health preoperatively accounted in good part for his rapid recovery postoperatively. For all of the remaining participants, health problems were prior strains and indeed could be viewed as ongoing, for management of the problems would have to continue after discharge. Two patients did comment on the number of health problems they have had to face, particularly in the past several years.

One patient required admission to ICU as a result of exacerbation of existing maladies and development of new ones, subsequent to surgery. Another man had to take insulin for his diabetes while in hospital, but his oral hypoglycemic agent was resumed prior to discharge, so that from his perspective his diabetes management was unchanged. Of more concern to him was the revelation during his pre-operative work-up that he may require additional heart surgery in the near future. All other patients, regardless of the type of co-existing illness, did not identify them as major areas of concern during their recent surgery and post operative recovery.

Indeed, for a number of patients, other health problems seemed almost a secondary consideration. One patient with obvious arthritis claimed she had no additional health difficulties. It was only when questioned about medications that she alluded to her arthritis. She had learned to live with the problem and did not see it as a major factor with an impact upon the present surgical experience.

Of those patients with spouses, only one spouse stated she had no known health deficits, although she was one of only two participants that smoked. One spouse required help managing her diabetes while her husband was in hospital. Another developed a stress fracture of her hip six days after her husband was discharged. Although she was not hospitalized, she was totally immobilized for several days and then could only be up for short periods with the assistance of crutches. This couple found that they could cope with the situation only by having help come into the home for the next six weeks. A real sense of stressor pile-up was apparent as the wife and husband stated that the home had been a "disaster area". They hoped they would now get "a little bit of peace and quiet". No other spouses indicated that their health deteriorated either before or after the patient's surgery.

Of the seven children interviewed, only one son admitted to a health difficulty, and he was managing it with over-the-counter medication. He and his brother both wore hearing aids. Several other health concerns intra-family surfaced. In one family, a granddaughter was suffering from cerebral palsy and a grandson has been treated for Hodgkin's Disease within the past year. In addition, his son, aged one year, was soon to undergo a second open heart surgery to correct birth defects. In another family, their only son had experienced severe depression over the past three years, having been transformed from a highly successful business man to someone unable to cope with day to day life. It is only within the past six months that this person's parents and family have seen major improvement in his mental health.

Two of the patients and their spouses had children who had died. One child had died suddenly in her early twenties with no cause of death given. Another couple had a son die of cancer only three years ago.

The patients and their families all had experience with prior stressors, and given the age of the patients in the study this exposure was quite extensive and varied. The residue from these stressors was not necessarily negative and indeed their success in coping with prior strains set the expectation of success in handling the current stressor of surgery. The strain also was not always prior but current and ongoing.

Consequences of family efforts to cope. A family may use specific behaviours in an effort to cope with a crisis situation and these behaviors may in themselves contribute to pile-up of demands. None of the patients were smokers and only one patient admitted to the use of alcohol and then only socially. One patient indicated that he had not smoked nor drank alcohol for three years. Two wives smoked but none of the children interviewed smoked or abused alcohol.

One elderly woman had been driving herself to the hospital to see her husband, and close to the date of his discharge she had an accident on the way to the hospital. She found the accident distressing and cried as she talked about the incident. She did drive prior to the surgery but had been driving more and in unfamiliar areas as a result of her husband's hospitalization. Certainly the accident was stressful for her, as was being without her car for a period of time. She felt very dependent when she had to have others drive her about and refused to use the loaner car she had as it was different from her own.

From the interviews, these were the only coping behaviours identified that might have contributed to a sense of pile-up of demands. All other strategies utilized by the families as coping approaches were directed toward reducing the impact of the stressor and appeared to be successful in achieving this end.

Intrafamily and social ambiguity. The members comprising the families in the study were quite clearly defined. In one family the children were not the patient's natural children but those of his wife from a previous marriage. The children had been adolescents when their mother remarried after the death of her first husband and considered the patient their father.

One daughter-in-law had parents who were divorced and remarried. For her this had created some difficulties. Her father had been abused by his current wife. She and her family felt very powerless in dealing with the situation. She also felt a certain amount of guilt as she wondered if there was something she could have done to prevent the abuse.

The relationships in the families interviewed were of long standing and no boundary ambiguity was apparent. Daughters-in-law saw themselves as active participants in providing support to their in-laws. No sons-in-law were interviewed.

Family Adaptive Resources (bB Factor)

Family resources are those resources or capabilities available as families attempt to cope with the demands that emerge as a consequence of the present situation. Resources include personal resources, family system resources and social support.

Personal resources. This refers "to the broad range of characteristics of individual family members which are potentially available to any family member in times of crisis" (McCubbin & Patterson, 1983, p.16). This includes finances, education, health and psychological resources.

Neither patients nor participants found that the surgical experience created financial demands that they were unable to meet. Several of the patients had comprehensive government health plans that defrayed any additional costs they might have incurred with extras such as semi-private rooms in hospital.

Family members incurred some financial demands as a result of having to travel to the area to be with their parent. Most arranged these visits around work schedules and did not lose any pay as a result of the visit. The one daughter who did make an extended visit did not perceive the experience as disruptive to her job since she was self-employed.

All patients in the study were retired with pension income. Their surgery did not change or alter their income in any way or create additional financial demands that they felt unable to meet. Several of the patients and their spouses did indicate that they had to watch their money carefully, but the surgery did not add any strain to their financial situations. One couple did spend considerable funds in getting someone to come into the house to help them. They indicated they had adequate finances to cover this expenditure. One other couple chose not to have home care. Their family felt they could well afford the service but a life long habit of caring for themselves and carefully controlling money outlay kept them from availing themselves of this resource.

All patients returned to the home environment in which they had been prior to surgery. One patient lived with his son and daughter-in-law while all other patients either lived alone or with their spouses. Connidis (1989) reported that only 5 to 8.5% of all Canadians aged 65 and older currently live in institutional settings. The majority live with a family member, predominantly a spouse and there is a trend toward living alone in the absence of a spouse. These trends were confirmed in this study.

The home settings included two storey homes, bilevel homes and seven bungalow type homes two of which had at least six steps leading up to the entrance. Two patients lived in homes where the bedrooms were on the second floor. One patient had relocated her bedroom to the main floor to be near the bathroom. The other patient maintained her bedroom on the second floor but used it only at night and would lie down on the couch during the day. Her daughter-in-law felt this arrangement was contributing to the patient getting inadequate rest.

Two patients had to go up steps to get into their homes but both had handrails in place and felt confident about their ability to manage these stairs. The children of one of the couples were concerned about these stairs and the safety hazard they presented. The parents refused to make any changes that might improve the safety factor although the children stated that their parents could well afford to have the necessary changes made.

Patients and their spouses seemed quite satisfied with their home environments. They felt capable of doing their day to day housekeeping tasks and only getting help with heavier tasks. Children seemed more concerned about safety in the environment than did their parents.

Nine of the eleven patients still drove their own cars, although one of them did have some restrictions on his driving privileges. All but one of the spouses of the married patients were still able to drive also. It was of some concern for several of them that their licenses were coming due and that there was the possibility that they might not be renewed. Driving was restricted to their home areas for the most part. The need to travel to other centers for treatment created some strain and necessitated making alternate arrangements for transportation or having other family members or friends help.

One 85 year old women had just bought a new car, and because she lived some distance from all services her ability to drive was very important to her. She had not driven since her surgery and was considering how to cover the seat belt so that it would not rub on her incision. She planned on driving with her daughter before she left so that they could both see how the patient would manage.

One couple had been without a car for about a year and now relied on being able to use the neighbors' car or the services of Handidart to get to things such as doctor's appointments. The husband had been unable to visit his wife in hospital because the bus schedule to his area did not extend into the evening hours.

The patients were scattered around the community, often living at some distance from services such as grocery stores. Only three patients actually lived within walking distance of the grocery store. Having their own car and being able to drive afforded them a greater feeling of freedom and independence. For some it may have meant they were even able to live in their own homes for longer periods of time. Children also commented that the fact that the parent was able to drive minimized the day to day demands on their time although they did drive their parents as the need arose.

All patients in the study demonstrated an active role in decision making regarding their health care. If there was a spouse, decision making was a shared process except for the patient whose wife had Alzheimer's disease. This patient indicated that he really had no one with whom to talk regarding his decisions due to his wife's mental limitations, the unsupportive attitude of his daughter and his son living at some distance. He had recently had a call to place his wife in a care facility. He decided to keep her home for the time being, although he recognized that this could change if his or his wife's health deteriorated. The person with whom he confided was the homemaker, who had been coming into their home for the past three years.

In several instances patients and family members showed assertiveness in challenging decisions regarding health care. Two patients actually refused to accept the scheduled surgeon, opting to delay surgery until their preferred surgeon was available. In both instances the medical staff informed patients and their families about the possible health risks that might develop as a result of the delay but the patients were adamant. In the one situation the wife phoned the family doctor to make arrangements for another surgeon to see her husband and was informed that this had already been done. The interviewee indicated that she had been prepared for a confrontation and was really pleased by the cooperative stance taken by the health team. The other patient stated she knew the risks but was "determined to hang on" because she wanted consistency in her medical management.

One patient had her family doctor suggest that she delay her scheduled eye surgery until after her mastectomy. Her response to this suggestion was, "Look here, doctor, I have been waiting three months now. I am having it!"

The wife of one of the patients had insisted that a nurse come into her home and give her insulin while her husband was in hospital. The nurses felt the patient's wife could give her own insulin or drive to one of the seniors' centres and receive it. The woman held fast to her refusal to give her own insulin, going so far as to tell the doctor "I am going to die then". She received the service for the period of her husband's hospitalization, and he resumed giving her the insulin the first morning he was home.

Patients and family members have a good understanding of their health problems. All patients regardless of health difficulty indicated that they saw their doctor on a regular basis and knew the medications they were taking and why. However one family stated that they did not have a clear picture of the surgery done, although the doctor had spoken with both the patient and his wife. They were elderly and deaf. Their children found they mixed things up or misunderstood what was said. The parents knew the father had to have surgery and that the diagnosis might be cancer, but they were unable to provide their children any other information.

Three of the eleven patients had a family member who was a nurse and found this person an invaluable resource. Two nurses were daughters who were present while the patient was in hospital. The other was a daughter-in-law, and she was actively involved in helping the patient both during hospitalization and after discharge. One wife participated in the volunteer program in the hospital, and she felt that her familiarity with the setting and the people in it was also advantageous.

Patients and family members' knowledge of their health problems, the surgery and the health care system were seen as definite assets. Indeed this knowledge contributed to a demonstration of assertive behavior in seeking out health care and in the management of care in the hospital and home.

Family system resources. These are resources within the family system itself. Family cohesion or integration and adaptability appear to be two important resources which help families to deal with stressors and make the changes necessary for them to cope with the crisis.

Spousal willingness to help care for the patients was instrumental in deciding when patients could be discharged. Spouses changed dressings for two of the patients in the study, while another wife had learned to care for her husband's colostomy. Wives worked out diet restrictions and monitored activity limits. Husbands assumed responsibility for household tasks when wives were the patients. This necessitated greater exchange of roles than when the husband was the patient. One son and daughter-in-law stated that their father's willingness to assume this role would be short lived and already they felt he was tiring of the additional chores.

As long as the husband and wife were both able to be mobile, the couple managed well requiring only minimal help with day to day tasks or health-related activities. The ability to cope however decreased in direct relation to a deterioration in the health of either of the members of the marriage relationship.

Families and patients made decisions regarding the timing of discharge in several cases. In one instance, when the patient came home a little sooner than expected, the family stated they were "accepting" of the plan, and did not feel put upon. They did have to scramble to get home nursing care established, but they felt they managed well. In several other situations doctors had offered to delay discharge for at least 24 hours, but the families declined, stating that they could manage just as well at home.

When families and patients received home nursing care they were involved in deciding the frequency of visits and determining when the services were no longer needed. No one stated dissatisfaction with the length of time these services were made available.

Patients and spouses perceived themselves as fairly independent and stated a reluctance about asking for help from their children or other family members or friends. As one husband put it "we can work as a team" and that approach enabled them to remain independent. A daughter-in-law of an elderly couple stated that the patient and his wife were "supportive of one another" and this minimized the demands placed on other family members.

Offspring interviewed stated that their parent(s) were indeed independent. This independence was, at times, referred to by their offspring as being stubborn or determined but at the same time they acknowledged the parent's right to independent decision making. "We leave them alone unless they ask" or " you dare not butt in" were comments made. A daughter stated that her mother, a widow, "is obviously so independent" that she wondered if her mother would ask for help if she needed it. She also stated that she could understand her mother's independent spirit because she too was independent.

The 96 year old man willingly accepted his family caring for his colostomy and his diet because he recognized that he needed help. He was very proud of the fact that he was independent in other activities of daily living. His family commented on his independence and recognized how important this was to the patient.

While another patient and her husband readily accepted the daughter-in-law's help in dealing with the doctor, the health care system and dressing changes after discharge, they declined any help with housework. This patient had a friend who had a mastectomy. When she was asked if this friend proved to be a source of support, the patient said that people of her cultural background "don't tell you or talk to you about anything. They are very backward about coming forward about anything." Her daughter-in-law, with the same cultural background, was distressed that the patient had not shared her health problems with her family sooner so that she, a nurse, might have directed the patient to get medical advice sooner. The daughter-in-law felt some guilt that she had not determined sooner whether or not her mother-in-law was doing self breast examinations or having regular mammograms. As a nurse she did this kind of teaching at work, but she had not done the same teaching with her family. She recognized that this was not negligence but rather a difference in roles and responsibilities. Her awareness was heightened by this experience, and she indicated that she would follow-up to make sure that the patient did self breast exams from now on.

Offspring did provide short term help for parents but the ongoing support was provided primarily by spouses or in some instances the patients themselves. Families seemed to feel comfortable with this arrangement, and patients gained a sense of satisfaction and control by maintaining their independence.

All patients had contact with children and/or other family members either in person, by mail or phone on a fairly regular basis prior to the surgery. The hospitalization for surgery and the early discharge period saw a change in the pattern of these contacts.

The number of phone calls from family living at a distance increased. One participant indicated that the phone lines were "burned up by calls" between herself and her daughter living in another province, particularly when the patient was acutely ill. Another participant commented on receiving calls from family in England. Although she said the family was upset about her husband requiring surgery, the phone contact appeared to be a source of support for her and her husband. In other situations calls were received from extended family members living in other provinces.

Offspring of three of the patients were interviewed, but in only one family did all the children and their spouses participate in the study. In all situations, including this latter family, one child was assuming the major support role.

One daughter flew 2500 miles to be with her 85 year old mother during her hospitalization and first two weeks at home. She had a job which afforded her some flexibility and a husband capable and willing to look after himself,and she did not view this time commitment as a hardship. Prior to this surgery, mother and daughter had talked on the phone at least once a month, but both indicated that the frequency of these calls would increase when the daughter returned home. The mother has no other family living in the area capable of providing her any support; consequently, the increased phone contact seemed to be an ongoing plan whereby the daughter could lend support to her mother and monitor the situation from a distance.

This patient's sons had not come to see her and although her daughter-in-law was visiting in the area, she was occupied caring for her own mother, who was very ill. The patient commented on the special relationship between herself and her daughter, who always seemed to be on hand to help, and added that "boys are quite different." The daughter was glad she had been able to be with her mother, but she wished she lived closer to be of even greater assistance. She gave no indication of wishing her brothers more actively involved.

Two other patients had daughters who were nurses and they too managed to rearrange their schedules to come from other cities to be with the patient during at least a portion of the hospitalization. One son travelled some distance to see his father during hospitalization. He took his mother, who suffers from Alzheimer's to the hospital to see his father but he had left the area prior to his father's discharge.

A step son noted that since his step father's discharge from hospital, he now stopped by his parents' home every day rather than every other day, although he did not perceive an increase in the number of tasks he was doing for his parents. Neither he nor his wife resented this time commitment nor felt that it inconvenienced them in any way as they lived close by. Meanwhile his brother did not feel that his visits with the parents had increased. He continued to see them at least three days a week. The brothers readily acknowledged that one of them did more for the parents, but they both seemed comfortable with the arrangement. The daughters-in-law felt they did not play as active a role as their husbands, but indicated a willingness to help. They assisted in transporting them to their medical appointments and in dealing with unexpected occurrences, but they declined to assist with housework, as they felt their parents-in-law could afford to pay for such a service.

Another patient and her husband commented that, where the family used to phone frequently, they now dropped by to see if there was anything they could do to help. The younger son and his wife were the major source of support for the patient and her husband. This was partially due to the fact that the daughter-in-law was a nurse and also because the other brother and his wife were simultaneously dealing with other family health difficulties.

This patient's daughter resided in another community, and her siblings felt that she preferred to distance herself, and she could not be relied upon to provide support to the parents. While recognizing this in the sibling, they did not voice anger or resentment toward her failure to take a share in the responsibility, exhibiting instead an acceptance of the circumstances. They related that they felt quite comfortable providing the needed support. The daughter-in-law saw this as an opportunity to reciprocate for past support she had received from her mother-in-law and felt that she, her own mother and the other daughter-in-law would be able to provide any care needed in the future.

One patient was living with his son and wife at the time of surgery. His daughter, who was a nurse, flew to be with him during surgery, returning to her residence in Los Angeles shortly after his discharge. When the father returned to his home in Los Angeles, the daughter would assume responsibility for ensuring that he had the appropriate home care. In the meantime, the son and daughter-in-law had assisted him through the immediate post operative experience. Another brother was not at all involved, but the other two siblings took turns being the primary support person for the patient.

While the change in the pattern of family contact was usually an increase in contact there was one patient who had become estranged from his daughter during his hospitalization. The mother was at home with Alzheimer's and prior to surgery the husband and wife had managed with the help of a homemaker. The patient had made arrangements for someone to stay with his wife while he was in hospital for a bowel resection for cancer of the rectum. The daughter had her mother admitted to a long term care facility while the he was in hospital. The patient was very angry at his daughter's attempts to take over his decision making and as of six weeks post discharge they were not speaking to one another.

The pattern of family contact changed as a result of the patients' surgery and subsequent discharge. For the most part the change was an increase in phone contact or trips to see the patient, particularly during hospitalization and the immediate discharge period. Patients and participants viewed these as supportive for the most part. The time span of the study did not reveal whether a pattern of increased contact persisted or whether family members resumed their pre-surgery contact routine.

Social support. The availability and ability of networks to provide care can vary greatly. "In general, social support serves as a protector against the effects of stressors and promotes recovery from stress or crises experienced in the family"(McCubbin & Patterson, 1983, p.18).

In this study neighbors and friends provided various forms of support for patients and family members. This included transporting the patient for appointments and staying with or having the patient stay with them for a day or two after discharge from hospital. Neighbors with medical background were particularly valued.

The older the patient the smaller the circle of friends upon which they had to draw. For those patients with no family in the area or a family unwilling to help, friends and neighbors were viewed as an invaluable asset. One patient commented that "if it had not been for (the friends) I would have been completely at a loss." A daughter stated that if her mother did not have a lot of friends around she would have to stay longer.

Three of the eleven patients identified their church or religion as a major source of support. One other participant did refer to God, as she said "I hope we haven't made God any angrier because maybe next year He might let us have a little bit of peace and quiet."

One wife stated that religion was very important to her husband, and indeed his surgery had been planned around a month long religious retreat. When asked the name of the religious group or church, her response was "whatever suits him at the moment" and that he liked to check churches out. She did not share this interest with her husband.

The second patient was a clergyman still leading a small congregation. A friend within the church congregation offered him his only real consistent source of support. The patient stated that friends "rallied" around and had helped him with the stress of the surgery and family life.

The third patient had no family nearby. She stated that many of her friends had been acquired through her involvement in the Unitarian church.

Eight of the eleven patients required some form of support for themselves or a family member either prior, during or after hospitalization. Support ranged from short term assistance from home care nurses to the ongoing services of a home maker (see Table 3).

Two patients had some support prior to hospitalization and continued with these services after discharge. One participant required help managing her diabetes while her husband was in hospital.

Five families needed help at home following the patients' discharge. In two instances this help was initiated by the family, not the hospital. In two instances the nurses came to change dressing but this usually only lasted about four days. In the two other situations the patients went home with colostomies, and those families required help for a longer period of time.

TABLE 3

Families Utilization of Support Services

Patient/Family	Homemaker Service	Home Care Nursing Service	Hired Help
A		During hospitalization	
B	Before/after hospitalization		
C			Before/After hospitalization
D		After hospitalization	
E		After hospitalization	
F			
G	After hospitalization	After hospitalization	
H			After hospitalization
I			
J			
K		After hospitalization	

The arrangements for the nursing visits were made prior to discharge for the one patient with a colostomy. Both he and his wife found the support and teaching received as a result of these visits invaluable. For the other family dealing with the colostomy, the fact that the patient was from the United States meant that they had to seek their own help. The patient's daughter was a nurse and her presence the first couple of days after discharge gave the family time to seek out appropriate resources. They found there were plenty of services available and that the support they provided was adequate to meet their needs.

In two other situations family members changed dressings for the patient rather than having a nurse come into the home. In one of these situations the dressing included hot compresses because the surgical site was infected. The wife said that the doctor just told her what to do and although she was a bit unsure of how to proceed she said she managed and it was no longer infected.

The one patient who had no family nearby had been assessed for the homemaker program and this service was scheduled to start just after her daughter went home. The homemaker would be coming in every two weeks for two hours at a time. The daughter would have preferred that the homemaker come in every week, but she was relieved that she and her mother had been able to organize any support at all. Her mother had almost been refused for the program because even though she was 85 years of age and alone, she did not have any other health problems aside from the surgery. The nurse who did the assessment utilized the fact that the patient was being treated for hypertension as justification for enrolling her in the program.

When one of the patients was discharged it appeared that he and his wife would be able to manage but six days after he got home his wife suffered a stress fracture of her hip. She went by ambulance to the hospital but was sent home and was confined to her bed for several days. The wife called to see about getting a homemaker but was told they would have to go through an assessment process and this could take as long as two months. The couple however needed immediate help. In the local paper they found an advertisement for someone willing to come into the home to provide such a service and were able to engage her right away. For six weeks they had this person come in every day for two hours. They paid her $10 per hour and showed no resentment over having to independently pay for this service as evidenced by the wife's comment, "I didn't resent her at all-she came in and took over when neither one of us were able." At the time of the interview the couple had just discontinued the service but had arranged with this person to get further help as needed.

The network of friends and neighbors can definitely be supportive, and appreciated by both patients and families. The size of this network is influenced by factors such as the patient's age and personality and length of time living in the area. Those who have retired to the area and spent no time in the work force or have not joined any organized activities tend to have a particularly limited number of support persons upon whom to call.

Family Definition and Meaning (cC factor)

In the face of crisis situations families define the seriousness of the stressor and attempt to define the general impact and demand for change being faced by the family system (McCubbin & Patterson, 1983). A positive outlook results in families perceiving the stressor as a challenge and, while requiring adaptation within the system, it is also viewed as an opportunity for growth. A negative perspective means families discern the stressor as a threat and are much more likely to experience distress and ultimately find themselves in crisis.

For the six families of cancer patients it was for most of them their first experience with this diagnosis in a close family member. All patients had their surgery within three weeks of diagnosis. Although the quickness with which surgery was arranged added a sense of urgency, without exception patients and families were glad they did not have a long wait.

The initial diagnosis of cancer was called a "shock" by several patients and family members. "The presence of cancer in a family signals the beginning of a time of stress" (Green, 1980, p.21). One wife admitted that she initially felt anger in addition to shock. She had just spent the last three years helping their son cope with his mental health problems. Life had only just returned to normal and now she was faced with having to help her husband cope with his diagnosis of cancer. She put her life "on hold" and was only just resuming activities outside the home when this couple was interviewed a month after discharge. Caregiving tasks that confine caregivers either "temporally or geographically constitute burdens" (Woods, Yates & Primona, 1989, p. 49). She stated her family was very important to her and she would do everything she could to support her husband, just as she had her son. In retrospect this couple viewed this surgical experience as a positive one.

Humor was used by several patients as they described hospital experiences or various health problems. One woman jokingly referred to herself as "the condemned lady" as she talked about stopping at the pub for a last drink before she went into hospital. Indeed this participant used humor frequently throughout the interview. Another woman was frustrated by the fact that she could not wear a bra after surgery and said she was able to joke with a friend about "scotch taping them up into place". One man recalled the health problems he had experienced over the last few years and in summary he laughed and said, "I am paying for my bad deeds."

An elderly patient had been quite confused after surgery and both he and his family laughingly discussed how entertaining he had been for the staff. This was retrospective to the actual experience, but the entire family seemed to be able put this rather frightening experience into perspective by their use of humor.

Humor was apparent in the majority of the interviews.

It appeared to help both patients and families cope more successfully with what could have been a very stressful situation.

None of the patients admitted to being overly concerned about undergoing surgery. Several commented that they never had any doubts at all about the outcome. Indeed several commented that once they knew they had to have surgery they just wanted to get it finished. As one patient commented, "I think it is very wise once you find out, to get something done if possible instead of hanging on."

The one exception was the patient facing further treatment. She admitted to finding the morning of surgery quite stressful because her operation was re-scheduled for later in the day. She said she would have preferred having it finished. Her husband did spend the preoperative morning with her and this seemed to help them both. She and her family then found their stress level rose again when she saw the doctor and realized there was uncertainty about the need for further treatment. Once they were aware of the plan for treatment and the likelihood of its success they felt their stress level dropped slightly. This patient also readily admitted that she was anxious in new situations so it would seem likely that her anxiety level would remain high until she started her radiotherapy treatments and knew what to expect.

All support persons felt the patient had recovered well from surgery. Several commented that the patient had done much better than they would have anticipated given the age of the patient, their other health problems and the nature of the surgery. Patients shared this perception. This gave both patients and their support persons a feeling of pride and accomplishment. None of the families seemed overwhelmed by the surgical experience, although several people interviewed admitted to feeling somewhat burdened by stressor pile-up.

Family Adaptation (xX Factor)

Surgery in the older population, particularly for cancer, can create a crisis situation for the patient and family. However none of the patients or families in the study considered themselves to be in a crisis situation. They perceived themselves as having changed and adapted to meet the demands of the situation while creating minimal distress or disruption in their lives.

Perceptions and Expectations of Physicians

Patients and family members all voiced their satisfaction with the quality of care they received from the surgeon. The surgeon explained the procedure to the patient and their spouse several times prior to the operation and phoned them immediately after surgery.

When families sometimes had difficulties contacting the surgeon it may have been related to the fact that for a period of time his office was closed two weeks out of every month. One patient became quite "panicky" when unable to contact the surgeon. His son intervened and contacted him through the hospital.

Understanding the diagnosis, operation and post operative instructions were problematic for three of the families due to distrust in authority figures such as the surgeon, language barriers or delays in communication or dissemination of accurate information to family members by the elderly patient.

In one family the children questioned their parents' understanding of the surgeon's explanation of the surgery. The patient and his wife had both talked with the surgeon but when the son asked him what the surgery was for he said "I really don't know but I guess if I need an operation I need an operation." The wife thought it was cancer but she was not sure. The daughter-in-law's observation was that "they believe totally in doctors" and this was the situation regardless of whether the doctor is "right or wrong."

In another situation the surgeon had explained to the patient and her husband when they went for the two week post-operative check-up, that there was some question about whether the patient might need more surgery or further treatment with chemotherapy or radiotherapy. They were to phone again early the next week. The couple spent the entire weekend in a state of uncertainty. Their anxiety was apparent when they were interviewed. The daughter-in-law, a nurse, had the surgeon explain the situation to her and she was then able to make a simplified explanation to the couple and allay their fears somewhat. The surgeon was quite surprised when informed of the patient's response but acknowledged that perhaps he should have talked with the patient person to person rather than over the phone.

Another patient's daughter arrived in the area just prior to her mother's surgery and said she would have liked more explanation about her mother's surgery and what to expect post-operatively. She had particularly wanted to be at the hospital when her mother returned to the ward from the operating room. The doctor had told her the patient would be in recovery room until a given time but this proved to be inaccurate. When she arrived she found her mother sitting in bed having lunch. She felt she had let her mother down by not being there as planned.

Patients stated that they felt ready to come home by the time they were discharged. Physicians showed sensitivity to patients' requests about timing of discharge from hospital. Several patients returned home a day earlier than their family physician preferred. One man asked that he stay in 24 hours longer than the surgeon suggested because he simply did not feel able to go home. The surgeon was quite agreeable.

The family often did not have much warning about the patient coming home. One wife was visiting her husband and the surgeon enquired whether they could manage at home. They answered in the affirmative and the patient was released that afternoon. Several family members commented that the patient came home quite early. One husband stated, "Its okay for you to say you are ready to come home, but what about the one that must look after you."

Patients felt they adhered to the discharge directions given to them by the surgeon although the forced inactivity and restrictions in lifting became increasingly frustrating particularly for male patients. Family members read the instruction sheet, monitored the patient's compliance with directions as much as possible. One wife indicated that she tried to anticipate her husband's needs as much as possible in an attempt to minimize the frustration he experienced.

One patient did encounter some conflict between the surgeon's directions regarding diet and those outlined by his family doctor. He was very satisfied with his surgery, and while recognizing the contradictory information, he made a conscious decision to listen to his "own" doctor rather than clarifying the discrepancy.

Another patient when interviewed six weeks post discharge had not yet gone to see the surgeon for his follow-up visit. He indicated that if the doctor wanted to see him he could call and set up the appointment. He did not seem to feel it was the patient's responsibility to make these arrangements. His family physician had made a house call to see him since he had been home and he felt this was adequate.

The patient, who had the laparoscopic cholecystectomy, while pleased with how she had recovered from her surgery, was distressed when her preoperative pain returned approximately two weeks after she was discharged. She indicated that she had expected the pain would disappear once she had her gallbladder removed and that to have the pain return was a disappointing outcome. "I thought I'd have the surgery and it would be all over." She was now facing further investigative studies including a bone scan.

Most patients went home with a prescription for Tylenol #3. Several admitted to some reluctance toward using this medication due to its constipating effect and the likelihood of it exacerbating an already existing problem. A 65 year old women was allergic to codeine and was sent home on propoxyphene. After only one pill she experienced nightmares and refused to take any more of this medication. At the time of the interview she admitted to some discomfort.

One 70 year old man actually refused the Tylenol #3 prescription offered by the surgeon and went home with no pain medication. He stated he "didn't want to be one of those people that rely on pills". He incurred some back spasms about two weeks after discharge. He admitted that he "hated like heck to say he was wrong" but conceded that the doctor was right and he should have taken the prescription.

Another patient and her husband commented that she had experienced much less pain with this surgery as compared to previous operations. The doctor had explained his surgical approach to them, clarifying why this minimized the pain.

Post-operative pain was not identified as a major problem by any of the patients or their family members. Dissatisfaction with management of post-operative pain at home was primarily related to the side effects of the drugs.

Patients and spouses commented that the surgeon was very "straight" with them and they really appreciated this. One patient facing surgery for cancer of the bowel said the doctor was "not alarmist" and this inspired confidence in him regarding the outcome of this surgery and influenced the family's positive attitude about the experience. The word confident was used by another patient and she too attributed this confidence to the fact that the surgeon "put his cards on the table."

All patients expressed their satisfaction with the care received from their family doctor. However the reputation of their doctor could overshadow and color their relative's view of their parent's care. One son questioned why his mother had not been receiving mammograms on a regular basis so that her cancer might have been identified earlier. He had a family friend die recently and she had the same doctor and there was some indication that her family had been less than satisfied with the management of her care. Both the son and his wife, a nurse, recognized that the mother's confidence in her doctor was steadfast and she was unlikely to make any changes. Another family interviewed described this same physician as "very caring." No doubt these varying perceptions are influenced by past experience and education.

The surgeon was perceived as a "straight shooter" with a positive approach and a "caring" attitude with families. Families found him approachable and willing to involve family members in the surgical experience. There were times when families found it hard to contact the surgeon and explanations, although made, were not always clearly understood by the patients. The overwhelming consensus however was one of satisfaction and trust in the physicians' care. The participants in the study held physicians in high esteem and credited them with considerable power. As one of the participants observed in regard to the medical profession "We depend on them. It's your health."

Perceptions and Expectations Of Nurses

The perception of nursing care in the hospital varied from family to family and from clinical area to clinical area. Among families requiring home nursing service the perception of the nursing care provided was more consistent.

Four patient's families stated they were satisfied with the care received. The families of the remaining seven patients in the study identified at least one area of concern, and three families voiced major dissatisfaction with the quality of care given in the general ward setting. Areas identified included pre and post operative teaching, delays, basic care, diet, assistance with activities of daily living, colostomy management and home care.

One patient stated that while the care was adequate, she received virtually no pre or post operative teaching. She had numerous surgeries in large metropolitan centers. She felt that previous pre-op teaching that focused on leg exercises and pain management had accelerated her post operative recovery. She commented, "They simply don't do it here!" She was able to draw upon previous experience to assist her post operatively on this occasion.

Another family found the care somewhat disjointed. They did not receive as much teaching "as promised". They had been unable to made contact with the nurse specializing in ostomy care at any time during their father's hospitalization. The hospital staff were aware that the sister was a nurse, and that the family had arranged for a home care nurse. The family were told they could also contact the emergency department 24 hours a day. Consequently the son's comment was, "We were well covered".

In addition, this family encountered difficulty getting their father discharged from the hospital even though they had been told verbally he could return home. The family did not fault the nursing staff for the confusing situations they encountered, but they did question whether there could not have been better follow-through as it pertains to care. They commented that, as a family, they were very "accepting" of all that happened. They felt that perhaps they should have taken greater responsibility in requesting follow-up. They wondered if the fact that a family member was a nurse led the nurses to assume the family had an adequate source of information.

This family also found that hospital information pertaining to diet management for the individual with a colostomy conflicted with information received from the home care nurse. The hospital data proved to be outdated. The family suffered frustration as a result of this confusion.

Another patient felt that call bells were not answered quickly. She did state, however, that her post-operative pain was well managed. She claimed she had "gotten hell" because she did not ring as soon as the pain started. She was told not to wait until the pain got really bad. The patient received discharge instructions and physiotherapy exercises, but her daughter felt that she herself had received inadequate teaching to prepare her to care for her mother at home. Both mother and daughter claimed that the nurses had not told them about the home care service they would be receiving. The daughter commented that she would have felt a lot better about bringing her mother home if she had been informed that the home care nurse would be visiting. She also wished that she had been prepared to expect the extreme fatigue her mother experienced for several days. This was the only family receiving home care nursing who were not aware of the arrangements prior to discharge.

When the daughter compared the mother's experience to her own, two years previous in Ontario, she saw few differences. She commented that her husband was not involved by the staff during that incident, any more than she had been in this instance.

Several patients and/or family members commented on the fact that nurses refused to help patients get in or out of bed, or even move them while in their bed. One son noted that his father had difficulty lying down in bed. The father said he had requested that the nurses help him, but they had refused. The son queried whether this was done in order to "attempt to compel him to do it for himself".

Patients and relatives who had previous hospital experience found a change in the provision of basic care, while acknowledging that prompt attention was given if anything went wrong with either the patient or the equipment. One patient stated that he never felt the nurses came in "just to chat". He wondered if he was perhaps not ill enough to merit the attention.

The family members of both of the patients who had been in ICU stated that the patient received much less attention and relatives fewer explanations in the ward setting. One patient accepted this as a consequence of altered nurse/patient ratios and stated that nurses were "right there if he needed them". The other patient felt the nurses on the general surgical floor "didn't even try" and that the "one thing they accomplish is that they make the patient so angry he wants out". His wife felt she had received few angry he wants out". His wife felt she had received few explanations on the ward and that the nurses were very "abrupt" with the patients.

This patient's wife wondered whether understaffing was the problem. Her husband claimed there were enough nurses, as he saw them all at the desk doing "bookwork". Another wife, who had also voiced concerns about the care, felt the nurses "have far too much to do", but questioned the amount of time apparently spent on paperwork. Another patient stated that "the nurses haven't got the time to spend with you, but I have no complaints with them". Two other patients commented on how short-staffed the ward appeared. One of these patients was making the observation as a comparison to larger centers where she had received more teaching from the nursing staff.

None of the patients or family members stated that a nurse had reviewed the discharge instruction sheet with the patient or relative. Three patients and/or family members saw the dietitian. One wife still felt that she had to develop the patient's diet plan more or less on her own because the dietitian had not given her enough specific information to meet the diet requirements stipulated by the doctor. The wife felt she managed, but perceived this as probably the biggest challenge she had to meet in helping her husband at home.

The perceptions about nursing care were varied. While interviewees did not want to criticize the nurses they wanted to make their observations known. Basic nursing care, bathing, positioning, assistance with elimination and mobilizing were viewed as inadequate. The technical aspects of the nursing profession, such as management of equipment, was commended. Interviewees expected "caring" from nurses and felt this was missing. This was viewed as not necessarily the fault of the nurses, but the fault of a system that places unrealistic demands upon too few nurses.

In this chapter the findings of the study have been outlined. The majority of the findings reflect the categories of the double ABCX model of family stress (McCubbin & Patterson, 1983), and the findings regarding perceptions and expectations of physicians and nurses have been identified and presented as separate categories. The subsequent chapter will discuss the conclusions drawn from these findings regarding the degree of stress the surgical experience created for the elderly patient and their family members, the moderating factors in this process and resulting implications for those providing health care to this patient and family group.

CHAPTER 6

Discussion

Family systems theory and the double ABCX model of family stress (McCubbin & Patterson, 1983) provided the sensitizing framework for this qualitative study. In the previous chapter the findings of the study were outlined according to the categories that evolved, many of which related to the double ABCX model.

All patients were members of a family system. The spouses of all but two of the patients were alive and identified as a major support person except in one instance. The surgical experience had an impact on each of the spouses, including the one not interviewed because she had Alzheimer's disease. Indeed the impact was perhaps greater for this wife as she was temporarily removed from her home. This was very disruptive for her.

The surgical experience affected adult offspring to varying degrees. In all instances one adult child carried greater responsibility than other siblings for helping the parent(s) through the experience. Family members assuming this major caregiver role accepted the situation as a reality and did not indicate anger or frustration over what could have been perceived as inequities in siblings sharing responsibilities.

The surgical experience contributed to the marked deterioration in the relationship of one patient and his daughter. As only the father was available for interview the situation was explored solely from his perspective. He perceived his daughter as being threatened by his surgery due to it creating demands for her that she was unwilling or unable to meet. His son-in-law and grandchildren were viewed as being totally unsupportive. Whatever the cause of the estrangement, the daughter was not a support, rather an additional stressor for her father. The father found the timing of the withdrawal of support very distressing but commented "I understand it now. I've put it in its place." He indicated that he would not bother his daughter but that the "door is open" if she wished to reestablish the relationship.

The need for surgery created demands for the elderly patient and their family members. Family systems theory would suggest that illness of any kind is a change that places demands on the individual and the family unit. Initially the research was directed at interviewing the patient's relatives, however it soon became clear that the surgical experience was best explored by involving the patient as well as the major support persons.

The remainder of this chapter will discuss the utility of the double ABCX model in exploring the surgical experience from the perspective of elderly patients and their families. The perceptions and expectations of physicians and nurses will be discussed with specific attention directed to implications these findings have for nursing. The limitations of the present study and the impact they have on the generalizability of the study findings will also be addressed.

Double ABCX Model of Family Stress

The family system, in interaction with a multitude of variables, helps determine the course and outcome of illness. The double ABCX model of family stress (McCubbin & Patterson, 1983) proved to be a useful framework for examining the many variables confronting elderly surgical patients and their family members. The stress model also helped to determine the degree of stress created for families during hospitalization and after discharge. The findings relevant to each factor will be discussed and those variables that proved to be primary determinants in the degree of stress experienced will be identified.

The majority of families in this study clearly identified various aspects of the surgical experience as stressful. For some this encompassed the preoperative period when the patient experienced fatigue and uncertainty created by preoperative tests. It was anticipated that the patient being 65 years of age or older would create additional stress for the family. The immediate postoperative period did see the development of age related hardships for both patients and family members. A major problem was the confusion experienced by several of the patients. Families were told that this was age and drug related. Although it did resolve within a short period of time, considerable stress was created for the relatives while the confusion lasted. For two patients cardiac complications necessitated their admission to ICU and this consequently increased the stress experienced by these families. Other patients experienced irritants such as nausea and urinary frequency postoperatively. The overall perception of all families was that their family member made remarkable progress after surgery.

This perception was influenced by patients in this study group being discharged on the average of 6.5 days after surgery, which was significantly shorter than the 17.1 day stay for women and 20.9 day stay for men in the 65 years and older group reported in 1987-88 (Statistics Canada, 1990). Patients stated they felt ready to come home. Elderly patients usually have a greater degree of dependency at time of discharge than immediately prior to admission (Jackson, 1990). Fletcher and Winslow (1991) reported that formal and informal caregivers of the frail elderly often rate the individual as more dependent than do the patients themselves. Family members sometimes had reservations about being able to adequately care for the patient but the concerns were directed more toward treatments such as dressings than activities of daily living.

Several patients encountered problems post discharge but none of these necessitated readmission to hospital. Bowel regularity was a concern due to the age of the group as well as the type of surgery they had undergone. Diet also presented a major challenge for the family once the patient went home. This appeared to be related to the type of surgery and allergies of the individual patients rather than being age specific. Within six weeks of surgery, patients had resumed the majority of activities engaged in prior to surgery. Golfing and heavy gardening were the only activities still restricted. Patients and families continued in their belief that the surgery had gone well and were pleased with how they as a family had managed at home.

The diagnosis of cancer had an impact on the family response to the surgical event. Benner and Wrubel (1989) stated that as a consequence of past experiences influencing their perception of stress or their identification of coping options, older people typically respond to cancer with more equanimity than do young people. "A life threatening illness has different implications for the person with a young family than for the person with adult children" (Benner & Wrubel, 1989, p. 276).

Cancer patients and their families were all interviewed after the treatment phase had begun. Some recalled feeling shock when told the diagnosis was cancer. However at the time of the interview families of five of the six cancer patients stated that they felt confident that the cancer had been caught early. The fact that the patient required no follow up treatment and that they had been able to resume their previous life style were positives for both the patient and the family as was identified in previous studies (Cassileth et al., 1985; Northouse, 1988). There was no evidence of denial of the diagnosis or excessive concern over what might lie ahead.

Several families commented on the additional stress created by waiting. This included waiting for test results, surgery dates, treatment plans or even waiting for the doctor to return a call. Benner and Wrubel (1989) stated that anxiety may lessen during the treatment phase because the situation is clearer as are the goals, the tasks and the demands. Only one patient required further treatment and her anxiety level, as well as that of her family, diminished once they received a clear explanation of her diagnosis and the recommended course of treatment.

Age increased the hardships encountered by both the patient and the family during the post operative period. The sensation of stress was compounded for families whose member received the diagnosis of cancer. It was the issue of dealing with the unknown and waiting for answers that intensified the stress more than the diagnosis itself.

For the most part normative transitions did not contribute to a sense of pile-up of demands in regards to the surgical experience. Indeed patients and their spouses stated that being retired minimized the upheaval created for them by the surgery. Although all patients returned to their homes after surgery, some families recognized that the patients' living arrangements might have to undergo change in the near future. The magnitude of these anticipated changes was quite dramatic and included things such as selling homes and moving patients or spouses into long term care facilities. Surgery had not precipitated any of these changes but raised families awareness of the likelihood of having to make such changes in the not too distant future. One adult child was concerned about the burden of having to help several sets of elderly parents with these types of decisions when she herself was approaching the age of 65.

Patients and spouses had coped with a number of prior strains over their life span. Previous contact with hospitals and surgical experiences were perceived as having a positive impact. Several patients commented that previous surgery had been much more stressful.

Existing health problems of either the patient or the spouse were major factors having an impact on the current situation. While McCubbin and Patterson (1983) did not list health as an aspect of prior strain, it was an important prior strain for these families. Families had been coping satisfactorily with health problems but the surgical experience necessitated a variance in the pre-existing management regime. Previous routines were resumed as soon as the patient was discharged and consequently patients who did have other existing health problems did not always perceive these as having a direct impact on the recent surgical experience.

Additional problems shortly after discharge from the hospital can virtually replace the surgical event as the stressor. This was the case when the wife of one of the patients experienced a stress fracture of her hip. For older adult caregivers, the responsibilities accompanying the caregiving role are frequently compounded by their own physical disabilities. Jacob (1991) advocated that health care professionals become partners with the caregivers of the older adult and recognize that their needs are as vital as those of the care receiver. "Focusing attention on their needs might alleviate burden and promote caregivers' health and well being" (Bull, 1990, p.769). As a consequence of coping with her husband's surgery this spouse neglected her own health and delayed her own healing. There was no indication that health care workers had considered the potential for this development which points to the necessity of providing care for the whole family.

The issue of boundary ambiguity was an aspect to be considered only in the family where the father and daughter had become estranged. It was unclear whether this was a temporary circumstance or a permanent one. If the father and daughter remained estranged then there could be some confusion as to actually makes up the family and certainly the daughter could not be called upon to provide support for either the patient or his wife. The estrangement had created distress for the patient but it had not immobilized him and he still perceived his daughter as a member of his family.

The patients with spouses had been married for many years, and the spouse was consistently identified as a major support person by the patients. Adult offspring maintained contact with parents although, for a variety of reasons, the pattern varied within and among families.

Pile-up of stressors, the "aA" factor of the double ABCX model, was relevant for most of the families in the study, although not all the stressors as identified by McCubbin and Patterson (1983) were significant. Uncertainties about diagnosis and prognosis, some age related complications post-operatively and the number of health problems of either the patient or the spouse were the major distressors created by the surgical experience. The model considered prior strains but did not directly address health as an ongoing or concurrent stressor. Health problems of the patient and/or the spouse had been controlled but the surgical experience necessitated change in the management of problems and in two instances precipitated new health problems. This would suggest a need to broaden the scope of the prior strains for health was certainly a major contributor to the stressor pile-up experienced by the patients and their family members.

"Resources are a part of the family's capabilities for meeting the demands and needs which emerge in the context of a crisis" (McCubbin & Patterson, 1983, p. 16). The "bB" factor of the double ABCX model includes the family member's personal resources, the family system's internal resources and social support.

Financial resources were perceived as being adequate and virtually unchanged as a result of surgery. In the U.S.A. financial demands resulting from health care are a frequent concern for the elderly , but Canadian elderly find that the health care system meets their needs without creating inordinate financial demands. They may incur some financial disutility in acquiring extra care in the home, but once again there are a number of governmental programs to assist them. The portion they are asked to pay is frequently based on the income tax they pay. Only one patient in this study voiced any resentment in having to pay for this service. Others who were using or had used these services merely seemed grateful for the aid and stated that their payment portion was fair. The one patient in the study who would be returning to his home in the United States indicated that he had private insurance as well as the financial resources to pay for additional services he might need.

The freedom and independence afforded by patients' ability to drive their own car was highly valued by both the patient and family members. Friends or community services adequately met the transportation needs of those patients without a car but this necessity created a sense of dependence.

"Cognitive abilities that allow for the realistic perception of stress and adequate problem-solving skills contribute to the successful management of illness" (Quinn & Herndon, 1986, p.47). Patients and family members were knowledgeable about the management of their medical problems, recognizing the limits these problems imposed and adapting accordingly. As long as the health problems of either the patient or their spouse remained stable the couple managed to cope quite well with their daily needs. However, an exacerbation of an existing problem or development of an additional problem severely strained their ability to cope independently rendering health the most tenuous of all the personal resources.

All patients and most spouses had received an explanation of the surgery and the discharge care from the surgeon. Most patients felt this information helped them make informed decisions about proceeding with the surgery and managing their care at home.

The need for more understandable information about their members' illnesses and prescribed medical regime has been identified by family members in a number of studies (Bouman, 1984; Jackson, 1990; Leske, 1986; Molter, 1979; Norris & Grove, 1986; Silva, 1987). In the current study the brevity of information some elderly parents were able to give their offspring raised concerns about the patients' comprehension and retention of information and left offspring feeling inadequately prepared to help the patient.

One interviewee suggested that particularly when the parent is elderly and whose first language was not English, the doctor should be responsible for asking the patient if he/she would like another family member to be involved in the discussions. The offspring would not feel they were forcing the issue and the patient would have the right to say yes or no.

The lack of information was frequently recognized but family members did not always seek the information. One family member said they decided the doctor knew what he was doing and did not pursue the issue. Another participant, a nurse did approach the doctor to get the needed information and to inform him of the anxiety the patient had experienced as a result of the information he had given her. Another family found that the home care was able to provide them with the needed information. The two latter families had post secondary education and were more familiar with the health care system which may have accounted for their information seeking behaviour.

Several elderly patients demonstrated assertiveness in challenging the plan of care proposed for them. While this is an adaptive characteristic it can be threatening to the medical team, as Baird and Doherty (1986) found. Initially there was tension for several families when a surgeon other than the one preferred was consulted. The physicians in this study listened to the requests of the patients and their family members and facilitated the implementation of their wishes. The collaborative and sensitive response by the health team helped defuse the tension. Beckingham and Baumann (1990) refer to this type of decision making as informed and participatory. For the most part the elderly patients did not delegate their decision making to their spouses, family members or their doctors but rather consulted with them in a shared form of decision making. Certainly for the families their active role in decision making enhanced their feeling of control and confidence in the outcome of the surgical event.

Having a family member who was familiar with the health care system was seen as an asset by other family members. Baird and Doherty (1986) suggested that accepting the input of these family members and working with them can result in better care for the patient. The patient and other family members perceived the expert family member as enhancing the understanding of the whole family and having a positive impact on the care the patient. There was some question however that this may have also resulted in a faulty assumption about the amount of information and teaching needed by other family members.

Several participants commented on the high value they placed on "family" and their perception of themselves as cohesive units which was translated into support for patients both in hospital and after discharge home. Family members presence during illness "offers love, warmth and an atmosphere of caring" (Baird & Doherty, 1986, p. 373).

When the patient had a spouse the couple managed the discharge period primarily on their own. Burke and Weir (1982) pointed to the central role of spousal helping in coping with crisis situations and suggested that there is a higher quality of helping present from the spouse than from those outside the marital relationship. Only one patient identified his wife and both his step sons and their wives as his support people. One step son had already been participating in what Bowers (1987) refers to as supervisory caregiving by doing a number of tasks to help the elderly parents maintain their yard and home and did increase time spent with the parents after the surgery. Other patients had adult offspring living in the area but while indicating that the adult offspring were supportive usually identified their spouse as their major support person and the one to be interviewed. Adult children were seen as providing emotional support more than lending help with day to day tasks. When there was no spouse the adult offspring assumed a much more active support role.

No study participant, regardless of his or her relationship to the patient, indicated that the needed support created excessive physical or mental demands for them. "It is the caregiver's perception of the situation rather than the care recipient's needs that most directly influence the well-being of the caregiver" (Fletcher & Winslow, 1991, p. 61).

Families were satisfied with the pattern and quality of intergenerational contacts, although distance limited the preferred frequency of contact for several families. The telephone provided an alternate and frequently used vehicle whereby family members provided support. The importance of the phone contact increased in direct relation to the distance the family lived from the patient and the number of local supports available to the patient.

Jacob (1990) reported that daughters or other female family members assume the primary caregiver role for the elderly individual. The families in this study did not necessarily reflect these trends as in several instances sons assumed the major support role. Two daughters were actually perceived as having distanced themselves from the caregiving relationship. These findings may be related to the uniqueness of the families in the study but could also be a reflection of changing societal views regarding male/female roles. Bond, Harvey and Greenwood (1991) found sons gave a lot of support to well elderly parents.

Friends and neighbors were a source of support for patients and family members, but consistent with Jackson's 1990 findings, family members remained the major source of support for discharged elderly patients in all but one family situation. The patient with no family supports admitted that when he came home from the hospital he felt very "low and alone". Friends provided the needed support enabling this man to recover his health and resume his caregiving role for his wife.

Religious attitudes and activities have been reported as a predominant coping behavior in older adults (Koenig, George, Siegler, 1988). Religious or church affiliation can offer visible support in the form of friends ready to provide help as needed, or it may take a much less obvious or overt form that enables individuals to provide a meaning and structure to cope with stress. Religion was identified as a source of support by three patients but no family members. For two of these patients the availability of family support was very limited, and the church and the circle of friends from the church served as a substitute and much valued source of support for these two individuals. With the other patient, while religion was identified as being important, the context of its importance and the form of support it provided was unclear.

Medical and hospital services were utilized for immediate care and supervision immediately upon discharge but only two families required these services on an ongoing basis. For a couple of patients there appeared to be some dissatisfaction with the process of establishing the home maker service as well as some confusion over its responsibilities in the home. One family found that government or community agencies could not meet the immediacy of their needs. Fortunately this couple were able to independently find and hire the needed help; without this input they would have indeed faced a crisis situation. These findings despite the smallness of the sample raise questions about how well homemaker services are understood by the general public or whether they are meeting the needs of the community in crisis situations.

The availability of resources, the "bB" factor, positively influenced families' abilities to cope with the health related challenge. Personal resources and family systems resources served a pivotal role in the families' ability to adapt and change to meet the needs created by the elderly family members' surgery. The most fragile and unstable personal resource was health. As long as the health of the patient and/or the spouse remained stable, health was a resource but if it became unstable it then contributed to stressor pile-up. Families then drew upon other resources in their attempts to re-establish stability and avert crisis. When family support was not available friends, neighbors and community services assumed much more significance as support resources for the elderly patient. Availability of resources did not necessarily result in their use. No family felt they had inadequate resources to meet the demands encountered. There were times when resources were strained but infusion of new or alternate resources restored a balance and a sense of being able to cope.

The meaning families attached to the situation was the result of many interacting factors. Gottesman and Lewis (1982) found that surgery patients experienced a "short term stress", but when the surgery was for cancer the nature of the stress changed considerably. Silva (1987) stated that there is increasing evidence that surgery can be even more stressful for individual family members than for patients. When the diagnosis is cancer family members can be active, vital participants in the patient's treatment and care but they have needs of their own that change and must be considered throughout the course of the illness (Lewandowski & Jones, 1988).

The majority of families perceived the surgical experience as being stressful. The situation was threatening when families were dealing with unknowns but once the problem was defined and a plan of action developed, families perceived themselves as dealing with a challenge and mobilized all available resources to enable them to successfully meet this challenge. They had experienced a plethora of trauma such as the past death of a child or a spouse, serious accidents or health problems, and forced changes in careers. Past experiences had helped them develop coping skills upon which they were now able to draw.

The speed with which the patient recovered and resumed his/her previous life style encouraged families to view the situation as minimally disruptive.

Thorne (1985) found that families articulated their "life concept" in the form of a shared philosophy or family motto. Families were able to explain the role this belief played in their selection of coping strategies when they confronted a diagnosis of cancer. An 85 year old woman's comment was "Maybe I am nuts, but my theory is it's better to wear out than rust out." Patients and family members in this study also used sayings to convey their attitude about coping independently with the situation. This included sayings such as "the helping hand's on the end of your arm" and "I can't is a slugger too lazy to try".

The elderly in this study were functioning independently in their day to day living. For the most part they still maintained a zest for life. A pioneer spirit, a hardiness was apparent in all these patients. This surgical experience was just another obstacle to overcome not something through which to be defeated. This included the man who found his family relationships seriously threatened by his need for surgery. This was the meaning, the "cC" factor, patients attached to the surgery and consequently this was the pervasive attitude of family members as well.

"The concerns, background meanings, skills, and practices of the person set up what counts as stressful and what coping possibilities are" (Benner & Wrubel, 1989, p. 63). None of the families perceived themselves as being in crisis as a result of the elderly family members' surgery. Hardships were created but families viewed these as being minimally disruptive, and families expressed a sense of confidence, accomplishment and pride in how they resolved with problems that arose as result of the elderly family members' surgery. Several families commented that the experience had been a positive one and that they as a family had coped well. Indeed the ones who seemed most overwhelmed by their surgery and problems were at the younger end of the age scale for this study.

Acute illness or surgery can cause family disequilibrium but the disturbance is usually temporary (Gottesman & Lewis, 1982; Griffin, 1980). For the families in this study, surgery was perceived as a temporary stressor the intensity of which was related to the unknown more than the diagnosis itself. The double ABCX model (McCubbin & Patterson, 1983) provided a framework that clearly identified the factors influencing family members perception of the stress created by the their elderly relatives' surgical experience and to a somewhat lesser extent delineated the needs consequently created for the family unit. The model further demonstrated the fragile nature of some of the resources and how something that may be a positive resource such as health can very quickly become a negative factor or a stressor necessitating further change and adjustment. Families also recognized that as a unit they face ongoing demands and that the surgical experience may be a signal of greater changes to come. The elderly patients and families in this study perceived themselves as having successfully adapted to the surgical experience and averting crisis and re-establishing a sense of equilibrium to the unit. They were realistic in recognizing that this could change quite quickly given the age and health problems of the patient.

Perceptions and Expectations of Physicians

Patients and family members wanted honest answers from their physicians and most felt they got them from the surgeon and their own family physicians. Difficulty contacting physicians or having to wait for results were the two irritants noted by participants.

Scheduling surgery soon after diagnosis was much appreciated by the family.The surgeon discharged the patients much sooner than the national average but families were often consulted regarding this decision. The early discharge was perceived as indicating how successful the surgery had been.

The written discharge instructions provided by the surgeon served as a resource for the family at home, enabling them to better help the patient. These instructions were perceived as the only discharge teaching received by the patient or the family aside from verbal additions made by the surgeon or brief sessions with dietitians or physiotherapists.

Physicians met the expectations of the patient and their spouses. The only criticism of physicians' care came from adult offspring. There was concern over parents' understanding of explanations made by the surgeon. Another family also questioned the existence of gaps in the ongoing medical supervision provided by the family physician. Offspring acknowledged however that the parents had the right and were capable of making their own judgements regarding physicians.

Families were for the most part satisfied with the physicians' care. Spouses felt their needs and concerns were taken into consideration by the physician. There was some indication that physicians need to expand their perception of family to include adult offspring even when the patient has a spouse. Families suggested that it was the responsibility of the physician to recognize the need to include additional family members in his/her explanations.

Perceptions and Expectations of Nurses

Nurses were not perceived as having a major decision making or teaching role in patient care. Consistent with other studies families did not perceive the nurses as having a significant information giving role (Dyck & Wright, 1985; Frank-Stromberg & Wright, 1984). Families stated that nurses could not give them information nor act upon many of their requests regarding the patient's care. Both these functions were understood to be within the domain of the doctor. One family even stated that the doctor was responsible for ensuring that the kitchen sent the correct diet for the patient. From these findings it appears obvious that families were unaware of the roles that nurses may have had regarding planning and implementing patient care.

Nurses were regarded as competent in caring for technical and emergency aspects of patient care. Nurses in the ICU setting were rated as giving care superior to nurses working in the general surgical ward setting. Pain was felt to be well managed, and yet nurses were seen as being abrupt and uncaring because they did not carry out activities such as fluffing pillows or helping patients in and out of bed. When patients and families were unhappy with care it was usually related to the helping activities rather than the technical competence of the nursing staff. This is somewhat at variance with other studies where family members found surveillance and demonstration of professional knowledge as key indicators of care on the part of the nurse (Larson, 1986; Larson, 1987; Brown, 1986; Mayer, 1986).

The facility where these patients were hospitalized is a 145 bed acute care setting that employs a team nursing approach to patient care. Nurses are assigned to a team rather than given a specific patient. Usually a registered nurse and a licensed practical nurse care for 15 patients with some help from an additional nurse during a portion of the day. This leaves families and patients unclear as to who is doing what and whom to approach with concerns or questions about the patients care or progress. A sense of confusion or a perceived lack of consistency in approaches to care is created.

Nurses were also not viewed as having a teaching role. No patient or participant in the study identified having received teaching from nursing staff. Some recognized the absence of teaching from hospital experiences in other centres. Several patients regarded the lack of teaching as their own fault for not having asked questions. It is an expectation of hospital administration that discharge instructions be reviewed with all patients prior to discharge. From data collected in this study it was not clear whether the teaching is integrated so unobtrusively into the daily care that it is not perceived as such or is not being carried through in practise.

Several patients indicated that they had received instruction from specialties such as physiotherapy but they seemed to have no awareness of the role nursing played in making these arrangements. By delegating teaching to these specialties, it is possible that nurses cease to be seen as an integral part of the teaching team.

Patients and family members willingly shared their observations about nursing care. Most did not blame the nursing staff for the gaps seen but instead directed the blame toward staffing shortages and tasks not seen as crucial nursing functions such as charting.

The study participants had a mix of past hospital experience and knowledge upon which to base their opinions about the quality of care received and the nurses' role in this process. Yet for many it was their first surgery for some time. They needed help moving through this experience but the nursing staff were not regarded as primary facilitators. Benner and Wrubel (1989) referred to concern and how it "allows the nurse to tune into the otherness, the singularity of the patient" (p. 92). A nurse uses previous knowledge to identify the uniqueness of the situation for the individual and the family rather than looking for types of patients which leads to distancing and dismissal (Benner & Wrubel, 1989).

Nurses were seen as being technically competent but not empowered to make decisions about anything that really mattered from the families' points of view. Families perceptions of the quality of care varied within the study sample. Nurses in the hospital were not viewed as providing support that helped the family cope at home. Home care nurses were regarded in a much more positive light. Most patients and families were satisfied with the help received from home care nurses and homemakers. Families had to initiate help themselves in several instances but showed resourcefulness in doing so. In retrospect they were satisfied with the services they were able to establish.

Implications for Nursing

Other studies have indicated that families do not perceive nurses as a major source of support and these data support this contention (Koenig, George & Siegler, 1988; Lindsey, Norbeck, Carrieri, & Perry, 1981). As noted by previous authors this has serious implications for all areas of nursing.

Much of the research has focused on the needs of family members in different clinical settings, but there has been little research done regarding nursing approaches to assist families in meeting these needs. It has also been demonstrated that in critical care settings nurses' perceptions of family needs vary considerably from those identified by the family members themselves. Exploring the surgical experience of the elderly patient from the perspective of families indicates future research should be directed at comparing nurses' and family members' perceptions of the experience. Through this type of analysis we can perhaps determine why there are perceptual differences, and begin to develop approaches to rectify inconsistencies.

The perceived lack of teaching or caring from nurses has serious implication for nursing practise. The suggested variation in identification of caring behaviours identified by families in this study as compared to families in critical care or oncology areas suggests an area for further research particularly in view of our increasing elderly patient population. The question of public expectation and professional resources available to meet these demands is another factor practise must consider. The assessment of the needs of informal caregivers of the elderly surgical patient is an area of nursing practise that has received inadequate attention.

Nursing administration needs to become more attuned to the community's perception of the care their centres are providing. Mechanisms must be invoked to ensure that activities such as discharge teaching are truly being implemented and subsequently determine the quality of this implementation. Dwindling budgets are a constant reality for hospital administration, but when cuts are made there must be a careful scrutiny of the ramifications of cutbacks. Families perceived the shortened hospital stay in a positive light but suggested that a lack of funding was having an impact on the quality of caring nurses are giving patients. "Nursing administrators must be able to articulate to other decision makers as decisions are made about where limited health care resources should be distributed" (Valentine, 1989, p. 28)

Wright and Bell (1989) reported that "family nursing education in Canadian schools of nursing is flourishing in undergraduate programs, and is particularly strong in the content areas of family assessment and families and illness" (p. 72). The area of intervention is not as well developed and "few nursing texts consider what types of interventions are appropriate for what types of families with what types of illness" (Wright & Leahey, 1990). The fact that nurses were not perceived as making a difference in families' abilities to cope with the surgical experience may be the result of inadequate education regarding appropriate intervention for the family as a whole.

Nurses in hospitals can assume a major role in assisting families to cope positively with the crisis of illness (Leavitt, 1984). The surgical experience from the perception of both the patient and their family members was positive, but this was not necessarily the direct result of nursing practise. Indeed for three families the perception of the nursing care added to the stress of the situation.

Limitations of the Study

The findings of this study were limited in their generalizability for several reasons. The size of the sample was small and drawn from a specific geographical area. The sample is primarily confined to elderly patients with spouses. The adult offspring of four patients were interviewed and their perspectives added a dimension to the findings that was missing from the other families interviewed.

The fact that the patients all had the same surgeon had an impact on the post operative management of the overall group. The surgeries within the group varied and included those for cancer and benign diagnosis, which influenced the degree of stress experienced by families.

The patients' presence during a portion of the interview may have hindered disclosure on the part of the other family member. The presence of the patient did however clarify aspects of the experience in a way that did not occur when the patient was absent.

In an hour long interview participants disclosed only that information about their health and life circumstance about which they are comfortable, and findings must be viewed with this in mind. The initial part of the interview was spent in establishing rapport and a sense of trust in the interviewer. Summarizing at the end of the interview helped participants clarify what impact the experience had on their families. There are no doubt factors withheld or forgotten that might shed a slightly different perspective on the overall situation. The findings can only be interpreted in terms of the information shared and findings must be viewed from this perspective.

Conclusion

The first research question was to identify the self perceived needs of family members of the elderly surgical patient. The demands or stresses created for the family unit were clearly delineated but family members isolated few self perceived needs. However the one need that was specifically identified and highly valued was a need for information. This was a finding consistent with findings of other studies exploring the needs of family members of oncology or critical care patients.

The second research question asked family members what health care professionals or others did that helped them cope with the family member at home. The surgeon and home care nurses were perceived as the health care workers providing the most information or support, while hospital nurses were generally not expected to nor found to do so. The surgery presented families with a short term stressor, but all the families in the study felt they had adequate internal and external resources to cope with the demands created. The elderly patients proved to be independent in their activities of daily living and active participants in decision making regarding their care.

Elderly surgical patients and their families are confronting early discharge after surgery. The families interviewed perceived themselves as having coped well with the expectations and demands created by this development. In difficult economic times early discharge programs can continue to help decrease the cost of hospital stays, but the needs of those at home who take on new caring responsibilities and the human and economic costs of family caregiving must be carefully considered.

References

Adaskin, E. (1987). Stress resistance in relocated families: hardiness and healthy family functioning as mediators of stress-strain relationship. Unpublished doctoral dissertation, The University of Texas at Austin.

Alderman, M. & Cruise, M. (1989) The coming of age in nursing care of the elderly. International Nursing Review, 36(2), 47-49,60.

Archbold, P. (1986). Ethical issues in qualitative research. In W. Chenitz & J. Swanson (Eds.), From Practice to Grounded Theory (p.p. 155-163). Don Mills, Ontario: Addison-Wesley Publishing Co.

Arkley, C. (1990). The needs of visitors in intensive care. Nursing, 4(3), 9-12.

Baird, M. & Doherty, W. (1986). Family resources in coping with serious illness. In M. Karpel (Ed.), Family Resources, the Hidden Partner in Family Therapy (pp. 359-383). New York: Guilford Press.

Banning, J. (1991). Nurses an important component of a restructured system. Canadian Nurse, 87(2), 11.

Beckingham, A. & Baumann, A. (1990). The aging family in crisis: assessment and decision making models. Journal of Advanced Nursing, 15, 782-787.

Benner, P. (1985). Quality of life: a phenomenological perspective on explanation, prediction, and understanding in nursing science. Advances in Nursing Science, 8(1), 1-14.

Benner, P. & Wrubel, J. (1989). The Primacy of Caring. Stress and Coping in Health and Illness. Don Mills, Ontario: Addison-Wesley Publishing Company.

Blythe, B. J. (1983). Social support networks in health care and health promotion. In J.K. Whittaker, J. Garbarino & Assocs. (Eds), Social Support Networks: informal helping in the human services (p.p. 107-129). New York: Aldin Publishing Co.

Bond, J., Harvey, C. & Greenwood, L. (1991). Satisfaction, happiness, and self-esteem of older rural parents. Unpublished study. University of Manitoba, Winnipeg.

Bouman, C. (1984). Identifying priority concerns of families of ICU patients. Dimensions of Critical Care Nursing, 3 (5), 313-319.

Bowers, B. (1987). Intergenerational caregiving: adult caregivers and their aging parents. Advanced Nursing Science, 9(2), 20-31.

Brandt, M. (1984). Consider the patient part of a family. Nursing Forum, 21(1), 19-23.

Brown, L. (1986). The experience of care: patient perspectives. Topics in Clinical Nursing, 8(2), 56-62.

Bull, M. (1990). Factors influencing family caregiver burden and health. Western Journal of Nursing Research, 12(6), 756-776.

Bullough, B. (1981). Nurses as teachers and support persons for breast cancer patients. Cancer Nursing, 4, 221-225.

Burke, R. & Wier, T. (1982). Husband-wife helping relationships as moderators of experienced stress: the "mental hygiene" function in marriage. In H. McCubbin, E. Cauble, & J. Patterson (Eds.), Family Stress, Coping and Social Support (p.p. 221-238). Springfield, Illinois: Thomas Books.

Burns, N. (1989). Standards for qualitative research. Nursing Science Quarterly, 2(1), 44-52.

Caplan, G. (1982). The family as a support system. In H. McCubbin, A. Cauble & J. Patterson (Eds.), Family Stress, Coping, and Social Support. Springfield, Illinois: Charles C Thomas.

Cassileth, B., Lusk, E., Strouse, T., Miller, D., Brown, L. & Cross, P. (1985). A psychological analysis of cancer patients and their next-of-kin. Cancer, 55, 72-76.

Cobb, S. (1982). Social support and health through the life course. In H. McCubbin, E. Cauble & J. Patterson (Eds.), Family Stress, Coping, and Social Support (p.p. 189-199). Springfield, Illinois: Thomas Books.

Connidis, I. (1989). Family Ties and Aging. Vancouver: Butterworths.

Coutu-Wakulczyk, G. & Chartier, L. (1990). French validation of the critical care family needs inventory. Heart & Lung, 19(2), 192-196.

Craven, R., & Sharp, B. (1972). The effects of illness on family functions. Nursing Forum, 11(2), 186-193.

Daley, L. (1984). The perceived immediate needs of families with relatives in the intensive care setting. Heart & Lung, 13(3), 231-237.

Dellefield, M. (1986). Caring for the elderly patient with cancer. Onocology Nursing Forum, 13(3), 19-27.

DiMatteo, M. R., & Hays, R. (1981). Social support and serious illness. In B. J. Gottlieb (Ed.), Social Networks and Social Support (p.p. 117-148). Beverly Hills: Sage Publications.

Dimond, M. (1989). Health care and the aging population. Nursing Outlook, 37(2), 76-77.

Dracup, K. & Breu, C. (1978). Using nursing research findings to meet the needs of grieving spouses. Nursing Research, 27(4), 212-216.

Dracup, K. (1987). Critical care nursing. In J. Fitzpatrick & R. Taunton (Eds.), Annual Review of Nursing Research, Volume 5. New York: Springer Publishing Co.

Duffy, M. (1985). Designing nursing research: the qualitative-quantitative debate. Journal of Advanced Nursing, 10, 225-232.

Dyck, S. & Wright, K. (1985). Family perceptions: the role of the nurse throughout an adult's cancer experience. Onocology Nursing Forum, 12(5), 53-56.

Fawcett, J. (1986). The relationship between theory and research: a double helix. In Leslie H. Nicoll (Ed.), Perspectives on Nursing Theory. Toronto: Little, Brown and Company.

Field, P.A. & Morse, J. (1985). Nursing Research. The Application of qualitative Approaches. Rockville, Maryland: Aspen Publishers, Inc.

Firsch, S., Groom, L., Sequin, E., Edgar, L. & Peplar, C. (1990). Ambulatory surgery a study of patients and helpers experience. AORN Journal, 52(5), 1000-1009.

Fletcher, K. & Winslow, S. (1991). Informal caregivers: a composite and review of needs and community resources. Family and Community Health, 14(2), 59-67.

Ford, J & Reutter, L. (1990). Ethical dilemmas associated with small samples. Journal of Advanced Nursing, 15, 187-191.

Forrester, D.A., Murphy, P., Price, D. & Monaghan, J. (1990). Critical care family needs: nurse-family member confederate pairs. Heart & Lung, 19(6), 655-661.

Frank-Stromberg, M. & Wright, P. (1984). Ambulatory cancer patients' perception of the physical and psychosocial changes in their lives since the diagnosis of cancer. Cancer Nursing, 7(2), 117-129.

Friedman, M. (1986). Family Nursing Theory and Assessment. Norwalk, Connecticut: Appleton-Century-Crofts.

Friehofer, P. & Felton, G. (1976). Nursing behaviours in bereavement: an exploratory study. *Nursing Research*, *25*(5), 332-337.

Gaglione, K. (1984). Assessing and intervening with families of CCU patients. *Nursing Clinics of North America*, *19*(3), 427-133.

Gardner, D & Stewart, N. (1978). Staff involvement with families of patients in critical-care units. *Heart & Lung*, *7*, 105- 110.

Gilliss, C. (1984). Reducing family stress during and after coronary artery bypass surgery. *Nursing Clinics of North America*, *19*(1), 103-112.

Given, B., & Given, W. (1989). Cancer nursing for the elderly a target for research. *Cancer Nursing*, *12*(2), 71-77.

Glaser, B. & Strauss, A. (1967). *The Discovery of Grounded Theory*: *Strategy for Qualitative Research*. Chicago: Aldine.

Goodwin, L. & Goodwin, W. (1984). Qualitative vs quantitative research or qualitative and qualitative research? *Nursing Research*, *33*(6), 378-380.

Gottesman, D & Lewis, M. (1982) Differences in crisis reactions among cancer and surgery patients. *Journal of Counselling and Clinical Psychology*, *50*(3), 381-388.

Green, C. (1980). Working with the family with cancer- a nursing perspective. *Nursing Leadership*, *3*(4), 16-22.

Griffin, J. (1980). In J. Miller & E. Janosik (Eds.), *Family-Focused Care* (p.p. 245-268). Toronto: McGraw-Hill Book Company.

Haggmark, C. (1990). Attitudes to increased involvement of relatives in the care of cancer patients. *Cancer Nursing*, 13(1), 39-47.

Hampe, S. (1975). Needs of the grieving spouse in a hospital setting. Nursing Research, 24(2), 113-120.

Hanson, S. (1987). Family nursing and chronic illness. In L.M. Wright & M. Leahey (Eds.). Families and Chronic Illness (p.p. 2-32). Springhouse, Penn.: Springhouse Co.

Hare, J., Skinner, D. & Kliewer, D. (1989). Family systems approach to pediatric bone marrow transportation. Child Health Care, 18(1), 30-35.

Hawe, P., Gebski, V., & Andrews, G. (1986). Elderly patients after they leave the hospital. The Medical Journal of Australia, 145, 251-254.

Hendrickson, G. & Doddato, T. (1989). Setting priorities during the shortage. Nursing Outlook, 37(6), 280-284.

Hickey, M. (1990). What are the needs of families of critically ill patients? A review of the literature. Heart & Lung, 19(4), 401-415.

Hill, R. (1949). Families under Stress. New York: Harper & Row.

Hill, R. (1958). Generic features of families under stress. Social Casework, 49, 139-150.

Hymovich, D. (1974). Incorporating the family into care. Journal of the New York State Nurses Association, 5(1), 9-14.

Jacano, J., Hicks, G., Antonioni, C., O'Brien, K., & Rasi, M. (1990). Comparison of perceived needs of family members between registered nurses and family members of critically ill patients in intensive care and neonatal intensive care units. Heart & Lung, 19(1), 72-78.

Jackson, M. (1990). Use of community support services by elderly patients discharged from general medical and geriatric medical wards. Journal of Advanced Nursing, 15, 167-175.

Jacob, S. (1991). Support for family caregivers in the community. Family Community Health, 14(1), 16-21.

Kamenir, S. (1989). Are you ready for that elderly patient? Canadian Critical Care Nursing Journal, 6 , 23-27.

Knacck, P. (1984). Phenomenological research. Western Journal of Nursing Research, 6(1), 107-114.

Knafl, K. & Howard, M. (1986). Interpreting, reporting and evaluating qualitative research. In P. Munhall & C. Oiler (Eds.), Nursing Research a Qualitative Perspective. (pp. 265-278), Norwalk, Connecticut: Appleton-century-Crofts.

Koenig, H., George, L., & Siegler, I. (1988). The use of religion and other emotion-regulating coping strategies among older adults. The Gerontologist, 28(3), 303-310.

Lapierre, L. (1990). Health of the elderly and the extent of family mutual aid. Health Reports 1990, 2(3), 253-268.

Larson, P. (1986). Cancer nurses' perception of caring. Cancer Nursing, 9(2), 80-91.

Larson, P. (1987). Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviors. Heart & Lung, 16(2), 187-193.

Leavitt, M. (1984). Nursing and family focused care. Nursing Clinics of North America, 19(1), 83-87.

LeCompte, M. & Goetz, J. (1982). Problems of reliability and validity in ethnographic research. Review of Educational Research, 52(1), 31-60.

Leininger, M. (1985). Qualitative Research methods in Nursing. Toronto: Grune & Stratton Inc.

Leske, J. (1986). Needs of relatives of critically ill patients: a follow-up. Heart & Lung, 15(2), 189-193.

Lewandowski, W. & Jones, S. (1988). The family with cancer. Nursing interventions throughout the course of living with cancer. Cancer Nursing, 11(6), 313-321.

Lewis, J. (1986). Family structure and stress. Family Process, Inc., 22, 235-247.

Lincoln, Y. & Guba, E. (1985). Naturalistic Inquiry. London: Sage Publications.

Lindsay, A., Norbeck, J., Carrieri, V. & Perry, E. (1981). Social support and health outcomes in postmastectomy women: a review. Cancer Nursing, 4, 377-384.

Lovejoy, N. (1986). Family responses to cancer hospitalization. Oncology Nursing Forum, 13(2), 33-37.

Lust, B. (1984). The patient in ICU: a family experience. Critical Care Quarterly, 6, 49-57.

Lynch-Sauer, J. (1985). Using phenomenological research methods to study nursing phenomena. In M. Leininger (Ed.), Qualitative Research Methods in Nursing (pp. 93-107). Toronto: Grune & Stratton Inc.

Lynn-McHale, D. & Bellinger, A. (1988). Need satisfaction levels of family members of critical care patients and accuracy of nurses' perception. Heart & Lung, 17(4), 447-453.

Mathis, M. (1984). Personal needs of family members of critically ill patients with and without acute brain injury. Journal of Neurological Nursing, 16(1), 36-44.

Mayer, D. (1986). Cancer patients' and families' perceptions of nurse caring behaviors. Topics in Clinical Nursing, 8(2), 63-69.

McCubbin, H. & Patterson, J. (1983). Family transitions: adaptation to stress. In H. McCubbin & C. Figley (Eds.), Stress and the Family Volume 1: Coping With Normative Transitions (p.p. 5-25). New York: Brunner/Mazel, Inc.

Miles, M & Huberman, A. (1984). Qualitative Data Analysis. Beverly Hills: Sage publications.

Mimoto, H. (1989). Aging of the population. Health Reports, 1(1), 123-124.

Molter, N. (1979). Needs of relatives of critically ill patients: a descriptive study. Heart & Lung, 8(2), 332-339.

Moon, S.; Dillon, D. & Sprenkle, D. (1990). Family therapy and qualitative research. Journal of Marital and Family Therapy, 16(4), 357-373.

Moriarty, H. (1990). Key issues in the family research process: strategies for nurse researchers. Advances in Nursing Science, 12(3), 1-14.

Mullens, A. (1991, June 24). Healing at home: cure for an aging nation. Vancouver Sun, p. A6.

Munhall, P. (1982). Nursing philosophy and nursing research in apposition or opposition. Nursing Research, 31(3),176 -181.

Munhall, P. & Oiler, C. (1986). Nursing Research: a Qualitative Perspective. Norwalk, Connecticut: Appleton-Century-Crofts.

Munhall, P. (1988). Ethical considerations in qualitative research. Western Journal of Nursing Research, 10(2), 150-162.

Naylor, M. (1990). Comprehensive discharge planning for hospitalized elderly: a pilot study. Nursing Research, 39(3), 156-161.

Norheim, C. (1989). Family needs of patients having coronary artery bypass graft surgery during the intraoperative period. Heart & Lung, 18(6), 622-626.

Norris, L. & Grove, S. (1986). Investigation of selected psychosocial needs of family members of critically ill adult patients. Heart & Lung, 15(2), 194-199.

Northouse, L. (1988). Family issues in cancer care. Advanced Psychosomatic Medicine, 18, 82-101.

Nyberg, J. (1990). Theoretic explorations of human care and economics: foundations of nursing administration practice. Advances in Nursing Science, 13(1), 74-84.

Oberest, M. & James, R. (1985). Going home: patient and spouse adjustment following cancer surgery. Topics in Clinical Nursing, 7(1), 46-57.

Oberest, M. & Scott, D. (1988). Postdischarge distress in surgically treated cancer patients and spouses. Research in Nursing & Health, 11, 223-233.

O'Brien, M. (1983). An identification of the needs of family members of terminally ill patients in a hospital setting. Military Medicine, 148, 712-716.

O'Connell, M. (1989). Special presentation: anxiety reduction in family members of patients in surgery and postanesthesia care: a pilot study. Journal of Post Anaesthesia Nursing, 4(1), 7-16.

O'Malley, P., Favalaro, R., Anderson, B., Anderson, M., Siewe, S., Benson-Landau, M., Deane, D., Feeney, J., Gmeiner, J., Keefer, N., Mains, J. & Riddle, K. (1991). Critical care nurses perceptions of family needs. Heart & Lung, 20(2), 189-201.

Omery, A. (1983). Phenomenology: a method for nursing research. Advances in Nursing Science, 5(5), 49-63.

Papalia, D. & Olds, R. (1989). Human Development (4th ed.). Toronto: McGraw-Hill Book Company.

Price, D., Forrester, A., Murphy, P. & Monaghan, J. (1991). Critical care family needs in an urban teaching medical center. Heart & Lung, 20(2). 183-188.

Quinn, W. & Herndon, A. (1986). The family ecology of cancer. Journal of Psychosocial Oncology, 4(1/2), 45-59.

Ramsey, J. (1991, June 21). In sickness or in health? The Vancouver Sun, pp. A1, A12.

Rasie, S. (1980). Meeting families needs helps you meet ICU patients' needs. Nursing, 10, 32-35.

Ray, M. (1985). A philosophical method to study nursing phenomena. In M. Leininger (Ed.), Qualitative Research Methods in Nursing. (p.p. 81-92). Toronto: Grune & Stratton Inc.

Reigle, J. (1990). Limiting care: should age be a criterion? Clinical Issues in Critical Care Nursing, 1(1), 199-205.

Riley, R. (1989). Hospital morbidity, 1985-86. Health Reports, 1(2), 249-252.

Riley, R. & Kanigan, M. (1989). Surgical procedures and treatments 1985-86. Health Reports, 1(2), 253-254.

Robinson, J. (1988). Support systems. Nursing Times, 84(14). 30-31.

Roudot-Thorval, F., Boubert, M., Fourestie, V., & Lejonc, J. (1987). Social future of elderly admitted to acute care hospital: opinion of patient or family as predictive factor of subsequent transfer to long term care. British Medical Journal, 294, 608-609.

Roy, C. (1976). Introduction to Nursing: An Adaptation Model. Englewood Cliffs, New Jersey: Prentice-Hall Inc.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Sarason, I., Levine, H., Basham, R. & Sarason, R. (1983). Assessing social support: the social support questionnaire. Journal of Personality and Social Psychology, 44(1), 127-139.

Silva, M. (1987). Needs of spouses of surgical patients: a conceptualization within the Roy Adaptation Model. Scholarly Inquiry for Nursing Practise, 1(1), 29-44.

Stanik, J. (1990). Caring for the family of the critically ill surgical patient. Critical Care Nurse, 10(1), 43-46.

Stansfield, K. (1989). Adaptation of family members of brain injured patients: self perception of needs. Unpublished master's thesis, University of Manitoba, Winnipeg, Manitoba.

Statistics Canada (1990). Health Reports Supplement No. 2: Surgical Procedures and Treatments 1987-88. Ottawa,Ont: Canadian Centre for Health Information.

Swanson-Kauffman, K. (1986). A combined qualitative methodology for nursing research. Advances In Nursing Science, 8(3), 58-69.

Swanson-Kauffman, K. & Schonwald, E. (1988). Phenomenology. In B. Sarter (Ed.), Paths to Knowledge: Innovative Research Methods for Nursing. National League for Nursing.

Thompson, J. V. (1989). The elderly and their informal social networks. Canadian Journal on Aging, 8(4), 319-332.

Thorne, S. (1985). The family cancer experience. Cancer Nursing, 8(5), 285-291.

Tringali, C. (1986). The needs of family members of cancer patients. Oncology Nursing Forum, 13(4), 65-70.

Turk, D. & Kerns, R. (1985). The family in health and illness. In D. C. Turk & R. D. Kerns (Eds.), Health, Illness and Families: A Life Span Perspective (p.p. 4-20). Toronto: John Wiley & Sons.

Valentine, K. (1989). Caring is more than kindness: modeling its complexities. Journal of Nursing Administration, 19(11), 28-34.

Vess, J., Moreland, J., Schwebel, A., & Kraut, E. (1988). Psychosocial needs of cancer patients: learning from patients and their spouses. Journal of Psychosocial Oncology, 6(1/2), 31-51.

Welch, D. (1981). Planning nursing interventions for family members of adult cancer patients. Cancer Nursing, 4, 165-370.

Wilson-Barnett, J. (1988). Patient teaching or counselling? Journal of Advanced Nursing, 13, 215-222.

Wilson, L. (1982). How to develop a support group for families of open heart patients. Dimensions of Critical Care, 1(2), 108-116.

Wolock, I., Schlesinger, E., Dinerman, M., & Seaton, R. (1987). The posthospital needs and care of patients: implications for discharge planning. Social Work in Health Care, 12(4), 61-76.

Woods, N., Yates, B., & Primomo, J. (1989). Supporting families during chronic illness. IMAGE: Journal of Nursing Scholarship, 21(1), 46-50.

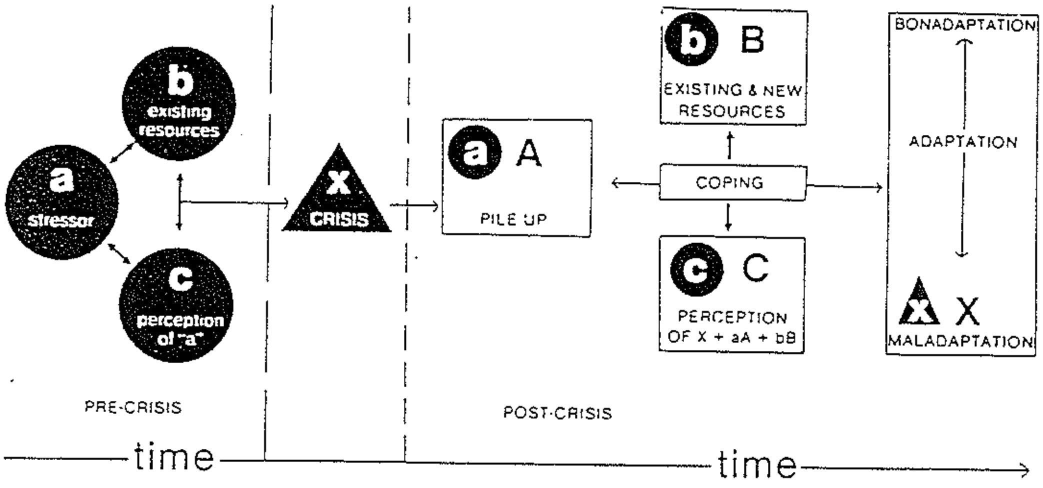
Wright, L. & Bell, J. (1989). A survey of family nursing education in Canadian universities. The Canadian Journal of Nursing Research, 21(3), 59-74.

Wright, L. & Leahey, M. (1990). Trends in nursing of families. Journal of Advanced Nursing, 15, 148-154.

Appendix A

Double ABCX Model

From: McCubbin, H. and Patterson, J. (1983). Family transitions: adaptation to stress. In H. McCubbin & C. Figley (Eds.). Stress and the Family, Volume I: Coping with Normative Transitions. New York: Brunner/Mazel, Publishers. p. 12. Reprinted by permission.



Appendix B

Self Perceived Needs of the Family Members of the Elderly Surgical Patient

Explanation of the Study to the Patient

My name is Lynne Parsons. I am a Registered Nurse and a student in the Master of Nursing Program at the University of Manitoba. As part of my nursing program, I am conducting a study to look at the needs of the family members of the older surgical patient. The Ethics Review Committee of the University of Manitoba, School of Nursing have given me permission to carry out this study.

The purpose of the study is to explore what family members identified as their own needs during hospitalization and after discharge of the older surgical patient. Family members will also be asked to discuss activities that did or could have helped them support their family member through this experience.

Dr. T'ien has identified you and your family because you might be interested in this study. I am asking you to identify your main support persons and invite them to participate.

If you and your family member agree to participate, I will be asking them for approximately one hour to talk with me. If possible I would like to contact your family while you are in hospital and arrange for the interview after your discharge. The time and place will be agreed upon but with as little inconvenience to you or your family as possible. The interviews will be tape recorded but these will be erased at the completion of the study and no names will appear in the written transcripts or reports.

Participation in the study is entirely voluntary and you and your family are free to withdraw at any time without consequence.

Whether you decide to participate or not will have no impact on the care you receive. Although there are no direct benefits to you, the study will help nurses give better care to patients and their families in the future. There are no risks or costs involved in participating in this study either for you or your family member.

You are assured of confidentiality. Neither your name or that of any of your family members will be used in any written material or any public report of this study. The tapes will be erased at the conclusion of the study.

I will be happy to answer any questions you may have about this study. I can be reached at 338-6264. If you wish to speak with my study advisor, Dr. Erna Schilder, you can call her at my expense, at the School of Nursing, University of Manitoba (204-474-9664)

Thank you for your willingness and that of your family members to participate.

If you wish to receive a summary of the findings, please indicate: YES: NO:

Appendix C

Self Perceived Needs of the Family Members of The Elderly Surgical Patient

Explanation of the Study to the Participant

My name is Lynne Parsons. I am a registered nurse and a student in the Master of Nursing program at the University of Manitoba. As part of my nursing program, I am conducting a study to look at the needs of the family members of the older surgical patient. The Ethics Review Committee of the University of Manitoba, School of Nursing have given me permission to carry out this study.

The purpose of this study is to explore what family members identify as their own needs during hospitalization and after discharge of the older surgical patient. Family members will be asked to discuss activities that did or could have helped them support their family member through this experience.

Dr. T'ien has identified your family as possibly being interested in this study. The patient has identified you as one of their support persons and you are invited to participate. You are being asked to share your views in an interview. Your agreement to participate in this interview indicates your consent to be a participant in the study.

You are being asked to meet with me for an interview that will involve approximately one hour of your time. The interview will take place at a time and location convenient to you. You may choose to answer some or all of the questions, if you so desire. The interview will be tape recorded but no names will appear in written transcripts.

Participation in the study is entirely voluntary and you are free to withdraw at any time without consequence to you or anyone else in the family.

Whether you decide to participate or not in the study there will be no impact on the care of the patient. There are no direct benefits to you or the patient but the study will help nurses give better care to patients and their families in the future. Participating in the study does not involve any risks or costs to any member of the family.

You are assured of confidentiality. Neither your name or that of any of your family members will be used in written material or any public report of this study. The tapes will be erased at the conclusion of the study.

I will be happy to answer any questions you may have about the study. I can be reached at 338-6264. If you wish to speak with my study advisor, Dr. Erna Schilder, you may call her at my expense, at the School of Nursing, University of Manitoba (204-474-9664).

Thank you for your willingness to participate in this study.

If you wish to receive a summary of the findings, please indicate: YES: NO:

Appendix D

Interview Sheet

Code______
Date____________
Address__________________ Phone_____________
Start Time _____________ Stop time__________ Total time________

1. Who makes up your family?

2. Where are your family members located?

3. What is you family's past experience with surgery or other health problems?
patient:
Participant:
Other family members:

4. Where did the patient live prior to surgery? What was the home situation prior to surgery.?

5. What kind of support if any did th patient require prior to surgery? Who provided it?

6. Did the patients surgery create stress for you or any other member of the family?

7. During hospitalization what would you identify as your own personal needs? Who helped you meet these?

8. How did you feel about the patient coming home?

9. Did you and/or the patient feel prepared to manage at home? Who helped prepare you? What might have been more helpful?

10. What supports did you or should you have had to help the patient convalesce at home? Did you initiate these or did the health professionals?

11. Did your perceptions of how the patient recovered at home meet with your expectations?

12. Can you identify any of your own needs during the patients first month at home? How did you meet these?

13. How would you rate the surgical experience from a family perspective?

14. Of the things you identified as important in caring for a family member at home, which would you rank first? Which least important?

<u>General Demographic Info</u>:

1. Age of the patient______
2. Surgery of the patient______________
3. Time spent in hospital:
   prior to surgery__________
   after surgery____________
   How long a wait for surgery______________
4. Relationship of participant to patient:
   spouse_____
   daughter___
   son_____
   Daughter in law_____
   son in law_____
   other_____
5. Age of participant______
6. Home address of participant______
7. Educational level achieved by participant__________________
8. Approximate annual income of patient
   under $15,000__
   $16,000-$30,000__
   $31,000-$50,000__
   over $50,000__
9. Does the family have any religious affiliation that might serve as a source of support?
10. Are you or the patient ex-military? Yes __ No__
    If yes what if any support services are provided through this association?
11. Are there any other areas we haven't talked about that you feel are important to help someone cope when they are discharged from hospital?

Appendix E

TABLE 1

Characteristics of Patients

Patient	Age	Gender	Patient Surgery	Days In Hospital	Days in Hospital after surgery	Marital Status	Place of Residence
A	81	Male	Bowel Resection	13	11	M	H
B	75	Male	Bowel Resection	10	7	M	H
C	69	Female	Hernia Repair	4	2	M	H
D	96	Male	Bowel Resection	10	8	W	F
E	67	Male	Bowel Resection	9	7	M	H
F	68	Female	Cholecystectomy	3	1	M	H
G	85	Female	Mastectomy	5	3	W	H
H	81	Male	Cholecystectomy	18	12	M	A
I	65	Female	Mastectomy	5	3	M	H
J	72	Male	Hernia Repair	5	3	M	H
K	70	Male	Bowel Resection	14	12	M	H

Key: Marital Status:
M = Married
W = Widow/Widower

Place of Residence:
H = Own home
F = With adult children
A = Seniors apartment