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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

LIVED EXPERIENCE AFTER SURGERY AMONG HISPANIC ADULTS

by

Kimberly Sanchez

A dissertation presented to the

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UNIVERSITY OF SAN DIEGO

In partial fulfillment of the

requirements for the degree

DOCTOR OF PHILOSOPHY IN NURSING

May 2019

Dissertation Committee

Dr. Jane M. Georges, PhD, RN, Chairperson

Dr. Ann M. Mayo, DNSc, RN, FAAN

Dr. Kathleen Stacy, PhD, RN

UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

CANDIDATE'S

NAME: Kimberly Sanchez

TITLE OF

DISSERTATION: Lived Experience after Surgery
among Hispanic Adults

DISSERTATION

COMMITTEE:

Dr. Jane M. Georges, PhD, RN
Chairperson

Dr. Ann M. Mayo, DNSc, RN, FAAN
Committee Member

Dr. Kathleen Stacy, PhD, RN
Committee Member

Abstract

Background: In 2010, more than 51.4 million procedures were performed in hospitals in the United States. Almost half of all patients had a surgical procedure prior to their hospital discharge and over 80% of patients experienced acute pain after surgery. When acute pain persists for two or more months after surgery, chronic pain develops, costing the United States up to \$635 billion annually. Hispanics, in particular, disproportionately experience disparities in pain treatment as they are less likely to receive analgesics. Routine pain assessments conducted using instruments may be inaccurately capturing the pain experience of Hispanic adults. No research has revealed the essence of the experience after surgery among hospitalized, Hispanic adults.

Purpose: To describe the lived experience after surgery among Hispanics adults.

Methods: This qualitative study followed a descriptive phenomenological approach. Hispanic adults, who experienced and communicated pain after surgery, were interviewed while hospitalized at an academic medical center in Southern California. Purposive, criterion sampling continued until data saturation was reached. In-person, semi-structured interviews were digitally recorded and transcribed. Then, a descriptive identification of the lived experience was formulated following Colaizzi's procedural steps for analyzing phenomenological data. The 10 participants, of whom five were female, were aged 23 to 83 years. Six participants were interviewed in Spanish and all interviews occurred 1 to 15 days from the most recent inpatient surgery.

Findings: Five clusters of themes emerged and represented the fundamental structure of the phenomenon: (a) uniquely distressing and individually defined, (b) conflicting emotional, psychological, and spiritual needs, (c) extreme vulnerability and reliance on

others, (d) underlying inequality in knowing and being, and (e) awareness of mortality. A descriptive identification of the phenomenon was formulated from the themes and revealed the meaning and essence of the lived experience after surgery among Hispanic adults.

Conclusion: The lived experience after surgery among Hispanic adults exposes a dichotomy between recipients and providers of care within hospitals that must be addressed to promote compassion and alleviate suffering. Within the narrow context of acute pain after surgery, further research is needed to modify existing or develop new instruments used for routine pain assessments in order to improve subsequent treatment.

Dedication

To my Mother and Father

Dedicataria:

Para mi Ma y mi Pa

Gracias a ustedes he aprendido que con esfuerzo y dedicación la lucha para seguir adelante y hacer los sueños realidad es posible. Al terminar otra etapa de mi vida y conseguir uno más de mis sueños, reconozco que en mucho se debe al apoyo y consejos que constantemente durante mi vida me han dado. Es muy importante reconocer todos sus sacrificios y su amor, para que nunca nada nos hiciera falta, no importando lo mucho o poco que tenían, y así poder lograr las metas que nos hemos trazado. Pero lo que sí es importante recalzar, es el inmenso amor que nos dan. Otras cosas importantes que recibimos de ustedes son apoyo y animo incondicionales que solo se da en la manera única de La Ene y El Pepón. Sé que ustedes como padres no esperan un reconocimiento, no está en su naturaleza ser así, pero quiero hacer patente por sobre todas las cosas que ustedes sepan que los amo y los admiro. Estoy orgullosa de ser su hija, tener unos padres bondadosos y con una fuerza de voluntad tan férrea a prueba de todo y que no se doblegan ante nada y nadie. Les agradeceré por siempre todo, todito - desde el cafecito en la mañana, hasta los aventones a cualquier hora de la noche, hasta la mera madrugada. Solo me resta decir que no hay palabras suficientes para mostrar todo el inmenso amor y el profundo agradecimiento que siento por ustedes...

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CHAPTER 1

INTRODUCTION

Procedures performed in hospitals across the United States have steadily increased with more than 51.4 million procedures performed in 2010 (Centers for Disease Control and Prevention [CDC], 2015b). Almost half of all patients had a surgical procedure prior to being discharged from a hospital (CDC, 2015b). Acute pain after surgery affects over 80% of patients (Gan, Habib, Miller, White & Apfelbaum, 2014). When acute pain persists for two or more months after surgery, chronic pain develops (Chapman & Vierck, 2017), costing the United States up to \$635 billion annually (Institute of Medicine, 2011). Common pain assessment methods may be inappropriate without consideration of ethnicity and culture and may be inaccurately guiding pain treatment as a result (Aziato & Adejumo, 2015; Callister, 2003; Cassisi et al., 2004; Lovering, 2006; Melzack & Torgerson, 1971; Villarruel & Ortiz de Montellano, 1992; Waddie, 1996).

Hispanics, in particular, disproportionately experience disparities in pain treatment as they are less likely to receive analgesics (Shavers, Bakos, & Sheppard, 2010). Additionally, Hispanics are more likely to wait longer for analgesics in hospitals and receive inadequate analgesic dosing (Shavers et al., 2010). This study described the lived experience after surgery among Hispanic adults. This chapter provides an overview of the study. First, the background and significance of assessing pain among Hispanics is described. Following the background and significance, a clear problem statement is identified. Next, the study purpose and line of inquiry are presented. After the purpose and line of inquiry, an overview of the sensitizing framework of the study is discussed.

Then, the research question is provided and the plan of inquiry is substantiated. The chapter concludes with the researcher's philosophical assumptions.

Background and Significance

National attention on pain practices by professional organizations has reignited an interest in pain assessment and treatment. The focus on performing pain assessments can be traced back to the late 1990s when pain as the fifth vital sign was introduced by the American Pain Society, equating the importance of assessing pain to assessing vital signs (Campbell, 1996). Then, in the early 2000s, The Joint Commission (TJC) published its pain standards listing assessment and treatment of pain as a right for all patients (The Joint Commission, 2001). Almost a decade later, TJC modified its pain standards by (1) narrowing the scope of patients to be assessed and (2) redirecting attention to nonpharmacologic interventions for pain treatment (Baker, 2017). Now, TJC has again revisited its pain assessment and treatment standards to prioritize pain assessments, monitor opioid prescribing for safety, and minimize treatment-associated risks (The Joint Commission, 2017). These pain standard revisions by TJC coincide with new recommendations for opioid prescribing practices implemented to address the widespread national overuse of opioids (Dowell, Haegerich, & Chou, 2016; Washington State Agency Medical Directors' Group, 2015). Collectively, positions held by and standards of professional organizations and accrediting agencies, along with an increase in opioid use, have refocused attention on pain assessment and treatment practices.

Pain is uniquely experienced and described by individuals (Callister, 2003; Lovering, 2006; Radnovich et al., 2014; Villarruel & Ortiz de Montellano, 1992). Comprehensive, multidimensional pain assessments are needed to (1) capture the

complex and subjective phenomena of pain (McGuire, 1992; Melzack & Katz, 2013; Radnovich et al., 2014) and (2) assist providers in treating the type of pain experienced by the individual (Bible, 2006; Dowell et al., 2016; Radnovich et al., 2014; Washington State Agency Medical Directors' Group, 2015). Pain assessments, inclusive of multidimensional categories and individual-specific components, are dependent on an individual's desire and ability to inform others of the pain being experienced (Waddie, 1996). Individual pain experiences and expressions may be influenced by culture or belief systems (Aziato & Adejumo, 2015; Callister, 2003; Calvillo & Flaskerud, 1993; Juarez, Ferrell, & Borneman, 1998; Lovering, 2006; Sherwood, McNeill, Palos, & Starck, 2003), language, education, knowledge (Waddie, 1996), age (Wilkie et al., 1990), and gender (Aziato & Adejumo, 2015). When pain experiences are described, a lack of communication ability increases the risk for communication-related adverse events, including inadequate assessments of a condition, as noted with Spanish-speaking populations with limited English proficiency when compared to English-speaking populations (Divi, Koss, Schmaltz, & Loeb, 2007; McDonald, Ambrose, & Morey, 2015). Hispanics, many of whom may be Spanish-speaking, are a group of individuals with unique pain experiences (Callister, 2003; Juarez et al., 1998; Ryan, 2013; Sherwood et al., 2003).

The Hispanic population in the United States is growing and accounts for about 16% of the total population (Ennis, Rios-Vargas, & Albert, 2011). Of the three most populated counties in Southern California, Los Angeles County has the highest percentage of individuals of Hispanic origin, reaching almost 50% (United States Census Bureau, 2018). Hispanics are increasing their utilization of healthcare services with this

growth in population and, as a result, their interaction with healthcare providers has also increased (CDC, 2015a). Despite increased interactions with healthcare providers, Hispanics experience disparities in pain treatment (Shavers et al., 2010; Starck, Sherwood, Adams-McNeill, & Thomas, 2001). Hispanics experience unrelieved pain from incorrect analgesic selection, delayed analgesic administration, and inadequate analgesic dosing (Shavers et al., 2010), increasing their risk for persistent pain for two or more months after surgery (Chapman & Vierck, 2017; Schug & Bruce, 2017). Currently, persistent pain after surgery is experienced by up to 85% of individuals, not specific to Hispanic adults, (Schug & Bruce, 2017) and is part of the \$635 billion spent annually by the United States on chronic pain. A better understanding of the health-related experiences of Hispanic adults is needed to improve pain assessments, address disparities in pain treatment, and prevent the development of persistent pain.

Problem Statement

Routine pain assessments conducted using instruments may be inaccurately capturing the experience after surgery by Hispanic adults, as population-specific instruments have not been developed for this group (Cassisi et al., 2004; Melzack & Torgerson, 1971; Waddie, 1996). The first step toward developing a culturally appropriate assessment of Hispanic adults is to gain an understanding of the essence of their experience after surgery. No research has explored the experience of this population while hospitalized after surgery.

Purpose and Line of Inquiry

The purpose of this phenomenological study was to describe the lived experience after surgery among Hispanic adults. The line of inquiry for the study revealed more fully the meaning and essence of the experience.

Sensitizing Framework

Current pain theories and pain communication models illustrate the multidimensionality of pain, providing a sensitizing framework for the study. Pain theories have evolved over the years as more has been learned about the physiological, psychological, and social aspects of pain (Melzack & Katz, 2013). Initially, pain transmission was explained by a rudimentary linear pathway (Melzack & Katz, 2013). With further research, pain was identified as a complex process involving the brain as a processing center of painful stimuli being regulated by a gating mechanism (Melzack & Katz, 2013). The latest pain theory, the Neuromatrix Theory, attempts to explain the brain's involvement in pain as a receiver and originator of the pain experience (Melzack & Katz, 2013). The Neuromatrix Theory on pain includes sensory, motivational, and cognitive dimensions to explain the subjective nature of the pain experience. The Social Communication Model of Pain builds on known biological and psychological factors of pain, as explained by the Neuromatrix Theory, and incorporates social factors of pain, including culture, to depict a more comprehensive approach to the pain experience (Craig, 2009). The Neuromatrix Theory and the Social Communication Model of Pain are rooted in the notion that pain is multidimensional and requires evaluation in each of the dimensions.

Research Question

How do English-, Spanish-, and bilingual-speaking Hispanic adults describe their experience after surgery?

Plan of Inquiry

The qualitative study followed Husserl's phenomenological approach to describe the lived experience after surgery among Hispanic adults. A descriptive phenomenological approach allowed for insight into the wholeness of the human experience by those who directly experienced the phenomena of interest (Moustakas, 1994). In this study, the experience after surgery was the phenomenon of interest. A careful and accurate description of the acute pain experience after surgery was warranted for two reasons. First, Hispanic adults experience disparities in pain treatment (Shavers et al., 2010). Second, pain dimensions, including pain quality, have been explored with inconsistencies, focusing on what is said and rated by individuals as a proxy for what is experienced (Gélinas, Gillion, Puntillo, Viens, & Fortier, 2006; Jensen, Gammaitoni et al., 2006; Melzack, 1975; Puntillo & Neighbor, 1997). The experience while hospitalized after surgery among English-, Spanish-, and bilingual-speaking Hispanic adults was unexplored. As a result, a qualitative approach that encouraged participants to divulge their experiential knowledge and understanding through interviews was needed to address this knowledge gap regarding assessments after surgery (Moustakas, 1994). In descriptive phenomenological research, interview transcripts are one source of data for analysis when exploring a phenomenon (Colaizzi, 1978). The outcome of descriptive phenomenological research is a descriptive identification of the fundamental structure of the phenomenon formulated from within the transcripts (Colaizzi, 1978). A descriptive

phenomenological approach was chosen and revealed the meaning and essence of the experience after surgery among Hispanic adults.

Philosophical Assumptions

My philosophical assumptions are rooted in social constructivism perspectives, looking at individual experiences shaped by the social, historical, and cultural contexts in which those experiences occur (Creswell, 2013). My interest in pursuing this qualitative study are linked to my personal and professional background as a Hispanic woman who worked as a direct care nurse and is now working as an adult-gerontology clinical nurse specialist.

In social constructivism, reality is formed from lived experiences (Creswell, 2013). My ontological assumption is that care provided for individuals or groups in hospitals is limited without an understanding of the complex realities of those receiving care, yet there is an expectation for providers to care for individuals or groups without truly knowing these realities. I have spent the majority of my time providing direct care for patients in a surgical intensive care unit. The subjective nature of pain learned in my undergraduate program was reinforced in the predominantly surgical hospital where I cared for a diverse patient population in Los Angeles. Routinely, I asked patients about their pain intensity and proceeded to ask about pain quality. In a fast-paced surgical unit, when patients did not describe their pain in physiological ‘textbook’ terms (e.g., sharp, dull, ache, pressure, etc.) I had learned in school, I would prompt them by asking, “Is it sharp? Is it dull? Does it ache? Or how would you say it feels?”. I did this because, many times, their descriptions were not options in the documentation system. After

experiencing this several times, I began to think there may be a disconnect between what is learned in school and what is experienced in practice, particularly with pain.

Reality is known through inquiry and interactions with individuals or groups in social constructivism (Creswell, 2013). My epistemological assumption is that these complex realities are only known to others because they are shared by individuals experiencing those realities. I learned the value of being a proficient communicator as a child because my Spanish-speaking parents needed someone to facilitate the exchange of information between them and others. Both my parents began to speak some English three years after their arrival in the United States from their respective countries. My parents' limited English proficiency left them to rely on gestures, a few common words, or others to communicate. Even after being in the United States for over 40 years, my parents prefer to communicate in Spanish, influencing what they share and how they interact with others.

My personal and professional backgrounds collided a few years ago when I learned my bilingual-speaking cousin suffered a life-threatening condition, resulting in his death. He did not communicate his pain using trigger or 'textbook' words indicative of the cardinal signs of a heart attack and was not triaged in a timely manner. By the time he was seen and treated, it was too late, and he died on the procedure table. I am left wondering if the outcome would have been different had he communicated his pain another way, had he someone to communicate his needs in ways a provider could understand, or had the providers known he was communicating symptoms of a heart attack using communication methods common for his culture. As a result of these experiences, my ontological and epistemological assumptions shape my methodological

belief of describing the lived experience of individuals or groups by relying on information directly from those who experience the reality.

Summary

Improving pain assessments after surgery may prevent the development of persistent pain and reduce the annual expenditure on chronic pain, but the experience after surgery among Hispanic adults needs to be explored first. The study was timely as procedures performed were increasing steadily and focus on pain practices increased recently (CDC, 2015b). Additionally, the experience among Hispanic adults was important as this population experienced disparities in pain treatment (Shavers et al., 2010) and accounted for an increasing percentage of the nation's census (Ennis et al., 2011). The problem statement, purpose, and line of inquiry were clearly identified and presented. The sensitizing framework of the study was discussed and the study was informed by pain theories supporting the multidimensionality of an individual's pain experience (Melzack & Katz, 2013). Then, the research question was provided and the rationale for following a phenomenological approach was explained. Lastly, the researcher's philosophical assumptions were presented.

CHAPTER 2

REVIEW OF LITERATURE

Acute pain is known to affect over 80% of patients after surgery (Gan et al., 2014) and a review of pain assessments provides the context for one aspect of the lived experience after surgery. The American Pain Society has identified three goals of pain assessments, to: (1) capture and trend an individual's pain, (2) guide treatment decisions, and (3) evaluate the effectiveness of treatments (Shavers et al., 2010). These three goals of pain assessments may be influenced by culture and language as well as the instruments used to assess pain.

This chapter begins with an overview of current pain theories and pain communication models to illustrate the multidimensionality of pain, providing a sensitizing framework for the study. Next, the influence of culture on pain assessments is described. The chapter concludes with a review of pain assessments including the measurement of pain intensity and pain quality.

Sensitizing Framework

Neuromatrix Theory

Previous pain theories including specificity, summation, sensory interaction, and gate control contributed to the development of the Neuromatrix Theory on pain (Melzack & Katz, 2013). Prior to the Neuromatrix Theory, earlier theories focused on the transmission of the painful stimuli from the periphery to the brain through an established pathway (Melzack & Katz, 2013). These theoretical explanations of pain experiences were narrowly associating pain with peripheral injury, then more broadly linking pain to physiological activity in the spinal cord, and finally including the brain as a processing

center, not simply a passive receiver of painful stimuli (Melzack & Katz, 2013). The Neuromatrix Theory, building on these aforementioned theories, explains pain experiences as a function of sensory, motivational, and cognitive dimensions in the brain (Melzack & Katz, 2013). This theory emphasizes the sensory, motivational, and cognitive contributors to pain, not simply the transmission of pain (Melzack & Katz, 2013). This evolution of pain theories has moved the concept of pain from a sensation to an experience (Melzack & Katz, 2013).

Unlike initial theories, the Neuromatrix Theory attempts to explain the multidimensionality of pain (Melzack & Katz, 2013). It supports that individual brain processes create what is known as quality descriptors for the evaluation of one's pain experience (Melzack & Katz, 2013). Pain, then, is no longer merely the presence or extent of physical injury (Melzack & Katz, 2013). Therefore, the complexity of pain, evident from these evolving pain theories, requires comprehensive, multidimensional assessments (McGuire, 1992; Melzack & Katz, 2013).

Social Communication Model of Pain

Social factors influencing the pain experience are lacking in theories focusing solely on the biological and psychological features of pain (Craig, 2009). The Social Communication Model of Pain incorporates social, biological, and psychological factors on pain to explain the continuum from noxious stimuli, pain experience, pain expression, pain assessment, and pain management (Craig, 2009). In addition, this model of pain depicts the relationship between an individual in pain and a person other than the individual in pain, also called the observer (Craig, 2009). In the model, social, biological, and psychological factors are divided into intra- and interpersonal influences on both the

individual in pain and the observer, beginning once an actual or perceived trauma occurs. This model includes culture as an interpersonal influencer of pain and has been subsequently adapted to include influences specific to Hispanic Americans such as acculturation, cultural stigma, and access to translators (Hollingshead, Ashburn-Nardo, Stewart, & Hirsh, 2016). The biological and psychological factors influencing the pain experience are similar to the sensory, motivational, and cognitive contributors to pain in the Neuromatrix Theory. However, the Social Communication Model of Pain depicts a more comprehensive approach to the pain experience by incorporating social factors as influencers to already known biological and psychological factors on pain. (Craig, 2009).

The Neuromatrix Theory and Social Communication Model of Pain are rooted in the notion that pain is multidimensional (Jensen, Dworkin et al., 2006; McGuire, 1992; Melzack & Katz, 2013) and influences one's pain awareness, experience, and response (Melzack & Katz, 2013). More robust pain assessments may result in more appropriate treatment interventions by not disproportionately emphasizing a single dimension of the pain experience (Bible, 2006; McGuire, 1992; Radnovich et al., 2014; Waddie, 1996). Currently, treatment is reliant on assessments with a unidimensional focus despite literature supporting pain communication practices are influenced by several factors like an individual's culture and language (Aziato & Adejumo, 2015; Callister, 2003; Calvillo & Flaskerud, 1993; Craig, 2009; Hollingshead et al., 2016; Juarez et al., 1998; Lovering, 2006; Melzack & Torgerson, 1971; Sherwood et al., 2003; Waddie, 1996). Several studies have described the pain experience with descriptors using actual words (Melzack, 1975, Sherwood et al., 2003), behaviors (Gélinas et al., 2006), numeric or verbal intensity scales (Puntillo & Neighbor, 1997), or words with numeric intensity scales (Jensen,

Gammaitoni et al., 2006). Current pain theories and pain communication models support the complexity of the pain experience and the meaning of pain may influence the entire experience after surgery as a vast majority of patients report pain after surgery (Gan et al., 2014). Therefore, current pain theories and pain communication models provide a sensitizing framework for describing the lived experience after surgery among Hispanic adults.

Culture

Pain is a subjective experience and culture impacts an individual's pain experience and pain expression (Aziato & Adejumo, 2015; Callister, 2003; Lovering, 2006; Villarruel & Ortiz de Montellano, 1992; Waddie, 1996). For example, cultural traditions may limit verbal and encourage behavioral expressions of pain (Aziato & Adejumo, 2015; Lovering, 2006; Villarruel & Ortiz de Montellano, 1992; Waddie, 1996). Even when a pain descriptor or behavior is communicated, variations are noted among different cultures (Callister, 2003) and within the same culture (Lazaro et al., 2001), yet assessments of pain descriptors are routinely performed.

Certain pain behaviors may be more commonly accepted by a culture (Villarruel & Ortiz de Montellano, 1992) and may be more frequently expressed by the culture (Aziato & Adejumo, 2015). The relationship between pain and culture warrants consideration when performing pain assessments as certain ethnic groups may respond differently to standardized pain instruments of intensity and quality (Cassisi et al., 2004). When performing pain assessments, cultural considerations continue to be a gap in current healthcare practice.

Characteristics specific to a culture require evaluation when assessing pain (Radnovich et al., 2014). Language, in particular, may influence an individual's preference for the type of instruments used to assess pain (Puntillo & Neighbor, 1997). For example, Spanish-speaking patients may prefer pain intensity instruments with word components instead of pain intensity instruments composed solely of numeric values (Puntillo & Neighbor, 1997). When assessing pain quality, verbal descriptors communicated by individuals may differ between cultures with different languages or forms of expression (Cassisi et al., 2004). The pain experience needs to be captured with consideration of the influence of culture and language to ensure accurate assessments and optimal treatment of pain (Radnovich et al., 2014).

Pain Assessment Measurement Instruments

Pain assessment measurement instruments have not been developed from the unique cultural and language characteristics of the Hispanic population; rather, adaptations of already established instruments are used to assess pain in this group (Costa, Maher, McAuley, & Costa, 2009). Pain assessments need to account for population-specific characteristics and include multidimensional aspects of pain because they will be used to guide treatment decisions by healthcare providers (Bible, 2006; Radnovich et al., 2014). For this reason, instruments used to assess unique dimensions of pain and capture accurate assessments of pain need to be reliable and generate valid data from the specific population assessed (Costa et al., 2009). Without appropriate validity testing after adaptations of instruments to various populations are made, these instruments may have undetermined value or unknown meaningfulness of the data produced (Costa et al., 2009). For example, pain quality descriptors used in one

instrument may have a different meaning when used with different populations (Radnovich et al., 2014). Assessment methods may not be truly representative or signifying of the pain experienced, as there is widespread focus on what is rated and said by individuals as a proxy for what is experienced (Bible, 2006; Calvillo & Flaskerud, 1993). Therefore, it is essential to understand the lived experience prior to considering the development of an instrument to determine the appropriateness of quantifying what may not or should not be quantifiable, as may be the case with a truly subjective experience. In particular, when pain assessment measurement instruments are developed, they need to accurately capture the pain experience and have known value and meaning in the intended population in order to truly guide treatments based on valid assessment findings (Costa et al., 2009; McGuire, 1992; Radnovich et al., 2014).

Pain Intensity Measurement Instruments

Pain intensity measurement instruments capture the severity of pain felt. Pain intensity assessments with the numeric rating scale (NRS) have been shown to be clinically preferable over other instruments, including the visual analog scale, the verbal rating scale, and the FACES pain scale-revised (Ferreira-Valente, Pais-Ribeiro, & Jensen, 2011). The NRS is the most sensitive to changes in pain of the four intensity measurement instruments and is easy to administer (Ferreira-Valente et al., 2011). Increased use of unidimensional pain assessment instruments like the NRS forces patients to incorporate other aspects of the pain experience into unidimensional assessments (Williams, Davies, & Chadury, 2000). Because pain is multidimensional, each aspect of the pain experience needs to be individually assessed (McGuire, 1992; Radnovich et al., 2015). Superimposing other dimensions of pain into an assessment can misguide

treatment because (1) each aspect of the pain experience provides different information to healthcare providers about unique pain features (Galer & Jensen, 1997; Radnovich et al., 2014; Waddie, 1996) and (2) treatment guidelines are predicated on the assumption that clinicians are using standardized assessment instruments (Waltz, Strickland, & Lenz, 2017). The amount of pain and the quality of the pain are distinct and need to be assessed independently to inform pain management practices, especially when pain treatment guidelines are being used (Radnovich et al., 2014). There are opportunities to improve acute pain assessments by better understanding the complexity, trajectory, and key dimensions of pain (Radnovich et al., 2014).

Pain Quality Measurement Instruments

Pain quality measurement instruments capture the characteristics of the pain experienced. Instruments assessing pain dimensions other than intensity have not been shown to be feasibly administered clinically considering current time constraints in healthcare (Radnovich et al., 2014). Several instruments were developed to measure pain quality descriptors including the McGill Pain Questionnaire (MPQ), Pain Descriptor System (PDS), Multidimensional Affect and Pain Survey (MAPS), and Pain Quality Assessment Scale (PQAS).

McGill Pain Questionnaire. The MPQ was developed to capture various qualities associated with the pain experience by using words as descriptors (Melzack & Torgerson, 1971). The MPQ contains 20 subclasses of words listed in rank order from least to most intense (Melzack, 1975). The limitation of the MPQ is the unknown variability across populations during the stages of the instrument's development phase. First, the researchers classified the words from previously compiled word lists and

literature relating to pain (Melzack & Torgerson, 1971). Second, college-educated, young adults determined the reliability of the word classifications (Melzack & Torgerson, 1971). Next, the words were ranked based on perceived intensity of the implied pain associated with the word by three groups of participants: (1) upper- and middle-class, young adult physicians; (2) lower-class, lesser educated, English-speaking, Protestant, young adult patients; and (3) college-educated, young adults with varying cultural and socioeconomic backgrounds (Melzack & Torgerson, 1971). Lastly, the completed questionnaire was then used with patients experiencing pain (Melzack, 1975). However, there was no consistency between the populations used to develop the instrument and the *patient* population upon whom the instrument was eventually tested (Melzack, 1975; Melzack & Torgerson, 1971).

The MPQ uses words as descriptors to evaluate several pain dimensions (Melzack & Torgerson, 1971), but those words may not be representative of the words that might be chosen by populations for whom the instrument were intended—patients. Patients only provided input during the stage of instrument development requiring one to rank the perceived intensity of the pain descriptor and not the initial selection of the pain descriptors. No other stages of development included individuals with pain; therefore, the population for whom the instrument was intended was not represented. Additionally, it is unclear whether the words selected for the instrument were communicated by individuals experiencing painful stimuli. The MPQ subclasses may be designed to capture the multidimensionality of pain, but it may not be descriptive of the pain experienced by individuals with the actual noxious stimuli and it may show no sensitivity or specificity across cultures in studies (Calvillo & Flaskerud, 1993).

Pain Descriptor System. The PDS was developed in response to the need to clarify the words and reclassify the word groups in the MPQ (Fernandez, Krusz, & Hall, 2011). The PDS is a 12-category word list ranked from least to most intense (Fernandez et al., 2011) and shares the MPQ's limitations—differences between the populations used during the stages of instrument development and those upon whom the instrument is intended to be used (Fernandez & Towery, 1996). First, college-educated, young adults clarified, reclassified, and ranked the words used in the MPQ (Fernandez & Towery, 1996). Second, the final word list from the initial studies was given to middle-aged adult, chronic pain patients with some college education to classify and rank (Fernandez et al., 2011). Similar to the MPQ development, only one stage of the PDS's development included individuals with pain. The same uncertainty pertaining to the source of the words persists with the PDS because the initial word selection for the PDS originated from the MPQ. Again, the words incorporated into the PDS may not be the expressive language used by a wide range of individuals experiencing painful stimuli.

Multidimensional Affect and Pain Survey. Like the MPQ, the MAPS was developed to expand on the idea that pain is multidimensional and needs to be assessed as such (Clark, Yang, Tsui, Ng, & Clark, 2002). The MAPS comprises 30 subclusters of words, used in sentences, and paired with a 6-point intensity scale (Clark et al., 2002; Yang, Clark, Tsui, Ng, & Clark, 2000). Its limitation is an unclear source for the words selected to be included in the instrument and its advantage is an attempt at generalizability in its use (Clark et al., 2002; Yang et al., 2000). Words used to describe pain and emotions were initially selected and grouped by similarities (Clark et al., 2002; Yang et al., 2000). Similar to the MPQ and PDS, the source of the words chosen for the

MAPS is unclear. Next, college-educated, young adults from Puerto Rican, European-American, and African American backgrounds evaluated the meaning of the words to identify and eliminate those with gender- or ethnic-specific significance (Clark et al., 2002; Yang et al., 2000). An attempt to include gender- or ethnic-neutral words allows for generalizability of the instrument. The MAPS was then used with Cantonese speaking patients with postoperative pain (Clark et al., 2002). The development of the MAPS lacked a distinct selection of words specifically communicated by individuals feeling painful stimuli versus ones used by other individuals, such as clinicians, to describe pain but did attempt generalizability (Clark et al., 2002; Yang et al., 2000).

Pain Quality Assessment Scale. The PQAS was developed to expand the use of the Neuropathic Pain Scale (NPS) to patients with non-neuropathic pain (Jensen, Gammaitoni et al., 2006). The PQAS assesses neuropathic and non-neuropathic pain with its 20-item scale (Jensen, Gammaitoni et al., 2006). The 20-item scale is paired with an 11-point intensity scale (Jensen, Gammaitoni et al., 2006) and shares limitations similar to the other pain quality instruments: a selection of words not determined to be those used specifically by individuals experiencing the type of pain the instrument assesses. The NPS includes words from clinical experiences with patients diagnosed with neuropathic pain (Galer & Jensen, 1997). It is unclear if the words are a provider's interpretation of what was communicated by patients or communicated by patients themselves. Then, in development of the PQAS, words not included in the NPS but commonly identified in patients with and without neuropathy, as well as other pain conditions, were included in the PQAS (Jensen, Gammaitoni et al., 2006). Again, the

words chosen for instrument development may not be those expressed by the individuals on whom the assessment will be performed.

These four pain quality assessment instruments share one commonality: none were developed from the words communicated by individuals, including Hispanics, experiencing the painful stimuli. Rather, the words selected for the instruments' development originated from previously compiled word lists and literature (Melzack & Torgerson, 1971), previous instruments (Fernandez et al., 2011), unclear sources (Yang et al., 2000), or commonly noted clinical experiences with patients (Galer & Jensen, 1997; Jensen, Gammaitoni et al., 2006). Of the four instruments, the MPQ has been adapted for use with different languages and cultures, but many, including the Spanish version, have either no information, unclear design or methods descriptions, or negative ratings when evaluated against defined quality criteria for health status questionnaires (Costa et al., 2009). Additionally, some words on the Spanish version of the MPQ were not applicable or appropriate among certain Hispanic countries (Lazaro et al., 2001). There is an opportunity to shift the focus from what is rated and said by individuals, including Hispanic adults, to what is experienced.

Summary

Current pain theories and models support the multidimensionality of an individual's pain experience (Melzack & Katz, 2013). The subjectivity of one's pain experience requires it be captured in a manner consistent with one's culture (Callister, 2003; Lovering, 2006; Radnovich et al., 2014; Villarruel & Ortiz de Montellano, 1992). Current pain quality instruments are limited in informing others of the pain experiences of the Hispanic population since this population was not involved in the initial instrument

development and testing. No research has explored the experience of English-, Spanish-, or bilingual-speaking Hispanic adults while hospitalized after surgery. Research exploring this understudied phenomenon after surgery among Hispanic adults is needed as a first step toward developing a culturally appropriate pain assessment of Hispanic adults with the content of this chapter providing a contextual basis for the qualitative study.

CHAPTER 3

PLAN OF INQUIRY

The purpose of this descriptive phenomenological study was to describe the lived experience after surgery among Hispanic adults. A descriptive phenomenological approach allowed for insight into the wholeness of the human experience by those who directly experienced the phenomenon of interest (Moustakas, 1994). In this study, the experience after surgery was the phenomenon of interest. Therefore, the study answered the research question, “How do English-, Spanish-, and bilingual-speaking Hispanic adults describe their experience after surgery?”

This chapter explains the plan of inquiry followed to answer the research question. This chapter begins with a description of and rationale for the study approach. Following the approach, the setting for the study is identified. Next, the sample inclusion criteria, exclusion criteria, and recruitment are explained. Detailed methods for data collection and analysis are provided separately. Following data collection and analysis, trustworthiness criteria and protection of human subjects for the study are then presented. The chapter concludes with the researcher’s process for bracketing assumptions.

Methods

Approach

This qualitative study followed a descriptive phenomenological approach, viewed through a social constructivist lens, and described the lived experience after surgery among Hispanic adults. A descriptive phenomenological approach reveals more fully the meaning and essence of an experience (Moustakas, 1994), but assumptions are made and limitations exist when following a phenomenological approach (Polit & Beck, 2016). For

example, participants must have experienced the phenomenon of interest (Polit & Beck, 2016) and they must have been willing and able to communicate their lived experience (Creswell, 2013; Omery, 1983; Polit & Beck, 2016). As a result, the sample selection criteria for the study included these elements.

Additionally, timing of interviews may yield information influenced by external factors (Craig, 2009; Omery, 1983), duration of interviews may not be sufficient to fully understand the participants' experience (Omery, 1983), and location of interviews may influence the participants' comfort with sharing their experience (Creswell, 2013; Omery, 1983). Data collection procedures were developed accordingly to explore the experience with participants while they were still hospitalized to allow participants ample time to convey their experience and to facilitate the conversation between the participant and researcher so the meaning of the experience may be captured and represented during data analysis. These assumptions and limitations of following a phenomenological approach were considered and incorporated into the plan of inquiry.

With the increasing volume of hospital procedures, the vast majority of patients affected by acute pain after surgery, the national attention on pain practices, and the growing Hispanic population, a careful and accurate description of the entire experience after surgery among Hispanic adults was warranted considering the narrow exploration of pain (Gélinas et al., 2006; Jensen, Gammaitoni et al., 2006; Melzack, 1975; Puntillo & Neighbor, 1997; Sherwood et al., 2003) and the disparity in pain treatment among Hispanics (Shavers et al., 2010). A qualitative approach that encouraged participants to express their experiential knowledge and understanding of their experience after surgery through interviews (Moustakas, 1994) may begin to address the knowledge gap regarding

assessments after surgery among Hispanic adults. For this reason, a descriptive phenomenological approach was chosen and revealed the meaning and essence of the experience after surgery among Hispanic adults.

Setting

The study was conducted at an academic medical center in Southern California. The academic medical center is a tertiary hospital and quaternary referral center for Central and Southern California. The site was chosen based on the volume of surgical procedures performed at the hospital, the location of the site in Southern California with its growing Hispanic population, and the researcher's affiliation with the healthcare system.

Sample

Inclusion criteria. Inclusion criteria ensured the sample selected was appropriate for the purpose of the study. For this reason, participants (1) were adults 18 years of age or older, (2) self-identified as Hispanic, (3) were current inpatients hospitalized for greater than 24 hours, (4) had surgery during their hospitalization, (5) experienced acute pain after their surgery, and (6) were able to communicate their pain in English or Spanish. Age and ethnicity criteria were in place to narrow the population to the sample of interest and were verbalized by the participant. An inpatient status of greater than 24 hours was in place to minimize interfering with completion of regulatory admission requirements within those 24 hours and were measured by the admission date and time. Surgical status during hospitalization was measured by the completion of an operative note after the admission date and time. Pain presence was measured by a pain intensity rating greater than 0 out of 10 or other than "no pain" at any point during their

hospitalization. Ability to communicate was measured by use of a self-report pain assessment measurement instrument on the day of the interview.

Exclusion criteria. Participants not meeting the inclusion criteria outlined above were excluded. In phenomenological research, participants must have experienced the phenomenon of interest and must be able to communicate their lived experience (Creswell, 2013; Moustakas, 1994; Polit & Beck, 2016).

Recruitment. Study participants were recruited with purposive, criterion sampling methods. In one year, the selected site had a sampling pool of over 8,000 adults admitted for surgery. The inclusion criteria were used to screen patients for eligibility. Recruitment flyers were distributed to identify interested potential participants (Appendix A). Participants were recruited and enrolled until saturation of themes was accomplished and no new data that generated new themes were found.

Data Collection

Demographic data. Demographic data were obtained verbally by the researcher or from the electronic health record using a 14-item researcher-designed survey (Appendix B). These items included (1) age in years; (2) gender (male or female); (3) country where participant was raised (US, non-US country, or prefer not to answer); (4) country where participant's parents were raised (US, non-US country, unknown, or prefer not to answer); (5) length of time in the US in years; (6) number of years of education completed; (7) preferred spoken language; (8) self-rated percentage of time English and Spanish are spoken; (9) frequency of visits with healthcare providers; (10) occupation; (11) religious preference; (12) type of surgery identified by the surgical

service on the operative note; (13) last documented pain intensity with date and time; and (14) last documented pain medication with dose, route, date, and time.

Semi-structured Interviews. Interviews were conducted in English or Spanish, depending on participant preference. Interview length varied based on the participant's willingness to explore their experience with the researcher, but did not exceed two hours and were conducted in the participant's hospital room. These interviews were recorded with a digital recorder. For standardization at the beginning of the interview and to be a reference during the interview, the researcher used an interview guide with pre-established questions to assist the exploration of the participant's experience (Appendix C). The interviews began with the same opening statement (Moustakas, 1994), identifying the participant as a partner in the understanding of their experience after surgery. Following the introductory statement, participants were encouraged to immerse themselves in their experience, focusing on notable incidents, and share recollections of the experience coming to awareness (Moustakas, 1994). Due to the open and interactive nature of the interviews, clarification was sought throughout the interviews with follow-up questions and statements (Moustakas, 1994) that may not have been on the interview guide. The semi-structured interview was sufficient to focus discussion on the research question by asking how the participant felt, asking the participant to elaborate on those expressed feelings, and encouraging the participant to explore what contributed to their feelings.

Field notes and memos. Field notes and memos were recorded to capture the researcher's reaction at various points throughout the study. Field notes were taken during and after the interviews and included descriptions of the setting and the

researcher's impressions. Memos were taken while listening to transcripts and during data analysis. Field notes and memos did not contain participant identifying information.

Data management. Participant interviews were digitally recorded and transcribed. Digital recordings of participant interviews were sent to a bilingual transcription service with only one interview transcribed by the researcher. All interview recordings were transcribed verbatim and verified against the audio-recorded file. The digital recordings and full intact transcriptions were kept for reference to ensure the context of the conversations were preserved (Burnard, 1991). All sources of data will be destroyed after 5 years.

Data Analysis

Demographic data were reviewed and used to describe the group interviewed. Colaizzi's (1978) procedural steps for analyzing phenomenological data were followed. First, each transcript was read with consideration of each statement for a description of the experience (Moustakas, 1994). Next, a general feeling acquired from having read the transcripts was noted (Colaizzi, 1978; Moustakas, 1994). Transcripts were then reread and significant statements were extracted (Colaizzi, 1978). For participants who were interviewed in Spanish, the extracted significant statements were translated by the researcher. After listing all significant statements, duplicates were removed (Colaizzi, 1978) and meaning units were formulated from the significant statements (Colaizzi, 1978; Moustakas, 1994). Field notes were then reviewed and noted in the analysis thus far. These steps, from initially reading the transcripts for consideration of statements to adding relevant field notes in the analysis, were performed for all transcripts prior to organizing the clusters of themes (Colaizzi, 1978). Themes emerged from commonalities

noted in the aggregated formulated meaning units (Colaizzi, 1978). The themes were then substantiated by verifying the meaning units from the transcripts were accounted for in the cluster of themes and verifying the cluster of themes were rooted in the transcripts (Colaizzi, 1978). At this point in the analysis, the results from all steps were incorporated into an exhaustive description of the phenomenon (Colaizzi, 1978). The last of Colaizzi's (1978) procedural steps completed for analyzing phenomenological data was the descriptive identification of the phenomenon revealing the meaning and essence of the lived experience (Moustakas, 1994). The researcher conferred with the dissertation chairperson throughout this process to ensure trustworthiness.

Trustworthiness Criteria

The quality of the study was assessed using trustworthiness criteria: credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985; Schwandt, 2015). In the study, credibility was addressed using constant review of data by the dissertation chairperson and reflexivity by the researcher during data analysis procedures outlined above. Credibility is achieved when findings accurately represent what has been shared by the participants (Creswell, 2013). This can be accomplished by following a plan of inquiry that increases the probability of credible representations of data by the researcher and allows for review of those representations by those from whom data were derived (Lincoln & Guba, 1985). When credibility is achieved, the shared meaning of the participants' experience aligns with what has been described by the researcher (Schwandt, 2015). The researcher created a visualization for use with the dissertation chairperson to support derivation of the formulated meanings from significant statements and transcript passages as well as to encourage discourse of emerging themes prior to

conveying the descriptive identification of the phenomenon. Direct quotes from participants were then used to support documented themes. Translation from Spanish to English occurred for the quotes containing dialogue in the Spanish language with attention to understanding the conveyed meaning (Esposito, 2001). Memos were kept to address credibility.

In the study, dependability, transferability, and confirmability were addressed using audit trail and dissertation committee review. Dependability is achieved when the research process is well documented to show it is conducted systematically and logically (Creswell, 2013; Schwandt, 2015). This can be accomplished by accounting for the process of inquiry and analysis including inconsistencies or changes in methodology (Lincoln & Guba, 1985). The researcher outlined and reviewed the plan of inquiry prior to recruitment to maintain dependability. Additionally, field notes and memos were used to show consistencies in the process and development of the product of inquiry, including interviews and analysis respectively, for use with dissertation committee review. Transferability is achieved when descriptions are detailed enough for readers to determine if findings may be applicable to similar groups (Creswell, 2013; Schwandt, 2015). This can be accomplished by collecting descriptive information about the context under which the phenomenon is explored so judgements of similarities may even be possible (Lincoln & Guba, 1985). The researcher documented participant demographic data and quotes for a better understanding of the sample and their experience to allow for transferability judgements. Confirmability is achieved when findings are objective and not fabricated by the researcher (Creswell, 2013; Schwandt, 2015). This can be accomplished by reviewing characteristics of the data and tracing data back to their

sources (Lincoln & Guba, 1985). All materials used or developed during the research process were kept for audit and dissertation committee review.

Protection of Human Subjects

Institutional review board (IRB) oversight was provided by the hospital system's IRB and the University of San Diego (Appendix D). The purpose and conduct of the study were explained to eligible participants (Moustakas, 1994). Information on the risks and benefits of participating in the study along with the processes to maintain anonymity and confidentiality was also shared (Moustakas, 1994). For anonymity, no identifying data linking information to the participant was collected. For confidentiality, transcription details revealing participant-specific information that may be used to identify the participant were removed. Eligible participants were encouraged to ask clarifying questions and any questions were addressed prior to obtaining consent. Written informed consent, including permission to digitally record interviews, was obtained. A copy of the consent was provided to the participants to ensure adequate disclosure of the voluntary nature of the study and the option to withdraw at any time. These consent procedures occurred in English or Spanish as preferred by the participant.

Limited English proficiency among Spanish-speaking populations increases their risk for communication-related adverse events in healthcare when compared to English-speaking populations, potentially contributing to the vulnerability of Hispanics and requiring consideration when obtaining informed consent (Divi et al., 2007; McDonald et al., 2015). The vulnerability among Hispanics with limited English proficiency results from an inability to understand or communicate information, placing another individual or group in a position to coerce, persuade, manipulate, or unduly influence (National

Institutes of Health, 2009). To reduce language as a contributor to the participant's vulnerability, potential language barriers in English or Spanish were addressed by using available resources including use of a Spanish consent and Spanish interpreter services. Certified interpreter services were used at the selected site during the consent process for participants requesting a Spanish interview, as outlined in their institutional policies.

Bracketing Philosophical Assumptions

As described in chapter one, the researcher reflected on her suppositions, prejudgments, assumptions, and preconceived ideas of the phenomenon prior to conducting the study. During the study, field notes and memos were taken during participant interviews and data analysis. Reflecting and note taking allowed the researcher to suspend assumptions during participant interviews and explore the phenomenon with openness during data analysis (Moustakas, 1994; Schwandt, 2015).

Summary

A descriptive phenomenological approach was needed to allow for the description of the lived experience after surgery among Hispanic adults. By interviewing this population, insights into the meanings of the experience were revealed. This chapter reviewed the chosen qualitative approach, setting, and sample for the study. Then, data collection and analysis processes were explained in detail. Next, trustworthiness criteria and the process for obtaining IRB oversight were reviewed. Lastly, the researcher's process for bracketing assumptions was outlined.

CHAPTER 4

FINDINGS

The purpose of this phenomenological study was to describe the lived experience after surgery among Hispanic adults. Colaizzi's (1978) procedural steps for analyzing phenomenological data, described in the previous chapter, revealed more fully the meaning and essence of the experience after surgery among this population. This chapter represents the findings from interviews with Hispanic adults after study oversight was obtained by the hospital system's institutional review board and the University of San Diego. This chapter begins with a description of the participants, continues with the clusters of themes, and ends with the descriptive identification of the phenomenon. In this study, the experience after surgery was the phenomenon of interest.

Description of Participants

The sample of 10 participants was composed of 5 females and 5 males with their ages ranging from 23 to 83 years. All participants were interviewed in their hospital rooms. Interviews occurred 1 to 15 days from the participant's most recent inpatient surgery and ranged in duration from 13 to 66 minutes. The surgeries differed with no one participant having the same surgery. Seven participants preferred speaking Spanish while 3 participants preferred speaking English. An overview of participant demographics is provided (Table 1).

Table 1

Participant Demographics

Ppt (#)	Age (years)	Gender	Country where Raised	Length of Time in US (years)	Preferred Spoken Language	Language Spoken during Interview	Type of Surgery	Level of Care	Education Completed (years)	Days from Most Recent Surgery to Interview
1	69	Female	Guatemala	40	Spanish	Spanish	Spine	Telemetry	13	5
2	31	Female	USA	31	English	English	Urology	Telemetry	12	1
3	65	Male	Mexico	45	Spanish	Spanish	Vascular	Intensive Care	11	1
4	23	Female	USA	23	English	English	Otolaryngolog y	Stepdown	11	6
5	56	Male	Mexico	45	Spanish	Spanish	Transplant	Telemetry	3	4
6	83	Male	Mexico	45	Spanish	Spanish	Orthopedic	Medical/ Surgical	2	4
7	40	Male	USA	40	Spanish	English	General	Intensive Care	13	4
8	64	Male	USA	64	English	English	Thoracic	Telemetry	16	1
9	41	Female	Mexico	24	Spanish	Spanish	Transplant	Telemetry	9	15
10	79	Female	Mexico	35	Spanish	Spanish	Hepatobiliary	Telemetry	3	12

Clusters of Themes

Five clusters of themes emerged from the aggregated formulated meanings and represented the fundamental structure of the phenomenon: (a) uniquely distressing and individually defined, (b) conflicting emotional, psychological, and spiritual needs, (c) extreme vulnerability and reliance on others, (d) underlying inequality in knowing and being, and (e) awareness of mortality.

Uniquely Distressing and Individually Defined

All participants shared a uniquely distressing experience that was only truly understood by those who felt it. Despite attempts to describe the experience, participants

felt they could only speak on behalf of themselves and only explain what they experienced. Several times, the experience was described as inhumane and not wished upon anyone.

Participants explained everyone was naturally different. One can be told about an experience but not know it or its meaning until it is actually experienced firsthand. This understanding was communicated throughout the interviews. When initially asked to share how she felt after surgery, Participant 1 said, *“Oh my God, I think no one can understand it until they are in the same [situation]. It is a very terrible experience.”* Participant 5 shared, *“You know that the whole body –aren’t the same. Not everyone is the same.”* He continued, *“There are people that introduce fear in you and it isn’t until one then feels it.”* He explained, *“It is natural to get cut...[and] it burn. Yeah, that’s the only thing I felt...A little pain only like only at the cut they made.”* And when asked to not move until completion of a diagnostic procedure where pressure was applied to his “cut”, Participant 5’s response, *“Yeah well it doesn’t hurt you,”* is an example of the disconnect between being told an experience is painful and knowing what it is or means to be in pain. The uniqueness of the experience was also explained by Participant 6 when he said, *“But that is me because I believe that other people well are different.”* Participant 6 shared his expectations of being in pain as he thought it was normal to be in pain after surgery, *“For example, like if I move a bit like this, it does hurt a little, but yeah right.”* He then shared his perception of severity was dependent on pain pattern and stated, *“Like a 7 or 8...No, I don’t think that is severe, no. It hurt yes, but it would go away and – no, not that it was a stable pain, no.”* Later in the interview he continued

explaining his expectations of being in pain, “*Well only a little pain there upon sitting and getting up...Like I said, if they move me like this or that, yes, if not, well no.*”

When asked to share her experiences now when compared to others, Participant 9 similarly shared it was a unique experience that she felt stemmed from distress:

Because pain, I did have pain but not as strong. Not so, so strong like one from labor, no... This one was in reality – I think at times one feels despair; it is like you are afraid. I was afraid to feel more pain. But, when I started to pray and do that, it would relax. But, it wasn't so much the pain, like strong pain. Instead the tension I had and the fatigue that was there, from like a month ago...it was the fatigue and the wear that I was very tired, emotionally. I was already extremely exhausted.

Participant 8 recounted his prior surgeries and explained he tolerated a lot of pain but only knew about what he had gone through:

I think I have a pretty good threshold for pain. Um, with this particular operation done now, removing liquid, fluids from my, uh, from my lungs. There's, uh, a little tube coming out of me, and that can be quite painful. Nothing that I can't handle... Um, but, if I apply too much pressure to it, it just gives me a very sharp pain, and, uh, so, see... [grunts], so it kind of goes up my back [straining]. Ah. Yeah. It's horrible. And sometimes, I over – I overreact. It's painful now.

He continued, “*It's hard for everybody, I think. I've heard a few stories. Um. But, otherwise, just – to be honest [straining] being in the hospital was kinda new to me because I haven't experienced a lot of it.*” He then shared how someone does not truly know an experience until they themselves have experienced it:

Everything I've read about recovery, I've – I've suffered the symptoms. The one difference between a patient and a doctor or a nurse, regardless of how good they are, they've never gone through this. They – they may know everything about it, but they've never gone through it. They can't tell you what it feels like. You know, I'm sure there are a few, but those who can't tell you what it feels like to be confined like this to having your chest cut open.

The participants' accounts after surgery described a uniquely distressing experience.

In exploring their distressing experience, participants provided illustrative comparisons to describe their feelings after surgery and recognized they could only speak to or explain what they knew and felt. Throughout the interview, Participant 1 frequently described her experience as “*terrible*”:

Oh, my love. Look, the pain from the head was a 10 pain. I don't know if you have at one time had a 10 pain, that you feel like you are going to go crazy...It is a terrible pain...if you ask me from 1 to 10, I'd tell you 20.

She then spoke of the moment when the source of pain was removed, “*Oh my God. When they took them off, it felt, wow.*” The relief from having the source of pain addressed was also communicated by Participant 7 when he said, “*Oh my God. Night and day,*” after being asked about how he felt at the time of the interview in comparison to when the pain was at its worst. Similarly, Participant 10 exclaimed, “*Well what a difference!*”, when asked how she was now after having her “*very bad*” pain addressed. At the end of the interview, Participant 1 said, “*That's it, my my my nightmare that I was able to finally wake from [chuckles] but well, I don't wish that on anyone, on anyone.*” This sentiment of not wanting others to experience the same was echoed by Participant 3 when he said, “*I don't wish for you to go through what I have gone through*” and went on to share his “*terrible pain after the surgery, a tremendous pain.*” In a similar manner to Participant 1, Participant 7 shared his “*excruciating*” pain experience after being asked about his first night after surgery and said, “*Oh my God, painful...I mean. It was just painful. [pause] Highly painful. Um. It's kinda hard to explain...for me. [pause] I found myself in excruciating pain.*” He continued with an example of having received a therapy and explained, “*So, when pssh when that happens it's like oh my god. I mean I'm not a yell*

I'm not but I'll I'll give a yell here and there cause it's that painful. Literally a 12."

Participant 8 was "shocked" about how much pain he was experiencing:

I haven't had so much pain over the last few years. So, this was, uh, a kind of a shock to me because, I haven't experienced a lot of pain. But, this is a – it's kind of very painful. You know, people talk about pain in the hospital, I never could really relate, but it's probably what- offhand, the most painful experience in my – in my experience. To be honest? I was thinking, 'Oh, so this is what a hospital experience is like.' Because, people always talk about the pain being in a hospital. I haven't experienced a lot. But, now, when I experienced this, I said, 'Okay, maybe the hospital experience is a little bit different than I thought.' It's a lot of – this is painful. It's hard to move around. They drugged me up a little bit yesterday so I could tolerate it overnight. But, I would – it just changed kind of my thoughts on being in the hospital because, this is the pain everybody says, you know, they talk about.

Prior to a feeling of relief, Participant 10 described her pain and said it was "very bad, very bad. It hurts a lot the abdomen, the mouth. I couldn't speak well [and] it it throbbed everywhere, my entire abdomen throbbed. It burned." The descriptions of the experience were as perceived by the participants and were not wished upon anyone.

Other graphic depictions of the experience were also provided with comparisons to known painful, torturous, or violent experiences. The experience for Participant 2 was more distressing than expected and more distressing than a known painful experience as gauged by that known experience:

[The surgeries are] not the same at all. This is more painful than this one... They told me I was gonna be in a lot of pain. Yeah. But I didn't experience that much – I didn't think it was that much pain. Because it was, like, my first surgery I had. I didn't think it would be worse than having a baby [Laughs].

Participant 2 repeatedly described her experience as "worser than having a baby" and further said, "It felt like someone just pulling the inside of you." Participant 4 shared an "excruciating" pain, though unlike childbirth, she compared it to torturous and violent acts:

It's like a burning sensation with sharp needles... Really, really sharp needles. You just – thousands of them coming in one spot, you know? Really... any little move I made, it felt like I was gonna burst open. Luckily, it didn't (laughs). The pain was excruciating... I woke up crying. I woke up to the pain, like if someone had just punched you more than 20 times in your throat, you know?

The experience may be described as inhumane and is individually defined.

Conflicting Emotional, Psychological, and Spiritual Needs

The experience exposed emotional, psychological, and spiritual needs, requiring them to be addressed simultaneously after surgery. These conflicting needs were uncovered as participants shared the events leading up to and in the aftermath of the experience.

The prolonged experience, whether literally or figuratively perceived, elicited an emotional and psychological response. Participant 1 shared that although the experience was time-limited, it felt much longer than the actual time it was happening. She said, “*Depression, anxiety, nerves come in that destroy oneself, and one feels like if one had that tube on for years.*” She was in need of support and reassurance:

Look, one becomes very sensitive...and one wants to receive a hug from everyone, one wants to be pampered/ indulged/ coddled, one wants to be told nice things, because the way one feels, forget it man.

Oh no, let me tell you, what horror, what fright, I don't want – that was a nightmare for me... It was seven days that I had it, but for me it was – years. So, it feels very good when they take it off you, because one counts the night, the hours, and one feels like the hours are never-ending, that the that the nights no that the day never will come, that the night will not arrive.

Participant 4 shared a similar story:

The stay, sometimes it's longer than it should be or you expect it to be... I expected it to be easy, you know, to make – I'm gonna go through with it and I'm gonna have [my family's] support and everything's gonna be fine and everything's gonna be done quick. But there were setbacks.

Participant 8 explained how he passed the nights:

They go very slow. I know, they go – they seem to go very slow. And I can't sleep. Uh. With – with the scars, uh, the incision, it's pretty new, and they – they just – I can't move around a lot. I just can't get in a position that makes me comfortable. And I always help them raise me up, but eventually, I slide down. When my feet are touching this, I know I'm too far down. And, uh... So, I can't move, um, I just sit there, I'm alone with my thoughts. My brain doesn't turn itself off. I wish it would, but it really doesn't.

Participants described feeling trapped, as though they were suffocating, during the prolonged experience. Participant 1 shared, “*A depression, a suffocation, a terrible anxiety comes in. Yes, terrible.*” Participant 2 repeatedly shared she “*just couldn't breathe*” and said, “*Felt like I couldn't breathe. Yeah. I was in so much pain, like I couldn't breathe...I told them I couldn't breathe. I'm in a lot of pain.*” Participant 4 shared:

I got to the point where I just got so hectic that I got mad and again, I was regretting the procedure, like I was regretting it. But because, again, I felt trapped, so then from there, again, I allowed the pain to take over.

Participant 10 felt trapped in a state of not getting better but being constantly asked by others about her progress with no avail:

Yes, because I'd be asked by my family about how I felt, the nurses also. I would say, how am I going to feel good, if it hurts? Just don't ask me... Why do they ask me? Yes, it still hurts me.

She continued and said she would tell the nurses, “*Listen nurse, how do you think I am going to feel good? Just don't ask me.*” These emotional and psychological reactions occurred concurrently after surgery and sometimes the responses were contradictory.

The conflicting emotional and psychological responses were uncovered when participants reflected on their experience. Participant 3 shared his contentment and frustration as he spoke of his experience. He said, “*After the surgery, I felt very very satisfied with having decided to undergo surgery... I felt, I felt, like I said, satisfied with*

having made a a decision, the correct decision.” This sentiment was contrasted by frustration and Participant 3 explained, “But after – I was feeling, how do I say, frustrated because, because I didn’t take care of myself. Why didn’t I take of myself? That. It is so easy to do, so easy and so difficult.”

Similarly, Participant 9 shared battling her feelings of sadness with that of hope and happiness:

Well I felt a little sad, but I said, ‘No, if God has me here it is for something and it is until where God takes me is fine.’ I said, ‘God, I stay by Your side and You know.’ To pray and ask of God. And, here we are...happy, happy. Filled with emotion.

Participant 4’s experience exposed her inner struggle with being raised not to cry and being in so much pain she had to cry. When initially asked how she felt her first night after surgery, Participant 4 shared the following:

I don’t think I felt the pain right away. The pain wasn’t there until like probably hours after. [Then], pretty bad. I cried. The first two nights, they were pretty painful... like the first night, you don’t want to move. You just don’t want to move. I didn’t want to move.”

She shared her psychological conflict, “*I allowed [the pain] to take over. So, I felt weak-minded, but then again, that day I was very emotional.*” This was unlike her and she shared, “*My brothers didn’t put up with crying. They’re guys. So, I was built strong. I was built – if you fall, get up. Why are you gonna cry for?*” These inner, contrasting assessments of her experience were present until the end of the interview when she said, “*You regret [the surgery], but you know... I’m very, very thankful for what I’ve been through in a way.*” Participant 10 also shared her struggles with fighting the urge to cry and simply bearing the pain and said, “*But not even like that, not even like that would I*

cry, I would simply bear it and not cry.” Participant 7 shared his psychological struggle with wanting to maintain a positive outlook:

Mainly just to kinda talk to someone because I wasn't feeling too good. Well the um the at the beginning of everything going on there were moments where I wasn't feeling too good...I just told her I needed to talk to someone about trying to stay positive and that kind of stuff.

Later he shared how having “answers” helped his outlook, “*Everything has been positive so you know...My mind is strong enough that I know that [pause] it's a process. So, it's not like it's not something that I feel is gonna knock me down or anything like that. I'll get through it.*”

Participant 8 also shared his perception of the psychological aspect of the experience:

One thing that is not also addressed is the psychological part of the surgery and recovery. The physical part is pretty straightforward, in feeling – better. But, they don't address the psychological part. It takes years, for instance, certainly months, more months if it takes a great sense to recover. It's, uh, it's kind of taken a toll on me.

He went on to further explain how the body is “*delicate*” despite how “*strong and resilient*” it may be because one goes

from being 100 percent well to being on your death bed. So, I do worry about that, and especially now, even when I recover – I'm recovered, well, from my first surgery. Um, but even, after this surgery, I don't think I'm going to recover mentally, as well, um because, I know infection never occurred to me the first time. That I'm – just – occurred to me that I could get infected. And when I did, you know, that's when I came to the realization that, uh, that these things can happen, despite how strong you are. It started bringing on some depression. It's not my nature to be depressed. And I know that's a symptom of, uh, of recovery. Um. But, I started getting very depressed. And, and I kind of broke down... I was feeling sorry for myself.

Participants had to manage the entirety of the experience including emotional, psychological, and spiritual needs as they arose.

The spiritual aspect of the experience was made known with references to God. Participant 3 questioned why the experience happened to him but also looked to God for guidance, *“I felt afraid, I felt afraid...I got scared, Me? But why me?... My wife took me to church, I didn’t want to go...Now, I am the one that goes to church and she no longer wants to go.”* Participant 6 felt *“encouragement”* and *“hope”* after every surgery thanks to *“Him”*. He shared, *“No, well look I’ve had various surgeries and God has helped me.”* Similarly, Participant 5 shared:

I said, ‘no, well let them put another, one that is not mine and what will happen?’ Then when they put the anesthesia I said, ‘no, that’s it’... And thank God, that is what I was afraid of, of what would happen in surgery when they would be doing that. No ay, it was fear but there, once being here in the room there, I started to forget...But thank God I made it out, and that was my only fear, [pause] you made me cry you see.

Participant 9 also shared her hope in God’s plan to overcome what lied ahead, *“Because when I was going to surgery, well, I said I’m going for life, pray for me, I told the nurses. I’m going with God, I don’t let go of Him. And let’s go, I’m going for life – God-willing.”*

Conflicting emotional, psychological, and spiritual needs were part of the experience after surgery.

Extreme Vulnerability and Reliance on Others

The experience after surgery left the individual extremely vulnerable, in need for support, and reliant on others. The individual was positioned to need help from others and left to succumb to the experience from an ultimate loss of autonomy.

While sharing their experience, participants expressed a fear of being alone, abandoned, or in more pain. Participant 1 was afraid and left alone:

Because one’s fear, in a case like this is ‘They are going to leave me alone, I will be pushing the bell and no one will ever come here.’ And, that happened to me various times. On one occasion, I – the anxiety came in, that depression, and I

wanted someone to come to see me and no one came. I was pushing the bell and what they did was turn it off. That was worst thing they could've done because then I felt lost and I started to scream and cry. So, all that for me was was – I got really scared. I told them to please not leave me alone, to not turn off my emergency control because if something were to happen I said, 'You won't know.' Then, does that mean I am going to die here?

Participant 4 was also afraid and felt alone. She said, *"I don't know how to explain it, honest. Waking up from surgery, I was scared."* She later explained, *"I guess because I was left alone, like my family had things to do. So, I was left alone... I felt alone."*

Participant 8 elaborated on his experience anticipating yet another procedure:

The operation I'm going through today, they drugged me up a little bit. They said there might – might be some pain. And frankly, that frightens me. You know? Uh, I don't, obviously, like anybody, I don't like pain. Um. But I want to be healthy, and I guess, I'll associate the pain to something that was done to me, that is very serious. I associate the pain with something that was done to me that was serious. Making me think that I'm not in a good state. I'm told I am. But, uh, so that makes me nervous. [Chuckles] I like living, and maybe I over-dramatize it, but, um, pain kind of takes me to a different place, mentally. [He reflected on feeling alone.] Even when you have people with you, you're still alone. You know...I'm always alone with my thoughts. It doesn't matter how many people are – are here. My thoughts drift to, uh, am I going to be okay?

Participants were vulnerable and in need of help from others.

Participants communicated a presence of support from others during their experience including nurses, physicians, family, and God. Participant 1 shared, *"And, yes, well yes I felt that support [from the nurses]. Well, I'm not going to say one feels fine, but at least it helped."* Participant 8 also said his nurse *"shook"* his spirit, *"She said, 'Remember, the clock's always moving forward.' And that really shook my spirit. Because, she was right. It's always moving forward. The way you felt – the way I feel today."* He also recalled feeling the support from his physicians. *"Now that this has occurred, the infection, you know, they [the physicians] give me a lot of encouragement."*

Participant 8 further shared the support he felt from his brother and wife and recognized

the benefit of having a support system, *“I do realize that at some point, I have to live with this. To take advantage of that – that network of friends you have, that support group.”*

Participant 3 shared feeling a similar support after surgery, saying, *“But on the other had I began to feel the support of the people. The the support, including people that one doesn’t know. They wish you the best, ‘we are with you’.”* After being asked about effects of her experience, Participant 2 shared she found strength from others despite the severity of the pain. She said, *“Encouraging you to keep on going. Because I’m like, my mom could do it. I could do it.”* Other participants then spoke about relying on God for support. Participant 5 shared, *“‘No, whatever happens’, I entrust myself to God and in His hand I place myself...whatever happens.”* Similarly, Participant 6 shared:

Well that for me God is the one that is always there with someone, and if one calls on Him, He does not forsake, because that’s how He is, I’ve seen all my life, I’ve needed something and I believe He with me always.

Participants shared how they were not well and were put in a position of needing external support.

Participants were left to succumb to the consequences of the experience that warranted help from others. Participant 1 spoke about needing familial help. *“One, well, sees how to come out ahead with the help from their family...[my son] even learned to give me the bedpan and everything, to not bother.”* Participant 4 also shared how she needed help from her family to cope with the stress from the experience. She said, *“I have a [child]. It’s kind of hard to just be stuck in one spot for a week already. So, I would let the pain win, just let the pain take over...Like there was just so much on my plate.”* Similarly, Participant 9 expressed relying on family throughout her life when she said, *“We are always supportive amongst us. We always try to support ourselves.”* She

also recognized she relied on God. *“I am Catholic and well I say, ‘God Help me!’”*

When asked about how he communicated what he was feeling, Participant 3 repeatedly said, *“Well I need help. I need help.”* And when he was not feeling well all he could say was, *“I’ve never felt like that...and I told my daughter, ‘Hey, you know what? I feel really bad/I don’t feel well.’”* Similarly, Participant 7 explained his experience as being visibly in need of help:

I go over there um I’m like [pause] not in a good state. Um, right honey? I was like near passing out. You could tell. I was very weak. Like just in my body demeanor. You can tell... something was not right. Um, like I wasn’t good... But, I mean, look at me. I’m, I’m like in dire need of uh something”

Participant 8 described himself also as visibly in need of help:

Well, look at me, how can I help myself in this state? You don’t call them – I can’t get up, and you know – you know. If I want to bother them, ‘I need help to take me to the bathroom’ um, if I need to get up in the bed, I need help. I mean, if you look at me, you’ll say, ‘Well, yeah, you should call for help.’ You know, obviously, not in a position to do things by yourself.

Participant 10 shared needing help from the surgery that was done to her because she was unable to move. She said, *“I couldn’t move myself. Because I couldn’t, it hurt a lot...it feels very bad a surgery like the one they did to me.”* She later shared how she felt weak once she started to recover but was still in need of help. The experience left the individuals reliant on others.

Underlying Inequality in Knowing and Being

The experience exposed an underlying inequality in knowing and being between the recipient of care and the providers of care. Within this inequality, there were elements that dehumanized the recipient of care, requiring he or she to concede to taking pain medication when an individually established threshold was reached despite an aversion to the effects of being on pain medication.

Though participants had expressed only they truly understood their experience, they relinquished or were put in a position requiring them to relinquish what they knew and needed to what was known and expected by the providers of care. Participant 1 shared the following:

They [physicians and nurses] know a lot about this. So, they understood whatever little thing I told them and they tried to help me...Them [nurses] tending to you is more than enough. So, I couldn't speak, but they [doctors and nurses] understood me, yes, they [doctors and nurses] understood me.

She explained a time when she was asked about her pain but medication had not yet been given:

They [nurses] would always ask, 'What is your pain? From 1 to 10.' They would tell me, 'We have your pain medicine, let us know when you need it and we can give it to you, ... [but] when the pain would come and they hadn't given me the pills, I – I cried. Cried from pure pain.

Participant 3 shared the following:

He [the nurse] asked me the the limit...what degree was the pain. I told him, well a 10. He said, 'No, no, you'd be crying with a 10'...I said, 'It's 'cause it hurts a lot, it hurts a lot. Since you aren't the one feeling it right now.' I also remember that I called the nurse, it was at night, I say, 'Hey, it hurts a lot'. 'Yes, it's natural', they said. They gave me another dose of I don't know what it was of a drug at that time. They said, 'goodnight', and I no longer felt anything and I stayed there very asleep.

This explanation or observation of the participant's experience from the providers of care was also communicated by Participant 10 who shared, "*Well I had to bear it...I told the nurses and they would give me pills so the pain would go away [and] they said, 'It's that you recently had surgery. That's why.'*" Similarly, Participant 2 shared, "*They told me, 'The reason you're – can't breathe because you're in so much pain...They'll ask me what number is the pain. So, I'll tell them it's like a 7, 8. Because 10 is the most.'*"

Participant 2 further explained, "*Yeah, they come in – every time they come in, ask me if*

I'm – I need pain medication, am I okay. Or if I – I need it, I'll call them –that I'm in pain.” Participant 9 questioned her safety from herself when placed on restraints without understanding if she, in fact, was a danger to herself:

The first night when they took, when I left intensive care, right, I was afraid I was going to remove something because I was already afraid because they tied me up the first night that I took this thing off and they tied me up the first night and I said, “What if I hurt myself? It is better if I don't sleep.’ Because asleep I am going to hurt myself.

She further explained the restraints were removed and she was afraid to move her hands and didn't sleep out of fear that she would harm herself.

The providers of care were questioning and almost blaming the participants for their experience. Participant 7 shared, *“I would just hit the button and the nurse would come in an uh, ‘what's wrong’, ‘I need some pain medication’, ‘why’, ‘uh this is why’. They would do the best that they could to accommodate me.”* When asked what she did when she had pain and felt alone, Participant 4 shared, *“Cried... Called the nurse. They came in and she said why did I let it get to that point?”* She continued, *“Um... Some staff, you know, they're nice. Some have their days, I guess.”* In recalling previous surgeries, Participant 4 shared having been in several hospitals and having been cared for by several nurses and she remembers *“them being very rough.”*

Participant 3 also commented on providers of care and hospitals:

I don't if they are trained like that, to treat the patient, they direct themselves with a lot – some are direct...some are very – more, a bit more, with more caution/carefulness... But, it is a very nice experience. I should say apart from being in the hospital.

The inequality of transactions present after surgery while in the hospital stemmed from providers of care using their knowledge of the experience to challenge and seek

justifications by recipients of care for needing treatment to meet an expectation before care is rendered.

Dehumanizing. Actions and interactions during the experience were viewed as simply performing a job, but participants expressed a need for compassionate interpersonal interaction. Participant 1 explained how treatment from nurses changed without understanding the experience of the patient:

Well...because at times when, when according to them [nurses], they have a sick person that for them is a bother, the treatment is no longer the same, it is no longer the same. I understand that they come to work, they don't only come to serve me. Then, I tried to understand and tried the way to control myself to not make too much of a fuss. Because I do think one becomes a bit annoying with that, but it's only... all that horrible frustration comes in...So, one of them answers me, 'Oh, yes Ms. _____ but you know we have a lot of patients and we can't attend to each one.' Well, then you should have more personnel because the patient is not at fault. The patient only wants to receive attention.

Participant 5 also spoke about this divide between a completing a job function and engaging in an interpersonal interaction when he shared his experience during a diagnostic procedure:

Two days ago I had an ultrasound. You see that they push there on the ball. And it starts like that, yes they push – and I would – I moved. 'Don't move', well it hurts me a little still, what do you want? The wound is still fresh.

Similarly, Participant 7 shared his experience where he wasn't cared for as a whole person:

I personally asked the doctor. I said, 'Look. I don't feel well. I don't feel that the infection is completely gone... he went on to tell me that I needed to quickly get under the treatment of a primary care of some sort...But, I thought it was pretty rude that he would verbatim and I'm, and I'm telling you verbatim how he said it. He said, 'You know what, I'm a surgeon. I don't have time to put you under my care and kinda help you with that kinda stuff. I just go and I just do surgeries. That's, that's, that's what I do.' And, I thought that was kinda rude... I understand that he's a surgeon and that that I needed to get somebody else.

Participant 8 also commented on some of his interactions with nurses:

It's, um... it's kind of a double-edged sword. They're there to help you. But, my impression is, they're here to help you, just don't bug them too much. Uh, so, you kind of figure out who you're going to ask questions – when – when I call on speaker to the nurse's desk. You don't know who they're going to send, and it might be a person who's fed up with you. So, how – how do I end the discomfort? I just kind of deal with it, mostly. Unless it's really bad, I'll call for help. Otherwise, I just deal with it. I will ask them at night, sometimes. If I do not ask them –. It just – it just, I mean, it's the nature of the hospital, you know, the busy... and just because they're busy doesn't mean I can't be included in their busyness. Uh. But, like I said, I just try and do this myself.

He explained this desire to do things himself began when he was being treated differently because he kept calling on the nurse for help:

And then, you could just kind of see it in their – uh, in the way they treat you that, um, that – they consider me one of the annoying people on the floor. So, I just stopped asking so much. And I got treated better... They encouraged me, 'If you need something, ask. Don't worry about it. Ask us for anything.' Uh, but I could tell, I could just see the way I was being treated after a couple of calls, that they – they were kind of fed up. So, I don't just call for anything... now.

There was a disregard or rationalization of the experience, despite attempts to communicate a need for compassion, in order to complete a task.

Aversion to medications. The benefits of pain medication were experienced, side effects of medication were avoided, and medication was ultimately not sought after until absolutely necessary.

Participants shared some benefits of taking pain medication, including lowering the severity of the pain and being able to sleep. When asked how she felt after receiving medication, Participant 2 said, *“It felt more better, more relaxed... I was able to tolerate the pain... It wasn't that much painful. Like, it was, like, calming down.”* Participant 9 shared she felt more relaxed after taking medication, *“I take a pill and I relax quickly,”* but also commented that prayer helped her as well, *“I begin to pray and I relax.”*

Similarly, Participant 10 shared having taken medication but first she mentioned, *“Well I*

would reposition myself – I would reposition myself a certain way to be able to sleep.”

Participant 6 explained why he decided to take pain medication:

Yes because yeah it hurt a bit, and it would rise the pain up to here, up to the top, yes mainly when a times it came at night, or when I was asleep – I needed to get up to take something corr- Tylenol or Advil, or something, yeah.

Participant 7 also shared how he was able to sleep after changes to pain medication. He said, *“The pain has been the same. There hasn’t been any change. Um, however with the change of the medication uh because it was consistently getting um harder and harder and harder to deal with at night.”* Participant 8 explained having to take medication to get through the nights, *“I don’t want to take too many drugs. Um. If it was up to me, I’d take none. Um. But, I have – uh, medication at night this week, mostly.”* There were known benefits to taking pain medication but there was also a desire to avoid taking medication because of the side effects of being on medication.

Participants expressed an avoidance of medication, mainly because they experienced or were informed of side effects. Participant 5 shared a prior experience where he avoided medications because of a concern for addiction that was communicated by his son:

The other time I had [surgery], they gave me a bottle of pills. My son told me, ‘those pills are very strong’, he said, ‘You could become addicted to those pills’...And so for - so the [pain] can - calm down I’m going to take the pills. But, then when my son told me that [humming no sound] I didn’t need them anymore, it was gone. It was gone from my mind the pain.

Participant 8 shared not wanting to be dependent on medication:

I don’t want to – I don’t want to become sort of depending on it every night...[and] run into a state where I’m now controlled by the drug”, but also said, “I know this drug is going to help me, [but] I don’t want any adverse reaction. That’s why I worry about taking the pain meds because, they do make me feel better, and there have been a couple of nights where I just force myself to go to bed without any pain pills because, I just didn’t want to take them. With this thing, like I said, this

is one of the hardest things I've gone through so far. So, I'm not looking forward to taking more pills. Uh, so I – I just – I just don't like taking pills. I – I think it's going to have an effect on me, which is probably foolish. But, I think it's going to have an effect on me that's out of my control.

Participant 7 spoke of his reason for avoiding medication. He said, *“I know that it really, uh, pain medication really, uh, affects your liver, your organs, and and I'd rather not have those issues and or and/or be dependent. I'd rather not be in that situation so I just stay away.”* There was an aversion to the effects of being on pain medication but also a recognized need for medication, and it was sought after as a last resort.

Pain medication was not taken until absolutely necessary. When asked how she feels when she needs something for pain, Participant 2 said, *“When I'm really in pain. Because I really don't like to take a lot of pills. So, when I know I need it, I'll take it. But — if I could tolerate it, I won't take the pills.”* Participant 4 explained she would not communicate actually being in pain to the nurses because she didn't want to receive pain medication:

Yeah, I was [in pain], but I held back like I also didn't want to be all pumped up and you know drugged and stuff like that. Out of it...Now, I've got experience with so many hospitals already. I was always in and out of the hospital because of what I had and I had so much experience, like, the nurses just feeding you pills and stuff, you know.

Participant 5 explained, *“I was bearing it, because I could, and when I could not tolerate it yes I will ask for a pill.”* Participant 7 said, *“I pretty much I never filled any prescriptions for pain meds... Oh this is extremely, extremely on on the other spectrum. Super high pain. I still try to do what I can to stay away from...I mean it's hard now.”*

Participants conceded to taking pain medication when an individually established threshold was reached.

Awareness of Mortality

As a result of the experience, the participants became aware of their mortality and recognized the opportunity to continue living. The participants reflected on the experience, questioned actions surrounding the experience, and planned life after the experience.

Participants felt surviving the experience was another chance at life. For example, Participant 4 said:

It's crazy. What situations like this do – situations like this bring you, in a way, like – childbirth gives you a child, brings you happiness. This compares to it because it's giving you a second chance in life. So, you – you enjoy both things, you know? And meanwhile, I have a child. So, I experienced that. I got joy once. And now, it is again. I got this removed and now I get my life back and I get to be a mother to her again. So, it's similar in certain ways.

Participant 5 also said:

In my mind I I did feel, I had this thought, I said, 'maybe I don't, I don't come out of this' but-. Inside. It is the only fear I had. I tell you... Thank God that- my eyes, another opportunity [pause]. Yeah. And here we are, you see.

Participant 6 shared, “*Various things I've had in life, and well, I've been saved, I'm still here.*” Participant 9 expressed her gratitude at being able to live again, saying, “*Giving thanks to God, to life...I returned and was born again.*” She was filled with emotion and continued, “*Happiness. Ay, no! I was very happy, thankful to God. I am thankful with God. I'm wanting to scream to all people, 'I'm alive, I'm alive!' I said I was going for life and I don't give up.*” Upon reflecting on the experience, participants recognized the positive consequences of the experience, the opportunity to continue to continue living, and the limited time of life.

There was a focus on the future to get through the experience, offering an external sense of purpose. Participant 1 said, “*I get sad, believe me, and sometimes one*

sometimes questions God.” Then she said, “Oh, only there one has to demonstrate how strong one is in this world [pause] to be able to continue forward.”

Participant 3 said:

Mentally, I focused on the things I would do after the surgery. The things that that many times because of negligence – or aft- one doesn't consider those details of life, you know... Physically, change my way of life, change my way of life because it was a my own disregard. Well, to do do the things I hadn't done, that I hadn't done before.... a lot of time is wasted. But then one says, 'no, the time is mine, I need—', but no. No, one misses out on so many things...those details that people say, 'No, not us. That is for the women, not us, not the men', no. I, I remember of one, one kiss I gave my father in a long time, that I don't really know if he noticed because in that moment he died. And well, like I said, there is time to do so many things, there's time, a lot...primarily with the family.

Participant 4 also shared:

I just thought happy thoughts, like you know, you're going through this now, you're gonna, it's a must. Think about it like still with it for the meanwhile and then later on in life, your life's gonna be better in the future.

Participant 5 said, “*One needs to take care of oneself. A lot now. A lot, a lot.*” Similarly,

Participant 7 said, “*It's been it's been like alright let's go you know let's keep going forward let's gotta keep moving forward gotta keep moving forward gotta gotta do this.*”

When sharing how she looked forward to being able to attend her daughter's graduation or to make it to another birthday for herself, Participant 9 shared:

But I sai- I was always thin- at times I would say, 'It could be I don't make it to December.' But I said, 'No, No! I have to get there...God will help me. I won't distance myself from God. I have God in my heart. And it is until where God takes me. Because it is until God says. The doctor yes they know but the boss is over there. They know scientifically, but the main main doctor is up there.

Participant 8 was thinking back on his experience:

You know, my whole thought process has kind of changed about recovery, and maybe the ability to live long. I realized I have a – an obligation to, uh, to help those, or to be strong so that I can share the message. But it is harder. But, I want to be strong for my – for my mental wellbeing. And so, perhaps I can help someone with this – I can help someone later.

Participants embraced the opportunity to continue their life journey as a result of the newfound awareness of their mortality.

Descriptive Identification of the Phenomenon

The descriptive identification of the phenomenon was the last of Colaizzi's (1978) procedural steps completed for analyzing phenomenological data and revealed the meaning and essence of the lived experience after surgery among Hispanic adults.

The experience after surgery, whether expected or not, is uniquely distressing and individually defined. It is an experience that can only be understood by someone who has already gone through a similar experience. However, even if someone else has gone through a similar experience, one can only speak for one's own experience. The experience is inhumane and no one should be subjected to it. Simultaneously occurring emotional, psychological, or spiritual experiences are uncovered and need to be addressed concurrently after surgery.

The experience after surgery leaves the individual extremely vulnerable and reliant on others both within and outside of the hospital. The individual is positioned to need help from others and left to succumb to the experience from an ultimate loss of autonomy. The experience exposes an underlying inequality in knowing and being between the recipient of care and the providers of care. Within this inequality, there are elements that dehumanize the recipient of care and require the recipient of care to concede to taking pain medication when an individually established threshold is reached, despite an aversion to the effects of being on pain medication. Recipient-provider interactions inform the type of care sought after by the individual and the form in which the provider renders care. Mainly, providers of care challenge the experience

communicated by the recipient of care and expect criteria to be met for care to be rendered. These criteria include interpretations and explanations of the experience from the providers of care. Then, actions by providers of care are executed without compassion in a transactional manner.

As a result of this extremely distressing experience where one is almost devoid of personhood for the sake of another's normalcy, the individual creates his or her own value of life and becomes aware of his or her mortality, reflecting on his or her life, questioning actions, and planning for the future. Surviving the experience is another opportunity to continue living and one recognizes changes must occur to maintain life.

Summary

The findings from 10 interviews conducted after surgery with hospitalized English-, Spanish-, and bilingual-speak Hispanic adults were represented. The clusters of themes that emerged during data analysis were described and substantiated with direct quotes from the participants. The five clusters of themes were (a) uniquely distressing and individually defined, (b) conflicting emotional, psychological, and spiritual needs, (c) extreme vulnerability and reliance on others, (d) underlying inequality in knowing and being, and (d) awareness of mortality. Lastly, the meaning and essence of the lived experience after surgery is revealed with a descriptive identification of phenomenon.

CHAPTER 5

CONCLUSION

This descriptive phenomenological study described the lived experience after surgery among Hispanic adults. A descriptive identification of the phenomenon was formulated from the themes and revealed more fully the meaning and essence of the experience. This chapter synthesizes the study findings and implications for future study. First, findings are discussed and their contributions to the current body of literature are presented. Following the discussion of findings, the study's strengths and limitations are described separately. The chapter then concludes with implications for future research.

Discussion of Findings

Nursing practice comprises a dynamic relationship with the interdependent aspects of people, health status, and environmental circumstances and not simply with one of these elements in isolation (Bender, 2018). This dynamic relationship is supported by the findings represented from this qualitative inquiry, describing the lived experience after surgery among Hispanic adults. Prior to this study, the experience after surgery was an unexplored phenomenon. Previous studies that have specifically explored the pain experience following qualitative or quantitative methodologies, synthesized in Chapter 2, do not describe the entirety of the experience after surgery. To review, the specific pain experience was explored in a narrow context with patients postoperatively but not while hospitalized (Aziato & Adejumo, 2015), at end of life (Larsson & Wijk, 2007), or with cancer (Juarez et al., 1998). The pain experience has also been explored with descriptors using actual words (Calvillo & Flaskerud, 1993; Cassisi et al., 2004; Melzack, 1975, Sherwood et al., 2003), behaviors (Gélinas et al., 2006), numeric or verbal intensity

scales (McDonald et al., 2015; Puntillo & Neighbor, 1997), and words with numeric intensity scales (Jensen, Gammaitoni et al., 2006). This study's line of inquiry, asking how participants felt after surgery, asking participants to elaborate on those expressed feelings, and encouraging participants to explore what contributed to their feelings, revealed more fully the meaning and essence of the experience among Hispanic adults. The dynamic relationship among the interdependent aspects of people, health status, and environmental circumstances is seen in nursing (Bender, 2018) and this study's findings contribute to that current body of literature.

Routine pain assessments may be inaccurately capturing the experience after surgery by Hispanic adults, as population-specific instruments have not been developed for this group (Cassisi et al., 2004; Melzack & Torgerson, 1971; Waddie, 1996). The first step toward developing a culturally appropriate assessment was to gain an understanding of the essence of the experience after surgery. Findings from this qualitative study identify the experience after surgery as uniquely distressing and individually defined, lacking a shared understanding of the pain experience from a unique cultural perspective despite self-identification as Hispanic as an inclusion criterion for participation in the study. Previous studies have reported on differences in pain perception, tolerance, and behaviors among cultural groups (Callister, 2003; Hollingshead et al., 2016; Lovering, 2006), relying mainly on data generated from quantitative methods (e.g. using existing instruments). In this study, in which data were generated from qualitative methods (e.g. participant interviews), cultural commonalities were not overtly present in shaping the pain experience; rather, the pain experience was marked more notably by unique differences at the individual level. Additional qualitative

work is needed to identify a relationship between the lived experience and reported differences among cultures. Implications for nursing research are discussed later in this the chapter.

Theory of Unpleasant Symptoms

Two of themes that emerged from this study were consistent with the Theory of Unpleasant Symptoms (Lenz, Pugh, Milligan, Gift, & Suppe, 1997). Those themes were (1) uniquely distressing and individually defined and (2) conflicting emotional, psychological, and spiritual needs. All participants shared a uniquely distressing experience after surgery that was only truly understood by those who felt it. The experience also exposed conflicting emotional, psychological, and spiritual needs, requiring those needs to be addressed simultaneously after surgery. The emergence of these two themes, as part of the experience after surgery, is credible as they are supported by the Theory of Unpleasant Symptoms.

The symptom experience, explicated by the theory, is made up of a multidirectional interaction among influencing factors, the symptom(s), and consequences (Lenz et al., 1997). The influencing factors include physiological, psychological, and situational factors (Lenz et al., 1997). The symptom experienced may be one or several, may be related or unrelated to other symptoms, and may trigger or augment other symptoms (Lenz et al., 1997). The consequences of the symptom affect functional and cognitive activities (Lenz et al., 1997). Though not explicitly stated, the three components influencing factors, the symptom(s), and consequences of the Theory of Unpleasant Symptoms include the interdependent aspects of people, health status, and environmental circumstances.

Consistent with the theory, there was a multidirectional interaction among the three components in the study. In this study, surgery was an “influencing factor” precipitating the distressing physiologic, emotional, and psychological “symptoms” experienced by all participants. Some “consequences” of the “symptoms” that arose among participants were the emotional, psychological, and spiritual needs that were then addressed by someone or something. Participants explained the connectedness of the three components throughout the interview. For example, the surgery, as the influencing factor, induced pain; the pain, as the symptom, resulted in immobility; then the immobility, as the consequence, became the influencing factor for changes in mood, now another symptom that moderates another component, and so on. The lived experience after surgery among Hispanic adults included the moderating effect of the interdependent aspects of people, health status, and environmental circumstances.

Emancipatory Theory of Compassion

Two of themes that emerged from this study were consistent with the Emancipatory Theory of Compassion (Georges, 2013). Those themes were (1) extreme vulnerability and reliance on others and (2) underlying inequality in knowing and being. The experience after surgery left the individual positioned to need help from others and to succumb to the experience from an ultimate loss of autonomy. The experience also exposed an underlying inequality in knowing and being between the recipient of care and the providers of care where recipients of care relinquished or were put in a position requiring them to relinquish what they knew and needed to what was known and expected by the providers of care. The emergence of these two themes, as part of the

experience after surgery, is credible as they are supported by the Emancipatory Theory of Compassion.

Compassion is possible when suffering is mitigated within the context of where it occurs (Georges, 2013). The Emancipatory Theory of Compassion highlights that compassion and suffering are influenced by power relations that may be present in places where this power may be used (Georges, 2013). Ultimately, hospitals are a place where this power, particularly power over life or biopower, may be exerted and compassion may be impossible because of a constructed division among individuals or groups of individuals within hospitals, acceptance of or conforming to the normalcy of hospital operations, and dissociation from processes contributing to experiences of being in hospitals (Georges, 2013). The relationship among compassion, suffering, and biopower is proposed in the Emancipatory Theory of Compassion (Georges, 2013).

The participants' descriptions of the experience after surgery were as if they had been transplanted into an environment where fear, loneliness, and a reliance on others were routine, which is consistent with the Emancipatory Theory of Compassion. In this study, there were power relations between recipients and providers of care. This division was made evident with providers of care challenging the experience of the participants and questioning the participants prior to rendering care. The hospital environment allowed for this division to occur and it is almost expected. Participants were positioned to relinquish what they knew and needed to conform to the expectations set by the providers of care or care delivery system itself. The dissociation or distancing from processes contributing to experiences, as part of the Emancipatory Theory of Compassion, was described by participants as actions and interactions that were viewed

as simply performing a job. This study exposed the dichotomy between recipients and providers of care within the hospital that must be addressed to promote compassion and alleviate suffering.

Awareness of Mortality

The last theme from this study, awareness of mortality, is consistent with both the Theory of Unpleasant Symptoms and the Emancipatory Theory of Compassion. Participants felt surviving the experience was another chance at life. As a result of this extremely distressing experience where one is almost devoid of personhood for the sake of another's normalcy, the individual creates his or her own value of life and becomes aware of his or her mortality, reflecting on his or her life, questioning actions, and planning for the future. Surviving the experience is another opportunity to continue living and one recognizes changes must occur to maintain life. The unique contribution of this study was the descriptive identification of the phenomenon of the experience after surgery among Hispanic adults. The meaning and essence of the lived experience contributes to and is consistent with current theories in nursing.

Study Strengths

Elements of quality for the study were identified with trustworthiness criteria (Lincoln & Guba, 1985). The strengths in credibility, dependability, transferability, and confirmability will be described. First, credibility was increased by creation of a visualization table for use with the dissertation chairperson during the constant review of data. The visualization facilitated explaining the derivation of the formulated meanings from significant statements and transcript passages as well as encouraged discourse of emerging themes prior to conveying the descriptive identification of the phenomenon.

The visualization included the general feeling acquired from having read the transcripts, passages from where direct quotes and significant statements were extracted, translations of the direct quotes from Spanish to English when applicable, and formulated meaning units. The visualization was also used to document and substantiate the emerging themes and the descriptive identification of the phenomenon. Also included in this review of data was the quality of the interviews by the dissertation chairperson. The semi-structured interview was sufficient to focus discussion on the research question by asking how the participant felt, asking the participant to elaborate on those expressed feelings, and encouraging the participant to explore what contributed to their feelings. Credibility is achieved when the shared meaning of the participants' experience aligns with what has been described by the researcher (Schwandt, 2015).

Next, documentation of the research process by the researcher enhanced dependability. The researcher outlined and reviewed the plan of inquiry prior to recruitment to maintain dependability. Additionally, field notes and memos were used to show either consistencies or changes in the data collection process and development of the product of inquiry through data analysis for use with dissertation committee review. Dependability is achieved when the research process is well-documented to show it was conducted systematically and logically (Creswell, 2013; Schwandt, 2015).

Transferability is the third criteria of trustworthiness. The volume of surgeries performed at the study setting and the differences in sample characteristics (Table 1) added to the transferability of the findings. The setting performs over 8,000 surgeries a year, and not one participant had the same surgery. The sample included 5 female and 5 male participants, with differences in age, length of time in the United States, preferred

spoken language, level of care, and education completed. These differences within the sample do not limit transferability to a single gender, age group, level of acculturation, severity of illness, or education, but enough description is provided to enhance transferability to applicable groups. Transferability is achieved when descriptions are detailed enough for readers to determine if findings may be applicable to similar groups (Creswell, 2013; Schwandt, 2015).

Lastly, the experience after surgery was the phenomenon of interest and confirmability of the findings was increased with interviews conducted as close to the experience as possible. Interviews conducted further from when the experience occurred may yield information influenced by external factors (Omery, 1983). In this study, interviews occurred 1 to 15 days from the participant's most recent inpatient surgery and all but two occurred within a week of the surgical procedure. The timing of the interviews facilitated the participant's focus on notable incidents and recollections of the experience coming to awareness. Confirmability is achieved when findings are objective and not fabricated by the researcher (Creswell, 2013; Schwandt, 2015). Overall, the strength of this study was established as elements of credibility, dependability, transferability, and confirmability were achieved, but it is also established from its contributions to the current body of knowledge as outlined above.

Study Limitations

Threats to the quality of the study arose from evaluating the degree to which trustworthiness was achieved (Lincoln & Guba, 1985). There were certain limitations to this study and will be described in terms of credibility, transferability, and confirmability. First, formulated meanings and clusters of themes were not reviewed by participants as a

recommended technique to increase the credibility of findings (Lincoln & Guba, 1985). In this study, the researcher followed Colaizzi's (1978) procedural steps as originally outlined with the exception of the last step of returning to each participant for a single interview or a series of additional interviews to inquire about how the study findings compared to their experience. Colaizzi (1978) describes the procedural steps for analyzing phenomenological data as descriptive, not prescriptive, because the procedural steps may need to be modified based on the researcher's approach or the phenomenon under study. With the average length of stay in hospitals being almost five days, the last step of returning to each participant was not included since completing this step would have occurred after the participant has been discharged and may have yielded information influenced by external factors when the experience while hospitalized after surgery was the phenomenon of interest (CDC, 2015b; Omery, 1983). As a result, this limitation was addressed with constant review of data by the dissertation chairperson and reflexivity by the researcher during data analysis procedures, allowing for findings to accurately represent what has been shared by the participants (Creswell, 2013).

Next, the setting where the study was conducted and the characteristics of the sample interviewed limit the extent of transferability of the findings. The study was conducted in Southern California at tertiary hospital and quaternary referral center for Central and Southern California. The sample comprised Hispanic adults and all but one were raised in Mexico or the United States. The participants interviewed in this setting may not be similar to those interviewed at other hospitals. To address this limitation, the researcher provided descriptive information about the context under which the phenomenon was explored, including participant demographic data (Table 1) and quotes,

so judgements of similarities for transferability may even be possible (Lincoln & Guba, 1985).

Lastly, emphasis lies on the characteristics of the data when addressing confirmability and that may be influenced by data collection and analysis procedures (Lincoln & Guba). In phenomenological research, the participant and researcher are partners in exploring the phenomenon of interest and both affect data collection procedures (Moustakas, 1994). The extent to which participants divulge their experiential knowledge and understanding throughout the interview may influence the confirmability of the findings. Additionally, the researcher's personal and professional background as a Hispanic woman who worked as a direct care nurse and is now working as an adult-gerontology clinical nurse specialist, as well as the researcher's affiliation with the healthcare system, may also influence confirmability of the findings. In this study, all participants were interviewed in their hospital rooms and interviews ranged in duration from 13 to 66 minutes. Participants were then encouraged to share their experience and clarification was sought throughout the interviews with follow-up questions and statements to address this limitation. Reflecting and note-taking were also part of the plan of inquiry to address this limitation, allowing the researcher to suspend assumptions during participant interviews and explore the phenomenon with openness during data analysis (Moustakas, 1994; Schwandt, 2015). All materials that facilitated an audit of data and their sources were kept.

Study Implications

Participants in this study shared their experiential knowledge and understanding of their experience after surgery. They openly described their distressing physiological,

emotional, and psychological states and corresponding physiological, emotional, psychological, and spiritual needs. Additionally, they divulged their extreme vulnerability and reliance on others, underlying inequality in knowing and being, and awareness of mortality. The meaning and essence of the lived experience after surgery has implications for the entirety of nursing.

Nursing Education and Practice

Though implications for education and practice are not the primary goal of phenomenological research, the dynamic relationship among the interdependent aspects of people, health status, and environmental circumstances in nursing practice may be influenced by simply increasing awareness of nursing's role in the experience after surgery (Bender, 2018). Nurses must know a dichotomy between recipients and providers of care exists even if only within the sample of this study. With further research, nursing endeavors may address this disparate relationship, promote compassion, and alleviate suffering of patients in hospitals.

Nursing Research

The participants in this study were uniquely distressed and experienced conflicting needs after surgery. It is known that pain is multidimensional (Jensen, Dworkin et al., 2006; McGuire, 1992; Melzack & Katz, 2013). As reviewed in chapter 2, routine pain assessments may be inaccurately capturing the experience after surgery by Hispanic adults, as population-specific instruments have not been developed for this group (Cassisi et al., 2004; Melzack & Torgerson, 1971; Waddie, 1996). Within the narrow context of pain after surgery among Hispanic adults, further research is needed to modify existing or develop new instruments used for routine pain assessments to improve

subsequent treatment. Alternatively, further research may evaluate if an instrument may even reliably measure the entirety of the pain experience and generate valid data considering the interrelated dimensions of pain and the complexity of the context in which pain is experienced.

The findings of this study represented an experience among Hispanic adults where compassion was limited and suffering was perpetuated. This study excluded adults who did not self-identify as Hispanic and future studies should explore the experience after surgery among other populations to make known similarities and differences across cultures. Additionally, the study was conducted at a tertiary hospital and quaternary referral center for Central and Southern California with a high volume of surgical procedures and future studies should explore the phenomenon in different geographic areas and care delivery models. Future research may then evaluate the relationship between the meaning and essence of the experience and the known healthcare disparities among populations. Assessments guide treatments in healthcare and the fundamental structure of what is being assessed should be known.

The phenomenon of interest in this study was the experience after surgery. Current management of surgical patients is often guided by clinical pathways having emerged conceptually in research in the 1970s and later in practice in the 1980s (Coffey et al., 1992). By definition, clinical pathways are multidisciplinary plans of care that translate evidence into hospital processes, outline the specific intervention timeframes, and standardize care for a specific population (Lawal et al., 2016). Management of surgical patients with clinical pathways limits individualized care (Kaptain, Ulsoe, & Dreyer, 2019; Sibbern et al., 2016) and may account for the delivery of care by providers

and the resulting experience after surgery by recipients of care despite being on a 'pathway.' For this reason, replicating this study with non-surgical patients may provide insight into differences in the experience while hospitalized between medical and surgical patients as surgical patients may constitute a qualitatively different group in today's practice standards.

Summary

This study described the lived experience after surgery among English-, Spanish-, and bilingual-speaking Hispanic adults while hospitalized after surgery. Despite the increase in surgical procedures across the United States, the experience after surgery among this population was an unexplored phenomenon prior to this study. This gap in knowledge was narrowed with this qualitative inquiry that revealed more fully the meaning and essence of the experience. The findings were discussed and contributions of these findings to current theories were presented. Additionally, study strengths, limitations, and implications were described separately.

The unique contribution of this study was the descriptive identification of the phenomenon of the experience after surgery among Hispanic adults. The lived experience after surgery included the moderating effect of the interdependent aspects of people, health status, and environmental circumstances. This study exposed the dichotomy between recipients of care and providers of care within the hospital that must be addressed to promote compassion and alleviate suffering. As a result of this extremely distressing experience where one is almost devoid of personhood for the sake of another's normalcy, the individual creates his or her own value of life and becomes aware of his or her mortality, reflecting on his or her life, questioning actions, and planning for

the future. Surviving the experience is another opportunity to continue living and one recognizes changes must occur to maintain life.

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Appendix A

Recruitment Flyer

RESEARCH PARTICIPANTS NEEDED!

Lived Experience of Acute Pain after Surgery among Hispanic Adults

I am seeking Hispanic adults who had surgery and have been in the hospital for longer than 24 hours.

I am a doctoral nursing student at the University of San Diego conducting a study to find out how Hispanic adults describe their pain experience after surgery.

Participation involves a private interview answering questions about yourself and your pain experience. The interview takes about two hours.

Please contact Kimberly Sanchez at 213-924-1919 for more information or email at kimbsance@gmail.com

Appendix B
Demographic Survey

1. Age in years: _____
2. Gender: Male/Female
3. Country where participant was raised:
 - a. US
 - b. Non-US country: _____
 - c. Prefer not to answer
4. Country where participant's parents were raised:
 - a. Mother:
 - i. US
 - ii. Non-US country: _____
 - iii. Unknown
 - iv. Prefer not to answer
 - b. Father:
 - i. US
 - ii. Non-US country: _____
 - iii. Unknown
 - iv. Prefer not to answer
5. Length of time in the US in years: _____
6. Number of years of education completed: _____
7. Preferred spoken language: _____
8. Self-rated percentage of time English and Spanish are spoken: _____

9. Frequency of visits with healthcare providers: _____

10. Occupation: _____

11. Religious preference: _____

12. Type of surgery identified by the surgical service on the operative note:

13. Last documented pain intensity with date and time: _____

14. Last documented pain medication with dose, route, date, and time: _____

Appendix C

Interview Guide

Note time and date of interview: _____

Participant number: _____

Opening statement: Thank you for partnering with me in trying to understand your experience after surgery. Together, we will try to reveal your experience more fully by immersing ourselves in the experience. I will be asking you questions to share your recollections of the experience and focus on notable incidents coming to awareness.

Questions:

1. Tell me about how you felt after surgery. / Digame como se sintio despues de su sirugia.
 - a. How would you describe what you were feeling? / ¿Como le explicaria ha alguien lo que usted estaba sintiendo?
2. Tell me about a time when your pain after surgery was bad during your hospital stay. / Comparte conmigo un momento en cual su dolor despues de su sirugia estaba bien grave durante este tiempo en el hospital.
 - a. What did you feel? / ¿Que sintio?
 - i. What does it feel like to be in pain after surgery? /¿Como se siente tener dolor despues de una sirugia?
 - ii. When you felt pain, what did you do? /¿Cuando usted sentia dolor que hacia?

1. If no action as a result of feeling pain: How did the nurse ask you, to find out, if you were in pain? /¿Como le pregunto la enfermera, para averiguar, si usted sentia dolor?
- b. Who did you tell? / ¿A quien le dijo?
 - i. How did you communicate (let the nurse know) you were in pain? /¿Como le comunico (dijo a la enfermera) que usted sentia dolor?
 1. If mention words: What words did you use to communicate what you were feeling at the time of the pain to the nurse? /¿Cuales palabras uso para comunicarle (decirle a la enfermera) las características (el tipo de dolor) del dolor que usted sentia a la enfermera?
- c. What did they do? / ¿Y que hicieron?
 - i. Was what they did helpful? / ¿Le ayudo lo que hicieron?
 - ii. How did you feel after they did something? ¿Como se sintio despue de que hicieron algo?
3. Under what circumstances have you experienced pain previously? / ¿Cuales eran las circunstancias (cuando) en cual usted ha sentido dolor anteriormente?
4. What remedies have you tried for pain relief prior to surgery? After surgery? / ¿Cuales remedios ha usado para el dolor antes de la sirugia? ¿Despues de la siriugia?

Closing statement: Thank you for sharing your experience with me during this interview.

Appendix D

Institutional Review Board Oversight – University of San Diego



Aug 6, 2018 9:11 AM PDT

Kimberly Sanchez
Hahn School of Nursing & Health Science

Re: Expedited - Initial - IRB-2018-528, Lived Experience of Acute Pain after Surgery among Hispanic Adults

Dear Kimberly Sanchez

The Institutional Review Board has rendered the decision below for IRB-2018-528, Lived Experience of Acute Pain after Surgery among Hispanic Adults.

Decision: Approved

Selected Category: 5. Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Findings: None

Research Notes:

Internal Notes:

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,

*Dr. Thomas R. Herrinton
Administrator, Institutional Review Board*

**Office of the Vice President and Provost
Hughes Administration Center, Room 214
5998 Alcalá Park, San Diego, CA 92110-2492
Phone (619) 260-4553 • Fax (619) 260-2210 • www.sandiego.edu**