stressed all patients were free to withdraw at any time. Strict confidentiality was maintained.

Patients were interviewed using open-ended interviews based on grounded theory. They were asked to describe their experience of critical illness and its impact after discharge from critical care. They also completed questionnaires on the follow-up service six and 12 months later.

The questionnaires were analysed using statistical package SPSS. The interview data was analysed using a grounded-theory approach. The validity of the questionnaires was assessed through the patient expert advisory group.

RESULTS
Twenty-eight patients took part in interviews, of whom 22 completed questionnaires. Thirty-seven interviews were carried out. None of the patients reported no benefit from attending the follow-up clinic, although some said they were unsure (Table 1, p18). Themes emerged under four main categories (Fig 1), with reassurance as a core theme.

Rehabilitation from critical care

Cancer-specific issues

There were specific issues not found in other literature, such as GI effects directly from major cancer surgery. Some led to interventions such as repeated oesophageal stenting. Sarcoma patients outlined issues related to pain, mobility and wound healing.

Interrelationship between issues

Interrelationships between psychological and physiological problems were noted as a result of operations and cancers. These affected recuperation from critical care as well as body image, masculinity and femininity. Patients who had been intubated in critical care found this difficult to manage. Communication was impaired to the point of not being able to convey basic needs at times and this caused feelings of depression among some. Pain after critical illness and cancer surgery was a difficult issue for a few; the presence of pain may indicate the consequences of major surgery, but also lead to fears of cancer recurrence, which needed reassurance.

Nursing ability to meet needs

One-to-one nursing provided reassurance for critically ill patients. On the whole, care was positively reviewed, with specific instances of poor care being put in a context of overall good care. Nurses’ ability to care for relatives, as well as patients, was noted by many respondents, for example: ‘I couldn’t believe it, there is always someone there… They were just incredible…’

The poorer aspects of care, though infrequently mentioned, seemed to reflect instances of nurses’ intolerance or lack of understanding and consideration. In the three situations where nurses had let their impatience show, patients were quick to emphasise this did not reflect their whole experience and care was otherwise good.

Longer-term needs

Some patients said how useful the critical care follow-up clinic was as part of the recovery process. Talking through feelings about critical care and cancer was highly valued.

Fatigue

‘Pacing oneself’ after critical illness was something that some found easier than others. Patients talked of feeling ‘knocked out’. Despite having cancer, not all patients defined themselves as ill. Work was viewed as a sign of normality. However, the second interview revealed that, for three patients, working proved too much and they had to relinquish responsibility, cut hours or stop altogether.

Memories – real and unreal

Memory

Patients found their memory could be distorted when in a critical care environment and some found this distressing. The ability to recall varied, with a significant number appearing to remember nothing or very little but, on cautious further inquiry, remembering certain incidents. A small number found they were able to recall things at the second interview, when more time had elapsed: ‘Sometimes I’ve closed my eyes and I’ve tried but the only thing that I’ve really remembered is that [bad] dream.’

Dreams, hallucinations and nightmares

These were recounted by numerous participants, including disturbing nightmares and ASD or PTSD symptoms. They often

FIG 1. THEMES EMERGING FROM THE RESEARCH