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Patients' experience of acute unplanned surgical reoperation



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ABSTRACT

Background: Undergoing surgery always involves various risks of complications, often depending on the type of surgery. Because of complications, a second surgical intervention, a reoperation, must occasionally be done, which in turn often causes an extended hospital stay, a longer recovery phase, greater suffering for the patient, and higher health care costs. Even though complications after general surgery are relatively common, little is known regarding patient experience of a reoperation. Knowledge of this could impact on care models in the future. The aim of this study was to describe patients' experience of acute, unplanned reoperation during a planned hospital stay.

Materials and methods: A purposive sampling strategy was used, and 16 patients were included, all who had undergone acute unplanned reoperation during a planned hospital stay. Semi-structured interviews were used to collect data, and a content analysis with an inductive approach was used for data analysis.

Results: The analysis resulted in two main themes: (1) health professionals' importance, having its foundation in categories trust and information, and (2) reaction, based on the categories anxiety and sadness.

Conclusions: Unplanned reoperation caused psychological, social, and existential reactions. Health care professionals were perceived as important because good communication, accurate information, their presence, and creating feelings of confident and safe care were meaningful factors for the patients as they managed the situation.

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Introduction

Complications after surgery are relatively common; almost one of five patients (17%) was affected according to the systematic review from Kazaure *et al.*¹ on 550,000 general surgery patients in the United States, and 6% of these patients also needed a reoperation. This second surgical intervention

causes extended hospital stay, longer recovery phase, greater suffering for the patient, and higher health care costs.²⁻⁴ Because there is no established definition of a complication, it is difficult to obtain a precise prevalence of its frequency. Another problem is the large variation in the number of reported complications correlated to the type of surgery done.^{3,5} Despite this, commonly reported complications after surgery

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are different types of infections, pulmonary embolism, sepsis, pneumonia,¹ bleeding, and anastomotic leakage.⁴

It is known that the prevalence of complications and reoperations varies considerably depending on the primary surgical operation.^{1,6} Overall, surgery in the gastrointestinal tract leads to a high risk of complications within 30 d (25%–30%), whereas the lowest risk of complications occurs in endocrine interventions and breast and bariatric surgery. Complication rates later than 30 d postoperatively are most frequent in breast surgery (79%) and bariatric surgery (69%).^{1,6}

Primary complications can also cause impair long-term survival and long-term health impacts, e.g., patients who underwent surgery for esophageal cancer and suffered a serious postoperative complication had more symptoms of respiratory distress, feeding difficulties, and fatigue until 5 y after surgery compared with patients with no postoperative complications.^{7,8}

Complications and reoperations often lead to an extended hospital stay and increased cost for both the health care system and patients.⁴ The length of the stay and the number of days in the intensive care unit (ICU) increase with complications after primary surgery, which also double the cost compared with patients without complications. One example is pancreatic surgery, where the average length of stay is 11 d without complications, compared with 20 d after experiencing complications.²

Even if the medical diagnosis is clear, surgery is elective, and the surgical procedure is performed as planned, patients often feel vulnerable both physically and psychologically.⁹ If a patient suffers from a complication and has to undergo a reoperation, it is important that health professionals provide honest and open communication so that patients and their relatives receive accurate explanations and information about what happened.¹⁰ Good communication reduces feelings of the unexpected incident as a malpractice on the part of the caregivers, so that an accident or a complication can rather be perceived as a natural and possible event.¹¹

In the field of reoperation after surgery, the patient's experience of suffering a reoperation and how this might affect provided care for these patients are sparsely investigated in current research. The aim of this study was thus to describe patients' experience of acute, unplanned reoperation during a planned hospital stay.

Materials and methods

Participants

A purposive sampling strategy was used based on patients having experiences that could address the research question.¹² Patients were identified through the hospital's medical record on two occasions, and all patients who fulfilled inclusion and exclusion criteria at these occasions were asked if they were willing to participate. In total, 16 patients at a university hospital in Sweden, from different geographical sites in the city, were approached with a request to participate in the study during the autumn of 2014. They had all undergone reoperations due to complications in connection with their planned surgery; everyone

was aged >18 y and well familiar with the Swedish language. All patients who were approached, except one, agreed to participate. The mean age was 55 y (range 32–79), the dominant sex was female (11/15), and most patients were married with children and had employment. Three were single, two were unemployed, and four were retired. The mean hospital stay was 23.7 d, with a range between 2 and 64 d. [Table 1](#) gives an overview of the participants' type of surgery, the reason for reoperation, and the length of the hospital stay.

Data collection

Semi-structured interviews were used to collect data. The interviews, lasting a mean of 17 min (range 5–29 min), were audio-taped and transcribed verbatim by one of the authors (M.D.). An interview guide was used, starting with the question: "What are your thoughts on your unplanned reoperation?" This was followed by questions concerning emotions, information, and support when needed. Before the interviews ended, the patients were asked whether there was something more they wished to express or if the interviewer had missed something important about their experiences. All the interviews were conducted at the hospital, but three patients had been discharged before the interview was held.

Data analysis

Data were analyzed using content analysis with an inductive approach. Content analysis involves a systematic approach to interrogation of the collected data, enabling the analysis to proceed from the specific to the general, i.e., individual citations are highlighted and by several steps condensed and combined into general conclusions, i.e., categories and themes,¹² [Figure](#) and [Table 2](#).

When performing an inductive analysis, in contrast to a deductive approach, data are not quantified, i.e., exactly how many participants that states each code/category are not reported. Nevertheless, a category cannot emerge without several similar codes and meaning units thus avoiding undue prominence being given to isolated comments in interview transcripts.¹²

This is well suited to exploring topics that are sparsely investigated, in which the lack of existing data precludes prior identification of the key phenomena to be interrogated. Using a manifest framework (as in this study), abstraction from the primary data is limited to ensure that the conclusions drawn closely reflect the content of data source, i.e., the interviews.¹² The inductive content analysis process according to Elo and Kyngäs,¹² with inspiration from Graneheim and Lundman,¹³ The fundamental steps in the analysis are illustrated in [Figure](#) and proceed as follows^{12,13}:

- reading through the interviews several times to understand their content,
- highlighting meaning units,
- condensing meaning units and labelling with codes,
- grouping similar codes from all interviews together into categories,

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