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Acting Slow in a Fast World: A Phenomenological Study of Caring in the Recovery Room

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Abstract

In this paper, we discuss "the slow in the fast" related to care situations in a "fast-track" hospital setting were the length of patients' stay has been reduced significantly. The discussion is based on a narrative created from observations made in a postoperative care unit where patients are intensively observed and cared for during a very short time span.

We found that within the phenomenological notions of lived time, lived space and lived illness, it is possible to create an imaginative space in time – to make a time warp. Despite being in a setting where the objective time measure dominates, the nurse can create a rhythm of her own in the room. Thus, acting slow in the quick meeting means that nurse-patient relationship is characterized by calmness and quietness, the nurse's engagement in the patient's suffering and her help to the patient to endure the present and hold the now.

A High-Paced Environment

Worldwide, healthcare systems and settings are evolving rapidly. New treatments are continuously being introduced and there is a concurrent demand for more efficient healthcare systems. Well-established treatments and procedures have been dramatically changed as standardised fast-track treatments and care programmes are introduced for a wide range of more or less common treatments (Kehlet & Wilmore, 2008; Zargar-Shoshtari & Hill, 2008). A study by Specht, Kjaersgaard-Andersen, Kehlet, and Pedersen (2015) may serve to illustrate this trend. They document a decrease in length of stay (LOS) in hospital during the 2002-2012 period from 8.6 to 3.3 days for patients undergoing total hip arthroplasty. Similarly, LOS was reduced from 8.0 to 3.1 days for total knee arthroplasty. Treatments that used to require several days of hospital admission are now often performed on a day-to-day basis or as same-day surgery. These standardised pathways are generally based on high-impact medical evidence. The aim of such pathways is to provide the highest possible quality of treatment and care. "Improved surgical techniques and improved pain management that allows patients to be mobilised within a few hours after surgery are two specific reasons why early admission with a good outcome is possible." (Specht, Kjaersgaard-Andersen, & Pedersen, 2016).

Research reports support that early mobilisation shortly after surgery reduces postoperative complications while being beneficial for the recovery process and facilitating early discharge as well as prevention of readmission. Also, early mobilisation is often found to be cost-effective (Loftus, Stelton, Efaw, and Bloomstone, 2015; Brustia et al., 2015). Thus, some would argue that staying too long in hospital is not good for your health, and it seems that fast-track programmes are well argued and substantiated by high-impact evidence. Nevertheless, fast-track programmes also reflect an ideology based on cost-benefit considerations. Nanavati and Prabhakar (2014) describe fast-track surgery as a means of "protocolising" patient care. They emphasize the importance of involving a multidisciplinary team throughout the process to ensure successful implementation of fast-track programmes, but they do not mention involving patients or considering the importance of the patient perspective for a successful outcome. One critique aimed at fast-track treatment and care is that it risks becoming too standardised. When programmes are based exclusively on cost-benefit and efficiency considerations, the freedom to plan and to provide the treatment and care for each patient individually diminishes, and we risk overlooking the needs of the individual as we strive to meet the standards of our treatment packages where time is one of the main parameters by which success is measured. Studies that focus on patients' and relatives' experiences of going through fast-track treatments report that patients may be challenged by early discharge from hospital as they feel uncertain and are not always prepared to take responsibility on their own (Norlyk & Harder, 2011, Norlyk & Martinsen, 2013). A study by Norlyk (2009) describes a tension between the evidence-based recommendations and the increased patient involvement in fast-track programmes that can be seen as an example of two conflicting development trends. A trend towards democratisation based on shared responsibility and patients' active involvement in care, and a trend towards specialisation based on evidence-based recommendations that lay out specific rules that the patient must follow. However, involving patients and making time to see patients as individual persons is crucial. Olsson, Karlsson, Kärrholm, and Hansson (2014) performed a quasi-experimental study comparing person-centred care with standardised care for patients undergoing total hip arthroplasty and found that the mean LOS in hospital was lower in the group that received person-centred care.

Historically, nurses are expected to focus on the patient perspective. Several nurse theorists have stated that nurses engage in a unique relationship with their patients and not only care for the physical body (Benner & Wrubel, 1989; Martinsen, 1993, 2006, 2012; Munhall, 1998; Travelbee, 1971). With reference to Lawler (1993), Munhall (1998) states that besides

taking care of the physical body that is in need of nursing care, we deal with humans. Lawler details this notion as follows:

> this must be grounded in experiential knowledge gained from being a nurse, and doing nursing. Knowledge, or evidence, for practice thus comes to us from a variety of disciplines, from particular paradigms or ways of "looking at" the world, and from our own professional and non-professional life experiences. (p.5).

Nurses, then, need to incorporate this aspect into their patient care by making time to form a relationship with each individual. However, nursing has also changed along with the increased activity in hospitals and the implementation of fast-track programmes. Specht et al. (2016) make several interesting conclusions in this respect. They show that despite a significant increase in surgery activity, nursing staffing levels remained the same over a decade. At the same time, they shed light on an interesting change in nursing tasks during the same period. Nurses had taken over more tasks from the surgeons like managing pain administration and discharging patients independently.

From a phenomenological point of view, the question of "time" thus seems to be essential for the understanding of healthcare situations where professionals have only limited time to establish a relationship and getting to "know the patient as a person." (Tanner, Benner, Chesla, and Gordon 1993). Lived time is subjective time as opposed to clock time or objective time. As expressed by van Manen (1990), lived time is the time that appears to speed up when we enjoy ourselves, or slow down when we feel bored during an uninteresting lecture or when we are anxious, as in the dentist's chair. Also, van Manen refers to the temporal dimensions of past, present and future as aspects that constitute the horizon of a person's temporal landscape. Van Manen (1990) argues that "through hope and expectations we have a perspective on life to come, or through desperation and lack of will to live we may have lost such perspective" (p. 104). As caring is a long-established ideal within the nursing discipline, which is rooted in an ethical obligation to maintain and respect the individual's dignity and integrity, this holistic approach calls for consideration of the patients' lived time – even, and maybe particularly so, in a fast world.

Today's healthcare systems are pervaded by busyness and influenced by values that are measurable and reflect effectiveness. Martinsen (2012) unfolds how these differences in perception of time may cause discrepancies in the context of healthcare. Thus, says Martinsen (2012), being busy has become a *mode of being*. What characterizes that being is that you cease to notice how this mode of being affects the whole body and the bodies of the patients we nurse. Being busy has instead become a way of living that is controlled by enterprise (Martinsen, 2012). What characterises busyness is an urge to act quickly, to engage in hectic doings. This occurs at the cost of actually being present in both body and mind with the patient.

Martinsen (2012) argues that it is possible to be attentively present in a high-paced environment where a focus on effectiveness may be in the patient's best interest. But this requires resort to skilful nursing, where the nurse employs knowledge and personal experience in the judgement of each individual situation. Using her senses, she works silently and smoothly with the patient, acting fast. To do this, the nurse needs to *act slowly in the quick meeting*.

In this context, acting slowly means to be present, not only in body but also as a whole person. Martinsen (2012) uses the expression to grasp the time and hold it in space, because to Martinsen it is essential that the nurse is capable of using her senses, to smell, listen and see. The art is to not let the technical procedures dominate the caring acts that are based on intuition and experienced-based knowledge.

An Example of a Fast-Track Setting

An example of fast, standardised care is a postoperative care unit were nursing care has to be provided within a short time span. Patients are usually staying for about 2 hours and follow a standard care programme while recovering after anaesthesia and surgery. One of the latest developments within healthcare in postoperative care units is the introduction of a special room where patients are observed intensely for a very short time compared with the usual duration of the stay in the postoperative unit. The objective is that patients should stay in the postoperative care unit only for a mean period of 30 minutes, which places more responsibility on the nurse or increases the burden of care.

In this hospital context, the objective measure of time sets the agenda for the postoperative treatment and care, and this agenda may not necessarily be aligned with the patient's needs. Thus, clock time and standardised treatments risks becoming the centre of all treatment and care and the individual patient's needs are fitted to the standardised patient pathways. In this paper, we discuss "the slow in the fast" related to care situations in a "fast-track" hospital setting where the length of patients' stay has been reduced significantly. The discussion will be based on a narrative created from 24 hours of observations made in a postoperative care unit where patients are intensively observed and cared for during a very short time span from 15 minutes to 2 hours. We analysed the data material, and on basis of this analysis, we wrote narratives representing a care situation with a typical patient and nurse. We describe the questions raised by Martinsen and debate these questions in light of nursing theory and the phenomenological understanding of time. We ask if and how it is possible for the nurse to create an imaginative space in time where she can engage in the suffering and take part in the patients' lifeworlds.

Observations were made to generate a narrative featuring actions and interactions in the postoperative fast-track care unit. The researcher played a passive, non-participatory role; and immediately after making the observations, field notes were written as accurately as possible. Observation focussed on nurses' caring for patients and specifically on signs of slowness in the nurse's interaction with the patients. The field notes were used to generate a narrative that illustrates signs of slowness in this fast-track space (Dreyer & Pedersen, 2009). Notes were made to document observations relating to touch, sounds, talking, non-verbal communication and the impressions of the room. A narrative presenting nursing care in the fast-track recovery room is presented below:

Fast-track slowness

> The porter gently pushes the bed in place by the window. Big trees are standing just outside the window and behind them there is a wide two-lane road where cars whiz along. You can vaguely hear the heavy traffic moving down towards the harbor. The sound from the tall waving trees outside the window seems to create a peaceful harmony that permeates the soundproof windows and fill the room. Mary places her hand on the patient's arm. Maybe she observes something; maybe she just gives it a squeeze. The patient has pulled the covers up over her head. Mary gently lifts the covers, "Hello and welcome to the recovery ward." Mary places a hand on the patient's head, "How are you?", "I'm tired. Is it over? Did it go well? What have they done?" Mary replies that she does not know anything about the operation, but that she is here to look after the patient until she is fully awake. "When the doctor comes, you should ask him how it went." Mary places the monitoring devices on the patient and at the

> same time asks, "Do we know each other? You've been here before, haven't you?" The patient responds affirmatively and tells Mary when it was. Mary writes on the computer. The computer is in the middle of the room, standing on large mobile feet. Mary can take it wherever she goes. She writes on the computer while talking to the patient. About when they last met, where she is from and who will be picking her up later in the day. With a grimace the patient moves slightly in the bed, it looks difficult and everything is done slowly. Mary asks if she is in pain. Perhaps the leg is not correctly positioned? Maybe it's too stretched; it is usually never positioned like this. Mary fetches a pillow and places it under the leg. Mary pain scores the patient, the patient thinks for a little while about how the pain is experienced compared with previous experiences - "7," is the definite answer. "Then you can have some painkillers/analgesics now," Mary says. They talk a little about the experience compared with the previous time, "and if the pills do not kick in, you can have some more in about 15 minutes." She asks for the time, the patient closes her eyes and quite quickly the patient's facial expression seems more relaxed. After 15 minutes she is pain-scored again and now the pain experience is reduced to "3." The doctor arrives to let her know how the surgery went. "Now be sure to ask the questions you asked me," Mary says while attending to another patient in the room. "Well… How much am I allowed to do when I get home? When can I stand on the leg?"

Signs of Slowness in the Fast

In the following, we reflect on how signs of slowness surface in the narrative. We return to the questions raised by Martinsen (2012), asking what happens to nursing when the measurable clock, the objective time has become the dominant instrument for navigating in the healthcare system and if it is possible for the patient and the nurse to engage in each other, to be joined in time in a moment of closeness. We do this by drawing on the phenomenological notions of lived time, lived space and lived illness.

Lived Time

Lived time is an existential theme that refers us to the world or to settings in which we move and which belong to the life world. As Husserl (1984/1936) explains:

> Our focus on the world of perception (and it is no accident that we begin here) gives us, as far as the world is concerned, only the temporal mode of the present; this mode itself points to its horizons, the temporal modes of past and future. (p. 168)

Hence, the horizon of a "now" consists of the past and the future. In other words, the present is not an isolated instant along a given time-line, but rather a present moment that is always experienced within the horizons of the past and the future. This is reflected in the narrative when patients are anxious to know what is going to happen from now on and when Mary pays attention to the patients' history by listening to their individual stories and referring to previous encounters.

Illness relates to lived time. It is simply lived and belongs to the 'category of the indefinable and indescribable' (Toombs, 1990). Illness may resist language in so far as it may not always be possible do describe it. There simply are no words that adequately describe one's

experience of illness to another person. Consequently, one of the most strident characteristics of illness is its 'unsharability'. According to Toombs (1990), the incommensurability of inner and outer time is a crucial factor in the unsharability of illness. The patient must describe his illness in terms of outer time, but he experiences his illness in its immediacy in terms of inner time (Toombs, 1990). Mary, in her short meeting with the patient, seems to use her senses to grasp the patient's unsharable experiences and creates a relational space with the patient. Then does so, among others, gently lifting the covers, touching the patient's head and asking the patient about when they first met.

Arguing that temporality cannot be separated from the life world as such, Merleau-Ponty (2005/1945) states that time is "not like a river, not a flowing substance…; instead time arises from my relation to things. Within things themselves, the future and the past are in a kind of eternal state of pre-existence…what is past or future for me is present in the world" (Merleau-Ponty 2005/1945, p. 477-478). Hence, we are temporarily situated in the world; and both the past, present and anticipated future form part of how we perceive our being in the present.

Lived Space

In the philosophy of phenomenology, there is an intimate relationship between time and space. For Husserl, lived time is a part of our existence that is closely interrelated with lived space. The above narrative illustrates the close relationship between lived time and lived space. As we learned from Husserl, lived time together with lived space are crucial existential life world themes that refer us to the world and settings in which we move. According to Husserl (1984/1936), "The world is a spatiotemporal world; spatiotemporality (as "living," not as logicomathematical) belongs to its own ontic meaning as lifeworld" (p. 168). The narrative illustrates that Mary creates a specific atmosphere in this specific setting through the ways in which she acts, moves bodily and relates to patients in this setting. For example, the tone of voice used by Mary was pleasant and calm, signalling that clock time was not a crucial factor in the relationship between her and the patients. Also, her gentle touch seems to create closeness between her and the patients and the touch has a calming influence that permeates the atmosphere of the room. It seems as if Mary creates a space within the space. In other words, she creates a specific space within the hospital space; a space which has its own slow rhythm dominated by calmness and pace.

With its specific rhythm in the room, this space stands in contrast to the fast rhythm of the hospital space and the outside world. A world dominated by a busy atmosphere and a constant, high level of activity, as revealed by the noises and the quick footsteps. As expressed by Løgstrup (1978), there is a battle between time and space in our existence. The space is what we are embedded in and refers to stability, whereas time refers to the transient nature of life and death. But with help from lived space, we can forget time, *get off from time*, as he expresses it.

Relating to the narrative, Mary seems to bridge the discrepancies between lived time and clock time by setting the agenda of time through the way in which she constitutes space in this setting. It seems that the space has taken over time in such a way that there is room for time in this setting owing to Mary's bodily ability to embed time and space. This is in line with Merleau-Ponty (2005) underlining how our existence is embedded in time and space due to our bodily existence, "The experience of our body teaches us to embed space in existence. To be a body, is to be tied to a certain world" (Merleau-Ponty, 2005, p. 171).

In other words, the space in which we find ourselves affects the way we feel, and we may say that we become the space we are in, and the space becomes us (Merleau-Ponty, 2005). Following Merleau-Ponty, the hospital setting may be seen as a special space that has its own

resonance which is transferred to patients. The narrative illustrates that the tempo of this resonance as well as its vibrations are strongly influenced by Mary. The narrative shows that in her relationship with the patients, by her tone of voice and by adjusting her bodily movements to the individual patient and the present situation, Mary creates a mutual rhythm between her and each of the patients; a rhythm which has a pace of its own. It seems, then, that Mary creates an imaginative space in time in which she engages in the patients' life world by putting on standby the frenzied activity of the hospital.

Lived Illness

Toombs (1990) states that illness results in a change in temporal experience. Normally we act in the present in the light of more or less specific goals, which relate to the future. In illness, such goals suddenly appear irrelevant or out of reach. One finds oneself preoccupied with demands of the here and now, confined to the present moment, unable to proceed into the future. Life projects may have to be set aside, modified or abandoned. As cited in Hull (1990, p.78), Toombs (1990) writes: "Rather than trying to cram every minute with necessary tasks and to squeeze the last drop out of time in order to get to the next moment, one is forced to concentrate on the present moment and the present task." (Toombs, 1990, p. 68). In the narrative, pain forces the patient to focus on the present instead of projecting into the future.

Living through illness is experienced as an ever-present consciousness of disorder that defies being measured in terms of objective time. In the preoccupation with the now, the person who is ill pays little attention to clock time. Minutes may seem like hours, hours like days. The nurse, on the other hand, uses the objective time scale to monitor the physical events and biological processes that define the patient's illness as a disease state and to plan therapeutic interventions.

Consequently, nurse and patient constitute the temporality of illness and the disease state according to two different and incommensurable time dimensions. When relating his or her experience of illness to the nurse, the patient must do so in terms of "objective time." However, the patient experiences the illness in "lived" time. As an example, Mary uses the objective time scale to measure the physical events and biological processes, which define the patient's illness as an objective "disease," and to plan therapeutic interventions. Being in pain and being asked to wait 15 minutes for the painkillers to be effective is an example of a clash between lived and objective time. This span of time may seem endless to the ill person, but short for one who is healthy. Objective time differs fundamentally from the immediate and pre-reflexive inner experience that is subjective time.

Mary does not know the patients' history; nor is she aware of how the patient's illness experiences were before the admission. In the "fast-track room," the present space filled with pain and bodily sensations seems hard to bear. Mary silently helps the patients' endure these present moments and holds the now in the postoperative space in her short meeting with the patient as she seems to use her senses to grasp the patient's "unsharable" experiences and creates a relational space with the patient.

Challenges in Caring for Patients in a Fast-Track Programme

In a fast-track programme, it is possible to create an imaginative space in time – to make a time warp. Despite being in a setting where the objective time measure dominates, the nurse can create a rhythm of her own in the room. Thus, acting slow in the quick meeting, the meeting is characterized by calmness and quietness, engagement in the patient's suffering; and the nurse helps the patient endure the present and holds the now. We agree with Martinsen (2012) that

this is only possible when the nurse pays attention to each individual patient and aims to engage in the patient's life-world.

Patients will continue to be offered fast-track treatments within today's healthcare setting. Furthermore, we must expect that the LOS will be reduced even further. In turn, patient pathways will become even more challenged, which will require nurses to critically reflect on the conditions for nursing care in fast-track settings. The challenge in caring for patients in standardised fast-track pathways lies mainly in the incompatibility of demands; hence nurses need to simultaneously meet the objectives of the programme and fulfill any person-centred needs, and in doing so without creating what Løgstrup (1978) delineated a battle between time and space in our existence. Nurses' caring space has to take over time in such a way that there is room for both patient-time and fast-track-time. Nurses need a bodily ability to embed time and space and be present in the now with the patient while performing the standardised tasks that form part of a fast-track programme.

In the future, nurses in fast-track settings will need to think and act in the present moment to form a nurse-patient relationship not only constituted by objective clock time and following the requirements of standardised programmes, but also based on attentive presence and smoothly acting upon the patient's needs. More research needs to be done to determine additional ways to prevent the nurse from strictly following standardised protocols forgetful of the patient, but to incorporate such protocols as a blended imaginative space.

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