Patients’ Perceptions of Pre-operative Enhanced Information Leaflets for ‘Fast-track’ Colorectal Resections: A Qualitative study

Walter, C., Khair, G., Drew, P., Monson, J. (University of Hull)

Abstract

Background - ‘Fast-track’ packages specify the need for pre-operative patient education covering expected hospital events and recovery rates; yet the nature and value of such information remains unclear. This study aims to explore patients’ perspectives on receiving a pre-operative enhanced information leaflet (EIL) designed for ‘fast-track’ colorectal surgery.

Methods - Nine consenting, consecutive patients were given an EIL at pre-assessment clinic prior to their elective colorectal operations using ‘traditional’ surgical care. A qualitative assessment of the patients’ perceptions of the leaflets was made using one-to-one semi-structured interviews which were audio-taped and later transcribed. Transcripts underwent thematic analysis using a framework approach.

Results - The leaflet layout, format and content were acceptable to the participants. Four themes emerged from the data: the leaflet layout, format and content; information provision; reassurance; and empowerment.

Conclusion - The EIL acts as an acceptable source of preoperative information to elective patients undergoing colorectal resections, their relatives and carers. Patients identified it as a valuable source of information on the sensitive issues surrounding their surgery, as well as offering them reassurance. In keeping with the ‘fast-track’ ethos, it challenges traditional, socially-constructed, models of patient behaviour by encouraging patients to actively participate in their rehabilitation.

Key Words

‘Fast-track’ Surgery, Qualitative, Patient Information, Colorectal Resection, Enhanced Recovery

Introduction
A number of clinical studies have demonstrated the needs of both patients and carers to receive appropriate good quality information about illnesses and treatment (Kenny et al, 1998). Broughton, Bailey and Linney’s (2004) work highlights the need to provide good quality information for patients undergoing treatment for large bowel cancer and for their carers.

‘Fast-track’ colorectal surgery uses evidence-informed protocols to optimise surgical patients’ perioperative care and enhance their post-operative recovery (Wilmore and Kehlet, 2001). Despite the ‘fast-track’ packages advocating pre-operative patient education outlining expected lengths of stay and recovery rates, there are no studies examining the content or nature of such information in the ‘fast-track’ setting. Furthermore the role or such information in enhancing recovery within the ‘fast-track’ programmes remains unclear.

A series of Enhanced Information Leaflets (EILs) detailing expected ‘fast-track’ pre-, peri- and post-operative hospital management and recovery following elective colorectal surgery were designed. They reinforced ‘fast-track’ principles by informing patients about early oral intake and mobilisation in the post-operative period as well as quoting recovery rates consistent with those seen in the ‘fast-track’ studies, ‘Some people leave hospital as early as 2 – 4 days after this operation.’

It was felt that before recruiting patients to a Randomised Controlled Trial (RCT) examining the effects of the EIL on patients’ operative anxiety and recovery rates, both within and outside of ‘fast-track’ programmes, a qualitative study assessing patients’ perceptions on receiving such information was needed. It would also allow the a priori issue, that undue worry may be provoked in those patients who fail to meet the recovery rates outlined in the leaflet, to be explored. The current literature lacks studies exploring this question, hence we identified it as being important to establish, in order to ensure our leaflets did no harm, prior to adopting the EIL as part of a trial.
Methods

A qualitative approach was used, as the data sought aimed to explain what patients felt about the leaflets. The goals of qualitative research, as described by Mays and Pope (1996: 5) are, ‘the development of concepts which help us to understand phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of all participants.’

Following approval from the Scarborough Research and Ethics Committee (reference number 04/Q1106/32) and Clinical Governance Departments of Hull and East Yorkshire and Scarborough Acute NHS Trusts, consecutive patients undergoing elective colorectal resections were approached for their consent to enter the study. Patients were told that we had developed a new patient information leaflet for their operation which we would like them to trial and provide feedback on. Those who agreed were given an EIL when they attended pre-operative assessment clinic. Prior to discharge, data were collected using one-to-one semi-structured interviews based around open-ended questions. Where patients were in their own side room, the interviews were conducted within those rooms with the door to the ward closed. Patients were provided with a comfortable armchair to sit in during the interview which was placed at an angle to that of the interviewer’s chair. Where the patient was staying on a shared bay of a ward, the interviews were held in a private room (sister’s office) on the ward, again with the door to the ward closed and a similar arrangement of furniture. All interviews were conducted by one of the authors (CW). To ensure similar issues were covered in all interviews a topic guide was used, within this guide careful thought was given to the language used to present the discussion topics and questions to leave answers as open as possible and focus on each patient’s individual thoughts. The interviews explored the patients’ opinions and feelings surrounding the concept of receiving an EIL and their
appraisal of its structure, format and content. Audiotape recordings and field notes of the interviews were transcribed for analysis.

*Leaflet Development* - The EIL’s structure matched existing commercial leaflets used within many NHS trusts which chronologically detail expected pre-, peri- and post-operative hospital management and recovery events within a 20-page leaflet. The EIL, unlike the commercial leaflets, emphasised the elements of ‘fast-track’ care, such as early oral feeding and mobilisation and encouraged patient participation in the recovery process as well as quoting recovery rates consistent with those seen in the ‘fast-track’ studies.

In order to accommodate the target population text was written for a reading age of 8 (assessed using the Flesch Reading Ease Score) in a font size of 14 point (Boulos, 2005). The leaflet was reviewed, revised and piloted by a steering group composed of members from the colorectal multi-disciplinary team and a local colorectal patient group before the final version was agreed.

*Sample* - This study selected consecutive patients to produce a maximum variation sample aimed at capturing common themes from within the heterogeneous population of patients (age, gender, underlying pathology, pre-operative health status and social situations) undergoing major colorectal surgery. All patients recruited were from a unit using ‘standard surgical care’ rather than a specific ‘fast-track’ approach. Whilst many of the elements of the ‘standard’ approach to care would overlap with those used in the ‘fast-track’ approach the patients and staff would not be encouraged to chase the early recovery goals sought with the ‘fast-track’ approach to care (Walter, Smith and Guillou, 2006). These patients were specifically selected as they were likely to have longer recovery rates than the optimistic ‘fast-track’ rates quoted in the EILs and therefore allowed better exploration of our *a priori*
question. Recruitment was continued until saturation, that is, recruitment continued until there were three consecutive interviews where no new themes emerged from the new data collected.

Data analysis (by CW) using coding, indexing, charting and mapping to develop a thematic analysis using the framework approach was used. This approach aimed to generate identifiable relationships and patterns in data through the generation of a series of themes and sub-themes (Bryman and Burgess, 1994) (Fig. 1).

![Figure 1: Richie and Spencer’s (1994) Framework Approach](image)

Investigator triangulation using a second, independent investigator (GK) was performed. GK was provided with the manuscripts and was blinded to CW’s analysis; he also used a framework approach to formulate a thematic analysis of the data.

Both investigators (CW and GK) compared their analysis; this is known as double coding and is a technique which was included in an attempt to add rigour (Gilbert, 1994). Together they agreed on a final set of themes and subthemes. In general the consistency between the two investigators’ analyses was high, however where minor discrepancies occurred these were revisited and discussed until investigator agreement was achieved. By introducing reflexivity through explicitly encouraging challenges to the data analysis
(through the involvement of more than one researcher) we aimed to strengthen the validity of the study.

Results

Nine patients (5 women and 4 men) between 48 and 78 years of age, whose interviews lasted between 14 to 23 minutes, allowed the sample size requirements to be fulfilled. Details of the participants are outlined in Table 1.

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Benign or Malignant disease</th>
<th>Operation</th>
<th>Stoma</th>
<th>Days since operation interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75</td>
<td>Female</td>
<td>Malignant</td>
<td>Right Hemicolecotomy</td>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>78</td>
<td>Male</td>
<td>Malignant</td>
<td>Anterior Resection</td>
<td>No</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>59</td>
<td>Male</td>
<td>Malignant</td>
<td>Abdomino-perineal Resection</td>
<td>Yes</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>68</td>
<td>Female</td>
<td>Malignant</td>
<td>Extended Left Hemicolecotomy</td>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>78</td>
<td>Male</td>
<td>Malignant</td>
<td>Right Hemicolecotomy</td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>65</td>
<td>Female</td>
<td>Malignant</td>
<td>Abdomino-perineal Resection</td>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>52</td>
<td>Male</td>
<td>Benign</td>
<td>Pan-total Colectomy</td>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>70</td>
<td>Female</td>
<td>Malignant</td>
<td>Sigmoid Colectomy</td>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td>9</td>
<td>48</td>
<td>Female</td>
<td>Benign</td>
<td>Colectomy and ileo-anal pouch</td>
<td>Yes (temporary)</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 1: Participants’ Details
The Role of the EIL - Four main themes emerged from the data regarding the role of the EIL: leaflet layout, format and content; information provision; reassurance; and empowerment.

Leaflet Layout, Format and Content - The participants interviewed commented that the large font, spacing of text, content page and bold headings used throughout the leaflets made them easy and acceptable to use. All but one of the patients interviewed acknowledged that the leaflet was useful to them and contained information that they found relevant (Table 2).

<table>
<thead>
<tr>
<th>P1</th>
<th>“I don’t want a leaflet with the word cancer on it” – NB: The leaflet does not use the word cancer anywhere in it.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“It kept making me think about cancer, more and more about cancer and that reminded me of my sister”</td>
</tr>
<tr>
<td></td>
<td>“I don’t want a leaflet reminding me about it.”</td>
</tr>
<tr>
<td>P2</td>
<td>“There’s some information in this leaflet that I really hadn’t realised.”</td>
</tr>
<tr>
<td></td>
<td>“... all this information about eating and walking about. That’s useful.”</td>
</tr>
<tr>
<td></td>
<td>“... a good source of reference. All this information is interesting and useful. The whole process happens so fast you can’t take it all in. This leaflet will help. Overall I thought it was very good.”</td>
</tr>
<tr>
<td>P3</td>
<td>“This leaflet is good, it reminds you of some of the things you need to know like to fast on the morning. I couldn’t remember whether I was to take my blood pressure tablet so I ended up ringing the ward.” “The leaflet says what to do about medications, what to remember to bring in. It’s a good aide memoir, there’s so much to remember, it’s a good reference text.”</td>
</tr>
<tr>
<td></td>
<td>“I think the idea of the leaflet is good and I think the structure taking you through the events is good. It’s helpful and easy.”</td>
</tr>
<tr>
<td>P4</td>
<td>“... handy having these phone numbers in the back.”</td>
</tr>
<tr>
<td>P5</td>
<td>“... where the leaflet basically talks you through everything that you need to know. Everything about what is going to happen to you from the moment you step in through those hospital doors. Thought that was brilliant, really brilliant. I was really interested in that, you know, what happens before the operation, what happens in theatre.”</td>
</tr>
<tr>
<td></td>
<td>“And afterwards too, it tells you what level of pain to expect, that’s important”</td>
</tr>
</tbody>
</table>
P6  “I think it would be helpful to patients before surgery too”
   “I mean this leaflet really just backs up what everyone, well the nurses, physios, stoma people, everyone has already said. It’s just a written reference to the information that you’re given”
   “This leaflet really reiterates a lot of that”

P7  “The leaflet is just good to dip into if I need to remind myself of something or something, you know”
   “I just need things like the list of contact numbers and things in the back- that’s handy.”

P8  “...where it tells you what to expect”

P9  “I think it’s better to pitch these things at a lower level and explain stuff than to be overly complex, yes.”
   “The general content is I guess fine”

Table 2: Patients’ Views on the Value of the EIL to Them

They also commented on the value of information on stomas (n=1), injections (n=2), epidurals (n=2), post-operative eating (n=3), post-operative mobilisation (n=4), in-hospital events (n=3) and telephone contact numbers (n=4). Both of the oldest two patients (both 78 years) found the pictures less helpful, ‘the picture was a bit busy though. Couldn’t make much sense of the pictures – think it’s my vision’ (P5), and ‘I’ve not really looked at the pictures … they didn’t interest me as much as the text’ (P2).

Eight of the 9 patients discussed the rate of recovery shown in the EIL which states ‘Some people leave hospital as early as 2 – 4 days after this operation’. All of those 8 patients had themselves exceeded the ‘fast-track’ length of stay at the time of their interview, and 5 of them acknowledged this in their discussion. Three of those 8 participants (P2, 5 and 7) felt their recovery rates reflected those given in the leaflets:

‘Ummm, I think you said we’d be out of hospital in a few days, well that’s about right, I’m hoping to go soon’ (P2, day 6 post-op.)
‘I suppose even having had the leaflet I asked the nurses what they thought [talking about length of stay] as my circumstances are slightly different, errr, special anyway’ (P6, who had a dependent disabled son at home whom she supported and cared for.)

No patients reported this information had worried them. Two patients did acknowledge the possibility that other patients may, however, find this information upsetting:

‘If you produce a leaflet saying people will be discharged early and then they need longer and you get their hopes up, yeh - I don’t know really - it’s not really been a bother to me’(P7)

Role of Leaflet in Information Provision - Our results showed that the patients interviewed relied on a variety of different resources to gain information about their operation (Table 3).
<table>
<thead>
<tr>
<th>Resource</th>
<th>Patients Using It</th>
<th>Quotations</th>
</tr>
</thead>
</table>
| Other written leaflets and posters     | P3, P6, P7        | “First you go to the GP with some bleeding and stuff, and in the waiting room there are posters and leaflets about every disease, some on bowel cancer.” (P3)  
“Ann [stoma nurse] gave me loads of her leaflets too” (P6) |
| Prior experience or knowledge of friend or relative with similar experience | P1, P6, P7        | “I’ve seen my sister go through the same. She died.” “My sister was very ill and I nursed her single-handedly through it. Just me no-one else - I know all about it.” (P1)  
“I mean my dad had to have an operation on his bowel for a cancer probably about 25 years ago and I remember it well.” (P6)  
“Had previous operations in my twenties too so I had a fair idea how I’d actually feel afterwards and everything. Spent patches of my whole life going in and out of hospital so I’m glad that I’ve probably got a fair idea about what to expect.” (P7) |
| Healthcare Professionals               | P3, P5, P6, P7    | “They [the staff in outpatients clinic] spent quite a lot of time talking about it.” “A specialist nurse who looks after all the bowel cancer patients, she has a chat goes over it all again.” “The pre-assessment clinic and you go over it again but it doesn’t really sink in.” (P3)  
“I was happy with what the doctor said, ‘there is a bit of bowel with cancer in that needs to be removed’, or something like that anyway.” (P5)  
“Well this leaflet alone is not enough to replace all the information that Ann has given me. I don’t think it should replace that.” (P6) |
| Internet                               | P7, P9            | “I’d done all the reading – you know, been on the internet and everything.” (P7)  
“I knew a bit about the operation from the internet and stuff” (P9) |
| Support Groups and Charities           | P7                | “So I’d found out all about it from the Crohns society.” |

Table 3 Sources of Information Patients Used Prior to Undergoing Major Colorectal Surgery
Despite the diversity of sources the participants used to gain information eight of them acknowledged they found the leaflet useful in providing information:

‘The leaflet basically talks you through everything that you need to know … what happens before the operation, what happens in theatre and afterwards too. It tells you what level of pain to expect, that’s important I think, reassuring’ (P5)

Participants 1 and 4 both felt that there was too much information for their needs:

‘All this stuff [patient flicks through the first few pages] I’d rather not know all of this.’(P4)

‘I’ve seen my sister go through the same. She died. I don’t want a leaflet reminding me about it and all its risks. I just want to get this whole thing over and done with and forget about it. [Brief pause]

My sister was very ill and I nursed her single handedly through it. Just me, noone else. I know all about it. I don’t need a leaflet … I’ve had cancer you know, I just hope it’s all out. I don’t want a leaflet with the word cancer on it. I don’t want to think about cancer. I don’t want to read about cancer. I hate cancer … [crying] I did look at a few pages, but it kept making me think about cancer, more and more about cancer and that reminded me of my sister and I got upset. [Patient cries some more]
I: Why do you think the leaflet made you think about cancer?

P1: Because that’s what I’ve got, haven’t I? and that’s what I nursed my sister through, and she died and I’m scared of cancer and I don’t want to die, and everything to do with hospitals and bowel cancer and operations reminds me of my sister and it upsets me.’ (P1)

Despite this, participant 4, unlike participant 1, still recognised the value of the EIL to her:

‘It’s probably the kind of thing that I’d like to have hold of, then once I’m home if there’s a question I have I can look for answer in leaflet but otherwise I’m not the sort of person that would go for all this information.’ (P4)

‘I don’t want a leaflet reminding me about it and all its risks. I just want to get this whole thing over and done with and forget about it.’ (P1)

Participant 1, a 75 year old female, interviewed five days following a right hemicolecctomy for a caecal carcinoma, could be described as a ‘deviant’ case as analysis of her data did not always support, and on occasions contradicted, the patterns and explanations that were emerging from the rest of the data (Mays and Pope, 2006). This patient lived alone in her own home and denied having any support from family members or friends following her discharge, unlike the other eight participants. The interview was led by the patient, who was distressed, upset and tearful during parts, such that it was not possible to ask all the planned questions. This was the only case where the participant totally rejected the leaflet and failed to acknowledge it held any value.
Two main sub-themes emerged for the particular role of the EIL in providing information; information on sensitive issues and information for family members. Five patients recognised the role of the EIL in providing sensitive information:

‘Well [laughing] if you get a leaflet saying that your sexual function may be altered, wouldn’t you be scared? No, seriously, I found that bit about the sex nerves very interesting. No-one in the clinic or at the pre-assessment or when I was consented had really mentioned anything about the potential to alter sexual function, you know, which I do think is relevant. Yes, I did want to know that, certainly.’ (P9)

During 5 interviews patients mentioned their carer’s needs for information. They felt the EIL helped fulfil this role and remove some of the pressure from themselves to provide this information:

‘Of course, another thing is the family. They like to know what’s going on, don’t they? They like to be able to plan. This leaflet is good for them too. They worry, you see, they worry. I showed the wife the leaflet. Yes, she had a good read too. I think she liked it. I think she did.’ (P2)

‘Well, I think it’s good for the family, my wife and children have all asked lots of questions, they want to know all about it you know and sometimes I need a break. They’ve all read the leaflet … it seems to interest them. I think it helps them.’ (P3)

_Reassurance_
Five of the patients felt that having detailed written information about their operation acted to reassure them by equipping them with information (P2, 3, 5, 6 and 9).

‘Where the leaflet basically talks you through everything that you need to know. Everything about what is going to happen to you from the moment you step in through those hospital doors. Thought that was brilliant, really brilliant … I like the way this takes you through it step-by-step. It tells you things so you can have confidence in your treatment, like it’s normal to need an epidural … it’s normal to have injections … it’s safe to eat without making yourself ill…what else, oh, all that about moving about. I was scared to try and move about at first you know … and afterwards too, it tells you what level of pain to expect, that’s important I think, reassuring. Yes, reassuring … all that you would want to know really.’ (P5)

One further patient (P7) who had chronic benign disease, had previous experience of operations and was already well informed noted the value of having a list of useful phone numbers at discharge as a reassurance. Two patients (P1 and 4) alluded to the fact that they were less likely to find written information something that they’d find helpful in reassuring them;

‘It’s probably the kind of thing that I’d like to have hold of, then once I’m home, if there’s a question I have, I can look for an answer in the leaflet but otherwise I’m not the sort of person that would go for all this information.’ (P4),

whereas Patient 8 acknowledged the leaflet’s value, but did not suggest that it played a role in providing her reassurance.
Empowerment

The final theme that emerged from the data was that some of the participants found that having the information allowed them confidence to play a more active role in furthering their recovery;

‘The leaflet’s very positive, isn’t it? It almost empowers you, the patient. You can move about eat and all this. I like its positive angle, personally. I think it makes a very clear message that we all heal at different rates.’ (P3)

‘The leaflet encourages you to do deep breathing, coughing, er… sitting up straight and so on … I was able to start practising each thing. Building up more and more each day’. (P5)

Some patients demonstrated a trust in the leaflet such that they were willing to undertake some self-led rehabilitation, without waiting to seek approval from the medical and nursing staff.

‘I learnt about physio, the injections for circulation, when I could eat … I had known to get going with these things straight away. I started on my own.’ (P6)

Discussion

EILs: Patients’ Needs and Effects - Wallace’s (1995) previous study of 131 consecutive patients undergoing gynaecological surgery demonstrated approximately 90% of all patients welcome written preparation before surgery. These findings were reflected in our study, where 8 of the 9 patients interviewed supported the idea of the EIL.

Our study showed pre-operative patients’ information needs fell into two groups; the majority wanting larger amounts of detailed information and the minority only wanting to
receive limited information. One explanation for this lies with the theory that divides patients into two groups; ‘monitors’ who cope with ill health by finding out as much as they can about their illness, and ‘blunters’ who would try and avoid any relevant information (Salmon, 2000). Monitors are helped by pre-operative information and may use ‘cognitive problem-focused coping’ to facilitate their adjustment. Blunters by contrast are made more anxious by being given information that they neither need nor seek. Their operative anxiety is minimised and optimised by avoiding excess information (Salmon, 2000; Miller and Mangan, 1983). Whilst our data suggested that these two types of patient existed in our study group our future planned RCT will examine and document this effect in more detail.

The two patients who had expressed a desire for less detailed information identified two areas as being in excess of their needs: the operative procedure and its complications and risks. Lankton et al’s (1997) work recognises that some patients are unable or unwilling to tolerate detailed discussion of procedural events including detailed explanations of possible risks. Such information may also act to trigger apprehension in such patients.

These two patients may have represented ‘blunters’. They demonstrated ‘avoidance’ in their coping behaviour. Current suggestion is that there is a linear relationship between anxiety and surgical recovery. The greater the level of anxiety before surgery the poorer the post-operative recovery (Porter et al., 2004) ‘Blunters’, therefore, should not have excess information imposed on them as it increases their anxiety. By giving patients an information booklet they can chose how much information they want to read about. The two patients in this study with avoidant coping styles demonstrated this behaviour and admitted to not having fully read the leaflets.

Salmon (2000) suggests that patients bring to hospital, “firmly engrained expectations that staff will take control”. Peerbhoy et al (1998) interviewed surgical patients and demonstrated that they see surgeons as having specific authority over them. It is suggested
that by accepting this authority of hospital staff patients may be seen by nurses and doctors as ‘good’ patients. They obey instructions and are easy to care for (Salmon, 2000). This encouragement for patients to develop a passive attitude is known as ‘learned helplessness’. Learned helplessness describes individuals who hold generalised beliefs that they cannot control events that happen to them. Raps et al (1982) have demonstrated that this ‘learned helplessness’ can develop during a hospital stay. Their study concludes that with this helplessness patients develop passive demotivation which can interfere with motivation for selfcare and rehabilitation.

We hoped that by informing patients of their recovery rates we are providing them with rehabilitation goals. The EIL may play a role in overcoming this ‘passive demotivation’ in post-operative patients and promote their ‘fast-track’ recovery through improving patient-participation, as it has done in other fields of medicine. A trial which randomised diabetic patients to receive either standard information or information designed to improve patient information-seeking skills so that patients could interact in a more participatory fashion with their physician, demonstrated better glycaemic control in the patients who were encourage to interact more (Greenfield et al, 1998). In keeping with this study our results revealed that patients who received the EIL felt ‘empowered’ to be self-led in some areas of their post-operative rehabilitation and were reassured by the optimistic information they received.

Our initial concerns that if a patients’ recovery took longer than the EIL-quoted time this might precipitate undue worry were unfounded according to our data. Similar findings have also been seen in studies of patients who are undergoing cardiac surgery. Here the difference in recovery in patients randomised to receive either realistic or optimistic pre-operative information was examined. No significant differences in pre- and post-operative anxiety, or recovery rates were seen between the patients receiving the different information
and no detrimental effects of optimistic pre-operative recovery rates were noted (Mahler and Kulik, 1995).

*Sensitive Information* - Broughton et al’s work (2004) identified colorectal cancer patients who had dependent relatives or children or who had nursed relatives with the same disease, found it more difficult to adjust to their diagnosis. Our study complied with this observation, the 2 patients (P1 and P6) with these backgrounds, also demonstrated specific anxieties relating to their situation which was reflected in their information needs.

With respect to stoma formation: satisfaction with pre-operative information has been demonstrated to reduce risks of problems with the psychological adjustment during the post-operative period and it is suggested that appropriate pre-operative patient satisfaction offers better psychological adjustment to all colorectal patients (Daley, 1984). Our study demonstrated this, and noted other subjects causing patient concern, such as issues relating to sexual relationships, were also identified as areas of information need. It appeared that our participants had found that the EIL covered some areas of ‘sensitive’ information in more detail than the other sources of information available to them fulfilling an important educative role and supporting their psychologically adaptation.

*The Need for Information for Patients’ Families and Carers* - Most of the previous studies examining pre-operative information needs have focused on the patients’ needs. Our data clearly identifies that patients have real concerns about fulfilling their relatives’ and carers information needs. Majasaari et al (2005, pp 1030-1039) used a questionnaire composed of 36 Likert-type scale questions to assess how adult patients undergoing day-case procedures perceived emotional support and information provision. Accepting the limitations of a 60% response rate and the potential for leading answers through Likert-scales used by this study;
80% of their patients wanted their families to learn about their condition; specifically, 72% wanted them to learn about their illness and 73% about their operative and post-operative care. The reported information needs of family members responsible for delivering post-operative care has also been studied recently in a trial randomising 110 spouses of patients undergoing prostate surgery to the intervention package of 16 educational sessions with an advanced nurse practitioner throughout the peri-operative period. (Giarelli, McCorkle and Monturo, 2003: 453-485). Over half of all spouses studied demonstrated a need to access information in order to help prepare for being the care-giver with those receiving the educational intervention reporting it aided their acquisition of the care-giver role and reduced their informational needs.

Potential Limitations

Consideration of the potential biasing resulting from respondents’ perceptions of the interviewer’s possible influences should be considered when interpreting the interview data. Other studies examining post-operative patients have noted that patients interviewed soon after surgery are reluctant to criticise their surgeon (Broughton et al, 2004). Furthermore our study aimed to assess whether undue worry may be provoked in those patients who fail to meet the recovery rates outlined in the pre-operative ‘fast-track’ information leaflet. We sampled patients who were expected to have longer-than-stated LOS by using patients managed in a ‘traditional surgical care’ environment. It is possible that patients in a ‘fast-track’ environment, where the enhanced recovery goals are continually re-iterated by written information, nursing staff and their doctors may feel more pressure to attain these early recovery goals and therefore find failure to meet such targets more distressing than the patients sampled in this study.
Subjective bias applied by the interviewer and primary analyser (CW) may have altered interpretation of data. Double coding and reflexivity using a second analyser (GK) was employed in an attempt to address this bias.

Conclusion

Our data suggest that EILs outlining pre-operative, operative, post-operative and post-discharge details in elective ‘fast-track’ colorectal resections can be a valuable source of information for patients, their families and carers. Not only are they particularly good at covering sensitive issues but also they can act to offer reassurance, and, in keeping with the ‘fast-track’ ethos, empower patients to be more actively involved with their post-operative recovery. Our study did not produce any data to support concerns that optimistic recovery goals may worry unduly patients nor did it demonstrate that patients who prefer to receive less pre-operative information were adversely affected by receiving an EIL; although we would like to repeat and confirm this finding with patients managed exclusively within ‘fast-track’ packages.

Bibliography


