

ORIGINAL ARTICLE

After colonic surgery: The lived experience of participating in a fast-track programme

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Abstract

Postoperative recovery can be accelerated and hospitalization reduced through fast-track programmes. However, documented knowledge is limited and primarily focusing on a medical perspective whereas the patients' perspective lacks documentation. This study describes the lived experience of participating in a fast-track programme after colonic surgery. Sixteen patients were interviewed twice. The interviews were analysed using a descriptive phenomenological approach. Participating in a fast-track programme is characterized by a process where patients experience how the daily regimen works both with them and against them. To succeed in the overall goal of recovering fast according to the evidence-based care plan involves facing dilemmas and mobilizing courage and will to follow the regimen. Support from the professionals is crucial. The participants had a strong desire to comply and regain health; but this role of being a good and cooperative patient had a built-in asymmetric power relationship favouring the professionals' expectations. The complexities of this power relationship were related to both patient factors and contextual factors, e.g. the daily regimen and hospital norms. Although patient participation in care is an accepted ideal, it is demanding and difficult to accomplish. More studies on fast-track programmes are needed, with special attention to patient autonomy and partnership.

Key words: *Colonic surgery, fast-track recovery, patient perspective, caring science, phenomenology, patient participation*

Introduction

Fast-track programmes are examples of the recent changes in health care toward standardized evidence-based plans, increase of patient involvement and decrease of hospitalization. Medical research has documented that postoperative recovery can be accelerated and that hospitalization can be reduced through fast-track programmes (Kehlet, 2008; Fearon et al., 2005; Wind et al., 2006). Today, patients who have undergone colonic surgery are discharged two to three days after open surgery compared with seven to ten days previously (Kehlet & Mogensen, 1999; Basse et al., 2001). The implementation of fast-track programmes is increasing internationally and several studies have documented their benefits. Organ functions, muscle mass, strength and physical performance are not deteriorated compared with the preoperative level (Basse et al., 2002; Kehlet & Dahl, 2003; Folkersen et al., 2005). However, documented knowledge is limited

and primarily related to a medical perspective whereas research into the patients' experience of participating in fast-track programmes is lacking. This article presents the lived experience of participating in a fast-track programme as seen from the patients' perspective.

Fast-track programmes, also referred to as fast-track surgery, fast-track regimen or fast-track rehabilitation, is an interdisciplinary, evidence-based multimodal concept aimed at improving peri-operative treatment. By the end of the 1990s, significant scientific evidence was available regarding the optimization of peri-operative care for elective surgical patients. Investigators synthesized, integrated and applied this new information in comprehensive programmes (Walter, Smith & Guillou, 2006; Wilmore & Kehlet, 2001). These programmes consist of a number of evidenced-based interventions which individually are associated with improved outcomes following colonic surgery (Fearon et al., 2005; Kehlet

& Wilmore, 2008). The focus is on effective pain relief, reduction of surgical stress responses, immediate mobilization and oral nutrition together with detailed patient information about the postoperative care plan and plan for discharge (Folkersen et al., 2005; Jakobsen, Sonne & Kehlet, 2006; Kehlet & Dahl, 2003; Kehlet & Wilmore, 2008).

A fast-track programme requires a cooperating team of motivated nurses, physiotherapists, anaesthesiologists and surgeons, in addition to continuous improvement of the processes involved. The active role of the patient is emphasized, therefore extended patient information about the procedures and the expected time course is of major importance (Fearon et al., 2005; Kehlet & Wilmore, 2008; Jakobsen et al., 2006). The patients are explicitly expected to share the responsibility and to participate actively in meeting the appointed goals and the plan for early discharge (Kehlet, 2008; Jakobsen et al., 2006; Folkersen et al., 2005). A core aspect of fast-track programmes is a standardized nursing care plan focusing specifically on evidence-based goals for nutrition and mobilization. The daily regimen is based on ideals about shared responsibility and self-care.

Documentation of colonic patients' experiences of engaging in a fast-track programme is limited to subjective parameters of satisfaction. Satisfaction with information and pain relief is unchanged or better in fast-track programmes compared with conventional programmes. However, 34% of fast-track patients would have preferred to remain hospitalized for longer compared with 10% of conventional patients, and they had significantly more readmissions and an increased need for home care (Folkersen et al., 2005).

Patients' health and well-being during the trajectory from surgery to expected recovery is well described in relation to a number of diseases; such as coronary disease (Johansson & Ekebergh, 2006; Karlsson, Johansson & Lidell, 2006) and breast cancer (Coward & Kahn, 2005; Chapman & Purushotham, 2002), but there is little research into colonic patients' experiences. One quantitative study among older adults found that pain, depression and fatigue were significant contributors to variation in the patients' functional status after discharge (Zalon, 2004). These patients were discharged directly to their home after major abdominal surgery and 22.4% of them had undergone colonic resection. The experience of being diagnosed with colorectal cancer is identified as posing a major threat to patients' lives and having an impact on their everyday life and social activities (Taylor, 2001). Additionally, a malignancy diagnosis among colonic patients appears to correspond with high levels of

anxiety and stress already prior to surgery which is often not identified and affirmed by the nurses (Moene, Bergbom & Skott, 2006). The aim of the present study was to describe the lived experience of participating in a fast-track programme during hospitalization, as seen from the perspective of persons diagnosed with cancer who have undergone colonic surgery.

Methodological approach

Reflective lifeworld research, as developed by Dahlberg, Dahlberg and Nyström (2008) was employed as research design. This phenomenological approach has an explicit epistemological and ontological point of departure building primarily on the philosophy of Husserl and Merleau-Ponty. The world is not taken for granted, nor is human life considered an independent existence. Hence, the lifeworld is seen as the unreflected background for our experiences and actions in which the question of meaning is primary. Reflective lifeworld research aims at describing a phenomenon's essential meanings, i.e. its structure of meanings. Essence belongs to the in-between world, i.e. essences belong to the everyday experiencing of the world, to the intentional relationship between the phenomena and us (Dahlberg, 2006). Consequently, essences are not something that we as researchers explicitly add to the research, it is already there. Reflective lifeworld research directs the researcher toward openness during the whole research process in order to come close to the phenomenon without taking the meaning for granted. In doing so the researcher has to be open to the investigated phenomenon and careful not to make definite what is indefinite. This demand for an open attitude is not easily accomplished. It includes a process of attempting to suspend presuppositions and go beyond our "natural attitude" of taken-for-granted understanding in order to attend more actively to participants' views. This process Dahlberg and colleagues name "bridling", which is a renaming of Husserl's notion of bracketing. The challenge is to slow down and be aware of the process of understanding meanings in order to see the world differently, by retaining an open discovering way of being and possibly be surprised by new meanings as they arise (Dahlberg et al., 2008).

During the research process, we adopted this critical attitude and scrutinized our emerging understanding of the phenomenon "participating in a fast-track programme" by discussing it with each other in order to let the phenomenon reveal something of itself in a fresh way. This shift from immediate understanding of the phenomenon into the reflective

attitude was crucial aiming at achieving scientific objectivity (Dahlberg et al., 2008).

Participants

The participants were selected from a unit at a Danish university hospital in which fast-track programmes had been practised for several years. As most colonic patients have cancer (Kehlet & Mogensen, 1999; Basse et al., 2001) the study was limited to patients with cancer who had undergone colonic surgery. Sixteen participants aged 53–77 years were included. Inclusion criteria were patients who had undergone colonic resection, followed a fast-track programme, and were capable of answering questions. Seven patients were discharged two days after surgery, four patients after three days and two patients after four and five days. Nine patients had undergone radical surgery while seven of the patients were referred to chemotherapy after surgery. Three of the patients lived alone while the others were living with their spouses. Although the participants were recruited consecutively, the group was heterogeneous representing individuals from a wide range of backgrounds.

The interviews

In-depth interviews were conducted by the first author (AN). The patients were interviewed twice, two weeks and two months after discharge in 2006–2007. The interviews took place in the patient's home except one interview which took place at AN's office. Open ended questions were asked, allowing the patients to use their own words and talk about what really mattered to them. The patients were asked to describe what it was like for them having experienced the postoperative period and participating in the daily regimen. Probes, in the form of additional questions were asked when necessary in order to facilitate their stories, like "Tell me what happened next?" or "Can you give another example of this?". The patients were encouraged to describe and elaborate on concrete situations such as "What was it like for you to get out of bed the first time after surgery?" "How did it make you feel?". The interviews were recorded and transcribed by the first author.

Ethical considerations

The participants were invited to participate in the study by a nurse from the hospital unit. The participants received written and verbal information about the purpose of the study, including the right to withdraw, the guarantee of anonymity, and the confidentiality of the data given (Northern Nurses Federation, 2003). Formal approval by the local

ethical committee was not required according to national and local directives in Denmark.

Analysis

The main aim of the analysis was to describe an essential structure of the phenomenon which involved a search for the invariant structure of meanings. The structure is understood as a description of the essence and its constituents, i.e. the meanings that constitute the essence. Accordingly, the essence must be seen in each meaning constituent while the constituents are interrelating aspects of the structure that reflect patterns and essential elements of the structure of which they are a part (Dahlberg et al., 2008).

The analysis was characterized by an intensive dialogue with the text, moving between the interview texts and emerging patterns of meanings. The transcriptions were systematically and repeatedly read in an attempt to become empathically immersed in the individual descriptions and get an overall sense of each description. Attempting to discover the meanings from the participants' point of view, analysis then slowed down. The text was carefully reread and divided into meaning units. An effort was made to linger over these meaning units in order to cluster the various meanings into patterns of understanding that mirrored their interrelationships. This was followed by a process of active and open reflection and elaboration of the emerging meanings which aimed at synthesizing the clustered meaning units representing a new whole, i.e. the typicality of the phenomenon. This was done by picking up one meaning and watching it as a figure against the others as background, then picking up another meaning making it a temporary figure, and so on.

The phenomenon participating in a fast-track programme is presented below as one general structure with five constituents. Quotes from the interviews are provided as examples of explicated meanings to bring the reader into a closer and more meaningful relationship with the phenomenon and its nuances of meaning (Dahlberg et al., 2008).

Findings

The essential meaning of the lived experience of participating in a fast-track programme during hospitalisation can be described as an ongoing challenge which involves tensions. It is characterized by a process in which the patients experience how the daily regimen is working both with them and against them. Having colonic cancer implies a life-situation initially followed by chaos, marked by existential insecurity and consequently the patients are in a

vulnerable position. The structured fast-track programme for care and treatment brings trust and security into this life-situation but also involves struggle and feelings of ambivalence. To participate in a fast-track programme entails that patients take on the responsibility of following the instructions. During hospitalisation, the daily regimen defines the premises for the patients' commitment, and the patients' autonomy comes under pressure. Participating in a fast-track programme implies that the patient will live up to the professionals' expectations and the patient's own expectations of being a good and cooperative patient, who actively works toward the goal. However, postoperative discomfort creates a dilemma for patients between following the professionals' advice regarding the regimen objectives or responding to their own intuition of what could also contribute to their health and well-being. Taking on the responsibility of participating in a fast-track programme requires personal courage and will to suppress discomfort and comply with the instructions. Support from the professionals and a sense of trust and security laid the foundation for the patients' resources, necessary to engage in the daily regimen.

Facing vulnerability

To be diagnosed with colonic cancer meant having to live with a life-threatening disease. This implied dependency on care and treatment, and a need for protection and support from others. Life was not just going on, the diagnosis and being in suspense about the progression of the disease involved unpredictability and loss of control. These existential threats changed the patients' life and created feelings of fear and anxiety about surviving the operation and ensuing treatment. Being in this vulnerable position made the patients susceptible to influence and prepared to go far to contribute to their own health and well-being, "I am very, very willing to do almost anything to recover". The patients were highly attentive toward the professionals' advice and past experience with the programme, and they prepared themselves to live up to the expectations of being actively committed. The thought of being able to do something themselves to recover more quickly was motivating. The patients were ready to be cooperative and take responsibility. The terms of the daily regimen were encoded in the patients during their recovery process and they participated actively in meeting the appointed goals, e.g. by thorough preparation, "I had done my homework before I was admitted".

The professionals' expectations constituted a major part of the patients' understanding of participating in the fast-track programme and promoted a

desire to be a good and cooperative patient. The structured programme and the awareness of the professionals' expectations gave the patients a feeling of security and some control of their vulnerable situation.

The patients' were also aware that the programme did determine their activities in the postoperative period, "The consultant said that when you wake up, we will kick you out of bed as quickly as it is absolutely possible". However, they gained energy from feelings of relief and gratitude that surgery was behind them, and the patients saw the operation as the first important part of their trajectory from surgery to recovery.

Responsible participation

The fast-track programme appeared as a model for the patients' participation. The patients adopted the professionals' expectations regarding shared responsibility by trying to adapt to the postoperative regimen. The patients strove to take on the regimen unconditionally and comply with the role of being good and cooperative. Accordingly, the patients also expected a lot of themselves. "If you want to get through it as quickly and as well as possible, then you need to show a will to comply with the existing rules".

Awareness of the risk of complications encouraged the patients to share the responsibility and not prolong the course of recovery. Although the patients experienced that the professionals might be willing to adjust the objectives and did not take them as fixed rules, the patients themselves took their responsibility very literally. One patient kept an eye on himself, whether he fulfilled the goal of staying out of bed for eight hours.

I would love to stay in bed, but I know that there is a risk of having a blood clot and I don't want to risk that . . . so my attitude was to comply with the rules . . . and I kept an eye on my watch so I was sure that I was out of bed for about 8 hours.

Unfamiliar and unpleasant reactions such as fatigue, nausea or pain occurred and made the patients feel weak and incompetent regarding actively doing as recommended. At the same time they were expected to be strong and mobilize will to participate according to the objectives. To act responsibly implied that the patients faced having to live up to the expectations and having to work on mobilizing the necessary strength to cope with the expectations. Also, the hospital represented a place associated with certain norms, and having to act within a fixed set of rules meant that the patients

were in a situation with a high degree of personal responsibility and a low degree of influence, "It's like a soldier's life, living in barracks, there is nowhere to go . . . you are obliged to live with the way things are, and you can't do anything about it".

Responsible participation also involved a tension experienced as conditional cooperation. On the one hand the professionals expected the patients to be active, independent and self-sufficient patients. On the other hand, the professionals defined what the patients should do. The tension surfaced if the patients tried to adjust the regimen norms to their own liking and they were corrected by the professionals. The patients' autonomy came under pressure and revealed an asymmetric power relationship between the patients' responsibility and their influence.

One evening I tried to cheat (from the instructions) by eating in bed and watching TV, because I felt I had been running around so much. No, the nurse said, she didn't think it was a good idea that I sat up in bed eating . . . it didn't matter what I said, so I had to get up (laughing).

Even though it might be hard to follow the instructions, the patients expressed belief in the regimen and they saw it as having several purposes. Apart from enhancing recovery, they also felt that there was an implicit responsibility to reduce the waiting list.

The cutbacks in epidural painkillers are tough and a cold turkey when it is forced on you . . . but despite this, I have no doubt that this is the right course. Not just for the waiting list, but also for the patients . . . because of the blood clots and other complications.

The scheduled discharge emerged as a success criterion for the patients that framed the length of their stay in hospital. The patients, who were not discharged at the scheduled time, felt that they were getting more from the hospital or the professionals than they were entitled to. The early discharge could cause worry, but it also served as a motivating factor to take an active part in the regimen. Some patients regarded the fixed schedule as a chance to get home despite some discomfort. Being at home could be seen as a better alternative toward recovery than being hospitalized.

At the back of my mind I felt that now you have to be a big boy, because you must go home as quickly as possible. I wanted to get away from that environment. They were nice and . . . friendly,

everybody around me, incredibly . . . incredibly nice. Yet, it was at the back of my mind . . . that it would be nice to come home.

The patients construed their own realm of understanding about the professionals' actions. This understanding was based on the regimen objectives, as they understood them, and created a relational distance between the staff and themselves. For example, one patient described a situation where he had the idea that the staff expected him to pull himself together and take responsibility for his fluid balance. This meant that he avoided dialogue and proceeded in line with the objectives he thought that the staff had.

I threw up most of the night . . . and then they put up a drip to maintain the fluid balance, but they quickly took it down again . . . presumably from the understanding that I should pull myself together and get some liquids down me. So I had to force myself to drink.

The role of being a good and cooperative patient implied a latent risk that the patients' responsibility may extend beyond the regimen.

Compliance – defiance relationship

Participating in the fast-track programme during hospitalisation meant coping with a tension between compliance and defiance. Right after the operation, the patients felt that they had a fragile body that called for rest and passivity, while the professional recommendations dictated activity. It became a dilemma for the patients whether to mobilize the strength to follow the professional advice or follow their own intuition of what would contribute to their health and well-being. The patients pushed themselves to overcome this dilemma and mobilized courage and will to suppress bodily reactions in order to be responsible and comply with both the professional recommendations and their own personal desire to live up to these expectations. This could be manageable, but due to fatigue, nausea or pain it could also be a struggle. When discomfort set in they experienced loss of control of the body and the situation. Some patients felt that the body had taken control and acted as an opponent, which must be overcome in their attempt to meet the objectives. "When I got out of bed the first time, I nearly fainted and threw up . . . I had pain all over . . . and well . . . I did as I was told".

This loss of bodily integrity created an ambivalent body experience for the patients; the body was both a-part from and a-part of themselves. Likewise, the

patients could experience their body as an object instituting sanctions, when its signs were ignored to the advantage of the professional advice.

Protein drink ... that's a killer. And I had to drink it, the nurse said ... I had also read in the brochure that you lose a lot of muscle power ... so the only thing to do was to get it down. So I forced myself to drink it but it came up just as quickly as it went down, both times.

Knowledge of possible postoperative complications together with the professionals' interventions supported the patients in overcoming the dilemma between intuition and instructions. To be somewhat pressurized could also be deemed necessary by the patients. From their perspective it was described as an art to convince them and apply the pressure that was conducive without being authoritarian. This involved achieving a positive relationship with the professionals:

"They were incredibly nice ... it shouldn't be too soppy and I can be a silly billy, too, but they know where to draw the line ... they were good at that in the hospital".

To overcome the first hurdle of getting out of bed and move around directly after the operation was one milestone. For some, actually overcoming the dilemma between their inner signs and the demands of the regimen was associated with a surprise feeling of being stronger than expected. That gave them a sense of success. The professionals could promote this success by creating a situation in which the patients felt supported and cared for.

When they came and said I was to get out of bed, I thought, my goodness, I don't dare, but it really went very well. They showed me how to lie on my side and then roll over. It really was very easy ... and not unpleasant at all.

The regimen norm of being self-supporting during hospitalization and accordingly expecting the patient to manage personal hygiene and fetch their own meals could give the patients a feeling that part of the regimen was working against them. Even though the patients were physically able to fetch their meals, some experienced this part of the regimen as being alone in a struggle. Simply to fetch a meal required a lot of effort, the smell of food increased nausea, and a fear of throwing up again. Complying with these seemingly minor activities could feel like climbing mountains and involved a tension between I can—I cannot.

"As soon as the meal trolley arrives and you can smell the food ... it is overwhelming. You get it up to here ... sometimes I stood in the corridor and thought to myself, I can't do this".

Especially postoperative nausea could rob the patients of all initiative and leave them with a feeling of coming to the end of their resources.

"The nausea completely incapacitates you. You have no inclination to eat and they tell you that you must eat and ... and it makes you immobile, the nausea".

Even though the regimen norm of being self-supportive had a negative influence on their well-being the patients did not necessarily request help from the professionals.

The tension between giving in to one's preferences, versus the double pressure of the professionals' expectations and one's own expectations, implied that the patients felt strong when they lived up to the expectations and weak when they did not.

Getting professional support

The obstacles that the patients could experience during hospitalisation posed a threat to their courage and will. Being in a situation characterized by the demands of the regimen and one's own ability to mobilize the necessary resources to live up to the regimen was difficult to manage and lead to resignation for some patients. Therefore, one-to-one contacts with and support from the staff were decisive factors. Some perceived the relationship with the professionals very differently at the time of the preoperative interview and during their hospitalisation, and felt that they moved from being the centre of attention to being one of many. This transformation from closeness to distance had an impact on the dialogue between the professionals and the patients. It became sporadic after the first mobilization and left some patients with a feeling of being on their own.

"Before (emphasis), you feel that you are the only one ... and then, when you get up there, there is a whole lot of people, coming and going ... and you really are only a little fish".

The patients worried about deviating from the norms of the fast-track programme and focused on whether they lived up to the norms. They used any feedback from the professionals as indicators. Accordingly, the patients were aware of and interpreted explicit as well as implicit responses from the professionals. For example, a patient described

how she suppressed her pain and coped by herself, because she felt that if the staff did not offer her help, then they were implying that she herself must take on the responsibility for her mobilization.

It was difficult to sit up, after lying down ... oh dear, that was difficult and I thought, they could at least help me get up, but they didn't ... I thought, if they won't help, then you'll just have to do it yourself, but I could have used a little help.

The patients saw positive feedback as an appreciation of their efforts and confirmation that they were fully compliant with the expectations to participate actively. This positive feedback was significant for the patients to increase their energy to engage in the regimen. A humorous tone was helpful.

Then she comes along and gives you a pat on the back and says, 'very good, you take a couple of more rounds'. So you say to yourself, well, I'll just take a couple of more rounds. It really helps ... that you aren't just a pin on the wall. That they are keeping an eye on you.

Feedback from the staff could also be experienced as authoritarian or top-down, and without instigation of a positive relationship. This kind of response increased the asymmetric power relationship between patient and professional and created more distance. The patient was spoken to, but not spoken with.

There was a nurse who said that she hadn't seen me out in the corridor, haven't you been doing your rounds (said in a strict voice), and then I thought, well, well, you better get going then, up and down the corridor.

The staff could also respond in a more cooperative way by involving and working together with the patient. This kind of intervention was experienced as positive and supportive.

The way they do it, you know, you feel as though you are part of it ... they come in and say that it is time for your bath. No, no, I have just gone to bed. 'OK then, I'll be back in 20 minutes, and then I won't take any nonsense' (laughing) ... but it was as though we made a deal.

Discomfort, feelings of weakness and loss of control could exacerbate each other and bring the patient in a state of resignation and inactivity, which was difficult to break away from. A positive relationship with the staff could function as a catalyst to leave this passivity behind. A patient described a

positive relationship where his discomfort was acknowledged and enabled him to break the negative pattern that his was stuck in.

I felt really sick ... and when I talked to anybody, the tears just ran down my face // the next evening, there was a nurse ... he took the time, stroked my hand ... and used words I would use. He managed to get me to the living room, and then he said, 'would you like some hot broccoli soup?'. I thought, well, why not, and there is something about broccoli being able to prevent cancer ... so I thought, well, I'll give it a try and then I snapped out of it.

While some patients appeared to be capable of participating in the daily regimen, the professionals' supportive behaviour was a decisive factor that led to patients' recovering according to the objectives of the regime. The existential insecurity caused by the disease was lurking in the background, all the time ready to surface and fill the patient with a negative sentiment. A humorous tone could help push away these thoughts. However, the patients experienced that there was no invitation to dialogue about their suffering, although they experienced this part as difficult to manage and requiring a lot of effort.

Feeling safe

It took courage from the patients to ignore their body's signs and have complete trust in the professional assurances that their body would not be overworked by following the regimen. In addition, the patients wanted to reciprocate the professionals' confidence in them, by being prepared to overcome obstacles that may transpire. Professional knowledge and understanding were supportive aspects and strengthened the patients' ability to mobilize their energy, minimize fear and increase trust. "If they believe in you, then you can as well". This trust, however, was challenged if the patient experienced misgivings in the professionals' competence. Professionals' apparent lack of knowledge regarding technical equipment or feeling forgotten despite problems when urinating caused insecurity and planted seeds of feeling unsafe in the patients. Nevertheless, the patients upheld their confidence in the professionals by making excuses for them and explaining away incidents that they first saw as mistakes. The trust in the professionals was also challenged if the patients experienced inconsistency between their own assessment and the professionals' assessment. For example, if the patient did not feel ready for discharge and the patient was not involved in making the decision.

When the consultant said ... Mr X can be discharged this afternoon, then I thought, the man is mad. I wasn't feeling well at all ... before the operation I weighed 70 kg and that day I weighed 76 kg. My bowels were full of fluid and it was pressing and pressing ... the doctor said, that my stomach was rumbling as it should. But I felt terrible.

Discharge was also associated with trusting the professionals' assessment that they would be able to cope with the situation at home, "If they say, I am well enough to be discharged, then of course, I want to go home. If all was not as it should be, they would have kept me".

It was crucial to all the patients to regain their usual bodily functions. These were seen as signs of gradual recovery and promoted a feeling of security. To participate actively in meeting the appointed goals was seen as a guide to return to a normal bodily state. Improvements boosted the patients' optimism and belief in the regimen, while discomfort created insecurity. The reestablishment of the digestive system became a tangible symbol that the operation was a success. However, for some patients the re-establishment of the digestion was associated with increased pain and discomfort, which then caused unrest and insecurity and their trust in the professionals, could be undermined. All the patient's attention and energy were directed toward getting the bowels moving again.

And I had been up all night ... out to the lavatory and up and down the corridor ... I just could not find rest anywhere. I was so tense ... if your bowels don't move and you can't get rid of the wind ... you wonder whether your bowels can manage this.

The re-establishment of the digestion was a milestone and it contributed significantly to the patients' well-being. Their focus was redirected from this particular body function and toward life itself. Regaining these basic bodily functions was crucial for the patients because they were very aware that soon they had to cope on their own after discharge.

Discussion

This study provides an understanding of the structure of the lived experience of participating in a fast-track programme during hospitalisation as described by patients having undergone colonic surgery. The findings demonstrate that it is a challenge for the patients to succeed in the overall goal of recovering both fast and well according to the evidence-based and predefined objectives for activity.

Participation in a fast-track programme involves facing dilemmas and generating personal strength. While some patients in our study appeared to cope with the daily regimen, they all experienced times of struggle in which support from the professionals was crucial. The patients were in a vulnerable situation marked by uncertainty about surviving both the surgery and cancer. They clearly had a strong desire to regain their health and well-being by taking on the regimen unconditionally and by being active participants. This role of being a good and cooperative patient was dominant and underlined the asymmetric power relationship between patient and professionals. This could cause distance and lack of communication that influenced the patients' well-being.

In recent years, patients' move from a more passive role to being active participants in their care has developed into an accepted ideal in health care internationally. Several studies on patient participation show that it is a highly complex concept with many different aspects, and a concept that is still developing (Cahill, 1996, 1998; Sahlsten, Larsson, Sjostrom, Lindenkrona & Plos, 2007; Sahlsten, Larsson, Sjostrom & Plos, 2008). Empirical research into patient participation demonstrates that it is a challenge for both professionals and patients, and that patients are not always successfully involved (Sahlsten, Larsson, Plos & Lindenkrona, 2005; Florin, Ehrenberg & Ehnfors, 2006; Eldh, Ekman & Ehnfors, 2006). Increasing patients' motivation to improve their condition using standardized plans has built-in problems such as conflicting values between patients and nurses (Eldh, Ehnfors & Ekman, 2006) and differences in their understanding of what participation entails (Gallant, Beaulieu & Carnevale, 2002; Henderson, 2003). Patients are encouraged to participate in decisions although the decisions have often already been made (Efraimsson, Sandman, Hyden & Rasmussen, 2004). What we also found in our study is that not all patients feel comfortable adopting an active role and nurses might overestimate the patients' perspective and preferences in assuming an active role in clinical nursing practice (Florin et al., 2006). Cahill's (1998) call for professional re-socialization and patient re-education about this new role still has to be addressed in more depth.

Generally, our findings support existing knowledge of patient participation and illustrate how challenges and obstacles exist in fast-track programmes. The study points to a latent conflict because the patients are met with specific expectations about being active and responsible participants and at the same time presented with predefined and specific objectives for their engagement in the recovery process. Patients' active involvement in their care

requires a shift of power and control, thus bringing the patients' autonomy in the foreground. In a fast-track programme this dilemma between fixed rules and patient autonomy seems to be inescapable, but it can be acknowledged and explored further. Our analysis revealed a fine line between convincing and persuading. Based on a trusting relationship, the patients could be convinced about their own ability by being invited to dialogue and cooperation by the professionals. Similarly, the professionals seemed to be able to function temporarily as a substitute for the patients' will and energy in ways that would acknowledge the patients' individual efforts. Studies show that although professionals may talk of patient participation or empowerment they often act according to a traditional biomedical model in which they are the ultimate decision makers (Paterson, 2001; Powers, 2003; Brown, McWilliam & Ward-Griffin, 2006). This was also the case in our study and appeared to determine why some patients felt that they struggled alone.

A fast-track programme has a potential risk that the responsibility expected of the patients may develop beyond the intentions of the daily regimen. The patients would very literally do as told and feel completely responsible for the success of the regimen. They tried to fit in with what was expected of them or what they thought was expected of them. This role of being a good and cooperative patient is also identified by Henderson (2002) and Penney and Wellard (2007). It is emphasized in patient participation research that surrendering power to the patients is a main issue to succeed in patients' involvement in care (Gallant, Beaulieu & Carnevale, 2002; Henderson, 2003; Sahlsten et al., 2005). The complexity of the good patient role, the concomitant power asymmetry as well as a dominating medical perspective in fast-track programmes make a shift of power very challenging for both patients and professionals.

Power asymmetry holds major ethical aspects that have to be recognized in fast-track programmes. According to the Danish moral philosopher Løgstrup it is impossible to avoid having power over the person with whom we associate. It is a fact of life and we are always in advance compelled to decide whether to use our power over the other person for serving him or her, or for serving ourselves (Løgstrup, 1997/1956). To exercise power in a positive and ethically defensible way, power needs to be a part of but second to the case. If power is detached from the case it becomes power only for the sake of power, and this power is unlimited and oppressive. If power is bounded to a case it is not random but positive. Therefore, power should not be eliminated but bridled (Løgstrup, 1993/1972). Our findings suggest that the case was reduced to

disease and treatment, which for the patients was only a part of the case. For the patients the other part of the case was their experience of being ill and the situation this brought along. Lack of clarification of the case involves a risk that the power is not bridled but stays in the hands of the professionals.

Dahlberg, Todres and Galvin (2008) argue that change of power is a more fundamental challenge which requires that the professionals direct their attention to the patients' lifeworld and their existential issues. This includes an existential partnership that acknowledges differential levels of expertise and understanding between patient and professionals (Dahlberg et al., 2008). Similarly, Schoot, Proot, Meulen and Witte (2005) argue that the patients are strengthened through recognition of client values which implies that the patients regard themselves in an equal position to the professionals and as an interdependent partner in care. The intention of involving the patients as active partners in their recovery process is an important and positive characteristic of fast-track programmes. However, patient participation in the process of care and treatment is complex and intertwined with visible and invisible power structures and requires more attention. More knowledge of how patients themselves understand the role of shared responsibility is needed. Our study suggests that the good patient role is a condition in fast-track programmes but also that there is room for improvement.

Conclusion

The analysis makes evident a strong desire to be a good and cooperative patient who complies with the expectations of the professionals. This very role underlines the asymmetric power relationship between the professionals and the patients.

Our findings illuminate some of the complexities of this relationship that exists in fast-track programmes. In particular the complexities seem to be related to the professionals' general lack of focus into the patient world, i.e. their individual lifeworld. The wish for patient participation in the care, which is an aim from both parties, is undermined by the professionals' lack of insight into the insecurity and vulnerability of the ill patient. Contextual factors like the regimen itself and hospital norms in general must be more sensitive to the patient lifeworld in order for the fast-track programme to be efficient.

Although patient participation in care is an accepted ideal, it is also a challenging enterprise. The study shows that patients can contribute considerably to the quality of fast-track initiatives that both patients and professionals see as valuable. More research is needed into planning, implementation

and evaluation processes of fast-track programmes with special attention toward the experiences of both patients and professionals.

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