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Patients' Experience Before Cardiac Surgery During the COVID-19 Pandemic: A Qualitative Study

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ABSTRACT

Background: Cardiovascular diseases, with their high mortality rates, significantly impact patients' quality of life, contribute to disability, and impose a substantial financial burden on society.

Aims and Objectives: This study aimed to illuminate patients' experiences before undergoing cardiac surgery during the COVID-19 pandemic.

Design: This is a qualitative interview study.

Methods: A purposive sampling technique was employed, with participants recruited from Department Cardiovascular surgery and interviewed to explore their experiences. An inductive thematic analysis was conducted, and reporting adhered to the EQUATOR guideline: COREQ.

Results: The study identified numerous challenges faced by patients during the preoperative period. Consequently, two prominent themes emerged from the patients' experiences while awaiting cardiac surgery during the COVID-19 pandemic: the feeling of loneliness and the feeling of losing oneself.

Conclusions: The psychological vulnerability of patients during the perioperative phase, intensified by circumstances such as a pandemic, can lead to emotional and behavioural instability, significantly impacting the patient negatively.

Relevance to Clinical Practice: Prioritising the patient's experience is crucial in fortifying presurgical care. Delving into the nuanced perspectives of patients fosters a comprehensive understanding that transcends conventional approaches. This research underscores the significance of giving prominence to the patient perspective, offering opportunities for healthcare professionals to elevate the standard of patient care. Recognising and addressing the challenges faced by patients awaiting cardiac surgery can contribute to a more holistic and patient-centered approach in clinical practice.

Patient or Public Contribution: Patients contributed by sharing their experiences during interviews, providing first-hand insights that are presented in the study results.

1 | Aims and Objectives

This study aimed to illuminate the patients' experiences waiting for cardiac surgery during the COVID-19 pandemic in Bosnia and Herzegovina.

2 | Introduction

Cardiovascular diseases (CVDs) remain the leading cause of morbidity and mortality worldwide. Although recent reports indicate a decline in CVD incidence in high-income countries,

the burden continues to rise in many middle- and low-income settings (World Health Organization 2021). Beyond their contribution to mortality, CVDs impose substantial social and economic burdens, including reduced quality of life, disability, and significant productivity loss (Itagaki et al. 2019; Kotseva et al. 2019). For example, Kotseva et al. (2019) reported that cardiovascular events may lead to approximately 25% productivity loss, further compounded by reduced work attendance among family caregivers.

While preventive strategies implemented in high-income contexts have contributed to declining CVD-related mortality, as seen in the United Kingdom, where annual deaths decreased from 259 in 2000 to 99 in 2022 (British Heart Foundation 2022), such measures remain less accessible in resource-constrained countries. As a result, disparities in outcomes persist.

In this context, understanding patients' experiences becomes crucial, particularly in settings where structural limitations and psychosocial stressors intersect. This study therefore illuminated patients' experiences waiting for cardiac surgery during the COVID-19 pandemic in Bosnia and Herzegovina.

3 | Background

Despite advances in prevention and treatment, many patients with CVD still require surgical intervention to alleviate symptoms, prevent disability, and reduce mortality (Salzmann et al. 2020). In middle- and low-income countries, preventive measures are often difficult to implement consistently, contributing to persistently high CVD-related mortality rates.

Cardiac illness is frequently associated with emotional distress, including anxiety, fear, and depressive symptoms (Christensen et al. 2020; Salzmann et al. 2020; Carr et al. 2017). Patients awaiting cardiac surgery face both physical and psychological challenges. As highlighted in a large-scale study by Sbolli et al. (2020), nearly one-third of patients exhibited signs of depression upon receiving information about their condition or the need for surgery, symptoms linked to decreased quality of life. The preoperative phase is thus recognised as a period of heightened psychological vulnerability, during which patients may experience emotional instability and loss of control (Gomes et al. 2018).

Previous research has emphasised various stressors affecting cardiac patients, including waiting times, separation from family, and fear of pain or complications (Salzmann et al. 2020; Altinbas and Van Giersbergen 2021). More recent work, such as Van Schalkwijk et al. (2023), has illustrated patients' journeys using patient-centered care frameworks, highlighting the importance of addressing both informational and emotional needs.

The COVID-19 pandemic further intensified these stressors. Restrictions on movement, the suspension of hospital visits, and protective measures such as mandatory masking and social distancing disrupted patients' access to support. Studies conducted during the pandemic have reported increased levels of anxiety, depression, sleep disturbances, and psychosocial strain among cardiac patients (Sinanovic et al. 2020; Wu et al. 2022).

This study was therefore motivated by the growing burden of CVDs in middle- and low-income countries, the need to enhance patient-centered care, and the limited research on preoperative experiences in such settings. The context of Bosnia and Herzegovina is particularly relevant due to its high prevalence of mental health conditions—including post-traumatic stress disorder (Avdibegovic et al. 2009)—and the additional strain caused by pandemic-related restrictions.

4 | Design

4.1 | Study Design

This study employed a qualitative inductive approach using data from semi-structured interviews with patients from Bosnia and Herzegovina before scheduled cardiac surgeries. The consolidated criteria for reporting qualitative research (COREQ) was used to report the results and prepare this manuscript (Tong et al. 2007). Furthermore, Braun and Clarke (2006, 2021) inductive thematic analysis was used to analyse the data from face-to-face interviews.

4.2 | Setting and Sample

Data from the Health Statistics Annual of Bosnia and Herzzegovina (2019) showed that the total population before the pandemic was 2,196,233 and the number of confirmed CVD cases was 360.099. Moreover, the leading cause of death was acute myocardial infarction ($n = 2053$). The number of CVD patients receiving hospital care at the time was 17,742, including 1695 undergoing cardiac surgery which were performed in three hospitals in Bosnia and Herzegovina. This data was established by monitoring risk factor trends like hypertension, smoking, irregular nutrition and lack of physical activity. According to the data, nearly half (42.1%) of the total number of adults in the country had hypertension and nearly half of the adult population (44.1%) smokes (56.3%) of men and (31.6%) of women. Importantly, a high percentage of CVD risk factors have been attributed to stress caused by wartime events, which have harmed the socio-economic situation in the country and increased chronic non-communicable diseases, as well as affected the mental status of the entire population, the pandemic became an added stressor and CVD risk factor (Sinanovic et al. 2020).

The present study was performed in a hospital in the northeastern part of Bosnia and Herzegovina. An average of about 450 heart surgeries and about 2000 Cath lab procedures are performed at this hospital every year. A purposive sampling strategy was used, as recommended by Moorley and Cathala (2019), to ensure that participants had experience relevant to the research question. Twenty-one patients scheduled for elective cardiac surgery were invited to participate: one declined, resulting in 20 interviews conducted between August 2020 and January 2021. The sample included 17 men and 3 women from various regions of Bosnia and Herzegovina, ensuring diversity beyond the hospital's immediate catchment area. Regarding the number of informants, there are various recommendations (Braun and Clarke 2006; Moorley and Cathala 2019) where the depth of responses can be more crucial than the actual number

of participants. Participants were eligible for inclusion if they were adults aged 18–65 years scheduled for elective cardiac surgery, had sufficient physical and mental capacity to participate, and were able to speak and understand the spoken language. Patients were excluded if they were undergoing emergency cardiac surgery, had cognitive impairment or severe mental illness that prevented participation, or were unable to communicate in the spoken language. The patients in this study came from all over Bosnia and Herzegovina, so the study was not limited to one region.

4.3 | Data Collection

The study was approved by the hospital research ethics committee. Prior to data collection, the first author (Marina Ahmetbegovic) informed all relevant hospital staff, including the nurse coordinator, surgical team, and administrative personnel, about the study's purpose, procedures, and inclusion criteria.

Patients typically waited 3–6 months for surgery due to pandemic-related delays. The administrative process for participants recruitment involved multiple steps:

The nurse coordinator, responsible for scheduling cardiac surgeries, identified eligible patients and informed them orally about the study when confirming their admission seven days prior to surgery.

Oral consent was obtained upon hospital admission two days before surgery. Additionally, the first author provided detailed verbal and written information about the study, ensuring patients understood their participation was voluntary and confidential.

Interviews were arranged for the day before surgery in a private room, providing a comfortable and confidential setting.

Alongside qualitative interviews, sociodemographic and clinical data including gender, age, and level of education were collected to describe the study sample (Table 1).

5 | Methods

5.1 | Interview

Semi-structured interviews were used to illuminate the patients' experiences before the surgery, and they were conducted by the first author (Marina Ahmetbegovic). The interview started with a general open question such as, "Could you, please, tell me about your experience of waiting for surgery?" A follow-up question was then asked, "Could you, please, describe your feelings?" The interviews comprised open-ended questions, such as "Could you, please, tell me more about ...?" or "What exactly do you mean by ...?" The interviews lasted between 23 and 62 min (with a mean of 30 min). With permission from the participants, the interviews were all audio recorded.

5.2 | Data Analysis

The interview data were analysed using a reflexive thematic analysis (TA). Themes were identified following Braun and Clarke's (2006) six-phase process, while adopting the reflexive principles outlined in Braun and Clarke (2021). This approach emphasises researcher subjectivity and reflexivity as integral to theme development. The inductive approach ensured that themes were grounded in the data rather than shaped by preconceptions (Jowsey et al. 2021). TA is particularly effective for exploring diverse perspectives and generating unexpected insights, especially when working with large datasets, as it encourages iterative engagement and critical reflection (Nowell et al. 2017; Lochmiller 2021). The analysis was carried out as follows: the six-phase process by Braun and Clarke (2006) which includes:

Familiarisation with the data: The authors thoroughly reviewed all interview transcripts to become deeply familiar with the content.

Generating initial codes: The first author systematically coded interesting features of the data across the entire dataset, using the coding techniques suggested in the recent framework. This process is presented in Table 2.

Searching for themes: The authors collated codes into potential themes, considering the more nuanced thematic structures introduced in the updated framework. An example of how a theme was defined and named is presented in Figure 1.

Reviewing themes: All authors reviewed themes to ensure they accurately reflected the data, applying the rigorous criteria for theme coherence and distinctiveness outlined in the updated framework.

Defining and naming themes: The author has refined each theme, clearly defining and naming them in line with the updated guidelines to ensure they captured the essence of the data accurately.

TABLE 1 | Participants sociodemographic and medical data.

Gender	Education level	Occupation	Marital status	Type of operation
Male 17	Primary school 4	Employed 18	Married 15	Bypass surgery 14
Female 3	Secondary school 11	Unemployed 2	Unmarried 5	Mitral valvae replacement 5
	Higher education 5			Aortic valvae replacement 1

TABLE 2 | Extracts from interviews and examples of coding qualitative data.

Interview extract	Codes
"The life between me and my wife and all that. You're moving away" (IP11)	Emotional distance
"So, I couldn't even have intimacy with a wife" (IP18)	Sexual distance
"You're always in some fear so he started to back off somehow" (IP12)	Emotional withdrawal

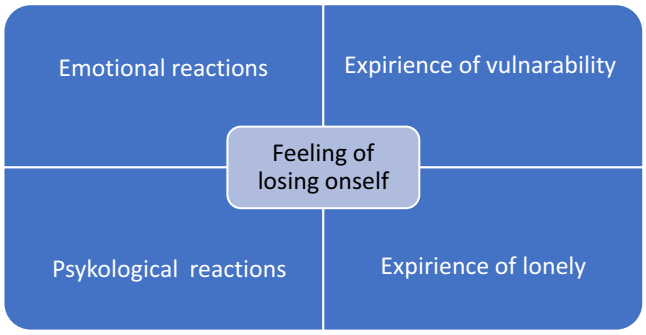

FIGURE 1 | Example of defining and naming themes.

Producing the report: The authors compiled findings into a cohesive narrative, ensuring that our analysis was grounded in the updated thematic framework Braun and Clarke (2021) and that it provided a clear and insightful interpretation of the data.

5.3 | Ethical Considerations

This study was approved by the Ethics Review Authority under protocol number 421/20 and conducted in accordance with the ethical principles outlined in the Declaration of Helsinki (World Medical Association 2013). Participants were fully informed about the study's purpose and procedures, had the opportunity to ask questions, and were assured that they could withdraw at any time without consequences.

To ensure confidentiality and protect participants' privacy, interviews were coded, and transcripts were accessible only to the research team. Additionally, psychological support was available if participation or discussion of experiences evoked distress.

6 | Results

This study explored the experiences of patients waiting for cardiac surgery in Bosnia and Herzegovina. The analysis of interviews revealed two prominent themes: the feeling of loneliness and the feeling of losing oneself. The patients expressed a strong need to share the feelings and thoughts related to their illness but felt unable to burden their loved ones, especially given the fear and anxiety associated with the pandemic. The sense of being alone with their thoughts and worries weighed heavily on them, particularly during the quiet nights leading up to the surgery. Physical symptoms, such as chest pain and limited mobility, further contributed to their feelings of isolation and affected their social interactions. In one moment, patients noticed a change in themselves and the feeling of losing oneself.

6.1 | Feeling of Loneliness

In the days leading up to surgery, they experienced strong feelings of loneliness. During the interviews, they said that they had a great need to talk about a lot of things but lacked the words to express themselves. The patients stated that they did not have the chance to talk about the feelings and thoughts related to their disease with their loved ones when they were at home. They avoided burdening their partners or children. It did not get any easier when the COVID-19 pandemic started, and everyone felt fear and anxiety regarding an unknown disease. The fear for the family's health was stronger than the fear for their own health, but the patients still needed to open and talk to someone. The feeling of being alone, with heavy thoughts and worries for their own life as well as the lives of relatives was described as difficult to bear. Having concerns for the family and the future, having existential questions, and staying at home were the sources of negative feelings. Some of the patients said that being at home was difficult.

> I thought coming to the hospital would bring some relief. But that only made it worse, especially at night, when it was quiet, without intervention, and when only occasionally the steps from the staff could be heard. I could not sleep, thinking all the time, so I wished it was not night, so I could call someone.
>
> (IP5)

During quiet nights, patients reported spending a lot of time thinking about their illness. They described their symptoms, such as chest pain, as stronger than usual. They thought about certain activities they could no longer perform and how that pain led to the limitation of everything in daily life. They even linked physical exertion and pain to death. Those feelings of pain were reflected in the physical limitation of activities but also had a negative impact on the patient's social life even before the pandemic.

> I felt sick with fear. I cannot go up or down the stairs. If I do just a little bit of something I am all soaked and sweaty. And if I tried to do something, I just felt tired, and I must lie down and rest a little, and it bothered me.
>
> (IP19)

Physical limitations and constant thoughts about heart problems contributed to most of the patients distancing themselves from their social contacts, which they claim contributed to changes in their mood. This negatively affected their relationship and communication with family members and friends and increased their feelings of loneliness. On the other hand, the patients talked

about the various restrictions that were introduced during the pandemic and how these, in some strange way, often felt like a relief. Pandemic restrictions applied to everyone, even healthy people, and this reduced the demands the patients felt from others around them. Now they could be at home without having to explain themselves since these rules were for everyone.

> There is Covid. It made me think about it, and I felt anxious about it. But it is easier now that everyone should stay in their home, not only me. It is a relief I do not have to go out because my disease had an impact on everything, including my marriage. You drift apart from your partner and friends.
>
> (IP11)

The patients believed that all these feelings would disappear once they were under hospital care. They believed that they would be relieved as they would be protected from pandemics, that the surgery would help them feel better, and that they would be able to freely talk to someone about their fears and hopes. However, for most of the patients, the hospital stay was not what they expected. After arriving at the hospital, they met the staff in special uniforms and masked faces. Most patients described this situation as stressful. It did not get any easier when they were told that no visits were allowed. This felt terrifying, and the feeling of loneliness became more intense during the hospital stay. The patients stated that they needed someone to talk to face-to-face and to share their thoughts with, but they "only had their cell phone" (IP11) as a means of communication.

> It is very difficult. No one is here. There is my cell phone, but it cannot hug me or take my hand.
>
> (IP6)

Patients spoke of seeing hospital staff as the only opportunity to talk to someone in person. However, the staff usually called on them to inform them about the operation itself, or to give them practical information about preparations for the operation. It was not customary for them to talk to a patient about feelings and everyone was so busy that there was no time for another conversation. Eventually, the patients understood that the hospital environment would not provide them with relief.

> I am very afraid of the doctors and the hospital and the staff. Everyone talked to me nicely, but I couldn't hear them or see them under those masks, and I did not understand them. I am all stressed out.
>
> (IP12)

Nonetheless, the hospital offered some relief. At home, nobody understood that they lost some of their abilities but in the hospital, they are surrounded by other patients who were going through the same or similar experiences. Even when the pandemic restrictions forced them to remain apart in different hospital rooms, they were somehow relieved that there were others with similar problems.

The patients emphasised the problems connected with physical activity. They were not talking about running a marathon but wanting to do simple things such as going to the market, taking a bath, working in the garden, going for a walk, or having intimacy. Some of the patients were particularly bothered by their inability to be intimate with their partners. They avoided intimacy because they were afraid it would cause pain and worsen their heart condition. Consequently, they started to withdraw from their partners or avoid everything that could lead to intimacy including touch, kisses, and deep conversation. Being apart from their partners to avoid having to explain how the illness has affected their intimacy was a relief, but it deepened their loneliness. The inability to be intimate also made them feel unworthy.

> I made an effort to be as gentle as I could be, so that it wouldn't be difficult for them. When a young man is unable to be with a woman, it is difficult for him. And my wife looks at me differently, so you are incompetent, you are useless.
>
> (IP18)

However, several of the patients already lived alone and carried a feeling of loneliness that only deepened with the knowledge that they needed surgery. They frequently stated that they have no one to talk to but they are used to it. After some time during the interview, their words described a significant fear of death and concern about whether they will be able to take care of themselves if they survive the operation.

> It is quite difficult to say. There is no one you can ask for help with because you are by yourself. It is hard because no one listens to you; you are on your own.
>
> (IP9)

Loneliness is a subjective feeling, and the patients' experiences were not all the same. While some of the patients described loneliness as accompanied by a deep fear and sadness, others found strength through faith. In some of the interviews, the patients describe being shocked by their diagnosis and the news that they needed surgery, but that they spoke about it as God's will. They said that they miss their family and feel lonely without them, but they are not alone, God being with them. Their faith in God was usually cited as the source of their psychological stability. They were motivated by the belief that everything comes from God, such as life or death, health, or disease, so they overcome their fear is through prayer to God to help them in these challenging times.

> This disease is an ordeal of my faith, and I do not know how to call it. It will pass.
>
> (IP7)

In sum, the patients often describe loneliness is an unpleasant emotional reaction to perceived lack of connection and intimacy. They appear to carry this burden silently and by themselves in the hospital room, believing that their illness means the end of their life. In the interviews, the patients expressed fear, worry about an uncertain future, worry for their family, physical and social isolation caused by a pandemic, and feeling useless but they conveyed a deep feeling of loneliness. They describe it in a few words, and when tears appear in their eyes, they turn their heads and stop talking.

> You go through all this alone (the patient turned his back and looked out the window), and I felt like it was the end of my life; miserable and hard, yet it is a heart.
>
> (IP12)

6.2 | The Feeling of Losing Oneself

The feeling of losing oneself is crystallised from the patient's stories. The patients described how all the changes that have occurred, both physical and psychological, have contributed to them not recognising themselves. The changes were noticeable from the beginning, but not to them. Most often it was family members or friends who commented on these changes. When these comments came, the patients initially felt confused because they did not understand the meaning of these comments. Eventually, they became aware that their lives had taken a different direction from the one they lived before. Fears and existential questions raced through their minds, leaving little space for what used to make life exciting. Some of them talked about moments where they felt like life was already lost.

> I felt lost. I could not believe it was a heart problem, and I hoped it was something else. When they told me /.../ I just got lost. I thought at that moment that it was. That this is the end.
>
> (IP5)

Losing oneself was a feeling that the patients frequently described during the interviews. They said that they were slowly but surely losing their grip on their lives. Just thinking about the current situation, they noticed how images of the life they lived before the diagnosis were slowly beginning to fade from memory. The phrases they used to describe themselves included "lost and confused," "helpless," and "scared". The pandemic contributed to amplifying all these negative feelings. The patients felt they were not just threatened by heart disease anymore.

> I complained about the symptoms, and I was taken to a ward called the Corona tent. They mistakenly thought I was a corona patient rather than a heart patient and placed me in the Corona quarantine area.
>
> (IP15)

The patients' relationships with family and their social circles were also affected. Some patients said that they were so busy with their own health that they forgot that their surroundings were also affected:

> I was looking out the hospital window at my son and wife; she appeared older and different. She sounded and looked at me differently.
>
> (IP11)

Moreover, they stated that people from their environment were initially keen to call or visit them and that this decreased over time. According to the patients, the people around them had noticed they were closing themselves off and getting lost in thought after learning they needed surgery. Even the patients themselves started noticing that they had lost the desire to see all the happy people who lived their lives unhindered and that they had been going deeper and deeper into their own world built of anxiety and unhappiness. They reported that family gatherings usually became too much, that they received too many questions, and that all this only made them stressed.

> Sometimes I prefer to be quiet. I can't listen to anything or anyone when I'm anxious, so I just keep quiet. I have no one to share my thoughts with.
>
> (IP13)

The patients said they noticed that noise disrupts their thoughts and causes them to feel more apprehensive. They hoped for silence in one hospital environment, where they could ask questions about their illness instead of answering different ones.

Patients talked about their emotions, fears, and hopes when they arrived at the hospital. They explained why they were worried about needing cardiac surgery, especially during the pandemic. COVID-19 put the patients in uncomfortable situations. For example, they noticed that their stress levels grew during the period of pandemic restrictions. The pandemic brought in a variety of policies and restrictions that made it difficult for the patients to access primary care and prolonged the waiting time for surgery procedures.

The interviews were conducted at the beginning of the pandemic when primary care was still in the process of being reorganised. The patients were confronted with medical workers in safety clothing, masks and visors, and they described this scenario as unpleasant. They were in the hospital awaiting surgery, and their fear was accompanied by a sense of insecurity because of the constant testing for COVID-19. If the test comes back positive, they will not be operated on and would be transferred to the COVID-19 ward until the test comes back negative. Thus, being infected by a patient means delaying their heart operation, further pain and discomfort, and possibly the end of life. As a result, to avoid testing positively, the patients reduced their contact with others, leading to social isolation. They felt threatened, which resulted in an unusual reaction in everyday life.

> You cannot talk to anyone back home, so I become aggressive., I know that I should not, but I have to.
>
> (IP11)

During these stressful situations, not only did they feel as if they were losing themselves, but their illness and symptoms also worsened. Because they struggled to cope with the psychological changes, the patients chose to focus on the physical ones. During the interviews when the patients realised they were openly talking about how their illness changed them they turned the conversation in another direction. They started to concentrate on their physical abilities. They began by expressing how they were beginning to lose their image of themselves as useful members of society and how it bothered them that they

would no longer be able to achieve anything. They describe how their abilities have changed.

> I'm aware that I may never be strong as I used to be. I am just afraid that I will not have the strength, that I will not have the power, and that I will die.
>
> (IP5)

They recounted the feeling that something was wrong with them, physically. They described a situation when they experienced something like panic attacks. These psychological reactions that manifested physically influenced their work. For example, one of the patients described his communication with a doctor who then sent him to a psychiatrist.

> My hands start sweating as soon as I sit down in the room and once, they do, it's all over. I am not coming back. If that happens at work, the only thing I can do is go home and rest. I am no longer able to work. People don't understand it.
>
> (IP10)

From their hospital bed, the patients talked about an unclear and unpredictable future. Fear what they felt changes them, they start to be aware during interviews that they are loosing themselves.

7 | Discussion

This study explored the experiences of patients waiting for cardiac surgery during the COVID-19 pandemic, revealing two central themes: the feeling of loneliness and the feeling of losing oneself. Patients expressed a strong need to share their feelings and thoughts related to their illness but refrained from burdening family members, particularly in the context of the pandemic. The sense of being alone with their worries, combined with physical limitations such as chest pain and restricted mobility, intensified their psychological distress.

Our findings are consistent with those reported by Sjödahl Hammarlund et al. (2023), who showed that individuals with cardiovascular disease in Sweden experienced substantial changes in daily routines, reduced social contact, limited access to healthcare, and heightened emotional distress during the COVID-19 pandemic. In our study, patients described similar challenges: the fear of infection, reduced social activity, and the perception that hospital restrictions increased their isolation. These contextual factors appear to amplify pre-existing vulnerabilities related to chronic illness, highlighting the interaction between physical limitations, emotional well-being, and environmental constraints.

The theme of loneliness was particularly pronounced in the preoperative period. Patients reported spending quiet nights thinking over their illness and the potential risks associated with surgery, sometimes linking physical symptoms to existential concerns. This aligns with prior research indicating that preoperative patients often experience emotional distress and perceive a lack of social support (Gomes et al. 2018; Kok et al. 2023). The pandemic, with its restrictions on visitation and social interactions, seems to have intensified these feelings, creating a unique intersection between chronic illness and public health measures.

While previous studies have documented anxiety and fear before cardiac surgery, this study emphasises the interplay between physical limitations, social isolation, and the unique stressors introduced by the pandemic.

7.1 | Loneliness and Social Isolation

Patients described intense feelings of loneliness in the days leading up to surgery, intensified by their reluctance to burden family members and by pandemic-related restrictions. These findings align with previous research showing that preoperative patients often experience emotional distress and perceive a lack of social support (Krampe et al. 2018; Kok et al. 2023). However, our study highlights the added complexity of a global health crisis: pandemic measures, while intended to protect patients, inadvertently reinforced feelings of isolation. This is in line with a study by Forner et al. (2021), which examined the experiences of cancer patients awaiting surgery during COVID-19 and found that patients experienced substantial levels of psychosocial distress. Importantly, coping strategies and effective communication with the healthcare team were able to mitigate some of these negative feelings. Nonetheless, symptoms of anxiety and depression, perceived stress, and fear of their cancer progressing remained high. Interestingly, some patients in our study reported a paradoxical sense of relief in pandemic restrictions, as societal limitations normalised their need to withdraw and rest, reducing the perceived pressure to perform social roles. This nuance illustrates the contextual and cultural dimensions of patients' experiences, suggesting that external circumstances can both exacerbate and alleviate emotional distress.

The participants' narratives also underscore the relationship between physical symptoms and social withdrawal. Chest pain, fatigue, and reduced mobility not only constrained daily activities but also limited social interactions, contributing to emotional isolation. A strong association between loneliness and poor patient-reported outcomes and 1-year mortality was previously found in both men and women across cardiac diagnoses (Christensen et al. 2020). Our results suggest that loneliness should be a priority for public health initiatives and should also be included in clinical risk assessment in cardiac patients. Importantly, the interviews reveal that the hospital environment, although expected to provide relief, often failed to meet patients' psychosocial needs. Staff interactions were primarily task-focused, and protective measures such as masks and visitation restrictions hindered meaningful human connection, emphasising the need for integrated psychosocial support in perioperative care.

7.2 | The Feeling of Losing Oneself

The second theme, the feeling of losing oneself, captures patients' perceptions of profound identity disruption. Patients reported a gradual detachment from their previous roles and self-image, a

phenomenon amplified by anxiety about their prognosis, physical limitations, and social isolation. Notably, the pandemic context intensified these effects, as patients were confronted with unfamiliar hospital procedures, heightened uncertainty, and limited social interactions.

The narratives also highlight the psychological mechanisms patients employed to cope, such as focusing on physical capabilities or relying on faith. While some drew strength from spiritual beliefs, others experienced heightened fear and helplessness, suggesting variability in coping strategies. This finding is consistent with studies demonstrating that spirituality and personal belief systems can buffer the psychological impact of serious illness and may be strongly associated with less depression (Sedaghat et al. 2019). Recognising these coping mechanisms may be critical for developing patient-centered interventions that address both physical and emotional well-being.

7.3 | Strengths and Limitations

This study provides rich, detailed accounts of patients' experiences during a unique and stressful period, capturing both psychological and physical aspects of preoperative life. By conducting interviews during the COVID-19 pandemic, the study highlights how public health measures and hospital restrictions influenced patients' experiences, which adds new knowledge to the field of cardiac care. The use of direct patient narratives allows for a better understanding of the subjective impact of illness and hospitalisation, which can help future nursing practice and psychosocial support interventions. The study identifies two interrelated themes: loneliness and losing oneself, that may guide future interventions to improve preoperative care and patient well-being. However, patients were recruited from a single hospital, which may limit the transferability of findings to other contexts. While qualitative studies prioritise depth over breadth, a relatively small and potentially homogeneous sample may limit the diversity of experiences captured. Interviews were conducted at the beginning of the pandemic, which may reflect experiences specific to early COVID-19 restrictions and not generalisable to later stages or post-pandemic periods. Participants' accounts may be influenced by current emotional state, memory limitations, or social desirability, potentially affecting the authenticity of reported experiences. The study did not include perspectives of healthcare professionals or family members, which could have provided additional contextual understanding of the challenges faced during this period. Despite these limitations, the study offers valuable insights into the complex interplay between physical illness, emotional distress, and social isolation during a global health crisis, contributing to improved understanding and care of preoperative cardiac patients.

8 | Conclusion

In conclusion, this study explores the experiences of patients awaiting cardiac surgery, highlights the significant impact of the COVID-19 pandemic on these patients and reveals this previously unexplored dimension in the context of Bosnia and Herzegovina. The findings not only confirm results observed in other countries but also highlight the unique challenges posed by the pandemic in this specific region.

This study shows how the pandemic not only exacerbated the existing disease symptoms but also triggered changes in sleep, diet and overall mental well-being of the patients. In terms of implications, the findings underscore the importance of recognizing and addressing the multifaceted challenges that patients face in the preoperative period. Considering these insights, the study not only adds to the existing body of knowledge but also advocates a more holistic approach to patient care, especially in the context of unforeseen global challenges such as the COVID-19 pandemic. It becomes necessary for healthcare systems and practitioners to integrate comprehensive support mechanisms in the preoperative period to ensure patients' well-being beyond the limits of their medical conditions.

9 | Relevance to Clinical Practice

Our research has significant implications for clinical practice in several key areas. By understanding patients' experiences before cardiac surgery during the COVID-19 pandemic, healthcare providers can tailor their preoperative care strategies to address specific anxieties and concerns. This personalised approach can enhance patient satisfaction and potentially improve surgical outcomes. The present study highlights the importance of effective communication between healthcare providers and patients. By incorporating our findings, clinicians can develop more effective communication protocols that ensure patients feel heard and supported, which is crucial during stressful preoperative periods. Our findings underscore the need for integrated mental health support for patients undergoing cardiac surgery. By recognising the psychological impacts highlighted in our study, clinical practices can incorporate routine psychological assessments and timely referrals to mental health professionals. The insights from our study can be used to support the training and education of healthcare professionals. Understanding the specific challenges and needs of patients, training programs can better prepare clinicians to provide empathetic and comprehensive care.

By emphasising the importance of addressing both physical and emotional needs, our study supports a more holistic approach to patient care. This approach can lead to more effective treatment plans that consider all aspects of a patient's well-being.

In conclusion, our research offers valuable insights that can directly enhance clinical practice by improving patient care strategies, communication, mental health support, and overall healthcare delivery. We believe that integrating these findings into clinical practice will lead to better patient outcomes and a more supportive healthcare environment.

Author Contributions

The researcher and her mentors worked together on every part of the study, from planning the research, finding the right methodology, and designing the study to writing the article.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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