Congenital cataract in newborns: A qualitative study on parents’ experiences of the surgery and subsequent care

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ABSTRACT.
Purpose: Having a child with congenital cataract that requires surgery, contact lens treatment, and frequent medication is a life-altering experience. The aim of this study was to provide more in-depth knowledge of parents’ experiences of diagnosis, surgery, and subsequent care, in order to find the areas for improvement.

Methods: Data were collected via semi-structured interviews with parents recruited from St. Erik Eye Hospital, Sweden. The children were operated for congenital cataract before 3 months of age and were aged 12–24 months at the time of the interviews. The interviews were analysed using qualitative content analysis with an inductive approach.

Results: Three themes emerged from the data: living in a turbulent time before the diagnosis, coping during the time of initial treatment, and managing the responsibility of their child’s visual development. All parents expressed confidence in the operating unit. However, there was a clear need for reliable information on the condition, the surgery, and likely the long-term outcome in the time between receiving the preliminary diagnosis at the maternity ward and getting it confirmed by a paediatric ophthalmologist.

Conclusion: Much of the parents’ concern in this turbulent time is linked to poor information before the visit to the eye hospital. We, therefore, recommend earlier contact with the eye hospital, preferably at the time of writing the referral. Moreover, the possibility of providing up-to-date information via alternative information channels such as smartphone apps should be investigated.

Key words: congenital cataract – paediatric cataract – paediatric contact lenses – parents – qualitative content analysis – quality of life

Introduction
Congenital bilateral cataract accounts for 5% to 20% of treatable childhood blindness, making it the most common cause worldwide (Foster et al. 1997). Congenital cataract can be unilateral or bilateral, idiopathic or inherited, and can also be a result of metabolic disease and complex syndromes. If the cataract in infants is dense, early surgery is warranted to ensure a sufficient influx of light to enable visual development. If the eye is big enough, an intraocular lens (IOL) may be inserted, but if the eye is too small, the child is left aphakic. Visual development also requires correct refraction and so preferably contact lenses are fitted following surgery, regardless of whether the child is left aphakic or implanted with an IOL. Contact lenses for children are not available in all countries, in such case, glasses should be prescribed. The power of the IOL is calculated to fit the full-grown eye and so the postoperative refraction even with an implanted IOL is largely hyperopic in infants. In industrialized countries, the prognosis for obtained vision is relatively good in bilateral cases (Lundvall & Kugelberg 2002a) due to early diagnosis, surgery, and management by paediatric ophthalmologists. In unilateral cases, good vision can sometimes be achieved if the child is operated before 3 months of age and the parents adhere to the occlusion therapy schedule (Lundvall & Kugelberg 2002b). After cataract surgery, anti-inflammatory and mydriatic eye drops are prescribed for several weeks; the drops need to be instilled 8–10 times a day. Insertion and removal of the contact lenses as well as administering the eye drops require a firm holding of the infant, often engaging both parents.

In Sweden, all children are screened for congenital cataract first at the maternity ward and then 4 weeks later at the health care centre. Approximately 40
children in Sweden are born with the disease every year and more than 100 children develop cataract within the first few years of life (Abrahamsson et al. 1999). If suspicion of congenital cataract arises in the maternity ward, the child is referred to an ophthalmologist who confirms the diagnosis and, if necessary, refers the child for surgery. Currently, the operations and follow-up visits in Sweden are located at two hospitals appointed by the Swedish National Board of Health and Welfare to perform National Specialized Medical Care of children with a congenital cataract: St. Erik Eye Hospital in Stockholm and Sahlgrenska University Hospital in Gothenburg. In Stockholm, the preoperative visit and all follow-up visits take place at the St. Erik Eye hospital, but in children under 1 year of age and under 10 kg the surgery itself is performed in a nearby paediatric hospital by surgeons from the St. Erik Eye Hospital.

For some families, this centralized care means travelling a long way to the clinic within the first year of life, as visits are scheduled at least once a month and even more often if complications arise.

The clinical outcome of the surgery is closely monitored in the Swedish Paediatric Cataract Register (PECARE), which focuses on measurable parameters such as visual outcome and possible complications. There are a few studies that address the parental situation, including a PECARE-based study from 2015 in which parents expressed a need for more information (Gyllen et al. 2019b).

In 2016, an interview-based study involving both children and their parents revealed a wide range of cataract-related concerns in the physical, emotional, and social domains (Castañeda et al. 2016). A 2017 study used a validated questionnaire to show that the quality of life for children with visual impairment due to congenital cataract could be compared to the grading of children with severe congenital cardiac defects or liver transplants (Tailor et al. 2017). In 2019, two studies based on interviews with parents showed the importance of family care, in terms of the parents’ role as co-caregivers (Gyllen et al. 2019a) and the need to guide parents in finding a balance between uncertainty and acceptance in order to achieve self-efficacy (Gyllen et al. 2019b).

Having a child with congenital cataract that requires surgery, contact lens treatment, and frequent medication is a life-altering experience. Even though there are a few studies on the subject area, more in-depth knowledge is needed about families’ experiences in relation to having a child born with congenital cataract. The aim of this study was to explore parents’ experiences regarding diagnosis, surgery, and subsequent care.

**Material and Methods**

**Design and sample**

Individual interviews were conducted by one of the researchers (SDL) with nine parents recruited from the St. Erik eye hospital. Eighteen parents of a total of 10 children aged 12–24 months at the time of the interviews, met the inclusion criteria for the study, the child had been operated for congenital cataract before the age of 3 months and had visited the contact lens team at least once within 6 months prior to the interview. Before recruiting, five parents were excluded, one was the parent of a child with a severe systemic disease and two parents were not living in Sweden having a different health care system which might have influenced the result and two parents were not able to understand and express themselves in Swedish or English. Hence, 13 parents of a total of seven children were invited over the phone to participate in the study, of which two declined for unknown reasons. Of the 11 parents who agreed to participate, two cancelled their interviews due to sickness, resulting in interviews with nine parents to a total of five children. The interviews lasted for 27–55 min and were conducted within a time span of 10 days during October 2018 in the homes of the participants, who lived at different distances (56–560 km) from the clinic. Before the interview, the parents completed a questionnaire on demographic data such as age, gender, place of residence, education, and occupation. In cases where both parents participated, they were interviewed separately and subsequently to avoid interfering with each other.

**Data collection and analysis**

The data were collected via interviews conducted in Swedish with the help of a semi-structured interview guide. As described by Tod (2015) and Polit & Beck (2017), the semi-structured interview guide consisted of topics to be covered during the interview. During the interviews, the laddered technique described by Price was used, starting with questions about action, moving on to questions about knowledge and ladder up to questions of a more philosophical character (Price 2002).

The interview topics were discussed with the contact lens coordinator at the clinic, whose function is to link between the parents and the hospital and has good knowledge of what type of questions and concerns the parents have. Furthermore, it was piloted on a parent not included in the study. The interviewer (SDL) was an optometrist who worked with fitting contact lenses to babies after cataract surgery and had a preunderstanding of the parental situation. All interviews were audio-recorded, listened to, and transcribed verbatim. The topics in the interview guide covered the parents’ experiences of getting the diagnosis, information, hospital care, support, and coping with the life-altering experience. Questions included: Can you tell me where you were when you got the diagnosis? What information did you get? Can you describe the day of surgery? What experiences do you have from the care and health care staff in connection with the surgery? How did it work out to manage the contact lenses at home in the beginning? Did you have anyone to turn to if you had questions?

The data from the interviews were rich and the nine interviews were considered sufficient to obtain information power (Malterud et al. 2016). Early in the analysis process, it was identified that the data covered two different areas and so the data were divided into two domains. The first domain, which is the focus of this article, covered the child being diagnosed with congenital cataract, the experience of the surgery, and hospital care. The second domain covered the parents’ adaptation to their new life situation; this data is currently being analysed and the results will be presented separately.

The interviews were analysed using qualitative content analysis with an inductive approach according to Graneheim & Lundman (2004). Each transcript was seen as a single unit of analysis. First, the text was read several times to gain an overview and understanding of the content. The text was
Table 1. Example of meaning units transferred to condensed meaning units, subthemes, and theme.

<table>
<thead>
<tr>
<th>Quotation</th>
<th>Condensed meaning unit</th>
<th>Code</th>
<th>Subtheme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>First author: Did he say there was something weird?</td>
<td>Parent 8: Yeah, he said he saw, I don’t remember his words but he saw there was something with the lens. That he didn’t get the reflex he wanted but he was unsure because he didn’t know if he was doing it right. And then we were uncertain about it and didn’t know what that meant.</td>
<td>He said he thought there was something with the lens because he did not get the reflex he wanted, but he was unsure if he was doing it right</td>
<td>Suspicion of cataract</td>
<td>Insecurity during the time around diagnosis</td>
</tr>
<tr>
<td>First author: Did you try to find information yourself? Online or something? Parent 5: Yes, we did. Absolutely.</td>
<td>We searched on congenital cataracts but tried to stick to medical pages without Googling around too much</td>
<td>Searching for information</td>
<td>Lacking information about the diagnosis</td>
<td>Living in a turbulent time before the diagnosis</td>
</tr>
</tbody>
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Results

Three themes emerged from the data: living in a turbulent time before the diagnosis, coping during the time of initial treatment, and managing the responsibility of their child’s visual development. The themes, derived from six subthemes, are shown in Table 2 and illustrated by quotations in the text.

Theme 1: Living in a turbulent time before the diagnosis

If suspicion of congenital cataract arises at the 48-hr checkup at the maternity ward, this may well be the first time the paediatrician has come across it, since it is a rare disease. Their knowledge cannot, therefore, be expected to be extensive and the patient is referred to an ophthalmologist at the regional hospital to confirm the diagnosis. If the suspicion is confirmed, the child is referred to one of the two hospitals in Sweden that handle the medical care of children with a congenital cataract.

Insecurity during the time around diagnosis

All parents described a stressful feeling of living in uncertainty for weeks, from the first realisation that something was wrong until getting the confirmed diagnosis and finally the surgery. The initial information given at the 48-hr check-up before the child was referred to an ophthalmologist was very brief in all cases.

We got it (the preliminary diagnosis) at the maternity ward at John’s check-up. She saw that he had no reflex in his left eye. Then she immediately said “I suspect it’s cataract,” and then she said “Do you understand what that means?” We said “No…” She didn’t say much more and we didn’t understand either. At that point, we’d only heard about it in elderly people. (Parent 3)

He (the doctor) looked quite a lot of times and said “I’m very unsure. I don’t really know if there’s anything here,” and then he started talking about the red reflex. We didn’t get any more information about it except that we’d get a referral to an ophthalmologist a few days later. So we didn’t really get more than a concern that something was going on. (Parent 9)

Once the regional ophthalmologist had diagnosed the cataract and written a referral, an anxious wait began for

Ethical considerations

The study was set up according to the Helsinki declaration and approved by the ethical review board in Stockholm (No. 20 18/693-3 1/2). Written informed consent was obtained and the participants’ confidentiality was ensured. Pseudonyms were used for the participants, their children, and other relatives. The distance to the clinic was of value to the research question, but will be mentioned only in terms of the distance between the home and the clinic in order to avoid identification since the population is small.
the parents. Many of them expressed a desire for a contact person to address their questions before they got to the eye hospital, which in most cases took 2–4 weeks. Some of them reached out and tried to make contact themselves, with varying results:

We both thought we were on our own, with nobody to turn to in the gap between the maternity ward and the eye hospital. I called and tried to find out how things would work in practical terms on the day of the operation. The person I was talking to didn’t seem to know, and it was difficult to get an answer about how things would work with fasting and a hotel and so on. (Parent 5)

In one case, a mother got very good assistance from a nurse at the child care centre. The nurse did not know anything about congenital cataract, but she knew how to guide the family through a difficult time and helped them with practical arrangements.

Lacking information about the diagnosis
There was substantial variation in how much information was provided by the first ophthalmologist and how the parents’ questions were answered, which was reflected in how they coped with the situation. However, all of them said that they experienced the information as insufficient and that they sought answers on their own:

It took three weeks before we got to the regional hospital and met a doctor who said that she had cataracts. We asked what that meant but he just said “She has cataracts, you’ll get a date for surgery. Bye!” We asked if it would be good after the operation and he replied that it depended on how we handled the aftercare. I was on Google before we left the room. (Parent 7)

I Googled everything and came across family pages where people wrote about it and it sounded problematic. You’d have to keep on with contact lenses, there were eye drops, and it sounded really tough. So I built up a lot of concern before we went there. (Parent 9)

Theme 2: Coping during the time of initial treatment
When a child is referred to the eye hospital for assessment and possible surgery, a pre-surgical examination is booked for the day before the planned operation. This visit includes an examination by a paediatric ophthalmologist, a cataract surgeon, an orthoptist, and an optometrist. The parents are informed about the disease, how the surgery is performed, and the aftercare including eye drops, contact lenses, and in unilateral cases patching. Following this assessment, the family is transferred to the children’s hospital for preanaesthetic evaluation.

Need for information about the treatment
The regional ophthalmologists always referred the child to the eye hospital for final diagnosis and surgery if needed. Most of the parents felt that the information from the operating unit before the visit was unsatisfactory:

Someone from the eye hospital called us and we got a date and a time that we wrote down. However, it was just that phone call and it felt a bit volatile. When you’ve got a newborn, everything’s very messy, and you’re just dazed. It felt like you really wanted a piece of paper or some mail with the information so you could have looked at it if you became uncertain. (Parent 8)

In order to make the parents feel secure about the operation, it was crucial for them to receive sufficient information about the treatment and for the health care professional to be perceived as competent. All parents described a sense of relief when they came to the operating unit and got their questions answered. However, most of them pointed out that there was a lot of information to take in at once:

The visit didn’t take very long; we felt that we didn’t really get… this broader information about the disease and the consequences. It felt like it was very practically oriented. We thought it was difficult in that situation to ask questions. We hadn’t really been able to formulate them yet. (Parent 6)

This was also reflected by parents who expressed a need for more written information or links to reliable information on the condition and treatment:

I would have liked to receive a list of papers on children with congenital cataracts, with statistics on visual acuity and the risk of complications. (Parent 4)

We wanted to know more about what it would mean if we decided against the operation, because that, and general anaesthesia, is not something you just do, I think. Adam (the father) read a lot and also called and talked to the surgeon the day before the operation. The choice we made was ours. We listened to the surgeon, who has long experience, and we felt that the surgery would give him (their child) the best chance. (Parent 3)

Feelings in relation to surgery
All parents described anxiety before and during the operation and anaesthesia, and said that leaving their child with the operating unit was especially distressing. Children under 3 months of age

Table 2. Subthemes and themes.

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Theme</th>
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<tbody>
<tr>
<td>Insecurity during the time around diagnosis</td>
<td>Living in a turbulent time before the diagnosis</td>
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<tr>
<td>Lacking answers about the diagnosis</td>
<td>Coping during the time of initial treatment</td>
</tr>
<tr>
<td>Need for information about the treatment</td>
<td>Managing the responsibility of their child’s visual development</td>
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<tr>
<td>Feelings in relation to surgery</td>
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<tr>
<td>Managing the aftercare</td>
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<tr>
<td>Making return visits work in everyday life</td>
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were handed over awake and the parents were not allowed in the operating room during the sedation. One mother described this as horrible and the worst thing she had ever done. In one case, this routine was not communicated to the parents beforehand at all, leading to a very traumatic experience:

They said they thought I was going to be allowed in, but when we got to the door, we were told that we weren't. It felt awkward, crying and panic. Who will take care of her? It would have been good to know in advance that when she's under three months they'll take care of it. (Parent 1)

All of the parents said that the nursing staff in the paediatric hospital cared for them very well, which made them feel more at ease in a stressful situation. After the surgery, they all expressed a feeling of relief.

Theme 3: Managing the responsibility of their child's visual rehabilitation

All of the parents expressed an awareness of the great responsibility they had in giving their child the best possible conditions for visual development by managing the eye drops, contact lenses, and sometimes patching of one eye. This was time-consuming in everyday life and was described as stressful in the beginning.

Managing the aftercare

Several parents said that they had not fully understood that the topical steroid drops were to be administered eight times a day and the mydriatic eye drops three times a day in the beginning and stated that they wished they had been given more information on this beforehand:

What we didn’t expect before, that might be a good tip for others, is that it might not be so easy to put the eye drops in by yourself. There might need to be two of you, and then you might need to prepare for the other one to be home from work, or work from home as Eric did then. I could do it if necessary, but it wasn’t easy and I wasn’t sure it was perfect. (Parent 5)

When the parents learned that their infant needed contact lenses, all of them described a feeling of wondering how this would even be possible. However, when they described the visit to the nurse to learn how to handle the contact lenses, all of them said it was easier than expected and they went home with the feeling that it would work. The big challenge was to get into a routine with the contact lenses at home in everyday life, for example how to arrange the nursing table so that one parent could hold the baby and the other one could insert or remove the lens. One parent said they only managed to remove the contact lens when the baby was deeply asleep:

Having to wait until he was sleeping deeply was pretty hard. He fell asleep at ten, so at half past ten he'd be sleeping deeply enough, and we could start trying to remove the lens. We were tired and it was frustrating. (Parent 4)

Inserting and removing contact lenses, as well as installing eye drops, often required the child to be held very firmly. The parents struggled with a feeling of abuse in the situation:

And above all, how does he experience it himself? When you hold him like that so he can't move? That thought was the strongest, and you don’t get an answer to that. It was probably the hardest thing, to see him like that. When you can’t explain at all what it means. (Parent 6)

Being well informed about visual development helped the parents to follow the treatment plan. They felt that it just had to be done. In order to do this, they distanced themselves emotionally:

Well, it had to be done. Of course, it's not fun, but it's for her own good. It's because she's going to get as good vision as possible, and then you can't just skip it because she doesn't want to. You just had to do it anyway, so it didn't feel that hard after all. (Parent 2)

In unilateral cases, patching of the healthy eye was necessary to achieve visual development on the operated eye. When the child was old enough to remove the patch, they would often do so, which led to a struggle between the child and the parent. The parents had to be innovative in order to keep the eye patched for the recommended daily amount of hours:

Parent: Some days it isn’t possible. She'll just decide that today she won't.

Interviewer: What does she do then? Remove it?

Parent: Tears it away, yes. Then she might throw away ten patches that day. It's just not possible, she won't have it. But some days she doesn't care at all. (Parent 7)

Making follow-up visits work in everyday life

During the first year, there were follow-up visits at least once a month, and even more often if complications occurred. The parents were confident in the competence of the staff at the clinic, and hence felt secure about the care and did not find the journeys to be a problem. However, two parents living a long way from the clinic pointed out that the travel arrangements could be better. Their home county only paid for train tickets and not flights:

What is included is the train, but it takes six hours, which means getting up at five in the morning and returning at ten in the evening, so I've chosen to pay for flights. That's a financial setback, it's tough. Still, I'd rather do it than sit on the train for 10–12 hours. (Parent 1)

Once the child was registered as a patient at the clinic, a contact lens coordinator was the link between the parents and caregivers. The parents could contact the coordinator with all types of questions, which made them feel safe:

We've had this number for the coordinator all the time so you can call. So, it's never like when you hear criticism of health care in the media (reference made in relation to the health care system in general, not St. Erik Eye Hospital). /.../ that's why you're so pleasantly surprised when health care works. We always get appointments, and we
Discussion

It is inevitably stressful to have your newborn child undergo surgery. However, all the parents in this study seemed to understand that it was something that needed to be done. They felt well cared for and had confidence in the surgical team, which helped them to cope well with the situation. Our study shows that most areas for improvement in the care of children born with congenital cataract are linked to uncertainty due to poor information before the visit to the eye hospital.

Our results reveal that in the time between receiving the preliminary diagnosis at the maternity ward and getting the diagnosis confirmed by a paediatric ophthalmologist, there is a need for reliable information on the condition, the surgery, and likely the long-term outcome. This desire is shared with the parents of children with other congenital diseases such as VACTERL association (Kassa et al. 2019) and congenital heart disease (Bratt et al. 2015). The lack of information leaves the parents in a state of uncertainty, which leads them to seek information on their own with the risk of ending up on non-academic websites or social media platforms with misleading or even inaccurate information. Again, there are parallels to parents whose children are born with congenital heart disease (Williams et al. 2019). Several parents proposed that the situation could be improved by using the eye hospital’s website to link to reliable information and current articles in the area. Another suggestion was a more informative appointment where there was more time for questions, perhaps with a nurse, orthoptist, or optometrist, in order to help them handle the information overload that they experienced at their first visit to the eye hospital.

Two of the parents in the present study described how they contacted the eye hospital with questions regarding practical arrangements before the visit, but were not able to get any answers. Furthermore, two parents were given incorrect information, in one case on the routines for anaesthesia, and in the other on the importance of not delaying the surgery for too long given the visual development. Along with the different levels of knowledge about the diagnosis amongst the different health care professionals that the parents encountered on their child’s path from preliminary diagnosis to surgery, this shows a need to establish early contact with a specialist eye hospital. Ideally, this contact would be made at the time of writing the referral. This is supported by our finding that once the surgery was done and the aftercare programme had started, the parents in this study had easy access to the contact lens coordinator and received good help from them. Gyllen et al. (2019a,b) have proposed an extension of that role to a case manager who guides the parents through the child’s treatment plan.

Parents of children with congenital diseases frequently use social media platforms out of a desire for more information. In a previous study, 97% of parents active in Facebook groups related to their child’s disease stated that they used Facebook pages for support and 85% wished for more interaction from health care professionals. The study concluded that health care needs to adapt to the use of social media and the opportunity to use it for additional support (Jacobs et al. 2016). Many hospitals today have official pages on social media platforms and one way to address this could be a section for congenital cataract on the hospital’s social media accounts monitored by the coordinator. Another way to provide information is through the use of smartphone applications. A recent review showed that smartphone apps are a well-functioning method for providing health care services to families with children and adolescents with cancer (Mehdizadeh et al. 2019). The advantage of a smartphone app in relation to social media platforms is that it is easier for the hospital to verify that the information contained there is accurate. For congenital cataract, this information could include facts about the disease, links to current research and support groups, and practical tips. In the present study, all parents seemed to be well acquainted with why the aftercare was so important for visual development and followed the programme carefully. However, there is a lot to keep track of, such as the frequent administration of eye drops and the number of hours the eye patch should stay on, and an alarm function in the app could facilitate this. The contact lens treatment is usually easier to handle than parents expect, after an initial ‘run-in period’. The feeling of doing what is best for the child counteracts the feeling of abuse. However, parents often have problems with the patching, because children can be more active there and remove the patch themselves. This then becomes a struggle between the child and parent, with the parent having to be innovative in order to keep the eye patched for the recommended daily number of hours (Dixon-Woods et al. 2006). Practical tips in an app could be helpful here.

Methodological considerations

Different options for data collection were considered when planning the study. A validated survey could have been an option if the population had been larger. However, the inclusion criteria were set narrowly in order to avoid recall bias. It was important that there was not too long a time between the surgery and the interview, but, conducting the interview too soon after the surgery would have risked it becoming too emotional. Because of the small material, it is difficult to draw general conclusions. However, 69% of those who fulfilled the inclusion criteria participated in the study. A semi-structured interview guide was used, and so the interviews did not all follow exactly the same pattern, which needs to be considered in the analysis process. The choice of a semi-structured interview guide was made according to Hand, who suggests that prior knowledge on the subject is an asset rather than a weakness when formulating the questions (Hand 2003). The parent and the interviewer worked together in the interview as part of the process of gaining information, rather than making the researcher totally objective. The participants were from different backgrounds in terms of the level of education and previous knowledge of congenital cataract, different in age, and geographically dispersed; nevertheless, it is worth keeping in mind that all of them were recruited from one out of two possible hospitals. One limitation is that all participants were native speakers of Swedish and so there was always a direct contact with the coordinator. (Parent 3)
no opportunity to elicit information on how a person who struggles to understand the language or receives information through an interpreter experiences the care. Another limitation is that, as the care team is on a rotating schedule, the interviewer was a part of the team on a few occasions before the interviews (ranging from 1-4 times). However, the role is only to assess the contact lens fit as it is the ophthalmologist that is the main caregiver. A strength of the study is that all interviews were conducted by the same person (SDL) using the same interview guide. Furthermore, all the interviews were analysed by the same two researchers (SDL and MJ). When planning this study, it was to our knowledge the first one done in this area, and so it was considered theory generating rather than theory testing. However, after the analysis was finalised Gyllen et al. (2019a,b) presented two studies on the topic where the results derived from interviews with parents from the other hospital appointed by the Swedish National Board of Health and Welfare to perform National Specialized Medical Care of children with a congenital cataract. Although their setting differs in terms of selection criteria and choice of method, their conclusions are well in line with ours, so it was considered theory generating and assessing evidence for nursing practice. Philadelphia, USA: Wolters Kluwer.


