Care for the elderly: a challenge in the anaesthesia context

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To my ‘mormor’ (grandma) Anna Schultz

We graduated as nurses from the same school: Södra Sveriges Sjuksköterskehems Sjuksköterskeskola. She graduated in 1908; I graduated in 1969. After getting married in 1914, my grandma was forced to give up nursing and to give her broach back. Times have changed since then. I am fortunate to have the opportunity to stay on in the field of nursing …
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ABSTRACT

Care for the elderly: a challenge in the anaesthesia context

Anaesthesia care involves bioscience and technical knowledge. Provision of anaesthesia care for elderly surgical patients can be a significant challenge when promoting patient comfort, safety, and satisfaction in a high-tech context with time constraints. Many patients in anaesthesia care are old and frail and have multiple illnesses and other problems, such as delicate skin, malnutrition, and pain. All this must be accounted for when caring for the elderly. Extra time in anaesthesia care is required to prepare elderly surgical patients for anaesthesia and surgery. And surgical patients have limited opportunities to influence their situations while in anaesthesia and surgery.

So the overall aim of the research was to obtain insight into what anaesthesia care means in the lifeworld of anaesthesia – through accounts of experiences of nurse anaesthetists (NAs) and elderly patients. Research objectives were to: qualitatively identify and describe ways in which new NAs experience and perceive anaesthesia (I), describe the essence of the problematic anaesthesia-care situation phenomenon (as it relates to NAs) that involves elderly patients (II), illuminate what it means for a nurse anaesthetist to be in a problematic anaesthesia care situation (III), and illuminate what it means for elderly patients to be in intra-anaesthesia care and surgical situations (IV).

The research takes a phenomenological approach to facilitate understanding of human beings (nurse anaesthetists and elderly patients) in a specific context (anaesthesia care). Three analysis methods were used in an effort to find congruence between research questions and methods: phenomenography (I), descriptive phenomenology (II), and interpretive phenomenology (III and IV).

In study I, nine newly graduated nurse anaesthetists had one month of clinical experience when they responded to four open-ended questions. These questions dealt with their views on anaesthesia care, and they provided clinical examples that further clarified their written answers. In studies II and III, seven experienced nurse anaesthetists were interviewed. Their narrations focused on concrete experiences in problematic anaesthesia care situations. In study IV, seven elderly patients (ages 64–79) were interviewed within six months after they had had hip replacement surgery or femur fracture surgery with regional anaesthesia. All participants were told that participations were voluntary and that they could withdraw from the studies at any time.

The results show three ways of approaching anaesthesia care. Two ways were patient centred, while the third emphasised demands on efficiency. The favoured approach (patient centred) was selected because of each newly graduated nurse anaesthetist’s understanding of care-giving in an anaesthesia situation. This meant that similar situations could be approached differently (I). Unforeseen situations were an inevitable part of anaesthesia care and proved to be problematic because they could not be predicted. They were accentuated in acute anaesthesia care situations with little time to come to terms with what was happening. Re-lived memories from former unpleasant situations affected and reshaped the present anaesthesia care situations. In addition, conflicting views of values were problematic in anaesthesia care (II). Being in problematic anaesthesia care situations was experienced as highly morally demanding when involving elderly patients and raised moral distress that evolved from the experience of being prevented from acting on one’s legal and moral duties. In addition, moral distress occurred when they felt that they weren’t authorised to use their professional expertise or when others did not authorise them to use it (III). Elderly patients comfort and well-being were shown to be substantially challenged in anaesthesia care and surgery. The cognitive and emotional experience of time made some waiting and pain episodes in anaesthesia care to be experienced as endless. Severe pain could preoccupy to them to such an extent that they could not co-operate with the team, e.g., they could not communicate. Lost control of their bodies made the elderly sense a distance with themselves and made the anaesthesia care and surgery situation seem unreal. Sensing distrust created situations in which the elderly felt unsafe, so they felt that they had to be on their guards (IV).

The research illuminates anaesthesia care from two perspectives. The results describe what anaesthesia care means and its consequences from the perspective of care providers (NAs) and what anaesthesia means from the perspective of care recipients (elderly patients). The research points out consequences of unforeseen problems and consequences for different approaches to anaesthesia care. Problematic anaesthesia care situations, i.e., experiences of difficult situations that require solutions seemed to be an inevitable part in anaesthesia care and effect anaesthesia care-giving and conditions for receiving anaesthesia care. Further, the importance of recognising the experience of temporality as linear and non-chronological was put forward through NAs’ recollections and elderly patients’ experiences of pain and waiting. The research describes the need to articulate NAs’ legal and professional authority in relation to given practice mandates. It also gives an account of elderly patient’s needs to be understood – from an insider perspective – to help overcome challenges such as pain and wait in anaesthesia care and surgical situations. Finally, the research calls for further study of the experience of time in relation to care providers and patients in anaesthesia care as well as more research about moral distress and its consequences in anaesthesia care.

Key words: anaesthesia care, anaesthesia nursing, elderly patients, intra-operative care, moral distress, nurse anaesthetists, paradigm case, patient experiences, problematic care, phenomenology

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ORIGINAl PAPERS

This doctoral thesis is based on the following original papers, which are referred to in the text by their Roman numerals:


II Larsson Mauleon, A., Palo-Bengtsson, L. and Ekman, S-L. Problematic situations in anesthesia care involving elderly patients - As they relate to nurse anesthetists. (Resubmitted)

III Larsson Mauleon, A., Palo-Bengtsson, L. and Ekman, S-L. Anaesthesia care of older patients as experienced by nurse anaesthetists. (In print Nursing Ethics)

IV Larsson Mauleon A., Palo-Bengtsson L. and Ekman S-L. Being in an anaesthesia-care and surgical situation - Elderly patients experiences. (Submitted)

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INTRODUCTION

The elderly population is increasing in number and age and a growing number of elderly patients (60+) will need anaesthesia care in coming years. Few studies investigated anaesthesia care in relations to elderly surgical patients anaesthesia care situations from elderly patients’ and care providers’ perspectives.

Anaesthesia care practice incorporates bioscience and technical knowledge into surgical patient care. As a nurse anaesthetist (NA) for more than 15 years and later, as a lecturer in nurse-anaesthetist specialist education for more than 15 years, I learned that it’s difficult to identify anaesthesia care in the process of practice. I also learned that in situations when anaesthesia care was insufficient, the need of it was noticed; this metaphor, which I told to students when discussing anaesthesia care, illustrates: In a dirty room, you notice the need to clean. In a clean room, you hardly notice that it’s been cleaned because cleaning is taken for granted.

Further, I’ve met administrators and other providers, in nursing and education professions, who questioned bringing anaesthesia care into the practice. They said care in anaesthesia only focused on medical and technical issues. In discussions with them, I found that it was easier for me to give examples of what anaesthesia care was not, i.e., situations in which patients’ physical needs were ‘merely’ dealt with. I also met students who frequently stated that surgical patients’ needs were emphasised and judged very differently in the anaesthesia care practice. But when discussing the matter, students had difficulties precisely describing qualitative anaesthesia when it comes to what care is really about. It was easier for them to point out situations in which patients appeared to be powerless or had suffered from injustice or abuse, but they still thought that the patients received good care – medically and physically.
So I turned to practicing nurse anaesthetists (newly graduated and highly experienced) and elderly persons, because I recognised that their experiences of anaesthesia care – in good and bad times – would say something important and would teach me something in terms of care in an anaesthesia context.

BACKGROUND

Anaesthesia care
Anaesthesia care is complex when it comes to patients’ comfort, wellbeing, and physical conditions; treatment; and specific circumstances in the anaesthesia environment (Kolcaba and Wilson, 2002). Anaesthesia care is carried out in a high-tech milieu in which urgent, complex, important decisions must often be dealt with immediately. Anaesthesia care incorporates medical and technological activities for individual patients and puts time demands on care providers (Wood, 2001).

The daily practice of anaesthesia care involves issues about pain relief, informed consent, integrity and safety (Green, 2000). And in everyday anaesthesia care practice, medical treatments are not seen as separated entities when performed on patients (Lindwall, 2004a; Scott et al., 1999). It is argued that care in anaesthesia situations must be improved in terms of relieving patients’ operation-related anxiety in connection with anaesthesia and surgery (Leach et al., 2000; Leinonen et al., 1996) and that differences in values have impact on anaesthesia care-giving and outcomes of anaesthesia care (Aprile, 1998; Schultz, 1998; von Post, 1998).
Anaesthesia care and elderly patients

Populations in all western countries are aging. Sweden, for example, has a population of nine million; almost two million are age 60+. In coming years, elderly patients will have an influence on the anaesthesia environment because of their numbers and ages (Parker et al., 2002). Elderly patients, who would not be considered for surgical interventions because of their concomitant disease, routinely receive operations today. They often have multiple problems, such as delicate skin, pain, malnutrition and reduced hearing (Parker et al., 2002). Anaesthesia care must account for all this, which means that more time is needed to prepare elderly patients. They represent a frail group, which requires more time when being prepared for anaesthesia and surgery; their physical condition must be considered (Rohdes et al., 2003). Efficiency and strict time-limitation norms affect care quality and the elderly patients’ situations in anaesthesia and surgical contexts (Heggen and Wellard, 2004). But it is claimed that patients expect that caregivers will receive and protect their bodies from harm and disgrace when they abandon themselves to caregivers in anaesthesia and surgical situations (Lindwall, 2004; Lindwall et al., 2003; Kolcaba and Wilson, 2002). It is also claimed that patients’ integrity might be violated because their bodies will be naked and touched in some situations during their stay in operating rooms (Lindwall, 2004; Suhonen et al., 2003).

Elderly patients’ physical needs are fulfilled in emergency care but desires to know and understand what is happening to them and around them is neglected in emergency care environments (Nydén et al., 2003). Patients in perioperative care experience that they have little or limited influence on their situations, but these patients were very satisfied with physical treatment they received during their stays in operating rooms (Leinonen et al., 2001). In addition, others claimed that when patients are respected, listened to and shown concern, they feel secure; they can take more active roles in their recoveries (Åkesdotter Gustafsson et al., 2000; Dodds 1993).
Patients who are scheduled for surgery express concerns about their safety (Royston and Cox 2003). Anxiousness, fear and feelings of discomfort pain and agony are well-known concerns for surgical patients undergoing anaesthesia care and surgery (Caumo et al., 2001; Warrén Stomberg et al., 2001; Sjöström, 1995) and loss of control is argued to be a fear-producing event for many patients – regardless of length of time and extent of surgery and anaesthesia (Kolcaba and Wilson, 2002).

Regional anaesthetic is a common, often preferred treatment for elderly patients in Sweden (Parker et al., 2002). Regional anaesthetics might cause fear of getting “needle sticks”, of being “awake” and of paralysis – because of rumours and myths (De Andrés et al., 1995; Stoelting and Miller, 1994). Patients who get local anaesthetic will stay awake (apart from those who are sedated) during the entire procedure. Local anaesthetics produce sensory and motor blockades that reduce or limit patients’ abilities to move or feel things in a normal way. These blockades might differ in intensity because of local anaesthetics and administration sites (Halldin 2000; De Andrés et al., 1995; Stoelting and Miller, 1994).

**Anaesthesia and anaesthesia care environment**

The anaesthesia profession is relatively young and was recognised as a speciality from the mid-19th century when Long, 1842, used diethyl ether to produce surgical anaesthesia (Stoelting and Miller, 1994). Since then, anaesthesia developed rapidly because of medical, technical and surgical progress. This development has facilitated treatment and care for today’s growing number of frail, vulnerable and older patients (Royston and Cox, 2003), as well as trends in medical and technical development (Parker et al., 2002).

Anaesthesia care practice consists of efficient work performance – with few delays and need for immediate decisions (Larsson, 2004). NAs work in teams with members from different professions; the NAs have different duties when it comes to patients and
organisation (cf. Flin et al., 2003). Patients in anaesthesia and surgery are put into dependent situations; they must more or less leave themselves in the hands of care providers during these situations (Kolecaba and Wilson, 2002).

Anaesthesia is usually confined to operating rooms with strict schedules that are planned in advance. Sophisticated technology, fast working paces, and need for immediate decisions challenge anaesthesia care quality and treatment (Larsson, 2004; Leinonen et al., 2001). NAs work in teams with multiple care providers who come from different professions and have different responsibilities and intentions for patient care; this moulds anaesthesia care outcomes (Scott et al., 1999). Constantly changing health care systems, limited resources and technology under development are other anaesthesia care challenges (Wood, 2001).

Complications in anaesthesia are shown to be rare for relatively healthy patients who have simple elective operations. Regardless of the risk of anaesthesia, it is estimated that 50% to 75% of anaesthesia-related deaths are preventable (Stoelting and Miller, 1994).

**Anaesthesia care and the nurse anaesthetists profession**

Anaesthesia became a necessity because of rapid surgery developments. Early on, surgeons had responsibility for administering anaesthesia. This area became a medical speciality in Sweden when Torsten Gordh, the first anaesthetist, was appointed in 1940 (Wiklund, 2000). Later, with sophisticated medical knowledge and technological innovations and a shortage of anaesthetists, specialist nurses in anaesthesia care became a necessity. Today, most anaesthetics in Sweden are implemented with help from NAs, in collaboration with anaesthesiologists (Larsson, 2004). Compared to the US, where many published studies are done, almost 50% of anaesthetics were administrated in the US by NAs, most often with physicians’ supervision (Stoelting and Miller, 1994).
It is argued that NAs in Sweden are “to a considerable extent involved in practical routine anaesthetic management of surgical patients and may, at times, be solely responsible for the patient’s anaesthetic safety and comfort in the operating theatre” (Warrén Stomberg et al., 2001 p. 434).

In 1996, Sweden’s National Board of Health and Welfare defined areas of responsibility and authority for NAs. They have legal and professional responsibilities that include nursing treatment and medical-technical equipment usage. The same responsibilities apply in other units, such as pre-operative and postoperative care, pain clinics and accident and emergency units. NAs participate in anaesthesia and analgesia treatment, and they care for patients in surgical units. NAs work in close collaboration with unit policies and in close collaboration with anaesthesiologists and patients. NAs implement patients’ individual care plans, which anaesthesiologists initiated and planned. NAs participate in pre-anaesthesia interviews and physiological assessments. With shared responsibility with operating room nurses, they either position patients on the operating table, or supervise positioning of patients – to assure the physiological function, the safety of patient, and the patient’s wellbeing. NAs administer and/or participate in administration of anaesthesia and anaesthesia care for patients in surgical units. This includes assessment and planning of anaesthesia care, treatment (e.g., administrating drugs, intubations and managing fluid and blood therapy within the care plan) and monitoring. They also assist anaesthesiologists with administration of epidural- and spinal anaesthesia. In operating rooms, they work in a multidisciplinary team, in close collaboration with operating room nurses, surgeons and enrolled nurses (Swedish Statue Book, Appendix §38, 1993:23). NAs may play a key role in securing qualitative care, because they stay with the same surgical patient throughout the entire anaesthetic and surgery process.
RATIONALE FOR THE RESEARCH

Facilitating anaesthesia care to a growing number of elderly patients is an important issue in the field of anaesthesia care. Few studies are based on an “inside perspective”, i.e., carers (nurse anaesthetists) and elderly patients experiences and descriptions of anaesthesia care. It seemed important to probe into how their challenges, understandings, difficulties, beliefs and attitudes were related to giving and receiving anaesthesia care. That way, anaesthesia care could be recognised and understood in a broader perspective that accounts for the interplay among human beings – NAs and elderly patients. This facilitates understanding, which, in turn, increases knowledge about anaesthesia care and care situations. This knowledge can guide, shape and result in different values and expectations for providing future anaesthesia care. This facilitates understanding, which in turn increases knowledge about anaesthesia care and care situations. This knowledge can guide, shape and result in different values and expectations for providing future anaesthesia care.
PURPOSE OF THE RESEARCH

The overall aim of the research was to obtain insight into what anaesthesia care means in the lifeworld of anaesthesia – through accounts of experiences of nurse anaesthetists and elderly patients. The research objectives were to:

- Qualitatively identify and describe ways in which new NAs experience and perceive anaesthesia. (I)
- Describe the essence of the problematic anaesthesia-care situation phenomenon (as it relates to NAs) that involves elderly patients. (II)
- Illuminate what it means for a nurse anaesthetist to be in a problematic anaesthesia care situation. (III)
- Illuminate what it means for elderly patients to be in intra-anaesthesia care and surgical situations. (IV)

PHENOMENOLOGICAL FRAMEWORK

Phenomenology

This thesis describes data from four studies; phenomenology formed the foundation for the studies. The Greek word *phainomenon* means that “which appears/as given”, i.e., phenomena, mean objects as they appear to the subject (Grön et al., 1994). A phenomenological approach provides a theoretical opportunity to understand and express what anaesthesia care means for the individual.
Phenomenology embraces epistemology and ontology (Dahlberg et al., 2001a; Eriksson et al., 1999). Epistemology (*episteme*) means knowledge knowing science (Eriksson et al., 1999; Grön et al., 1994) and concerns questions based on *what* and *how*, e.g., in this thesis: *What* is anaesthesia care for the elderly patients? *How* can anaesthesia care be described from the NAs’ and elderly patients’ perspectives?

The theoretical departure in ontology is in meaning, i.e., our being. It concerns knowledge that aims to understand the meaning of our being (Eriksson et al., 1999; Grön et al., 1994), for example: What does it mean to be in problematic anaesthesia care situations that involve elderly patients? What does it mean to be in intra-anaesthesia care and surgical situations?

Objectives of the first two studies (I and II) were epistemological; they sought answers to *what* and *how*. Objectives of the other studies (III and IV) emphasised existence and were ontological; they sought meaning.

A phenomenological approach was used to gain insight into the lifeworld of anaesthesia care. Through the senses, people experience objects (phenomena) in this world, i.e., phenomena are manifested through perception. A person *is created by* and *is creating* his or her own world, Husserl (1992/1948; 1989/1913) calls it the *lifeworld* (Dahlberg et al., 2001a; Svenaeus, 2001; Bengtsson, 1999). Husserl’s idea (1992/1948; 1989/1913) was that reductionism must be avoided when studying humans in human sciences. The starting point must be from an experienced world, i.e., a lifeworld, which is how we live and perceive our lives together with others (Dahlberg et al., 2001a; Svenaeus, 2001; Bengtsson, 1988). So the lifeworld is something more than the world itself and more than the subject itself. This phenomenological perspective was used in the studies to understand and accept the surrounding lifeworld meaning and that this everyday world cannot be reduced (Dahlberg et al., 2001a; Benner, 2000).
Three phenomenological approaches

The philosophy of phenomenology led to several phenomenological approaches. Three different qualitative approaches were used in the studies: *phenomenography, descriptive scientific phenomenology* and *interpretive phenomenology*. These approaches are further described in the following sections.

*Phenomenography*

Phenomenography is based on the assumption that things or events in the human environment can be experienced in qualitatively different ways (Dahlberg et al., 2001b; Uljens, 1989; Marton, 1986).

Phenomenography is a qualitative method for exploring various ways in which something has been shown to be understood and viewed by an individual (Uljens, 1989; Larsson, 1986; Marton 1986; Marton, 1981). In turn, these views are judged to be fundamental regarding ways in which people act, understand, form their beliefs and experience their worlds (Barnard et al., 1999). So study I was not directed at the phenomenon (anaesthesia care), but at the people in this study – newly graduated NAs – and how they experience and understand the phenomenon of anaesthesia care. The informative undertaking\(^1\) intended to glean meaning and understanding from their views on anaesthesia care – subjective views based on subjective knowledge.

\(^1\) *Informative undertaking* indicates that the act of communicating information involves a pre-existing and pervasive cultural agreement that an utterance will have some content that reflects subjective knowledge common to both parties in the communication, i.e., both parties have an underlying mutual understanding that the utterance makes some kind of sense.
Descriptive phenomenology

Descriptive phenomenology (Giorgi & Giorgi, 2003) provides a description of subjective phenomena. The goal is to make the implicit explicit. This approach describes a phenomenon from a lived experience that is based on a person’s natural attitude toward the phenomenon; in study II, highly experienced NAs described problematic anaesthesia care situations that occur in everyday anaesthesia care.

Giorgi (1994; 2003) developed the modified scientific phenomenological approached used in study II. His method is based on Husserlian philosophical phenomenology (Husserl, 1992/1948; 1989/1913). Phenomenology is about clarifying events or situations, e.g., things experienced by persons in their daily surroundings. To the greatest extent possible, researchers, who use the phenomenological method, strive to be faithful to the phenomenon in the context in which it is experienced (cf. Sandelowski, 2000). This leads to a search for the phenomenon in situations in which a person has first-hand experience and in the context in which the experience occurred (problematic anaesthesia care situations) (Giorgi and Giorgi, 2003; Giorgi, 1994).

Interpretive phenomenology

Interpretive phenomenology, which was developed by Benner (1994), is based on Heidegger’s (1993/1927) thoughts about keeping the essence – what something is – and the existence – that something is – in a togetherness (Benner, 2001; 1994; Leonard, 1994). It focuses on people’s experiences as their relations with others, the involvement of their temporalities with other modes of history and lifeworld. Temporality emphasises time as continuous, contextual and as having direction. Temporality is to be understood as a dynamic field that includes past, present and future. From this phenomenological view, people are
situated within their lifeworlds and life histories that they share with others; meanings are called forth in concrete situations (Leonard, 1994).

Selection of phenomenological methods

The phenomenographic study (I) contributed to understanding the variation of the ways NAs act and approach anaesthesia care due to their beliefs and views, i.e., a way of understanding what they talked about and how they talked about it. NAs approached similar anaesthesia care situations differently. The results indicated that difficulties influenced different ways in which newly graduated NAs approached anaesthesia care. The indicated difficulties created a new question for this research about problematic situations within anaesthesia care (I). The ambition was then to find a purposeful method that corresponds to this issue of describing the problematic anaesthesia-care situation phenomenon.

This researched (II) focused on finding answers regarding how this phenomenon was experienced and understood, i.e., what is problematic anaesthesia care and how can problematic anaesthesia care be described. Because the guiding, overall theme was to describe the phenomenon of problematic anaesthesia care situations based on a natural attitude (the phenomenon as given), a descriptive phenomenological method was selected to develop a description (Giorgi and Giorgi, 2003; Giorgi, 1994).

This method contributed to a description of the phenomenon, i.e., problematic anaesthesia care situations and different aspects of the phenomenon. But the given (i.e., things as they appear) was understood as presence – with no commitment to existential claims of what it means to be. This brought a new issue to this research (III-IV), namely, the issue of being (cf. Benner 1994). So the next phase of the research explored what it means to be in a problematic anaesthesia care situation and what it means to be in anaesthesia care and surgery situations.
The goal was then to find a method that facilitates understanding of what a human experience means from the perspective of being situated in a lifeworld. Benner’s (1994) interpretive phenomenology embraces the existential tradition of phenomenology. It concerns a shift from what to know is (epistemology) to questions about why and how we know and what constitutes our knowing (ontology) (Benner, 1994). The interpretive phenomenology method contributed to understanding; it accounted for individuals’ experienced lifeworlds and life histories.

**METHOD**

The studies embraces newly graduated NAs, experienced NAs and elderly surgical patients described in the following text. (Table 1)

<table>
<thead>
<tr>
<th>Paper</th>
<th>Participants</th>
<th>Data collection</th>
<th>Methods</th>
<th>Type of knowledge</th>
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<tbody>
<tr>
<td>I</td>
<td>9 Nurse anaesthetists new graduated with 1 month of experience</td>
<td>Open-ended questions with written answers</td>
<td>Phenomenographic method</td>
<td>A description of the different ways in which anaesthesia care is perceived and approached</td>
</tr>
<tr>
<td>II</td>
<td>7 Nurse anaesthetists with 9-30 years of anaesthesia experience</td>
<td>Tape recorded qualitative interviews</td>
<td>Descriptive phenomenology</td>
<td>A description of the phenomenon problematic anaesthesia care situation and its constituents</td>
</tr>
<tr>
<td>III</td>
<td>7 Nurse anaesthetists with 9-30 years of anaesthesia experience</td>
<td>Tape recorded qualitative interviews</td>
<td>Interpretive phenomenology</td>
<td>An interpretation of what it means to be in a problematic anaesthesia care situation</td>
</tr>
<tr>
<td>IV</td>
<td>7 Surgical patients 61 to 79 years</td>
<td>Tape recorded qualitative research interviews</td>
<td>Interpretive phenomenology</td>
<td>An interpretation of what it means to be in anaesthesia care surgery performed in regional anaesthesia</td>
</tr>
</tbody>
</table>
Participants

**Study I:** This study was conducted with newly graduated nurse anaesthetists (NAs) who had one month of experience from their new professions. The criterion for inclusion was a completed anaesthesia nursing program, previous experience from caring on a medical or surgical ward as an RN, one month of experience as a graduated NA and willingness to participate. The idea was that the NAs had former experience of care from which they viewed the anaesthesia care in their new profession. To recruit voluntary participants, all (11) nurses in one course for nurse anaesthesia were asked about participation. Nine completed the education on time and participated. All were female ages 25 to 46, and all had previous RN experience (2 to 10+ years) on surgical and medical wards.

**Study II-III:** Seven, female NAs with 9-30 years of experience as nurse anaesthetists were selected from an orthopaedic anaesthesia department at one large hospital in the middle of Sweden. Participant selection criteria included the NA’s length of professional experience (more than five years as a NA), anaesthesia care experience (three years or more) for anaesthesia care in relation to elderly (60+) surgical patients and willingness to participate. The NAs were told about the study at group meetings at the anaesthesia department. Those who fulfilled the criteria were invited to participate; all agreed. These interviewed NAs ranged in age from 43 to 55 years.

**Study IV:** Seven surgical patients (one man and six women) participated. Besides a willingness to participate, selection criteria were: age 60+, experience from hip surgery or femur fracture surgery within the six last month, total recall of anaesthesia and surgical situation experiences, ability to describe those situations and no personal links to the anaesthesia and surgery department. They ranged in age from 61 to 79 years; three women
had previous experience from hip surgery situations. Three participants were recruited through a regional osteoporosis association; the chairperson told the members about the study and the criteria for study participation. The author contacted the persons by telephone; and they received oral and written information about the study. Four participants were recruited at a convalescent hospital. The head nurse at the hospital told them about the study after their arrival at the hospital; these interviews took place 5 to 10 days after surgery. All received written information about the study before they agreed to participate. The participants had their experiences from three operating room settings at three large emergency hospitals in an urban area of Sweden. The participants had their operations at public hospitals, so surgery was free of charge. Regional anaesthetic situations in connection with the orthopaedic situations (femur fracture surgery and hip replacement surgery) were chosen because they are common treatments among elderly persons. These are relatively large operations, which are done with regional anaesthetics. So patients might be awake all or most of the time during the procedure. The procedure takes about 2.5 hours, including patient preparation, anaesthesia administration and surgery, which takes about one hour.

**Data collection methods**

According to Kvale (1996), collected data in phenomenological research must be from concrete experienced situations. In addition, he states that the interview can be understood as a human relationship in which questions are asked and answered. The purpose was to get rich descriptions of participants’ experiences when they were in anaesthesia care situations (Kvale, 1996). Consequently, persons, who could describe and share experiences of events that could represent each study’s research topic, were sought.
Open-ended questions

When using a phenomenographic method, data are collected through interviews or open-ended questions (Larsson, 1986). In study (I), the responses of the new NAs were written in narrative form and based on 4 open-ended questions. The concept ‘good’ was used in the questions to emphasise the ‘ought to’ be aspects of nursing – that which is thought to be in the patients’ best interest when it comes to qualitative anaesthesia care (objects, actions, persons, and qualities). The NAs were asked to give examples from experiences in their clinical situations to illustrate their answers. The questions were distributed to the nurses just before graduation from the NA program. When they had one month of experience in their new profession, they sent their answers to the author.

Qualitative research interviews

Data were collected using qualitative research interviews cf. (Kvale, 1996) to gain the knowledge embedded in the narrations (II, III, and IV). The interviews were carried out as dialogues. The purpose of the studies was to get concrete description of events in problematic anaesthesia care situations as experienced by highly experienced NAs (II, III) and to get concrete descriptions of events in intra-anaesthesia care and surgery situations as experienced by elderly patients (IV).

The interviews took place in an environment that they selected. An interview started with a request “please tell …”. The participants spoke freely about their experiences and were only interrupted when clarification was needed, i.e., when it was difficult to understand what they meant. Questions gently probed, e.g., how can I understand that, tell me more about that, and you mentioned something before about that. The interviews lasted about 90 minutes.
The author conducted, taped, and transcribed all interviews with NAs and elderly patients. All participants (I-IV) were informed of the voluntary nature of participation and their rights as participants.

Data analysis methods

Phenomenographic analysis was used for study I, descriptive phenomenology was used for study II, and interpretive phenomenology, was used for studies III and IV. Data were analysed using following processes:

Phenomenographic analysis (I)

The phenomenographic method, developed by Marton (1988; 1986), involved analysis of different interrelated phases. Data analysis was done in these stages (Dahlgren and Fallsberg, 1992).

1. This stage involved all movement – from getting acquainted with the responses – to attaining an overview of the data to generate ideas for subsequent stages.

2. All data were processed to provide significant statements that represented versions of different ways in which anaesthesia nursing was perceived.

3. Fundamental characteristics were identified and compared to find differences and similarities among the statements.

4. The statements were gathered into preliminary categories; a category is delineated as an area of content.

5. The preliminary categories were described by contrasting suitable expressions. Each category represented a different pattern in which anaesthesia was experienced, perceived and described.

6. The categories were labelled
The categories were compared once again by contrasting their similarities and differences.

**Descriptive phenomenological analysis (II)**

The descriptive scientific phenomenological data analysis, developed by Giorgi (2000) was done in these stages.

1. Narratives were read to grasp a sense of the whole and to become sensitive to the richness of the text.

2. Each narrative was divided into meaning units. A division of meaning unit took place whenever there was a shift in meaning in the text.

3. All defined meaning units were examined and organised and transformed into disciplinary language, i.e., language that suits and is in accordance with the discipline of nursing and the subject of care. This transformation to disciplinary language uses imaginative variations, which means that different aspects of the phenomenon are tried and varied. This includes asking questions of the problematic anaesthesia care phenomenon – to remove unessential features or to test its limits so that all possible meaning related to aspects of the phenomenon could be explored.

4. The transformed meaning units were structured into five aspects (constituents) and the content was described within each constituent. The constituents were synthesised into a single structure. The synthesis was done at the end of the analysis by combining all data and its described relations. Only constituents that were defining the phenomenon were included.

The entire process uses bracketing (Giorgi and Giorgi, 2003; Giorgi, 2000; Giorgi, 1994), to make the researcher aware of his or her understanding of the studied phenomenon. To bracket is not the same as to deny that theories exist. Instead, it indicates awareness of their existence.
and enables the researcher to put aside hypotheses, theories and models that explain the phenomenon. Bracketing reminds the researcher of his or her pre-understanding (bias/preconceptions).

**Interpretive phenomenological analysis (III-IV)**

The interpretive phenomenological method, developed by Benner (1994), involved several interrelated stages.

1. The verbatim-transcribed narratives were read several times to grasp a general understanding of all narrative context and the participants’ experiences of what it means to be in a problematic anaesthesia care situation and to be in intra-anaesthesia care and surgical situations.

2. Each interview was read to understand each narrative; here, focus was on the events that each participant experienced.

3. Two paradigm cases (explained below) were identified as strong examples of episodes in problematic situations and in anaesthesia care and surgery, which offered examples of the participants concerns and ways of acting that were embodied in their experiences of situatedness.

4. The selected cases were analysed to gain understanding of what it means to be in a problematic anaesthesia care situation and to be in anaesthesia and surgery. The procedure involved imaging different aspects of understandings to enable the researcher to ask questions and probe into different aspects of the cases – seeking answers that illuminate the participants’ experiences.

5. All text was analysed using paradigm cases. Possible ways to describe what it means to be in a problematic anaesthesia care situation and to be in anaesthesia and surgery were looked for and studied.
6 Descriptions with similar content were sought after, identified and grouped. The various groups were organised into themes that relate to experiences – to reveal what situatedness meant to participants (Benner, 1994). Paradigm cases offer ways to illustrate and engage in the practical world and to come close to experiences revealed through interpretive phenomenology. A paradigm case is a selected episode that may serve as a means of gaining new insights; it is a resource for understanding similar experiences that are otherwise difficult to understand (Benner, 1994; Benner et al. 1999).

METHODOLOGICAL CONSIDERATIONS

Appropriate data

The importance of reaching good participants is emphasized in qualitative research, i.e., persons willing and ability to tell about their experiences and reaching participants who have knowledge and ability to represent the research topic (Morse et al., 2002).

In study I, the interviewed participants were new graduated NAs; in studies II and III, experienced NAs; and in study IV, elderly patients. NAs described problematic events in anaesthesia care that had occurred in the past – ranging from a few days to many years. One bias here might be that they (I-IV) may reconstruct the past within a framework they have learned later. But, the interviews provided opportunities for them to share their lived experiences with someone who took time to listen to (II-IV) the described events. According to Field and Morse (1992), this sharing situation (II-IV) can be viewed as indicating closeness that in turn strengthens the credibility.

Newly graduated NAs were selected because they were in a key situation of being new in the profession and not yet influenced by the anaesthesia care context. The
experienced NAs complemented and contributed to the newly graduated NAs’ brief experiences (II-III).

Did the interviews express genuine personal experiences? Every effort was made to give make the interviews seem like dialogue and to stimulate the interviewees by asking questions for clarification. So the interviewees’ narrations became more expressive and richer (II-IV).

Regular seminars were held to discuss transcribed data in comparison within the natural data from the narrations. An effort was made to reveal preconceived ideas and premature explanatory constructions – to avoid preconceived notions regarding the data.

**Methodological coherence**

According to Morse et al. (2002), methodological coherence must be ensured between research questions and components of the methods must be ensured to facilitate rigorous research. How were these factors achieved in the research in the studies? Every effort was made to match questions from the results with an adequate method (I-IV). So the methods were modified when new data and research questions arose, which demanded different treatment. In studies II and III, data were analysed from the same narrations using two different analysis methods aligned with research questions that dealt with epistemological issues (II) and ontological issues (III). Three different methods were used throughout the research – to be flexible and responsive to the forthcoming data.

**Temporality and represented data**

Study IV focused on the elderly patients’ situatedness in anaesthesia and surgery. Sandelowski (1999) states that “temporal factors play a critical role in understanding the representation of data”. The data constitute a historical way of knowing and must be understood
through historical perspective, in a meaning of temporality, and the narrations entail data from a past experience. This is aligned with results of this study, which showed that being in a situation was a difficult moment for most of the elderly patients when facing different difficulties. But when referring to Sandelowski (1999), a past experience can also be seen in the course of recovering time. Then the situation of anaesthesia care is a past experience that has moved from being something difficult to something that was helpful to reach the goal of getting better and well. This means that patients’ experiences might lead to different conclusions in the presentation of results, which is why some studies claim (Leionen et al., 2001) that the elderly patients were satisfied with their physical treatment, while in this study, when focusing on their specific situatedness of what it means to be in an anaesthesia and surgical situation, situatedness was shown to be a difficult moment for the elderly patients to overcome (Sandelowski, 1999).

Claimed knowledge

The claimed knowledge provide an understanding for how the results can be theoretically understood through generalisation – to make it possible to transfer these results in the study to another context (cf. Horsburgh, 2003; Fossey et al., 2002). If results from qualitative studies are to be applied, Fossey et al. (2002) stress that the readers must know the particular context. A contextual description was included in this thesis to allow readers to make a comparison and judge transferability (I-IV).

The purpose of qualitative research is to illuminate results so that the phenomenon can be theoretically understood and applied in similar situations (Horsburg 2003). Results from study I (phenomenography) describe qualitative understandings which constitute a principle for an epistemological framework (Marton, 1986). According to and Giorgi and Girogi (2003) and Einstein et al. (1989), the results (II) acquired through
phenomenology cannot be mutually related to objective law or truth or judged in terms of correct or incorrect. The results can assist in understanding and illuminating similar situations.

According to Benner (2001) (III-IV), details and content of one’s situatedness are in an individual’s understanding of everyday practical concerns. People who have the same experience, for example from an earthquake, have something in common that they share – something that others can learn and benefit from (Benner, 2001).

ETHICAL CONSIDERATIONS

The Ethics Committee at Karolinska Institutet (no 96-197; 04374 T) approved the studies (I-IV). Ethical considerations in studies relate to individual confidentiality, informed consent and the risk for emotional injury, in relation to participation. Regarding participation in the studies, the participants were informed about the nature of the studies and were guaranteed confidentiality. In all the studies, the nurse anaesthetists (I-III) and the patients (IV) were informed verbally and in writing about the study’s aim and about confidentiality and anonymity, which would be assured during analyses and publication of the results. All persons were told that participation was voluntary and that they could withdraw at any time during and after the interviews. It was also emphasised to patients that their care would not at any time be changed if they wanted to withdraw from the study. The interviewers’ telephone numbers and addresses were given on the written information sheet. All participants in this project gave their informed consent to participation and to audio taping of all interviews. The audio tapes are stored in a safe at Karolinska Institutet.

SUMMARY OF RESULTS

The following sections summarise the results regarding how anaesthesia care is approached and understood, impacts from problematic anaesthesia care situations on anaesthesia care-
giving, moral demands as experienced by NAs, and overcoming challenges that substantially interfere with comfort and wellbeing – as experienced by elderly patients in anaesthesia care and surgery.

**Anaesthesia care as approached and understood**

Three ways of approaching anaesthesia care were discovered. One was to maintain the patients’ physical wellbeing by focusing on their vital functions and by administering anaesthesia. A second was to help (to stand by) and speak for patients – to be the patients’ voice. A third was to provide efficient care, follow schedules and fulfil the department’s demands on efficiency when carrying out patient care. The newly graduated NAs knew about all the approaches, but similar situations were understood differently and thus approached differently (I). In addition, difficulties in the milieu had a great influence on opportunities to provide anaesthesia care in approaches. This also generated feelings of inadequacy in the NAs as carried out their new professional roles (I, II and III).

**Problematic situations that affect anaesthesia care**

Problematic anaesthesia care situations were an inevitable part of anaesthesia care. Contextual restrictions were problematic when barriers were raised, which limited anaesthesia care-giving opportunities. Conflicting values were problematic (II and III). Experienced NAs said that contextual difficulties could have a direct impact on anaesthesia care that involves elderly patients. So they experienced an inability to provide intended anaesthesia-care quality in all situations. The results point out that unforeseen events led to uncertain anaesthesia care situations. These situations became worse in acute care when decisions had to be taken and time did not allow the NAs to come to terms with what was happening. This lack of balance in dealing with, and prioritising within, critical situations was threatening and frightening in
anaesthesia care; it was impossible to evaluate ahead of time if selected actions were the right actions (II and III). Temporal issues affected anaesthesia care situations (I, II, III and IV). Problems arose because of time restrictions, i.e., not having enough time to see to the patient’s needs (I, II and III). Problems arose when unpleasant, re-lived memories reshaped anaesthesia care and led to painful feelings of isolation (II). Problematic situations arose among elderly patients because they experienced time as endless when they were in pain and they had to wait. Time represented a here-and-now situation for elderly patients; they experienced ongoing pain and waiting to be without end (IV). To sense distrust was problematic for elderly patients. It created feelings of uneasiness and anxiousness in anaesthesia care and surgery situations, which led to experiences of being in unsafe situations, which put elderly patients on their guards. (IV).

**Problematic situations that raise moral demands in anaesthesia care**

Problematic anaesthesia care that involved elderly patients was experienced to be morally demanding for experienced NAs when they experienced conflict between an inner and an external demand (II and III). The sense of obligation to provide and fulfil the intention of anaesthesia care for elderly patients appeared to be an impossible achievement in all situations (I, II and III). Problematic anaesthesia care might mean an experience of moral distress that arises from the experience of being prevented from acting on one’s legal and moral duty (III). Moral distress occurred when professional or legal goals or emotional goals could not be realised when others did not recognize the NAs’ professional expertise and knowledge. Temporality played an important role because restricted time had consequences in terms NAs’ opportunities to attend to patients’ wellbeing. Experiences of having failed to see to patients’ interests led to feelings of lost self-respect (II and III).
Dealing and overcoming challenges that substantially interfere with comfort and well-being in anaesthesia care

Study IV revealed that elderly patients’ challenges substantially interfere with their comfort and wellbeing in anaesthesia care and surgery. Sensing pain, trust and distrust, waiting, and self-as-an-outsider in an unreal surrounding were challenges that elderly patients had to deal with and overcome in anaesthesia care and surgery. Time did not represent itself in terms of minutes on a clock for elderly patients who experienced difficult anaesthesia care and surgery. Instead, time held meaning: it was something that preoccupied and challenged elderly patients. Dealing with severe pain was experienced as ongoing agony that could not be escaped from; it affected patients’ minds to such an extent that they could not think of anything else. Waiting and pain situations called for relief; elderly patients questioned these situations and sought explanations for their suffering. To be in anaesthesia and surgery led to experiences of an unreal situatedness. These situations were hard to grasp for elderly patients, especially in situations when they sensed an inability to get in touch with their bodies that were being anaesthetised and operated on (IV).

REFLECTIONS ON RESULTS

This thesis provides insight into the lifeworld of anaesthesia care through NAs’ and elderly patients’ experiences. The research point out consequences for different ways of approaching anaesthesia, for the outcomes of problematic situations and for the experience of trust. Further, the results show that anaesthesia care raises moral issues. The importance of experiencing time in relation to wait and pain was also enlightened by the results.

The consequences of understanding anaesthesia care in different ways
The research revealed that one way of approaching anaesthesia care was experienced as preferred or emphasised. Although individual NAs had more than one way to approach anaesthesia care. Anaesthesia care approaches were taken in relation to an individual NA’s understanding of contextual circumstances that affect patients’ situations. So similar situations were approached differently because NAs experienced and understood anaesthesia care in relation to patients’ needs differently (I). Aspects of approaches were almost identical to results published in a phenomenographic study (Larsson, 2004) that described anaesthetists’ ways of approaching anaesthesia care in clinical practice. They also claimed that approaches relate to an individual anaesthetist’s understanding of the situation. But these results differed slightly, because four ways of understanding anaesthesia in clinical practice were described. Two ways were patient centred; one focused on the patient as individual subject and the other on the patient’s vital functions. The other two ways focused on the organisation, and emphasised the hospital system and production (operations) (Larsson, 2004; Larsson et al., 2003). This points out that individual understanding is important because it directs, and has consequences, for what will be emphasised in anaesthesia care. In addition, patients, team members and organisations affect the consequences of anaesthesia care as do NAs’ individual experiences of anaesthesia care outcomes, for example, NAs’ experiences of not being able to deliver sufficient anaesthesia care (I, II and III). The results of this research and that of Larsson (2004) and Larsson et al (2003) point out that the individual is acting from individual understanding, which means that similar situations might have different consequences in practice of anaesthesia care (cf. Larsson, 2004; cf. Larsson et al., 2003).

**Responsibilities and actions**

The results showed that NAs experienced that they were forced to choose anaesthesia care based on actions. In some situations, they could not provide anaesthesia care that is based on
comfort and psychological wellbeing. These situations were problematic when NAs experienced that their professional responsibilities of seeing to all the elderly patients’ needs were not fulfilled (II and III). Contextual preconditions and patients’ conditions in acute, hasty anaesthesia care situations were reasons for the experience of an insufficient ability to live up to all the elderly patients’ needs (II and III).

Lindseth (1992) states that doctors’ and nurses’ duties are to act and to care. He states that physicians often prioritise actions, while nurses, who usually stay by the patients’ sides and have more continuous caring responsibilities, prioritise relation-oriented care. Both approaches are needed and must be considered when looking into patient care. Consequently, a caring relationship cannot be developed in opposition to “a physician’s” perspective that prioritises problem-solving actions. He claims that professional duties and responsibilities may create (and result in the selection of) different alternatives in terms of emphasising acting and relations in patient care. He also claims that all care providers are responsible for their actions and their ways of participating in relations. Lindseth (1992) argues that relation ethics must be the foundation on which qualitative care is built.

This research revealed that actions must be preferred in some hasty anaesthesia care situations. It also showed that anaesthesia care for elderly patients must be balanced between patients’ psychological wellbeing and comfort and patients’ physiological wellbeing and safety. But when this balance in some situations cannot be kept, it has consequences for NAs in terms of their experiences of not fulfilling their responsibilities toward elderly patients. These results, in keeping with Lützén et al. (2003), show that nurses have problems upholding ethical principles when it comes to relation-oriented care. Moral awareness of obligations and insufficient control over situations could raise stress on a moral level among nurses (cf. Flin et al., 2003; Lützén et al., 2003). Cronqvist et al. (2004) claim that it is assumed that moral and work responsibilities are complementary aspects in balance. And she
also claims that morals and work are not in balance in intensive care (Cronqvist et al., 2004) – an area that is closely related to anaesthesia care.

**Moral distress in anaesthesia care**

This research revealed that moral distress arises when NAs cannot act (are prevented from acting) or experience that they cannot carry out their legal or moral duties within anaesthesia care. Moral distress was experienced as moral failures because of the necessity to yield to a demand that was considered wrong. Moreover, moral distress was experienced when NAs’ authorities and professional expertise were not recognised, and they did not receive the respect they deserved (I, II and III).

Ahern and McDonald (2002) claim that nurses act to favour patients’ rights and safety and that nurses advocate for patients when they believe the patients are put at risk. To blow the whistle and report misconduct is claimed to involve personal and professional risks, because opposing authority or tradition might be costly (physically and emotionally) and professionally damaging (Ahern and McDonald, 2002). As Kälvemark et al. (2004) claim, moral distress arises among all staff categories. It generally appears in situations when conflicting goals must be fulfilled – primarily in the interests of organisations versus interests related to the particular patient. Moral distress is caused by demands on efficiency and shortages of resources in relation to care providers’ values and intentions and the complex reality of health care delivery. But different commitments to patients, among care providers, and differences in knowledge and access to varying factors, about the situation, might also cause moral distress (Kälvemark et al., 2004). According to Lützén (2003), nurses are held responsible for the care they provide, but they are seldom able to participate in policy discussions that regulate the conditions of care. Further, nurses’ care of patients is oriented
toward the individual level, while health care policies and organisations are oriented toward health efficiency and maximising health benefits (Lützén et al., 2003).

**The importance of trust in anaesthesia care**

The results showed that elderly patients believed they had to accept anaesthesia care and surgery as it was – if they wanted to be operated on and get well. They felt that they did not have choices and that they had to have faith in their situatedness, and they had to trust their care providers. This supports earlier research, which argues that patients who feel that they are in difficult situations rationalise their positions and thus accept what comes in terms of difficulties (Matiti and Trorey, 2004). Situations of sensing trust gave the elderly confidence. Those, who were confident, experienced that they had control of the situation and that this helped them to challenge and overcome difficulties in anaesthesia care and surgical situations. Sensing distrust created anxiety and uneasiness that led to feelings of being in unsafe situations. The elderly seemed to lose confidence in situations that led to feelings that they had to be on their guards. Reduced confidence influenced their abilities to meet and overcome difficulties, which challenged them in anaesthesia care and surgery (III). Løgstrup (1971) states that relying on and being open to others is what leads us to face each other. Reliance on other people means trusting them, and if this trust is violated, it leads to feelings of deep disappointment (Løgstrup 1971). For elderly patients to experience trust is thus the foundation of their situatedness in anaesthesia care and surgery situations (IV).

According to Løgstrup (1971), trust is something that belongs to our existence as humans and an expression of life between humans (Løgstrup, 1971). Trust is an emotion that belongs to our lives as humans and a person to whom faith, confidence and belief can be invested exhibits attributes of reliability and trustworthiness (de Raeve, 2002). Trust is
something that is natural, and unnecessary to show or confirm, but distrust usually needs a reason or explanation (Løgstrup, 1971).

**Time in anaesthesia care**

Through the results, it became apparent that temporal issues played an important role and were linked to the NAs’ and patients’ experiences of anaesthesia care. Time was not experienced in a linear way (clock time) by the NAs and patients (cf. Walsh, 1997). Instead, time was experienced as containing events (II, III and IV).

Time has influences on anaesthesia care-giving. In practice, nursing is done ‘within a non-linear complex and parallel temporal world’ (Jones, 2001; Walsh, 1997). As Jones (2001) claims, dynamic time has influence on acting in care and that the time embeds and surrounds all received care actions. It is argued that the present can be seen as a dynamic field that holds the past, present and future (Jones, 2001). These claims offer insight into why former encounters with patients remain significant and ‘vivid’ – long after they were experienced and why memories from former experience were reconsidered in present and future anaesthesia care situations (II).

It has been claimed that the duration of time in anaesthesia care can be experienced differently in relation to the experienced intensity of the time. The conditions, which include cognitive and emotional involvement during the period that time is experienced, influence people’s subjective experiences of time as slow and prolonged or as accelerated and compressed. Time slows down during conditions such as boredom, physical discomfort, anxiety and threat (Jones, 2001). For elderly patients in anaesthesia care and surgery, time was experienced as a slowing down – a waiting situation that leads to feelings of uncertainty, threat and anxiety (IV). Gibson (1994) claimed that temporality affects people’s lives and that spending time on an action conveys a message about how the actions are
regarded in relation to status and importance (Gibson, 1994). Conveyed messages are not always verbalised, but the length of time that is spent can be seen as a statement on the relative importance of the activity (Jones, 2001; Gibson, 1994). This research showed that in anaesthesia care, many NAs schedules were dictated by the organisation’s demands on efficiency. Feelings of pain must be recognised in their context as conditions that slow down the experience of time. Violations of patients’ expectations, i.e., the sense that the painful situation is taking longer than it should, prolong the experience of time and thus influence the pain by protracting it (IV), (cf. Buetow, 2004).

Conflicts arose in anaesthesia care when professional schedules were not aligned with those of the individual (I, II and III). This indicates that social time is a significant component of anaesthesia care, that it is costly, and that time for anaesthesia care must be counted and valued in money.

**Problematic situations – a part of being in anaesthesia care**

Problematic anaesthesia care situations, i.e., experiences of difficult situations that require solutions, seemed to be inevitable in anaesthesia care and affect anaesthesia care-giving and conditions for receiving anaesthesia care (II; III and IV). Payne et al. (1998) claim that nurses working in acute care contexts do not accept treatments that were not successful for the patients and that nurses blamed themselves for having failed in these situations (Payne et al., 1998). Some events were unforeseen in anaesthesia care and could not be planned for in advance. So the given treatments in these situations were regarded as difficult to evaluate in these anaesthesia care situations. Insufficient knowledge, about whether the right anaesthesia care solution and treatment were used, raised feelings of insecurity regarding whether or not the right things were done during anaesthesia care-giving (II). Contextual barriers, such as insufficient time, inability to communicate and stress, are constraints that inhibit care in
intensive care (Wilkin and Slevin, 2004). NAs and elderly patients experienced similar constrains as problematic because the constraints were difficult to overcome or because they were experienced as having no solutions in the anaesthesia context (II, III and IV).

This research showed that severe pain grabs the elderly patients’ total attention (IV). According to Madjar (2001), pain grips the body and leads to experiences of pain as “my pain” and “my body” (Madjar, 2001, pp 263-277). So pain cannot just be recognised as a theoretical idea that can be reported by another person from an objective perspective. In addition, it was also shown that elderly patients sensed a distance to the self in some situations and that this led to a sense of inability to get in touch with one’s own body (IV). Madjar (2001) claims that the gulf between being outside the other’s private lifeworld – the other’s experienced lifeworld – must be recognised (Madjar, 2001). So elderly patients’ experiences of being a body in pain cannot be fully or directly shared.

Being in anaesthesia care and surgery was hard to grasp and could be recognised as unreal situatedness by the elderly patients – a situation in which the elderly patients lost control on their bodies because of anaesthesia and surgery. These situations made the elderly sense a distance to the self’s situatedness: “it was like visiting a service station” (IV). Lindwall (2004) claims that patients separate body and mind in situations when focus is experienced to be just on their bodies and on illness – in treatment situations such as surgery (Lindwall, 2004). But keeping a distance to the self is not the same as separating the body and mind; instead, the results indicate that the situatedness raises inability to get in touch with one’s own body.

CONCLUSION

The foundation of this research was a care perspective that presupposes an interest for humans and their relations to health, suffering, life and existence. This perspective requires an
understanding for the individual human – without reduction, atomisation and objectification (Benner, 2000; Benner, 1994; Norberg et al., 1992).

The research illuminates anaesthesia care from two perspectives. The results describe what anaesthesia care means and its consequences from the perspectives of care providers’ (NAs) and what anaesthesia means from the perspectives of care recipients (elderly patients). The research points out consequences of unforeseen problems and of consequences for different approaches to anaesthesia care. Further, the results show that anaesthesia care raises moral issues for NAs when they experience that professional and emotional goals for anaesthesia care cannot be fulfilled or when they have insufficient authority to act. The importance of recognising the experience of temporality as linear and non-chronological was put forward through NAs’ recollections and elderly patients’ experiences of pain and waiting. These situations are experienced in terms of being here and now, i.e., to be in the present, for the elderly, these situations were experienced as endless. The challenges presented in anaesthesia care situations can be applied to other acute and emergency care contexts. So knowledge gained from this research can be used in other areas of clinical practice and education.

This research highlights the need for practical guidance and a forum that could articulate and discuss important moral and ethical issues. It describes the need to articulate NAs’ legal and professional authority in relation to the given practice mandates. It also gives an account of elderly patients’ needs to be understood – from an “insider” perspective – to help them overcome challenges such as pain and wait in anaesthesia care and surgical situations.

Finally, the research calls for more research about the experience of time in relation to care providers and patients in anaesthesia care. It calls for more research about moral distress and its consequences in anaesthesia care.


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POPULÄRVETENSKAPLIG SAMMANFATTNING

Vård av äldre – en utmaning i anestesi miljön

Vården i en anestesisituation skall tillgodose olika mänskliga behov i en mycket högteknologisk och effektiv miljö där många av patienterna som opereras är både gamla och sköra. Enbart i Sverige där nästan två miljoner av landets nio miljoner invånare är 60 år eller äldre genomgick drygt 14000 en höftoperation (primär samt sekundär ledprotesoperation) år 2002. Eftersom de äldre patienterna i många fall dessutom lider av olika besvär ökar kraven på omvårdnad för denna grupp. I vården av patienten skall anestesisjuksköterskan ansvara och tillförsäkra patienten såväl säkerhet som välbefinnande. De äldre patienterna är sårbara och deras möjligheter att påverka sin situation under en anestesi och operation är begränsad.

Studiens överbripande syfte var att belysa vad det innebär att vårda och att vårdas under en anestesi- och operationssituation genom anestesisjuksköterskors och äldre patienters berättelser.

Syftet med studie (I) var att beskriva nyblivna anestesisjuksköterskors olika sätt att se på vårdandet för att förstå hur intentioner och avsikter i vården varierar bland dem. Syftet med studie (II) var att beskriva innebörden av fenomenet problematisk anestesivårdssituation i anknytning till äldre patienter, utifrån erfarna anestesisjuksköterskors upplevelser, för att förstå olika aspekter av fenomenet, dess uppkomst och inverkan på vården. Syftet med studie (III) var att belysa vad det innebär att vara i en problematisk anestesivårdssituation, för att förstå hur den kan upplevas och vilka konsekvenser den har för individen. Syftet med studie (IV) var att belysa vad det innebär för den äldre patienten (60+) att vara i en anestesivårds- och operationssituation under en höftoperation i regionalanestesi.
En fenomenologisk ansats har varit utgångspunkten för samtliga studier då kunskapen som eftersökts har varit att förstå människan (anestesisjuksköterskan och den äldre patienten) i ett specifikt kontext (anestesimiljön). För att vara följsam mot forskningsfrågan valdes tre olika kvalitativa metoder (fenomenografi, deskriptiv fenomenologi och tolkande fenomenologi).

Analysmetoder: I Studie (I) användes en fenomenografisk metod (utarbetad av Martons grupp, Göteborgs Universitet) som utfördes i olika steg: först gjordes en första genomläsning av svaren för att bli förtrogen med texten; i nästa steg gjordes en avgränsning av representativa helheter för olika sätt att betrakta anestesiomvårdnaden; därefter gjordes en särskiljning och uppdelning av helhetskvalitéer som representerar olika sätt att betrakta anestesiomvårdnaden; slutligen gjordes en beskrivning av likheter och olikheter i helhetskvalitéernas mening i form av kategorier och relationer mellan kategorier. I Studie (II) användes en deskriptiv fenomenologisk metod (utarbetad av Giorgi, Saybrook University, USA), med databearbetning i fyra steg. Samtliga berättelser lästes för att få en överblick av uttalandena. Därefter delades varje berättelse upp i meningsenheter med avseende på det eftersökta fenomenet ‘problematiska anestesisituationer’. Varje meningsensitet undersöktes, prövades med intentionen att komma åt innehållet i varje meningsensitet utifrån ett vårdperspektiv och transformerades. I sista steget strukturerades de transformerade meningsehheterna till konstituenter som syntetiserades till en generell struktur av fenomenet. I Studie (III-IV) användes en tolkande fenomenologisk metod (utarbetad av Benner, University of California, San Fransisco, USA). Analysen genomfördes i olika steg. Samtliga berättelser lästes för att få en överblick och första förståelse av innehållet. Därefter lästes varje intervju med fokusering på innehåll med anknytning till syftet. Paradigm case identifierades och användes som hjälp för att belysa och klargöra olika områden som framkommit i berättelsernas innehåll. Det framkomna innehållet sorterades till olika teman.

Resultat: Studie (I) visade tre olika uppfattningar och förhållningssätt: att ansvara för patientens fysiska välmåga utifrån ett uppgifts-, medicinsk-, och teknisktorienterat perspektiv, att beskydda och försvara patienten, att i samband med vårdandet av patienten underkasta sig och uppfylla effektivitetskraven på avdelningen. Samtliga förhållningssätt fanns med i de
olika uppfattningarna men gavs olika betydelse och prioritet. Studie (II) visade att problematiska anestesivårds-situationer uppträdde utifrån såväl kontextuell som individuell nivå. Oförutsågbara situationer var problematiska genom att de inte kunde planeras för i förväg och genom att de accentuerades i en akut situation. Problematiska situationer uppkom också genom att anestesimiljön inte var i överensstämmelse med de värdinger anestesijuksköterskan hade. Återuppväckta minnen från tidigare obehagliga upplevelser omformade omständigheterna i den rådande vårdsituationen till en problematisk situation. Även en avvikande inställning i vårdsituationen var problematisk genom att den gav upphov till känslor i form av att anestesijuksköterskan upplevde sig isolerad och ensam. Studie (III) visade att en problematisk anestesivårds-situation innebar ett känslomässigt moraliskt trångmål. Det moraliska trångmålet uppkom när anestesijuksköterskan upplevde att hon/han saknade befogenhet och mandat att handla utifrån juridiska och eller moraliska förpliktelser. Studie (IV) visade att i en anestesivård- och operationssituation försattes den äldre patienten att hantera och bemästra sin upplevelse av smärta, att hysa tilltro eller misstro. Studien visade även patientens syn på väntan samt på känslor av utanförskap och overklighet.

**Slutsats:** Studien genomfördes i ett specifikt kontext. Men, utmaningarna som kommer till uttryck i anestesimiljön kan även finnas i andra vårdkontext. Den kunskap som framkommit kan därför användas i andra sammanhang inom klinisk vård och utbildning. Studien visar på betydelsen av att fånga vårdens yttre utmaningar från ett individuellt upplevt perspektiv för att därigenom förstå kärnan i de underliggande frågor och problem som kommer till uttryck i: olika förhållningssätt till vård, oförutsågbara problematiska situationer, moraliska trångmål när professionella och känslomässiga mål för vården inte kan förverkligas på grund av att det saknas mandat för att handla. Betydelsen av att inte uppleva tiden kronologisk framkommer i den äldre patientens upplevelser av smärta och i situationer av väntan. Dessa situationer
upplevdes som att beförrna sig i händelsen och i ’nuet’ och därför kunde dessa upplevas som att vara utan slut. Slutligen väckte studien frågan om behovet av etiskt forum.