

# THREE PATIENT CONFERENCES

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After having two years' experience as a clinical instructor on a female surgical ward, the author has often wondered if patients going to surgery have been adequately prepared for their operations. Have their questions been answered and their psychological needs been met? As students must work under the limitations of time, knowledge and skills, it is the author's intention to find a different approach to that of the traditional bed-side teaching, so that the needs of both the patient and student may be better satisfied.

In recent years, there has been an increasing number of group sessions employed in teaching-learning situations. Such experiences are integral parts of programs of nursing, medicine and other health sciences(1, 2, 3). Their use is particularly noted in clinical areas, for example the antenatal clinics, preoperative patient teaching conferences and psychosocial therapeutic sessions etc. The author does not need to belabour the advantages of group sessions; it has been widely recognized that members of a small group seek and receive support from one another. They enjoy the sense of group identity and a satisfaction of attainment of the aims and objectives of the group. Studies have revealed that many patients experience a certain amount of anxiety, preoperatively(4, 5, 6), and that such patients may obtain support and help by sharing their anticipated experiences with other patients and with a knowledgeable professional, such as a nurse(7, 8, 9, 10). Hearing others verbalize their fears, concerns and apprehensions about surgery may encourage a patient to do the same. Explanations by a nurse will help to increase, in a meaningful way, the patient's knowledge about his forthcoming surgery. It was thus decided that group sessions be tried to prepare patients for their operations.

When the proposal of a presurgical patient conference was presented to a clinical group of second year baccalaureate students, it was met with instant acceptance and great enthusiasm. Students considered this an opportunity to test their knowledge and skills in health teaching, which is a major component of nursing, and to experience group dynamics under their own leadership.

Two students immediately volunteered to conduct the first of such conferences. It was agreed that this would be a self-directed learning experience, and the instructor would merely serve as a re-

source person to provide assistance, if needed. The two students involved themselves in detailed preparation, under the guidance of their instructor. Special attention was paid to both content and method of presentation to ensure patient-centeredness. In order to facilitate patient-comprehension, medical terminology was minimized and technology simplified. The first conference was then held three days after the project was launched.

#### *FIRST CONFERENCE: PREOPERATIVE*

In forming a group, principles of group dynamics were fully utilized. Most writers agree that the essential fundamental quality of a group is the sense of a mutual goal. Accordingly, in order to form a common goal within the group, we included only those patients who were preoperative. The size of a group was also important in relation to group interaction and logistics. The group must be large enough to create a group-atmosphere, yet not too large to feel a loss of identity in the crowd. For our purposes, we invited seven patients for our first conference. The third point we deliberated was the timing of the meeting which must be acceptable to both patients and students. We contemplated a session of one-hour in the evening. The ward staff was consulted, and it was agreed that the period from 8:30 p.m. to 9:30 p.m. would be most desirable.

The two students invited patients, matching their ages and diagnoses to form a homogeneous group. As most patients were either English or French speaking, it was decided that the conference would be bilingual. The conference room was duly prepared to provide atmosphere, good visibility, comfort and opportunity for interaction. Beverages were also served to enhance atmosphere.

The speakers approached the group by introducing to each other all those present and by restating the purpose of the discussion session. It was made clear that purposes of the conference were to familiarize patients with their hospital environment, to inform them about their respective surgeries and to answer questions raised by the participants. The patients responded positively to the introduction, as one of them exclaimed: "What a good idea!" and another commented: "I have had six operations and this is the first time I am being taught something."

The group's attention was then drawn to the black-board where the content was outlined as given in table 1.

The first area dealt with the admission day for surgical patients. There was a great deal of discussion with regard to admission procedure. One patient inquired of the students if soap-suds enemas were routinely given the night before operation for minor surgeries,

TABLE 1

AGENDA FOR PRE-OPERATIVE CONFERENCE

Preoperation Day	Operation Day	Immediately
—admission	IN THE ROOM	Postoperation
—physical examination	—still fasting	RECOVERY ROOM
—laboratory tests:	—a good bath	—cared by special team
urine, blood, and	—gowning	—regain consciousness
chest X ray	—removal of jewellery,	—back to ward
—signing of surgical	pins, underwear,	BACK TO ROOM
consent	dentures, nail polish,	—vital signs checking
—cleansing of	make-up and	—bedside rails up
operative site (with	other accessories	—intravenous infusion
soap and possibly	—urinate before	routinely
shaved)	preanesthetic	—operating room
—enema the night	medication	dressing
before	—preanesthetic	—good expansion
—fasting from	medication	of lungs:
midnight	—accompanied by	change position
	nurse to operating	deep breathing and
	room	coughing exercises
	INTRAOPERATION	—good circulatory
	—drowsiness	exercises;
	—the environment	in-bed exercises
	—the surgical team	early ambulation etc..
	—loss of consciousness	

and if so, why? Another was quick to point out that routine blood works were hemoglobin tests and not blood typing and cross-matching as stated. A third patient was concerned that if, upon physical examination, she was found unfit to receive the scheduled operation, what would then happen? Bedtime sedation and fasting after midnight, the night before operation, were also discussed. Some patients were worried about the fact that they had never slept in a strange environment and wondered whether sedatives were going to help. Others were anxious to know if a light breakfast might be provided, should the operation be scheduled in the coming afternoon.

The second part of the session dealt with the immediate pre-operative preparation in the morning prior to the surgery. Group members were informed that fasting should be continued, and that maintaining cleanliness, gowning and removing all artificial accessories were to be observed. The purpose and effects of preanesthetic medication were also thoroughly explained. Patients were reassured that when sent to the operating room by stretchers, they were always to be accompanied by nurses.

Many of the patient-participants were anxious to know how soon the preanesthetic medication would be effective. Would they still be awake when arriving at the operating room? One asked how many injections she was to receive, and added that she would not mind them if she would be unconscious soon after. Practically all patients requested knowledge of the surgery itself:

- how anesthesia was given and what its effects were.
- how long a procedure of stripping and ligation of varicose veins would last.
- where on the abdomen the doctors would incise for cholecystectomy.
- whether thyroidectomy was considered a major operation.

Another area with which patients were concerned was the recovery room. Most of them were concerned about the length of time required of them to stay there. Some worried about who the experts caring for them during the semi-conscious period would be. All patients shared what they knew with each other, and the interaction was warm and cordial. The instructor added pertinent information when appropriate to clarify a point or to enhance discussion. In this capacity, she fulfilled the role as a catalyst.

The last part of the session dealt with the immediate postoperative period. Patients were informed that it was not uncommon for them to return to the ward with intravenous infusions, levine tubes, suction etc. The purpose of each was explained and questions encouraged. Samples of gauzes, pads and bandages were presented as visual aids, and were passed around for patients to reach an understanding of their different functions. Some felt relieved, as they learned that layers of dressing, in most cases, merely serve to provide support and a sterile field, and the size of dressings was no indication of the size of the incision. When examining various dressings, one patient remarked that she was allergic to tape and she had neglected to mention this information to the nursing staff upon admission.

There were a number of questions of common interest. One patient asked why intravenous infusion was necessary and the usual location for administration of same. Another asked how soon she could begin dieting after the operation. Still another worried if she would be nauseated postoperatively, as she had always been in the past. In answering these questions, the students supported each other, and the two-way participation pattern soon became multidirectional. In assuring patients of their role in their own recovery, group members were apprised of the importance of deep breathing and coughing exercises and early ambulation. Speakers demonstrated physiotherapy exercises and patients followed. One patient asked in anxiety if she should perform the same coughing exercises, since she was to have a thyroidectomy.

As the session continued, more and more discussion was generated. Patients began to explore their feelings towards their surgeries and

began sharing their experiences. One patient stated that she was so nervous about her breast surgery that she would perspire every time she thought about it. Another responded sympathetically and said: "I know how you feel because I, too, am going to have lumps removed from my breast." At this stage, patient-members readily supported and comforted each other. The instructor and students assisted patients only when required.

When the conclusion was finally reached, it was realized that the conference had lasted approximately one hour and twenty minutes and was longer than anticipated. Patients all seemed to have enjoyed and benefited from the conference. As they left, each expressed her appreciation to the nursing members. One patient, with her right index finger raised, remarked that she would write an article on the importance of such conferences, if she were a journalist.

A brief meeting was held immediately following the patient-conference to evaluate the experiment. Students' responses were overwhelmingly positive. They were stimulated by the opportunity to assume an independent role and to challenge that role in public. Students learned, very quickly, the importance of good theoretical preparation and intellectual honesty as one remarked: "The patients know a lot. You really have to know what you are talking about, or you would not last".

The group conceded that the following points should be noted for future references:

1. A good introduction was important, as it set the pattern for the subsequent behaviour of the group
2. A unilingual conference would be preferred, since it would facilitate discussion
3. The conference be scheduled at different hours, so it should not end too late in the evening
4. Comfort measures for patients should be more carefully observed, as we neglected to elevate the legs of a patient who had varicose veins and was experiencing discomfort in the conference.

The joy of achievement soon spread to other students. In our following conferences, we had student-observers from other clinical groups.

### *SECOND CONFERENCE: DISCHARGE*

As the preoperative conference was well received, students were now eager to explore other opportunities. The idea of preparing patients to go home was then conceived for the second conference, since it was felt that the topic of discharge would be of common interest to patients as well as students.



Two other students volunteered for the assignment and preparatory work was similar to the previous conference. As the students examined the terms of reference of the conference, it was realized that patients would have different needs and problems, based on their disease processes; homogeneity in the group regarding diagnoses was then important. Having studied the possibilities, the two students concluded that they would form a group and would invite only those who had abdominal surgery and those with venous disorders. Other patients were not considered suitable for group participation, since they either had isolated problems or were not ready to anticipate discharge.

The schedule for the conference was discussed and it was agreed to try the time between 4 P.M. and 5 P.M., immediately after students reported for their afternoon shift.

Five patients were invited to attend the conference: three with cholecystectomy, one with stripping and ligation of varicose veins and the other postoperative phlebitis. Only three students, including one observer, other than the two speakers were admitted in order not to out-number the patients.

Comfort measures were carefully observed this time with special attention to those with venous problems. Soft chairs were provided for patients and cold beverages served. The conference began with an informal introduction, and the attention was then drawn to the black-board on which the agenda was outlined as in Table 2.

Very few questions were raised from the topic of "the day of discharge" except regarding time and arrangement. A great deal of discussion generated, however, from the item of personal care. It was obvious to the writer that patients were inadequately prepared to go home. They were concerned about when to take a bath, how to wash their hair, whether they could wear girdles with abdominal incisions, and especially how to care for the wound. One patient who had an operation for varicose veins was to be discharged with sutures in. She was very much worried about the job of taking care of the numerous small incisions on her legs.

Diet appeared to be a common interest to all females and was discussed at great length. Patients were familiar with dietary terms like low cholesterol, low fat, high protein etc., but were uncertain about right kinds of food. Examples and explanations were given by students, and a diagram was drawn to illustrate the gastrointestinal system with specific reference to cholecystectomy. Cooking and eating habits of family members were among topics discussed relating to food preparation.

TABLE 2: AGENDA FOR POST-OPERATIVE CONFERENCE

ON THE DAY OF DISCHARGE	PERSONAL CARE
—authorization of discharge by physician	—personal hygiene
—time of discharge	—care of the wound with and without sutures
—transportation services	—how to change dressings, if any
—payment of bills, if any	—diet
—return of safe-keeping articles, if any, including valuables and medication	—activity
—return appointments, if any	—rest and sleep
HOME PREPARATION	—medication, if any
—transportation of patient	—community resources for nursing services
—domestic help: private arrangements and community resources	—in case of emergency
—preparation for receiving the patient	FOLLOW-UP APPOINTMENTS
	—how to obtain them
	—importance of keeping appointments

Activity was an area of great concern. For example, how soon after surgery could one go back to work? What kind of domestic activity was allowed? One patient, who was an active golf player, asked how long should she wait before she could go back to the "back-swing" following cholecystectomy while another patient with the same diagnosis wondered if she could travel fifteen miles to attend a wedding in two month's time. A patient with varicose veins presented different problems: she had a family of three young children and had to help in supporting them by working as a housekeeper in a department store. It was obvious that the mother could not obtain sufficient rest after discharge. Students felt somewhat helpless to improve the situation, but, nevertheless, provided her with some practical advice. One patient, who had dehiscence of wound and was going home with gauze packings, expressed her fear of the open wound and wanted to know more about the arranged services of the Victorian Order of Nurses.

Patients all appeared to appreciate fully the importance of rest, sleep and of keeping follow-up appointments. Few questions were asked in these areas.

At our evaluation session, immediately after the patients' conference, it was generally agreed among the participants that we definitely gained some knowledge in needs of patients of which we had not been aware before, though students were not totally satisfied with the degree of success achieved from this conference. In retrospect, it was recognized that patients were worried about their individual problems, and they interacted mainly with the speakers to obtain vital information. Discussion was also interrupted by repeating whatever was said in both English and French. One patient with post-operative phlebitis did not participate actively and seemed to be isolated by her distinct disease process. Students all openly expressed their

opinions during the evaluation. One doubted the selected topic of the conference and pointed out that "going home is an individual thing." Another suggested that patients be given advance notice, so they could think of questions ahead of time. Still a third student recommended that the session be presented to patients as "a gathering to discuss the questions they had" rather than "a conference", to ensure patients' active role of participation. However, all agreed that homogeneity of the group was the paramount factor affecting group dynamics, and for future discharge conferences, the following were to be emphasized:

1. Advanced notice will be given to patients in order they might be better prepared
2. Group homogeneity should be observed in order to promote a sense of identity among members
3. The sessions should be patient-centered, rather than nurse-oriented.

It was also felt that certain topics which were not included in the discussion could be admitted in the future sessions:

For example:

- the question of pregnancy; whether it is advisable immediately following abdominal surgery
- the question of sexual activity following cholecystectomy
- patient's psychological preparation for returning home after hospitalization
- the psychological preparation of members of the family for receiving patient, especially, if patient still requires nursing care.

### *THIRD CONFERENCE: PREOPERATIVE*

Although they felt some disappointment from the second experiment of group teaching, students were still eager to learn. A third conference on presurgery was then held in the following week.

Only one student was asked to chair the session, as the intended participants would form a unilingual group. Advance notice was given to patients, in order to prepare them psychologically, and it was emphasized that the aim of the session was to answer their questions. There were four possible candidates; three were waiting for cholecystectomy, and one for anal fistula, and none refused our invitation. The conference was held once again in the evening from 8:30 P.M. to 9:30 P.M. to avoid class conflict. Punctuality would be observed and the bed-time routines should not be disrupted.

An outline similar to the first conference was used as a guide for discussion, but a great number of questions were encouraged. All participants experienced an exceedingly relaxed atmosphere, and the interaction could be described as intimate as the conference proceeded.



It was felt that the third conference achieved a more patient-centered discussion and had achieved a greater magnitude of communication among the group. The following questions, asked by patients, exemplify the content and extent of discussion:

- I understand the anesthesia is given in the shoulder and I would be awake with it, is that true?
- Does one's blood pressure go up during the anesthesia?
- Does one have a stroke with the anesthesia? This is what I was told.
- Is there any danger of waking up during the anesthesia?
- Do the doctors give you medication to restore you to consciousness?
- How long does one usually stay in the recovery room?
- Why are there different incision lines for the same procedure of cholecystectomy?
- Is the incision long for cholecystectomy?
- Does one have a tube (a drain) in the abdomen with the above operation?
- What happens to bile following removal of the gall bladder?
- Does one get a tube (a levine tube) in the nose?
- Is the above tubing bothersome?
- Do they insert the levine while you are unconscious?
- Do we eat and drink with it in?
- Does one have a sick stomach with the levine?
- Would blood transfusion make one sick?
- Do I need a special nurse following surgery?
- Do we drink a lot of water right after operation?
- Is the operation of cholecystectomy worse than hysterectomy?
- Can you eat eggs after surgery? What about the yolk?

It was noted that patients talked, not only about their own problems, but also those of their family members and friends. For example, one patient wanted to know the purpose of a one-month-old indwelling T tube connected with a bile bag her sister-in-law had while recovering from cholecystectomy at home, and another about her husband's low cholesterol diet.

As the academic term was drawing to a close, the third conference was the last in the series. In our evaluation of the experimentation of group patient teaching, we felt that we had certainly found an approach which can better meet patients', as well as students', needs. This simultaneous satisfaction should be an integral goal to all nursing educational programs. Our rudimentary data command the attention of educators who plan for effective, self-directed learning and of administrators who aspire to provide quality care. It is hoped that our continued experimentation in this area shall provide data required to formulate guidelines for future nursing practice.

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#### REFERENCES

1. E. R. Grogan, "Group Methods and Personal Growth of Freshman Nursing Students," *Nursing Papers*, Vol. 5, No. 2, September, 1973, pp. 12-17.
2. Faculty of Medicine, McMaster University, *The McMaster Philosophy, An Approach to Medical Education*, Hamilton, Ontario: McMaster University, Education Monograph No. 5, January, 1974, pp. 10-12.
3. R. Veninga & D. J. Fredlund, "Teaching the Group Approach," *Nursing Outlook*, Vol. 22, No. 6, June, 1974, pp. 373-376.
4. D. L. Carnevali, "Preoperative Anxiety," *American Journal of Nursing*, Vol. 66, No. 7, July, 1966, pp. 1536-1538.
5. J. R. Cassady & J. Altrocchi, "Patients' Concerns about Surgery," *Nursing Research*, Vol. 9, No. 4, Fall, 1960, pp. 219-221.
6. E. H. Winslow & M. F. Fuhs, "Preoperative Assessment for Postoperative Evaluation," *American Journal of Nursing*, Vol. 73, No. 8, August, 1973, pp. 1372-1374.
7. K. M. Healy, "Does Preoperative Instruction Make a Difference," *American Journal of Nursing*, Vol. 68, No. 1, January, 1968, pp. 62-67.
8. C. A. Lindeman & B. Van Aernam, "Nursing Intervention with the Pre-surgical Patient — the Effects of Structured and Unstructured Pre-operative Teaching," *Nursing Research*, Vol. 20, No. 4, July-August, 1971, pp. 319-332.
9. C. A. Lindeman, "Nursing Intervention with the Presurgical Patient: Effectiveness and Efficiency of Group and Individual Preoperative Teaching — Phase Two," *Nursing Research*, Vol. 21, No. 3, May-June, 1972, pp. 196-209.
10. F. E. Schmitt & P. J. Wooldridge "Psychological Preparation of Surgical Patients," *Nursing Research*, Vol. 22, No. 2, March-April, 1973, pp. 108-116.

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#### RESPONSE TO "THREE PATIENT CONFERENCES"

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Choi-Lao's paper, "Three Patient Conferences" describes an effort to alleviate a perceived clinical problem, inadequate client education particularly in the preoperative period, by utilizing group teaching sessions. Her purpose was to enhance both client and student satisfaction by introducing an approach differing from traditional bedside teaching.

The literature supports the choice of the group process in teaching-learning situations and the benefits of mutual client support. Through experience, the students learned the importance of a homogenous group with a common goal in facilitating learning. Redman discusses the importance of analysing the milieu in which learning takes place "since it can powerfully influence behavior and potentiate or negate any teaching efforts" (1). Since fellow group members form the most