5-1965

A Comparative Study of Discomfort Experienced by Surgical Patients on Three Selected Postoperative Days

Lillian Barker Bartlett

LOMA LINDA UNIVERSITY

Graduate School

A COMPARATIVE STUDY OF DISCOMFORT EXPERIENCED BY SURGICAL PATIENTS ON THREE SELECTED POSTOPERATIVE DAYS

by

Lillian Barker Bartlett

A Thesis in Partial Fulfillment

of the Requirements for the Degree

Master of Science in the Field of Nursing

May, 1965

Each person whose signature appears below certifies that he has read this thesis and that in his opinion it is adequate, in scope and quality, as a thesis for the degree of Master of Science.

Winifred M. Edwards, Chairman
Winifred M. Edwards, M.A., Associate Professor of Nursing

Matilda Anabelle Mills
Matilda Anabelle Mills, M.S., Associate Professor of Nursing

Evelyn H. Domke
Evelyn H. Domke, M.S., Assistant Director of Nursing Service White Memorial Medical Center

ACKNOWLEDGMENTS

Sincere appreciation is expressed to those who have helped to make the completion of this study possible. To Mrs. Winifred Edwards, who served as major advisor, special gratitude for her guidance, support and encouragement. Sincere appreciation is given to Miss Anabelle Mills and to Miss Evelyn Domke for their interest and support, and to Dr. Betty Stirling for her helpful suggestions and encouragement.

Recognition is paid to the patients of the Glendale Sanitarium and Hospital and of the White Memorial Medical Center who cooperated so wholeheartedly in the research for this thesis.

Financial assistance in the form of a traineeship grant from the Department of Health, Education and Welfare of the United States made possible the course of study which led to the undertaking of this project. For this assistance, the writer is deeply grateful.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION TO THE STUDY

Patients having had major surgery present problems of various kinds to their families and the hospital staff. Irritability, hostility, aggression, uncooperativeness, excessive demands for attention of one kind or another are examples of these problems. Much has been written about the general needs and problems of the hospitalized patient but little is stated about the specific needs of particular days of postoperative patients.

Twenty-five nurses informally interviewed by the writer stated that patients who have had major abdominal surgery experience more difficulty on the third postoperative day than on other days. Since the majority of them first heard of this concept from instructors in nursing and find it borne out in practice, it is assumed that it is generally accepted by nurses. Nothing has been found in literature to substantiate this belief. There are many books and articles, however, regarding the various factors which effect the course of hospitalization. These will be reviewed to show a possible relationship between these factors and postoperative progress.

When the patient comes to the hospital, his concept of the nurse has been developed through contact with other nurses, experiences he had heard from friends and relatives and perhaps by stories he has read. This concept is definitely colored by his cultural background. Any patient tends to regress to some extent when he becomes ill and may respond to the nurse as he did to his mother during childhood. He may

respond with contradictory or stubborn behavior which the nurse must try to understand.[1] The nurse is in a key position to help the patient with his emotional problems.[2]

Nurses react to impressions resulting from patient behavior. These impressions must be based on observations which will then provide clues to give understanding of the patient's needs and feelings.[3]

I. THE PROBLEM

Statement of the Problem

During the first twenty-four to forty-eight hours postoperatively surgical patients are medicated and are still more or less under the influence of the anesthetic. Varying amount of discomfort are experienced by the patients throughout the hospitalization. Nurses tend to identify the third day as the most uncomfortable.

Purpose of the Study

The purpose of the study was to compare the discomfort experienced on three postoperative days to determine if there is one day identified by the patient as most uncomfortable and to assess the symptoms of which he might complain by use of the following questions:

1. Which day does the patient say is most uncomfortable as determined by his statement of discomfort on each of the three days?
2. Which day does he report on the fourth postoperative day as being remembered as the most uncomfortable day?

---

[1]Kathleen Newton Shafer, et al. Medical-Surgical Nursing, (St. Louis: The C. V. Mosby Company, 1958), p. 17.

[2]Helen Segul. "Nurse Plays Key Role In Care After Surgery for Pain Relief," Hospital Topics, 42:85, May, 1963.

[3]Betty J. Thomas. "Clues to Patient Behavior," The American Journal of Nursing, 63:101, July, 1963.

3. Which physical symptom is most troublesome on each of the days?

4. How many complaints were primarily of an emotional nature?

5. Which physical and emotional symptom is of least importance?

6. Is there a significant difference between any of these symptoms?

7. How do the sexes compare on the number of complaints on each day?

Scope of the Study

Patients who have had major abdominal surgery, with no complications, were included in the population.

All English-speaking, adult patients, of all ethnic groups and all ages, were included.

The subjective nature of patient interviews may have influenced the findings.

Sample

The sampling was convenient due to limitations of time and patients available. All patients meeting the criteria as set forth in the scope of the study were included in the sample. A total of thirty-four patients were interviewed.

II. SIGNIFICANCE OF THE STUDY

Nurses hold the theory that the third postoperative day is the most difficult for surgical patients. A survey of literature reveals that no studies have been done to determine if there is a day which can be said to be the most uncomfortable. Therefore, it would seem of value to conduct a study which would try to find out if there is a day so identified by the patient.

The findings of this study might be used to show areas in which

more comprehensive care should be planned and which day the patient is most in need of extra support.

III. METHOD OF THE STUDY

A review of literature was done of the effects upon the convalescent period of the cultural background and family influences; reactions to hospitalization, pain and illness; the nurse's influence on the formation of patient attitudes; and early ambulation.

Permission to conduct the survey was received from the administration, nursing service and the medical staff of two hospitals in the Los Angeles area.

A checklist was prepared to assess the amount of discomfort experienced on three consecutive days. A pilot study of five patients was conducted to test the effectiveness of the checklist. A total of thirty-four patients were included in the study.

The researcher visited each subject the evening before surgery to explain the purpose and the method of the study and to elicit his permission to include him in the study. Subsequent visits were made on the second, third, and fourth postoperative evenings. The checklist was filled out each evening, either by the patient or the researcher if the patient preferred.

Data were compiled and analyzed. Percentages were computed and Chi square test applied to the differences between the days that were indicated as most difficult and to the differences between the diagnosis and complaints. A mean score was determined for the men and for the women for each of the three days that were compared. Conclusions were drawn and recommendations made.

IV. DEFINITION OF TERMS

For the purpose of this study terms are defined as follows:

1) Discomfort is defined as variations from the state of well-being in the physical and emotional areas of health as recognized and reported by the patient.

2) Major abdominal surgery is defined as any abdominal surgery exclusive of appendectomies and renal surgery.

V. OVERVIEW OF THE THESIS

The remainder of the thesis is organized as follows:

Chapter II --- Review of Literature

III --- Methodology

IV --- Analysis and Interpretation

V --- Summary, Conclusions and Recommendations

CHAPTER II

REVIEW OF LITERATURE

Much has been written regarding various factors which affect the patient's feelings regarding the postoperative period. These factors may be divided into two categories; personal and hospital factors. In the first group are included: (1) cultural background and family influences; (2) reaction to hospitalization; (3) reaction to illness; and (4) reaction to pain. The hospital factors are: (1) the nurse's influence on the formation of patient attitudes; and (2) the affects of early ambulation. These areas have been explored in this chapter. The researcher has been unable to find reports specifically related to the difficulty experienced on certain postoperative days.

I. PERSONAL FACTORS WHICH INFLUENCE PATIENT REACTION

Culture and Family Influences

People live in a world that they take with them wherever they go. In many ways, the nature of this world, and of man himself, is determined by the socio-cultural background. Some knowledge of this cultural background is needful for the nurse who is caring for the patient. When the culture and society are not maintained in a pure state, and when the culture contains many variables, the possibilities of individual variation must, of necessity, be taken into account. However, there are trends and general patterns that are pertinent. A child learns many responses from his family. The mother, by belittling pain or comforting and cajoling her child implants in him the basis for reactions in later years. To

this pattern are added new dimensions from experiences outside the home and from the style and pattern of living the person develops.[1]

Case history data, reported by Jackson, suggest that attitudes, values and behavior patterns related to illness are transmitted by families. These influence the probability that a member will define himself as ill (and perhaps become ill) and the types of illness that he will recognize, accept, deny and fear. The socialization experience of the child affects the probability of a certain illness occuring. Jackson further stated that there are marked variations in families as to whom they will seek for help with symptoms. Chiropractors, naturopaths, osteopaths, faith healers, grandmothers or others may be preferred over physicians. The family choice is influenced by socio-economic and ethnic factors as well as past experience with illness. Further study indicates that family expectations of hospital and treatment and the type of crisis that the illness poses for the family are relevant to the type and extent of family cooperation in illness and its treatment. The flexibility of the family structure affects the course and outcome of the illness.[2]

Society and culture affect man's perception of pain and his response to it. Zborowski's study indicated that Jews were concerned with the meaning of pain and its relationship to general health, whereas Italians were concerned with the immediacy of the pain and the discomfort involved. Old Americans were less emotional, more given to reporting,

---

[1]Margaret A. Kaufmann and Dorothy E. Brown, "Pain Wears Many Faces," The American Journal of Nursing, 61:49, January, 1961.

[2]Joan K. Jackson, "The Role of the Patient's Family in Illness," Nursing Forum, 1:121-125, Summer, 1962.

defining, quality, location and duration. They tried to seek approval and avoid being a nuisance.[3]

Spanish-American Culture. Spanish-American people make up the largest culturally distinct population within the larger population of the United States. There are cultural differences between them and the majority population, many of which have important implications for attitudes and practices with respect to illness and health.[4] Therefore, some specific practices will be reviewed, assuming that the principles will transfer to other ethnic groups.

In a study by Paynich among the Spanish-Americans of New Mexico, it was found that when an interpreter was used, understanding was lessened, for the interpreter tended to add to the information being given, many times using erroneous ideas. When one or two terms were clarified, understanding was increased. An implication of this finding is that nurses should use simple language and explain any technical terms that must be used. More understanding developed when the interview was conducted in the clinic than when it was in the home. Probably the authority of the nurse was enhanced by the health setting.[5]

Moore and Faraone further pointed up the fact that when nurses tried to use the Spanish language, even though they knew only a few words,

---

[3]Mark Zborowski, "Cultural Components in Response to Pain," in Sociological Studies of Health and Sickness, ed. Dorrian Apple (New York: McGraw Hill Book Company, Inc., 1960), p. 120.

[4]Lyle Saunders, Cultural Differences and Medical Care. (New York: Russell Sage Foundation, 1954), p. 12.

[5]Mary Louise Paynich, "Cultural Barriers to Nurse Communications," The American Journal of Nursing, 64:82, February, 1964.

the people felt accepted and that the nurse really cared for them as individuals. It also served as an incentive for the patients to try to learn English. It was shown that medical care was more effective and satisfactory when the personnel tried to use the native language.[6]

Saunders related that a strong family relationship exists among the Spanish-Americans. For instance, one woman left a tuberculosis ward seven times against medical advice. Each time there had been a minor family crisis which she thought necessitated her presence. But this woman was regarded as a problem by the "Anglo" staff. Recognition of the importance of family relationships can result in better physician or nurse-patient relationships. Another trait which the Anglos find difficult to understand is the tendency to dependency. Furthermore, there is a lack of emphasis on the need for independence. When a Spanish-American comes into the Anglo community, he must be given time to learn new ways. Anglo doctors and nurses must be prepared to make more decisions than they would in a group of Anglos. It is not enough to present alternatives and differing courses of action, for the Spanish-American, if he makes a decision, may choose as a result of considerations that are either outside the Anglo cultural pattern or not highly valued in it.

Saunders also stated that although there is no formula that will serve as an infallible guide to working with these people, some suggestions can be made. Health personnel should not equate cultural differences in behavior with ignorance or lack of intelligence. Depending

---

[6]Janice Eaton Moore and Helen Bradley Faraone, "Habla Usted Espanol?" Nursing Outlook, 10:251, April, 1962.

on their background, they have different ideas about diagnosis and treatment of illness, but this is not the same as no ideas. Their judgments are different from the Anglos because of difference in knowledge and the way the situation is defined. Since Spanish-Americans are inclined to be more uneasy and to feel more anxiety or fear in a medical situation than do Anglos, professional personnel need to give additional patience, gentleness and consideration. Often many of these people will not say that they do not understand. Rather, they will agree to what is asked of them, responding in the way they think the nurse or doctor wants them to respond, and replying in the affirmative when asked if they understand, even if they do not. He stated further that rigid adherence to time schedules cannot be expected. Family affairs or other so-called trivial matters may take precedence over medical appointments. Long-in-the-future appointments should be avoided, for it is very easy to "forget" to keep them. Also, when medication is perscribed, it is best to give directions that are connected with meals or other routine events, for it is difficult to remember special times.

Ethnocentricism, the tendency to believe that the way one's people think, act, and believe is the only right, proper and natural way and that all other practices are wrong or strange, is a pervasive characteristic and one that is difficult to avoid. Unless care is taken, medical personnel are apt to make judgments about the people who impress them as being dirty, lazy, unambitious, promiscuous, ignorant, superstitious, and backward, while those being served may talk about the crazy foreigners who make a fetish of time, wear outlandish clothes, are compulsive about bathing, do women's work, and know nothing about the real causes of illness and disease. Saunders pointed out that in situations of this sort

only limited cooperation can be expected. Those providing medical services will have to take the initiative in preventing the baleful effects of ethnocentrism. They must be prepared to make an effort to understand the behavior and viewpoint of the people for whom they are working and to make some modification in professional practices in order to make them acceptable.[7]

Reactions to Hospitalization

When a patient is admitted to the hospital, he tends to feel split up and shared out with no one staff member being interested in him as a person. There are so many people involved in admitting him, doing examinations and tests, and giving nursing care that he feels lost and that no one really cares what happens to him.[8] Furthermore, he is leaving a familiar environment for an unfamiliar one and is temporarily forfeiting his independent role in the home and community for a dependent one created by the facts of illness and hospitalization. He brings with him various misconceptions colored by previous experiences with hospitals and medical personnel, or, at least, superstitions, fears and misinformation. In the hospital, he has no authority; his freedom is curtailed; he must allow others to do for him what he has previously done for himself; he has little privacy and must submit to embarrassing situations and procedures performed by people he does not know.[9]

---

[7]Saunders, op cit. pp. 211-238.

[8]Elizabeth Barnes, People in Hospital. (London: Macmillan and Company, Ltd., 1961), p. 15.

[9]Roslyn R. Elms and Donna K. Diers, "The Patient Comes to the Hospital," Nursing Forum, 2:89, 90, Number 3, 1963.

Dichter believed that any patient, regardless of age, in an environment different from the one to which he is accustomed, becomes uncomfortable and insecure. His personality changes and he becomes a child emotionally. How he reacts to the crisis effects his recovery.[10] Thus it is extremely important that a warm accepting relationship be established with some member of the staff. Although the patient may find in his doctor or a family member the confidant to whom he needs to talk of his fears, he may want to put the nurse into this role. Rather than expecting solutions for his problems, often he wants only a sympathetic, understanding listener.[11]

Reactions to Illness

Patients react to illness in various ways. Creighton and Richard found that fears are states of apprehension which focus on recognizable threats which may be judiciously appraised and realistically countered. On the other hand, anxieties are diffuse states of tension which magnify and may even cause the illusion of danger without pointing to any avenue of defense or mastery. Fear is a characteristic response to a threat against self-preservation.[12] Anxiety can interfere with the patient's ability to communicate. Thus the environment the nurse provides may

---

[10]Ernest Dichter, "What the Patient Really Wants From the Hospital," The Modern Hospital, 83:52, September, 1954.

[11]George R. Sissler, "The Nurse and the Emotional Needs of the patient," The Canadian Nurse, 54:316, April, 1959.

[12]Helen Creighton and Sister Gabriella Richard, "When You Are Scared," The American Journal of Nursing, 63:63, January, 1963.

well influence his feeling about himself and the rest of the world.[13]

Richter wrote that some patients react to illness with anger. The nurse must be able to recognize the dynamics of anger in order to help her patient work through this emotion. First, there is a blocked goal. The patient feels frustrated by his illness, reduced self-respect, or unmet expectations. Next, he experiences an unpleasant, uncanny powerless feeling, which is a part of anxiety. This feeling is changed, sometimes without the recognition of the anxiety, into feelings of power, directed against the blocking object, a substitute or self. The final step is a feeling of relief. If the nurse understands these reactions in her patient she is in a better position to accept and control her own and her patient's behavior.[14]

Dichter felt that one way to meet the reactions of the patient is to be sure he feels safe, cared for, at home. Relationships between members had a bearing on the security feelings of the patient. If the personnel work well together for the good of the patients, the patient feels safe in their care. When the nurses give the impression of busyness, the patient feels lost, like a "cog on a wheel." Many times only a change in attitudes is necessary to alter the patient-hospital relationship.

Dichter went on to say that to many people, a cup of hot coffee signifies warmth, friendship, adultness. Thus if the morning coffee is always cold, the patient interprets this as meaning that here is a cold,

---

[13]Joan K. Jackson, "Communication Is Important," The American Journal of Nursing, 59:91, January, 1959.

[14]Dorothy Richter, "Anger: A Clinical Problem," Nursing World, 132:22, 23, December, 1958.

unfriendly place and feels unaccepted. On the other hand, if some one takes time to see that the coffee is hot and good, he feels that he is accepted, a friend and an adult.[15]

Reactions to Pain

Pain is a psychological phenomenon, according to Engel, and it is one of the greatest problems to be met in the hospital. It does not occur without the operation of psychic mechanisms which give rise to identifiable qualities and which permit its perception.[16]

Farnsworth found that the attitude toward pain differs greatly from one individual to another and within one individual at different times. Strong attention to an outside stimulus raises the threshold for pain. A headache may disappear when one is busy with a pleasurable pastime, only to recurr when one is alone or not occupied. It may appear when a disagreeable task is to be done. Pain is more easily borne when hope is high, when the end is in sight or when the reason is clear. The patient's confidence in his physician has a bearing on the amount of pain experienced. Pain may be used to test the affection of those about the patient. It may be the means of determining if others care.[17]

Reaction to postoperative pain is modified by experience, expectations and culture. The most important factor in the degree of pain and the response to it is anxiety. According to Brown, the physician's

---

[15]Ernest Dichter, "How Secure is Your Hospital?" The Modern Hospital, 83:61, November, 1954.

[16]George E. Engel, "'Psychogenic' Pain," The Medical Clinics of North America, 6:1495, November, 1958.

[17]Dana L. Farnsworth, "Pain and The Individual," The New England Journal of Medicine, 254:560, March 22, 1956.

explanation to the patient of his ailment, treatment and prognosis as well as his understanding and sympathy does much to allay anxiety. His ability to instill confidence and maintain a warm personal relationship without sacrificing control gives support which enables the patient to face postoperative pain without narcotics. "Narcotics do not remove pain; they modify the patient's reaction to it."[18] People usually respond to pain as they are expected to respond. When the nurse asks the patient if he wants a shot, she is suggesting that he should hurt. By assisting the patient to see that his discomfort can be tolerated, but if it becomes intolerable medication will be given, decreases anxiety and thus makes it easier to bear pain.

Giving medication may or may not be the best way of alleviating pain. By giving medication, the nurse may be avoiding listening and understanding and using nursing measures which might bring comfort. Support, assurance and understanding may relieve the necessity for having pain. But, according to Kaufman and Brown, by withholding medication the nurse may reflect a decision on her part that the patient does not or should not have pain, perhaps because in her eyes the patient's condition does not warrant pain. Whether pain is physical or psychogenic, pain is felt. The better therapeutic effort is directed toward discovering and relieving the cause rather than denial of the existence of the relief of a symptom.

Pain must be distinguished from discomfort and anxiety. Fear, hysteria, colic, scopolamine, abnormal reaction to morphine, hypoxia,

---

[18]Paul W. Brown, "Patient With Proper Support Can Tolerate Pain Without Drugs," Hospital Topics, 42:87, May, 1964.

[19]Kaufman and Brown, op. cit., p. 51.

or barbiturates may cause restlessness and discomfort. Physical factors, such as position, distended bladder, wrinkled bed clothes, tight dressings or sore throat may also be factors. Administration of sedatives alone when the patient is in pain may cause restlessness and excitement. Individual pain threshholds seem to vary with the mood, fatigue, fear and change of temperature. No correlations have been found between the incidence of pain and age, sex, previous medical history and personality type. Attitudes of the staff and visitors are a factor in the perception of pain. Cheerful but firm handling by the staff may allay self-pity and thus alleviate pain.[20]

Shelby found that conferences with apprehensive preoperative patients, in which explanations were made of what takes place during and after surgery and what would be expected of them in the way of exercises, deep breathing and coughing helped to allay fear and apprehension and enabled them to participate more fully in their postoperative care.[21] Aasterud pointed out that explanations "should be based on knowledge of how people behave under stress, of how anxiety affects the person's ability to communicate, and . . . on an assessment by the nurse of her own expectations."[22]

Dumas noted that adverse emotional reactions among surgical patients may, by reflex action, increase postoperative vomiting and

---

[20]Mark Swerdlow, "Relieving Pain After Operation," The Nursing Times, 59:62, March 1, 1963.

[21]C. Via Shelby, "A Presurgical Conference," The American Journal of Nursing, 60:1646, November, 1960.

[22]Margaret Aasterud, "Explanation to the Patient," Nursing Forum, 2:44, Number 4. 1963.

urinary retention, lower the threshold of postoperative pain and increase postoperative anorexia.[23] Shafer and others emphasized that patients who have had adequate preoperative instruction and who have confidence in the surgeon, in the nurses and in the outcome of the surgery will usually have less postoperative pain than will the apprehensive patient.[24]

II. HOSPITAL INFLUENCES ON PATIENT REACTION

The Nurse's Role in Influencing Attitudes

The Nurse's goals. In order to achieve the goals of nursing care, the nurse must take stock of her own feelings and thoughts and communicate with the patient in this context. By really identifying the needs of the patient, she may be able to readjust her own feelings. She must use her observations and try to understand the cues the patient gives her.[25]

Lewis and Holmes further indicate that if the nurse is to understand and accept patient behavior, it is essential that she have a basic knowledge of human behavior. Equally important is the nurse's need to recognize her own feelings and emotional reaction to a patient's behavior and to learn how to deal with these feelings in order to work effectively with patients.[26] Knowles pointed out that if the nurse feels anger that

---

[23]Rhetaugh Graves Dumas, "Psychological Preparation for Surgery," The American Journal of Nursing, 63:52, August, 1963.

[24]Kathleen Newton Shafer and others, Medical-Surgical Nursing. (St. Louis: The C. V. Mosby Company, 1958), p. 172.

[25]Ernestine Weidenbach, "The Helping Art of Nursing," The American Journal of Nursing, 63:54, 57, November, 1963.

[26]Garland K. Lewis and Marguerite J. Holmes, "Meddling With Emotions," Nursing Outlook, 9:405, July, 1961.

a disease cannot be cured, she may seem angry with the patient and avoid being near him, emotionally as well as physically. She may be a "Polly-anna", never allowing the conversation to get below the superficial level. She uses her cheerfulness to prevent the patient from telling her what he really feels. She may be so solicitous that in her efforts to make him comfortable she makes him uncomfortable. Or she may focus on the person, making him as comfortable as possible, accepting him with his fears, anxieties and depression, helping him to live day by day, hour by hour. She knows she has done her best.[27]

Feelings of dependency on the part of the patient many times threaten the nurse, according to McQuade and Goldfarb. She cannot accomplish her goals of nursing care so long as the patient persists in obstructive behavior. The nurse needs to see that with most persons, "goals must be determined by the patient's capacities rather than the nurse's aspirations."[28] Good nursing care, which, according to Ingles, is the objective of every nurse, conveys an unspoken message to the patient, a message which says,

> I am taking care of you because I want you to feel better and get better. . . . You can be yourself with me. If you are frightened, you may tell me you are frightened and I will understand. If you are angry, you may tell me you are angry and I will not judge you. If you are in pain, I will comfort you. I want to take care of you and I know how to take care of you. You are safe with me.[29]

---

[27]Lois M. Knowles, "How Our Behavior Affects Our Patients," The Canadian Nurse, 58:32, January, 1962.

[28]Ann McQuade and Alvin Goldfarb, "Coping With Feelings of Helplessness," The American Journal of Nursing, 63:78, September, 1963.

[29]Thelma Ingles, "What Is Good Nursing Care?" The American Journal of Nursing, 59:1246, September, 1959.

This message is conveyed by the nurse's attitudes and attributes. Compassion, one of the attributes of the good nurse, involves self acceptance as well as acceptance of others in the profoundest sense. The person who can most fully accept himself is the one who can most fully accept others. Jersild said, "Compassion is stronger than anger, mightier than love, more powerful than fear. It gives the measure of a person's strength as a human being. It is not the emotion of the weak. It is the hard gotten property of the strong."[30] Again, compassion is the key to good nursing. It involves the head as well as the heart. In the world today there can never be enough compassion. There is no good reason why nurses should not give a little of themselves to every person they care for.[31]

Speroff stated that empathy, another of the attributes of a good nurse, is the ability of an individual to put himself in the same position as that of another. It is not a matter of guessing how another feels, but rather, the ability to truly put yourself in the place of the other person and to respond as though you were that person. The ability to empathize forms the basis of understanding and provides a climate in which unity can be established in a hospital setting. It gives insight into the behavior of the other person.[32]

---

[30]Arthur T. Jersild, "Compassion," in When Teachers Face Themselves, (New York: The Bureau of Publications, Teachers College, Columbia University Press,) Reprinted in Nursing Forum, 1:66, Fall, 1962.

[31]Marilyn E. Hagans, "There's No Such Thing As Professional Empathy," RN, 27:45, January, 1964.

[32]B. J. Speroff, "Empathy is Important in Nursing," Nursing Outlook, 4:326, June, 1956.

However, Travelbee indicated that there is a warmth and urge to action in sympathy that is not present in empathy. Empathy enables one to percieve another's distress, identify the cause, and anticipate the behavior likely to result from it. But the sympathetic person feels another's distress, he is touched by it and wants to do something about it. Since taking action to meet the patient's needs is an essential nursing function, it would seem that empathy must be transformed into sympathy if the basic goal is to be reached. Sympathy is warmth and kindness, an expression of compassion, a quality of caring experienced on a feeling level and communicated from one human being to another. It cannot be feigned by even the most elaborate techniques.[33] Travelbee went on to state:

> To be sympathetic means that this helping human being we call the nurse is concerned about this human being we call the patient. She seeks to alleviate his distress because of, and in spite of, his role and hers. She is not afraid to show interest or to feel concern, but she is not engulfed to the point of inactivity.[34]

The nurse's professional education enables her to minister to the physical needs of her patients. Her cultural training helps her to understand and minister to the social and mental as well as spiritual needs. It is her cultural training that gives her sympathy, empathy and understanding which so often play an important role in the healing art.[35]

---

[33]Joyce Travelbee, "What's Wrong With Sympathy?" The American Journal of Nursing, 64:69, January, 1964.

[34]Ibid., p. 71.

[35]Rupert Kilgore, "Cultural Awareness and The Nursing Profession," The Journal of Nursing Education, 2:22, January, 1962.

Communication. In order for the nurse to be aware of the patient's needs, communication must be a two-way process, reception as well as transmission. Listening is a part of reception, according to Sister Muriel. You must think of what you hear. Listening implies a mental effort to evaluate what you hear and then to respond. "Communicating. . . is simply a matter of living out our charity, of giving real assent to the dignity of every person we meet. For there is no meaning in words, it is people who mean."[36] Harper believed that listening also requires that one tune out the emotional overtones of his own value system so that the speaker's concepts and ideas give meaning to the whole conversation.[37]

Peplau stated that talking with patients becomes productive when the nurse becomes aware of her own verbal patterns and then takes the responsibility for her part of the verbal exchange. When nursing is seen as an opportunity to further the patient's self-understanding, the focus in the nurse-patient relationship will be upon the patient and his needs.[38]

Non-verbal communication. Orlando pointed out that part of the reception of communication is observation of behavior of various kinds. The impressions and interpretations of these behaviors may be partially or wholly incorrect. However, thoughts do occur automatically, and even they may be incorrect or inadequate. If the nurse expresses her thoughts

---

[36]Sister Muriel, "Listen," The Canadian Nurse, 57:25, Jan. 1961.

[37]Mary S. Harper, "Were You Listening? What Did You Hear?" Hospital Topics, 42:71, January, 1961.

[38]Hildegard E. Peplau, "Talking With Patients," The American Journal of Nursing, 60:96, July, 1960.

to the patient, they convey permission to the patient to express his own meaning more clearly. Orlando further stated that the nurse should not assume that any part of her reaction to the patient is correct until she checks the validity with him. If the nurse automatically acts on any perception, thought or feeling before she explores it with the patient, the activity may well be ineffective in its purpose of helping the patient. On the other hand, if the nurse first checks her thoughts and explores her reactions with him, what she does is more likely to achieve its purpose.[39]

The automatic process of activity is ineffective for the following reasons: (1) it is based upon reasons other than the meaning of the patient's behavior and the need giving rise to it; (2) it does not allow the patient to let the nurse know how the action affects him; (3) it is unrelated to the patient's immediate need; (4) it may occur because the nurse is not free to explore her reaction with the patient; or (5) the nurse is not aware of the manner in which the activity affects the patient.

On the other hand, activities carried out deliberately are effective because they help the patient in the following ways: (1) they come about after the nurse is aware of the patient's behavior and the activity required to meet his need; (2) the activity is carried out so that the patient is helped to tell the nurse how it affects him; (3) it meets the patient's immediate need and achieves the nurse's purpose in helping the patient; (4) the nurse is available to respond to the patient's need for help, and (5) the nurse knows how her activity affects the patient.[40]

---

[39]Ida Jean Orlando, The Dynamic Nurse-Patient Relationship. New York: G. P. Putnam's Sons, 1961), p. 44.

[40]Ibid., p. 65.

This deliberative process is related to the professional function of being helpful to the patient, for the nurse is in the position to know if she is being helpful. She recognizes if she has met the patient's needs by noting the presence or absence of improvement in the presenting behavior. In the absence of improvement, the nurse knows that the needs have not yet been met, and if she remains available, she starts the process all over again with whatever presenting behavior is then observed.[41]

Effects of Early Ambulation

Shapiro stated that it is a medical fact that wound healing is delayed by bed rest because of the poor circulation and impaired tissue metabolism. When a patient is confined to bed, it is difficult to keep the calcium in balance and as much as twice the amount of protein is required to maintain the nitrogen balance.[42]

Meyer and others noted improved gastrointestinal function in patients who ambulated early in the postoperative period. There appears to be an earlier return of appetite, fewer gas pains, less distention, less ilieus, a need for fewer enemas and a decreased period of postoperative starvation. Another result of early ambulation is fewer adhesions due to the changes in the position of the viscera. There is a diminution of wound pain with lessened need for analgesics.[43]

According to Baigrie, the return to homeostasis and returning anabolism commences the third day. The patient feels better, he moves

---

[41] Ibid., p. 68.

[42] Harold P. Shapiro, "Early Ambulation in Postoperative Patients," The Ohio State Medical Journal, 45:136, February, 1949.

[43] Karl A. Meyer and others, "Early Ambulation: Clinical Results and Prerequisites," Minnesota Medicine, 31:882, August, 1948.

more freely, his appetite begins to return and his ambitions begin to extend beyond the immediate future.[44]

Blodget reported in 1949 in the Bulletin of New York Academy of Medicine:

> Clinical observations reveal the most striking benefits of early ambulation. The early rising patients have a definitely more rapid return to normal strength and activity. Their outlook and morale are better. Patients who are gotten up are less impressed with how sick they are and they are more willing to move about in bed and to assist with their own care. . . . One gains the distinct impression that wound pain is reduced at an earlier time among early rising patients. On about the fourth postoperative day, they move around quite freely and need no assistance in getting in or out of bed and rarely need medication for pain. . . . It is clear that early ambulation prevents the marked loss of strength that occurs with continued bed rest, and that it definitely shortens the period of convalescence.[45]

In a discussion of early ambulation in Practitioner for March, 1960, it is stated that healthy people resent strict confinement to bed. It implies surrender of the will, and control by others of bodily functions, feeding, personal cleanliness and even position. Sitting up in bed has several deleterious affects; atrophy of muscles, increased susceptibility to infection, constipation or distention of the bowel, retention of urine, embolism and thrombephlebitis, osteoporosis, disturbed nitrogen balance, and hypostasis of the lung, to say nothing of the psychological disturbances that may result. Is it not strange that the medical and nursing professions have accepted this state of affairs as a normal part of treatment?[46]

---

[44] R. D. H. Baigrie, "Surgical Convalescence," South African Medical Journal, 34:588, July 9, 1960.

[45] James B. Blodget, "Early Ambulation Following Surgical Procedures," Bulletin of New York Academy of Medicine, 25:177, 178, Mar. 1949.

[46] "Discussion on Early Ambulation," Practitioner, 184:374, March, 1960.

Thus it would seem that the consensus of opinion is that early ambulation obviates many of the harmful effects of prolonged bed rest. Perhaps these theories may negate the idea that the third day, or any other one day, is more difficult for the postoperative patient.

III. SUMMARY

In reviewing the literature, it was found that no studies which attempt to assess postoperative discomfort on specific days have been reported. However, a survey was made of several factors which affect the patients' feelings regarding the postoperative period.

Cultural background and family influences, reaction to hospitalization, illness and pain were classified as personal factors. The authors seem to agree that each patient reacts in his individual way within the framework of his experience, knowledge, and environment.

The nurse's influence on the formation of patient attitudes and the effects of early ambulation were grouped together under the heading of hospital factors. The nurse's goals and her skills in communication, verbal and non-verbal, play a large part in the patient's reaction to his hospitalization. Early ambulation, by assisting in maintaining homostasis as well as high morale, seems to exert a positive influence on the patient's attitudes.

CHAPTER III

METHODOLOGY

The purpose of the study was to compare the discomfort experienced by surgical patients on three selected postoperative days. Although no reports of studies of specific postoperative days have been found by the researcher, a review of literature was conducted concerning personal factors influencing the patient's feelings in regard to the postoperative period, including: (1) Cultural background and family influences, (2) the patient's reaction to hospitalization, (3) his reaction to illness, and (4) his reaction to pain. Also, hospital influences including the nurse's influence on the formation of patient attitudes and the effects of early ambulation have been reviewed.

I. METHOD OF RESEARCH

The descriptive survey was the method used in this study. Brown stated that "the term description, as used to categorize a method of research, includes induction, analysis, classification, enumeration, measurement, and evaluation." She continued, "the word survey is used to indicate the gathering of data concerning current situations."[1]

Permission to conduct the survey was received from the administration, the nursing service and medical staff of two private hospitals in the Los Angeles area. The supervisors of the surgical units of both hospitals also granted their permission. The study was conducted during a period of six weeks.

---

[1]Amy Frances Brown, Research in Nursing, (United States of America: W. B. Saunders Company, 1958), p. 154.

II. SELECTION AND DESCRIPTION OF THE SAMPLE

All adult, English-speaking patients scheduled for major abdominal surgery were included in the sample. Major abdominal surgery was defined as all such surgery exclusive of appendectomies and renal surgeries. It was felt that patients having appendectomies are often discharged too early to be able to conclude the interviews and that the type of incision involved in renal surgery resulted in problems differing from other abdominal surgeries.

The total of thirty-four patients varied in age from nineteen to eighty-three years with a mean of 49.85 years. There were five subjects from the Negro race, the remaining twenty-nine being Caucasian. Two were of Spanish-American origin.

III. COLLECTION OF THE DATA

The tool consisted of a check list developed by the researcher. It was designed to assess the discomfort experienced by the subjects. Twelve symptoms common to postsurgical patients were included, with ratings of slight, moderate and severe. The check list is reproduced in Appendix A.

The evening before surgery, the researcher visited each subject to acquaint him with the study and its purpose and to solicit his cooperation. Subsequent visits were made the evening of the second, third, and fourth days. The check list was completed each evening by the patient or the researcher, as the patient preferred. Remarks were solicited each day. The evening of the fourth day the patient was asked to evaluate the three days with which the study is concerned as to the difficulty experienced on each day and which day was most uncomfortable.

A pilot study of five patients was conducted to test the effectiveness of the tool. The sixth day was included in the pilot study as the evaluation visit. Because it was decided that this added nothing to the information obtained and only served to increase the time of recall between the days to be evaluated and the evaluation, this last day was eliminated from the remainder of the study.

IV. ANALYSIS OF THE DATA

Data was tabulated in such a manner that the following questions could be answered:

1. Which day does the patient say is most uncomfortable as determined by his statement on each of the three days?
2. Which day does he remember as the most difficult?
3. Which physical symptom is most troublesome on each of the days?
4. How many complaints were primarily emotional?
5. Which physical and emotional symptom was of least importance?
6. Is there a significant difference between any of these symptoms?
7. How do the sexes compare on the number of complaints on each day?

They were categorized into seven groups according to surgical diagnosis: (1) hysterectomies, oopherectomies and pelvic laporotomies, (2) colostomies, colon resections, and colectomies, (3) gastric resections, gastrectomies and pyloroplasties, (4) cholecystectomies, (5) adrenalectomies, (6) splenectomies, and (7) inguinal hernioorhophies. Each group was tabulated according to difficulty experienced on each day.

A comparison was made of the day the patient remembered as most difficult and his complaints score. The score was obtained by assigning one point for each symptom marked as slight, two points for moderate and

three points for severe. These points were then totaled for the final score.

An analysis of the symptoms according to rank from the most important to the least important was done. Symptoms were divided into two groups: (1) physical symptoms and (2) emotional symptoms. A Chi square was done to determine significance at the .05 level.

A comparison was made between the mean complaint score of the men and the women. The mean was taken as the measure, since there were nine men as compared with twenty-five women in the sample.

Interpretations were made of the data and the analysis. Conclusions were drawn and recommendations made.

V. SUMMARY

The descriptive survey method was chosen for this study because of the exploratory nature of the study. The study was conducted for the purpose of finding out if there is one postoperative day that is identified by the patient as being the most difficult.

A check list was developed by the researcher to use in assessing the difficulty experienced. It was felt that this could be more readily evaluated than other methods that might be used to gather the information. The check list was simpler and less tiring for the patient than a more comprehensive questionnaire would have been.

A pilot study of five patients was conducted to test the effectiveness of the tool. Minor adjustments were made and the list was then used for the remainder of the sample.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF THE DATA

The purpose of the study was to compare three postoperative days among adult patients with abdominal surgery to find out if there is one day identified by the patient as most uncomfortable and to assess the symptoms of which he might complain by use of the following questions:

1. Which day does the patient say is most uncomfortable as determined by his statement on each of the three days?
2. Which day does he report on the fourth postoperative day as being remembered as the most uncomfortable?
3. Which physical symptom is most troublesome on each of these days?
4. How many complaints were primarily of emotional problems?
5. Which physical and emotional symptom was least important?
6. Is there a significant difference between any of the symptoms?
7. How do the sexes compare on the number of complaints on each day?

Data were collected by means of a checklist administered by the researcher on the evenings of the second, third, and fourth postoperative days. This chapter is an analysis and interpretation of the data collected.

Four subjects indicated that the first day was most difficult, with each day being a little better than the last. Because the second, third and fourth days were being compared, these four were classified with the second day. Three elderly ladies could not remember which day was most uncomfortable. In these instances, the researcher determined which day the greatest number of problems had been checked and by comparing remarks made on each day, chose which day had been most difficult.

Twelve of the subjects spoke of fear of the diagnosis or of the surgical procedure itself at the time of the preoperative visit. One man talked for forty-five minutes of his fears and problems. The writer allowed as much time as any of the subjects seemed to want to explore these feelings. These conferences were mostly listening on the part of the researcher but the subjects seemed more relaxed after being allowed to talk. It was interesting and somewhat surprising to note how comparatively few of the subjects admitted to psychological discomfort. The question arises: might the preoperative calls made by the researcher when the patients were allowed to talk of their fears have a bearing on the emotional problems of the postoperative period?

The subjects were most willing to cooperate in the study. No one refused to be included. However, four were excluded: one who was discharged on the fourth day before the final call was made, one who did not have the surgery planned, one who had complications and was in the intensive care unit, and one who died on the second day.

I. ANALYSIS

Of the thirty-four subjects, nine or 26.5 per cent were men and twenty-five or 73.5 per cent were women. The days indicated as most uncomfortable were as follows:

	Second Day	%	Third Day	%	Fourth Day	%
Male	5	55.5	2	22.2	2	22.2
Female	14	56	7	28	4	16
TOTALS	19	56	9	27	6	17

TOTAL 34

These total to nineteen or 56 per cent indicating the second day, nine or 27 per cent naming the third and six or 17 per cent choosing the fourth day. A Chi square test at the .05 level of significance indicates that the difference among the days is significant. (Chi square is 7.169 with two degrees of freedom.)

The data were categorized according to surgical diagnosis, into seven groups: (1) hysterectomies, oopherectomies and pelvic laporatomies; (2) colostomies, colon resections and colectomies; (3) gastric resections, gastrectomies and pyloroplasties; (4) cholecystectomies; (5) adrenalectomies; (6) splenectomies; and (7) inguinal herniorrhophies. Table I shows the distribution of the indicated days according to diagnosis. Eight or 24 per cent fell in group 1: five or 15 per cent fell in group 2; seven or 20 per cent in group three; ten or 29 per cent in group 4; one or 3 per cent in each of groups 5 and 6; and two or 6 per cent in group 7.

Fifty per cent or four of the first group indicated the second day as most uncomfortable; 25 per cent or two indicated the third day as did the same number for the fourth day. Among those having colon surgery, 50 per cent or two indicated the second day and 50 per cent or two named the third day. In the third group, those with gastric surgery, three or 43 per cent indicated the second day, two or 28 per cent chose the third day and the same number the fourth. Among the fourth group, the cholecyctectomies, there were eight or 72.7 per cent who said the second day was the most uncomfortable, two or 18 per cent indicated the third day and one or 9 per cent named the fourth day. There was one in each of the next two groups, the adrenalectomy named the second day, whereas the splenectomy indicated the third day. Of the two in the final group, one mentioned the second day while the other indicated the fourth day. A

TABLE I

DISCOMFORT EXPERIENCED ON EACH OF THREE DAYS
AS DIFFERENTIATED BY DIAGNOSIS

Diagnosis	Second day	Third day	Fourth day	Total
Hysterectomy	4	2	2	8
Colon surgery	2	2	0	4
Gastric surgery	3	2	2	7
Cholecystectomy	8	2	1	11
Adrenalectomy	1	0	0	1
Splenectomy	0	1	0	1
Herniorrhophies	1	0	1	2
TOTALS	19	9	7	34

Chi square of the diagnosis and the day indicated was not significant.

A comparison of the day which the patient remembered as the most uncomfortable with the scores of the symptoms checked indicated that fourteen or 41 per cent of the subjects remembered a day different from the day the score indicated. The score was computed by ascribing one point for each "slight" check, two points for "moderate", and three points for "severe." Since this study was concerned with the patient's opinion, the day that he said was most difficult was taken as being most difficult, regardless of other factors.

Table II shows the difficulty experienced on each of the three days according to the symptoms that were assessed. An analysis of the symptoms which caused difficulty indicated that on each day, incisional pain was the most uncomfortable symptom, with all thirty-four subjects reporting it in varying amounts on the second day, thirty-one on the third day and twenty-eight on the fourth day. Gas pains, the second in difficulty, was most uncomfortable on the third day, with twenty-one reporting on that day and eighteen on each of the other days. Discomfort caused by getting out of bed, whether standing by the bed or actual ambulation, ranked third with nineteen checks on the second day, twelve on the third day and fifteen on the fourth day. Bachache was listed as fifth. Sixteen checked this symptom on the second day with twelve on the third day and ten on the fourth day. Nausea ranked seventh, with sixteen checks the second day, seven the third and nine the fourth days. Headache was the least important, with seven, eleven and eight checking the successive days.

The four symptoms which were classified as emotional ranked in the following order: (1) apprehensive or nervous; (2) lonely or home-

TABLE II

DIFFICULTY EXPERIENCED ON EACH OF THREE DAYS
ACCORDING TO SYMPTOMS ASSESSED

Physical symptom	Second day	Third day	Fourth day	Total
Incisional pain	34	31	28	93
Gas pain	18	21	18	57
Discomfort on getting up	19	12	15	46
Dizzy or faint	16	12	9	40
Backache	16	12	10	38
Generalized discomfort	9	12	14	35
Nausea	16	7	9	33
Headache	7	11	8	26
TOTALS	135	118	101	
Emotional symptom				
Apprehensive or nervous	13	14	13	40
Lonely or homesick	5	9	9	23
Discouraged	5	6	5	16
Feel "weepy"	2	3	2	7
TOTALS	25	32	29	

sick; (3) discouraged; and (4) feels "weepy". The checks for each of these symptoms show that thirteen felt apprehensive the second day, fourteen on the third day and thirteen on the fourth day. Five of the subjects reported loneliness or homesickness on the second day, nine on the third day and nine on the fourth. Five also reported discouragement on the second day, six on the third day and five on the fourth. Only two admitted to feeling "weepy" on the second day, three on the third day and two on the fourth.

The differences between these symptoms was not statistically significant. (Chi square is 14.078 with fourteen degrees of freedom.) The tendency was toward a lessening of physical symptoms on each successive day, as shown by the totals in Table II. Emotional symptoms appeared to be most distressing on the third day.

A comparison of the mean complaint scores of men and women showed the following results:

	Second day	Third day	Fourth day
Male	6.77	7.77	6.22
Female	9.48	10	8.6

The correlation coefficient was .867 which indicated a high correlation between the sexes for each day.

II. INTERPRETATION

Although the sample was too small to make generalized statements, it would seem that there are indications of some importance. The fact that fifty-six per cent of the subjects indicated the second day as the most uncomfortable has implications for nursing care. Perhaps more emotional support as well as physical attention is needful for surgical

patients on the second day. It might be helpful to acquaint patients with the fact that each day tends to be less difficult than the previous one, for as Farnsworth pointed out, pain is more easily borne when there is a prospect that it will be of short duration.[1]

Diagnosis apparently had little bearing on which day was considered most difficult. An implication here would be that each patient must be recognized as an individual and his unique needs and problems must be individually assessed.[2]

It was interesting to note that fourteen or 41 per cent of the entire group remembered a different day than their complaint score indicated as the most uncomfortable day. The complaint scores may not be entirely accurate since some of the patients indicated that they were too sick to talk on the second day. The following day, therefore, has higher complaint scores because the patients felt enough better to check specific symptoms. Lancet indicated that there may be a considerable period of amnesia between the time of apparent recovery of the full faculties and the return of the patient's memory.[3]

That incisional pain would be most distressing of the symptoms was to be expected. The physical trauma to nerve fibers resulting from

---

[1]Dana L. Farnsworth, "Pain and the Individual," The New England Journal of Medicine, 254:560, March 22, 1956.

[2]Ernestine Wiedenbach, Clinical Nursing: a Helping Art. (New York: Springer Publishing Company, Inc., 1964), p. 3.

[3]"Postoperative Pain," Lancet, 1:751, April 4, 1964.

surgery along with chemicals produced within the body cause pain.[4] Individual appraisal of the amounts of pain depends upon the whole response to the painful stimulus, emotional, mental and physical. This reaction varies markedly from individual to individual.[5]

Nausea was next to the last in importance. The types of anesthesia used and the antiemetics that are available are important in preventing nausea. Literature also indicated that careful preoperative preparation lessens nausea and other physical discomforts following surgery.[6]

Headache was of least importance to the subjects. The fact that early ambulation tends to keep the electrolytes in balance may be a factor here. Lessened apprehension on the part of the patients could affect the frequency of headaches also.

There was no significant difference in apprehension and nervousness on each of the three days. More reported loneliness on the third and fourth days than on the second. One reason might be that the subjects were beginning to feel better physically and could give more attention to emotional reactions. Maslow's heirachy of needs indicated that physical needs must be met before other needs, such as love and belonging, can be attended to.[7] The numbers reporting discouragement on

---

[4]James White and William Sweet, Pain: Its Mechanism and Neurosurgical Control. (Springfield, Illinois: Charles C. Thomas, Publisher, 1955), pp. 9-17: Sarah Tower, "Pain: Its Definition and Properties of the Unit for Sensory Perception," in Pain, eds. H. Wolff et all. Research Publications Association for Research in Nervous and Mental Disease. (Baltimore: The William and Wilkins Company, 1943) XXIII: 16.

[5]Dorothy M. Crowley, Pain and Its Alleviation. (Los Angeles: University of California, 1962), p. 22.

[6]Rhetaugh Graves Dumas, "Psychological Preparation for Surgery," The American Journal of Nursing, 63: August, 1963.

[7]James C. Coleman, Personality Dynamics and Effective Behavior. (Chicago: Scott, Foresman and Company, 1960), p. 136.

each of the days are too nearly alike to be significant. That so few reported feeling "weepy" may have been an unwillingness to admit to an emotion that is frowned upon by society.

The high correlation of .867 between the mean scores of the men and the women on each of the three days would seem to indicate that women have more difficulty than men or that women complain more than men. Again, the expectations of society that men are stronger and less inclined to "make a fuss" about discomfort may be operating in this instance.

Most of the comments were not specific, but generally expressed satisfaction with nursing care and the hospital experience.

Two patients stated that more information given before surgery on what to expect following surgery would have made it easier for them to cooperate in their care. However, six expressed the belief that additional information would have increased their apprehension and worry. The remainder of the sample seemed to feel that presurgical teaching had been adequate. No attempt was made to compare educational, socioeconomic or cultural backgrounds of these patients.

One patient stated that she had experienced less pain than she had anticipated. Two complained that infiltrated intravenous fluids caused the greatest difficulty.

One subject who had been receiving nothing by mouth stated that his mouth was very dry and he was "burning inside for lack of water."

One patient who had been under the care of several specialists expressed concern over who was giving orders for her hospital care, how many of the doctors she would have to pay and to what amounts, and the seeming lack of communication between the doctors. This tended to in-

crease her apprehension. She wished something could be done about the situation, for her own sake as well as for other patients, since she believed it might have a bearing on postsurgical progress.

III. SUMMARY

The purpose of the study was to compare three selected postoperative days among adult surgical patients to find out if there is one day that is identified by the patient as the most difficult and to assess the complaints he might have by using seven questions pertaining to symptoms common to postsurgical patients.

Thirty-four patients comprised the sample, nine men and twenty-five women. Of this group, nineteen or 56 per cent indicated that the second day was most uncomfortable, seven or 28 per cent indicated the third day and six or 17 per cent chose the fourth day. Analysis showed that fourteen of the subjects remembered a day as being more uncomfortable that was different from the day indicated by the complaint score. Incisional pain was considered the most important of physical complaints with apprehension and nervousness ranking highest among the emotional symptoms. Headache and a feeling of wanting to cry were the least important in the respective groups.

There was no significant differences between any of the symptoms on any day. Slight differences may be ascribed to chance.

The mean complaint score for men was lower on each day than was the mean complaint score for women.

A brief analysis of comments made by the subjects on each day was included.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

I. SUMMARY

The review of literature indicated that a number of factors influence the patient's feelings toward the postoperative period. These factors may be classified in two groups: (1) personal influences which include culture and family background, reactions to hospitalization, illness and pain; and (2) hospital influences which include the nurse's role in the formation of patient attitudes and the effects of early ambulation.

The socialization of the child determines to a great extent how he will react to illness. The flexibility of the family structure and how the family perceives the crisis of illness often affects the outcome of the disease.

The patient's concept of the nurse and the hospital experience is the result of previous experience, things he has heard from friends and relatives and, perhaps, superstitions. When he arrives at the hospital, he loses his identity and feels alone and insecure. The attitudes that he finds in the hospital play a large role in shaping his attitudes.

The patient may react to illness with anger or anxiety. He needs the nurse to help him work through his feelings to a good adjustment. People respond to pain much as they are expected to respond. However, if the doctors and nurses instill confidence in themselves and in the prognosis, the patient is better able to tolerate the situation and will probably have little pain.

The nurse's goal of giving good nursing care can be reached by

calling into play all of her attitudes, skills and attributes. Empathy, compassion, sympathy and understanding are essential adjuncts to her scientific knowledge and skills. By using her whole personality she is enabled to meet all the needs of her patients.

The consensus of opinion among authors seemed to be that early ambulation hastens a return to homostasis and prevents a host of ill effects resulting from long confinement to bed. No reports of studies relating to the problems of specific postoperative days were found. Therefore, this descriptive survey was undertaken in an attempt to find answers to seven questions, formulated by the researcher, pertaining to discomfort experienced on three postoperative days and to see if one day was identified as most uncomfortable by the patient. Adult patients who had major abdominal surgery were interviewed. A check list of twelve symptoms common to postsurgical patients was used. The second, third and fourth days were compared. Data indicated that 56 per cent of the thirty-four subjects felt the second day was the most uncomfortable. A Chi square indicated that the number who identified the day as most uncomfortable was significant.

Incisional pain was the most troublesome physical symptom and headache the least troublesome. Of the emotional symptoms, apprehension and nervousness ranked first, with feeling "weepy" being last.

A correlation between the mean scores of the men and the women of .867 was significant. Other differences shown by the data might be attributed to chance.

The fact that six of the subjects indicated that they would not want to be told more of what to expect after surgery while two stated that they would have been helped by having more information was interest-

ing. No attempt was made to compare educational or socio-economic backgrounds of these patients. The majority of the patients expressed satisfaction with the care they received.

II. CONCLUSIONS

Due to the small sample included in the study, inferences were limited. However, the following conclusions were drawn:

1. The majority of patients stated that they experienced more discomfort on the second postoperative day than on other days that were compared. Therefore it was concluded that the second, and not the third, was most uncomfortable.

2. The type of surgery had no relationship to the amount of discomfort experienced. Therefore it would appear that each patient must be assessed and treated individually.

3. A substantial proportion of the subjects remembered as most uncomfortable a day that was different from the day indicated by the complaint score. Thus it would seem that time tends to blur the memory of hospitalization discomforts.

4. It would appear that physical symptoms caused more discomfort than symptoms of an emotional nature.

5. Women had more discomfort than men following surgery. Women complain more. This would seem to negate the commonly held belief that men are less able to endure pain than are women.

6. The majority of the patients seemed satisfied with their presurgical knowledge. This would seem to indicate that the teaching program was adequate in the hospitals used in this study.

7. Further research is necessary before these conclusions may be

generalized to any population outside of the sample.

III. RECOMMENDATIONS

Recommendations based on the findings of this study were:

1. That a similar study be conducted among a larger sample in several hospitals to verify these findings.

2. That attitudes of patients concerning preoperative teaching be further investigated with regard to educational and socio-economic and cultural backgrounds.

3. That study be done to find out if women experience more discomfort postoperatively than men or if this would seem to be so because the women complain more.

BIBLIOGRAPHY

BIBLIOGRAPHY

A. BOOKS

Apple, Dorian, (ed.), Sociological Studies of Health and Sickness. New York: McGraw-Hill Book Company, Inc., 1960.

Barnes, Elizabeth. People in Hospital. London: Macmillan and Company, Ltd., 1961.

Coleman, James C. Personality Dynamics and Effective Behavior. Chicago: Scott, Foresman and Company, 1960.

Crowley, Dorothy, Pain and Its Alleviation. Los Angeles: University of California, 1962.

Jersild, Arthur T. When Teachers Face Themselves. New York: The Bureau of Publications, Teachers College, Columbia University Press, (n.d.)

Orlando, Ida Jean. The Dynamic Nurse-Patient Relationship. New York: P. G. Putnam's Sons, 1961.

Saunders, Lyle. Cultural Differences and Medical Care. New York: The Russell Sage Foundation, 1954.

Shafer, Kathleen Newton and others. Medical-Surgical Nursing, St. Louis: The C. V. Mosby Company, 1958.

White, James and William Sweet. Pain: Its Mechanism and Neurosurgical Control. Springfield, Illinois: Charles T. Thomas, Publisher, 1955.

Wiedenbach, Ernestine. Clinical Nursing: a Helping Art. New York: Springer Publishing Company, Inc., 1964.

Wolff, H. and others. Pain. Research Publication Association for Research in Nervous and Mental Disease. Baltimore: The William and Wilkins Company, 1943.

B. PERIODICALS

Aasterud, Margaret. "Explanation to the Patient," Nursing Forum, 2:37-44, Number 4, 1963.

Baigrie, R. D. H. "Surgical Convalescence," South African Medical Journal, 34:585-591, July 9, 1960.

Blodget, James B. "Early Ambulation Following Surgical Procedures," Bulletin of New York Academy of Medicine, 25:176-184, March, 1949.

Brown, Paul W. "Patient With Proper Support Can Tolerate Pain Without Drugs," Hospital Topics, 42:87, 88. May, 1964.

Creighton Helen and Sister Gabriella Richard. "When You Are Scared," The American Journal of Nursing, 63:61-63, January, 1963.

Dichter, Ernest. "How Secure Is Your Hospital?" The Modern Hospital, 83:61-64, November, 1954.

_____, "What the Patient Really Wants From The Hospital," The Modern Hospital, 83:51-54, September, 1954.

"Discussions on Early Ambulation," Practitioner, 184:374-377, March, 1960.

Dumas, Rhetaugh Graves, "Psychological Preparation for Surgery," The American Journal of Nursing, 63:52-55, August, 1963.

Elms, Roslyn R. and Donna K. Diers. "The Patient Comes to the Hospital," Nursing Forum, 2:89-97, Number 3, 1963.

Engle, George E. "Psychogenic Pain," The Medical Clinics of North America, 6:1481-1495, November, 1958.

Farnsworth, Dana L. "Pain and The Individual," The New England Journal of Medicine, 254:559-560, March 22, 1956.

Hagans, Marilyn E. "There's No Such Thing as Professional Empathy," RN, 27:44-45, January, 1964.

Harper, Mary S. "Were You Listening? What Did You Hear?" Hospital Progress, 42:70-71, January, 1961.

Ingles, Thelma. "What Is Good Nursing?" The American Journal of Nursing 59:1246-1249, September, 1959.

Jackson, Joan K. "Communication Is Important," The American Journal of Nursing, 59:90-93, January, 1959.

_____. "The Role of the Patient's Family in Illness," Nursing Forum, 1:118-128, Summer, 1962.

Kaufmann, Margaret A. and Dorothy E. Brown. "Pain Wears Many Faces," The American Journal of Nursing, 61:48-51, January, 1961.

Kilgore, Rupert. "Cultural Awareness and the Nursing Profession," The Journal of Nursing Education, 1:20-22, January, 1962.

Knowles, Lois M. "How Our Behavior Affects Patient Care," The Canadian Nurse, 58:30-32, January, 1962.

Lewis, Garland K. and Margeurite J. Holmes. "Meddling With Emotions," Nursing Outlook, 9:405-407, July, 1961.

McQuade, Ann and Alvin I. Goldfarb. "Coping With Feelings of Helplessness, The American Journal of Nursing, 63:77-79, May, 1963.

Meyer, Karl A. and others. "Early Ambulation: Clinical Results and Prerequisites," Minnesota Medicine, 31:882-890, August, 1948.

Moore, Janice Eaton and Helen Bradley Faraone. "Habla Usted Espanol?" Nursing Outlook, 10:250-252, April, 1962.

Paynich, Mary Louise, "Cultural Barriers to Nurse Communication," The American Journal of Nursing, 64:87-90, February, 1964.

Peplau, Hildegarde E. "Talking With Patients," The American Journal of Nursing, 60:964-966, July, 1960.

Richter, Dorothea. "Anger: A Clinical Problem," Nursing World, 132: 22-24, December, 1958.

Shapiro, Harold P. "Early Ambulation in Postoperative Patients," The Ohio State Medical Journal, 45:136, February, 1949.

Shelby, C. Via. "A Presurgical Conference," The American Journal of Nursing, 60:1664, November, 1960.

Sissler, George C. "The Nurse and the Emotional Needs of the Patient," The Canadian Nurse, 54:314-317, April, 1958.

Sister Muriel. "Listen," The Canadian Nurse, 57:23-25, January, 1961.

Speroff, B. J. "Empathy Is Important in Nursing," Nursing Outlook, 4:326-328, June, 1956.

Swerdlow, Mark. "Relieving Pain After Operation," Nursing Times, 59:267-269, March 1, 1963.

Travelbee, Joyce. "What's Wrong With Sympathy?" The American Journal of Nursing, 64:68-71, January, 1964.

Wiedenbach, Ernestine, "The Helping Art of Nursing," The American Journal of Nursing, 63:54-57, November, 1963.

APPENDIX A

CHECKLIST

Please place a check mark in the blank that most nearly describes the way you feel.

Headache:
Slight_____Moderate_____Severe_____

Pain in the surgical area:
Slight_____Moderate_____Severe_____

Gas Pains:
Slight_____Moderate_____Severe_____

Backache:
Slight_____Moderate_____Severe_____

Nausea:
Slight_____Moderate_____Severe_____

Dizzy or faint:
Slight_____Moderate_____Severe_____

Generalized discomfort:
Slight_____Moderate_____Severe_____

Discomfort on getting up:
Slight_____Moderate_____Severe_____

Apprehensive or nervous:
Slight_____Moderate_____Severe_____

Lonely or homesick:
Slight_____Moderate_____Severe_____

Discouraged:
Slight_____Moderate_____Severe_____

Feel "weepy":
Slight_____Moderate_____Severe_____

FIGURE I

Reproduction of Checklist Used
in Collection of Data

APPENDIX B

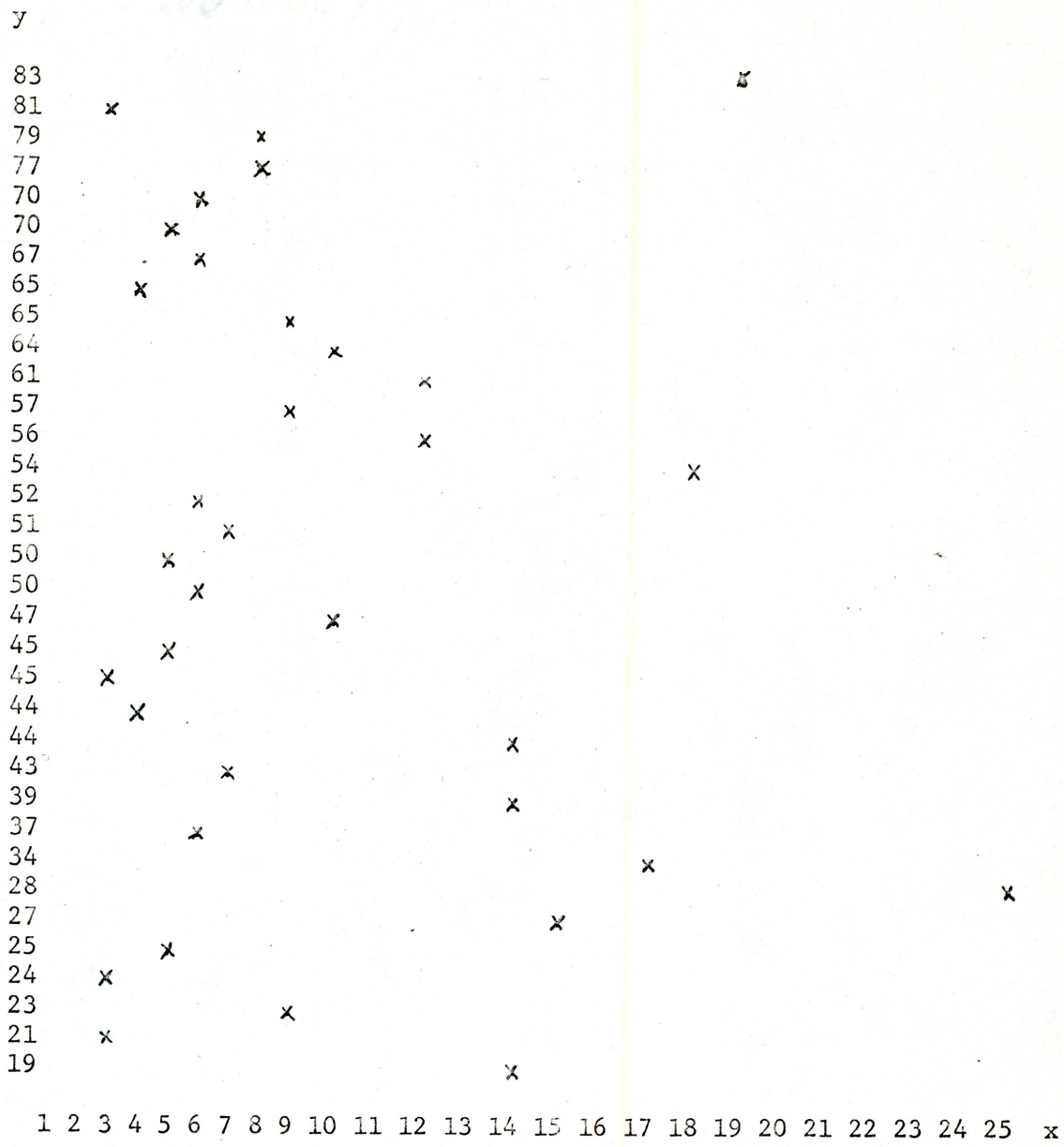

FIGURE II

SCATTERGRAM SHOWING RELATIONSHIP
OF AGE AND COMPLAINTS REPORTED ON SECOND DAY

y = Age in Years

x = Complaint Scores

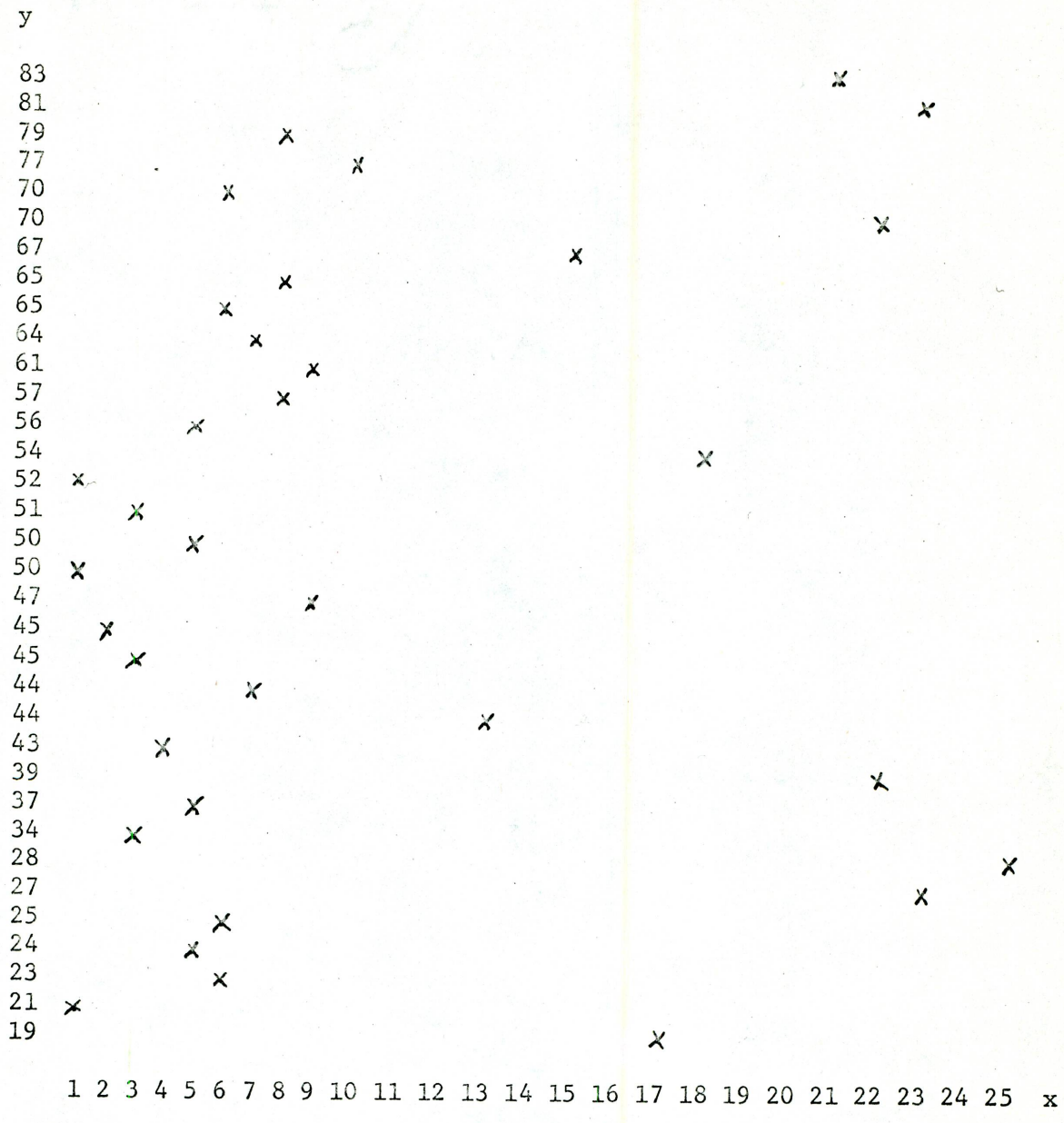

FIGURE III

SCATTERGRAM SHOWING RELATIONSHIP
OF AGE AND COMPLAINTS REPORTED ON THIRD DAY

y = Age in Years

x = Complaint Scores

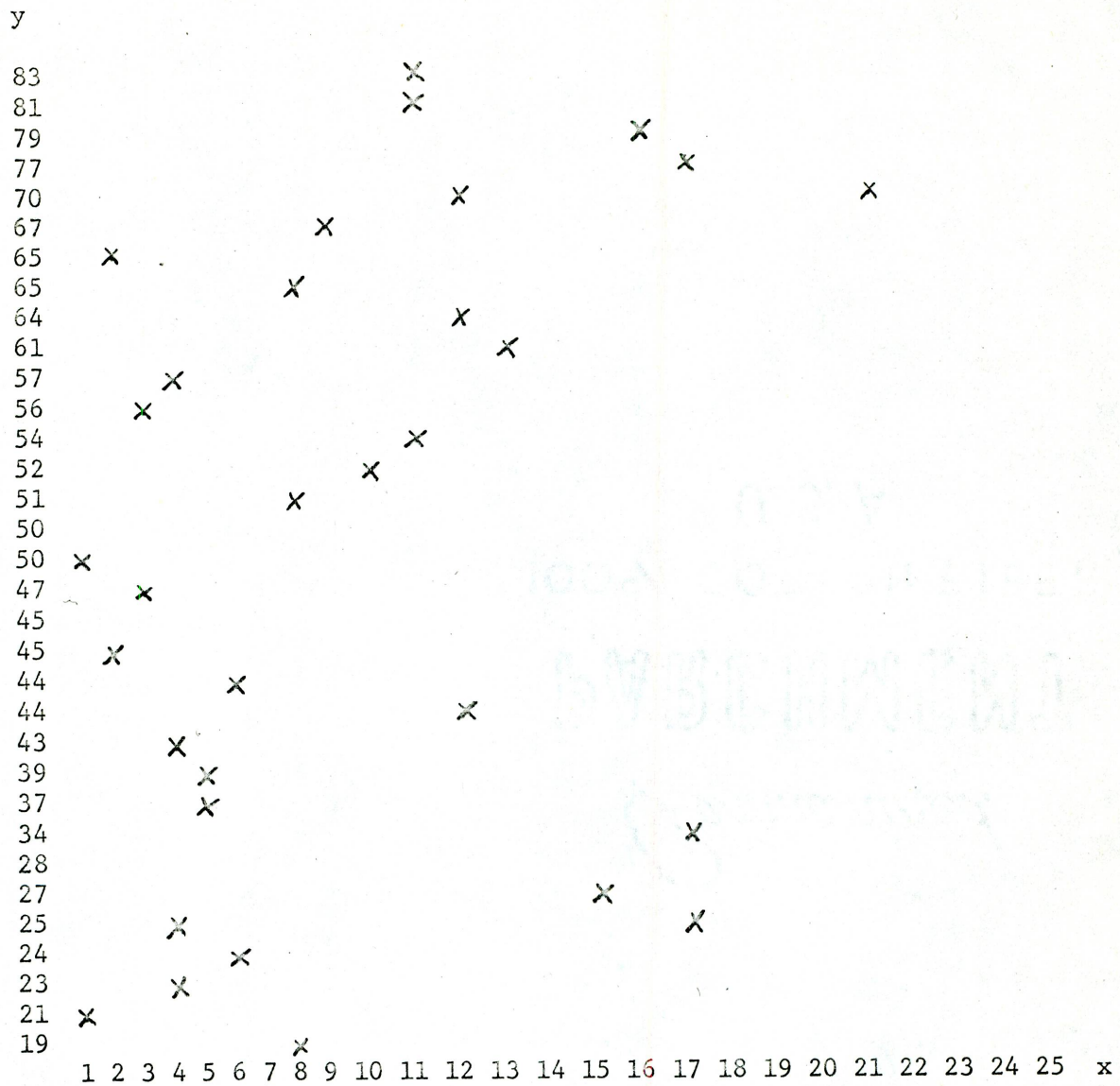

FIGURE IV

SCATTERGRAM SHOWING RELATIONSHIP
OF AGE AND COMPLAINTS REPORTED ON FOURTH DAY

y = Age in Years

x = Complaint Scores

LOMA LINDA UNIVERSITY

Graduate School

A COMPARATIVE STUDY OF DISCOMFORT EXPERIENCED BY SURGICAL PATIENTS ON THREE SELECTED POSTOPERATIVE DAYS

by

Lillian Barker Bartlett

An Abstract of a Thesis

in Partial Fulfillment of the Requirements

for the Degree Master of Science

in the Field of Nursing

May, 1965

ABSTRACT

A descriptive survey was conducted to compare the discomfort experienced on three selected postoperative days to determine if there is one day identified by the patient as the most uncomfortable and to assess the symptoms of which he might complain. A checklist of twelve symptoms common to postsurgical patients was administered on the evenings of the second, third and fourth postoperative days by the researcher. Findings indicated that nineteen or 56 per cent of the thirty-four patients interviewed stated that the second day was most uncomfortable, nine or 27 per cent the third and six or 17 per cent the fourth day. This difference is significant at the .05 level. Incisional pain caused the most discomfort while headache was the least important physical symptom.

Apprehension ranked highest with a feeling of wanting to cry was lowest among the symptoms of an emotional nature. No relationship was shown between the type of surgery and the statement of discomfort. There seemed to be a tendency toward lessening of severity of symptoms on each successive day. Mean complaint scores indicated that women have more discomfort or complaints than men. A correlation between the sexes of .867 is significant. It was concluded that the second day, rather than the third as commonly held among nurses, is most uncomfortable; that time tends to blur the memory of hospitalization discomforts; that physical symptoms caused more discomfort than symptoms of an emotional origin; and that men complain less than women. Recommendations included that a similar study be done among a larger sample in several hospitals to verify the findings of this study; that attitudes of patients concerning preoperative teaching be further investigated with regard to educational, socio-economic and educational backgrounds; and that a

study be done to find out if women have more discomfort postoperatively than men or if this would seem to be so because women complain more.