Patients with coronary artery disease adopted an accepting, progressive life course or a non-accepting, regressive life course

Lukkarinen H. *Life course of people with coronary artery disease.* *J Clin Nurs* 1999 Nov;8:701–11.

QUESTION: How do patients with coronary artery disease (CAD) experience their life course in the year after surgery?

Design

Phenomenology.

Setting

Oulu, Finland.

Patients

10 women and 9 men who had severe CAD and had been treated with either coronary artery bypass grafting or percutaneous transluminal coronary angioplasty.

Methods

Individual interviews of 90–120 minutes were conducted 1 year after treatment and addressed the course of treatment and patients' everyday experiences. Analysis proceeded according to Giorgi's method.

Main findings

2 types of general life course narratives were revealed: an *accepting, progressive life course* and a *non-accepting, regressive life course*, which differed in terms of the life situation, meaning of illness, and attitudes toward everyday life, work, family, and the future.

Patients who had an accepting, progressive life course were mostly older and living on an old age or disability pension after the onset of CAD. They were relieved to have a conclusive diagnosis of CAD, were content with the outcome of treatment, and had not had recurrent symptoms. These patients saw CAD as an insidious disease that had developed over time as a result of physical and emotional stress, an unhealthy lifestyle, and genetic factors. They shifted their values and life goals from material things to interpersonal relationships and health. Their attitude to treatment was characterised by activity, responsibility, and optimism. Their attitude to work reflected a realistic willingness to give up their jobs and find new ways to participate in society. Families were seen as a social haven, where the illness was a shared experience that united family members. These patients felt optimistic about their future, lived their lives realistically one day at a time, and did not postpone their goals.

Patients who adopted a non-accepting, regressive life course were relatively young (most were <54 y of age) and had been actively working. Typically, they had a serious myocardial infarction without any preceding symptoms. These patients felt that the onset of CAD was a shocking disruption to everyday life and expected surgery to allow them to return to their previous work and lifestyle. Their treatment was not as effective as they had expected, and their symptoms tended to recur. Their values did not change—material goals were only temporarily postponed. They attributed their illness to mental

stress caused by a demanding job or traumatic life experiences more than physical stress or an unhealthy diet. These patients were dissatisfied with their care after surgery and felt that healthcare providers were unable to meet their needs or recognise their problems. They found it difficult to change their attitudes to work and to accept their status as chronically ill. Patients, particularly women, felt that CAD separated them from their families. They lived one day at a time, with a lack of direction that thwarted their plans for the future.

Conclusion

The life course of people with coronary artery disease was revealed in 2 types of narratives: an accepting, progressive life course and a non-accepting, regressive life course.

Source of funding:
Finnish Academy.

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COMMENTARY

This study by Lukkarinen is interesting in that it focuses on the experiences of patients with CAD after coronary artery bypass grafting or percutaneous transluminal coronary angioplasty. Previous work in this area has concentrated on patients who were recovering from myocardial infarction, but who did not necessarily have treatment to address their CAD. The patients in this study seemed to have adopted 1 of 2 possible life courses, which differed in terms of the patient's expectations of treatment. The 2 life course narratives, which described patients who felt they had some control over their illness (accepting, progressive life course) and those who felt that the responsibility for symptom control and recovery lay with others (non-accepting, regressive life course) are consistent with other work on coping styles in chronic illness.¹

Lukkarinen has taken care to describe the research process used in this study. Participants' narratives were used effectively and revealingly, and nurses working in cardiac rehabilitation will recognise patterns of behaviour that apply to patients they have known. It would have been informative to know if any steps had been taken to ensure qualitative rigour.

The study's findings clarify the need for nurses working in rehabilitation settings to develop excellent interpersonal skills and to attempt to spend enough time with patients to make a thorough, individual assessment, using non-verbal and verbal indicators. The findings may also help nurses to recognise at an early stage the characteristics of patients who may need individualised efforts to help them to see the value of participating in cardiac rehabilitation at an optimum time for them. Previous studies have identified predictors of patient dropout from cardiac rehabilitation that are very similar to the characteristics of study participants who described a non-accepting, regressive life course.² This study also emphasises the need for cardiac rehabilitation to be a comprehensive experience for patients and their families that addresses the social and emotional aspects of adjustment to chronic illness, as well as the physical and educational aspects of recovery.

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- 1 Bandura A. Self-efficacy: toward a unifying theory of behavioral change. *Psychol Rev* 1977;84:191–215.
- 2 Mullinax C. Cardiac rehabilitation programmes and the problem of patient dropout. *Rehabil Nurs* 1995;20:90–2, 101.