

The process of experiencing the coronary revascularization surgery: an analysis of gender

O processo de viver a cirurgia de revascularização cardíaca: uma análise de gênero

El proceso de vivir la cirugía de revascularización cardíaca: un análisis de género

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ABSTRACT

Objective: To analyze the experiences of men and women on myocardial revascularization surgery in the perspective of gender. **Methods:** The Grounded Theory was used, including interviews with 17 participants (patients and families) in a referral hospital in cardiology in southern Brazil. **Results:** Men and women experience the wait for surgery, leisure and social relations differently. The family is considered as an important support to overcome the changes in sexuality after surgery and the need to adapt to new eating habits and a new occupation. **Conclusions:** It could be noted that there is a significant difference in how the genders deal with the experience of undergoing the process of myocardial revascularization surgery, and nurses can better plan the guidelines and care according to gender peculiarities.

Keywords: Nursing; Myocardial Revascularization; Gender and Health.

RESUMO

Objetivo: Analisar as vivências de homens e mulheres sobre a cirurgia de revascularização miocárdica na perspectiva de gênero. **Métodos:** Utilizou-se a Teoria Fundamentada nos Dados, através de entrevista com 17 participantes (pacientes e familiares) em um hospital referência em cardiologia no Sul do Brasil. **Resultados:** Homens e mulheres vivenciam de forma diferente a espera pela cirurgia, bem como o lazer e as relações sociais. Familiares são considerados um importante suporte para superar as mudanças na sexualidade após a cirurgia e a necessidade de se adaptar aos novos hábitos alimentares e a nova ocupação profissional. **Conclusões:** Percebe-se que há significativa diferença na forma como os gêneros lidam com as experiências vinculadas ao processo de viver a cirurgia de revascularização cardíaca, e que enfermeiros podem melhor planejar as orientações e cuidados de acordo com as peculiaridades de gênero.

Palavras-chave: Enfermagem; Revascularização Miocárdica; Gênero e Saúde.

RESUMEN

Objetivo: Analizar las vivencias de hombres y mujeres con respecto a la cirugía de revascularización miocárdica en la perspectiva de género. **Métodos:** Se utilizó la Teoría Fundamentada de Datos, a través de entrevistas con 17 participantes (pacientes y familiares) en un hospital de referencia en cardiología en el sur de Brasil. **Resultados:** Hombres y mujeres sienten de manera diferente la espera por la cirugía, así como el tiempo libre y relaciones en sociedad. Los parientes son considerados un importante apoyo para superar los cambios en la sexualidad después de la cirugía y la necesidad de adaptarse a los nuevos hábitos alimentares y la nueva profesión. **Conclusiones:** Se observa una diferencia significativa en la forma en que los géneros son afectados con la experiencia relacionada con el proceso de vivir la cirugía de revascularización cardíaca, y que los enfermeros pueden planificar mejor las orientaciones y cuidados según las peculiaridades de género.

Palabras clave: Enfermería; Revascularización Miocárdica; Gênero y Salud.

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INTRODUCTION

The term "gender" goes beyond the meaning of biological identity, which is exclusively restricted to sex. To be a man or a woman is a biological fact, while gender is associated with a socio-historical construction that emphasizes the dimension of social relations. Both sexes are capable of performing any functions. However, society imposes distinct behavior and norms on men and women, as human beings are born neutral in terms of attributions and society is the one that determines the roles, thus establishing gender¹. In the sphere of health, gender can be viewed as a transverse axis, when considering the evidence on health inequalities among men and women, resulting from historically constructed gender inequalities¹.

In the perspective of gender, the process of experiencing a myocardial revascularization surgery (MRS) can pose different challenges to those experiencing it. Cardiovascular surgery is a complex procedure, which requires thorough professional attention during the entire process, considering the peculiarities inherent to each individual and physiological and psychological manifestations in the pre- and postoperative periods, aiming to achieve better results in surgical practice. Anxiety, depression and fear are common psychological manifestations in individuals undergoing cardiovascular surgery. Additionally, they can have traumatic experiences, an altered perception of their current situation, and altered sexuality patterns²⁻⁴.

The experience of the surgical process of myocardial revascularization and manifestations occur differently between males and females⁵⁻⁷, mainly evidenced by biological and psychological manifestations.

Biological manifestations are characterized by women's greater predisposition to metabolic syndrome than men, which is directly associated with cardiovascular disease. Moreover, female and male anatomies have significant differences, which can be associated with the increase in postoperative morbidity in women when compared to men⁷.

With regard to the psychological aspect, men showed more improvement than women⁶. Women had a worse perception of postoperative quality of life, a fact associated with the historical role of this gender in society, as they were restricted to the home. The impossibility or restriction of such activities leads to the need for greater psychological support for women when they have a disease and during treatment^{6,3}. However, the experience of heart disease and surgery changes the way both males and females live and the way they understand the health/disease process^{8,9}.

Based on this reality, the following question arose for the present study: How do male and female patients give meaning to and experience the process of living with MRS? Thus, the purpose was to analyze men's and women's experiences with myocardial revascularization surgery in the perspective of gender.

The present study aims to significantly help nurses to provide better health care for patients undergoing myocardial revascularization surgery during the entire process, considering the differences and similarities in terms of male and female genders.

METHODS

The present study had a qualitative design and used the Grounded Theory. This theory helps to understand the actions and interactions experienced by individuals within a specific socio-cultural context and enables the exploration of diversity, plurality and singularity of human experience, allowing one to grasp the phenomenon experienced, based on simultaneously collected and analyzed data¹⁰.

This study was performed from the database of a Project entitled "Giving Meaning to the Surgical Experience and the Life Process of Patients Submitted to Myocardial Revascularization", whose data were collected between March and April 2010, in a referral hospital for cardiology in the state of Santa Catarina, Southern Brazil.

The original research project included 23 participants, among which were 12 patients, five family members and six health professionals. The gender aspects stood out in the reports, although this was not the initial focus of the study. In this sense, the database with all interviews from the two sample groups was retrieved, i.e. patients and family members, due to their contributions to this theme. With regard to the gender identity shown by participants, it should be emphasized that such was based on the biological condition, that is, on the male and female aspects, which led to family members being defined as the second sample group due to their closeness to and intimacy with one another. In contrast, the group of professionals made a small contribution to the approach, emphasizing general questions about the health treatment and follow-up.

The Grounded Theory selects participants according to theoretical sampling or sample group, i.e. a group of informers is taken into consideration (individuals, documents, observation of the place), from whom the maximum amount of data possible will be extracted to understand the phenomenon under study¹⁰. For the first sample group to be gathered, the researcher contacted the participants of the previously mentioned service who met the inclusion criteria: to be an adult, to be registered with the cardiac rehabilitation service and to have been submitted to MRS prior to 2010, with a minimum postoperative period of 90 days. This period was defined considering that patients transition from a situation of convalescence and greater need for check-up to another of greater stability and autonomy¹¹. The following exclusion criteria were adopted: to be younger than 18 years and to be a patient in the postoperative period for less than 90 days. Thus, the first sample group was comprised of 12 patients

who had had a MRS, of which six were women and the other six men, who were aged between 53 and 76 years, and who had undergone a MRS.

It should be emphasized that the use of the cardiac rehabilitation service as the place for data collection was justified by the convenient concentration of patients with the profile of interest of this study, as there is no time limit or any restrictions for the permanence of those undergoing rehabilitation.

The semi-structured interview was performed in the institution under study, in a reserved environment, guided by the following statement: Tell me about your experience of cardiac surgery. As recommended by the method of study, the guiding question for the interview must be open and broad to guarantee a deep exploration of the phenomenon¹⁰.

From the thorough reading of participants' speech, aspects associated with self-image and sexuality, which at times involved their partners as important elements to overcome several changes in their process of living, could be evidenced. The second sample group, formed by family members of patients, was taken into consideration as it significantly contributed to the process of consolidation of categories developed until this moment. The process of selecting this sample group was based on the contact with family members who followed patients in their rehabilitation, including five individuals (three wives and two husbands). The following guiding question was used with this group: How do you perceive your participation in the process of experiencing your family member's cardiac revascularization surgery? The inclusion criteria were as follows: to be an adult and main caregiver of the patient during hospitalization and post-discharge period. Thus, the data collection process included 17 participants.

The analysis process of this study began with a careful reading of interviews in the NVIVO® software, seeking incidents related to the experiences of gender in the process of experiencing a MRS. Data analysis was processed in two inter-dependent and concomitant stages: open coding and axial coding. Coding has the purpose of reducing data to achieve the understanding of the phenomenon under study¹⁰. This process began with open coding¹⁰, which occurred freely, including the definition of preliminary codes from the careful reading of interviews and with the identification of each incident. Next, axial coding¹⁰ was performed, seeking to establish a relationship between categories and sub-categories to provide accurate explanations about the phenomena studied. Therefore, during the entire process, we sought to maintain the constant comparison among data¹⁰, enabling reflections and questions to arise and to guide researchers when grouping preliminary codes. Apart from the similarity of content, this involved considering the different properties and dimensions of categories and subcategories to be developed in the results.

In order to maintain the confidentiality of information,

participants were identified by a letter that referred to their participation in the sample group, followed by an ordinal number corresponding to the order of interview. The letter M was attributed to the sample group comprised of male patients; F for the group comprised of female patients; FM for family members of male patients; and FF for family members of female patients...

Human research ethical aspects were respected during all stages of the present study, in accordance with Resolution 196/1996 of the National Health Council¹². This research project was approved by the Human Research Ethics Committee under number 001/2010.

RESULTS

Based on the re-analysis of data, the following five categories arose, showing different perspectives of the process of experiencing a MRS, according to the male and female genders.

Experiencing the wait for the surgery

With regard to the experience of waiting for a surgery, female patients showed more difficulty to accept the MRS than male patients as a key process in the treatment of heart failure, due to the fear of death. This is a condition to which every living being is exposed, as part of the life and death process.

In order to face the waiting period for the surgery, in the duality between the desire to have it performed and the fear of the unknown and death, women resorted to their spirituality as a higher power. The following reports confirm this:

Ah! It was very hard to accept the surgery. I had no choice. I was terrified of going there [surgical center] and not coming back alive, because this can happen to anyone [death]. I was afraid, who would do things at home for my family in my place? F6

And I was there waiting for the day and I'd pray for the time not to come, because I wanted it and I didn't want it. F1

In contrast, male patients showed excessive anxiety associated with the hope for a cure during the waiting period for the surgery. For the male gender, this surgery meant a required event for a positive change in their process of living, i.e. the transformation from a condition of disease to a condition of cure connected to a change of life, as observed in the following reports:

So, I always had high hopes. I felt anxious and couldn't wait for that moment [the surgery]. When the time came for my surgery, that wheelchair was such a joy. It felt like I was changing my life. M2

I wanted to go through the surgery, so my arrival at the surgical center was peaceful! The days I spent after the

surgery were joyful, because I'd been operated on. If I hadn't, I wouldn't have lived much longer. M1

In the present study, the male gender does not show a fear of death, although they may feel it. It could be noted that women are more open to revealing their fears and anxieties associated with the wait for the surgery as a key part of the treatment, while men emphasize the wait for the surgery as a possibility of cure and extension and change of life.

Bringing meaning to leisure before and after the surgery

The majority of women in this study pointed out that they had already been socially active prior to the surgery. According to participants, the leisure activities performed before the surgical experience were as follows: visiting and meeting family members and friends and performing activities in the community and church, among others.

In addition to the usual leisure activities, after the experience of cardiac revascularization, some participants affirmed having included new leisure options in their routine. These women observed that a proactive approach, seeking new pleasurable activities and actions such as dancing, had a positive influence on cardiac recovery and rehabilitation, in addition to broadening their social interaction and relationship network. The following report confirms this:

Ah, I didn't dance, now I do! A little, not fast, but I can dance. I feel good, but you have to care for yourself. It's not like, I had the surgery and now I'm good, no! (...) But I even feel lighter. I go out and I feel good when I'm walking, I don't like to stay at home... F4

Prior to the cardiac surgical procedure, males maintained an active social life as well as females. Soccer among friends and barbecues with family members were the leisure activities included in the routine of these men. However, these and other activities were also connected with unhealthy behavior such as the excessive consumption of fatty foods and alcoholic beverages in social events or meetings with friends and family members.

Some male patients, after experiencing MRS and understanding that inadequate eating habits should be avoided, began to refuse to participate in social events and/or meetings with friends and family members to prevent access to and consumption of unhealthy foods and beverages. Thus, these patients began to choose social isolation over facing the changes required and recommended for healthy living. The following reports reveal this:

I couldn't go to his party, because I couldn't drink. I get nervous [...] I get there and I'm among my friends and relatives [...] everybody is eating meat, drinking beer. So, I stay there, arms folded, just looking. I look at everyone and I can't do it. So, what can I do? I don't go! M4

He likes barbecues, fatty meat and beer. So he doesn't go not to feel the need. He stays home not to see this. FM6

The female gender was found to show more flexibility for changes in lifestyle and habits than the male gender, including healthy leisure options both for allowing themselves to continue to experience places they usually went to and for seeking new ways of social interaction.

With the recognition that lifestyles and habits prior to the surgical experience were harmful to health, males choose to be isolated, describing them as negative aspects for their social interaction. In this sense, it is understood that the decision of these patients not to participate in social activities that encourage them to consume foods and beverages that should be restricted, as recommended by health professionals, represents a barrier to social life.

Perceiving sexuality after the surgery

It was difficult for patients in this study to talk about sexuality, regardless of gender, probably because of the taboo on this theme. To discuss their experiences associated with sexual life after the surgery seemed to cause discomfort. This fact can be justified by the fact that this population is mainly elderly, so that approaching sexual experiences in this age group is more difficult than in other groups. Females had more difficulty to discuss this theme than males.

After surgery, it could be observed that both genders began to have a lower frequency and quality of sexual life. Incision pain is mentioned by males as a limiting factor, interfering with sexual intercourse. Pain during intercourse was also mentioned by females.

In women's experiences, the use of little effort and their spouse's understanding enable sexual intercourse to take place. However, for these patients, the changes experienced in their sexual life such as the reduction in or restriction of sexual practice seemed not to be very relevant, as observed in the following report:

He does his part, I do mine. It's OK, I don't have to make an effort. This is something we do well [...] There are some restrictions, there are things I can't do because, even if I'm well, sometimes it hurts, it hurts a lot. They say surgeries are like this, it takes time for us to be free from pain. Something has changed, changed and now I'm not as full of energy as I was before, but it's OK. F6

For men, the limitation caused by the incision pain interferes with their sexual performance, causing them to either reduce their sexual activities or choose abstinence, instead of using new strategies for sexual practice that are healthy and pleasurable for the couple. The following reports reveal this:

We began to do it less often, at first we stopped it! Then, we began, but it was colder, so to speak. Our relationship felt colder and now this rarely happens. Things got really cold, we basically don't do it. It's because I used to feel pain, it made me feel a lot of pain. It felt like my chest was opening and it was complicated, because I didn't feel like fully giving in to it, so to speak. M3

It changed completely, now he's afraid of making an effort. So it has to be within the limits, this is why I reduced it a lot. FM6

Both male and female genders perceived significant differences in their sexual life after the MRS. There was little room for dialogue about the changes experienced by partners, their fears, anguish, needs, desires and possibilities to adapt to a new condition, according to the limitations resulting from the recent surgical process that one of them had to undergo at a certain moment in life.

The theme of sexuality was also slightly approached by health professionals themselves, during perioperative guidance, particularly in the guidance and recommendations for discharge and follow-up of patients during cardiac rehabilitation. The sexual life of patients and their respective partners/spouses is affected, especially due to the lack of professional guidance on sexual practice after the surgical event, causing them to feel insecure and afraid of experiencing their sexuality with safety, as the surgery and recovery do not prevent couples from having an active and normal sexual life. The following report confirms this:

No, never, not during this time when I was hospitalized, not even later on, I never received guidance on whether I can do it or not, no guidance on any of this. I was the one who did it or didn't do it, under the circumstances, that was it! M3

Adapting to new eating habits

For both genders, the difficulties to change eating habits are greater in the beginning of the recovery and rehabilitation process. Such habits are steadily shaped, given the understanding that this is important for the recovery/rehabilitation process from a cardiac surgery, as well as for the prevention of recurrence of coronary artery disease. However, with regard to eating habits, the female gender is more flexible to adhere to the recommendations of a healthy and balanced diet than the male gender.

It could be observed that it is easier for women who cook for themselves and/or their family to think about and prepare healthier food than for those who depend on others for such preparation. Nonetheless, the remaining family members do not always appreciate a low-salt and low-fat diet. The following women confirmed this in their reports:

We can get used to new habits, I was already eating little salt. I don't even use olive oil to prepare chicken. You have to mind what you eat. We can definitely do it. It's just a matter of getting used to it. F4

In the beginning, the main difficulty is to get used to the diet, because my husband likes fattier food with more seasoning, for example, and I prepare what they like. And I eat my own food. But sometimes I get tired, you know? But I control myself. F6

According to data from the present study, males are less concerned about the need to change eating habits than females, even though they know and recognize the health risks inherent to an unhealthy diet. Thus, some male patients insisted in maintaining eating habits that were inadequate for the prevention of atherosclerotic disease and that promoted its recurrence.

Contraindicated foods for disease prevention and treatment such as hypertension, diabetes and other health conditions are consumed with caution, as observed in the following reports, whether from the wife of a male patient or from the patient himself:

He likes sweet foods, he can't see chocolate or things like this, he's got diabetes too... He wants to eat all day long. Diabetics can't eat all day long, just for some hours. FM3

I eat a lot, you know? I can't help it! When I eat, I know I've had enough, that I've gone too far. (...) I like candies and roasted meat. I like drinking a lot too. M4

According to this study, male patients are usually unwilling to stop the consumption of foods considered to be pleasurable and rich in saturated fats and sugars, for example. However, both the wife and family are important in this process of change in eating habits, whether to promote this change or to ignore it.

Giving meaning to changes in occupation/ profession

In the present study, female participants were in their majority women who did not perform formal professional activities. They were housewives and their tasks were the maintenance of and care for their home for the family or themselves. These women argued that, due to the surgery, they could not perform the same domestic activities they had done before and that other

individuals, usually family members, would do this for them, as described in the following report:

My daughter will be there with me (...) She's the one who'll take care of the house, she'll do the heavy work, which I can't do anymore. M4

Prior to surgery, other women who maintained formal or informal work activities reported they had to cease such activities due to the impossibility of resuming them, probably due to the use of excessive physical effort and/or stress, which triggered a feeling of uselessness. The following reports confirm this:

I only worked, that was all my life was about. Then, after two years of surgery, I was already retired. Permanent and full retirement and... So I felt useless after the surgery. I think I could do what I used to do before, when I was fine, you know? Then, when I feel pain, I remember that I can't and that I must stop. F1

She feels sad that she has to stop working. I can see my mom is very upset, feeling worthless. But she knows this is for her own good. FF8

Males also found it difficult to completely stop their professional life. Although men are aware of the possible risks and complications associated with occupational stress, they still insist in not letting go of their work and continuing the professional activities they used to perform prior to surgery, as observed in the following report:

I felt like being active again... With some difficulty... But after a while I realized that I'd never be as good as I was before. So I had to manage my disease and I went back to work, but my work was very stressful, I provided services. So I had all those commitments, it was difficult, but I continued working. M3

It was difficult for both genders to disconnect from their professional activities. Females mentioned their feeling of worthlessness, although they understand the need to readapt their activities, aiming to meet the recommendations required for healthy living. Males, in their turn, have the need to remain active, as they were prior to the surgery, without limitations or adjustments to guarantee health and to prevent new disease recurrences, as the performance of stress-generating professional activities is still identified.

DISCUSSION

The need to undergo a surgery arouses innumerable feelings such as anxiety, something that can negatively affect patients' clinical condition^{2,13}. Fear also plays a negative role in MRS, as it is understood as an essentially negative emotion^{2,14,15}. In this sense, we can observe the importance of emotional care for individuals waiting for the surgical process, regardless of gender and considering their needs and expectations, as they can feel vulnerable throughout the process.

Patients frequently mention fear after realizing that the surgery is a required procedure for a certain treatment^{2,7}. However, in the present study and among males, anxiety rather than fear predominated when surgery was required as a possible cure. This is due to the fact that men are still historically and socially characterized and expected to be a virile, strong and invulnerable figure and provider. Fear represents behavior that goes against that which is socially acceptable, having direct repercussions on individuals' health and life habits^{1,16}. On the other hand, fear and anxiety are very close to each other and associated with feelings and psychological disorders that can appear in patients during the surgical procedure^{2,5}. With regard to women and the wait for cardiac surgery, it was evident that many resort to spirituality in order to feel stronger, face the surgical procedure and maintain their hope for a cure. There is a greater search for faith and spirituality in both genders when it becomes impossible to control a situation and when the unexpected has to be faced². However, in the present study, women were found to show their faith more explicitly.

After having a MRS, certain changes and readjustments in individuals' lifestyle were required to help them to face the post-surgical period, which represent the possibility of maintaining their health, although a great challenge for patients^{14,17}. In this context, with regard to aspects associated with leisure, female participants have a greater social interaction network, with activities that they had performed before the MRS and others included after this surgery, without restrictions of locations or individuals accompanying them. The search for new types of leisure and entertainment activities can also be understood as an attempt to escape from the routine.

In contrast, among male participants, the maintenance of the same leisure activities performed prior to surgery can be considered as a risk factor for disease recurrence, as these activities were associated with unhealthy behavior such as the excessive consumption of high-fat foods and alcoholic beverages. Finally, in order to prevent unhealthy habits, men chose to be socially isolated. Readjustments in leisure habits are also required, as they aim to reintegrate individuals to

society. However, drastic changes and choices such as social isolation, among other symptoms resulting from and/or leading to depression, can contribute to a reduction in effective immune system response, directly reflecting on cardiovascular health¹⁵. In this sense, social relations significantly contribute to the quality of life of patients submitted to MRS, mainly having a positive effect on the psychological aspect^{5,15}. Thus, the search for new options of social interaction, leisure and entertainment becomes an important resource for the emotional health of individuals during the recovery process.

With regard to the acquisition of healthy eating habits, female participants revealed greater flexibility to meet the dietary instructions of the nursing and health team, as observed in other studies^{17,18}. This flexibility is associated with the close relationship between the female figure and food preparation and the frequent association between women and the consumption of healthy foods¹⁹. From a different perspective, male participants are more resistant to adhering to diets prescribed or recommended by professionals following their rehabilitation and, consequently, they maintain eating habits that are harmful to health. Men care less about their health than women^{17,18}, due to social prejudices and their stronger connection to work¹⁹.

Females were more flexible to understand the recovery process and to seek adjustments and strategies to meet the needs of both man and woman as biological beings and as a couple. However, understanding can only be mutual and there will only be consensual adjustments for an active healthy sexual life if they are open to dialogue about this theme which is still hardly mentioned by couples, a priori the elderly ones.

Considering the epidemiology of cardiovascular diseases in Brazil in recent decades, there has been a reduction in mortality rate, especially in the Southern and Southeastern regions, in patients aged over 60 years²⁰. This fact is mainly due to health developments in the treatment of these diseases, especially through MRS²¹.

Thus, the advanced age of the study population confirms the traditional role of men and women in society with regard to symbolisms, whether that of man's connection to work and/or women's household activities, in addition to other socially and historically constructed dimensions^{1,16}.

Innumerable factors can influence the quality of sexual life, such as physiological changes, drug-induced dysfunctions, and the emotional impact resulting from the cardiac disease, surgical process, recovery and cardiac rehabilitation. Additionally, patients submitted to CVS tend to change their attitudes towards sexual activity, avoiding it throughout the recovery and rehabilitation process and affecting its quality⁵. Although male individuals feel uncomfortable with the poor quality of sexual intercourse

after surgery, the theme of sexuality is not approached during hospital discharge or follow-up medical consultations either by professionals or patients. When approached by professionals, it is done in a superficial way, i.e. without meeting the patients' needs^{4,22,23}.

In this sense, the relevance of guidance on sexuality is considered to be a type of nursing care for surgical cardiac patients, appropriate for and inherent to nurses, prior to hospital discharge. Instructions on sexuality, in addition to those on other dimensions of care, can be extended to the outpatient level, so that all questions raised by patients are answered, effectively leading to the recovery and rehabilitation process of such individuals.

With regard to aspects associated with professional activities, both female and male participants had difficulty to understand the need to restrict or stop activities performed prior to the disease and surgical treatment. It could be noted that some women either stopped their occupational activities or sought to readjust them. However, some men, although recognizing the risk that activities inherent to their occupation poses to their health, continued to perform them. There are multiple factors associated with patients' return to the professional activities they used to perform before their disease and treatment, even if these are related to risk factors such as stress and physical effort. Work is something that confuses men, due to a historical and social association with their identity and essence, according to their role of family provider^{14,16}, factors which are important and encourage them to resume their professional activities, apart from the financial dependence, as other life aspects are closely associated with money^{4,14,22,24}. It is very common for patients with cardiovascular diseases submitted to MRS to resume their professional activities, which is healthy according to some points of view. On the other hand, the dilemma between maintaining or stopping professional activities is also closely associated with factors such as: age, social and family role, family's socioeconomic condition, clinical status, level of education, professional qualification, health team recommendations and leisure²⁴.

It should be noted that nursing, in their actions and attitudes towards care for patients experiencing the cardiac revascularization process, can turn the surgical experience into a positive one, reduce the risks of complications and enable adequate recovery as it encourages them to face the surgical process through an individual approach, considering the context in which they are included, their experiences prior to this process, and appreciating them as unique individuals, full of fears, anxieties and expectations^{7,14,25}.

Apart from establishing strategies to minimize the risks of a new cardiovascular event, nurses can help patients and their

families to establish goals that can be reached by discussing questions about the complex and broad concept of gender. These strategies and goals must include individuals cared for in their uniqueness and their family members, so that they are encouraged to reach the goals established²⁶.

According to data from the present study, nurses and other health professionals who care for patients undergoing cardiac revascularization must pay attention to the elements described and discussed in the perspective of gender, aiming to make adjustments and positively contribute to the rehabilitation and recovery process of these individuals, respecting individual limitations and time.

FINAL CONSIDERATIONS

The present study showed that women and men who were submitted to MRS had different experiences, considering the perspective of gender. This evidence is supported by the following categories: experiencing the wait for the surgery; giving meaning to leisure before and after the surgery; perceiving sexuality after the surgery; adapting to new eating habits; and giving meaning to changes in occupation/profession.

Although the present study is restricted to a group of participants, most of which were elderly individuals, and only one institution was included, there was a significant difference in the way males and females deal with the experiences associated with the MRS process. For this reason, nurses must consider the perspective of gender in nursing care management for women and men to better plan guidance and care, from the wait for the surgery to patient rehabilitation, aiming to create more efficient strategies that are closer to the reality of each individual.

Thus, it can be concluded that nurses, in their guidance and care and according to the perspective of gender, can help patients experiencing the cardiac surgery process, performing in the multiple aspects included in human care, especially those identified in the present study: exploring feelings of anxiety in the male population and the fear of death in the female population, during the wait for the surgery; strengthening spirituality, found to be more present among females; encouraging the practice of healthy leisure and helping to identify new leisure activities that promote cardiac recovery and rehabilitation, avoiding social isolation as observed among males; approaching the theme of sexuality to identify problems experienced in the sexual activity in both genders, promoting and guaranteeing quality in sexual life after the MRS; guiding and encouraging individuals to acquire healthy eating habits, especially males; stimulating patients to resume their professional activities and/or helping them to perceive the need for adjustments, when their occupation/

profession is associated with risk factors, mainly in the male population.

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