‘Being in for a day doesn’t count’ - A Parsonian Discourse of Patients’ Experiences of Day Surgery.

Abstract

Aim: The aim of the study was to explore patients’ experiences of day surgery utilising a sociological framework of analysis.

Background: Although day surgery has increased globally in the last twenty years little applied sociological research has been undertaken in this area.

Method: The Glaserian methodology of Grounded Theory was utilised. Semi - structured interviews were conducted with 145 patients and 100 carers on three occasions from 2004-2006. Analysis of the data involved line-by line analysis, compilation of key words and phrases (codes) and constant comparison of the codes until core categories emerged.

Findings: A major category to emerge from the data was the ambiguity presented to the patient in relation to the sick role. Of concern to the patients was society’s attitude which seems to deny to the day surgery patients the full entitlement of the privileges associated with the sick role. Day Surgery patients wanted to feel comfortable in a role that was socially acceptable to society –the sick role. However many patients actively resisted this role. This could have implications for recovery. A large number of patients wished for a limited ascription of the sick role whilst a minority actively sought to acquire the sick role.

Conclusion: The findings of this study offer a new perspective to the understanding of patients’ concerns. As day surgery expands globally it is important that nurses explore all aspects of the patient experience in order to provide a quality service.

Key words: Nursing, Parsons, Sick Role, Sociology, Day Surgery, Grounded Theory

What is already known about this topic?

- Globally day surgery is a rapidly expanding area of care.
- Patients are largely satisfied with day surgery.
- Parsons' Sick Role Theory is recognised as a major contribution to the study of health and illness

What this paper adds:

- Using Parsons' Sick Role Theory, this paper sheds new light on some of the problems experienced by day surgery patients.
- Demonstrates the continuing contemporary relevance of Parsons' Sick Role Theory to modern healthcare.
- A deeper understanding of the complexities of modern health care in the twenty-first century.

Implications for Practice

- Having extended understanding of patients' experiences will aid personnel to provide quality care.
- The study has implications for better information provision, pre-operative assessment and discharge advice for day surgery patients.
- Family members as well as society in general need to be better educated regarding the complexities of day surgery.

Introduction

Advances in surgery and anaesthesiology have led to an increase in the amount of complex surgical interventions now being performed globally (Jarrett and Staniszewski 2006). The International Association of Ambulatory Surgery has members from every continent in the world (Toftgaard and Parmentier 2006, Ojo et al 2008).Although day surgery offers numerous advantages to patients, in terms of less traumatic surgery and minimal disruption to daily life, it also presents some dilemmas regarding cultural norms and expectations concerning the sick role.

This paper reports the findings of a qualitative study, undertaken in the United Kingdom from 2004-2006, which examined patients' experiences of day surgery. A major concern of the patients' was the worry that, because of the short hospital stay, employers and families would not allow them the privileges normally accorded to the sick role. Patients' themselves sometimes had doubts as to whether they needed these and others denied they needed any such consideration. Parsons' sick role theory is applied as an explanatory framework for understanding patients' experiences of day surgery (Parsons 1951). A brief introduction to Parsons' work begins the discussion followed by a description of the study and, finally the findings and the implications for nursing care will be explored.

Background

It could be argued that Parsons' conception of 'the sick role' may not be a useful theory for understanding the complexities of health and illness in the twenty-first century. Indeed Parsons' work has excited many negative criticisms over the last forty years (Friedson 1970, Gallagher 1976, Freund and McGuire 2000). His work has been criticised as being "hyper-abstract, logically faulted and conservative" (Turner 1991: xviii). The Sick Role, specifically, has stimulated criticism. It has been accused of

ignoring cultures other than western cultures, ignoring the plight of the chronic sick, mental illness and pregnancy. He is blamed for considering patients to be passive recipients of health care thus ignoring the growth of 'information rich' insightful consumers of health (Shilling 2002:62). However there can be little doubt that Parsons' Sick Role is a major contribution to the study of health and illness (Holton 1998). It is considered to be important because it illustrates the social control functions of how society treats sickness. It also demonstrates Parsons' general theoretical concerns of norms and values in daily life (Holton 1998, Freund and McGuire 2000).

According to Parsons, (1951), the ill in modern society are expected to take up a clearly defined social role which ties them into the medical system. The 'sick role,' as he calls it, consists of two rights and two responsibilities. The rights are that sick people are exempted from undertaking their normal social roles and are not held responsible for their sickness. The sick person however is responsible for co-operating with medical help and is expected to want to get better. This role has emerged, for Parsons, because illness is a form of deviance which disrupts the social system by inhibiting individuals' performance of their social roles. As it is in role capacity that the patient falls ill, it is through a role, the 'sick role,' that the person recovers.

Parsons and Fox, (1952) imagine the sick role as a 'semi-legitimate channel of withdrawal' (p 34), from the individual's social roles. The sick role is perceived as a recess within the social system where they may retreat to recover with the help of the medical profession (Gerhardt 1989).

Throughout the data collection process in the study reported below, it was clear that there were some difficulties encountered by the patient sample regarding the cultural norms and expectations concerning the sick role.

Literature Review

The literature review took place after the category of the sick role emerged from the data. Glaser (1992) recommends, in grounded theory, that the literature review should take place only after categories emerge so that the researcher does not become contaminated by pre-formed ideas.

Much research has been undertaken investigating the application of the sick role to patients suffering from different disorders. Chalfont and Kurtz (1971) examined social workers attitudes to alcoholics. 224 social workers completed a questionnaire which indicated they did not accept alcoholics were entitled to the rights and privileges of the sick role. Although this study is more than thirty years old it is important because it demonstrates how social attitudes towards certain conditions were affected if it was deemed to be self-inflicted. Social judgements were also identified by Brown and Rawlinson (1975) who investigated the factors that encouraged patients to relinquish the sick role following cardiac surgery. Although issues such as the length of disability prior to surgery played a part, attitudes towards illness on the part of the patient were a significant factor. Patients, who believed sick individuals were generally not as 'good' as well people, abandoned the sick role readily. More recently, DiBenedetto-Carrato (1996) examined the ability to relinquish the sick role of 97 kidney transplant recipients. The ability to surrender the sick role was linked to coping abilities. However no long term follow-up of these patients was undertaken. Crossley (1998) considered the ambiguities that 38 individuals, diagnosed as being HIV positive, had towards the sick role. Although, on the one hand, they deplored the dependency character that was inherent in the sick role, they still needed the privileges accorded to them through the sick role to claim disability allowances. For them it was both a dis-empowering but also an empowering social

device. Glenton (2003) drawing on data collected from a Norwegian on-line discussion group of chronic back pain sufferers and from in-depth interviews, found that they expressed a fear that the reality of their pain was being questioned as a result of their inability to achieve the sick role. A lack of medical evidence that they were sick lead to accusations, both felt and enacted, of malingering and hypochondria. These two studies found that the sick role concept still reflects the expectations of health professionals, the public and the patient themselves. No research has as yet been located concerning the ambiguities presented by the sick role to patients undergoing day surgery. There is a gap in the literature concerning this, which this paper aims to fulfil.

The Study

Aim

The aim of the study was to explore patients' experiences of day surgery utilising a sociological framework of analysis.

Ethical Considerations

The Local Research Ethics Committee took a prescriptive approach. Ethical approval would only be granted if a sample size of at least 50 patients was obtained. They considered a sample size of less than fifty would not result in valid research. Although this seems counter to the spirit of grounded theory where sampling is guided by purposive and theoretical principles, without accepting this condition ethical approval would not have been granted. Patients from the urology and gynaecology specialities were to be excluded as well as any patients who may have been undergoing diagnostic tests which may have led to a cancer diagnosis. The Ethics Committee considered that these patients may have had conditions that may be considered embarrassing so must

be excluded from the study. Assurances were given regarding data protection; and information sheets and consent forms were produced for prospective recruits to the study.

Methodology

Sample

A purposive sample of 145 patients and 100 carers were interviewed over a two year period in two day surgery units in an urban area in the United Kingdom. Carers were recruited to the study because, in day surgery, they are now performing many of the tasks previously undertaken by nurses. Without their consent day surgery would not be able to take place. It is important to give them a voice. Patients were recruited to the study from the General Surgical, Ear, Nose and Throat and Orthopaedic Surgical Lists. They were all over the age of 18 years, undergoing general anaesthesia, and had never experienced day surgery before. Demographic characteristics of the patient sample are displayed in Table 1.

Data Collection

Semi-structured interviews took place on three occasions. Patients were recruited to the study in the pre-operative assessment clinic, usually two weeks before surgery, where the first interview took place. The second interview took place 48 hours following day surgery and the final one occurred one month after discharge. The latter two interviews took place by telephone. The timing of the interviews were undertaken to gain an insight into the patients' experiences at different stages in the day surgery journey. Interviews were structurally kept as loose as possible to allow the respondents freedom of expression. The opening question posed by the interviewer 'tell me what happened on the day of surgery' was usually all that was needed for the

respondents to speak of their experiences. Interviews with carers were shorter and largely concurred with the views of the patients. The third interview opened with the question 'how are you feeling now, a month after you have had day surgery?' The interviews were tape- recorded, typed verbatim and stored in a secure database. Field notes and memos were also recorded during data collection.

Data Analysis

The process adopted for data analysis was that advocated by Glaser (1992). This version of grounded theory is less prescriptive than the 1990 adaptation by Strauss and Corbin (Goulding 2002). Analysis incorporated simultaneous data collection and analysis from interview transcripts, field notes and memos. The act of interpreting the data was a very personal one. It occurred over a long period of time through a process of constantly reviewing and reflecting upon the interview data and memos. After spending two years in the field I had developed 'intimate familiarity' with the data (Lofland and Lofland 1983). I would not have liked to surrender the intimacy of this process of analysis by using a computer programme as, I feel, the richness of the final representation may have been lost.

The interview transcripts were typed and entered into a database, along with thoughts, reflections and incidents that occurred during each particular interview. This database was used, not for purposes of analysis, but purely to manage the data. After thorough reading of the data on several occasions open coding ensued by identifying key words and phrases. After these were underlined in one transcript, and also written in the margin of the page, they were then compared to other transcripts where similar words, phrases, ideas or associations occurred. Lists of codes were compiled. Analysis became a circular process as texts and codes were referred too many times. Often one list of codes could be subdivided into further lists. Thus the list of words and phrases

which contained references to concern over employers' attitude to day surgery, later became three lists which appeared to deal with the concerns of the patient sample: the reluctance of patients' to accept the sick role, those who actively sought the sick role, and those who had a realistic notion of its' uses. Thus a major category to emerge was the problematic area concerning the sick role. Charmaz (1990) advises that it is a mistake to rush into category development because it means that the researcher may not have fully explored the issues within their particular research scenario. To guard against this, transcripts and lists of codes were reflected upon many times.

Validity

The duration of the fieldwork which lasted over a two year period, added to the validity of the study as perceptions gained could be checked over time whilst in the field. Glaser states that researchers using grounded theory need not concern themselves with issues of validity because the proof is in the outcome (Glaser 1998). He suggests asking the following questions of the work: does the research work to explain relevant behaviour in the substantive area of the research? Does it have relevance to people in the substantive field? Does the theory fit the substantive area? If the research holds up to these criteria then that is 'product proof' of its validity (Glaser1998: 17). The integrity of the interview procedure was also considered according to quality standards developed by Kvale (1996).These include issues such as the naturalness of the answers, whether the researcher attempts to authenticate their explanations of the subjects' answers in the course of the interview, and that the interview is a self-contained story (Kvale 1996). I feel that I have met these criteria.

Findings

In relation to the adoption of the sick role, day surgery patients appeared to fall into three distinct categories: those who actively resisted adopting the sick role; those who desired a limited ascription of the sick role and those that actively sought the sick role. All names have been changed to protect patient anonymity.

Resisting the Sick Role

The majority of patients, 72%, interviewed fell into this category. Many were angry with themselves and their bodies for the incapacity they were presently experiencing. Paul, was determined he was not going to be ill. He was resolute in his intention to get back to work as soon as possible. When telephoned forty-eight hours after surgery, he reported that he was feeling 'very poorly.' Despite the day surgery staff taking time to explain that 'same day surgery does not mean same day recovery,' Paul had difficulty with this concept:

> That nurse in pre-op.assessment….she tried to tell me, she said I would be laid up for 6 weeks. I wasn't having any of it. I thought they would not be doing this in a day if I was going to be that bad. I just wasn't ready to listen.
>
> (Paul, .hernia repair)

Following his surgery, he was still resistant to the idea that he was incapacitated

> About three days after surgery I thought I could get up and do a few jobs around the house. But when I got up I felt like I was going to faint.
>
> You see my mind was ahead of my body. I thought I was more ready than I was.
>
> (Paul as above)

When Paul was contacted one month later, he reported how weak he had been. His debilitated condition had come as a surprise to him despite warnings from the staff. He said it had been a big 'strain for Jackie' (partner) such that 'we had about twenty arguments a day.' Reluctantly, Paul had to accept the sick role. He wished that he had

been an in-patient. When he was asked would he have day surgery again in the future he replied:

> Go through it again? I'd shoot myself….. (laughs) No. I would ask for at least one night's stay. I mean I had cold sweats, hot sweats…. I felt terrible. Having day surgery is hard work. (Paul as above)

Parents of teenage boys expressed concern that the concept of day surgery did not communicate explicit messages to their sons. Margery was worried about her son Euan:

> As soon as he came home he got dressed in his football kit... he said he was going to football practise.
> I said "oh no you're not!" I rang up the day surgery unit for advice.
> Much to his dismay they said after that kind of surgery he must not play sports for six weeks.
> (Margery, mother of Euan, hernia repair)

However Margery reported that she was unable to enforce such inactivity for long, and soon he was playing football again:

> I waited with baited breath for his wound to break open. I was worried sick. Maybe if they had kept him in a bit longer he may have taken their advice more seriously.
> (Margery as above)

Roth (1963) although writing about a different context of health care, demonstrated that control of patient's activity was a major focus for conflict between patients and staff in the tuberculosis hospital. However in the day surgery situation, time spent there is so short that health professionals can only advise on the curtailment of activities, it cannot enforce them. Within the in-patient scenario activities are automatically curtailed as patients are geographically separated from their social roles. Now, in day surgery, conflict may take place between patient and carers. This was demonstrated many times:

> I pleaded with him not to go back to work. I kept telling him that it was too soon. He said he didn't have a heavy manual job so he would be alright. I was getting very angry with him. I told him that for an intelligent man he was acting stupid. Anyway, after a week back at work he had to take some more time off.
>
> (Vera, wife of Tim, hernia repair)

The above narratives demonstrate the anxiety that is now being experienced by carers, when the day surgery patient resists adopting the sick role. It also reflects the shift that has taken place in recent years where the onus of care has been taken away from health service professionals and put upon the patient and their families.

Parsons and Fox (1952) argue that the best place for ill patients to recover is in hospital. They suggested that caring for sick individuals at home puts great strain on the modern family. The data collected above vindicates this view.

To summarise, the data collected from patients is replete with examples of individuals actively resisting the sick role but later incapacity has forced them grudgingly to accept it. This non-acceptance of the sick role could result in serious difficulties for the patients' and their families. Although a positive view of early recovery may be desirable; an unrealistic view may be disadvantageous for the future recovery of the patient (Minatti et al 2006). It may also place a burden on carers who may be unprepared for this resistance to the sick role and cannot understand how to deal with it.

Limited Ascription of the Sick Role- What do I tell my boss?

24% of the sample, who whilst not wishing to totally adopt the sick role, had a more realistic view of the amount of incapacity they may suffer afterwards than the 'resisting' group described above. They were especially worried how employers and family members would view their absence from work.

Some employers appeared to believe same-day surgery meant same- day recovery:

> My boss told me he had me down on the rota the next day.
> He said you can't be having that much done to you if you are only in for a day.
> (Anna, tendon repair)

This group of patients realised that by accepting the sick role they would gain some protection from employers who expected them to resume their employment immediately. Ben was delighted that the day surgery staff had given him a medical sickness certificate for two weeks:

> At least I have got something down in black and white now
> to show the bosses. It's official. I can have time off work. Two weeks should do it.
> I'm happy with that .I should be back to normal by then.
> (Ben, arthroscopy)

It was not only employers who may have high expectations of patients following day surgery but family members as well. Katrina was so worried that her partner might expect too much of her following day surgery that she asked the nurse to explain to him that she would need 'help just for a few days' afterwards:

> His mother has just come out of hospital. She's been in for six weeks.
> He says I don't know why I'm making such a fuss for one day.
> To him one day doesn't count.
> (Katrina, bunionectomy)

This group of people, although not actively seeking the sick role, seemed to feel that the day surgery process minimised their condition in the eyes of their employers and family. They realised that there are benefits in accepting the sick role in terms of the

rights of the sick to be exempted from their normal responsibilities for a limited period of time.

Actively seeking the sick role

In the sample under study, the group of patients actively seeking the sick role emerged as the smallest one. Only 4% of patients expressed a desire to avail themselves of the full rights and responsibilities of the sick role. Julie expressed a desire for the:

> full patient treatment. I want to have flowers, cards and chocolates (laughs).
>
> You don't get them if you are having day surgery.
>
> (Julie, ligation of varicose veins)

The need to be considered a sick person as legitimised by an in-patient stay in hospital was important:

> I was wishing for a longer stay. I have never been off sick in all the time I have worked for that company. I was really glad that when I came home two work mates came to see me and while they were there the district nurse came bringing a student nurse with her. This is great I thought. Two nurses. They will know now that they (health service personnel) are taking my knee seriously.
>
> (Frederick, arthroscopy)

Some patients felt that the sick role was being denied them by the day surgery system and day surgery personnel. The discharge advice given to patients by surgeons could be interpreted as a further attack on the patients' right to assume the sick role.

When Wilfred was asked how long he might stay off work he replied:

> I am going to stay off work until I am confident enough to go back. It's alright that surgeon telling me that I could go back to work in 3 weeks. He doesn't understand what I do. I have to lift heavy loads. It is hard manual work. So I am going to go with what my body tells me. I will know when I am fit for work.
>
> (Wilfred, arthroscopy)

Here the ability of the surgeon to perform the surgery was not in question. However his qualifications to pronounce on the patients lifestyle and the time needed for recovery was found wanting. Having so little knowledge of the patient's occupation makes it, certainly, in the patient's eyes, unreasonable of the surgeon to offer his opinion on when he should return to work.

Several patients who desired full sick role status felt that the introduction of day surgery was part of a cost- cutting drive by central government. This was often expressed as nostalgia for times past. Helen longed for the days, when, as a child of 11 years old, she had been in hospital for ten days:

> It was great being ill in the fifties. You were really well looked after. I had a nice long rest after the operation. Now you are just flung out at the earliest opportunity.
>
> (Helen, polypectomy)

The health service Helen remembered was more leisurely then. The importance of convalescence was acknowledged as being the responsibility of health professionals. Now the concept of convalescence has no parlance in the business vernacular of health care.

Helen, like John below, wished to have more time in hospital to recover slowly from surgery. John saw day surgery as a cost cutting measure. He expressed anger at the government for what he saw as the curtailing of public expenditure against the profligate lifestyle of the politicians:

> They don't know what it is like to have a fiver in your pocket and you have to decide shall I put petrol in the car or buy some bread and milk? They would not want to be thrown out of hospital the minute they have had an operation. No not them. (John, arthroscopy)

Although the percentage of patients interviewed in this study who wished to embrace the sick role was quite low (4%), this response is significant. These individuals felt the need for sick role status for a variety of reasons: to legitimise their illness or injury, to affirm their humanity, to avoid unpleasantness and worry for family members and to have a rest from normal responsibilities. This group saw the provision of Day Surgery as a cost-cutting exercise. The saving of time and speed of day surgery did not impress this group.

Discussion

Limitations

This was a relatively small study, which took place in two day surgery units in the United Kingdom. It may be difficult to generalise these findings across the international community. No comparisons were made between gender experiences or other sociological variables. This may be considered a weakness of the study. Other constraints were the exclusion of a large ethnic group, as financial considerations precluded the services of an interpreter.

Parsons in the 21st Century

It is more than half a century since Parsons' Sick Role Theory was published. Since then health care has changed considerably. Due to the 'cult of efficiency' that pervades all aspects of life in the western world (Gross-Stein 2001), and the emphasis on cost-containment, there is no room in health care provision for protracted recovery times and convalescence. Due to advanced technology surgery is less traumatic and healing times are faster than when Parsons was formulating his theories. However the importance of the adoption of roles, approved by the prevailing culture, to fit peculiar circumstances has not diminished. In spite of criticisms concerning Parsons' work it

has been demonstrated here that his work has contemporary relevance in throwing light on the ambiguities of patient status created by modern technologies in health care. Medical innovations, such as day surgery, may confuse patient and care-giver expectations. Shorter hospital stays, minimal interaction with the medical staff, greater responsibility placed on the patient and families for self-care all reduce the traditional markers and rituals of being accepted into the traditional sick role (Fox 1992). Because of the emotional aspect of health and injury it may be important for patients to have a clearly defined role to cope with illness and incapacity (Lupton 1996). Parsons' theory may sensitise health care personnel into exploring the expectations and beliefs of patients in an ever changing arena of health care to enable them to plan care accordingly.

Ambiguities and Conflicts

For many of the patients, their families and their employers the term 'same day surgery' was synonymous with the meaning 'same day recovery.' The confusion surrounding the sick role appears to be aggravated by society's expectation that serious illness is equated with in-patient hospital treatment of days or weeks. Consequently only individuals who undergo longer hospital stays are allowed the privileges of the sick role (Glenton 2003).

There are notable differences between the hospitalised patient and the day surgery patient in the ambiguities and conflict they experience in relation to the sick role. Once an in-patient, the individual is expected to set aside their usual roles to assume the sick role. This role is automatically ascribed to them both by the professional medical establishment and the rest of society whether they want it or not (Lambert and Lambert 1981). The patients have no choice about this. If they resist the sick role they are at risk of being labelled 'un-cooperative' 'difficult' or an 'unpopular patient'

(Stockwell 1984). According to Lambert and Lambert (1981) time is essential for the successful acquisition of new roles. One must first anticipate the new role, learn its formal and informal expectations, formulate a personal ideology regarding the role and then react to it. Finally, a synthesis of the expectations of, and acquisition of, the new role occurs (Lambert and Lambert 1981). However, time, which is necessary for sick role acquisition, is not available for the day surgery patient.

The perceived expectations, which meet the day surgery patient, are considerably different from those which meet the inpatient. The day surgery patient is expected to be 'street ready' within a few hours. S/he can only relinquish their social roles for a few hours at most. Even though they are advised to give themselves appropriate time for recovery, in many cases this is no time at all (Jones 1999, Mitchell 2003, Gilmartin 2007). The in-patient, on the other hand, must surrender his/her physical self from their commitments for the time they are in hospital even if they retain a moral or advisory commitment to their roles (Kubsch and Wichowski 1992).

Inter role conflict occurs when the patient fails to manifest behaviours as a result of opposing expectations from others concerning the correct behaviour for that particular situation. Sometimes it is difficult for the day surgery patients and their families to know what is expected of them. Even day surgery professionals appear to have differing views (Solly 2005, Smith 2006, Horton 2009).

There can be little doubt, and even Parsons (1964:218) agrees, that what he presents as the Sick Role model is really an ideal type and everyday realities of sickness can depart from this ideal (Nettleton 2006). Parsons work on the Sick Role, criticisms not withstanding, has stood the test of time, and at the beginning of the twenty-first century, can be applied to the experiences of patients undergoing day surgery.

Conclusion

By utilising a sociological approach to the study of day surgery patients, new understandings of the day surgery experience has emerged. Fears and anxieties of day surgery patients have surfaced that may not have previously been uncovered in other studies. Fear of censure by society for not immediately being able to perform their social and professional roles may not have appeared with such force as it has here. This study has many implications for nurses, nurse education and the wider society. The importance of nurses in providing supportive, psychological care, as well as to ensure patient and carer understanding of what day surgery entails cannot be overstated. If carers do not fully understand what their loved one has undergone whilst a day surgery patient, they will not be equipped to offer the best support. The providers of nurse education must encompass the changing nature of health care into their programmes. A recent study revealed that day surgery received little attention in undergraduate nursing curriculums in the United Kingdom (Mitchell 2006). This must be rectified to ensure that nurses of the future have the knowledge to provide appropriate care for day surgery patients. Day Surgery personnel must teach that day surgery is not minor surgery, recovery times may be protracted, during which patients will need support.

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Conflict of Interest

No conflict of interest has been declared.

Table 1: Demographic Characteristics of Sample

Sex	Women	87
	Men	58
Age	18-25	8
	26-35	19
	36-45	44
	46-55	33
	56-65	30
	66-75	11
Employment Status	Employed	105
	Retired	14
	Students	13
	Unemployed	5
	Child-rearing	7
	Religious Orders	1

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