Patients with comorbidities: perceptions of acute care services

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Background. Advances in medical science and improved lifestyles have reduced mortality rates in Australia and most Western countries. As a result, there is an ageing population with a concomitant growth in the number of people living with chronic illnesses. Indeed, a significant number of people will experience multiple chronic illnesses (comorbidities) and may require admission to hospital for acute care that is superimposed on their chronic illnesses.

Aim. The aim of this study was to investigate perceptions of quality of care by patients experiencing comorbidities who required an acute hospital stay.

Method. A qualitative descriptive design was adopted, informed by Colaizzi’s phenomenological method. Single semi-structured interviews were conducted with 12 patients within 14 days of being discharged home after an acute illness episode.

Findings. Data analysis revealed three themes: poor continuity of care for comorbidities, the inevitability of something going wrong during acute care and chronic conditions persisting after discharge. Combinations of chronic illnesses and treatments affected these patients’ experiences of acute care and recovery postdischarge. Medicalized conceptualizations of comorbidity failed to capture the underlying health care needs of these patients.

Limitations. No generalizations can be drawn because the findings and conclusions were derived from a purposive sample of patients who agreed to participate.

Conclusion. These findings have implications for a comprehensive and co-ordinated approach to this group of patients, and inform the body of nursing knowledge about how patients with comorbidities experience nursing care.

Keywords: chronic illness, comorbidities, acute care, continuity, quality of life, discharge, nursing

Introduction
Reduced mortality rates have resulted in a significant number of people living with chronic illnesses that have the potential to require repeated hospital admissions for episodic care. People with comorbidities have additional needs, as a combination of illnesses increases the complexity of care required. However, the current health care environment in Australia has made meeting the acute care and postdischarge needs of these patients difficult (Williams & Botti 2002). A gap in the nursing knowledge about the experience of people with comorbidities in general and, more specifically, in acute care settings has been identified. Little attention has been paid to consumer perspectives of health care (Poulton 1999, Oermann & Templin 2000), yet patient satisfaction is an important indicator of quality of care (Cox 1996, Armitage & Kavanagh 1998, Epstein et al. 1998, Aiken & Patrician 2000). This paper reports the findings of a qualitative study that investigated perceptions of quality of care in 12 patients with comorbidities who required an acute hospital stay.
Literature review

A consequence of reduced mortality rates in Western countries such as the United Kingdom, Canada, the United States of America and Australia is a marked growth in the number of people of all ages living with chronic illnesses (Davis & George 1990, Badley et al. 1999, Lubkin & Larsen 2002). Chronic illness is defined as ‘a permanently altered health state, caused by a non-reversible pathological condition, that leaves residual disability that cannot be corrected by a simple surgical procedure or cured by a short course of medical therapy’ (Miller 1992, p. 4). This increased prevalence of chronic illnesses has been described as the epidemic of the future (Ogle et al. 2000). Chronic illnesses are incurable, permanent, often progressive in nature, and require long-term monitoring by health professionals (Strauss 1975, Miller 1992, Thorne & Paterson 2000, Lubkin & Larsen 2002).

Unfortunately, having one chronic condition offers little or no protection against developing another, and is often associated with the development of comorbidities (Seeman et al. 1989). Comorbidity has been defined as ‘several chronic conditions simultaneously’ (Verbrugge et al. 1989, p. 450). Many people with comorbidities have the potential to require repeated admissions to hospital for acute care that is superimposed on the needs caused by their chronic ill-health. Indeed, more than 30% of admissions to public hospitals in Australia in the year 2000 had more than one diagnosis, and almost 17% had five or more diagnoses (Australian Institute of Health & Welfare 2001).

Patients with comorbidities present an added complexity to the dimensions of care required in the acute care setting (Grau & Kovner 1986). However, acute care is a single disease model of care (Nolan 1999), in which the focus of attention lies on the primary reason for admission (Jencks et al. 1988). Specialized medical knowledge is used to repair the acute problem and eradicate the disease condition. It is assumed that patients subsequently return to their previous autonomous lives, free of disease. This is not the case for people with comorbidities.


Patients require effective discharge planning that includes consideration of health problems additional to the primary reason for admission (Armitage & Kavanagh 1998). Chronic illnesses require long-term co-ordinated continuity of care that spans hospital and community settings (Evashwick 1996). However, health care professionals in the hospital and community frequently pass co-ordination responsibilities back and forth, risking fragmented services and increased costs (Papenhausen et al. 1998).

Various models of care, such as case management (Schaldach 1997, Hovenga 1998), have been developed to co-ordinate care across a number of settings. However, this care can also be disjointed (Sparbel & Anderson 2000a), and disease management programmes generally target individual chronic illnesses (Temmink et al. 2000). Additionally, an increasingly complex health care system and a lack of consensus on the meaning of ‘continuity of care’ compound this problem (Sparbel & Anderson 2000a).

The management of Australia’s current health care system has clearly been influenced by the biomedical approach (Willis 1989). Inadequacies have resulted from a failure to foresee the consequences of an ageing society, making it difficult to achieve the objective of co-ordinated continuity of care for people with comorbidities during acute care and following discharge (Williams & Botti 2002). Acute care has been favoured in an effort to cure diseases, although non-fatal chronic conditions far outweigh those diseases that are considered fatal (Verbrugge et al. 1991, Verbrugge & Patrick 1995, Hoffman et al. 1996, Krop et al. 1998, Badley et al. 1999). Medicine’s dominant philosophy of cure, on which acute care is based, is not appropriate for most patients because of their chronic illnesses (McElmurry et al. 1998).

In an era of health care marked by specialization (Willis 1989), it is evident that a comprehensive approach to patients with chronic illnesses is needed to achieve co-ordinated continuity of care (Ward 1990). Specifically, when a person with a variety of chronic conditions is admitted to acute care, careful thought and research evidence are required to guide nursing practice and promote continuity and co-ordination of care. Nursing implies holistic care and, in embracing well-being, goes beyond the notion of cure (Wilkes 1991, Haworth & Dluhy 2001).
The study

Aim

The broad aim of this qualitative descriptive study was to explore perceptions of quality of care by patients with comorbidities who required an acute hospital stay. The specific objectives were to investigate how episodic care was integrated into the ongoing care of patients with chronic illnesses, and how clinicians used the episodic illness as an opportunity to review overall management.

Participants

The purposeful sample targeted patients who had required acute care in a large Australian not-for-profit, metropolitan, private hospital in the year 2000. Entry criteria stipulated that participants must have had more than one chronic illness, for example arthritis or diabetes, for approximately 5 years, in order to capture the maximum impact and integration of comorbidities into their patterns of daily living. Participants had been admitted to hospital from their homes and had received more than 4 days of acute care in the hospital. This criterion ensured that there was time for impairments in functional status to become more apparent, and the opportunity for integrated care to be implemented. To facilitate data collection, participants had to understand and speak English, and be older than 18 years of age.

Not all prospective participants were interviewed. For example, one did not answer her telephone, another said he was too ill, another felt she did not strictly fit the selection criteria relating to chronic illnesses, and two were discharged to a rehabilitation ward and did not return home within a 2-week timeframe. All participants accepting the invitation to participate chose to be interviewed in their homes, where informed consent was obtained.

Ethical considerations

The ethics committee of the associated university and hospital approved the research proposal. Nurse unit managers of wards most likely to admit patients meeting the selection criteria were briefed about the study. They then informed potential participants about it during routine patient contact. I met those who expressed an interest 1 day prior to discharge to explain the study in more detail by talking through the information sheet (written in accordance with plain language guidelines), which was then given to them. I telephoned these patients after they had gone home to arrange an interview that would take place within 14 days after discharge, in order to capture experiences before recollections became less clear with the passage of time.

Data collection

The eligibility of patients who had expressed an interest in the study was established with Nurse Unit Managers. Details of each patient’s medical history were collected at the time of conducting the semi-structured interview, which featured open-ended questions about the hospital stay. Questions were informed by the literature review and adapted from validated patient satisfaction measures (Lorig 1996).

Data analysis

Data were analysed concurrently, as interviews continued until no new major themes were emerging (Holloway & Wheeler 1996). Analysis of the verbatim transcripts, field notes and patient medical histories was conducted according to the principles of qualitative description (Sandelowski 2000). The field notes and medical history were compared with the transcript data for congruence. A template analysis style was adopted, informed by Colaizzi’s (1978) phenomenological method of theme development and using QSR NVivo, a code-and-retrieve computer software package (Ezzy 2002).

Because of the possibility of my preconceptions unduly influencing the interpretation, an independent data analysis (Sandelowski 1986) was conducted by a second researcher, who confirmed the analysis. Additionally, a summary of the major findings was sent to each participant in an effort to verify interpretations (Colaizzi 1978), and was not contested by any participant.

Findings

The 12 participants ranged in age from 34 to 77 years, and had an average of 5.75 chronic conditions as defined by Miller (1992). Gender distribution was even (see Table 1). Two women were under the age of 40, one participant lived alone, and most were retired because of ill-health rather than age.

When comparing the field notes taken at the hospital and the patient transcripts, I initially noted a discrepancy between the accounts of nursing staff and participants in terms of how many comorbidities each participant had. Nurse unit managers identified patients with one or two comorbidities but this was clearly an underestimate, according to the patients. This finding is complicated by the diagnoses disclosed. For example, depression was rarely cited as a patient comorbidity by both nursing staff and participant, but a significant
number of participants suffered reactive depression to some extent, as indicated by the medications they were taking.

Overall, participants’ experiences of comorbidity gave rise to profound findings that had much in common with those on the experience of chronic illness (Strauss 1975, Miller 1992, Verbrugge et al. 1995, Kempen et al. 1997, Thorne & Paterson 2000, Paterson et al. 2001, Lubkin & Larsen 2002). However, themes specific to the comorbidity experience will be the focus of this paper.

### Poor continuity in the care of comorbidities

**Acute care setting**

According to participants, the nursing staff rarely asked patients on admission about how they managed their usual day at home. During the patient’s hospital stay, management of the acute problem took precedence over comorbidity. In some instances, management of the problem caused a comorbidity to become symptomatic. Interestingly, most of the patients did not expect care of and attention to their comorbidities. When asked why, patients reported that their chronic illnesses were incurable and could not be helped, and a typical comment was:

I was only in there to get my knee done…nothing else.

Yet, those patients who expected attention for their comorbidities were dissatisfied:

I don’t think they even considered it [leaky heart valves]. They were only concerned with the operation.

The significance of each comorbidity depended on how troublesome it was at that particular period in the person’s life, when other illnesses ‘paled into insignificance’. Comorbidities induced additional health problems, requiring frequent alterations to illness treatment practices:

One of the things with multiple illnesses too: it’s not just one thing, it’s another.

The paradoxical influence of the management of one disease on another was noted. For example, a patient perceived his reflux to be better from being nursed in a semi-upright position following a hip replacement. In some instances, participants instigated the additional care needs that their comorbidities required. However, secondary illnesses that were highly significant to nurses, such as diabetes, were closely monitored.

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**Table 1** Patient sample, including details of chronic conditions as disclosed by each participant

<table>
<thead>
<tr>
<th>Patient</th>
<th>Chronic illnesses</th>
<th>Age</th>
<th>Sex</th>
<th>Admission diagnosis</th>
<th>Length of stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Osteoarthritis, rheumatoid arthritis, glaucoma, chronic bronchitis/</td>
<td>74</td>
<td>M</td>
<td>Right knee replacement</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>emphysema, chronic back pain, collapsed foot arches, hypertension,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>long-standing duodenal ulcer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Ulcerative colitis, arthritis, depression, migraine, chronic lower back pain</td>
<td>65</td>
<td>M</td>
<td>Right total hip replacement</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>Crohn’s disease, Type 2 diabetes, chronic back pain, rosacea, hyper-</td>
<td>64</td>
<td>F</td>
<td>Acute on chronic sclerosing cholangitis</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>cholesterolaeemia, arthritis, cholangitis, reflux, thyroid disease,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[undisclosed depression]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Gilbert’s syndrome, psoriatic arthritis, chronic bronchitis, chronic back pain,</td>
<td>38</td>
<td>F</td>
<td>Laminectomy</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>[undisclosed depression]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Sciatica, chronic back pain, hypertension, osteoarthritis, Menière’s</td>
<td>54</td>
<td>M</td>
<td>Laminectomy</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>disease, depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Hiatus hernia, reflux, chronic low back pain, osteoarthritis, hypertension,</td>
<td>77</td>
<td>M</td>
<td>Revision of left total hip replacement</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>bilateral deafness, angina, Menière’s disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Crohn’s disease, reflux, osteoporosis, osteoarthritis, bilateral deafness,</td>
<td>34</td>
<td>F</td>
<td>Small bowel obstruction</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>malnutrition, hypotension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Osteoarthritis, whip lash injury, diverticular disease, coeliac disease,</td>
<td>63</td>
<td>F</td>
<td>Colectomy</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>mitral and tricuspid valve incompetence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Rectal cancer (colostomy), Type 1 diabetes, lung cancer, depression</td>
<td>66</td>
<td>M</td>
<td>Blocked colostomy</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td>Bronchiectasis, asthma, diverticulitis, osteoarthritis, psoriasis, osteoporosis,</td>
<td>65</td>
<td>F</td>
<td>Left total hip replacement</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>chronic back pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Rheumatoid vasculitis, below knee amputation, osteomyelitis, bilateral</td>
<td>62</td>
<td>M</td>
<td>Osteomyelitis</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>deafness, sleep apnoea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Atrial fibrillation, rheumatoid arthritis, bowel cancer (colostomy)</td>
<td>69</td>
<td>F</td>
<td>Bowel obstruction</td>
<td>27</td>
</tr>
</tbody>
</table>

A. Williams

Essentially, illnesses that created discomforts were seen as more troublesome than those that could cause death. Common discomforts reported by this group and requiring nursing consideration included pain, nausea, extreme fatigue, insomnia, poor memory, skin irregularities including split fingernails and toenails, dental concerns, sensitivity to extreme temperatures, weight fluctuations, and faecal and urinary incontinence. Many tolerated pain because they did not want to feel unwell from taking analgesia, and because they considered that the pain was incurable and would only come back again. All the participants had tried both medical and alternative treatments in an effort to alleviate symptoms or even obtain a cure, but they were disappointed and had become resigned to thinking that nothing could help them.

Another issue that may have impacted on the continuity of care of comorbidities was the difficulty that acute care nurses had in knowing what comorbidities each patient had. The length and complexity of the patient’s history made it difficult and time-consuming to navigate:

My file is so huge that there’s no way that they could ever keep up with all the things that you’ve got.

The nurses’ handover also reflected the acute care focus, as certain information was not reported, particularly as the patient’s length of stay increased. Patients also stated that some information was kept in different places other than the hospital, such as at the doctor’s surgery. They also had difficulty in recollecting what illnesses they thought they had, or their perceived importance and how they might impact on their hospital stay. This was augmented by the invisible nature of some comorbidities, such as Menière’s disease.

Most participants did not expect proper care as they viewed their cases as too complex and time-consuming. This was compounded by the fact that there was a range of nurses and hospital physicians who needed to be fully informed about, and involved in providing, this care. For example, nine of the 12 participants were on restricted diets of some sort, yet only two saw a dietician when they were in acute care. This was a surprising finding, given the extended length of hospital stays most of these patients experienced.

According to the participants, discharge planning did not include care of their comorbidities. Discharge planning was directed at the primary diagnosis, at best. These patients believed that this occurred because they were frequent consumers of health care services, and were expected to know what to do and how to do it. One patient commented:

At best, they tell you what to do, but not how to get around those don’ts.

This situation was compounded by unclear boundaries in relation to which health care provider was ultimately in control and had the ‘correct’ advice, leading patients to be confused about how they were to recuperate. Nurses, too, were not always clear about who was in charge once a patient’s acute illness had taken precedence:

One of the nurses rang him and was told off by his secretary [who said] that I wasn’t his patient at the moment, I was a surgeon’s patient.

Community setting

Although these participants were recovering from an acute illness, they all spoke about serious difficulties with the management of their comorbidities. In the community setting, poor continuity in the care of comorbidities was primarily because of the sheer difficulty for patients in following up each illness episode. First, these patients were in a chronic state of ill health and had an average of more than five chronic illnesses:

You just get over one...it’s hard enough for anyone to get over one chronic illness, er, get your life back.

Feeling unwell and having to continue with treatment limited the amount of follow-up that these patients could actually manage.

Secondly, each disease was treated by a different specialist who was generally located in a different clinic, creating transport and parking difficulties for each appointment. The closest approximation to rationalizing doctors’ visits was found in a patient who was able to see two general practitioners, a husband and wife team, in the same clinic. The husband oversaw her endocrine and bowel diseases, and the wife looked after her bone and gynaecological concerns.

Thirdly, often a particular specialist was unavailable because of holidays or conference leave, and the replacement was unfamiliar with the patient. Having a number of doctors often led patients to be unaware or uninformed about who was in charge of a specific comorbidity:

As I told you before, I’m not too sure which doctor I’m supposed to ring.

Fourthly, specialist appointments required a referral from a general practitioner and were difficult to obtain at short notice, as often needed by these patients:

To get an appointment with him he’s so busy that it’s just about impossible, so it’s better to go through your own doctor.

Yet, these patients’ general practitioners did not have the same level of knowledge about the specific comorbidity as the
specialist, and were generally contacted about issuing repeat prescriptions.

The general practitioner was accessible and, thus, the first port of call in comorbidity management, but as a participant noted:

It’s not [that] they know a lot about my condition. They get letters back from specialists.

This letter from the specialist was seen to be an important source of communication, which validated these patients’ health concerns. However, participants claimed that this communication was often incomplete or delayed and, in the case of hospitalization, it neglected to include other in-hospital occurrences that they considered significant.

Other communication difficulties contributing to poor continuity in the care of comorbidities included a lack of communication between specialists. These patients needed the services of a variety of specialist doctors, but perceived that each specialist treated their area of medical interest in isolation from their colleagues:

You really need a doctor that can… put the whole thing together, the whole picture together. But because a GP sends you to a specialist for one thing and another specialist for another…

As a consequence, some participants believed that their health problems could not be sorted out.

A lack of communication between doctors was also evidenced with respect to patients seeking direct payment to the service provider (bulk billing) for medical services. Australia has a universal health insurance system, and payments can be made directly from this so that individuals do not incur out-of-pocket costs. However, there is no legislation restricting how much a general practitioner can charge for a consultation (Young & Dobson 2003). Thus, some patients received their repeat medications from the hospital quickly and at lesser cost than by seeing their usual general practitioner:

Doctors don’t know we go elsewhere. They [bulk billing doctors] don’t know who co-ordinates illnesses and how often you see the GP.

Having a range of doctors also created the potential for the patient to receive conflicting information about their treatment:

It’s just so confusing…you get one doctor [who] says one thing, one doctor [who] says totally the opposite.

According to the perceptions of these patients, nurses played a minimal role in managing patients’ comorbidities in the community.

Something always goes wrong in hospital

Participants felt that if something could possibly go wrong in the acute care setting, it did go wrong, and chronic conditions were seen to rebound. While one health-related problem was resolved, another developed in its place. Patients expected problems to develop in hospital, leaving them apprehensive about each admission and resigned to managing additional problems after discharge. If participants thought that medical staff were ignoring their comorbidities, they were waiting for something ‘dreadful’ to go wrong. Alternatively, patients receiving more than their usual doses of medications to control a comorbidity during an admission considered themselves to be on ‘overkill’, taking ‘massive’ doses of ‘two-edged’ drugs that they knew had dangerous side effects.

Participants were invariably frequent hospital patients and perceived that they got ‘a bad deal’. The hospital bed and room was a significant concern for these people, as they required repeated admissions and needed special consideration because of the varying requirements of their comorbidities. One participant commented that ‘the last bed in the hospital seems to be the one I get’.

These patients felt that they were gossiped about and neglected in some way, particularly those with stays of longer than 7 days. Some participants felt that care was delivered in a detached manner and ‘dropped off’ over time:

If you press the buzzer, it’s a good ten minutes usually before anybody answers. Sometimes I get that frustrated I just turn the buzzer off and just wait until they come in.

Most of these participants knew the rules for using the call bell, but often needed assistance more than usual because of their comorbidities. Additionally, these patients were often in need of an advocate, usually a relative, to protect their interests when they were unable to articulate their needs.

Medication concerns were prolific. Comorbidities often interfered with the usual route of drug administration. For example, patients with gastro-intestinal diseases could not take some oral drugs. Additionally, complex states of health meant that patients were on multiple and uncommon drugs with which nurses were often unfamiliar. Taking medications was seen as supremely important to hospital staff:

I wasn’t allowed to eat, oh but you can always take pills!

Some patients resisted taking drugs dispensed by nurses because they had not been informed that their usual doses had been altered. Two participants reported enquiring, and even arguing with staff, about their medications; a third refused to have anything to do with her analgesia, as she had been previously accused of ‘tampering’ with the dose.
Some patients surreptitiously kept their own supply of medications.

The experience of pain was common. Patients were more inclined to have pain relief for their primary diagnosis in the early stages of recovery, and rarely took analgesia after this time, because of perceived side effects such as mood changes, constipation and nausea, and ‘putting up with pain’ to get better. Other sources of pain included comorbidities, or a complication such as a fall. Comorbidities were often symptomatic, and more troublesome than the acute illness. The ‘double trouble’ of the primary condition and specific comorbidities caused additional problems that neither individual illness produced separately. For example, one patient’s severe chronic back pain required narcotic analgesia. The analgesia was metabolized by the liver, but pre-existing liver disease negated this, causing intractable vomiting. The severe vomiting exacerbated the patient’s back pain while causing another symptom, faecal incontinence.

As seen in Table 1, recovery was protracted, increasing the expected length of stay in almost every case. Complications included deep vein thrombosis, urinary tract infections, falls and loss of skin integrity. Most patients already had fragile skin, and they developed tape allergies, rashes, pruritis, skin tears, pressure ulcers, wound infections and phlebitis, which required further treatment and care.

Weight gains and losses were common. One participant rapidly lost weight after developing severe diarrhoea from a ‘new’ antibiotic to treat one of her comorbidities. Following an episode of diarrhoea, she noticed that her wedding ring was missing when washing her hands. Despite an extensive search, it was never found. This participant said that she had to find something positive about this situation, although the ring was especially designed and her husband had died 2 years previously. For this reason, she decided that it would mark a new chapter in her life.

The complexity of the care that these patients required, and their prior experience, led them to judge the competence of the staff that were caring for them. Some participants identified oncoming problems before the nurses. Some said that they did not believe the nurse’s observations, having experienced chronicity over time and knowing the patterns of their physical signs and symptoms. Some nurses, particularly casual staff, were not trusted:

Others [nurses] have got no idea…they’re scary. I won’t let them near me.

Repeated procedures, such as venesection, were more difficult to perform each time, making them more painful or problematic. One participant commented:

He [the radiologist] couldn’t finish the procedure because he broke a piece of equipment…There could have been litigation if I’d wanted to, but what’s the point?

Yet, most of these participants claimed that they were satisfied with medical and nursing care. The type of nursing care that was most valued by patients was comforting care.

**Chronic conditions persist after discharge**

Participants said that there was no leeway for buffering additional health problems, and that drugs, such as cortisone, used to control symptoms of common chronic illnesses interfered with normal healing processes. Additionally, the symptoms of some comorbidities limited participants’ abilities to engage in recovery-promoting activities. For example, dizziness associated with Menière’s disease interfered with the patient’s ability to perform postoperative exercises.

Essentially, the presence of comorbidities was an added burden to manage alongside the demands of recovery from the acute illness. Nearly half the participants had to make regular visits to health care personnel to manage complications. Ongoing health maintenance had to be planned:

My teeth was [sic] a priority first, and then the gynae [problems] second, and J. [hearing referral] can come in third.

Having a number of chronic illnesses also contributed to these patients’ unanimous complaints of fatigue postdischarge. One participant said:

After I’ve had these hospital visits, it takes a couple of weeks for me to get back into harness.

Extreme fatigue was particularly troublesome in the morning, and was augmented by poor sleeping patterns. The majority of participants had arthritis and if they did manage to sleep well, this generally caused them to wake up feeling stiff.

Patients’ experiences of living with a resolving acute problem combined with on-going comorbidity and general health maintenance reflect the complexity of their health status and a necessity for comprehensive discharge planning. All patients had protracted hospital stays, yet it was questionable if all of them were ready to go home at the time of discharge. This was particularly so in view of the inadequate support services and poorly organized assistance with care, such as district nursing, that existed in the community. One participant felt that she was on an ‘island of sickness’, left to cope alone.
Discussion

In line with the literature reviewed (Williams & Botti 2002), in my study comorbidities negatively influenced outcomes of hospital care, and participants felt that specific chronic diseases that caused major symptoms were their worst health troubles, irrespective of their potential to cause death. Little has been written about comorbidities from a nursing perspective. For example, issues impacting on the delivery of care to older people have attracted research interest (Horn 1998, White 2001), but this is not the case with younger people with comorbidities. In particular, polypharmacy and the symptomatology associated with comorbidities were highlighted in my study. It was evident that having more than one chronic illness magnified the difficulties associated with being chronically ill, and that the whole of these patients’ health problems was bigger than the sum of the individual comorbidities.

The acute care setting did not fully acknowledge or accommodate the comprehensive care that these patients required, because the primary interest was the diagnosis that caused admission. These patients required complex care for extended lengths of stay, and developed complications that, arguably, may have been prevented with quality care. It seems that they were considered less acute because of their chronic conditions, and may have received less care because they were less favourable patients to care for (Stockwell 1984).

Continuity of care of comorbidities in the community was especially problematic, particularly specialist follow-up, and this resulted in complicated and fragmented chronic illness management, poorly accessed support services, and shifting of health care expenditure back onto the sufferer. Most participants demonstrated a passive resistance to medical treatment, evidenced by a dislike of taking prescribed medications. Consequently, they were generally disenchanted with the health care system and took a reactive approach to their health.

Conclusion

It was difficult to define exactly what a comorbidity was from a nursing perspective. Clearly, medicalized conceptualizations of comorbidity failed to capture the underlying health care needs of these patients adequately. Some of the participants’ illnesses did not strictly meet the medical definition of comorbidity, as sometimes symptoms of combined chronic illnesses, such as faecal incontinence or fragile skin, required specific nursing care.

There was an absence of evidence to suggest that patients received ongoing, integrated and co-ordinated care in the acute setting and postdischarge, and nurses did not utilize the episodic illness as an opportunity to review their overall management. As a consequence, these patients were discharged home with no improvement of their comfort in relation to their comorbidities. This situation warrants attention, given our increasingly ageing and chronically ill population.

Co-ordinated and seamless delivery of care may improve this group of patients’ satisfaction and corresponding well-being, factors that have the potential to reduce complications, readmission rates and associated health care costs. Opportunities exist to expand the role of nursing by utilizing episodic events to review the overall management and care of patients. In addition, the role of patient advocate has the potential to restore patients’ faith in a health care system that has, as yet, not recognized their needs.

Chronic care requires a proactive, planned, patient-oriented and longitudinal approach, rather than that provided through an acute care model (Glasgow 2001). Good control of chronic illness can reduce overall health care expenditure by minimizing hospitalizations, health care visits and costly complications (Horn 1998, Raddish 1999), and provide the patient with the opportunity to participate in community or paid work (Doran et al. 2001).
An important underpinning factor in co-ordinated continuity of care is communication (Sparbel & Anderson 2000b). Health care providers need the best possible communication skills to raise standards of professional practice in an era of complex patient care.

Limitations

The conclusions of this study are tentative, in that the findings are derived from the perceptions of a small purposeful sample taken from one private hospital and, thus, exclude the viewpoints of those in the public hospital domain. However, I did not set out to draw generalizations, but rather to inform nursing’s limited body of knowledge about care of patients with comorbidities.

Implications for nursing practice

This study informs the development of knowledge about nursing people with comorbidities. Research is needed to identify what facilitates seamless, co-ordinated, cost-effective care that improves outcomes for patients with comorbidities in acute care and everyday life.

References


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