BACKGROUND Care of cardiac surgery patients has changed substantially in the past decade, with an emphasis on streamlined procedures and shortened hospital stays. The few qualitative reports of patients’ perspectives of this experience focus primarily on physical complications and discomforts during the immediate postoperative period.

OBJECTIVE To examine patients’ perceptions of the quality of the nursing and medical care they received during their hospital stay after cardiac surgery.

METHODS Data were collected from a consecutive sample of 89 cardiac surgical patients who consented to participate in 2 telephone interviews at 1 week and 6 weeks after hospitalization. Patients responded to a single open-ended question: “What do you want your nurses and doctors to know to help them do a better job?” Thematic extraction analysis of patients’ responses was conducted by using commercially available statistical software. Extracted themes were applied to the structure-process-outcome framework of quality of care.

RESULTS Four major themes (and 12 subthemes) were identified: (1) being satisfied (having a positive experience, getting information), (2) not being cared for (feeling depersonalized, having expectations that did not match recovery experiences, not being listened to, experiencing unprofessional behavior by care providers, experiencing continued care needs after going home), (3) physical needs unmet (sleep, pain, complications, physical environment), and (4) informational needs unmet (needing more or different information).

CONCLUSIONS Patients want nurses and doctors to provide a smooth transition to home, recognize the patients as individuals, prepare them honestly for their experiences with specific information, and manage pain and sleep. (American Journal of Critical Care. 2002;11:333-343)
than the entire hospital stay. Of those studies that included the patients’ perspectives, a majority were investigations of outcomes related only to physical complications and discomforts in the immediate postoperative period. Because comparisons in other populations of patients suggest that patients and providers have different values and perceptions of quality care, clinicians and researchers must beware of making assumptions about what cardiac surgery patients value in their nursing and medical care after surgery. Therefore, the purpose of this study was to examine patients’ perceptions of the quality of the nursing and medical care they received during their hospital stay after cardiac surgery.

Review of the Literature

A review of the relevant nursing and medical literature revealed 2 concepts central to achieving the purpose of this study: quality of care and nurses’ caring. In addition, we reviewed literature on patients’ perceptions of care, because this perspective is the one we studied.

Quality of Care

Donabedian’s conceptual framework for evaluation of quality of care has influenced health services research for almost 3 decades. Donabedian defined quality healthcare by a triad of elements: structures of care, processes of care, and outcomes of care. In this structure-process-outcome framework, structure refers to facilities and equipment as well as human resources, including the qualifications and experience of healthcare professionals and the services available to patients. Process refers to how care is provided, in what circumstances and how patients are moved into, through, and out of the system. Outcome refers to the results of care and includes biological, functional, emotional, and social dimensions.

Within the structure-process-outcome framework, the elements of quality care are considered to be linear, so that structures affect processes, which in turn affect outcomes. However, phenomena are not exclusively classified under 1 of the 3 dimensions of quality, but rather change according to the context, purpose, and perspective of the analysis. This linear, but flexible framework is consistent with the interactive process between patients and their care providers, particularly nurses.

Nurses’ Caring

The phenomenon of caring has always been an integral part of nursing. Yet the data on the importance of nurses’ caring in acutely ill patients’ experiences are equivocal. Some investigators reported that cardiac patients perceive caring as a nurse’s ability to deliver care competently. Patients described a caring nurse as one who can demonstrate clinical expertise and one who spends time teaching them. Interestingly, these patients did not value “extra” or “individualized” actions by the nurse as a part of caring. Conversely, nurses overrated emotional needs of patients as indicators of caring. Other investigators reported that patients value nurses’ caring and that it is positively correlated with patients’ satisfaction. This finding was true regardless of the patients’ age, sex, or magnitude of pain. Williams suggested that nurses should place greater emphasis on caring behaviors individualized to each patient’s perception of what caring should be.

Patients’ Perceptions

To date, only a few studies have reported acutely ill patients’ recollections of their experiences. After talking with intensive care patients about their hospital stays, Holland et al found 4 areas of concern related to care providers: caring behavior, competence, communication, and anticipation of needs. Similar issues were addressed by Hunt in a study of cardiac surgery patients. Individual interviews revealed patients’ concerns related to vigilance, personalized care, and unexpected occurrences. In a unique approach, Jenny and Logan examined metaphors used by patients to ascertain what importance patients placed on their experiences. Four categories emerged from the data: physical discomfort, nursing caring, altered self, and patients’ work. Concepts related to patients’ work were detected in more than one third of the metaphors, making patients’ work the most prominent concern.

In summary, quality of care can be considered in terms of Donabedian’s structure-process-outcome framework, which is both linear and flexible and which supports an interactive process between patients and caregivers. Patients may value the caring behaviors of nurses, who are the most consistently present care providers, differently than nurses do. In fact, the degree to which nurses’ caring is important to patients remains unclear. Overall, patients’ perceptions of care have not been adequately reported, but reports to date indicate that personalized care and caring behavior are part of patients’ recollections of their care and are of concern to patients.

Methods

Design

The current study was part of a larger, prospective repeated-measures study to evaluate length of stay and outpatient use of healthcare resources by cardiac surgery patients. A qualitative, descriptive substudy...
was undertaken to evaluate patients’ comments about their care and to generate meaning from those comments about patients’ experiences of nursing and medical care after cardiac surgery.

Sample and Setting

Patients were recruited from a single urban, university-affiliated medical center after they had undergone cardiac surgery. Cardiac care at the center is provided in a service-line setting, which includes a dedicated intensive care unit and a monitored step-down unit. Each unit has a clinical nurse specialist, who is responsible for staff development, consultation on complex cases, and quality management. Acute care nurse practitioners are responsible for routine management of patients in the step-down units.

A total of 109 patients participated in structured telephone interviews after discharge from the hospital. In one or both interviews, 89 of those patients responded to an open-ended question on their concerns about their nursing and medical care in the hospital. Responders and nonresponders did not differ significantly in age, sex, type of procedure, preoperative mortality risk, or length of hospital stay. Demographic and clinical characteristics of the responders, who constitute the subject of the investigation reported here, are summarized in Table 1.

Procedure

After surgery and close to the time of discharge from the hospital, patients were approached by the investigators to obtain informed consent. Patients participated in 2 structured telephone interviews after discharge. The first interview was conducted within the first week after discharge, and the second interview was conducted 5 weeks later, or 6 weeks after discharge. At the end of the interviews, each of which lasted approximately 20 minutes, patients were asked the following question: “What do you want your nurses and doctors to know to help them do a better job?” Patients’ responses were recorded verbatim by trained interviewers, who were registered nurses with experience in care of cardiac patients. Before asking the question, the interviewers reminded patients that the patients’ answers were confidential and that no identifying information would be included in any reports. To give patients ample opportunity to respond to the question, interviewers paused and urged patients to take their time to think about the final question.

Analysis

Measures of central tendency were used to describe the sample’s characteristics. A thematic extraction analysis of patients’ responses was conducted by using NUD*IST VIVO statistical software (Scolari, Sage Publications Software, Thousand Oaks, Calif). The software is a Windows-based program in which verbatim transcripts are pasted into individual patients’ files. Within each patient’s file, comments are coded and sorted individually as part of the analysis process. The software user must generate codes and make coding decisions; these functions are not performed automatically. The thematic extraction method involves identification of patterns or themes that together uniquely inform the patients’ experiences of the nursing and medical care the patients received. Data from the first and second interviews were analyzed separately. For refinement of themes, an iterative process was used in which 2 investigators (LVD, AWM) coded data separately and then reviewed it jointly until agreement was reached. When a theme was identified, it was rechecked against all the data for that interview for authenticity. An expert panel of 2 advanced practice nurses with experience in postoperative care of cardiac surgery patients also did a confirmatory review of the data after themes were identified. Neither the investigators nor the reviewers were directly involved in the care of the patients included in the sample. Data were examined for inconsistencies as well as congruent findings. Inconsistencies were included as part of the data before conclusions were drawn. After themes had been extracted from the data, the investigators examined the fit between the identified themes and a well-accepted conceptual framework of quality of care, Donabedian’s structure-process-outcome framework, which is designed to explain how specific structure and process components of the healthcare system affect outcomes of care. The Donabedian framework was selected because it offered a multidimensional evaluation of patients’ perceptions of care and because it has proven applicability in the evaluation of quality of care.

Results

At the first interview, a total of 110 comments were made by 68 patients. At the second interview, a total of 90 comments were made by 59 patients. Thirty-seven patients had comments in response to the open-ended question at both interviews. Four major themes and 12 subthemes emerged from the thematic analysis (Table 2). The percentage of respondents who addressed each major theme and subtheme for the first and second interviews are presented in Figures 1 and 2, respectively.

Theme 1: Being Satisfied

Having a Positive Experience. Satisfaction was a major theme of patient’s responses to the question, Is
there anything you want your nurses or doctors to know to help them do a better job? At the first interview (within the first week following hospital discharge), 18 patients (26.5%) expressed satisfaction with their care. Thirty (51%) expressed satisfaction at the second interview (6 weeks after hospital discharge). At the first interview, typical comments were “Couldn’t ask for more” and “They are doing a good job now.” At the second interview, satisfied patients said, “Excellent care; no recommendations,” and “I give everyone an A+.” Of the patients who expressed satisfaction at the first interview, 14 (77.8%) had only positive comments, and 4 also specified areas for improvement. At the second interview, 21 (70%) of the 30 patients who expressed satisfaction did not identify any areas for improvement.

Typical statements of patients whose comments mixed satisfaction with areas for improvements were “I was very impressed [with care], but I needed more rest,” “Doing a good job. More assisted activity during first week at home needed. More pushing at home is needed . . . ,” and “I had a smooth recovery, but doctors were too slow returning phone calls.” Several mixed comments differentiated between care providers, such as “The nursing staff was very good, but other help was not so good,” and “MDs [were] very good; however, I was highly dissatisfied with nursing care.”

**Theme 2: Not Being Cared For**

*Feeling Depersonalized.* At both interviews, patients described situations that evoked feelings of depersonalization or alienation as part of their postoperative experiences. Nineteen percent of patients expressed such comments at the first interview, and 14% did so at the second interview. Examples of general comments indicating that a patient did not feel valued as a person were “Things were done for the convenience of others, not the patient,” “I was a commodity—an object on a factory assembly line,” and “I felt like a number.” Other patients recounted specific events or conditions that contributed to feelings of depersonalization: “The nurse was too busy to check my IV. I called for the nurse again and [she] didn’t come for hours . . . ,” “I felt alienated after surgery; [I] hated being tied down,” “Lack of privacy was uncomfortable,” and “The first time I got out of bed I was left alone.”

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD)</th>
<th>Number (%)</th>
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<tr>
<td>Age, years</td>
<td>57.6 (13.9)</td>
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<tr>
<td>Ejection fraction</td>
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<td></td>
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<tr>
<td>Length of stay in intensive care unit, days</td>
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<td></td>
</tr>
<tr>
<td>Length of stay in hospital, days</td>
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<tr>
<td>Female</td>
<td>23 (25.8)</td>
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<tr>
<td>Preoperative mortality risk*</td>
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<tr>
<td>Good</td>
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<td></td>
</tr>
<tr>
<td>Fair</td>
<td>15 (17.0)</td>
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<tr>
<td>Poor</td>
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<tr>
<td>Type of procedure*</td>
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<tr>
<td>Valve repair or replacement</td>
<td>30 (34.1)</td>
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<tr>
<td>Coronary artery bypass graft with valve repair or replacement</td>
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<td></td>
</tr>
<tr>
<td>Repair of congenital defect in an adult</td>
<td>4 (4.5)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>8 (9.1)</td>
<td></td>
</tr>
<tr>
<td>Received help with problems related to cardiac surgery from family and/or friends</td>
<td>74 (83.1)</td>
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*Data available for only 88 of the 89 respondents.
Having Expectations That Did Not Match Recovery Experiences. Sixteen percent of patients at the first interview and 24% at the second interview expressed having expectations that did not match their experiences of having cardiac surgery. At the first interview, many of these comments focused on patients being surprised by the intensity of the experience: “It was more stressful than I was prepared for,” “[There was no] preparation for other losses—weakness, thinking unclearly,” and “Hardest thing was not being told how tough it would be.” At the second interview, similar comments emerged, but were directed at patients’ posthospital experience: “Doctors told [me] it would take 4 to 6 weeks to recover; feels like it takes longer than that,” “[I was] not sufficiently informed regarding the difficult recovery in terms of incisions, feeling tired, lack of energy,” and “[I] had no idea I would experience this much pain so many days after surgery.” At both interviews, several specific issues related to care delivery emerged. These included “[I] would have felt more comfortable if a doctor or surgeon had inserted [the chest tube] instead of the nurse practitioner,” “In the hospital I only got to walk from bed to bathroom—never in the hallway,” and “I needed more time before discharge.”

Not Being Listened To. Fifteen patients (22%) at the first interview and 4 patients (7%) at the second interview commented on poor communication with care providers. When patients perceived a communication problem, the phrase “not listening” was often included, as follows: “Pain medication [was] a problem—no one listened,” “Night nurses were not listening,” “I felt the surgical staff would not listen to feelings; they were technically oriented,” and “Doctors didn’t listen when you said you hurt.” More rarely, patients made less direct comments about their needs to be heard by their care providers. These included “I would like the nurses to be active listeners . . . ,” “. . . understand a man’s anger when he comes out of surgery,” and “A doctor has to be a psychologist too.”

Experiencing Unprofessional Behavior by Care Providers. Patients expressed distress when care providers behaved in ways the patients considered inappropriate or unprofessional. Ten percent of patients discussed problems of this nature at the first interview, and 7% had similar concerns at the second interview. Both general and specific comments were reported. General comments included “The step-down unit was chaotic and unhelpful,” “[There was no] awareness of who is who in the hospital,” and “Staff [were] inconsiderate; no consideration of bothering a patient.” More specific comments included “humiliating events—the way I was talked to . . . disrespect in speaking [to me],” “Physician who did my angiogram was too rough,” and “The nurse was bossy . . . and talking very loud.”
Experiencing Continued Care Needs After Going Home. Nine percent of patients at the first interview and 7% of patients at the second interview commented about their need for continued nursing care after discharge from the hospital. Positive comments about the importance of home nursing care emerged at both interviews: “The visiting nurse was able to iron out and answer questions I had . . . when I went home” and “It was good to have [the] nurse come to the house—very helpful.” However, more comments were made about the lack of needed attention at home. These included the following about what care patients would have liked to receive: “More assisted activity during the first week at home; more pushing at home needed with skilled care worker,” and “Closer monitoring and contact after discharge.”

**Theme 3: Physical Needs Unmet**

**Sleep.** Nine percent of respondents commented on sleep disturbances related to nursing care at the first interview, and 3% made similar comments at the second interview. At both interviews, patients noted that they were not allowed uninterrupted sleep in the hospital. Comments included “I was awakened too often for medication and routine things” and “I did not feel I had enough rest in the hospital. Something should be done to improve patients’ ability to rest and sleep.”

**Pain.** The need for better pain management was mentioned by 15% of patients at the first interview and by 7% at the second interview. Most comments were general in nature, such as “Pain medication was a problem,” “Pain killers should be routine,” and “[I] didn’t get pain medication.”
Physical Environment. Comments about problems with the physical environment of the hospital were made by 10% of patients at the first interview and by 7% at the second interview. Some comments were directed at maintenance: “The room was too hot” and “Rooms needed to be cleaned.” Others were directed at lack of privacy: “Mood and recovery [were affected by] a semiprivate room . . . very sick roommate.”

Theme 4: Informational Needs Unmet

Needing More or Different Information. At the first interview, 22% of patients reported needing more or different information while in the hospital. Although some comments were general, such as “More information is better” and “[I] didn’t get any instruction,” most patients identified specific informational needs. These included “more specific instructions about getting up and how to move,” “more information about breathing exercises,” “know difficulty communicating [while intubated],” and “didn’t get a detailed explanation of the surgery.”

At the second interview, 19% of patients commented on unmet informational needs. At that interview, most patients wanted more general information to help them put their surgery into perspective. Their comments included suggestions, such as “Include a diagram of the surgery for all patients,” “Prepare patients more with respect to the incisions,” “Take more time to explain things to patients,” and “Doctors should explain in greater detail about the surgery . . .
and give patient a bigger picture.” One patient commented, “I didn’t really understand what they found in my heart.”

Patients commented at both interviews about the way in which information was presented. One patient, a registered nurse, thought that the healthcare team “assumed I should know things when they gave me explanations.” Another patient reported getting a pathology report with medical terminology and he “still didn’t know” what it meant.

Perceptions Over Time

The changes in responses of those patients who commented on the open-ended question at both interviews are summarized in Figure 3. The percentage of patients who commented on an area in the first interview did not differ significantly from the percentage who commented on that area in the second interview.

Integration of Themes With the Quality-of-Care Framework

Study themes were integrated with Donabedian’s quality-of-care framework (Figure 4). Each major theme was related to more than 1 element of the Donabedian framework. Similarly, within each major theme, subthemes were linked to separate elements of the structure-process-outcome framework.

Discussion

Identical themes in patients’ perceptions of care emerged at both interviews. At both times, patients were most concerned about issues related to their experiences of not being cared for and having physical needs remain unmet. Because less than half of our

![Figure 3](http://ajcc.aacnjournals.org/)

**Figure 3** Distribution of patients’ comments by themes among patients who responded at both interviews.
sample participated in both interviews, it is difficult to draw conclusions about patterns of change in patients’ concerns. However, of all patients responding to the open-ended question 6 weeks after discharge from the hospital, only half of them volunteered positive comments indicating that they were satisfied with their experience. At 6 weeks after discharge, approximately a fifth of patients remained concerned about having had unmet expectations related to their surgical experience, and an equal number were concerned about having needed more information than they received. A conservative implication of these findings is that clinicians should talk to patients about the patients’ expectations and assess informational needs of patients before and after surgery.

Our finding that no patients recounted experiences specific to the intensive care setting supports contentions by other investigators that patients do not remember stays in the intensive care unit. However, our finding that many patients recalled vividly distressing experiences related to their care up to 6 weeks after discharge suggests that patients’ perceptions of care are an important part of the hospitalization experience after cardiac surgery. Therefore, healthcare providers should not discount patients’ perceptions as likely to be forgotten after the patients go home.

**Quality of Care**

The elements of structure, process, and outcome were useful in organizing and evaluating themes and subthemes related to patients’ perceptions of care.

**Structure.** Structural aspects of care were reflected when patients expressed concerns about the continuity of care from hospital to home and when they reported...
that environmental deficits affected their care. These comments fit Donabedian’s definition of structure because they are related to services available to patients, as well as to the facilities in which patients receive care.13 Other investigators have described the adverse effects of environmental factors on patients’ recollections. However, patients’ concerns about transitional care from hospital to home after cardiac surgery have not been previously reported. Our finding is consistent with changes in care delivery during the past decade that place priority on early discharge and that may have created a need that remains unmet for many patients.

Process. Processes of care were important factors in patients’ perceptions of the quality of the care they received. Comments about the manner in which care was received are part of the process of care because they refer to the circumstances in which care was received.11 In general, the most frequent concerns patients reported at both interviews were those having to do with how the patients directly experienced nursing and medical care. Patients wanted their nurses and doctors to do a better job of acknowledging the patients’ individuality, preparing them for how they would feel physically and emotionally after surgery, listening to them, and behaving respectfully in ways that conformed to the patients’ notions of professionalism. These findings agree with those of other reports13,16 that patients’ perceptions of nurses’ caring include effective communication and personalized care. They differ from those of earlier reports because the patients in our study did not focus on technical competency as an aspect of nurses’ caring that was of concern to them. Other investigators11,14 have reported that technical competence is one of the most important behaviors of caring nurses. Perhaps the patients in our study were satisfied with the technical competence of their nursing care, and so they did not include it in their comments about how nurses could improve.

Also important were patients’ concerns that their preoperative expectations of what they would experience after surgery had not been realistic. Because patients perceive themselves as entering the unknown, they are vulnerable and apprehensive after surgery.16 Therefore, feelings of insecurity may have been magnified when patients felt unprepared for what they actually experienced. Patient reports that “nobody told me” about the intensity of the whole experience may indicate that, in retrospect, patients felt somehow deceived by their care providers. In our study, patients reported that they wanted an honest picture of the entire process of cardiac surgery, including descriptions of the intensity, difficulty, and stress they were likely to experience. These findings extend those of other investigators14 who reported that patients valued honest information about the patients’ medical conditions as an element of nurses’ caring. In contrast to the findings of other investigators,17 our findings did not indicate that patients expected their postoperative experiences of recovery to involve work on the patients’ part. In fact, patients’ reports that they underestimated the difficulty of their recovery imply that they may not have viewed surgical recovery as a process of work.21,22

Informational needs have been reported in relatively few previous studies.23,24 Previous reports identified either general informational needs related to such topics as deleterious effects of surgery, physical condition, and knowledge of disease25 or needs related to patients’ sensory experiences.26 In contrast, our findings indicate that patients want specific information about what they have to do as part of their recovery both in the hospital and at home. Importantly, they want information tailored for their individual needs and levels of understanding. Patients’ recognition of their need for individualized information that helps them participate in and manage their own recovery is important because it offers clinicians a timely opportunity to include patients in the planning of care and to introduce the concept of patients’ work in recovery.21,22,26

Outcomes. One week after discharge from the hospital, approximately 25% of patients were satisfied generally with the outcomes of their care. That number had increased to approximately 50% by 6 weeks after discharge. However, patients commented specifically on biological and functional dimensions of care outcomes. They wanted better pain management, fewer sleep disruptions, and more information before and after discharge. Inadequate pain management after discharge from the hospital may be a more recent concern, because routine hospital stays now are as short as 3 to 4 days. Sleeplessness has been reported less frequently after cardiac surgery than after other procedures,7 perhaps because most previous reports have focused on the intensive care experience rather than on the entire hospitalization. Because the intensive care experience is usually short, sleep disruption may not be recognized until later in the hospitalization. Our findings that patients considered sleep disruptions preventable is new, but not surprising. It parallels our finding that patients experience depersonalization and think that their individual needs are overlooked.

Limitations

Our study is limited because not all subjects responded to the open-ended question upon which the
findings are based. Possibly, this feature introduced an elite bias, that respondents were more articulate, accessible, or willing to talk about their experiences than were nonrespondents. This possible limitation to the external validity of the study is unlikely, however, because we found no demographic differences between respondents and nonrespondents. In addition, we attempted to counter this possibility by offering each patient as much time as necessary to think about his or her answers. We used supportive statements such as “Take your time, if you’d like to think about this question more.”

The fittingness of the study is supported by review of the findings for meaning and applicability by a panel of experts.\textsuperscript{27} Internal validity, or truth value, of the study may have been affected by the way in which the question asked of patients was framed. By asking what patients wanted nurses and doctors to know to help the caregivers do a better job, a focus on the negative aspects of patients’ experiences may have been inferred. However, this possibility is mitigated by the fact that patients readily volunteered comments about their satisfaction with care.

Neutrality may influence credibility. To limit this possibility, the interviewers and the advanced practice nurses who served as peer reviewers were not directly involved in the care of the patients. Also, we did not conduct a pilot study of the software before our analysis. However, the possible limitation in credibility because we had no data obtained in a pilot study is small because the data set was relatively small and we were able to perform multiple checks for accuracy and completeness. Finally, the lack of tape recordings limits the content validity of the study, because coding interrater reliability cannot be established.

**Clinical Implications**

This study provides important information about what cardiac surgery patients value and what they want their nurses and doctors to know about structures, processes, and outcomes of the patients’ care. Regarding structures of care, clinicians can improve the important processes, and outcomes of the patients’ care. Continued study of patients undergoing cardiac surgery to monitor what patients value in the structures, processes, and outcomes of their care is warranted.

**ACKNOWLEDGMENT**

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