

TITLE PAGE

Waiting for Health Care: a concept analysis

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## **WAITING FOR HEALTH CARE: A CONCEPT ANALYSIS**

### **ABSTRACT max. 250 words**

**Aim:** This paper is a report of an analysis of the concept of waiting for health care from the client's perspective.

**Background:** Waiting is commonplace in many areas of health care and has become a topical and politically-important issue in the provision of healthcare services. Whilst managers and governments search for solutions to this problem, it is important that this aspect of clients' healthcare experience is examined in order to evaluate its impact and implications for nursing practice.

**Methods:** The PubMed and CINAHL databases (dating from 1950 and 1982 to 2007 respectively) were searched using the keywords 'healthcare' and 'waiting'. The reference lists of papers identified were also checked and this revealed literature from a number of other disciplines related to the concept.

**Results:** Waiting for health care is an unspecified yet measurable period of time between identification of a healthcare problem and its diagnosis and treatment, during which clients experience uncertainty and powerlessness whilst anticipating a disease outcome. The critical attributes are a period of measured time, subjective interpretation of the perceived significance of the measured time, feeling uncertain and powerless and anticipation of a response to the healthcare need. The critical attributes of waiting for health care are; a period of measured time, subjective interpretation of the perceived significance of the measured time, feeling uncertain and powerless and anticipation of a response to the healthcare need. Antecedents include; the need for a healthcare service, the necessary healthcare service is not immediately available and the perception of potential for harm.

Consequences are; persistence or worsening of symptoms, poorer outcome, stress, anxiety, anger and frustration, altered social and family functioning and relationships, perceived satisfaction with service.

**Conclusion:** Strategies that facilitate contact with clients through pre-assessment clinics and giving written information and a contact point may seem obvious but are currently overlooked in busy healthcare environments. This is an area where nurses can lead in the delivery of person-centred care and could potentially increase satisfaction with how waiting is managed.

**KEYWORDS:** waiting, waiting lists, concept analysis, nursing, powerlessness, stress, coping

## **SUMMARY STATEMENT**

### **What is already known on this topic.**

- Waiting is a norm in contemporary health care
- Waiting for health care is both a topical and politically important issue and some literature suggests that nurses have a professional responsibility to address this.
- Waiting influences clients' healthcare experiences and may be the most stressful part of the hospital journey.

### **What this paper adds.**

- Waiting for health care is an unspecified yet measurable period of time between identification of a health care problem and its diagnosis and treatment.
- Clients experience uncertainty and powerlessness whilst waiting for diagnosis and treatment
- Nurses can improve the waiting experience through contact with clients at pre-assessment clinics and by giving written information and acting as a contact point during the waiting period

## **INTRODUCTION**

Waiting for health care is a commonly-encountered phenomenon and is viewed as a continuing and even worsening problem for those accessing healthcare services (Murray, 2000; Martin et al, 2003; Pitt et al, 2003). Martin et al (2003) suggest that waiting for health care in the United Kingdom National Health Service has changed little over the past 50 years and is a characteristic of many publicly-funded healthcare services. However, improving technology, higher client expectations and an ageing population combine to increase demand for healthcare services.

There are a number of stages in the decision to seek medical attention. A symptom is experienced and a judgement made about its importance to the individual, which in turn determines the decision to seek further medical opinion (Wilson and Cleary, 1995). In this concept analysis, the focus is on the period of time following initial consultation with a healthcare practitioner to assessment and diagnosis. This pre-diagnostic phase, according to Giske and Gjengedal (2006), is the most stressful of a client's illness trajectory, with waiting being a common feature (Thorne et al, 1999; Young et al, 2000; Lebel et al, 2003; Saegrov and Halding, 2004).

The rationale for choosing the concept of 'waiting for health care' is based on my clinical experience, where clients who present for diagnostic endoscopic procedures may have endured a considerable wait. Reflecting on their recounted experiences highlighted that although patients were aware of a health problem, the nature and extent of the threat to their life and well-being was not known. In addition, the presence of symptoms was distressing and there was little indication of when there would be resolution. This would suggest that patients who are waiting for health care are stressed. Although as healthcare

professionals we are aware of ‘waiting lists’ and ‘waiting times’ as performance indicators, it appears that we have little understanding of what it means to wait for health care from a client perspective. Nurses should identify situations that affect client healthcare choices, and they have a vital role in lobbying for improvements in those areas (Harris and Richman, 2004).

Concept analysis is a means of expanding the knowledge base of nursing, although it has not received the same attention as the more familiar realm of theory development (Rodgers 2005). It can be undertaken at any stage of the theory development cycle (Meleis, 2005) and is particularly useful for an emerging concept such as ‘waiting for health care’, where the definition appears to lack clarity and the characteristics, preconditions and outcomes are not clearly identified. In the inductive theory generation process, it is appropriate to use experience “as a source of ideas to develop concepts and consider relationships and prepare those ideas for further exploration, for testing, for generalisation, for being challenged and modified” (Meleis, 2005:125). A literature-based analysis such as that undertaken here is useful not only for determining the current status of the concept, but also for offering alternative perspectives or ways of thinking about it (Rodgers, 2005).

## **CONCEPT ANALYSIS**

There are a range of approaches to concept analysis, which Rodgers and Knafl (2000) suggest are geared to somewhat different purposes. The choice of Walker and Avant’s (2005) model is bound to their claim that it accommodates clarification of concepts for use in theory development and research. Critics of the model suggest that this method of concept

analysis is positivistic, reductionist and rigid (Gordon 2000, Trendall 2000, Rodgers and Knafel 2000). In their defence, Walker and Avant (2005) argue that it has never been their intention to subscribe to such outmoded tenets. They recognize that there is more than one approach to concept analysis but suggest that, regardless of the technique, what is important is the use of a reasonable and logical method that will provide solutions to problems in the discipline of nursing. From a practical perspective, this method is well-structured yet acknowledges the iterative nature of the process and has been used extensively in the concept analysis literature (Ridner, 2004; Cutcliffe and McKenna, 2005).

Walker and Avant's model was developed from Wilson's (1963) model and consists of eight stages. These are:

“(1) selecting a concept, (2) identifying the aim of the analysis, (3) identification of all the uses of the concept, (4) determination of the defining attributes, (5) identifying a model case, (6) identifying borderline, related, contrary and invented cases, (7) identifying the concepts antecedents and consequences and (8) defining the concepts empirical referents” (Walker and Avant, 2005:65).

## **AIM OF THE ANALYSIS**

The aim of the study was to conduct an analysis of the concept of waiting for health care from the client's perspective.

## **SEARCH METHODS**

In keeping with Walker and Avant's model (2005), all uses of the term “waiting” were examined. Its common usage was evidenced by its inclusion in a broad spectrum of areas such as entertainment, environment, travel and adoption, driving test facts, broadband

information, song lyrics and music. A number of health-related websites referenced the term in relation to waiting times for specific consultants, organ transplants, cancer care and other areas of the health service. In order to examine its use specifically in health care, the PubMed (1950s to 2007) and CINAHL (1982 to 2007) databases were searched using the keywords ‘healthcare’ and ‘waiting’, both separately and together. Literature that was not available in English or referred to waiting in disciplines other than health care was excluded. The reference lists of papers sourced from these databases were hand-checked for other relevant literature.

## **RESULTS**

### **Dictionary definition**

The Encarta World English Dictionary (2007) under “wait” lists the following definitions:

1. Do nothing expecting something to happen
2. Stop so somebody can catch up
3. Be hoping for something
4. Be delayed or ignored for now
5. Be ready or available
6. Delay something
7. Be waiter

(Encarta World English Dictionary, 2007: online)

## **Concept Usage in Health care**

The healthcare database searches generated literature that broadly encompassed quality of life, quality of the patient/client healthcare experience and the managerial aspects of waiting in many areas of health services. Analysis of this literature generated a number of themes, including measurement of waiting; clients' perception of the time waited; and the biopsychosocial impact of waiting for health care.

From a healthcare management perspective, according to Burstein et al (2005), waiting and waiting lists exist primarily because of inconsistency between supply and demand in healthcare provision. It has been suggested that waiting lists are a means of rationing and prioritising health care in a resource-limited service (Lovfendahl et al, 2005; Martin et al, 2003). It is therefore a challenge for government, managers and healthcare professionals to measure and reduce them (Pitt et al, 2003; Fitzpatrick et al, 2004). Some researchers have addressed the limitations of current methods of waiting list compilation and management, and suggest that they do not always measure the full extent of clients' waits for assessment through to waits for treatment (Kennedy, 2000; Pope and Sykes, 2003). Thompson (2000), in his critique of waiting list formulation techniques, argues that the strategy of concentrating on shorter procedures to improve waiting time statistics is a poor reflection of overall service. He further suggests that, as waiting lists are a controversial topic, they can be used for political advantage whilst their limitations in reflecting health service performance go unnoticed. A number of studies examining the effectiveness of the two-week wait directive (Campbell et al, 2000; Cant and Yu, 2000; Hanna et al, 2005)) in the U.K. in various areas of cancer treatment have shown that it does not always improve

access to health care and has increased the waiting time for those whose problems are not deemed to be non-urgent or routine. Hanna et al (2005) found that in some instances cancer detection rates dropped due to incorrect prioritisation of referrals and, in fact, 36% of breast cancers diagnosed were from non-urgent referrals. Walsh et al (2002), in their prospective audit of 421 referrals, further identified that while there was a reduction in waiting time for consultation, the wait for diagnosis and treatment remained unchanged. It appears, then, that this directive is limited in its effect and waiting time is simply pushed to a different treatment phase (Hanna et al, 2005).

The period of time spent waiting consistently appears in the literature as one of the measures of client satisfaction with health care provision (Di Tomasso and Willard, 1991; Dansky and Miles, 1997; Knudtson 2000). It is suggested that this is because clients find expertise difficult to measure and therefore it is the speed of service that becomes an indicator of quality of care (Eilers, 2004). Throughout the studies examined, it seemed that waiting was measured in different ways, that is as actual waiting times, estimates of waiting times and perceptions of waiting times. Cole et al (2001) state that expected waiting times are most consistently linked with client satisfaction. Studies have indicated that, when waiting times were less than expected, clients had higher levels of satisfaction with the care they received, staff were perceived as being more kind and compassionate and satisfaction with medical care increased (Thompson et al, 1996; Dansky and Miles, 1997; Spaite et al, 2002).

Dunn et al (1997), in an international prospective study of 550 clients awaiting cataract surgery in Canada, Denmark and Spain, found that increased anticipated wait increased client dissatisfaction, with 75% finding a wait of six months unacceptable. This

was independent of any sociodemographic or disease-extent factors. In their Swedish study, Lovfendahl et al (2005) had similar findings in their large sample of 1336 people awaiting a variety of surgical operations. Those who had shorter median waiting times identified their wait as acceptable whilst longer waiting times were statistically significantly associated with dissatisfaction, regardless of sociodemographics. Importantly, both studies suggest that satisfaction during the wait for treatment is influenced by clients' knowledge of local processes of referral and waiting list management, which influence the psychosocial impact of waiting for health care.

Clients' experiences of waiting for health care have been addressed in numerous international studies, which can be divided mainly into those that address the wait for diagnosis, those that focus on the wait for treatment phases in the areas of cancer treatment, coronary care, transplant or elective surgery of all types, and patients waiting for out-patient appointments across a wide variety of disciplines (Appleby and Lawrence,2000; Fitzsimons et al, 2000; Feldman et al, 2002; Fitzpatrick et al, 2004; Lebel et al, 2003; Lovfendahl et al, 2005; Sjolting et al, 2005;Wagg et al, 2005). The period identified as 'waiting for diagnosis' appears to incorporate two further distinct stages: the period following referral for secondary assessment (Lebel et al, 2003) and the period from secondary assessment to diagnosis (Fridfinnsdottir, 1997; Poole, 1997; Thorne et al, 1999; Giske and Gjengedal, 2006).

Saegrov and Halding's (2004), in a retrospective study of people with experience of cancer in Norway, found that the period from first identification of a problem until diagnosis of cancer was a time of immense stress. Young et al (2000) also state that delayed diagnosis of colorectal cancer produces great anxiety and a presumed belief of a poorer prognosis. Giske and Gjengedal (2006) identified 'preparative waiting' as a substantive theory

following a grounded theory study investigating hospitalised patients' experiences and coping during diagnostic workups for gastrointestinal problems. Their model of preparative waiting identifies waiting in the pre-diagnostic phase as comprising seeking and giving information, interpreting clues, struggling with existential threat, seeking respite and balancing between hope and despair. Individuals interpret symptoms subjectively and the decision to seek medical attention is based on this judgement (Wilson and Cleary, 1995). This subjective interpretation of symptoms and how the diagnosis is acquired are important in determining the perception of the symptom as a threat or not.

Giske and Gjengedal (2006) compare and develop the findings of their study in terms of Lazarus and Folkman's (1984) theory of appraisal, stress and coping. That waiting for health care is stressful is evidenced by the use of Lazarus and Folkman's (1984) theory to frame several of the studies reviewed for this concept analysis (Fridfinnsdottir, 1997; Giske and Gjengedal, 2006; Lebel et al, 2003; Poole and Lyne, 2000). According to this theory, primary and secondary cognitive appraisal is undertaken in order to determine the meaning of a stressful situation. Primary appraisal is the cognitive process of determining the significance of an event and the degree of perceived threat. Anxiety increases in situations where uncertainty and existential threat exist. Secondary appraisal concerns possible coping strategies and their effectiveness in reducing potential harm. Whilst it was not the intention of Giske and Gjengedal (2006) to study coping, they argue that their findings illustrate that uncertainty during the pre-diagnostic phase modulated the development of coping strategies.

Poole and Lyne (2000) identified interpreting clues as a stressor during the waiting period in their study of women awaiting investigation of breast disease. Lebel et al (2003),

in a Canadian study, found that uncertainty about diagnostic procedures was perceived as a threat, and over 50% of participants over-estimated their risk of breast malignancy during their wait for diagnosis.

In a literature review, Oudhoff et al (2004) assessed the biopsychosocial effects of waiting in clients needing a variety of hospital treatments for gallstones, breast cancer, varicose veins and inguinal hernia. In those awaiting a diagnosis for suspicion of breast cancer, a notable trend towards anxiety was illustrated in those with longer waiting times, which it appears affected prognosis in this group. Thorne et al (1999), using focus group interviews, examined the experiences of 33 women again in Canada who were waiting for diagnosis following an abnormal mammogram. The women had little understanding of the diagnostic procedures they required and were uncertain about when they would receive their diagnosis. They described the waiting experience during this time as a type of “limbo”, with a feeling of being “suspended from participation in normal living” (Thorne et al, 1999: 45). They identified anxiety, inability to concentrate and a reluctance to make plans for the future as influencing how this time was experienced. They further reported that their lack of knowledge and perceived powerlessness in the situation increased their anxiety during this time.

It is clear that at this stage of the disease trajectory uncertainty is characteristic during the waiting period. Although Giske and Gjengedal’s (2006) theory appears to usefully represent patients’ experiences, it does not address the phase before secondary assessment, except to state that their patients may have experienced a great deal of waiting prior to the work-up.

Other studies addressing waiting for treatment are mainly concerned with patients awaiting surgery. Fitzsimons et al (2000), in a study in Northern Ireland of 70 randomly selected patients waiting for coronary artery bypass surgery, identified three main themes associated with waiting for health care: anxiety, uncertainty and chest pain. Six secondary themes emerged from these interviews, namely loss of control, disappointment with treatment, rage and frustration, reduced physical activity, low morale and changes in family and social relationships. Clients felt that they were not given enough information whilst waiting, and described experiences of uncertainty and living a life on hold. This inability to plan for the future also affected their families. Participants felt powerless over their own lives and this feeling persisted throughout the wait for surgery, with interviewees suggesting they tried to adapt to this loss of control. Anxiety was identified as an important component of waiting and persisted throughout its entirety.

Derrett et al (1999), in a cross-sectional study of quality of life of 149 people in New Zealand awaiting admission for urinary or orthopaedic surgery, identified uncertainty, powerlessness and subsequent psychological distress. Interviews were conducted using both a general and disease-specific quality of life scale. Anger at the length of time spent waiting, lack of information or contact from the hospital regarding waiting list position and barriers within the hospital system were specifically identified as contributing to the perception of uncertainty and powerlessness over healthcare choice. This contributed to poorer emotional and social functioning scores amongst this group.

Worsening of symptoms and poorer outcomes have also been associated with waiting for health care (Fitzpatrick et al, 2004; Sampalis et al, 2002; Vermeulen et al, 2005) In Fitzpatrick's et al (2004) U.K. study of over 6000 people waiting for total hip

replacement a positive correlation was found between the wait for surgery and pain and disability. Vermeulen et al (2005) describe the worsening of symptoms while awaiting a lung transplant as one of the sources of stress. Sampalis et al (2001) examined the impact of waiting on clients needing coronary artery bypass grafting in Canada and found that those who waited longer had poorer physical health scores prior to surgery, and the incidence of post-operative complications in this group was significantly higher.

This combination of uncertainty, powerlessness and consequent psychological distress and worsening of physical symptoms are identified repeatedly throughout the literature. Many participants in the studies examined identified uncertainty and powerlessness as characteristic of their waiting experience (Derrett et al 1999; Thorne et al, 1999; Fitzsimons et al, 2000; Oudhoff et al, 2004). Powerlessness is a feature of the concept in this context and is described as a sense of loss of self-determination. As a result of this powerlessness, participants in several studies had little knowledge of hospital procedures or who to contact during this waiting period (Derrett et al, 1999; Fitzsimons et al, 2000).

Waiting for health care is identified in the literature as an unspecified yet measurable period of time between identification of a healthcare problem and its diagnosis and treatment, when clients experience uncertainty and powerlessness whilst anticipating a disease outcome.

Therefore the critical attributes of waiting for health care are:

1. Period of measured time
2. Subjective interpretation of the perceived significance of the measured time
3. Feeling uncertain and powerless
4. Anticipation of a response to the healthcare need

## **MODEL CASE**

A model case is an example of the concept that contains all the defining attributes (Walker and Avant, 2005):

Mrs White comes to the endoscopy unit for a gastroscopy. On admission, the nurse explains the procedure and questions her about her symptoms. She explains that she has been experiencing dyspepsia for about six months since her first presentation to her general practitioner (GP). Between going to her GP and her endoscopy appointment, Mrs. White feels that her symptoms have worsened and she is concerned about her diagnosis. She has been trying to manage the symptoms herself but is unsure that her efforts are worthwhile, as her daily activities have become more limited. She did not go back to her GP as she was told that there was nothing more he could do until after her endoscopy appointment. She did not know whom to contact to get an earlier appointment. She has been anticipating this appointment in the hope of receiving an explanation for her symptoms.

In this model case the patient identifies, when questioned on admission, the characteristics of waiting in this context, as previously identified. She has presented following a wait of six months since symptoms began (measurement of time), which she feels has been difficult (perception of time), expresses her anxiety in this situation (uncertainty and powerlessness) and is expecting a diagnosis (anticipating an outcome).

## **ADDITIONAL CASES**

Additional cases include borderline, related, contrary, invented and illegitimate cases that demonstrate facets of the concept.

### **Borderline Case**

Borderline cases contain some but not all of the critical attributes identified or one of the attributes may differ significantly (Walker and Avant, 2005). For example:

Dr. Green comes for his endoscopy appointment for investigation of dyspeptic symptoms. Whilst he has endured a wait of six weeks for his appointment and is expecting a diagnosis today, due to his medical knowledge he is aware of the implications of his symptoms and knows whom to contact if he needs an endoscopy appointment sooner.

Whilst Dr. Green has waited for a period of time and is expecting a diagnosis, he does not demonstrate uncertainty or powerlessness in this situation.

### **Related Case**

Related cases are similar examples of the concept but do not contain the critical attributes specific to the concept being studied (Walker and Avant, 2005). For example:

Mr. White has a sore throat. He phones his GP for an appointment, which he receives for later that day, at which he anticipates he will receive treatment.

### **Contrary Cases**

Contrary cases are instances where the concept is clearly not demonstrated (Walker and Avant, 2005). For example:

Mrs. Black presents for her yearly surveillance gastroscopy for Barrett's Oesophagus. On arrival she is seen immediately and taken for her procedure.

She does not have sedation, is given her report on completion of the procedure and is discharged.

## **ANTECEDENTS AND CONSEQUENCES**

Identifying antecedents and consequences of the concept is useful in clarifying the situations in which the concept exists, and also in honing the critical attributes (Walker and Avant, 2005).

### **Antecedents**

Antecedents are the precursors to the existence of the concept, and those of waiting for health care have been identified as:

1. The need for a healthcare service.
2. The necessary healthcare service is not immediately available.
3. The perception of potential for harm.

In the literature discussing the pre-diagnostic phase, delay in receiving a diagnosis to confirm or refute a potential threat to health was required for this concept to exist. Whilst there are differing circumstances in which clients must wait for health care, all attributes of the concept must be present for the concept in this context to exist. For example, if a client chooses to postpone a procedure, they are controlling the situation and therefore are not powerless whilst waiting.

### **Consequences**

Consequences are the outcomes of the concept having taken place (Walker and Avant, 2005). There are many important outcomes of the concept of waiting. In the literature, some positive experiences were identified, and time to prepare was one which was

highlighted by patients waiting for liver transplant (Jonsen et al, 2000). The ability to adapt was identified as having positive aspects by those awaiting orthopaedic surgery (Sjoling et al, 2005). Most of the studies, however, identified overwhelmingly negative consequences of waiting.

Persistence or worsening of symptoms were identified as consequences of the waiting period (Derrett et al, 1999; Fitzsimons et al, 2000; Sampalis et al, 2001), and the longer the wait for certain types of hospital assessment and treatment, the poorer the outcomes for some clients (Fitzpatrick et al, 2004; Burstein et al, 2005).

Stress, anxiety, anger and frustration were identified as a consequence of waiting in much of the literature (Derrett et al, 1999; Thorne et al, 1999; Fitzsimons et al, 2000; Sampalis et al, 2001; Oudhoff et al, 2004; Vermeulen et al, 2005). These emotions occur as a result of the attributes of uncertainty and powerlessness contributing to psychological distress during the waiting experience. These in turn lead to poorer quality of life, as physical and psychological effects can negatively influence social functioning; for example, people were reluctant to make plans and participants gave up many of their social activities. Family relationships were affected during this time, with clients identifying the strain of waiting as influencing their moods, roles and responsibilities within the household (Fitzsimons et al, 2000).

Finally, clients use waiting time as an indicator of satisfaction with a service, universally accepting actual or perceived shorter waiting times as equating to better service, and subsequently demonstrating increased satisfaction with that service (Dunn et al, 1997; Thomas et al, 1997; Fitzsimons et al, 2000; Cole et al, 2001; Eilers, 2004).

## **EMPIRICAL REFERENTS AND IMPLICATIONS FOR NURSING PRACTICE AND RESEARCH**

Identification of empirical referents has as its ultimate aim the measurement of observable phenomena by which to diagnose the existence of a concept in clinical practice (Walker and Avant, 2005). In many concepts, empirical referents may be identical to the critical attributes. However, if the critical attributes are abstract, then development of instruments for measurement is difficult. Empirical referents of waiting for health care are difficult to define, as waiting is a subjective experience for each client. However, it may be possible to observe or measure some aspects that are indicative of experiences of waiting for health care.

The critical attribute 'period of measured time' is captured primarily by means of waiting lists. However, these are limited in their ability to measure the full extent of the wait from assessment to diagnosis. Because the whole waiting time is not captured as a discrete period, the phases from identification of a problem to assessment and from assessment to diagnosis are measured separately. Furthermore, simply measuring time gives little indication of subjective perception or experience of the wait. Although the literature focuses mainly on the last of these phases and recommendations for nursing practice have been identified, there is little in relation to the experiences of clients at the problem identification stage. Therefore, the experiences of this group should be considered and incorporated into operational developments in relation to accessing outpatient services.

Whilst waiting lists may not help to inform us about the subjective experience of waiting, they can be used to help us study that experience. For example, Lebel et al (2003) proposed that research be undertaken to identify the optimal time at which distress is

minimised in clients waiting for health care. This could be facilitated by using psychological distress scales such as the Psychological Distress Manifestations Measurement Scale (Masseé, 2000), as this incorporates both qualitative and quantitative items.

The qualitative methodologies used in some of the studies examined suggest that the concept of waiting for health care can be illustrated through an examination of client uncertainty and powerlessness during the wait for health care. Uncertainty affecting quality of life has been described as a feeling of expectancy and doubt, living a life on hold, inability to make plans and fear of being forgotten. Although Mishel's (1981) Measurement of Uncertainty in Illness Scale (MUIS) was devised for use with hospitalised patients, it could be adapted for use in the non-hospital setting.

The provision of written information, support and contact details have been stated by Giske and Gjengedal (2006) as important for addressing issues of uncertainty whilst clients wait for health care. The potential for nursing pre-assessment clinics in the pre-diagnostic period should be explored as part of the process of enabling clients retain a sense of control over their waiting experiences. The importance of these strategies in empowering clients and building confidence and trust are emphasised by Giske and Gjendgedal (2006).

Powerlessness whilst waiting has been described in terms of loss of control over life choices, dealing with barriers within the system and waiting to be contacted. Consequent stress and frustration may contribute to persisting or worsening symptoms. Symptom severity can be measured using recognised scales to investigate relationships between these variables. Measuring clients' perceptions of their waiting for health care would provide valuable information about how this wait is experienced. This perception of time can, in

turn, contribute to psychological distress, reporting of symptoms and tolerance of diagnostic procedures (Irvin, 2001).

The theoretical implications for this concept are two-fold. There may be potential for extension of Giske and Gjendgedal's (2006) substantive theory of preparative waiting to include clients who are in the pre-diagnostic phase but who are not hospitalised. Inductive research with this group might enable further validation or indicate areas for refinement in respect of the four 'waiting' strategies of 'seeking and giving information', 'interpreting clues', 'struggling with existential threat', and 'seeking respite'.

Lazarus and Folkman's (1984) theory of stress and coping was used consistently to conceptually frame many of the studies reviewed. It appears that the uncertainty and powerlessness experienced by individuals waiting for health care may militate against the development of effective coping strategies. Further research using this theory could usefully identify how these barriers affect the ability to develop effective coping strategies. There is also the potential for identification of clients' perceptions of the adversity of their situation and a subjective evaluation of their coping styles and strategies.

## **CONCLUSION**

The implications of this concept analysis for nursing practice are that, as nurses, we must be aware of the consequences of waiting for health care for clients when they finally do have contact with these services. This contact with nursing staff may be limited and it is crucial that it is used effectively. Operational strategies and interventions that will facilitate contact with clients through pre-assessment clinics and giving written information and a contact point may seem obvious but are currently overlooked in busy healthcare

environments. This is an area where nurses can lead in the delivery of person-centred care. Whilst such strategies do not remove the actual wait, they address the uncertainty and powerlessness characteristic of the concept of waiting for health care and potentially increases satisfaction with how the wait is managed.

**REFERENCES some refs may have been deleted – pl re-check list**

Appleby, A. and Lawrence, C. (2000) From Blacklist to Beacon a case study in reducing dermatology outpatient waiting times. Clinical and Experimental Dermatology. 26: 548-555

Burstein, J., Lee, D.S. and Alter, D.A. (2005) Do Case Generic Measures of Queue Performance for By-pass Surgery Accurately Reflect the Waiting List Experiences of Those Most Urgent? Journal of Evaluation in Clinical Practice 12(1): 87-93

Campbell, L., Prance, S., Teasdale, C. and Watkins, R.M. (2000) The Two Week Wait for Suspected Breast Cancer; its impact on a symptomatic breast unit and correlation of referrals with outcome. British Journal of Surgery 87 (Suppl.1):37 (Abstract) Breast 005

Cant. P.J. and Yu, D.S.L. (2000) Impact of the “Two-Week” Wait Directive for Suspected Cancer on Service Provision in a Symptomatic Breast Clinic. British Journal Of Surgery 87: 1082-1086

Cole,F.L.,Mackey, T.A. and Lindenberg, J. (2001) Wait Time and Satisfaction with Care. Journal of the American Academy of Nurse Practitioners 13(10):467-472

Cutcliffe, J. and Mc Kenna, H. (2005) The Essential Concepts of Nursing: building blocks for practice. Edinburgh: Elsevier Churchill Livingstone

Dansky, K.H. and Miles, J. (1997) Patient Satisfaction With Ambulatory Health Care Services: Waiting Times and Filling Time. Hospital and Health Services Administration 42: 165-177

Derrett, S., Paul, C. and Morris, J. (1999) Waiting for Elective Surgery: Effects on Health Related Quality of Life. International Journal of Quality in Health Care 11(1): 47-57

DiTomasso, R.A. and Willard, M. (1991) Development of a Patient Satisfaction Questionnaire in the Ambulatory Setting. Family Medicine 23: 127-131

Dunn, E., Black, C., Alonso, J., Noregard, J.C. and Anderson, G.F. (1997) Patients Acceptance of Waiting for Cataract Surgery: What makes a wait too long? Social Science and Medicine 44(11): 1603-1610

Eilers, G (2004) Improving Patient satisfaction and Waiting Time. Journal of American College Health 53(1): 41-45

Encarta World English Dictionary(2007) North American Edition (online). Available: [http://encarta.msn.com/dictionary\\_/wait.html](http://encarta.msn.com/dictionary_/wait.html) (20 Feb 2007)

Feldman, D., Champagne, F., Korner-Bitensky, N. and Meshefedjian, G. (2002) Waiting for Rehabilitation Services for Children with Physical Disabilities. Child: Care, Health and Development 28(5): 351-358

Fitzpatrick, R., Norquist, J., Reeves, B., Morris, R., Murray, D. and Gregg, P. (2004) Equity and Need When Waiting for Total Hip Replacement Surgery. Journal of Evaluation in Clinical Practice 59(11) 1334-1339

Fitzsimons, D., Parahoo, K. and Stringer, M. (2000) Waiting for Coronary Artery Bypass Surgery: effects on health related quality of life. International Journal of Quality in Health Care 32(5): 1243-1252

Fridfinnsdottir, E. (1997) Icelandic women's identification of stressors and social support during the diagnostic phase of breast cancer. Journal of Advanced Nursing 25:526-531

Giske, T. and Gjengedal, E. (2006) "Preparative waiting" and coping theory with patients going through gastric diagnosis. Journal of Advanced Nursing 57(1):87-94

Gordon, L. (2000) Clinical Supervision: a concept analysis. Journal of Advanced Nursing 31(3): 722-729

Hanna, S. J., Muneer, A. and Khalil, K.H. (2005) The Two-Week Wait for Suspected Cancer: time for a rethink? International Journal of Clinical Practice 59(11) 1334-1339

Harris, M. and Richman, V. (2002) The Waiting List Reality: how can nurses effectively advocate for improvements in wait list management? The Canadian Nurse 98(4): 16-19

Irvin, S. (2001) Waiting: Concept Analysis. Nursing Diagnosis 12(4): 128-135

Jonsen, E., Athlin, E. and Suhr, O. (2000) Waiting for Liver Transplant: the experience of patients with familial amyloidotic polyneuropathy. Journal of Clinical Nursing 9(1): 63-70

Kennedy, M. (2000) Access to Care: What should we be measuring? Emergency Medicine 12(1) 66-69

Knudtson, N. (2000) Patient Satisfaction With a Nurse Practitioner Service in a Rural Setting. Journal of the American Academy of Nurse Practitioners 12: 405-412

Lazarus, R.S. and Folkman, S. (1984) Stress and Appraisal and Coping. Springer Publishing Co: New York

Lebel, S., Jakubovits, G., Rosberger, Z., Loiselle, C., Seguin, C., Cornaz, C., Ingram, J., August, L. and Lisbona, A. (2003) Waiting for a Breast Biopsy. Psychological Consequences and Coping Strategies. Journal of Psychosomatic Research 55: 435-443

Lovfendahl, S., Eckerlund, I., Hansagi, H., Malmquist, B., Resch, S. and Hanning, M. (2005) Waiting for Orthopaedic Surgery: factors associated with waiting times and patients' opinion. International Journal of Quality in Health Care 17(20) 133-140

Massee, R. (2000) Qualitative and Quantitative Analyses of Psychological Distress: methodological, complementary and ontological incommensurability. Qualitative Health Research: 10: 411-423

Martin, R. M., Sterne, J.A.C., Gunnell, D., Ebrahim, S., Davey-Smith, G. and Frankel, S. (2003) N. H. S. Waiting Lists and Evidence of National or Local Failure: analysis of health service data. British Medical Journal 326: 1-10

Meleis, A. (2005) Theoretical Nursing: Development and Progress. 3<sup>rd</sup> Ed Philadelphia: Lippincott

Mishel, M.H. (1981) The Measurement of Uncertainty in Illness. Nursing Research 30(5): 258-263

Murray, M. (2000) Patient Care: Access. British Medical Journal 320:1594-1596

Oudhoff, J.P., Timmermans, D.R., Bijnen, A.B. and Van Der Wal, G. (2004) Waiting for Elective General Surgery: Physical, Psychological and Social Consequences. ANZ Journal of Surgery 74: 361-367

Pitt, D., Noseworthy, T., Guilbert, J. and Williams, J. R. (2003) Waiting Lists: Management, Legalities and Ethics. Canadian Journal of Surgery 46(3): 170-175

Poole, K. (1997) The emergence of the “waiting game”: a critical examination of the psychosocial issues in diagnosing breast cancer. Journal of Advanced Nursing. 25:273-281

Poole, K. and Lyne, P. (2000) The “cues” to diagnosis: describing the monitoring activities of women undergoing diagnostic investigations for breast disease. Journal of Advanced Nursing 31(4): 752-758

Pope, V. and Sykes, P. (2003) The Forgotten Wait: Official waiting times often misleading. Clinical Governance 8(2): 108-111

Ridner, S. H. (2004) Psychological Distress: concept analysis Journal of Advanced Nursing 45(5) 536-545

Rodgers, B. (1989) Concepts, analysis and the development of nursing knowledge: the evolutionary cycle. Journal of Advanced Nursing 14:330-335

Rodgers, B.L. (2005) Developing Nursing Knowledge Philosophical Traditions and Influences. Philadelphia: Lippincott

Rodgers, B. and Knaf, K. (2000) Concept Development in Nursing. Foundations, techniques and applications. 2<sup>nd</sup> ed. London: WB Saunders

Saegrov, S. and Halding, C. (2004) What is it like living with diagnosis of cancer? European Journal of Cancer Care 13:145-153

Sampalis, J., Boukas, S., Lieberman, M., Reid, T. and Dupuis, G. (2001) Impact of Waiting Time on the Quality of Life of Patients Awaiting Coronary Artery Bypass Grafting. Canadian Medical Association Journal 165(4):429-433

Sjoling, M. Agren, Y., Olofson, N., Helzen, O. and Asplund, K. (2005) Waiting for Surgery; living a life on hold - a continuous struggle against a faceless system. International Journal of Nursing Studies 42: 539-547

Spaite, D.W., Bartholomeaus, F., Guisto, J. (2002) Rapid Process Design in a University Based Emergency Department Decreasing Waiting Time Intervals and Improving Patient Satisfaction. Annals Emergency Medicine 39(2): 168-177

Thomas, S., Glynne-Jones, R. and Chait, I. (1997) Is it Worth the Wait? A Survey of patients Satisfaction with an oncology out-patient clinic. European Journal of Cancer Care 6(1): 50-58

Thompson, D.A., Yarnold, P.R., Williams, D.R. and Adams, S.L. (1996) Effects of Actual Waiting Time, Perceived Waiting Time, Information Delivery and Expressive Quality on patient Satisfaction in the Emergency Department. Annals of Emergency Medicine 28: 657-665

Thompson, C.E. (2000) Waiting Lists: What do they measure? British Journal of Podiatry 3(4): 103-105

Thorne,S., Hams, S.R., Hislop, T.G. and Vestrop, J.A. (1999) The Experience of Waiting for Diagnosis after an Abnormal Mammogram. The Breast Journal 5(1): 42-51

Trendall, J. (2000) Concept Analysis: Chronic Fatigue. Journal of Advanced Nursing 32(5): 1126-1131

Vermeulen, K. M., Bosma, O.H., Van der Bij, W., Joeter, G.H. and TenVerget, E.M. (2005) Stress, Psychological Distress and Coping in Patients on the List for Lung Transplantation: an exploratory study. Transplant International 18: 954-959

Wagg, T., Das Gupta, R., Assasa, P., Shaw, C., Mayne, C. and Martin, M. (2005) Secondary Care Treatment Patterns in the UK for Women with Urinary Incontinence. British Journal of Urology 96(6): 839-942

Walker, L. and Avant, K. (2005) Strategies for Theory Construction in Nursing. 3<sup>rd</sup> Ed  
Norwalk: Appleton and Lange

Walsh,S., Bruce, C., Benningham, S. and Ravi, S. (2002) The 14 day Rule and Colorectal Cancer. Annals of Colorectal Surgery 84 386-388

Wilson, J. (1963) Thinking With Concepts. New York: Cambridge University Press

Wilson, I. and Cleary, P. (1995) Linking Clinical Variables with Health Related Quality of Life: a conceptual model of Patient outcomes. Journal of the American Medical Association 273(1):59-65

Young, C.J., Sweeney, J.L. and Hunter, A. (2000) Implications of Delayed Diagnosis in Colorectal Cancer. ANZ Journal of Surgery 70: 635-638