The meaning of well-being and participation in the process of health and care—women’s experiences following a myocardial infarction

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Abstract
In this article, the researchers explore women’s experiences of care and health process following a myocardial infarction (MI), with a particular focus on their experiences of well-being and participation. The phenomenon is illuminated from the approach of reflective lifeworld research, and in order to obtain expressions of the women’s lived experience phenomenological interviews were conducted. Participation and well-being are described as an experience of being involved in one’s own health process. This entails that the women have the potential to influence and take responsibility for their own lives and their own bodies in a meaningful way for them. Participation is a condition for the women to deal with their health and their lives, and seems to improve the women’s sense of well-being. At the same time as they sense a dependency on the health care professionals, they seek autonomy and a situation where they can find a new balance, including “the new” body and insecurity that the MI has brought with it. However, the findings also show that the women’s participation in the process of care and health, and their well-being, is a challenge for health care professionals. When the professionals are unable to encounter the women’s need of participation and desire to be met in their existential insecurity, well-being is affected.

Key words: Caring science, female, heart disease, lifeworld research, patients’ perspective

Introduction
Coronary heart disease is a major challenge for health care professionals. Mortality and morbidity can be reduced following a myocardial infarction (MI), and therefore prevention plays an important role in cardiac rehabilitation. Consequently, most cardiac rehabilitation programmes (CRP) consist of exercise training, health education and counselling regarding risk factors and lifestyle changes (Thompson, 2003). However, attendance at these CRPs is unfortunately low, especially by women. For example, only 50% of the investigated women in a Swedish study were found to participate in the CRPs (Fridlund, 2000). It has been argued, that these CRPs are not always adapted to women’s needs and conditions (Winberg & Fridlund, 2002). It is also a well-known fact that women seem to report lower self-rated health in comparison to men, when measured following a MI (Drory, Kravetz & Hirschberger, 2003; Brink, Karlsson & Hallberg, 2002; Covinsky, Chren, Harper, Way & Rosenthal, 2000; Radley, Grove, Wright & Thurston, 1998). Something seems to be lacking in the care of these women.

A disease such as a MI involves a subjective dimension of health. The philosopher Merleau-Ponty (1995/1945) emphasizes that the subjective body is not merely something concrete and biological. Instead the body is a lived whole of one’s existences, and it is through the body that life is accessed because the body and world are intertwined. From this point of view illness or disease, as well as health, must be understood as an embodied experience, not only physical attributes of disease, involving both the body and the lifeworld of the patient. In the most recent 10-year period, more and more attention has been paid to this subjective dimension of health and illness following a MI (see, e.g. Wiles, 1998; Roebuck, Furze & Thompson, 2001; Johansson, Dahlberg & Ekebergh,
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2003; Svedlund & Danielsson, 2004). It has been emphasized as important to understand the meaning of the cardiac illness for women recovering from a MI (Fleury, Kimbrell & Kruszewski, 1995; Rosenfield & Gilkenson, 2000; Johansson et al., 2003). However, it still seems as little attention has been paid to the meaning of the process of health and care, particularly from the perspective of women patients following a MI.

Participation following a MI event is mainly discussed in relation to attendance at CRPs (e.g. Clark, Barbour, White & MacIntryre, 2004; Winberg & Fridlund, 2002). Another aspect of participation is described in a study by Ivarsson, Larsson and Sjöberg (2004). They found that patients waiting for cardiac surgery feel as if they take part in care when they are informed about the disease, the forthcoming operation, or know where to turn in case of problems. In another study, they measured processes of care, focusing on quality of communication and health education discussion, as reported by patients (Covinsky et al., 2000). The relation between patient-centred processes of care and long-term outcomes of myocardial infarction has also been examined (Fremont, Cleary, Hargraves, Rowe, Jacobsen & Ayanian, 2001). In this study patients who experience the most problems pertaining to hospitalization and the transition home, had a worse health status and more symptoms than other patients during the first year after a MI. However, so far participation seems to be discussed primarily in relation to whether or not the patients are informed or engaged in decision-making or health-care counselling. Participation as involvement in the process of health and care, and its relation to well-being, studied from the patients’ lived perspective, still seems to be an unexplored area.

Method

The aim of this study was to explore women’s experience of the care and health process following a myocardial infarction, with a particular focus on their experience of participation and well-being. The phenomenon is illuminated from the approach of reflective lifeworld research (RLR), based on phenomenological epistemology as described by Dahlberg, Drew and Nyström (2001).

The reflective lifeworld approach is defined as building on an interest in the lifeworld, which forms the foundation for understanding humans, our lives, health, suffering, and well-being. Researching openness is emphasised, as well as “bridling” of the researchers’ emerging understanding of the phenomenon (Dahlberg, 2006). The RLR approach thus means an open research attitude to the world as it presents itself, a sensitiveness to the ambiguity of the lifeworld, and consequently an effort to not make definite what is indefinite (Dahlberg & Dahlberg, 2003). As researchers, adopting this approach, we have had the ambition to make ourselves available and sensitive to the studied phenomenon, in order to explore it as experienced, in this case from a female patient perspective.

The ambition to “bridle” the process of understanding does not mean that we totally set aside our pre-understanding, which firstly is impossible. Also, pre-understanding is a necessary condition for understanding. Instead the idea of “bridling” demands from us a reflective and critical attitude in which we endeavour to question our pre-understanding in order to minimize its influence on the emerging understanding. In the present research, we aimed at scrutinizing the emerging understanding, by ourselves, but also by discussing it with each other, at the same time as we went back and forth between the interview texts and the patterns of meanings. Bridling thus means to strive towards a scientific and reflective attitude, where the researchers slow down and are aware of the process of understanding of the meanings and the essence of the phenomenon, as far as it is possible.

Participants

Eight women with MI were interviewed in the autumn 2002. They were selected from a coronary care unit at a medium-sized hospital in Sweden. Inclusion criteria were women with a first diagnosis of a MI, aged below 75 years. Eighteen women were contacted by mail and informed of the study. They were also asked to fill in an answering letter if they were interested or not interested in participating in an interview about experiences of being a patient with a myocardial infarction. All of those who agreed were contacted by telephone by the main researcher (AJ). None of the women above 65 years of age were interested in participation in the research study. With ethical consideration to their autonomy and their willingness to participate in this research study, the researcher has not asked for the reasons for their decisions. At first nine women agreed to participate, but one woman changed her mind. Finally, eight women, aged between 45 and 65 years, were interviewed.

All of the women were interviewed by the main researcher (AJ), between one and three months after their hospital episode. Time and place for the interview were chosen by the women, two were interviewed in their home and six women were interviewed at the hospital. The interviews were tape-recorded and transcribed verbatim. The study
was approved by the local Ethical Committee in Gothenburg, Sweden, and conformed to the Declaration of Helsinki.

The interviews

In order to obtain expressions of the women’s lived experience phenomenological interviews were conducted (Dahlberg et al., 2001). The interviews were open, but not without structure, focusing on the lived experiences of health and illness, their suffering and well-being, following the MI event. The women were asked to tell their story about being a patient with MI, as well as relate their experience of healthcare and their health process following the illness event. They were also asked about their experience of participation from a patient perspective. During the interview, they were asked for clarification and exemplifications from daily life in order to deepen the interviewer’s understanding of the phenomenon. The interviews resulted in rich narratives from the women’s lived experiences. Their descriptions reflected the phenomenon of interest, and not least the complexity and uniqueness of each informant’s experience.

Analysis

The process of analysis was directed towards discovering patterns and the shades of qualitative meanings that emerged from the transcriptions. The analysis was characterized by an intensive dialogue with the text. An understanding of the phenomenon was sought where the whole was understood in terms of details, as well as details in terms of the whole. We tried to relate to the “challenge for lifeworld researchers...to be so sensitive to both whole and parts of the data and to the meanings of the phenomenon, and write so clearly and articulately, that the inherent ambiguity of the lifeworld and its meaning is captured” (Dahlberg et al., 2001, p. 186).

The process of analyzing entails going beyond given conditions and avoiding linear or causal explanations, allowing the varied meaning of the phenomenon to emerge. Finally, the phenomenon’s general structure was possible to describe. This essential meaning of the phenomenon is illustrated with the description of three constituents: Not having control over body and health, participation based on lifeworld, and false participation. The meaning within the constituents is exemplified by statements from the interviews. The essential meaning can be understood as the meaningful aspect of the phenomenon’s structure that binds the constituents together, and is that background against which the constituents “stand out” as figures. Therefore, the essential meaning is presented first in the results.

The researchers

The main researcher (AJ) works as a nurse at a Coronary Care Unit, while the other researcher has no experiences of MI care. Both researchers, however, are well experienced in phenomenological research, and have been involved throughout the research process, even if the second researcher served as advisor in the process.

Results

In one instant, the victims of a heart attack (MI) lose autonomy over their own health and well-being. The women in the present study describe how their lives have come to an abrupt stop in connection with the MI. Their daily life became characterized by an existential insecurity and they felt that they had no control over their own situation or their bodies. Suddenly, their lives are dominated by something that they never ever thought of before the MI. Their insecurity is difficult to deal with. They make efforts to try understanding what is happening. They are at a loss about what to do and find it hard to see independently how they can shape their own lives or influence their own health and well-being. They participate in the health process far too little; instead, they seem to be “pushed out” of their own health process.

The lifeworld of women with MI seems to be dominated by the search for a new autonomy. They strive for balance in their daily lives, and the daily chores and events, which earlier were not thought of, have now to be fought for. As before the MI, they must be able to relate to their own bodies and health, but the limits on their lives and bodies have been changed following the MI. Their well-being is aggravated additionally by the false participation that health care offers. The women are dependent on healthcare professionals and their knowledge in order to become healthy, but the professionals’ medical perspective takes over and dominates the health process. This means that the women are asked to participate under the conditions of the professionals’ perspective on illness and well-being, in which their lived experience has no room.

The women become reduced to an anonymous diagnosis when healthcare professionals do not pay attention to the women’s experiences or life situation. Neglected lived experience seems to be connected with the insecurity, which already is serious due to the MI and the vulnerability that the illness brought with it. This is confusing for the women,
who feel deserted with their existential questions. Their desire for “a normal life” and well-being is complicated by a sense of being lost that impedes their participation in the health process. They find it difficult to understand their own situation, and do not know how to get a grip on their own lives or where they can find support. False participation means that as well as the professionals can be of help and support, they can also be an impediment and make it even more difficult for the women to participate in the health process, getting well.

The women’s well-being following the MI is related to their lived body and world. Participation is about being active and being able to manage one’s own health process, to get to know one’s “new body”, one’s “new self”. This entails that the women have the potential to influence and take responsibility for their own lives and their own bodies in a meaningful way. In daily life, the women are faced with various obstacles and challenges related to their health, and that is where questions about the illness and their lives arise. When the women are able to understand what is happening, their experiences can be a guide for these women when striving towards a new autonomy. Participation is an important condition for dealing with health and life, and in this way, can improve the women’s sense of well-being.

Not having control over body and health

Suffering from MI entails existential insecurity. The women feel that they no longer have control over their own bodies or whatever is happening. The insecurity becomes particularly dominant when the women return home after the hospital stay. Their belief that life will go on as before turns out to be wrong, and nothing seems to be the same anymore.

I was very cautious, didn’t take any big steps or run down the stairs, but walked. I really gave a lot of thought to whatever I did so that I didn’t tax myself in any way or exert myself; scared to death in other words.

The woman above described how she felt like “Bambi on ice”, stumbling about and unsure of her health and body. In different ways, also the other women described how previous abilities that were taken for granted were lost. The women can no longer trust their bodies when daily life became characterized by insecurity. They are uncertain of their health and find it difficult to understand how they are really doing. The insecurity that comes with the MI is difficult to deal with and live with. Compared with life before the MI, the women feel that they no longer have control over their situation.

There is a lack of autonomy. The women do not know how they can shape their lives or influence their own health. They find it difficult to deal with or participate in their own health process and feel that they are dependent on the healthcare professionals and their knowledge. The professionals are presented as experts, they are expected to have control and see how the women are feeling. The professionals have a strong position, in contrast to the women who feel that it is difficult to assert themselves or make demands. This is what one woman says after her episode in the emergency ward (EW):

When I came to the EW they wondered if I maybe had a stomach-ache. I said that I didn’t. First of all I’m not scatterbrained and I’m not a hypochondriac either, but I really have chest pain. // Not all women are scatterbrained. // They could listen to the patient a little. If I say that I have pain, then I have pain and it’s not something I’m imagining. I also want to be better, I want to get rid of this, I want to go on and live my life.

The women described their experiences of not being taken seriously or being treated nonchalantly by healthcare staff. The women feel insulted and feel like they are being neglected when healthcare professionals do not see their needs. They even feel that they are sometimes met with doubt by the healthcare professionals, as if they are lying about their suffering and long for well-being. Despite this they adapt to the healthcare professionals, and at the same time as they show disappointment by being neglected, they express satisfaction and say that they have been looked after very well.

They were friendly and nice, you feel like you are being looked after, but there was no one who talked to me.

The women’s descriptions indicate vulnerability. They feel abandoned and alone when they have to try to understand their situation. It appears that the women’s existential questions are ignored and no attention is paid to their vulnerability.

That’s all I was told. // I didn’t ask very much, I know that others take care of me, so I don’t need to. // It doesn’t make any difference.

The women are impeded in different ways from participating in their health process. In a natural way and, as it seems, without any thought, responsibility is turned over to the healthcare professionals. Instead, the women play a passive and humble role. However, when they are deserted, when control
and responsibility are turned over to the healthcare professionals, the women’s own potential to care for themselves is impeded. The women’s double lack of independence means that they find it hard to get a grip on their health, well-being, and to continue with their lives.

**Participation based on lifeworld**

The women struggle to understand their existence and try to understand how their lives have changed because of the MI. They search for meaning in their illness experience in order to relate to their new bodies and health in a new way, and their health process is based on the women’s lifeworld. Nevertheless, in health care, they discover something else; that what they have experienced is not interesting.

I didn’t want to interrupt him (the doctor), he went on the whole time talking to them, and then, then they just left. I didn’t have a chance to say anything at all, if I had any questions.

No space is made for their lifeworld. For these women to be able to assist in the health process they need understanding of their own situation. It is important that they understand what is going on so that participating in the health process will become meaningful for them. When they cannot understand their situation, their “new” body, they don’t know how to influence their health or how to feel well.

You wonder a little bit what happens now. What should I do to have any influence?

When the women do not understand their situation, it becomes difficult for them to participate.

The women’s health process and needs are revealed in different ways, and they indicate complexity. The women find it difficult to describe what it is that they miss, or to put their own needs into words.

I hadn’t come so far along that I had a lot of questions, it sort of took awhile.

Thoughts and questions about life come about gradually. The women run into trouble when life is to go on as before. They live with constant insecurity and loss of direction, but their need for support to be able to understand is not satisfied.

It appears that dialogue can be a way for the women to make their existence more comprehensible. This meaning became clear for some of the women during the interviews. It was obvious how thinking about and describing everyday experiences helped the women to understand their situation better. In the interview dialogue, the women could reflect upon their experiences, which gave them a new understanding of themselves and their bodies. Such listening, such opportunity to formulate what is at stake, can make their everyday life easier to manage. Some said during the interviews, when they were given the opportunity to talk about their experiences, that they then could understand and find meaning in life following the MI in a new and different way. In this way, dialogue supported them in their health process. A care providing dialogue was something the women had missed without being aware of it, and consequently had not asked for. They did not know whom to talk with about their existential matters.

I (interviewer): This uncertainty you’re telling me about.
Yes.
I: Did the healthcare providers support you with these matters?
No, not yet, I haven’t been able to tell anyone about it, not about these apprehensions.

Participation that promotes the lifeworld can improve the women’s self-esteem. Based on their experiences the women can discern potential for shaping and influencing their life situation. The lifeworld can provide the women with support and guidance. This may be as simple as putting something into words in order to understand the difficulties and obstacles confronted in daily life. In this way, their independence improves and the women can be motivated to take greater responsibility for their own care and towards a lifestyle that promotes good health. Participation based on the lifeworld can improve the women’s potential to deal with their health and life situation in a manner that is meaningful to them.

**False participation**

Not least important is the finding that the health process of women with MI seems to be impeded by the offer of false participation of healthcare. The women are well informed about the disease, but the information cannot reach its goal if no attention is given to their deeper needs and existential matters. In that way, their participation becomes insufficient. They are offered participation that does not take into consideration their lived experience. Combined with the uncertainty and loss of direction that the women feel, this false participation is an additional impediment to their health process.

What can I do to perhaps have any impact, or am I to just take my medication and go around like this, I am on sick leave until the end of February. Well, I just don’t know.
They find it difficult to make demands and assist in their own situation. This cannot always be explained as a lack of knowledge or information. The women often describe that they have received information about their disease and about how they should live.

There was nothing wrong with the information, but as a patient I was perhaps not receptive to information at that time.

Another woman explained how she received information from one of the staff at the hospital during a longer conversation. The talk was entirely unplanned and no one had in advance told her that it would take place. At the interview, just a few weeks after her hospital stay, she had no memory of what they actually talked about. To be informed is not any guarantee for understanding or participation.

Even if the women are not dissatisfied with information per se, they said that it was difficult to see how it could be of any help in their health process. Their experiences indicate that they found it difficult to see how the information they received was meaningful or of any use. This is particularly clear in connection with the information provided during their hospital stay. The women did not seem to be ready for the information they were given at that time, when they were occupied with trying to understand what had happened.

The lack of encounters relating to existential matters sometimes becomes obvious when the women come home after the hospital stay. For example, one woman described how difficult questions about both the disease and her life situation popped up during the first time at home. Since she did not want to cause any trouble or disturb anyone, she waited for her forthcoming check-up to get answers to her questions. During her check-up, however, there was no time for her questions and no one inquired about her needs. Before she knew it, her check-up was over. It was first when she got home again that she realized that she never got answers to her questions. From her perspective, there was no interest in how she was to live and relate to her body after the MI. When coming home and life is supposed to go on as usual, the women are confronted with difficulties they could not foresee during the hospital care.

The women who suffer from MI are vulnerable. They are dependent on the healthcare professionals, but they leave them in their despair. The women described differences between their perspective and that of the professionals on what well-being and illness means, differences that additionally impede their already complex health process.

This is all about my life, for them I might just be a number in their statistics. I don’t feel that we’re looking at this from the same perspective. But up to now, things have worked out rather well; I’m alive after all.

Again, we can face the double experience of the care, how they suffer from the ignorance of their lifeworld at the same time as they are so grateful for being cared for and alive. However, the interviews show too clearly that the women perceive themselves as objects, reduced to a diagnosis. There is a lack of support and confirmation on the part of the healthcare professionals. In addition, there is unfortunately, false participation.

False participation means more than that the women’s experiences and contexts are not taken into consideration. The healthcare professionals’ medical knowledge takes over and steers, and even if the professionals invite them to participation, it is not a kind of participation that increases their well-being, because the medical approach is general and takes no consideration of their subjective needs and their way of suffering from the MI. There thus seems to be an imbalance between the women’s needs and the support offered by the professionals. Consequently, a negative spiral develops. The women’s needs remain unspoken, which complicates the women’s chances to relate to and manage their bodies and their health, they then turn to the professionals who meet them with medical information that do not appeal to their lived world, and their insecurity increases. While true participation, that recognizes the lifeworld of the women, promotes their commitment and assistance in striving for an existence, well-being and health process in harmony with their bodies, false participation separates them from their lived bodies and decreases the chance of a full life.

Discussion

Usually we do not reflect upon our health and well-being. Gadamer (1996/1993) states that health has a hidden character that does not actually present itself to us. Instead, illness objectifies itself and forces itself on us. Illness is an experience of a disturbance that no longer can be ignored. Thus, illness makes us aware of what is missing in our health. Gadamer (1996/1993) means that this is the experience of our own embodied nature as human beings. In this sense, the life of the body is a constant movement between the loss of equilibrium and the search for a new point of stability. This idea of balance is the bodily movement of life itself, and a rhythm of our living being. Thus far, our findings are not proble-
matic. The balance of the lives of the women in the article is disturbed, and owing to the MI, they become aware of the uncertainty of life and body. They need and want to find out how to handle and balance their illness and health, and they strive for well-being despite the MI. Gadamer makes us aware that the challenge in illness is not only to identify problems restricting us, but also to discover new possibilities in life. We can see from the findings that this is present in the lives of the women, who can identify a sense of having been given a new chance to live a good life despite illness, but a MI is not any illness. A MI is a strike against life itself, and the struck women need support from health care. However, the support seems to be lacking, at least for some women, and this lack has consequences, about which the findings are explicit.

Previously participation for the MI patient has been discussed in relation to whether or not the MI patient is informed about the disease or engaged in health-care education (Clark et al., 2004; Winberg & Fridlund, 2002; Ivarsson et al., 2004; Covinsky et al., 2000; Fremont et al., 2001), but this is not the case. This study contributes to a deeper understanding of participation in the health and care for MI patients. We found that participation for the MI patient means an experience of being involved in one’s own health process. Participation also involves existential dimensions of the disease, and the women need to understand their experiences in order to participate and manage everyday life and one’s health process in a meaningful way. Women’s insufficient participation and involvement in the health process can be an impediment when the women are supposed to manage activities as usual in their life following the hospital stay.

Other findings have shown that it is common that patients experience problems during recovery (see, e.g. Jaarsma, Kastermans, Dassen & Philipsen, 1995; Wiles, 1998; Sutherland & Jensen, 2000; Johansson et al., 2003). Following the MI, the uncertainty of life becomes obvious. This involves an existential dimension of the illness experience. The MI experience not only influences women’s health, their whole lifeworld is altered. When managing everyday life the women search for meaning. Finding meaning in the illness experience is one way to understand and learn about the life and health process following a MI, which Yamada and Holmes (1998) found, similar to our findings.

Anxiety is a common reaction following a MI. In this study and an earlier one (Johansson et al., 2003), we describe the uncertainty of life that follows the MI from a female patient perspective. Anxiety is supposed to have a negative impact on the MI patients’ recovery and prognoses. Welin, Lappas and Wilhelmsen (2000) argue that increased mortality among MI patients with depressive symptoms, probably caused by a biological response to anxiety, is not yet a well-elucidated area. We argue, on the basis of our research, that the understanding of anxiety must be more varied and deepened. There is no life without anxiety. The philosopher Sartre (1946/2002) understood anxiety as a foundation for human existence, and described anxiety as a resource helping us find out possibilities offered in everyday life and making us taking responsibility for our choices in life. From that point of view, some degree of anxiety is necessary for one’s involvement in everyday life. If that is the case, and even if anxiety causes temporary suffering for the women, it is possible that this anxiety has a meaning for their further well-being and involvement in life. According to our findings, anxiety is what makes the women rethink and reorganize their lives. However, in order to manage the anxiety caused by the MI there probably is a great need for support and guidance from professionals, based on the lifeworld of the patient. Especially, the women need such lifeworlds based support that makes them less insecure. If they can handle the insecurity, maybe the existential anxiety is more likely to guide them into a new sense of well-being.

The women express spontaneous satisfaction with healthcare. Nevertheless, they also express experiences that appear to be in conflict with that satisfaction. On the one hand, they are satisfied and think they have been well cared for and they are happy to be alive. On the other hand, situations occur where they appear to have been neglected or even insulted by healthcare professionals. Especially there seems to be a gap between the women’s perspective and that of healthcare professionals. Toombs (1992) has described how illness can be experienced in different ways by physician and patient, similar to our findings. She argued that it is “difficult to construct a shared world of meaning between physician and patient” (Toombs, 1992, p. 10). These differences can be an impediment in the care of MI patients. In order to support MI patients’ well-being, there is a need for caring encounters where the lived experiences of the patient deserve credit. It cannot be contra-productive if the professionals keep their medicine expertise at the same time as they address the lifeworld of the patients.

Following the MI, the women feel lost and confused in relation to their health and they need to find meaning in their illness experience. In some way, the MI is a breakdown of one’s existence. Illness as loss of health involves a sort of exclusion from life (Gadamer, 1996/1993). Fleury et al. (1995) described interesting patterns of women in
recovery after an acute cardiac event as a process of healing. Sometimes that process of healing is described as being both social and psychological (e.g. Fleury et al., 1995; Brink, 2003). Such theories may give valuable information about the process of healing and recovery. Furthermore, we maintain that attention must be paid to the subjective dimension of illness, meaning that the ill person cannot be understood in a dualistic manner. The diagnosis, symptoms and the body and soul cannot be discussed as separate entities. Rather, the patient must be understood in his or her living context, no matter if we are talking about psychological or somatic symptoms or attributes, the women's illness experiences are subjective and intertwined in a complex unity. The process of healing entails telling the illness story (Frank, 1995). We think that telling the illness story could have offered the interviewed women an opportunity to go forward and overcome the exclusion of life caused by the MI. When caring for MI patients, it may be of importance to be aware of that; “How you touch them, affects their healing” (Frank, 2001, p. 361). We argue that in the caring relationship professionals need to be open and sensitive to the women's lifeworld, if the professionals want to improve the women's health and well-being.

The women's health process is complex. They are in a vulnerable position, dependent upon professionals. We want to conclude that there are difficulties to overcome. We argue that the professionals are responsible not only of the medical care of patients with MI, but also in relation to the patients' participation in their health processes and well-being. A challenge for further research is the active participation of the patient in the health process following a MI, a matter that is also a challenge for the healthcare professionals who care for the patient. The most severe challenge seems to be to care on the basis of the lifeworld.

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References

Brink, E. (2003). To be stricken with first-time myocardial infarction – from acute symptoms onset to early readjustment in women and men. Dissertation. Sweden: Department of Psychology, Göteborg University.

Brink, E., Karlsson, B., & Hallberg, L.R-M. (2002). Health experiences of first-time myocardial infarction: factors influencing women's and men's health-related quality of life after five month. Psychology, Health & Medicine, 7, 5–16.

Clark, A., Barbour, R., White, M., & MacIntyre, P. (2004). Promoting participation in cardiac rehabilitation: patient choices and experiences. Journal of Advanced Nursing, 47, 5–14.

Covinsky, K. E., Chren, M.-M., Harper, D. L., Way, L. E., & Rosenthal, G. E. (2000). Differences in patient-reported processes and outcomes between men and women with myocardial infarction. Journal of General Internal Medicine, 15, 169–174.

Dahlgberg, H., & Dahlberg, K. (2003). To not make definite what is indefinite. A phenomenological analysis of perception and its epistemological consequences. Journal of the Humanistic Psychologist, 31(4), 34–50.

Dahlgberg, K. (2006). The essence of essences –the search for meaning structures in phenomenological analysis of lifeworld phenomena. QHW – International Journal of Qualitative Studies on Health and Well-being, 1, 11–19.

Dahlgberg, K., Drew, N. & Nyström, M. (2001). Reflective lifeworld research. Lund: Studentlitteratur.

Drey, Y., Kravetz, S., & Hirschberger, G. (2003). Long-term mental health of women after a first acute myocardial infarction. Archives of Physical Medicine and Rehabilitation, 84, 1492–1498.

Fleury, J., Kimbrell, C., & Kruuswetski, M.-A. (1995). Life after a cardiac event: women's experience in healing. Heart & Lung, 24, 474–482.

Frank, A. W. (1995). The wounded storyteller: body, illness, and ethics. Chicago: The University of Chicago Press.

Frank, A.W. (2001). Can we research suffering? Qualitative Health Research, 11, 353–361.

Fremont, A. M., Cleary, P. D., Hargraves, J. L., Rowe, R. M., Jacobsen, N. B., & Ayanian, J. Z. (2001). Patient-centered processes of care and long-term outcomes of myocardial infarction. Journal of General Internal Medicine, 16, 800–808.

Fridlund, B. (2000). Self-rated health in women after their first myocardial infarction: a 12-month comparison between participation and nonparticipation in a cardiac rehabilitation programme. Health Care for Women International, 21, 727–738.

Gadamer, H.-G. (1996/1993). The enigma of health. Stanford, CA: Stanford University Press.

Ivarsson, B., Larsson, S., & Sjöberg, T. (2004). Patient's experiences of support while waiting for cardiac surgery. A critical incident technique analysis. Cardiovascular Nursing, 16, 218–225.

Jaarsma, T., Kastermans, M., Dassen, T., & Philipsen, H. (1995). Experiences of first-time myocardial infarction. Journal of Advanced Nursing, 24, 169–174.

Jacobsen, N. B., & Ayanian, J. Z. (2001). Patient-centered processes and outcomes between men and women with coronary heart disease. Coronary Health Care, 2, 202–209.

Merleau-Ponty, M. (1995/1945). Phenomenology of perception. London: Routledge.

Radley, A., Grove, A., Wright, S., & Thurston, H. (1998). Problems of cardiac patients in early recovery. Journal of Advanced Nursing, 21, 21–27.

Roebuck, A., Furze, G., & Thompson, D. (2001). Health-related quality of life after myocardial infarction: an interview study. Journal of Advanced Nursing, 34, 787–794.

Rosenfeld, A., & Gilkeson, J. (2000). Meaning of illness for women with coronary hearth disease. Heart & Lung, 29, 105–112.

Sartre, J.-P. (1946/2002). Existentialismen är en humanisme. (A translated edition of L’existentialisme est un humanisme.) Stockholm, Sweden: Bonniers förlag.
Sutherland, B., & Jensen, L. (2000). Living with change: elderly women’s perceptions of having a myocardial infarction. *Qualitative Health Research, 10*, 661–676.

Svedlund, M., & Danielsson, E. (2004). Myocardial infarction: narrations by afflicted women and their partners of lived experiences in daily life following an acute myocardial infarction. *Journal of Clinical Nursing, 13*, 438–446.

Thompson, D. (2003). Improving the organisation and delivery of cardiac rehabilitation. *European Journal of Cardiovascular Nursing, 2*, 245–246.

Toombs, K. (1992). *The meaning of illness* – a phenomenological account of different perspectives of physician and patient. Boston: Kluwer Academic Publishers.

Welin, C., Lappas, G., & Wilhelmsen, L. (2000). Independent importance of psychosocial factors for prognosis after myocardial infarction. *Journal of Internal medicine, 247*, 629–639.

Wiles, R. (1998). Patients’ perceptions of their heart attack and recovery: the influence of epidemiological “evidence” and personal experience. *Social Science and Medicine, 46*, 1477–1486.

Winberg, B., & Fridlund, B. (2002). Self-reported behavioural and medical changes in women after their first myocardial infarction: a 4-year comparison between participation and non-participation in a cardiac rehabilitation programme. *European Journal of Cardiovascular Nursing, 1*, 101–107.

Yamada, P., & Holmes, V. (1998). Understanding the experience: Patients’ perceptions of postmyocardial infarction teaching. *Progress in Cardiovascular Nursing, 13*(4), 3–12, 23.