

Patient-Centered Care in the OR: Is This Possible?

By Anna Gabrielson RN, BSN

Operating rooms have long been known as care giving areas where the primary focus can often be on constantly evolving technology, not on a patient's needs as a person. Focusing on patients' needs by respecting and understanding their values, preferences and expressed needs is the foundation of patient-centered care as described by Gertis et al (1993). Therefore, patient-centered care is an approach that consciously adopts the patient's perspective. However, in a high technological area such as an operating room,

professionals feel the time required to 'keep up' with new technologies cuts into the time available to spend with patients. The great strides in science and technology have made an impact on the value and definition of caring. I agree that this is a 'catch 22' as both are important: the technology and the needs of the patient. However, in using the concepts of relational care found in current nursing literature, operating room nurses can evolve from a technically dominant care-giving paradigm towards a humanistic paradigm that focuses on the patient's expressed needs. This paper will present care-giving concepts from current nursing literature and how these concepts can be applied to operating room settings.

Abstract

Patient-centered care can be practiced in high technology areas such as the operating room if care-givers develop an attitude of seeing their care delivery through the patient's eyes. Through caring interactions with our patients, we can find out what matters most to them. It seems that the more complex our technology and the more bureaucratic our hospitals have become, the less respect and positive regard is being communicated to patients. In addition, time is becoming increasingly scarce in our busy operating rooms. However, it is not how much time we spend with our patients. Instead, it is how we are with our patients in these stressful moments before surgery. Using concepts of relational care discussed in current nursing literature, nurses can evolve from a technically dominant care-giving paradigm towards a humanistic paradigm that focuses on the patient's expressed needs. This enables our clients to experience health and healing in their context.

Literature Review

Due to the paucity in literature specifically focusing on patient centered care in operating rooms, literature that addresses caring in the nursing profession in general is applied to operating room nursing. Aiken and Aiken (1973) claim that respect and positive regard is communicated through concern for a patient's feelings, experiences, and potentials. However, the more complex our technology the less time there is to communicate respect and positive regard. Also Gray (1993) argues that caring is not just about

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"making nice." It is about taking time and energy to share concerns when those concerns are present. Gadow (1985) maintains that the image of a caring person is of one who is tender, sympathetic and supportive rather than detached and efficient. Gadow adds that caring is concern for the dignity of patients which is threatened by technology and experts. Specialized nurses tend to take over the care of bits of the patient rather than total patient care. Furthermore, Hawthorne & Yurlovich (1995) claim that nurses appear to function in systems where the focus is no longer on the client as a person but on the outcome to be achieved; a problem to be solved.

Enhancing Our Care Delivery Using the Caring Concepts

A compassionate connectedness can be fostered by using full eye contact and an unhurried approach with warmth and acceptance of the client as a whole person. Through touch, the nurse can assist the patient to overcome the depersonalization that often characterizes a patient's experience in the health care setting (Fry, 1989). Since hands and eyes are our most developed means of both receiving and altering the world, touch can affirm to the patient that he or she is a person rather than an object. However, I will mention that the caregiver should be discriminating, using intuition and experience to determine if touch would be therapeutic for his/her client.

Sherwood (1993) asserts that patients who experience this connected relationship in a crisis time found it to be a source of comfort. There was reassurance of being seen, being heard, and being with. I recognize that we are working within increasing time constraints with little possibility of changing. It is not how much time we spend with the patient, but rather how we are with the patient. An accepting, understanding approach with a situation-appropriate smile directed at the client could make a big difference in his/her psychological wellbeing.

Another issue that I will address is the general lack of encouragement for family involvement in the care giving process in our operating rooms. Three years ago a study cited by Gordon (1994) found that altering rigid visiting policies had a positive impact on client and family anxiety. It is important to remember that high technology and nursing procedures cannot replace the comforting presence of a caring family.

Recently, we permitted a family member to be

present throughout her elderly mother's surgical intervention and post anesthetic recovery. We followed a rigid protocol in acquiring the medical director's approval and signature before this could happen. The surgical procedure was performed under a local anesthetic with narcotic sedation. Consequently, the client was able to communicate with her adult daughter throughout her operation. I felt and could see that the patient was comfortable, both physically and psychologically, in the context of surrounding high technology operated by masked strangers. This experience demonstrated to me that we could open our doors even wider and perhaps let a family member come into the operating room until the anesthetic is given. I know that being alone on an operating room table can be frightening to many patients, even though very few openly articulate this.

Another issue that requires some critical thinking is the strictly enforced dress code for the clients. Patients are asked to replace all their clothing with a flimsy hospital gown. The gown is usually a one-layer cotton blend that provides little warmth in the air-conditioned surgical suite. Many patients are having minor procedures on their fingers and toes, therefore the 'strip down' is an unnecessary and uncomfortable process for the patient. We need to examine this ritual for patients undergoing minor surgical procedures.

Gordon (1994) asks the question: should nurses continue to enforce rules that threaten patient autonomy and their sense of survival? By sense of survival, Gordon is referring to situations of patients who wear neck strings or bracelets which they feel protects them and their spirit during a crisis. Most operating rooms today still continue to impose rules that forbid any jewelry or special garments. Perhaps we could be more flexible in certain situations after we have explored with the patient what he or she would need to feel more secure and less afraid.

We also need to begin asking our patients what is concerning them the most in the stressful moments before surgery. We cannot make any assumptions about what it is the patient wants to know: sometimes it can be a concern about a family member at home for whom they feel responsible. We also cannot make the assumption that the patient would like to know all the technical details of procedures. In some (or most) cases, this could cause more stress for the patient. Patient-centered care is practiced when nurses approach their patients as whole persons in their context and their situation instead of an object or 'category of illness.'

Conclusion

Patient-centered care can be practiced in high technology areas such as the operating room if the caregivers develop an attitude of seeing their care delivery through the patient's eyes. Through caring interactions with our patients, we can determine what matters most to them. It seems that the more complex our technology and the more bureaucratic our hospitals have become, the less respect and positive regard is communicated to patients. In addition, time is becoming increasingly scarce in our busy operating rooms. Interactions with our patients in the stressful moments before surgery should take precedence over how *much* time is spent. Using the concepts of relational care I have discussed, nurses can evolve from a technically dominant care-giving paradigm toward a humanistic paradigm that focuses on the patient's expressed needs. This will enable our clients to experience health and healing in their context. ■

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Why Do A Whipples ?

By Tracy Lebek, RN, BSc & Holli McLennan, RN

Much literature has been written over the years on "how to do a Whipples procedure." Just as many articles can be found on "should we do a Whipples?" What quality of life are we giving these patients by performing a Whipples? This is not a very upbeat topic, but by looking at it from a moral or ethical aspect, the next time we scrub for a pancreatic tumor, we will know a bit more about these tumors and understand why it is better "not to do a Whipples."

In my experience, when you put a group of surgeons together in a room, there is not much on which they agree. But, when you put a group of general surgeons together to discuss carcinoma of the pancreas, there is one subject on which they will agree. It is clear to all of them that pancreatic cancer is increasing but the cure rate remains dismal. For people with cancer of the pancreas, resection of the tumor has not significantly altered the natural history of the disease. For instance, in 1990, 2,750 people were newly diagnosed with pancreatic adenocarcinoma and 2,700 died of the disease (MacFarlane, 1991). Even careful pre-selection of patients for radical surgery does not alter the less than 2% five - year survival rate (MacFarlane, 1991; Cooperman, 1989). So why do a Whipples?

In general surgery circles, a Whipples is considered a high risk, challenging, macho procedure that is in the fast lane, on the cutting edge of surgery. Well, we are happy to report that, in our country, more general surgeons believe that surgery for tumor of the pancreas should be relegated to a more palliative role (MacFarlane, 1991; Wade et al, 1994). Cutting, just for the sake of cutting, is not the answer.

Much literature has been written on the surgical options available for people with pancreatic carcinoma. But, let us not forget the quality of life for these

patients. One of the most difficult decisions for a surgeon to make is when *not* to intervene. Often we are tempted to use the means available when the most humane approach would be to relieve the pain, and prepare the patient and family for death. Many surgeons now see management of pancreatic carcinoma as palliative and not curative (MacFarlane, 1991). A case can be made *not* to do the surgery and thus, leave the patient in as much comfort as possible.

Suggestions have been made that smoking, dietary factors like caffeine, and chemical and industrial carcinogens have been linked to possible reasons for the development of these tumors (MacFarlane, 1991; Cooperman, 1989). But, then again, could we not link those factors to almost any tumor?

Early diagnosis of a pancreatic tumor is almost impossible. The patient is asymptomatic until the tumor develops one of three characteristics:

- 1) becomes large enough to compress the common bile duct;
- 2) invades the retroperitoneal tissue; and
- 3) obstructs the flow of abdominal lymph.

The result is symptoms of jaundice, pain, or ascites, respectively (MacFarlane, 1991).

Criteria were developed to help a surgeon determine if a Whipples should be performed (MacFarlane, 1991). The criteria are as follows:

- 1) the absence of metastasis to the peritoneum;
- 2) no periportal lymph node involvement; and

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