Young Hip: an exploration into young patients' (aged $\leq$ 50 years) expectations following primary total hip arthroplasty

a qualitative study

From Milton Keynes University Hospital, Milton Keynes, UK

Correspondence should be sent to L. E. Mew louise.mew@mkuh.nhs.uk

Cite this article:
Bone Jt Open 2025;6(7): 807–815.

DOI: 10.1302/2633-1462.67.BJO-2025-0013.R1

L. E. Mew,[1,2] **V. Heaslip,**[3,4] **T. Immins,**[2] **T. W. Wainwright**[2,5]

[1]Milton Keynes University Hospital, Milton Keynes, UK
[2]Orthopaedic Research Institute, Bournemouth University, Poole, UK
[3]Equity School of Nursing and Society, University of Salford, Salford, UK
[4]Department of Social Work, Stavanger University, Stavanger, Norway
[5]Physiotherapy Department, University Hospitals Dorset NHS Foundation Trust, Poole, UK

Aims

Total hip arthroplasties (THAs) are common operations performed in orthopaedics. Though initially developed to address hip conditions in older patients, demand in younger patients is increasing. Research in older populations informs current practice, and it is unclear if outcome priorities are the same in younger patients. The study's aim was to explore the expectations and priorities of younger patients' (aged < 50 years) undergoing THA.

Methods

Using interpretive phenomenological analysis (IPA) methodology, ten patients were recruited from one UK hospital. Semistructured interviews occurred at three timepoints (pre-surgery, six weeks, and six months post-surgery). This study has been reported using the COnsolidated criteria for REporting Qualitative research (COREQ).

Results

Six themes were identified: 'I'm just constantly in pain', 'Giving up hope', 'Living a process that does not reflect me', 'This is not who I'm meant to be', 'My family didn't sign up for this', and 'I can't do anything'. Some themes were independent of patient age, such as pain, and experiences of healthcare. However, other findings may be more imperative to the younger patient than the older patient.

Conclusion

The Young Hip study highlighted aspects currently overlooked in younger THA patients. Participants were aware that they were not the accepted patient profile for THA, and expressed having to fight to be heard. Function was considered in terms of responsibilities and roles in society, rather than traditional clinical perceptions of mobility. The findings demonstrated that current care pathways are not fully addressing the needs of younger THA patients. Further development of a personalized THA pathway, allowing for more focus on person-centred care, could address issues raised by this study, more effectively supporting younger patients.

Take home message

- It is important to disseminate that total hip arthroplasty is appropriate for a younger age group, but their expectations, experiences, and insights are very different to an older population. This study shows that it is not just the surgery that is different, but the recovery.
- There was a disconnect between what healthcare professionals believed to be important to the participant, and the participant's own opinion.

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- Healthcare practitioners are using the research available to provide the best evidence-based practice possible to all patients. Unfortunately, this does not consider the younger patient's voice, nor does it recognize that this demographic potentially has very different priorities and needs compared to their older counterpart.

Introduction

Total hip arthroplasties (THAs) are recognized as cost-effective and successful interventions for painful and limiting hip conditions.[1] Despite originally being an operation targeted at patients aged over 65 years, demand for THA in younger patients is increasing.[2] In contrast to historical opinion, surgical attitudes towards THA in younger patients have become more positive.[3] This could potentially be attributed to the increase in implant survival times and reduction in revision surgeries, enabled by new surgical techniques and modern bearing surfaces and implants.[4] A reported 101,995 hip arthroplasties were carried out in the UK in 2022; 5,304 of these were in patients aged under 50 years.[5] Elective THA treats a diverse range of hip joint conditions, including (but not limited to) osteoarthritis, rheumatoid arthritis, avascular necrosis, and childhood conditions.[6-8] While underlying causes of these conditions vary, the presentation and symptoms can be similar.

Numerous studies focusing on younger patients explore implant type, implant survival, surgical methods, and outcomes using quantitative methods.[9-11] Patient-reported outcome measures (PROMs) are used in elective orthopaedic surgeries to measure the outcomes from the patient's perspective.[12,13] PROMs used in THA address a range of functional activities of daily living (ADLs), confining the patient's voice to only the topics included.[14] It is acknowledged that patients' priorities following orthopaedic interventions can differ from those of clinicians.[15] It is unclear if PROMs currently used in THA reflect aspects which are important to younger patients,[16] or primarily address topics that clinicians and healthcare professionals prioritize.

The purpose of qualitative research is to gain a deeper understanding of human behaviour, experience, and motivations of the participants.[17] Qualitative research has been instrumental in uncovering the absence of other orthopaedic patient priorities in existing PROMs,[18,19] indicating significant differences between quantifiable health outcomes and the patient-perceived quality of care. Qualitative findings exploring the patient's lived experience of undergoing THA and the efficacy of existing healthcare pathways are rare;[20] the voices of these younger patients are absent within the current evidence base.

The National Institute for Health and Care Excellence provides guidelines for professionals caring for patients undergoing THA.[8] The recommendations specify that additional rehabilitation support is indicated in patients with additional needs, such as dementia and cognitive impairment. Younger patients are not included in this category, despite their rehabilitation needs potentially differing from those of older patients.[21-23] Exploratory qualitative research into goals and priorities of these younger patients is essential to ensure they are met and supported.

The objective of the Young Hip study was to identify the priorities and expectations of the younger patient (aged $\leq$ 50 years) when undergoing a THA.

This study is reported in accordance with the COnsolidated criteria for REporting Qualitative research (COREQ) reporting guidelines.[24] The 32-point checklist is recommended to ensure the reporting of qualitative research be explicit and comprehensive (Supplementary Material).[25]

Methods

Young Hip was conducted using an interpretative phenomenological analysis (IPA) methodology. IPA has theoretical foundations in phenomenology and is recommended when exploring the experiences of individuals living through a significant event in their life, such as major surgery and joint replacement.[26] IPA uses an ideographic approach, allowing a rigorous exploration of the individual's personal lived experience and how specific phenomena affect the patient.[27] Ethical approval for the study was granted by NHS Research Ethics Committee (20/PR/0858) on 13 January 2021.

IPA methodology recommends that when determining sample size, it is more difficult to meet IPA requirements with larger samples, and advises caution with sample sizes over six participants.[26] In 2019, there were ten eligible patients recorded in the recruiting hospital (Milton Keynes University Hospital). Practicalities were considered, such as time constraints due to the pandemic, activities being conducted by a single researcher, and number of participants willing to participate and complete follow-up.[28]

Between March and November 2006, a purposeful homogeneity sample of ten patients fitting the eligibility criteria (Table I) were recruited. The sample was recruited consecutively; no patients declined to participate. Participants consisted of five males and five females; the youngest was aged 28 years and the oldest was aged 50 years (mean age 35.6 years (SD 9.38), median 39 years (IQR 36 to 49). Participants were given a pseudonym, ensuring confidentiality and anonymity. Anonymous participant characteristics are presented in Table II.

Participants were interviewed at three timepoints: preoperatively (between decision for surgery and operation date), six weeks postoperatively, and six months after THA. The longitudinal aspect of the study was implemented due to evidence that recovery continues until around six months.[30] Participants were given a study information sheet detailing why the study was being conducted, what was expected of them, and how the data generated would be used. Consent to participate was voluntary, and a consent form was completed prior to any study procedures. Efforts were taken to promote trusting relationships and a comfortable rapport between the researcher and participants, so clinical questions and terminology were intentionally avoided.[31] Information such as start of clinical symptoms, specific clinical diagnosis and potential underlying causes, date of diagnosis, and length of time on elective waiting list were not collected unless the participant volunteered the information within their interviews. To separate the researcher role from their clinical role, the researcher was never involved with participants' direct care.[32] Participants chose the time and place for the interviews that they were most comfortable with, allowing for

Table I. Inclusion/exclusion criteria.

Inclusion criteria	Rationale
Patients aged 18 to 50 years.	Consensus in the literature appears to classify 'young patients' undergoing THA as under 50 years, therefore the upper age limit was set to 50 to be congruent with the current literature available.[9–11,29]
Scheduled to undergo a primary elective THA in the next 12 to 18 months. Patients were still eligible if they had previously had a THA in the opposing hip.	All potential chronic health conditions resulting in the need for THA were included. Patients undergoing THA to treat traumatic fractures or dislocation of the hip joint were not eligible. This is due to the stark difference between patient pathways and experience prior to surgery.
Able to provide informed consent.	Participants had to have capacity to understand and consent to study procedures.
Exclusion criteria	
Undergoing a revision of THA in the index hip.	The study objective was to explore the lived experience of the patient undergoing a primary THA. Comparison between previous index hip surgery and experience of the revision may affect expectations and prioritized outcomes.

THA, total hip arthroplasty.

Table II. Participant characteristics.

Pseudonym	Sex	Age, yrs	Diagnosis
Claire	Female	40	Osteoarthritis
Diane	Female	50	Osteoarthritis
Annie	Female	49	Primary osteoarthritis
Patrick	Male	46	Osteoarthritis
Fran	Female	50	Osteoarthritis
Rob	Male	38	Idiopathic avascular necrosis
Chris	Male	33	Secondary osteoarthritis
Zoe	Female	36	Primary osteoarthritis
Henry	Male	36	Secondary avascular necrosis
Scott	Male	28	Rheumatoid arthritis

a quiet, confidential conversation. These interviews took place one-to-one and varied between face-to-face, telephone, and video call (Table III).

The public and patient involvement (PPI) exercise undertaken prior to the start of Young Hip also informed the study design and the potential important themes for exploration.[33] Guided by the PPI and IPA methodology,[26] an interview guide (Supplementary Material) was developed using a chronological format, with flexibility in adapting the question order and phrasing; this allowed open exploration of participants' perspectives and experiences, enabling participants to raise issues that may not have been anticipated. Participants dictated the interview length. The interviewer noted their thoughts and observations before and after each interview. Interviews were audio-recorded and transcribed verbatim by the researcher. The interview transcripts were not reviewed by participants unless requested. All interviews were conducted by one researcher as part of a PhD project (LM). The researcher is a nurse in the study hospital and has many years' experience in orthopaedics.

Results

Analysis followed the IPA six-step-process outlined by Smith et al.[26] An explanation of this process is in the Supplementary Material. Six superordinate themes were identified; each superordinate theme included several subordinate themes. Figure 1 presents the participants (identified by pseudonyms) in whose interviews these subordinate themes occur.

There was no clear distinction between priorities and goals which were important to the participants preoperatively, six weeks, and six months after surgery. Therefore, the findings are presented as a whole rather than divided into different time periods.

Living a process that does not reflect me

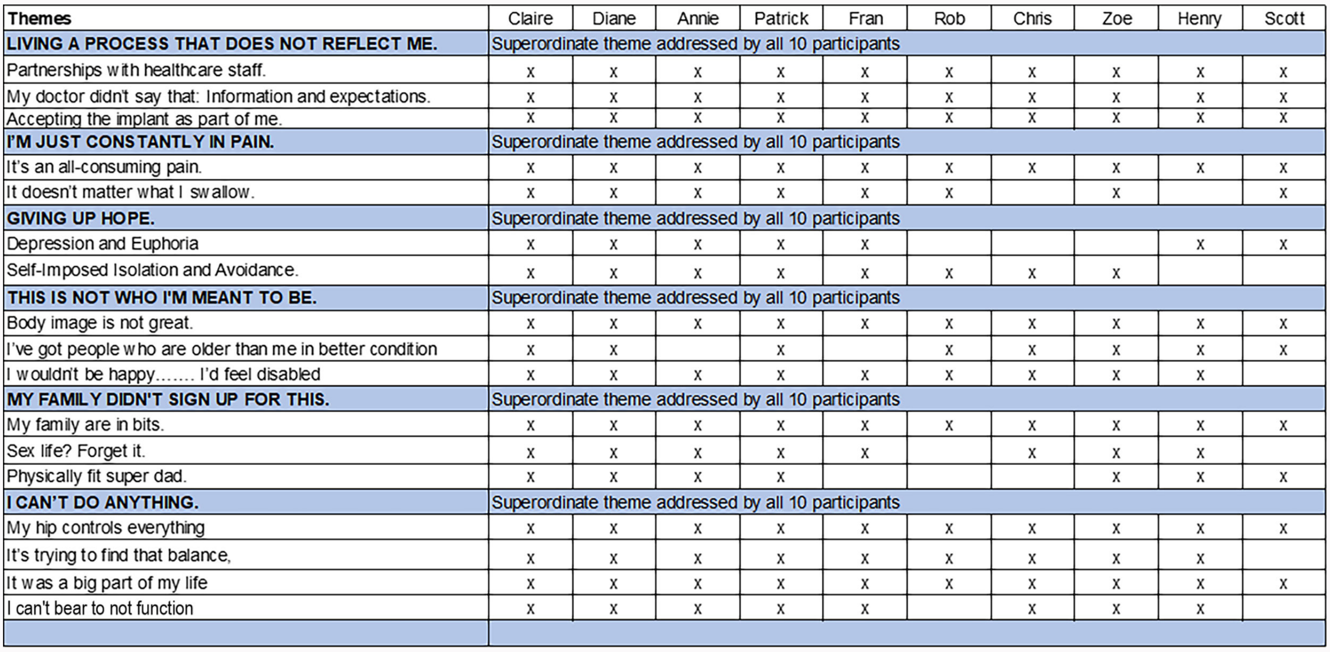
Participants were acutely aware that they were considered young for THA; they felt that they were at a disadvantage in comparison to other patients because of their younger age. They had to "fight" to be heard and be offered the same treatment as their older counterparts, to "battle" to have an equal voice.

> "I had to fight to get the operation." (Zoe, six weeks)

> "I had to really push …they're probably a little bit apprehensive to do… to give, you know a hip replacement to a 33-year-old." (Chris, baseline)

Information from healthcare professionals (HCPs) was often insufficient and inconsistent, resulting in unrealistic expectations for waiting times for surgery and the speed of recovery post-operation.

> "…recovery wasn't really explained at all, there was no, 'this is what to expect at this point and this is what to expect at that point', erm it was more kind of, 'let's get you up and walking' for discharge." (Zoe, six weeks)



Themes	Claire	Diane	Annie	Patrick	Fran	Rob	Chris	Zoe	Henry	Scott
LIVING A PROCESS THAT DOES NOT REFLECT ME.	Superordinate theme addressed by all 10 participants									
Partnerships with healthcare staff.	x	x	x	x	x	x	x	x	x	x
My doctor didn't say that: Information and expectations.	x	x	x	x	x	x	x	x	x	x
Accepting the implant as part of me.	x	x	x	x	x	x	x	x	x	x
I'M JUST CONSTANTLY IN PAIN.	Superordinate theme addressed by all 10 participants									
It's an all-consuming pain.	x	x	x	x	x	x	x	x	x	x
It doesn't matter what I swallow.	x	x	x	x	x	x		x		x
GIVING UP HOPE.	Superordinate theme addressed by all 10 participants									
Depression and Euphoria	x	x	x	x	x				x	x
Self-Imposed Isolation and Avoidance.	x	x	x	x	x	x	x	x		
THIS IS NOT WHO I'M MEANT TO BE.	Superordinate theme addressed by all 10 participants									
Body image is not great.	x	x	x	x	x	x	x	x	x	x
I've got people who are older than me in better condition	x	x		x		x	x	x	x	x
I wouldn't be happy……. I'd feel disabled	x	x	x	x	x	x	x	x	x	
MY FAMILY DIDN'T SIGN UP FOR THIS.	Superordinate theme addressed by all 10 participants									
My family are in bits.	x	x	x	x	x	x	x	x	x	x
Sex life? Forget it.	x	x	x	x	x		x	x	x	
Physically fit super dad.	x	x	x	x				x	x	x
I CAN'T DO ANYTHING.	Superordinate theme addressed by all 10 participants									
My hip controls everything	x	x	x	x	x	x	x	x	x	x
It's trying to find that balance,	x	x	x	x	x	x	x	x	x	
It was a big part of my life	x	x	x	x	x	x	x	x	x	x
I can't bear to not function	x	x	x	x	x		x	x	x	

Fig. 1

Identified occurrences of superordinate and subordinate themes in participant data.

Table III. Details of interviews.

Interview	Claire	Diane	Annie	Patrick	Fran	Rob	Chris	Zoe	Henry	Scott
Baseline										
Medium	Telephone	Video call	Telephone	Face to face	Telephone	Face to face	Telephone	Telephone	Telephone	Telephone
Duration	49 mins 5 s	36 mins 12 s	59 mins 16 s	49 mins 19 s	27 mins 27 s	12 mins 24 s	24 mins 25 s	38 mins 2 s	28 mins 10 s	21 mins 11 s
6 weeks										
Location	Face to face	Telephone	Face to face	Telephone	Telephone	Face to face	Face to face	Telephone	Telephone	Face to Face
Duration	43 mins 0 s	26 mins 41 s	11 mins 31 s	27 mins 40 s	26 mins 41 s	9 mins 44 s	23 mins 25 s	31 mins 12 s	17 mins 1 s	30 mins 24 s
6 months										
Location	Telephone	Telephone	Telephone	Telephone	Telephone	Telephone	Telephone	Telephone	Telephone	Face to Face
Duration	22 mins 48 s	26 mins 28 s	21 mins 28 s	33 mins 5 s	17 mins 25 s	6 mins 42 s	9 mins 55 s	26 mins 51 s	7 mins 55 s	11 mins 47 s

Expectations of both participants and clinicians were more optimistic due to their younger age; they presumed they would recover faster than older patients.

> "I thought I'd be up and walking like normal, within a week, you know, listening to all the old people that I've met who had had it." (Rob, six weeks)

This impacted the care provided after surgery.

> "…they didn't book me in for any follow-up or for any physio… they said because I'm young and because of that I would bounce back quicker, so they weren't worried about providing physio." (Zoe, six weeks)

I'm just constantly in pain

Living with pain was expressed by all participants as a major impact.

> "It's an all-consuming pain, every movement." (Zoe, six months)

Eager to avoid dependence on pharmaceutical medications and over-medicating, many participants preferred to tolerate levels of pain. They found limited support with managing their pain medications and attempting to reduce them.

> "It got to the point where I went to the GP to see about my medication and she said, well what do you expect me to do?" (Claire, six weeks)

Giving up hope

All participants reported a negative impact on their mental health as a consequence of their hip condition. Some acknowledged the psychological impact briefly, whereas for others, the negative implications on mental health were significant, resulting in depression, thoughts of self-harm, and suicidal ideation.

> "I was at the end of my tether; I didn't have any more give in me to try and keep going on. I needed the pain gone, telling people to…do whatever you have to do, just get rid of it or I'll get rid of myself." (Claire, six months)

Self-imposed isolation was a choice for many.

> "I just want to sit, and just sit on my own and just shut myself away because there's like nothing, I just don't want… I can't do nothing. It's horrible, I hate it." (Diane, baseline)

Not all participants experienced positive outcomes after THA; for some, there were expectations that their lives would begin again once the operation occurred, improving all negative aspects of their lives prior to surgery. This was not the experienced result.

> "…nothing changes. I expected like, you know, something like…'oh yeah, I'm feeling better, I've been aqua, I can do this, I can do that', and I can't even say I can do that." (Diane, six months)

This is not who I'm meant to be

Participants expressed negative body image caused by physical signs of their hip condition. Muscle wastage and the inability to exercise were highlighted as impacting body shape pre-surgery. After THA, scarring, leg length, and hip shape were cited as concerns.

> "I see old pictures of myself and that, I mean I used to have muscles, I used to be buff, and now I can't do anything, my legs are like b****y twiglets." (Rob, baseline)

Regaining the appearance of being as capable as others their age was a priority. The fear of being considered 'disabled', weak, less capable, or even less 'attractive' than others their age who had no limitations was apparent throughout.

> "…had one situation where the kid… sort of doing an impression of my walk… it does make me feel a bit s****y." (Chris, baseline)

Participants wanted society to view them as strong, capable individuals. It was important that any outwardly visible signs of disability or restricted function be minimal.

My family didn't sign up for this

Support from families, or the absence of support, was integral to the participants' mood and mental health throughout recovery.

> "My wife's been brilliant…erm…to be quite frank with you, the first couple of weeks, I genuinely struggled." (Patrick, six weeks)

The balance in relationships altered, because of the severity of the participants' condition and its overwhelming effect on their lives; emotional, physical, and in some cases financial support was solely provided by their partner.

Sexual activity (SA) was a significant concern for female participants. Male participants described the effect their hip condition had on intimate relationships as a factor, but not the primary reason, for the loss of intimacy.

> "Sex life, forget it, that's gone out the window, there's not many positions I can get into that is comfortable." (Annie, baseline)

For some, sexual relationships improved drastically after surgery. Unfortunately, this was not the scenario for all. Though function had improved, other factors remained, primarily confidence in ability post-surgery.

> "I don't think I would, just not knowing how flexible I would be, what positions would work." (Zoe, six months)

SA and intimacy were not commonly discussed with HCPs. When the subject was addressed, it focused on functional ability, rather than participants' feelings surrounding intimacy and perception of SA within this.

> "The consultant asked me a while ago, 'was I physically able?' I was like 'yes', he said 'good'; erm didn't really get into whether or not we were, but it was just kind of like could you still?" (Patrick, baseline)

Fulfilment of roles within social relationships and family units was identified as a significant priority. Whether a parent, partner, or support for their family, the failure to fulfil these roles caused distress and guilt to participants and was often one of the primary reasons to undergo surgery.

> "She is sort of my main carer so she, kind of err…she ends up helping me get dressed at times and looking after me if I can't get up or move easily." (Scott, baseline)

Failure to fulfil parenting roles for their children was an emotional aspect of the interviews. The perception of failure as parents was profound.

> "It just doesn't feel like you're parenting well, kind of failing at your job." (Zoe, baseline)

I can't do anything

The hip condition had an all-consuming impact on life. Participants identified it as all-encompassing, replacing and altering their personality, forcing them to compromise their lifestyle, and controlling every aspect of their life.

> "…it's become me, do you know, it's the only thing that I can concentrate on." (Zoe, baseline)

For some, the operation resulted in them becoming themselves again, the person they had lost.

> "I feel like I'm more than just a bad hip." (Claire, six months)

Mobility and active functional movement in limbs and joints were discussed; however, participants focused on how limited mobility and active functional movement affected their ability to contribute and play active roles in society.

> "…being 28, I want to be active, I want to do things, I want to go out, you know I want to do things with my partner, it's just got to that point where we can't do that." (Scott, baseline)

Post-surgery, though physically their function had improved, their confidence to actively participate in society took longer to recover.

> "I think it's trying to find that balance. You start to feel more and more normal as you're doing more and more, but you're also trying to rein that in because you're not necessarily as ready as you think you are." (Patrick, six weeks)

Physical activity and sport contributed to multiple aspects of participants' lives, encompassing fitness, body image, social life, and mental wellbeing.

> "Five-a-side or being on the seven-a-side team was…I loved it, it was a big part of my life." (Chris, six weeks)

Participants felt huge pressure to recover quickly. This increased pressure was influenced by financial issues and the roles participants considered others of their age to be embodying in society (i.e. active, independent, useful).

> "I have to be able to go to work, erm as a family we don't have any other options really at the moment." (Patrick, six months)

Discussion

The Young Hip study set out to explore the young person's (aged < 50 years) expectations following primary THA, and identify what outcomes are important to them. Notably, many findings (for example: 'I'm just constantly in pain') could be generalized across all age groups, however some differences in priorities are evident.

Improvement of function is a primary goal for patients undergoing THA;[34] in older patients, the term function is used to describe mobility and range of motion within the joint.[34,35] Young Hip findings represent a different meaning of the term 'function'. This perception centres around responsibilities and roles in society; for example, functioning at work or fulfilling roles in their family or social life. This alternative meaning of function results in many areas of concern being overlooked in THA care pathways. Current outcome measures used for THA use the word 'function' to focus on mobility and physical aspects of ADLs. Participants did not feel that concerns and requirements which were relevant to them as a younger patient had been identified or addressed. They expressed that assessment questionnaires (such as PROMs) and pre-surgery pathways focused on older THA patients.

Insufficient or inconsistent information provided by HCPs had a direct impact on participant expectations. This included failing to manage realistic expectations or forcing participants to seek answers and advice from potentially inaccurate or misleading sources.

Preoperative education successfully decreases patients' preoperative anxiety,[36,37] and contributes to successfully managing patient expectations.[35,38] There is no existing evidence exploring whether preoperative education should be tailored to patient characteristics, for example to younger active patients or older sedentary patients.[39] Young Hip indicates that the younger THA patients are not benefiting as fully from these pathways as their older counterparts. Further research is vital in order to clarify whether preoperative education should be adapted formally to specific patient group demographics.

Self-image and patients' self-perception is highlighted with Young Hip. Changes to body shape, due to muscle wastage, leg length, and weight gain from inability to exercise, all impact self-confidence and self-image. Outcome measures used routinely in clinical settings do not address this. These concerns are not explored unless the participant addresses it to HCPs. The multifaceted theme of self-image (physical and psychological) has significant impact on many other aspects within the participant's experience, including mental health, relationships, and role fulfilment. The perception of beauty and the ideal body is inescapable in society, meaning the pressure to conform to the ideal is immense.

The participants felt increased pressure to recover quickly; this pressure was both self-imposed and displayed by others, such as family, friends, and at times HCPs. There was pressure to fulfil roles which society considered to be their responsibility. These roles varied, and the responsibilities required to undertake them were created by participants. They included that of parent, partner, provider, supporter, and fulfilling the norm of what their peers were physically capable of. This differs from the roles expected of the older THA patient, who society assumes should require extra practical help, may be retired with no financial dependants, and potentially has other comorbidities contributing to the commonly held view of a slower, less capable individual.

Despite the high occurrence of impaired SA in patients with chronic musculoskeletal health conditions, the impact of THA on SA and intimacy is often unaddressed by HCPs.[40,41] Like other aspects of recovery, clinical assessment of improvement in SA focuses on the patient's physical function rather than their underlying psychological concerns. Although there was a singular attempt to approach the subject of SA in a clinical appointment in Young Hip, it was insufficient in obtaining the information important to the patient, and focused on the physicality of SA rather than the nuances of intimacy valued in relationships.

Many participants described a feeling of losing oneself and being reduced to "just a bad hip". Struggling to maintain one's identity when confronted with loss of independence and reliance on others is recognized in research focusing on chronic conditions.[42,43] Those suffering from chronic illnesses perceive themselves as increasingly disabled and ineffective,[44] often subconsciously transferring that belief onto other people and assuming that others see them the same way.[45] This difficulty in maintaining self-identity is compounded by the fact that participants did not fit the accepted profile for patients requiring THA; they did not fit in with the 'norm' that was expected by others.

Although there were some examples of positive therapeutic partnerships and shared decision-making between healthcare staff and patients, this was not the norm. Shared decision-making enhances patient autonomy in decisions relating to their health, presenting patients with more control and power over their condition and treatment.[46] Guidelines advocate the importance of shared decision-making in all areas of healthcare.[8]

Within Young Hip, surgeons appeared to focus primarily on the biomedical health considerations and the expected survival time of the implant. There was a disconnect between what the surgeon believed to be important to the participant, and the participant's own opinion. Surgeons' opinions and priorities are recognized to differ greatly from those of patients when considering what constitutes successful outcomes.[15,38,47] HCPs are utilizing the research available to provide the best evidence-based practice possible to all patients; unfortunately, the research currently available does not consider the younger patient's voice, nor does it recognize that this demographic potentially has very different priorities and needs compared to their older counterpart. Greater awareness on the part of HCPs and wider public regarding the increasing incidence of THA in young people could have avoided some of the negative experiences recounted in this study. These appear to have been based on clinician and healthcare staff's own assumptions and unconscious biases, underpinned by experience and evidence-based practice utilizing the current quantitative outcome measures, such as radiological outcomes, revision rates, and PROMs.

Although congruent with an IPA approach, the participant sample size in this study was small. As such, further research and exploration are recommended within the themes identified. Involving participants from only one NHS hospital is also a notable constraint. The scope of the research was selected for pragmatic reasons, as the researcher worked within the Trust and was familiar with its policies and patient pathways.

Adult patients aged 16 to 27 years were not represented in the study, which potentially means that data from this age bracket are absent in the findings. All ten participants identified as Caucasian. This was unavoidable, as the sampling process was not selective based on race or culture. However, this lack of ethnic or cultural diversity may limit the broadness of data, and result in omissions of important findings unique to different cultural backgrounds.

The study took place during the COVID-19 pandemic, which meant that usual care pathways, standard preoperative education pathways, and many face-to-face appointments were suspended due to social distancing and lockdown requirements. However, the participants had been on the elective surgery waiting list for a significant time (> 18 months), and some had experienced the preoperative planning process prior to the beginning of the pandemic.

In qualitative research, the findings result from both the participant and the researcher's subjective interpretation. Thus, steps were taken to ensure the rigour and credibility of this study's findings. As recommended in IPA, the researcher strived to put aside their own experience and preconceived assumptions before every research encounter.[26] The finished analysis was assessed by two further researchers (TWW, VH) to ensure the findings were true to the data and participant's original narrative.

In conclusion, the impact of undergoing a THA as a younger patient is significant for both the patient and their family. Clinicians and participants appeared to differ in their priorities and perception of successful outcomes post intervention; this resulted in participants feeling as if their goals were disregarded and unaddressed. Participants identified that, as they did not fit the accepted older patient profile for THA, the current care pathway did not always suit their needs. A care pathway offers a standardized approach for the implementation of best practice care; however, the benefit of this is limited without enough flexibility to accommodate the needs of individuals who do not fit the expected patient profile. Developing a more flexible THA care pathway that recognizes the increasingly non-homogeneous nature of THA patients could help to address some of the issues raised by this study, and more effectively support the recovery of younger patients. Further work to determine suitable person-centred measures for this specific patient group might help to address some of the issues raised by taking account of the specific needs of young individuals post THA.

Supplementary material

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist, interview guide followed throughout data collection in the Young Hip study, and six steps of analysis in interpretative phenomenological analysis methodology - further guidance on the method of analysis used within the Young Hip study.

References

1. **Learmonth ID**, **Young C**, **Rorabeck C**. The operation of the century: total hip replacement. *Lancet*. 2007;370(9597):1508–1519.
2. **Kurtz SM**, **Lau E**, **Ong K**, **Zhao K**, **Kelly M**, **Bozic KJ**. Future young patient demand for primary and revision joint replacement: national projections from 2010 to 2030. *Clin Orthop Relat Res*. 2009;467(10):2606–2612.
3. **Kumar A**, **Bloch BV**, **Esler C**. Trends in total hip arthroplasty in young patients - results from a regional register. *Hip Int*. 2017;27(5):443–448.
4. **Kamath AF**, **Sheth NP**, **Hosalkar HH**, **Babatunde OM**, **Lee G-C**, **Nelson CL**. Modern total hip arthroplasty in patients younger than 21 years. *J Arthroplasty*. 2012;27(3):402–408.
5. **Ben-Shlomo Y**, **Blom A**, **Clark E**, **et al**. National Joint Registry: 20th Annual Report, London: National Joint Registry. 2023. https://reports.njrcentre.org.uk/Portals/14/PDFdownloads/NJR%2020th%20Annual%20Report%202023.pdf (date last accessed 1 July 2025).
6. **Ferguson RJ**, **Palmer AJ**, **Taylor A**, **Porter ML**, **Malchau H**, **Glyn-Jones S**. Hip replacement. *Lancet*. 2018;392(10158):1662–1671.
7. **National Institute for Health and Care Excellence**. Joint replacement (primary): hip, knee and shoulder. NICE Guideline NG157. 2020. https://www.nice.org.uk/guidance/NG157 (date last accessed 1 July 2025).
8. **Pavelka K**. Osteonecrosis. *Best Pract Res Clin Rheumatol*. 2000;14(2):399–414.
9. **Delasotta LA**, **Rangavajjula AV**, **Porat MD**, **Frank ML**, **Orozco FR**, **Ong AC**. What are young patients doing after hip reconstruction? *J Arthroplasty*. 2012;27(8):1518–1525.
10. **Adelani MA**, **Keeney JA**, **Palisch A**, **Fowler SA**, **Clohisy JC**. Has total hip arthroplasty in patients 30 years or younger improved? A systematic review. *Clin Orthop Relat Res*. 2013;471(8):2595–2601.
11. **Kiran M**, **Johnston LR**, **Sripada S**, **Mcleod GG**, **Jariwala AC**. Cemented total hip replacement in patients under 55 years. *Acta Orthop*. 2018;89(2):152–155.
12. **Larsson A**, **Rolfson O**, **Kärrholm J**. Evaluation of Forgotten Joint Score in total hip arthroplasty with Oxford Hip Score as reference standard. *Acta Orthop*. 2019;90(3):253–257.
13. **Wright JG**, **Young NL**, **Waddell JP**. The reliability and validity of the self-reported patient-specific index for total hip arthroplasty. *J Bone Joint Surg Am*. 2000;82-A(6):829–837.
14. **Hamilton DF**, **Loth FL**, **Giesinger JM**, **et al**. Validation of the English language Forgotten Joint Score-12 as an outcome measure for total hip and knee arthroplasty in a British population. *Bone Joint J*. 2017;99-B(2):218–224.
15. **Marmura H**, **Bryant DM**, **Birmingham TB**, **et al**. Same knee, different goals: patients and surgeons have different priorities related to ACL reconstruction. *Knee Surg Sports Traumatol Arthrosc*. 2021;29(12):4286–4295.
16. **Clement ND**, **Haddad FS**. Are the current minimal clinically important differences fit for purpose? *Bone Joint J*. 2024;106-B(10):1033–1035.
17. **Braun V**, **Clarke V**. *Successful Qualitative Research – A Practical Guide for Beginners. 2013*. Thousand Oaks, CA: SAGE Publishing.
18. **Archibald G**. Patients' experiences of hip fracture. *J Adv Nurs*. 2003;44(4):385–392.
19. **Zidén L**, **Scherman MH**, **Wenestam C-G**. The break remains – elderly people's experiences of a hip fracture 1 year after discharge. *Disabil Rehabil*. 2010;32(2):103–113.

20. **Mew L**, **Heaslip V**, **Immins T**, **Wainwright T**. What is important to the younger person (≤50 years) when having a total hip arthroplasty: a systematic literature review. *Orthop Nurs*. 2023;42(4):213–229.
21. **Malcolm TL**, **Szubski CR**, **Nowacki AS**, **Klika AK**, **Iannotti JP**, **Barsoum WK**. Activity levels and functional outcomes of young patients undergoing total hip arthroplasty. *Orthopedics*. 2014;37(11):983–992.
22. **Conner-Spady BL**, **Marshall DA**, **Hawker GA**, **et al**. You'll know when you're ready: a qualitative study exploring how patients decide when the time is right for joint replacement surgery. *BMC Health Serv Res*. 2014;14(1):454.
23. **Wijnen A**, **Seeber GH**, **Dietz G**, **et al**. Effectiveness of rehabilitation for working-age patients after a total hip arthroplasty: a comparison of usual care between the Netherlands and Germany. *BMC Musculoskelet Disord*. 2023;24(1):525.
24. **EQUATOR Network**. Enhancing the QUAlity and transparency of health research, consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Last updated 06/12/2023. https://www.equator-network.org/reporting-guidelines/coreq/ (date last accessed 24 June 2025).
25. **Tong A**, **Sainsbury P**, **Craig J**. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–357.
26. **Smith JA**, **Flowers P**, **Larkin M**. *Interpretive Phenomenological Analysis: Theory Method and Research*. London: SAGE Publications, 2009.
27. **Biggerstaff D**, **Thompson AR**. Interpretative phenomenological analysis (IPA): a qualitative methodology of choice in healthcare research. *Qual Res Psychol*. 2008;5(3):214–224.
28. **Blaikie N**. Confounding issues related to determining sample size in qualitative research. *Int J Soc Res Methodol*. 2018;21(5):635–641.
29. **Stake CE**, **Talbert PY**, **Hopkinson WJ**, **Daley RJ**, **Alden KJ**, **Domb BG**. Hip arthroplasty or medical management: a challenging treatment decision for younger patients. *J Arthroplasty*. 2015;30(6):950–954.
30. **Jones CA**, **Beaupre LA**, **Johnston DWC**, **Suarez-Almazor ME**. Total joint arthroplasties: current concepts of patient outcomes after surgery. *Rheum Dis Clin North Am*. 2007;33(1):71–86.
31. **Jack S**. Guidelines to support nurse-researchers reflect on role conflict in qualitative interviewing. *Open Nurs J*. 2008;2:58–62.
32. **Tobiano G**, **Bucknall T**, **Marshall A**, **Guinane J**, **Chaboyer W**. Patients' perceptions of participation in nursing care on medical wards. *Scand J Caring Sci*. 2016;30(2):260–270.
33. **Mew L**, **Heaslip V**, **Immins T**, **Wainwright TW**. A patient and public involvement study to explore the need for further research into the experience of younger patients undergoing total hip arthroplasty. *J Patient Exp*. 2022;9:23743735221083166.
34. **Aalund PK**, **Glassou EN**, **Hansen TB**. The impact of age and preoperative health-related quality of life on patient-reported improvements after total hip arthroplasty. *Clin Interv Aging*. 2017;12:1951–1956.
35. **Scott CEH**, **Bugler KE**, **Clement ND**, **MacDonald D**, **Howie CR**, **Biant LC**. Patient expectations of arthroplasty of the hip and knee. *J Bone Joint Surg Br*. 2012;94-B(7):974–981.
36. **Alanazi AA**. Reducing anxiety in preoperative patients: a systematic review. *Br J Nurs*. 2014;23(7):387–393.
37. **McDonald S**, **Page MJ**, **Beringer K**, **Wasiak J**, **Sprowson A**. Preoperative education for hip or knee replacement. *Cochrane Database Syst Rev*. 2014;2014(5):CD003526.
38. **Jourdan C**, **Poiraudeau S**, **Descamps S**, **et al**. Comparison of patient and surgeon expectations of total hip arthroplasty. *PLoS One*. 2012; 7(1):e30195.
39. **Wainwright TW**, **Gill M**, **McDonald DA**, **et al**. Consensus statement for perioperative care in total hip replacement and total knee replacement surgery: Enhanced Recovery After Surgery (ERAS®) society recommendations. *Acta Orthop*. 2020;91(1):3–19.
40. **Harmsen RTE**, **den Oudsten BL**, **Putter H**, **et al**. Patient expectations of sexual activity after total hip arthroplasty: a prospective multicenter cohort study. *JB JS Open Access*. 2018;3(4):e0031.
41. **Manninen S-M**, **Polo-Kantola P**, **Vahlberg T**, **Kero K**. Patients with chronic diseases: is sexual health brought up by general practitioners during appointments? A web-based study. *Maturitas*. 2022;160:16–22.
42. **Fonte D**, **Lagouanelle-Simeoni MC**, **Apostolidis T**. "Behave like a responsible adult" – relation between social identity and psychosocial skills at stake in self-management of a chronic disease. *Self and Identity*. 2018;17(2):194–210.
43. **Trindade IA**, **Duarte J**, **Ferreira C**, **Coutinho M**, **Pinto-Gouveia J**. The impact of illness-related shame on psychological health and social relationships: Testing a mediational model in students with chronic illness. *Clin Psychol Psychother*. 2018;25(3):408–414.
44. **Bacconnier L**, **Rincheval N**, **Flipo R-M**, **et al**. Psychological distress over time in early rheumatoid arthritis: results from a longitudinal study in an early arthritis cohort. *Rheumatology (Oxford)*. 2015;54(3):520–527.
45. **Tice DM**, **Wallace HM**. The reflected self: creating yourself as (you think) others see you. In: Tangney MRLJP, ed. *Handbook of Self and Identity*. Guildford: The Guildford Press, 2003: 91–105.
46. **Veroff D**, **Marr A**, **Wennberg DE**. Enhanced support for shared decision making reduced costs of care for patients with preference-sensitive conditions. *Health Aff (Millwood)*. 2013;32(2):285–293.
47. **Ghomrawi HMK**, **Franco Ferrando N**, **Mandl LA**, **Do H**, **Noor N**, **Gonzalez Della Valle A**. How often are patient and surgeon recovery expectations for total joint arthroplasty aligned? Results of a pilot study. *HSS J*. 2011;7(3):229–234.

Author information

L. E. Mew, BSc (Hons), PhD, Research Nurse, Arthroplasty Specialist Nurse, Milton Keynes University Hospital, Milton Keynes, UK; Orthopaedic Research Institute, Bournemouth University, Poole, UK.

V. Heaslip, BSc (Hons), MA, PhD, Professor of Nursing and Healthcare Equity, Equity School of Nursing and Society, University of Salford, Salford, UK; Department of Social Work, Stavanger University, Stavanger, Norway.

T. Immins, MA, Research Development Manager , Orthopaedic Research Institute, Bournemouth University, Poole, UK.

T. W. Wainwright, BSc (Hons), PhD, PG Dip, PG Cert, Professor of Orthopaedics, Deputy Head of Department, Physiotherapy Department, University Hospitals Dorset NHS Foundation Trust, Poole, UK; Orthopaedic Research Institute, Bournemouth University, Poole, UK.

Author contributions

L. E. Mew: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Software, Validation, Visualization, Writing – original draft, Writing – review & editing.
V. Heaslip: Formal analysis, Funding acquisition, Methodology, Resources, Supervision, Writing – review & editing.
T. Immins: Funding acquisition, Methodology, Resources, Supervision, Validation, Writing – review & editing.
T. W. Wainwright: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Resources, Supervision, Validation, Writing – review & editing.

Funding statement

The author(s) disclose receipt of the following financial or material support for the research, authorship, and/or publication of this article: this study was supported by Milton Keynes University Hospital and Bournemouth University. Neither Milton Keynes University Hospital or Bournemouth University had any involvement in the study design, in the collection, analysis and interpretation of data; in writing of the manuscript; and in the decision to submit the manuscript for publication.

ICMJE COI statement

The authors report that the article processing charges for this article were funded by Bournemouth University. T. W. Wainwright reports institutional research grants from NIHR, Stryker, and Zimmer Biomet, personal consulting fees from Enhanced Medical Nutrition, Firstkind, and Pharmacosmos, and personal speaker fees from Mölnlycke Health Care all of which are unrelated to this study.

Data sharing

The data that support the findings for this study are available to other researchers from the corresponding author upon reasonable request.

Ethical review statement

Ethical approval for the study was granted by NHS Chelsea Research Ethics Committee (20/PR/0858) on 13/01/21.

Open access funding

The open access fee for this article was funded by Bournemouth University, UK.