Behind closed doors – the lived experience of caring for patients in the perioperative setting

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Copyright Statement

Abstract

Background There is an extensive literature base that researchers and practitioners can use to gain guidance and an understanding of the technical aspects of care in the perioperative setting. However, this focus can risk overshadowing the value of more subjective human ideas around care. This research aimed to better understand the lived experience of caring for patients in the perioperative setting.

Methods Giorgi's descriptive phenomenological method was used. Seven perioperative staff were interviewed in-depth and asked to describe their lived experience of care in a perioperative setting. Their verbatim transcripts were analysed using Giorgi's method of analysis.

Findings The general structure of perioperative care means accepting patients into an unfamiliar, alien environment as fictive kin. Within this sense of caring and being cared for, the usual human freedoms are silently handed over, with unconsciousness severing any final freedoms. In response, staff become custodians of their kin and their body. This custodianship places the highest level of responsibility on staff who know how to care with skill, morals, and ownership to protect the person who has lost freedoms with dignified care. Custodianship is transient. Some staff may transfer custodianship to others, but ultimately, there is an aim to return the body back to the patient. Constituent Parts include: (1) your patient and you: fictive kinship, (2) custodian of the body and the person, (3) knowing what to do, (4) making decisions about the patient without the patient.

Conclusion This novel description, including custodianship care within healthcare practice, can focus further research, contribute to education design, guide perioperative practitioners, inform new standards/best practices and unveil secrecy for patients. This study helped to make aspects which were implicit into something explicit so that the human elements of caring can be recognised and celebrated.

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Glossary

AA – Anaesthesia Associate

AfPP – Association for Perioperative Practice

AoA – Association of Anaesthetists

AORN – Association of periOperative Registered Nurses

ATP – Assistant Theatre Practitioner

CPOC - Centre for Perioperative Care

CODP – College of Operating Department Practitioners

EORNA – European Operating Room Nurses Association

HCA – Healthcare Assistant

HCPC – Health and Care Professions Council

HEI – Higher Education Institute

IFPN – International Federation of Perioperative Nurses

NICE – National Institute for Health and Care Excellence

NHS – National Health Service

NMC – Nursing & Midwifery Council

ODA – Operating Department Assistant

ODP – Operating Department Practitioner

PACU – Postanesthesia Care Unit (also known as ‘recovery’)

RCoA – Royal College of Anaesthetists

RCSE – Royal College of Surgeons of England

RNA – Registered Nurses Anaesthetist

RODP – Registered Operating Department Practitioner

SCP – Surgical Care Practitioner

SFA – Surgical First Assistant

WHO – World Health Organisation

WHO checklist – World Health Organisation Safer Surgery Checklist

Chapter 1 - Introduction

1.1 Introduction

Over 300 million operations and procedures are performed yearly worldwide (Meara et al. 2015). Each year, before the COVID-19 pandemic, the number of people admitted for surgery within the National Health Service (NHS) was around 5 million people in England and Wales (Dobbs et al. 2021). Following the pandemic, NHS England has reported a record high of 7.6 million patients waiting to start surgical treatment (National Health Service (NHS) England 2023*a*). This research explores the world of surgery. Most surgery takes place in an operating department, which usually consists of two or more operating theatres. Each operating theatre typically has an anteroom, called an anaesthetic room, where patients are checked in before receiving their anaesthetic. The staff then transfer the patient to the operating theatre for surgery. When their procedure is complete, they are taken to the postanaesthetic care unit (also known as recovery). Staff send patients back to the ward when they can safely be left alone (Whitaker et al. 2013). In the United Kingdom (UK), operating theatres are busy hubs of activity, aiming to achieve around 85% utilisation (NHS Improvement 2019). However, there is criticism that this target does not acknowledge the common experience of surgery not finishing on time (Pandit 2019). Operating departments are built to an exceptionally high standard in order to minimise infection risks due to exposure to body fluids, pathogens and staff putting hands inside body cavities, as well as the need to safely house sophisticated surgical and anaesthetic equipment, including ionising radiation, lasers, noxious gases, oxidising agents, and sharps (Gül 2021). Access to the operating department is restricted to authorised staff only, so whilst much of the population may have had surgery, most people will have very little idea of what goes on behind closed doors.

In this Chapter, I introduce the reader to myself and the world behind these closed doors, a world few know about. It begins with a personal introduction and reflections on why I chose to study this topic. Next, a historical overview shows how terminology has varied between countries, including how different professional bodies have changed their names, influencing how different roles have developed. Finally, I introduce some ideas about the nature of caring in a high-technology environment.

1.2 Getting to know the researcher

In qualitative research, the researcher must articulate their position and subjectivities (Sutton & Austin 2015). In this study, I am interested in exploring the human lifeworld. The term "lifeworld" was used by Husserl to address the limitations of naturalism, where people are seen as fitting into a neutral, objective world (Giorgi, 2009). Instead, Husserl viewed the lifeworld as a "relational reality" with "no objective world in itself nor an inner subjective world in itself; only a world given to consciousness" (Galvin & Todres, 2012, p. 25). However, the breadth and intricacy of the lifeworld extend beyond my research and methodology. Giorgi (2006) developed a research methodology that acknowledged that lifeworld experiences are complex but can be examined through a disciplinary framework to give specific meaning. Given the context of this study within the caring professions, the application of phenomenology with a human science perspective is deemed appropriate. Therefore, I have adopted Giorgi’s scientific phenomenological approach within a human science perspective to investigate the lived experience of caring for patients in the perioperative setting.

In Chapter 3, I will also outline my position related to research, but in this section, I wish to inform the reader about myself and things that may have shaped my perspectives and positionality.

Perhaps most relevant to this research is my clinical profession as a registered Operating Department Practitioner (ODP). As ODPs are unique to UK healthcare staffing, I will briefly describe some relevant aspects of the profession. An ODP is a non-medical healthcare professional registered with the Health and Care Professions

Council (HCPC). Registration requires successfully demonstrating capability in all HCPC Standards of Proficiency (Health and Care Professions Council (HCPC) 2023). This includes being able to care for patients in the three phases of the perioperative journey: anaesthesia, surgery and postanaesthetic care (these phases are shown in Figure 1.1). ODP is a relatively young profession and historically was seen as a more technical role where staff (previously called Operating Department Assistants (ODA) mainly worked in anaesthesia but would also work in surgery and postanaesthesia. The professional association had a magazine called ‘The Technic’, and it was common for the staff to be called technicians. In 2004, the NHS underwent a major reform known as the Agenda for Change (Department of Health 2004). Before this reform, ODAs (and then ODPs) were employed as Medical Technical Officers (MTO), being graded and paid as MTOs despite comparability between the work that registered nurses and ODAs would undertake in the operating department (Gov.UK 2005). In the 1990s, ODAs began to be phased out as new staff underwent an NVQ Level 3 in Operating Department Practice. In the early 2000s, education moved to universities, with students completing a Diploma in Higher Education. This enabled ODPs to demonstrate that they had a formal curriculum and voluntary register that supported the application to become a registered profession. In 2004, following an amendment to the Health Professions Order, ‘Operating Department Practitioner’ became a protected title, with HCPC taking on the statutory duty of regulating the profession and keeping the register of Registered Operating Department Practitioners (RODP) (House of Lords 2004). In the 2010s, there was a gradual move towards a graduate profession (Council of Deans 2013), and a change in the HCPC standards set a full degree as the minimum standard entry qualification from 2024 (HCPC 2021). In the UK, the common practice is for ODPs and nurses in the operating department to be called Theatre Practitioners as a collective term. Following the agenda for change, hospitals do not differentiate between ODPs and nurses in terms of their job descriptions and pay banding.

As an ODP, I began working for a university over twenty years ago. However, I still practice and care for patients in the perioperative setting. I now work in a small unit that provides care for vulnerable patients. When working in the operating theatre, I am usually one of the first faces that the patient sees. It is important to me that I greet the patient with a warm smile and let them know that I am there for them: "*Hi, my name is John, and I will help look after you today*". I had chosen to become an ODP after completing a degree in Medical Sciences. That course signposted graduates to work in the pharmaceutical industry or a university research laboratory. However, I wanted to use what I learned to work in a hospital and care for patients. So, I 'trained' as an ODP by completing a National Vocational Qualification (Level 3) in Operating Department Practice.

When I first attended an operating theatre, I remember feeling moved by how graceful the team worked together, despite everyone being from a different discipline with different skills and educational levels. It seemed remarkable that they did not appear to need to tell each other what to do; somehow, they just knew. There was a striking, almost poetic contrast between the elegance of how the skilled team worked together and the exposed patient's silent, vulnerable, 'lifeless' body. My training involved some taught sessions but mainly learning on the job. Assessments involved repeating textbook information and collecting signatures to demonstrate key competencies required of the role. The student experience stuck with me, and after qualifying, I became involved with the theatre education team. Around this time, education programmes for ODPs started to be delivered in Higher Education Institutions (HEIs) as the profession took steps to gain national recognition. I witnessed how this change led to unrest between staff and increased animosity in the operating department. Existing ODPs felt vulnerable with the prospect that more junior staff and students would have a higher level of educational preparation. Theatre nurses were concerned that there would not be a place for them [or nursing] within operating departments. There were also local, regional and national differences in what staff believed they could and should be allowed to do. As an ODP, you were sometimes labelled with the same identity as your predecessors, ‘technicians’. My first job as an ODP was graded as a Medical Technical Officer. It was a confusing time as the young profession was starting to grapple with developing and promoting the more human aspects of care despite the environment moving at a different pace. I believe that my priority has always remained to put the patient first.

I applied to work at Bournemouth University as a Lecturer Practitioner. I planned and led a new Diploma in Higher Education in Operating Department Practice. ODP was the first new pre-registration allied health programme in the University’s portfolio of programmes. Working as an academic requires me to understand my professional practice. That understanding is used to set standards and teach and assess students against those standards. The reader can see that I bring my insights of working in the operating department and caring for patients. In addition, I have set, taught, and assessed Operating Department Practice. In summary, I brought many ideas, beliefs and attitudes about caring for patients in the perioperative setting to this research. In acknowledging more about my position, I discuss in section 3.3.2 the importance of ‘bracketing’ this knowledge as part of the phenomenological attitude required in phenomenology.

1.3 Choosing my research area

In this section, I will share some influences, barriers and opportunities that led to my final decision about my research topic.

I started working at the University in 2002. My induction included meeting key staff that would support setting up the new ODP programme. I remember being introduced to a senior staff member, ‘*This is John, an ODP. John tells me that nurses do not need to care for patients in theatre as they are asleep*’. I was thrown and stumbled out some reply. I had not said those words but realised I had no answer. Of course, the statement was false. As an ODP who has worked in many different teams, I felt that the staff really did care for the patient. I also knew that I had experienced working in some brilliant teams where everything worked well, but I also witnessed teams where things were disconnected. With this background, I thought about what it is like for patients undergoing surgery. Do we, as practitioners, do a ’good job’? What is the experience like for patients? Can we establish what excellent care is?

Later in my academic work, I was introduced to the Humanisation Framework (Todres et al. 2009). As shown in Table 1.1, the framework comprises eight philosophically informed dimensions of the values of what it means to be human and will be discussed in more detail in Chapter 5.

Table 1.1 Conceptual framework of the dimensions of humanisation (Todres et al. 2009)

Forms of humanisation	Forms of dehumanisation
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenization
Togetherness	Isolation
Sense-making	Loss of meaning
Personal journey	Loss of personal journey
Sense of place	Dislocation
Embodiment	Reductionist body

Although the dimensions are presented in table form, they are not to be understood as opposite categories. The values represent a continuum of what makes people feel more human or less human. There may appear to be some degree of overlap between some of the values, but Todres et al. (2009) have put forward that each one has a unique emphasis, each pointing to the same phenomena (feeling more or less human). The interconnectedness means that changes in one dimension may impact the other dimensions. This way of describing how you can understand what it means to care for the patient appealed to me. However, I could not see clearly how they could be applied in the operating department, as many patients will receive an anaesthetic and are unconscious. Yet the humanisation framework felt very valuable as it addressed issues important to the work taking place in the operating department. The challenge remained of how to investigate the more human aspects in this setting. My interest in putting the patient first by understanding how the humanisation framework could inform patient care helped shape this research positively.

General anaesthetics are accepted as eradicating any consciousness. It is not just about not being able to recall surgery but also about not experiencing it at the time (Pandit et al. 2013). During surgery, there is an essential juxtaposition between how staff care and the patients they care for. The anaesthetised patient has no consciousness, and it is just their body that remains. All the things that make this person an individual – thinking, feeling, being – are absent during hypnosis. The absent patient creates a conundrum when trying to humanise the unconscious. If the patient is unconscious, then are they human? Whilst one never directly knows the contents of the unconscious (Miller 1942), the state of anaesthesia usually means that the patient has no experience or memory. This topic is distinct from accidental awareness under general anaesthesia, where the patient can experience implicit memory recall and post-traumatic stress disorder (Kent et al. 2013, Pandit et al. 2013, Almeida 2015, Kim et al. 2021). Technologies that monitor levels of consciousness can help safeguard against accidental awareness (Bhargava et al. 2004, Wang et al. 2012, Gwinnutt & Gwinnutt 2017).

With the loss of consciousness in the operating department, the eight dimensions of humanised care (Todres et al. 2009) are typically obscured. The ‘absence’ of the patient could limit care by only being able to be delivered in a more dehumanised fashion. The unconsciousness of patients limits researchers' ability to study certain topics in the operating department. The researcher is at a stalemate if they want to examine the patient experience. I thought about this and ended up dwelling on the tension between ‘caring’ and ‘recognising the presence’ of the patient. What is the relationship between the patient and staff, and how might they find ways to humanise the unconscious surgical patient? However, I was aware that it is not good research practice to start to think of answers, explanations, or what data I needed to extract from participants (Galdas 2017).

My interest was in gaining an understanding beyond the medical interventions and technical actions taken by staff in the operating department. The structural activity and perioperative tasks undertaken are well documented: what people are doing and what is done for the patient. What is less clear are the aspects that underpin the expertise and caring for the patient as a person. That is an understanding of what it is like for staff when they care for the patient, the objective and subjective components.

At this point, I have introduced myself as the researcher and highlighted why I am interested in this research area. In the following section, I provide some context and background to my chosen research area. Some of the international variations in terminology and staffing will be outlined, before clarifying how terms are defined in this research.

1.4 Background and context of the perioperative setting

1.4.1 History of Surgery

The history of surgery gives a background to how surgical practice developed into current practice and why the operating department is organised in its current form. Historically, surgery was not part of medicine in the UK until 1540 when the Company of Barber-Surgeons was formed. In 1745, surgeons wanting recognition for their skills and expertise broke away to form the Company of Surgeons (Royal College of Surgeons of England (RCSE) 2023*a*). Late in 1800, with a Royal Charter, the Company was renamed the Royal College of Surgeons. Before and during this time, the success of any operation was significantly limited by bleeding, infection and pain (Payne et al. 2021). At this point, realistically, surgery could only be performed on the body's surface. Anaesthesia was the turning point for surgery. An unsuccessful demonstration of pain-free surgery by Horace Wells (a dentist) took place at Harvard

Medical School in 1845. He used nitrous oxide to support a tooth extraction, but the patient cried out during the procedure, and Wells was accused of being a charlatan. While Wells is accredited with discovering inhalational anaesthesia (Jacobsohn 1995), Wells' student, William Morton, was undeterred and continued experimentation to find a better anaesthetic agent. The first successful use of anaesthesia for surgery occurred on 16th October 1846, in Massachusetts General Hospital in the United States of America (USA) (Wildsmith 2015). Using ether, a public display by Morton allowed sufficient dulling of pain to allow Dr John Warren to remove a neck tumour. The patient, Gilbert Abbott, showed no signs of distress, heralding a new era for surgery. Since then, anaesthesia has continued to grow with technological advancements, pharmacological options and clinical expertise. Anaesthesia allowed surgeons to carry out procedures inside the body as they could safely and effectively cut through its outer layers. Advancements in surgery and anaesthesia have maintained their momentum since the nineteenth century.

1.4.2 Operating departments developing into high-technology environments

With anaesthetised patients, time was no longer the enemy as surgeons did not have to race to finish, and the number of different types of surgery increased. Before anaesthesia, surgery involved a few simple tools and was endured for an agonising few minutes to remove a limb or around ten minutes to remove a bladder stone (Brown 2017). By comparison, in the twenty-first century, a cross-sectional study showed that on average an operation now takes 2hrs10mins (±1hr37mins) and anaesthesia lasts 2hrs58mins (±1hr50mins) (Costa 2017). The tools and equipment available to healthcare, have grown too, with the number of medical devices in 2021 for healthcare growing to around 600,000 medical devices available to the UK market (Department of Health & Social Care 2021) and two million devices available worldwide (World Health Organisation (WHO) 2023). Whilst there is no current method of identifying items specific to the operating department, the numbers indicate the vast amount of technology that has become available to healthcare over the last one hundred and fifty years. Developments in surgical capabilities have been made possible by increasing knowledge, equipment, and technical abilities and developing skilled staff and services. Developments have not slowed over time. For example, robotic surgery is becoming much more commonplace (Sheetz et al. 2020, Bonner et al. 2023), as is virtual reality (VR), augmented reality (AR), and mixed reality in surgical research (Zhang et al. 2022). In addition, the development of autonomous robots has meant that machines can now make decisions and learn (Jamjoom et al. 2022). The role of artificial intelligence (AI) is uncertain in determining what the future operating department will look like, including the role of staff (Trocin 2022). Changes must be matched by staff with a skill set who can work in contemporary high-technology environments. The ongoing growth of technological developments could make it hard to understand how staff can balance caring for a person with the demands of technical care.

1.4.3 The development of the Operating Department

Operating departments have developed into one of the most complex buildings in a hospital (Costa 2017). Over two hundred years ago, there were no operating departments; the surgical team would usually travel to where the patient was to perform surgery. Records suggest that operations were commonly performed on patients in their ward beds, and it was not until 1788 that it was recommended that a separate room should be used for operations (Al-Othman et al. 1998). There was a surge of interest in anatomy in the sixteenth and seventeenth centuries. The ‘theatre’ developed from this interest. Amphitheatres were built with a table in the centre that would support the patient's body or cadaver to accommodate learners and those who would pay to view (Enfield 2022). The German surgeon Gustav Neuber is credited with developing a separate room for surgery to prevent infection in 1883 and a redesign in 1885 that adopted principles of asepsis with different rooms for distinct purposes (Gkagkaris et al. 2022). In America, the first operating room was built in 1884 by William Halsted in Bellevue. It was somewhat make-shift, constructed in a tent, but had hardwood flooring and equipment to boil instruments (Al-Othman et al. 1998). Soon after, hospitals began setting aside surgery rooms that had restricted access and were focused on cleanliness.

The separation of this area continues today. In the operating department, patients, staff and the public are greeted with a placard stating, ‘Authorised Personnel only’. Historically, a painted line on the floor marked a dividing point to a semi-restricted area. In the UK, the line was staggered, allowing theatre staff to walk to the side of the patient trolley as they checked them in. This boundary led to the literary term, ‘behind closed doors’, that gives the sense that only a select few accompany the patient, anaesthetise them and then look after their body during and after surgery. Although this line provides access to a semi-restricted area, there is a further boundary for each operating theatre, which is a restricted area. The physical separation restricting access to the operating department may have caused misunderstandings in the views of non-theatre staff and the public regarding what takes place in the operating department. The term ‘behind closed doors’ appears to have first been used 30 years ago when it was used in literature to demonstrate that care in the operating department was more than technical provision (Dieffenbach 1985). In Chapter 2, the literature review reveals that international research has continued to try to describe an understanding of the care in operating departments.

It has to be recognised that surgical operations also take place outside of the operating department. For example, it is not common, but patients can receive treatment in areas such as dentistry, endoscopic suites, treatment rooms, and the emergency department. These will often involve local anaesthetics or conscious sedation (where the patient remains awake). In addition, a gas anaesthetic can be used for low-risk patients who have been assessed as low risk for a short procedure. However, intravenous anaesthetic agents or deep sedation require a qualified anaesthetist to be present (Royal College of Anaesthetists (RCoA) 2023*a*). This study is based solely on surgical operations in an operating department where major surgical procedures are common practice and the expected treatment for patients.

1.4.4 Operating Department staffing

An operating department is more than a technical building or space; it is made up of healthcare staff and patients. Unlike most other areas of healthcare, there is a high staff-to-patient ratio. The high staff levels are needed to ensure the right people with the right skills are present to support safe surgery (Association of Anaesthetists 2018, Association for Perioperative Practice (AfPP) 2022). Operating departments are an expensive resource, estimated to cost around £1200 per hour to run in the UK (Fletcher et al. 2017), raising the importance of efficiency whilst safety is maintained. The minimum staff-to-patient ratio for a surgical operation with anaesthesia is 5:1 (AfPP 2022). Yet, in my experience, it is unsurprising if a theatre has up to 15:1 when additional specialists and students are included for more extensive or more complex cases. This ratio reflects the technical demand and staff expertise. The greater the need for skills, the larger the number. For example, the world's first bilateral hand and forearm transplant on a child had a multidisciplinary team of forty staff (Children's Hospital of Philadelphia 2015). Operating department teams include people from different professional groups with different roles, priorities and demands. They require both intelligent approaches to technical work, sensitivity towards vulnerable patients, and good social skills to work together. These complex teams are likely to be highly diverse. In my experience, operating department teams have some differences from other healthcare staff groups. There is great diversity in the educational backgrounds of staff working directly together, for example, a medical consultant working directly alongside the HCA. In the UK, ODPs have a more even gender balance of 60% female and 39% male (HCPC 2021) than other professions such as nursing which has around 90% female staff on the Nursing and Midwifery Council (NMC) register (NMC 2023). In England, more surgeons are male than female, with a ratio of 8:1 (RCSE 2023*b*). Also, a practitioner's age does not necessarily equate to experience, that is, older staff does not always mean they have more perioperative experience. Demographic data of professional staff support this as they show that theatre staff tend to be older with an average ODP graduate age of 31-39 between 2004-2015 (HCPC 2015) and in the US nearly 2/3 of perioperative nurses are over 46 years old (Stobinski et al. 2022) compared to only around 1/3 of all US nurses being over 54 years old nationally (Smiley et al. 2023). Theatre teams contain a broad skill mix, where the novice Healthcare Assistant (HCA) may be working alongside the professor of surgery.

The diversity of the team may lead to undesirable challenges. For example, different staff groups working in different ways can lead to increased error (Catchpole et al. 2008). There is also the impact of gender stereotypes on leadership, with leadership adopting more ‘masculine’ approaches, which may account for the greater number of male leaders in the operating department (Minehart et al. 2020). A relatively recent systematic narrative review found that deeply formed hierarchies between and within the different professional groups can create incivility, intimidation and bullying that can inhibit staff from raising concerns and so impact on patient safety (Pattni et al. 2019). In the literature reviewed the authors found that staff with lower power in the operating department were adversely affected due to fear and intimidation. Minehart et al. (2020) point out that historically, the hierarchy is typically masculinised, making team members - who are responsible for patient advocacy - subject to existing power structures that can impede their duties. This is further compounded by unchallenged acts becoming the normal pattern of behaviour, which is something I recall as a student, where an experienced surgeon would only work with a chosen team of female staff who worked in fear and subordination.

Worldwide, the morbidity and mortality rates following surgery were becoming a public health concern, which led to the introduction of an international approach to safer surgery: The WHO Safer Surgery Checklist (WHO 2009). The underpinning data was drawn from international surgical outcomes, including economically challenged settings. There were concerns both for patients in poorer countries and the number of reported critical incidents in countries with a higher Gross Domestic Product (GDP). This included the UK, where annually, there were over 150,000 reported incidents related to surgery (Panesar et al. 2011). The WHO Safer Surgery checklist changed how operating department teams worked together by having scheduled, open conversations to check that critical safety information and activity were acknowledged (Gillespie et al. 2018). The checklist was introduced to 132 countries with the collective idea that teams needed to see if something had been forgotten, a mistake made, or an assumption that something had been done. It was found that at an international level, this change in approach to how teams work had a positive impact by reducing morbidity and mortality rates (Haynes et al. 2009) and affecting length of stay (Haugen et al. 2015). The checklist has become a way for the staff who will care for the patient to work together to reduce the risk of harm, regardless of their profession, experience or skill set. However, there is still more work to be done. In England, harm to patients in the operating department has continued, with 3,155 intraoperative ‘never events’ reported between 2012-2022 (Roberts et al. 2023). ’Never events’ are serious but largely avoidable patient safety incidents. During the intraoperative phase, these include wrong site surgery, wrong implant/prosthesis and retained foreign object post-procedure (NHS Improvement 2021). The modern operating department is a complex setting in which a diverse group of highly skilled staff is committed to providing high-quality and safe care.

1.4.5 History of operating department staffing

The staffing of operating departments has developed globally over the last hundred years. The modern operating department team now looks very different, and there are variations between different countries between which staff groups undertake which roles. This includes registered medical staff, registered nursing staff, registered allied health professionals and non-registered staff. It is important to understand the context and background of international literature and the participants in this study. In the nineteenth and early twentieth centuries, nursing was generalist with no identified areas of specialisation. Looking at how the operating department in the UK became an area of specialisation for non-medical staff reveals several events happening around the same time at the turn of the twentieth century. Although it is unclear what education and training was undertaken, a book by Oxford (1900), titled 'Handbook to Nursing' was published. The handbook provided guidance on asepsis, operations, and anaesthesia for probationary nurses at Guy's Hospital, London. Every nurse was expected to care for surgical patients in the wards pre- and postoperatively and be prepared for and support surgical procedures (Hamlin 2020, Nightingale 2000). It is also relevant to note that the first area of nursing care that Florence Nightingale named as a specialisation was surgery. In 1899, the first operating room nurse is recorded as being employed in the United States (Hamlin 2020). It is thought that it is likely that specialist roles were developing in other countries, such as Belgium, Germany and France, because, at the time, they were carrying out more advanced surgery (Hamlin 2020).

There have been ongoing changes to the workforce that have led to differences between countries. Three primary staff groups employed in operating departments worldwide included: registered medical staff, registered nursing staff and non-registered health care support workers. To meet workforce needs and political directives, registered and non-medical staff groups have developed and expanded so that the traditional boundaries of practice continue to shift. This has led to a significant variation in who does what worldwide. For example, the Nordic countries and America have nurse anaesthetists, where nurses can undertake training programmes to perform anaesthesia under supervision (Jeon et al. 2015, Ray & Desai 2016). America and Brazil developed a direct entry surgical technologist role to support surgery and under supervision to be involved in surgical procedures (Associação Nacional de Instrumentação Cirúrgica 2023, Shields et al. 2023). Australasia has direct entry programmes for anaesthetic technicians to support the anaesthetist in anaesthesia

(Australian Anaesthesia Allied Health Practitioners 2023, New Zealand Anaesthetic Technicians' Society, 2023).

The UK government reports (Lewin Report 1970, NHS Management Executive VFM Unit 1989) led to the development of the ODP role as a direct entry registrant to work in a non-medical role in all areas of the operating department. More recently, new roles have been developed for staff to take on responsibilities and tasks that traditionally more qualified staff had performed. These include HCAs becoming Assistant Theatre Practitioners (ATPs) to undertake the scrub role, surgical first assistants or assistant recovery practitioners (NHS England 2020). Registered staff or direct entry science graduates can now become Surgical Care Practitioners (RCSE 2016) or Anaesthesia Associates (RCoA 2023*b*) to undertake minor surgical procedures or perform anaesthesia, respectively. A summary is shown in Table 1.2 of the roles different staff groups can undertake:

	Staff Group				
ROLE	Medical Doctor	Healthcare Assistant	Nurse	Operating Department Practitioner	Other[1]
Anaesthetist	X				
Anaesthesia Associate			X	X	X
Anaesthetic Practitioner			X	X	
Assistant Theatre Practitioner		X			
Circulator		X	X	X	
Scrub Practitioner		X	X	X	
Surgeon	X				
Surgical First Assistant	X	X	X	X	X
Surgical Care Practitioner			X	X	X

Table 1.2 Summary of roles that staff groups can undertake in the UK

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[1] Typically a science graduate who undertakes a direct entry graduate programme that currently may or may not have statutory regulation or registration.

1.5 Defining the term, ‘perioperative’

Having explored the development and variations in surgery, operating departments and staffing, this section explores the evolution of the more collective term ‘perioperative’. The surgical environment in the UK is colloquially known as an operating theatre. This term has a historical meaning because operating rooms were built with areas for students (or paying guests) to watch operations (RCSE 2023*a*). Some countries, such as the USA, wanted to move away from the notion of others watching and use the term ‘operating room (OR)’. As already discussed, historically, surgery involved restraint and intoxication whilst somebody worked quickly to remove or treat the offending anatomy. Over the last few hundred years, this has become more sophisticated, involving anaesthesia and lengthier surgery, and it is more than just the surgeon performing surgery. Patients now receive anaesthetic care and post-anaesthetic care, the terms surgery and operation still dominate the language used. The term ‘perioperative’ is used to describe things more broadly.

There does not appear to be a definitive time when the concept of perioperative care was first used. When used in published literature or healthcare the term ‘perioperative’, can mean different things in different organisations, countries and articles. The pre-fix ‘*peri*’ describes the activities linked ‘around’ (Grk. *peri* = around, about, beyond) surgical operations, hence the term ‘peri-operative’ (referred to as ‘perioperative’ in this thesis). The variation in how the term is used in practice reflects the extent of what is included before or after a surgical operation. For example, The RCoA and the National Institute of Health & Care Research use the term in the broadest sense. That is, perioperative means when the patient first notices symptoms to a point after surgery, when the patient completes their rehabilitation (RCoA 2019, National Institute for Health and Care Research 2023). The term's narrowest use is by organisations such as the AfPP and the International Federation of Perioperative Nurses (IFPN). These organisations use the term to include when patients have their anaesthetic, surgical procedure and immediate post-operative recovery care (AfPP 2023, IPFN 2023). This limits the term to when patients are in the operating department as these three phases normally occur there (College of Operating Department Practitioners (CODP) 2021). Some variations lie between these two uses; for example, the Royal College of Nursing (RCN) describe it as starting from pre-operative assessment to the point of discharge from the surgical ward (RCN 2023) or the National Institute for Health and Care Excellence (NICE) use it to describe the time from when patients are booked for surgery to the point of discharge (National Institute for Health and Care Excellence (NICE) 2020).

There is a further variation in the literature when the term perioperative is used to describe perioperative medicine (Vetter and Bader, 2023). Perioperative medicine has a broad definition with a scope of starting when surgery is considered a medical option for full recovery (Balfour 2023). In addition, there is a move in the UK to evolve traditional anaesthetic services to become involved in the patient journey outside of the operating department, for example, the skill and knowledge of anaesthetic staff to be involved in the prehabilitation of patients before they arrive at the hospital (Hughes et al. 2019) and the recovery of patients in their home setting after leaving the hospital RCoA (2019). The RCoA have indicated that they are working on addressing the fragmentation of services by bringing together multiple specialities (Nicholson et al. 2023). The plan is to use perioperative medicine to help move away from traditional patient management models so that the complexities of both patients and services can be better served.

Trying to define perioperative could limit the development of patient services in that the term has a different use and meaning in different countries, different services (for example, prehabilitation) and for different staff groups. Claiming ownership of the term for one purpose could affect another use. For this study, I have used the following definition of perioperative: the duration and events in the operating department carried out by the multidisciplinary team, including the anaesthetic, surgical and recovery teams as they care for patients receiving surgery. To help illustrate this definition, Figure 1.1 shows a timeline of the patient's journey from the ward to the operating department and then back to the ward (occasionally, some patients are discharged home directly from the operating department). In the perioperative setting, patients are traditionally described as passing through three phases: anaesthetic, surgical and recovery. Figure 1.1 helps to show that there is an overlap between these phases.

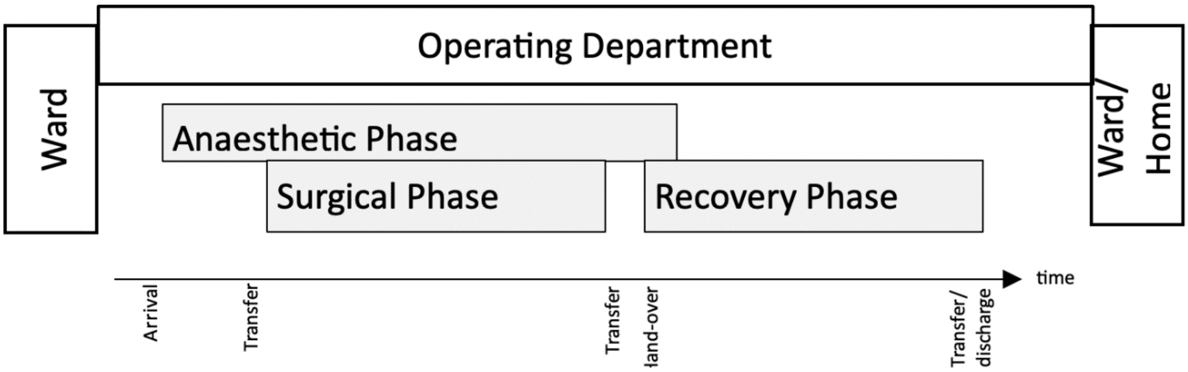

Figure 1.1 Timeline of the patient journey through the operating department

Having explored and defined the terms ‘operating department’ and ‘perioperative’, I now explore the term, ‘care’ and how some ideas of how this can be understood in the perioperative setting.

1.6 Some early considerations of the term, ‘care’

At a basic level, the word ‘care’ in English can mean what care [*noun*] is and what it is to care [*verb*]. It’s origin in British English includes Old English caru (noun), carian (verb), of Germanic origin; related to Old High German chara 'grief, lament', charon 'grieve', and Old Norse kǫr 'sickbed' (Simpson & Weiner 1989). It is important to acknowledge that the word ‘care’ is interchangeable to denote an idea (noun) or an act (verb). When the term is used it may mean different things, and people can then interchange the meaning, leading to misunderstanding. Therefore, the word ‘care’ can mean different things to different people and can appear to change its meaning for individuals and society as a whole. Whilst there is an abundance of work and literature that looks to measure care, it is often seen in terms of the task-based ‘doing’ within health & social care rather than in terms of the experience of people providing or receiving care (Galvin & Todres 2012). The perioperative setting is a high-technology environment that most patients worry about (Wetsch et al. 2009, Stamenkovic et al. 2018, Tulloch & Rubin 2019). Studies have started to consider the more human elements of perioperative care, but the setting has been dominated by investigations into the more structural aspects of medical interventions (Ewart & Blackman 2022). Over the last few decades, there has been an increase in research and literature on patient safety. This section briefly outlines some of these ideas and how they have influenced the current understanding of perioperative care.

Care as a noun may be attributed to a more technical approach to care: doing things. For example, the UK’s Centre for Perioperative Care (CPOC) has set its aims to:

> *“Improve quality, empower patients, support the workforce, influence policy, harness digital technology and promote research & innovation.”*
>
> (CPOC 2023).

Their work examines how high-quality safe care can be sustainably delivered to the whole population. This type of care is essential, and where technical care fails, the consequences are devastating. This was shown in 2008 when the Healthcare Commission reported a higher-than-expected number of deaths in the Mid-Staffordshire Trust, a public hospital in the West Midlands of England. The findings were significant, and a public enquiry followed. The mid-Staffordshire public inquiry reported on substantial failings of the Trust and staff in their care of patients, as follows:

> *"Above all, it [Mid-Staffordshire Trust] failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care."*
>
> (Francis 2013, pg. 3)

The striking patient, family and staff stories recorded in the initial independent inquiry (Francis 2010*a*, Francis 2010*b*) are vignettes of care experiences between Jan 2005 – March 2009. Sir Stephen Moss, former Chief Executive of Nottingham's Queens, was asked to Chair the failing Board and undertook this role in 2009-2012. In an interview with BBC News, Moss stated, '*It's the toughest job I've ever done*' (BBC News 2012). Later, in a presentation to care staff, Moss reflected on his experiences and shared that he has found aspects similar to that of Mid-Staffordshire in every organisation. Moss shared that staff should be vigilant and avoid complacency by thinking it would not occur in their organisation (Moss 2013). The tendency for organisations and those responsible for delivering care to revert to sub-standards of care is of concern. The report revealed, on a massive scale, the impact of an organisation not providing adequate technical care. The tension that arose for the Mid-Staffordshire Trust was that whilst care, as an idea, is a moral act for the health service, '*management thinking was…dominated by financial pressures'* (Francis 2010*a*, pg. 225). At a national level, NHS England (2023*b*), as the operational commissioning board for the NHS, states in its constitution that '*It provides high-quality care'* and quantifies this as *'safe, effective and focused on patient experience*'. As a constitutional statement, this means that in England, this is enshrined in legislation as a primary focus of the NHS. As reported in Chapter 2, Mid-Staffordshire Trust had believed that cuts were part of their strategic approach to meeting commissioned requirements which included a reduction in permanent staff numbers to break even financially despite the potential impact on patients with an increased number of patients per staff member (Francis 2010*a*).

This technical giving of care is vital to patients. Benner & Wrubel (1989) identified that people experienced caring relative to the context. For example, they felt cared for when they had a technical need and a carer demonstrated technical accuracy. Patients needing specialised care expect this to be skilfully done and will forgive staff who do not show as much of a caring attitude if they complete tasks correctly. Unfortunately, technical accuracy only sometimes equates to high standards of care. Technical proficiency is not always given at the right time, to the right person, in the right way. For example, inaccuracies in prescribing and giving medicines at the wrong time – or not at all – were found with medication errors at around 1 in every 133 anaesthetics (Glavin 2010). The need for care to be skilful, accurate and safe appears to underpin the focus of healthcare and the science of illness and treatment. When the more human aspects of caring [*verb*] are left out, it changes the view of care despite high patient satisfaction when things are carried out correctly and safely (Doyle et al. 2013).

Patient satisfaction is not the same as patient experience. However, the former is commonly used to determine quality of health (NHS England 2023*b*) and as a metric for success in positivistic research (Anufriyeva et al. 2021). Further, in their systematic review, Doyle et al. (2013) argue that patient satisfaction should be used to indicate effectiveness and safety. In the perioperative setting, there are obvious challenges to measuring patient satisfaction or understanding patient experience. An individual's actions, ideas, emotions, needs or drives (Miller 1942) are lost to unconsciousness and memory loss (Andrade et al. 2014).

Without a person *caring for* the patient, there is an absence of '*expert human practice*' (Benner & Wrubel 1989, pg. 4). Skill and knowledge do not fully compensate for the humanness of caring for somebody. 'Caring' means the things that matter to people, not just the doing, but the connection. It adds value to the scientific part of technical care. Benner and Wrubel (1989, pg. 1) describe this as '*…having things matter…fuses thought, feeling, and action – knowing and being*'. This builds on Benner's previous studies into how healthcare staff can master their skill (Benner 1984). With these ideas, meaning can be given to the act of caring for patients. Caring, under these terms, allows for the relational nature between carer and cared for, be that loss and pain or joy and fulfilment. This relationship requires trust to enable patients to receive the care offered and feel cared for (Benner & Wrubel 1989). In the perioperative setting, there are some staff that, on most days, will only care for unconscious patients. Therefore, without a relationship, care may be unacknowledged, absent or at best, assumed. Non-caring can be experienced when staff are there ‘only to get the job done’ as it can leave patients feeling dehumanised (Benner and Wrubel 1989).

Care has been arbitrarily divided into technical care given and caring for the patient. As an ODP, I have cared for patients in the perioperative setting behind closed doors. In this research, I have the privilege of investigating the nature of caring for patients and the challenges for staff. The complex stage involves many staff doing many things, and the need to complete ‘tasks’ or resolve ‘problems’ is met by the ever-increasing use of technology (Mitchell & Copplestone 1990). This study does not assess technical care alone but describes what it means to care for the patient.

This study explores the balance of caring for patients with technical care to keep them safe and caring for patients in more human ways to keep them dignified.

1.7 Overview of this thesis

Having introduced this thesis, a summary is now provided the next five Chapters:

In Chapter 2, an analysis of the literature is undertaken to identify gaps in this topic area. Identified themes include the impact of technology, the nature of caring, protection and dignity, working behind closed doors and resources/workforce challenges. The analysis identified a gap in the literature around the understanding of the experience of what it is like for staff in the operating department to care for patients.

Chapter 3 then explores the philosophical ideas, methodology and methods that help position and structure this research. Descriptive phenomenology is identified as a suitable research approach that can meet the aims and objectives. The Chapter also covers how recruitment took place, data collection, and the approach used to analyse the seven interviews.

Chapter 4 contains the findings from the analysis. These describe the phenomenon's general structure, followed by a more detailed description of the constituent parts.

Chapter 5 presents a new conceptual model of perioperative care based on this research's findings. The key elements are theorised and discussed alongside contemporary literature published after data collection. Recommendations are made for future research, including the integration of the conceptual model into training programmes and using the model to inform surgical briefing and debriefing.

Finally, in Chapter 6, I concluded the thesis with a reflective Chapter that will help inform the reader further about the consideration of my role and contribution to the data and findings within this study.

Chapter 2 - Literature Review

2.1 Introduction

In this chapter, I consider the existing relevant literature on caring for the patient in the perioperative setting. There is some debate in the literature about whether it is appropriate to undertake a literature review in qualitative research (Finlay 2011, Giles et al. 2013). The tension is around how a literature review could influence the researcher by affecting their data collection, analysis and findings. In phenomenological research, this should be considered as being outweighed by the benefit of helping to formulate an understanding of the research question, and identify a research gap, as after this, a phenomenological attitude is adopted to gather and analyse the data (Fry et al. 2017). The phenomenological attitude is discussed further in section 3.3.2.

A literature review is an important step in identifying what is known and, if there is a shortage of literature, what aspects have not yet been studied (Aveyard 2019). This chapter details my literature review and aims to show that my research question is worthy of study.

2.2 Literature search

There are numerous ways of categorising different types of literature reviews (Grant & Booth 2009). There are some challenges in defining the type of methodology a literature review uses due to the variation in how terms are used (Hewitt-Taylor 2017, Aveyard 2019). A literature review demonstrates the approach taken to locate and analyse relevant studies. In this research, I used the literature review to show what is already known about caring in the perioperative setting to identify gaps in the knowledge base. I undertook the literature review and used a systematic approach to inform this research that the reader can follow (Hewitt-Taylor 2017). During screening, all included studies were checked that they identified and followed ethical principles and that an appropriate methodology was used to address the research aim. This review is best described as a narrative review as this uses a systematic approach to search for suitable literature based on the type of research question this study aimed to address (Grant & Booth 2009). The review systematically locates literature to be analysed for themes and meanings. These are then used to synthesise a current understanding of this topic.

My search used the following databases (see Figure 2.1 for the number of identified results for each database): United States National Library of Medicines (MEDLINE Complete), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Academia Search Ultimate, and the American Psychological Association's (APA) PsychInfo. Searches were made up to December 31st, 2015, as this was the planned start of data collection. Searches were limited to publications that used the English language and were peer-reviewed. Subject to these limitations, all publications that looked at the meaning of perioperative care from the staff perspective were included. Of the 5,899 records identified, 70 were eligible for inclusion, leading to 24 studies that offered relevant insights.

As there is a gap in the time between the formal literature search and writing up this thesis, a second literature search was performed using the same search terms to check for any new research that would inform the discussion Chapter. The search included articles published between January 2016 and October 2023.

2.2.1 Rationale

Surgery is a significant area of acute patient care. The search was conducted to establish the existing literature on understanding caring in the perioperative setting. Searches looked for studies that explored staff understanding, descriptions or definitions of the more subjective aspects of the human side of caring for patients. The responsibility to care for patients in this acute setting could directly impact patients and staff by better-informing training, competency models and standards.

2.2.2 Objective

The objective of the literature review was to clarify the need for this research by looking at what is already known about how staff care for patients in the perioperative setting.

2.2.3 Search strategy

To develop my research question on perioperative care, I started by formulating a search strategy with a PEO framework, as shown in Table 2.1.

P	Population and their problems	Staff working in the perioperative setting
E	Exposure	Caring for patients
O	Outcomes or themes	Meaning of what it is to care for patients

Table 2.1 Population, Exposure, Outcomes (PEO) framework

Initially the search terms used were general and were used to help shape imagination to locate literature that was more inclusive of the broadness of the perioperative setting and range of staff. From this framework, I was able to consider the appropriate terms for searching literature; the terms used are in Table 2.2. Results were limited to the English language, peer-reviewed and up to 31st December 2015, which is the point that data collection started.

S1	perioperative OR operating theatre OR operating department OR an#esthetic room OR recovery room OR postan#esthe* room OR pacu OR operating room
S2	care OR caring
S3	staff OR nurse* OR health#care professional* OR professional* OR surgeon OR an#esthetist OR anesthesiologist OR technician OR health#care assistant OR HCA
S4	describe* OR define* OR description OR understand* OR view* OR perception
S5	S1 + S2 + S3 + S4

Table 2.2 Final search terms used for formal literature review

These final search terms were developed to overcome the challenge of language use and be more appropriately inclusive of the perioperative setting.

2.3 Finding, screening and identifying literature

The plurality of meaning and usage of the search terms made finding relevant literature difficult, not least due to the vast amount of research activities in the operating department. Initial searches started with locating care articles in the three perioperative phases of anaesthesia, surgery and postanaesthesia (the latter of which is also known as ‘recovery’ or ‘postanaesthesia care unit (PACU)). When limited to the English Language, peer-reviewed, and up to December 2015, there are significant publications, as shown in Table 2.3.

Search Terms	**Results (*n* =)**
Care	3,730,960
care AND surg* OR operation OR intraoperative OR intra-operative	429,278
care AND an#esthe*	116,383
care AND post#an#esthe* OR recovery OR PACU	63,833
care AND perioperative	36,853

Table 2.3 Results for the number of publications using ‘care’ in the operating department

Database searches cannot filter how words are used, so the results include when care is used as a noun and a verb. The enormous number of articles in Table 2.3 is dominated by care linked to medical intervention. Whilst there may be some overlap, this is evidenced by a large number of results for ‘surgery/operations. Positivistic studies generally look at ‘good/best care’ and swamps qualitative studies that consider the more human side of caring for a patient in this setting. When I started looking in the literature, I found a good example of this when a prize-winning article, titled ‘perioperative journey of an elderly lady’, was based only on bio-physical changes

(Prekopa 2015). I then looked for ‘perioperative care’ and found nearly 37k results compared to ‘surgical care OR surgery care’, which yields nearly 429k results and ‘care an#esthe*’ with 116K results. The size of the results reflects the broadness of the terms used to identify literature relating to the more medicalised aspects of patient treatment. To manage this challenge of identifying relevant papers, I used additional search terms to identify papers that investigated the nature of what it means to care (see row S4 in Table 2.2).

Searching needed both precision to identify relevant literature but needed to be broad enough to include studies that only focused on one of the three perioperative phases (anaesthesia, surgery and postanaesthesia). Using the PEO framework facilitated this by searching for specific terms that collectively comprise the subject of study. As described in Chapter 1, the operating department has a range of titles and words used for the staff, physical setting and stages of the patient journey. Additionally, key to my search was to include staff from one or more of the following staff groups: anaesthetists, HCAs, nurses, ODPs, surgeons or technicians. This is to try to understand what is already known about perioperative care from the staff involved. A further challenge was that, whilst the term ‘perioperative care’ includes the three different stages, different staff can deliver care in those settings. Perioperative care represents both the specific care that an individual is giving and the patient's whole care from all staff in all phases. The latter idea transcends the person or the phase but is important to capture the care for the patient. Therefore, the search needed to include one or more of the perioperative areas: anaesthetics, surgery or post-anaesthetics and the various terms and arrangements to locate them. Finally, to understand more about care, studies were included that explored the more human aspects of caring rather than medical interventions.

2.3.1 Selection process and data collection

Whilst it is efficient for one person to perform the selection, there is a risk of missing relevant studies. However, as the literature search was part of my PhD submission, I undertook the literature search, including the identification, screening and inclusion on my own. My literature search resulted in 4,721 records being identified for screening. These records were screened against predetermined inclusion criteria as identified in Table 2.4. This determined if the titles indicated the authors were undertaking studies into the meaning of caring for patients in the perioperative setting, if the study had taken place in the operating department and if the participants included a member of the operating department staff. This was necessary as some authors using the term 'perioperative' or 'surgical' were limited to just the surgical ward or nurses who did not work in the operating department. If there was uncertainty, then I examined the study in more detail. This was usually done to clarify if studies had only investigated physical care or if the care had taken place outside of the operating department; such studies were excluded.

Inclusion criteria	Exclusion criteria
Primary research relating to staff experience or perspectives of caring for patients Studies exploring the role of operating department staff (including anaesthetist, surgeons, nurses, ODPs and care assistants OR the following roles, healthcare professional, technician) when caring for patients Participants included any staff who could work in the operating department Peer-reviewed published literature English language Pre-2016	Studies carried out beyond the operating department setting. Studies which only investigated physical care General descriptions of the role rather than undertaking the more human aspects of care Studies that only had data from patients

Table 2.4 Inclusion and exclusion criteria used for screening studies

Inclusion was determined by either sufficient confirmation being available in the paper's abstract or by reading the paper for further information. Typically, the aims, methods, participants' information and findings were used to make the decision.

The first step in screening led to seventy studies being considered in the second step when articles were read in full. Figure 2.1 identifies the reasons for excluding studies at this stage. The main reason for excluding studies was because the findings related to the procedural roles of the operating department staff. As I reviewed the 70 studies, I had to refine my inclusion criteria to separate out findings that purely related to a description of the role compared to studies that revealed the role of staff when directly undertaking the more human aspects of care. This was determined using my own personal expertise in operating department practice as a clinically practising academic. To help illustrate an example of this screening, I refer to a paper looking at ‘Operating room workload, case difficulty and non-routine events’ (Minnick et al. 2012). The researchers took a qualitative approach that included three different operating department staff groups and conducted two rounds of focus groups. The study looked at activities taking place during the surgical phase. In the paper, the study looks at numerous factors affecting the patient’s likelihood of physical harm rather than the more human aspects of caring. There is, of course, an indirect link between harm and the humanness of a patient, but that would be outside the scope of this literature review to explore the multi-variations that impact patient safety. After reviewing seventy articles, twenty-four studies were considered suitable to be in included in the literature review. The identification, screening and inclusion of literature are recorded in Figure 2.1, which is presented as a modified Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram (Page et al. 2020).

2.3.2 Search Results

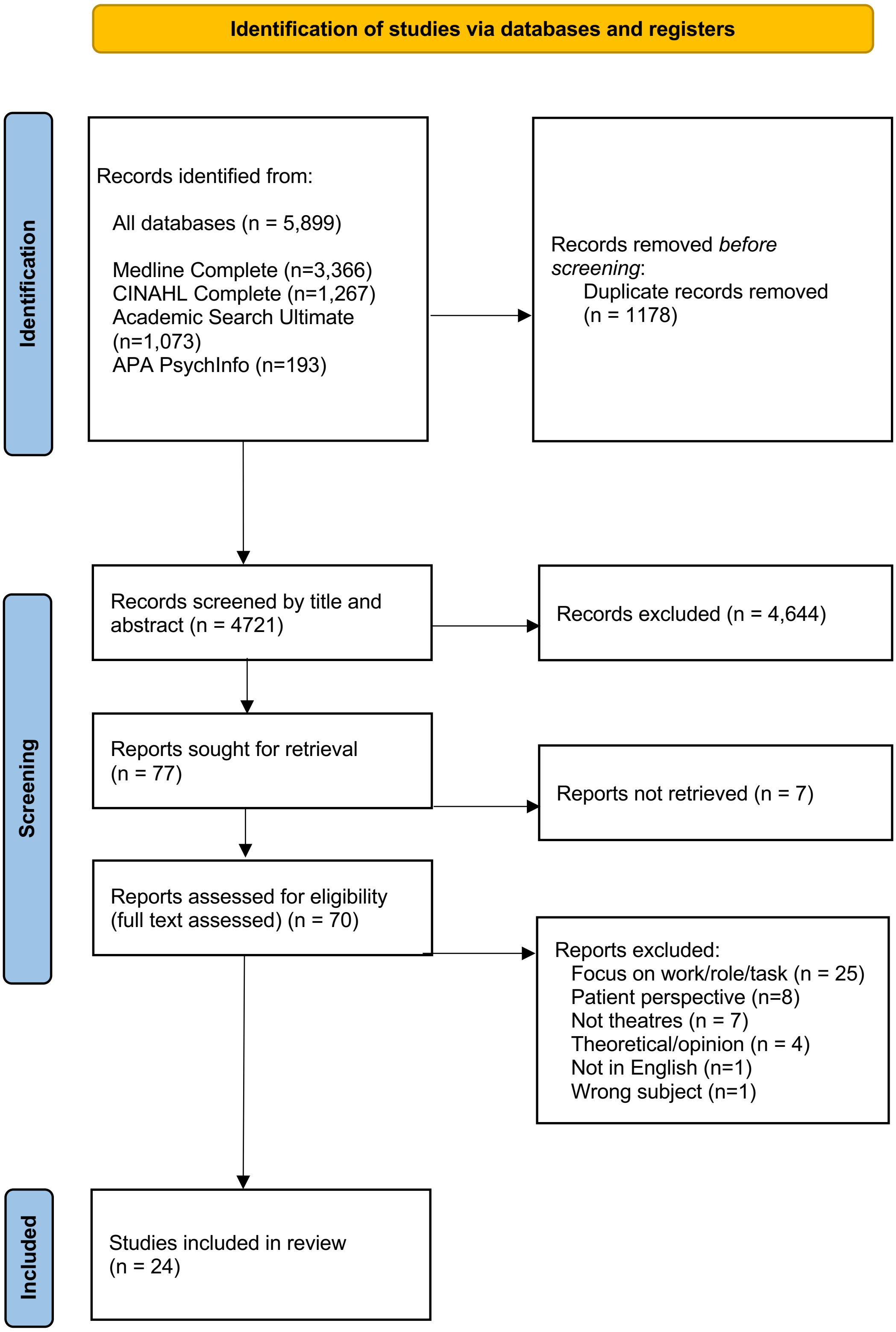

Figure 2.1 PRISMA diagram

2.3.3 Narrative synthesis

The final 24 studies that were included in the literature review have their characteristics and findings summaries in Table 2.5. My review included a range of qualitative methodologies and a quantitative study. Therefore, a narrative synthesis was appropriate to use, due to the different types of studies, as the best fitting approach to summarise the studies and then synthesise findings on the subjects (Hewitt-Taylor 2017, Aveyard 2019).

Popay et al. (2006) provide guidance on a narrative synthesis and using this, the studies were read, and data was extracted in Table 2.5. Narrative synthesis is a valuable and rich approach to telling a rich story of meaning that is useful when looking for meaning. This can be achieved by avoiding specifying predetermined understandings before the analysis (Morgan et al. 2020). The findings column was a summary of the study's findings that were sensitive to the objective of the literature search: 'to gain insights into what is already known about how staff care for patients in the perioperative setting to clarify the need for this research'. Thematic analysis was used to establish the following six themes:

1. The impact of technology
2. The nature of caring
3. Protection of the body
4. Dignity of the person
5. Behind closed doors
6. Resource and staffing

These are explored further in section 2.5.

Table 2.5 Summary characteristics and findings of included studies from the literature review

Year	Country	Authors	Title	Methodology	Method	Participants	Findings: what is perioperative care
1998	U.K.	Mardell, A.	How theatre nurses perceive their role: a study.	Qualitative (thematic analysis)	Semi-structured interviews	18 theatre nurses + 1 recovery nurse + 1 anaesthetic nurse	Nursing aspect of role: communication/reassurance Caring is: patient safety talking/reassuring dignity & patient comfort
1998	Sweden	von Post, I.	Perioperative nurses' encounter with value conflicts. A descriptive study.	Critical Incident Technique (hermeneutic text analysis)	Critical incident reports	46 nurse anaesthetists + 54 operating room nurses	Caring is absent when: nurses' freedom to choose has been eliminated They do things for the patient to protect the patient. They do not abandon the patient – they are their neighbour They keep silent and suffer along with patient
1999	Sweden	von Post, I. & Eriksson, K.	A hermeneutic textual analysis of suffering and caring in the perioperative context.	Critical Incident Technique (hermeneutic text analysis (Gadamer))	critical incident analysis	1 anaesthetic nurse	Notice when patient suffers from: body letting them down/abandoned by world around Nurse becomes patient's compassion, voice & hands. Nurse shares last minutes of patient's life.
2000	U.K.	McGarvey, H.E., Chambers, M.G.A. & Boore, J.R.P.	Development and definition of the role of the operating department nurse: a review.	Ethnography (Ethnographic analysis)	interviews + 32 hours of observations + analysis of 22 care plans	35 nurses 6 operating sessions	caring was described by nurses but observed as physical requirements medical/technical roles
2002	U.K.	Williams, M.	Quality in operating theatre nursing: a phenomenological research study.	Interpretive Phenomenological Analysis	Semi-structured interviews + written critical incident	28 operating room nurses	Positive experience when in comfort zone and working in own power base. Acting as advocate, accountability Largely contented group who: enjoy being theatre nurses

Year	Country	Authors	Title	Methodology	Method	Participants	Findings: what is perioperative care
							deliver safe care but care may be detached, routine and impersonal Lack of personal empowerment leads to a distancing from responsibility for quality of care.
2003	Sweden	Rudolfsson, G., Ringsberg, K.C. & von Post, I.	A source of strength – nurses' perspectives of the perioperative dialogue.	Grounded Theory (Glaser & Strauss' constant comparative analysis)	Semi-structured interviews	10 nurse anaesthetists 10 theatre nurses	Nurses are more committed to patient when they got to know them more Caring relation: Making a mutual agreement Special responsibility Developing caring competence Feelings of inadequacy Walking together: Becoming attuned to patient Keeping care of the patient throughout Moment of recognition Moment of appreciation
2003	Finland	Leinonen, T., Leino-Kilpi, H., Ståhlberg, M.R. & Lertola, K.	Comparing patient and nurse perceptions of perioperative care quality.	Quantitative descriptive study (descriptive statistical analysis)	Questionnaire	874 adult patients, 189 registered nurses	Patient's rate nurses better than they rate themselves using a modified Good Nursing Care instrument. Involve patients more in decisions and listen more if they have questions/uncertainty.
2003	U.K.	Mehigan, S.	Role perception in a climate of change. The role of the anaesthetic nurse.	Naturalistic approach (Principle Component Analysis)	Group's personal construct	9 nurses on an anaesthetic course 13 pre-registration student nurses on theatre placement + researcher	constructs between: sees patient as human - sees patient as case/number more personal exchange - less personal exchange patient contact - minimal contact

Year	Country	Authors	Title	Methodology	Method	Participants	Findings: what is perioperative care
2005	U.K.	Smith, A.F., Pope, C., Goodwin, D. & Mort, M.	Communication between anesthesiologists, patients and the anesthesia team: a descriptive study of induction and emergence.	Ethnography (ethnographic analysis)	Observations and interviews	133 hours of observation and interviews (consultant/ trainee anaesthetists, ODPs)	dignifying the patient through appropriate communication (words and timing)
2007	U.K.	Steevenson, G.	A reflective case study in the obstetric theatre: focusing on the principles of care involved.	Qualitative (narrative analysis)	Informal reflection	1 ODP	Patient autonomy
2007	Sweden	Lindwall, L., von Post, I. & Eriksson, K.	Caring perioperative culture: its ethos and ethic.	Critical Incident Technique (hermeneutic text analysis (Gadamer))	Secondary analysis	Operating room nurses and nurse anaesthetists.	Care for patient (have a heart) as suffering human. Confidence to take patient seriously. Courage - to be there for patient. Responsibility to take on burden. Protect & tending to body
2008	Sweden	Blegeberg, B., Bloomberg, A. & Hedelin, B.	Nurses conceptions of the professional role of operation theatre and psychiatric nurses.	Phenomenography (phenomenographic analysis)	Semi-structured interviews	16 participants with various experience including students	Dependent assistant: -passing tools, fixed in space and time responsible monitor - being well prepared, keeping things in place, securing the operation. Fragmented nurse: - giving incomplete care - no relation to the patient
2008	Sweden	Björn, C & Boström, E.L.	Theatre nurses' understanding of their work. A phenomenographic study at a hospital theatre.	Phenomenography (phenomenographic analysis)	Interviews	15 nurses	control of situation: appropriate equipment prepared maintaining sterility control patient, instrument, implant and department logistics remain one step ahead

Year	Country	Authors	Title	Methodology	Method	Participants	Findings: what is perioperative care
							good teamwork: attentive to spoken/unspoken wishes/needs of patient & team Development through practical experience.
2009	Sweden	Lindwall, L. & von Post, I.	Habits in perioperative nursing culture.	Qualitative research (Hermeneutic text analysis)	Focus groups	15 nurse anaesthetists + 15 theatre nurses	habits that promote ethical values: temporary friendship with patient showing respect for each other habits that hinder progress: seeing patient as surgical case not acknowledging each other not talking about ethics/caring habits that set the tone: hidden power structure achieving more in less time
2011	Sweden	Kelvered, M., Öhlén, J. & Gustafsson, B.A.	Operating theatre nurses' experience of patient-related, intraoperative nursing care.	Qualitative (descriptive analysis technique: inductive, systematic analysis)	6 paired & 4 unpaired interviews	16 nurses	create continuous confidence-based relationships: give patient confidence sharing thoughts of another human being enabling patient to be individual guarantee patient safety and Create wellbeing by keeping watchful eye: preparing collaboration with the surgeon staying safe acknowledge patient's right to professional care leading & evaluating Create secure environment: patient physical requirements
2013	Sweden	Sundqvist, A.S. & Carlsson, A.A.	Holding the patient's life in my hands: Swedish registered nurse anaesthetists'	Qualitative (content analysis)	Semi-structured interviews	20 nurse anaesthetists	Being the patient advocate means, holding patient's lives in my hands: - providing dignified care, providing safe care, moral commitment

Year	Country	Authors	Title	Methodology	Method	Participants	Findings: what is perioperative care
			perspective of advocacy.				- treat patient respectfully, establishing trust, defending patient's rights, vicarious autonomy, being one step ahead, safeguarding patient from harm, informing patient, obligation, moral stress, courage, satisfaction
2013	Brazil	Madeira, M.Z.A., Costa, C.P.V., Sousa, L.E.N., Batista, O.M.A., Vieira, C.P.B. & Trabasso, P.	Nurse's perception on nursing care in the postanaesthetic recovery room.	Qualitative (Bardin's content analysis)	Semi-structured interviews	7 recovery nurses	Care is meticulous and intensive, keeps the patient safe by restricting itself to technical and mechanistic actions that can overshadow personal, ethical and relational dimensions.
2014	Sweden	Rudolfsson, G.	Being altered by the unexpected: understanding the perioperative patient's experience: a case study.	Qualitative (Hermeneutic text interpretation (Gadamer))	Case study	1 perioperative nurse	listening to the patient to know them in a short time patient might feel ashamed of their body
2014	Denmark	Sørensen, E.E., Østrup Olsen, I., Tewes, M. & Uhrenfeldt, L.	Perioperative nursing in public university hospitals: an ethnography.	Ethnography (Hammersley and Atkinson's guidelines for hermeneutic back-and-forth process in a stabilization analysis phase and	Semi-structured interviews + observations	24 nurses	patients addressed as either human or objects technical skills observed as either with flair or lacking Interaction ranged between 'flexible and excellent' and 'inflexible and rigid'

Year	Country	Authors	Title	Methodology	Method	Participants	Findings: what is perioperative care
				an adaptation analysis phase)			
2015	Australia	Smith, Z., Leslie G. & Wynaden, D.	Australian perioperative nurses' experiences of assisting in multi-organ procurement surgery: a grounded theory study.	Grounded Theory (Glaser & Strauss' constant comparative analysis)	Semi-structured interviews	35 theatre nurses	struggled to connect to the humanness of the cadaver became objective connected when thinking of family and recipient
2015a	Sweden	Blomberg, A.-C., Bisholt, B., Nilsson, J. & Lindwall, L.	Making the invisible visible - operating theatre nurses' perceptions of caring in perioperative practice.	Phenomenography (Dahlgren and Fallsberg's phenomenographic analysis)	Semi-structured interviews	15 theatre nurses	to follow the patient all the way through: continuity of care, getting to know the patient be responsible for the patient & keeping a watchful eye, protect patient's body preserve patient dignity
2015b	Sweden & Norway	Blomberg, A.C., Willassen, E., von Post, I. & Lindwall L.	Student nurses' experiences of preserved dignity in perioperative practice - Part I.	Critical Incident Technique (hermeneutic text interpretation (Gadamer))	Written story analysis	60 nurses doing Operating theatre nurse education	Wanting to care for the patient like a human being. Dignity results from being present for each other & making themselves known to the patient Caring is being compassionate and preserving patient dignity
2015	Sweden & Norway	Willassen, E., Blomberg, A.C., von Post, I. & Lindwall L.	Student nurses' experiences of undignified caring in perioperative practice - Part II	Critical Incident Technique (hermeneutic text interpretation (Gadamer))	Written story analysis	60 nurses doing Operating theatre nurse education	Undignified care is careless behaviour: rendering the patient invisible ignoring the patient's worry and pain treating the patient as an object Undignified care is humiliating patient by: speaking in negative terms about the patient's body blaming patient for the situation they are in

Year	Country	Authors	Title	Methodology	Method	Participants	Findings: what is perioperative care
							Lack the willingness and courage to protect the patient's dignity in perioperative practice.
2015	Brazil	Salbego, C., Dornelles, C.S., Greco, P.B.T., Pradebon, V.M., & Alberti, G.F.	The meaning of care for operating room nursing.	Qualitative (thematic analysis)	Semi-structured interviews	8 nurses	Value psychological, social and affective aspects. Holistic view of caring for themselves and others. Meaning is detached from technical aspects to value psychological, social and emotional aspects.

2.4 Overview of literature review

As the date of the studies did not limit the literature search, it appears that despite operating theatres being one of the first specialities that Nightingale identified as a specific place for nurses (McGarvey et al. 2000) that this subject area was not studied in these terms until the late 1990s.

Amongst the twenty-four studies, there is a clear lead from the Nordic countries (n=15), particularly Sweden (n=13). These studies explore more human ways of understanding ‘care’ in the perioperative setting. Besides the Nordic countries, there are studies in Australia (n=1), Brazil (n=2) and the UK (n=6). The Nordic movement appears to emanate from Katie Eriksson, a Finnish nurse theorist, who developed the caritative care theory. Eriksson co-authors two of the studies and is cited in a further twelve, making the influence of her theory worthy of exploring at this stage.

2.4.1 Eriksson’s Caritative Care Theory

Eriksson, a Finnish nurse philosopher, is considered a pioneer of caring science in the Nordic countries. As a number of her writings are not in English, some information is taken from commentaries. Linström et al. (2005) document that Eriksson’s theories developed from ideas of caring as humanistic, building on Aristotle’s suggestion that the essences of reality are a motive (as a final cause, the reason, intention and purpose) for seeking to give to another. Care is sought by the skilled carer and is then realised. In order to care, the provider has to have love. Eriksson uses the word ‘caritas’ (Lat. = charity, love) as the amalgamation of eros (Grk = physical desire) and agape (Grk = [unconditional] fraternal love); later, she qualified that this love was innate and defining of being human.

Eriksson put into place that caritas, as an ethical motive, precedes care as an idea. As a human, the carer is driven towards revealing this love and charity (caritas): the physical love for another combined with an unconditional concern for the fellow human being. Thus, Eriksson considers these ideas of caritas as an ontological ethic that is realised and revealed by the caring communion between the carer and the patient (Eriksson 2007). This communion is defined as a:

> *'required meeting in time and space' and 'is characterised by intensity and validity, warmth, closeness, rest, respect, honesty, and tolerance.'*
>
> (Eriksson 1990 cited by Nyström et al. 2021, p. 195)

As Eriksson saw that caring ethics is inherently human and formed based on ethos (Eriksson 2007), she constructed a theory around humanistic aspects of caring (Nyström et al. 2021). The theory lays out a philosophical view, manifested through *Caritas*, that love and charity are primacy in humans. The theory can, therefore, be understood, according to Eriksson, as being a strong ethical framework of, amongst other things, dignity, responsibility, good and evil (Bergbom et al. 2022). The inner motives of love, mercy, and compassion are found in the relationship between the carer and the patient. Thus, staff's caring ethic is relational and importantly, this means that it is only realised at the point the patient decides (Bergbom et al. 2022).

Eriksson's theory means that as a relational ethic, caring is an inner value of respect and openness for the patient's world, and importantly, it is also found in each patient encounter (Arman et al. 2015). Therefore, the theory has strength in providing meaning to caring sciences. Eriksson's interest in the caring culture arises from her nursing background, where she saw that compassion and love are the main motives and ethos. This approach values how carers act beyond the mechanisms of a job role when taking on a more profound sense of responsibility and compassion towards patients and can inform meaning in the experiences of people caring. Finally, Eriksson's theory establishes an empathetic and patient-centred human connection by prioritising love and compassion. However, there are important limitations as the Caritative Caring Theory is highly philosophical and abstract, making it challenging to apply in clinical settings. In particular to my study, the theory does not provide insights into the application of Caritas with an unconscious patient that staff know very little, to nothing, of the person. Even with conscious patients, while the theory has a strong ethical and philosophical framework, Näsman (2020) argues there is a lack of validating empirical evidence and limited research exploring its effectiveness on patient outcomes. Furthermore, Eriksson’s Caritative Care Theory is part of Nordic caring science, and its universality to other cultures has not been explored. However, Näsman (2020) believes that there is a universality.

Eriksson’s science gives a broad and general understanding of - and proclaims a reason for - caring. The studies were based in Norway and Sweden and took place over two decades. In the studies, Eriksson writes with some of the early authors at a time when they were doctoral students. These students then became Professors in subsequent publications where they continued to explore Caritative Caring Theory in the operating department. Authors and co-authors include von Post, Lindwall, Bloomberg and Rudolfsson. Lindwall et al.’s (2007) description of caring identified six categories to express ideas of a caring perioperative culture, including staff having a heart for the patient as a suffering human being, taking responsibility for someone else’s burden and having the confidence to accept the body so that they can protect them and tend to their body. The description of caring was based on a hermeneutic study that Eriksson co-authored using the Caritative Caring Theory. It should be noted that whilst the study refers to the perioperative setting and the perioperative culture, the data is from theatre nurses and nurse anaesthetists. This could mean that it is more reflective of perioperative nursing culture, and this could be argued for most of the studies in this literature review.

2.4.2 Methodologies and participants

Besides the study that took place in Finland (Leinonen et al. 2003), qualitative methods were used. The qualitative studies used a range of methodologies, with hermeneutics and phenomenography being the most popular, particularly in Sweden. This gives some insight into how findings are interpreted with a strong presence of Eriksson's Caritative Caring Theory. Participants in the studies were mainly registered nurses, with a cumulative total of 690 nurses. Although the study by Leinonen et al. (2003) includes patient perspectives, it was included as there were also data from staff. Other sources of data included an ODP, consultant and trainee anaesthetist and some studies involved researcher observations. Studies also recruited participants who were students, but these were often qualified nurses undertaking a specialist course in operating theatre practice. Overall, there are perspectives from the three phases of anaesthetics, surgery and recovery but mainly from nursing staff.

2.4.3 Trying to measure perioperative care

The quantitative study was included as it looked at care using an instrument, the 'perioperative nursing care scale', to measure care in Finish operating departments (Leinonen et al. 2003). The study did not seek to understand the meaning of care further, although the authors did use their understanding to modify the tool based on their pilot study. Their study involved a sample of 874 patients and 189 nurses and found that very few responses were negative when using their criteria to measure care. Negative responses tended to describe care as impersonal, for example, like an assembly line. However, studies using semi-structured responses or inviting participants to write about incidents identified that most participants could recount events where patients were treated with undignified care. Despite this observation, the research papers were not dominated by reports of poor care, as most researchers were studying what good care meant. The studies included accounts from Brazil, Denmark, Sweden and the UK, with evocative accounts that show a disregard for the patient as a [vulnerable] person and at times, are pretty damning of the setting (von

Post 1998, von Post & Eriksson 1999, Mehigan 2003, Blegeberg et al. 2008, Lindwall & von Post 2009, Madeira et al.2013, Sørensen et al. 2014, Willassen et al. 2015). It is worth noting that in all the studies, harm is nearly always in terms of the patient as a person, not in terms of harm to the patient's body. This is interesting, as whilst all the studies refer to safety for the person and protecting their body as a tenant of patient care, examples of physical harm were sparse in findings and the narrative.

2.5 Themes identified in the literature review

As part of the narrative synthesis, six themes were identified from the papers; these were a) the impact of technology, b) the nature of caring, c) the protection of the body, d) the dignity of the person, e) behind closed doors, and f) resource and workforce challenges. Each theme is explored in more detail below.

2.5.1 The Impact of Technology

The authors of the studies acknowledge that operating departments have significant amounts of technology and equipment, requiring team members to have knowledge and skills to work in this environment. This creates a knowledge barrier for those staff and patients who are not familiar with this environment, and it is perceived as an area of concern for the patient by operating department staff (Mehigan 2003, Smith et al. 2005, Lindwall & von Post 2009, Kelvered et al. 2011, Sunqvist & Carlsson 2013). This included some theatre staff (Sørensen 2014), where during an ethnographic study, it was found that staff could operate at a declining or failing interaction level when they lack technical skills or fear new equipment, suggesting a correlation between declining technical skills and a greater objectification of the patient. This was felt to lead to inflexibility and a lack of interest. It seems that if the staff cannot look after the body, they are distanced from the patient as a person, too. Von Post (1999) refers to this as the challenge of caring in a high-technology setting. Procedural care requires confidence and experience (Kelvered et al. 2011) in a high-tech environment, but this may not be exclusive to the operating department.

2.5.2 The nature of caring

Overall, the studies in this review describe and give attributes to caring for patients in many ways. The word ‘care’ is an umbrella term that can be explained in numerous ways in the perioperative context. Table 2.6 illustrates the words found in the findings from the studies used to describe care. This range of terms helps give meaning and explanation but also reflects the challenge of providing precision to something complex. Staff and patient experiences of care will vary, and researchers interpret these experiences through a range of methods. These different ways that care is experienced seem to fall into two categories. The two main categories are the protection of the body and the dignity of the person. A functional category of co-requisites is also needed to link these two categories.

Protection of the body	Occurrences
Talking/reassuring/communication	4
Patient safety/Protecting patient/comfort	10
Tasks and Physical requirements	5
Dignity of the person	
Dignity/respect/being present	9
Being their neighbour/knowing patient/seeing as human/take seriously/courage/friendship/sharing thoughts/seeing as individual/listening	12
Staying silent and suffering with patient/attuned to the patient/seeing the patient as a suffering human/taking on burden/moral commitment/staying with patient/making self-known/ compassion	7
Advocacy/involving patient/autonomy/sharing	9
Co-requisites for caring	
Nurse being competent and free to choose	4
Special responsibility/noticing suffering	3

Table 2.6 Occurrence of descriptors of care taken from the study findings

These two main categories (protection of the body and dignity of the person) describe care as something that is primarily objective and subjective, respectively. This makes the former more measurable compared to the subjectivity of dignifying the person. The language used in the studies and shown in Table 2.6 shows that the terms used for protecting the body are clearer and more precise compared to the terms used for the dignity of the patient. Language seems well developed to describe the objective protection of the body, but there is a lack of clarity in the words used to describe the subjectivity of the dignity of the person.

2.5.3 Protection of the body

This category relies upon scientific knowledge of caring for the anatomy and physiology of the body through the safe use of interventions. Participants commonly describe the role and experience of caring for patients as keeping the patient safe or protecting the patient. This is a first priority, and when there is a lack of resources, it may become the only method of demonstrating caring for patients (Madeira et al. 2013). Whilst significant stretching of resources means that all staff are challenged to prioritise establishing patient physiological values, there are hints of this being seen as an important focus (Björn & Boström 2008). When thinking about their roles, nurses find it easy to identify with the management of equipment and how they work together as a team (Björn and Bostrom 2008, Bloomberg et al. 2014). While these findings help inform development in technology competence and working practices, they are limited in how they inform dignifying the patient or the links between technological competence and making space for the more human aspects of caring. All studies have reported the protection of the body - to keep it safe. However, there is little reference to the unconscious body's presence and perhaps the challenge of this. This is occasionally found in some participants' direct quotes but appears unremarkable in most data, findings and interpretations.

2.5.4 Dignity of the person

Maintaining and giving dignity to the patient is more subjective as it is commonly associated with ‘’what makes people feel human’ (Galvin et al. 2016, p. 7). In the operating department, some staff commonly only have a few minutes with a patient, and many will not be with the patient when awake. Finding out what makes a patient feel human under these conditions is difficult. In addition, the duty of the operating department staff to give dignity to patients in a high-technological caring setting (von Post 1998) is challenging. At worst, patients experience violations such as impoliteness, uncaring staff, or staff being prevented from giving good care by colleagues (von Post 1998, Willassen et al. 2015). It is an uncomfortable read to learn about accounts of undignified care, such as in the paper by Willassen et al. (2015) on undignified care, when a member of theatre staff stated there was little point in running tests as the patient was going to die, without realising that the patient was awake and then not saying anything when they were told. This illustrates the strength of qualitative research in relaying the stories and experiences of others, which can resonate and impact the reader to give them insights into this world behind closed doors. Von Post (1998) found that it was important for nurses to be able to care (and not be restricted – a co-requisite) and for them not to see uncaring acts towards the patient. As with the other studies in this literature review, perioperative care was not seen to be just about the individual practitioner but about the collective body of staff taking care of the patient (Lindwall & von Post 2009). As this body of people works closely together and – unusually for health care – has a high staff-to-patient ratio, the individual may face different challenges. It may be due to the emotive findings that von Post then works with Eriksson (1999) to study the data further. Using a hermeneutic analysis of one of the anaesthetic nurse's experiences, they explored suffering and caring in the perioperative setting, drawing on Eriksson’s Caritative Caring Theory. They found that they were confused by the participant’s lived experience. von Post and Eriksson (1999) felt that although they were nurses, they did not know enough about the perioperative setting and could not understand the environment as part of their hermeneutic analysis.

They took steps to deepen their knowledge of perioperative care. Using this new knowledge, they saw that the nurse anaesthetist chose to care for the patient by not using technology to look after the body but chose to care for the patient as a person. On finding the patient, the nurse had decided not to attach physiological monitoring to take any further diagnostic tests, and this had been confusing to the authors until they understood that the nurse had recognised that the patient was dying and that she was tending to the patient as a human being who needed companionship rather than being attached to monitoring and subjected to diagnostic treatment. The nurse decided that they would prioritise making themselves available and giving to the person rather than using technology to understand their body.

Trust is an essential co-requisite of the caring relationship (Sudqvist & Carolsson 2013) that enables patients to accept care and for staff to ‘hold patient’s lives in their hands’. Within this trust, prioritising the person over their body is a necessary separation. It helps to explain the difficulty participants (Mardell 1998, McGarvey et al.1999) have in identifying and describing their role and how they understand caring in the technologically rich environment where the patient’s body is a priority. Mehigan’s (2003) naturalistic approach described the risk of staff performing technical care rather than care of the patient and how objectifying care reduced communication, leading to less satisfaction. However, the participants were inexperienced in the anaesthetic setting being studied, potentially limiting the insights. Staff without perioperative experience can struggle to understand their role and the patient, leading to inappropriate communication (Smith et al. 2015). Inexperienced staff lack the experience of knowing a patient as they become anaesthetised. Similarly, staff without perioperative expertise do not always notice the subtility and value of human connections, such as holding the hand of an anxious patient (Mehigan 2003). Experienced staff may risk seeing caring for the individual patient as routine, but seeing the patient as an individual and not assuming reasons for anxiety or upset can allow for genuine listening to preserve the individual (Leinonen et al. 2003, Rudolsson 2014).

2.5.5 Behind closed doors

Looking at the challenges of inexperience further, several authors refer to perioperative care as taking place behind [closed] doors (von Post & Eriksson 1999, Steevenson 2007, Blomberg et al. 2015*a*, Smith et al. 2015). Participants and researchers infer that most people (staff and patients) need to learn what occurs in the operating department. The ongoing literature investigating this subject similarly supports this idea of unknown things and insights difficult to access. This does not just extend to staff outside of the operating department as, to some extent, it can extend to some perioperative staff. McGarvey et al. (1999), in an ethnographic study based in the UK, found a difference between what participants said and what they observed. Although most participants described their role using terms that were either medical/technical (e.g. equipment, scrubbing, instruments) or patient-related (e.g. safety, advocacy, dignity), they could also say that the nurse-patient relationship was significant. Smith et al. (2005) identified that anaesthetists, when communicating with patients, used different styles of language, including:

- Evocative - such as using stories and illustrations to explain the effects of the anaesthetic.
- Descriptive - letting the patient know what they would feel.
- Functional - where they ask the patient to do something to help them gauge the level of anaesthesia.

Smith et al. (2005) found that the implied relationship between the anaesthetist and patient was substituted by other team members (e.g. an ODP) when the anaesthetist did not communicate. For example, if the anaesthetist gave a drug that the ODP knew would make the patient feel disorientated before becoming unconscious, then they would speak up and describe to the patient what they might start to feel. This tacit knowledge is part of the caring attitude as it had not been previously studied; it was learned by observation in practice and not identified in training.

The absence of knowing makes it difficult to define or evaluate perioperative care, as asking staff suggests they may need help sharing things in language that the researcher can understand. Of course, they cannot necessarily share what they are not consciously aware of or have words for. As Smith et al. (2005) used ethnography, the researchers undertook observations to gather their data. Observations were also helpful to McGarvey et al. (1999) in an ethnographic study. They found a poor correlation between the nurse's time with a conscious patient and their relationship. Their data suggested that the longer a nurse spends with a patient, the less they interact. This may be an ‘outsider’s’ view of the observations, but the participants shared that most of their learning and teaching focused on technical aspects, not the person.

Similarly, in the UK, Williams (2002) studied care experienced by theatre nurses. The findings confirm the value the theatre nurses placed on delivering safe patient care but were sparse in finding ways of describing the human caring aspects as most descriptions were ‘*detached, routine and impersonal*’ (pg. 47). However, this paper limited the description of care to only part of the staff who were delivering that care, as ODPs were not included despite sharing the same job descriptions. There seems to be a dislocation between staff's hard work and the ability to express their care using language that others – outside of the operating department – can relate to. Blegberg et al. (2008) were also interested in the challenge of staffing operating departments, particularly why staff did not seem to want to work in Swedish operating theatres. They found that the perioperative staff role was seen as mechanistic and techno-focused by pre- and post-registration students (Blegberg et al. 2008). Non-theatre staff believed that nursing in theatres involved incomplete care and that there was no relation to the patient.

2.5.6 Resource and staffing

The UK studies in the late 1990s and early 2000s were affected by changes in the non-medical workforce. These changes led to some strong opinions amongst the staff and may have impacted the findings. As discussed in Chapter 1, this time of change and uncertainty started in the 1970s when ODAs became a recognised role with a national education pathway in the UK. ODAs were direct entry roles that involved staff taking on roles that traditionally nurses performed, e.g., scrub practitioner and postanaesthesia care (Lewin Report 1970). Almost twenty years later, the role of the ODA was phased out to be replaced by ODPs (NHS Management Executive 1989). Mardell (1998) writes at the turn of the millennia, at the height of an unsettled workforce, some nurses felt they would lose their place in theatres, and ODPs experienced a hostile workforce that tried to limit their roles. Some studies did not name the ODP role but referred to 'other staff'. Smith et al. (2005) include ODPs as participants, identifying their contribution, such as stepping in when medical staff gave undignified care. This might be because the authors are anaesthetists and sociologists, so they were not subject to the 'turf war' between the other staff groups. Mardell (1998) and others (Williams 2002, Mehigan 2003) picked out some of the tensions, mainly how some nurses felt threatened in their roles by introducing ODPs and their fears for the patient if nurses were no longer present in the operating department. Others have written papers suggesting that introducing ODPs should be unacceptable and considered a detriment to nursing (Timmons & Tanner 2004, Shields & Watson 2007). ODPs did not receive this well. However, the education of ODPs, driven by the UK government reports, set new goals of working in all three phases of perioperative practice and was more patient-centred than the previous ODA training. The reasons cited for not wanting 'technicians' to take on the role included that they do not have the knowledge of a well-educated, specialist perioperative nurse who can provide complete care for the patient. The authors cite the nurse-exclusive theatre roles as below in Table 2.7:

- Assuming responsibility
- Checking they have the right person
- Checking they are having the correct procedure
- Documenting potential hazards
- Preparing the surgical site
- Discussing the operation with the patient/family to seek any anxiety
- Liaise with anaesthetists
- Prepare patient positioning
- Placement of machines, trollies and tables so patient is comfortable and medical staff have access
- Liaise with recovery staff
- Support family and advise on progress
- Recover patients to make sure they are breathing, conscious, warm, pain-free and have an in-tact wound before discharge

Table 2.7 List of nurse-exclusive theatre roles - taken from Shields & Watson (2007).

The data and findings in this literature review reflect these points without naming them to specific staff or roles in studies with mixed staff groups. However, most study participants were registered nurses, making it unclear if these are [exclusively] attributable. In other countries, there are also different staffing models to the UK as staff undertake roles as part of the operating department. This includes nurse anaesthetists and where theatre staff meet the patient outside of the operating department. For example, Rudolfsson et al. (2003) looked at the use of the perioperative dialogue in Sweden, where a theatre or anaesthetic nurse first meets the patient on the ward, then in the operating department and back on the ward after their surgery. Rudolfsson and colleagues theorised that the additional time with the patient outside the theatre led to a closer relationship with the patient as they shared part of their life story, leading to nurses working harder to protect the patient. Following these visits by the nurses, they are no longer anonymous and become recognisable by the patients, leading to nurses feeling more committed to their work. The additional resources needed to adopt this practice in the UK have yet to be identified for successful implementation. Without the perioperative dialogue, UK operating department staff are left with the challenge of connecting to their patients and giving care without the benefit of time to develop a relationship.

The studies in this literature review mainly represent how nurses understand their role (n=21). The data and findings describe the nursing staff’s insights into their caring responsibilities rather than those of the wider multi-professional team. Research identifies numerous examples of nurses experiencing personal challenges because of undignified care that they witnessed (von Post 1998, von Post & Eriksson 1999 and Willassen et al. 2015). The current literature has shown that the care tradition in nursing is threatened by the demands of institutional care’s focus on throughput and biophysical needs. Healthcare systems moving towards more objectified and measurable activity has led to confusion with ‘care’ representing the delivery of these biophysical needs that risks creating an imbalance towards understanding the person. The limited data on perioperative care as a marginalised environment that places people at risk makes this research important and worthwhile.

2.6 Gaps in literature

During the initial screening, most perioperative studies that were excluded were studies looking at patient care as a more technical issue. These excluded studies were based on a positivistic approach that measured care through objective parameters and was inappropriate for my research topic. Many positivistic studies risk overshadowing the value of more subjective ideas around care that are far fewer in number. Of the twenty-four studies in this literature review, most looked at nurses' experiences, though none had all three phases in the perioperative setting. Many of the studies used hermeneutics to interpret participants’ experiences, and a third used Erikson’s Caritative Caring Theory to inform their interpretation. Whilst the studies find variations in an understanding of care, they all offer tangible aspects of what staff do. This focus and type of interpretation leaves a gap in exploring the experience of caring for patients in the perioperative setting, which is not limited by staff group or a particular perioperative phase. Further to this, a study that would help make sense, in general terms, of the experience of caring for patients and the relationship to the unconscious patient would help understand what it means to care in the operating department behind closed doors. Therefore, this study considers the important phenomenon of caring for vulnerable patients in the complexities of the perioperative setting.

2.7 Research aim

In this research, the aim is to contribute to phenomenological descriptive knowledge on caring for patients within the perioperative setting, as a lived-through experience.

Chapter 3 - Methods

3.1 Introduction

In the last Chapter, the literature review revealed a gap and the need for more research into caring for patients in the perioperative setting. As noted in Chapter 1, the perioperative setting is an umbrella term for the three different phases of the operating department: anaesthesia, surgery and postanaesthesia (Figure 1.1). In this research, I address the gap in the literature by asking the research question: '*What is the lived experience of caring for patients in the perioperative setting?'*. A better understanding could contribute empirical data to offer a stronger voice for the more human aspects of caring for patients in the operating department and informing the education and development of students and staff.

In this Chapter, I shall first consider the philosophy and then the chosen methodology underpinning my research question. Secondly, I will detail the methods and analysis used to answer the research question.

3.2 Philosophical considerations

Researchers must locate their research in a paradigm and justify this choice. Identifying the theoretical framework (Kuhn and Hacking 2012) helps to define the philosophical viewpoint, beliefs, influences, approaches and how meaning is given to the findings (Kivunja and Kuyini 2017). Knowing how a researcher positions their study and provides assumptions and understandings helps to offer insights into their philosophical position (Schwandt 2015).

3.2.1 Ontology and epistemology

Research is underpinned by two key philosophical aspects: ontology and epistemology (Grix 2019). Ontology is concerned with how the researcher views the nature of reality

(Creswell and Creswell 2018). Epistemology is the nature of knowledge and how knowledge can be gained and validated (Gall et al. 2006).

There are two main ontological views of reality, which revolve around assuming that either there is a single external reality that is fixed (objectivism) or that there are multiple realities that are not rigid but fluid and that these realities co-exist (relativism) (Patton, 2013). In this research, my position assumes the latter of these views: that is, everyone has their own experience that is unique to them and their world. In this research, I am studying the individual's experience and conceptualising that people will have differing experiences of the same phenomenon and that an understanding of the phenomenon can be learned from those individual experiences (Ross 2012). This ontological approach can give a more general sense of the phenomenon as individuals' realities are constructed from their world, and we can understand a phenomenon through understanding people's experiences (Neubauer et al. 2019). The varying perspectives will illustrate and illuminate the phenomenon being studied (Finlay 2011).

In research, how we know what we know shapes the researcher's assumptions and understanding of questions and answers: how to find knowledge and what knowledge is found. Epistemologically, natural science is limited to positivistic ideas of objectivity and measurable truths. Researchers using positivism believe that an absolute truth can be revealed and measured (Polit and Beck 2021). If truth is absolute, then it is also objective and predictable; it is just a matter of taking time and working out why something happens the way it does. The researcher can look for cause and effect within positivism; researchers can objectively describe what they observe and determine that if all variables are controlled, they can find causality. The belief is that further experimentation or observation will demonstrate that this is repeatable. Within this position, it can mean that if something is not observable, it cannot be the focus of research. This makes such things difficult to describe in typically quantifiable terms, leaving it subjective as it depends on [usually] individual ideas. This can lead to the position that if something is not observable, it is subjective with no objective truth (Ross 2012). For the current research, where I am investigating individuals and their lived experiences, positivism is not a helpful or appropriate approach.

Both Husserl (Zahvi 2013) and Giorgi (1985, 2009) place phenomenology as a rigorous science: not a natural science with its circumscribed single reality that is constituted of objectivity, rather, a world that contains objects constituted by consciousness. Husserl was interested in consciousness and what is necessary to the experiences of an object as it presents to the consciousness. This move away from what is thought of as real and measurable meant that phenomenology could examine what appears as real to the consciousness (Giorgi 2009). Therefore, the epistemology of phenomenology is not that of reality - whether given or individual - but of how the object presents itself through the lived experience. This research is therefore positioned as being underpinned by a descriptive phenomenological scientific philosophy, as described by Husserl (Giorgi 1985, 2009), where the lived experience as described by participants is displayed to the researcher’s consciousness. Therefore, analysis is undertaken within a phenomenological scientific reduction using a human-caring science position to create meaning to something not yet understood.

Within this reality, what a person knows is based on the individual personal experiences. As such the people being investigated hold knowledge of their experience, and their subjective experiences are sought rather than the researcher’s experiences (Rehman & Alharthi 2016). There is a recognition of the complexity of individuals and that knowledge depends on the individual and their interpretation of their reality (Wellington and Szczerbinski 2007). Multiple truths mean there is no absolute truth, as truth depends on the individual’s consciousness rather than a single reality existing independently of people (Collins 2018). Researchers work with the subjectivity of this plurality by seeking an understanding that comes from working very closely with the data. They will study the meaning of a subject as created in the world;

this can be what is individual and common to people (Hammersley 2013). The lived experience and the subjectivity of this knowledge are acknowledged and regarded as important, making ‘humans very knowledgeable and worthy of investigation’ (Ross 2012, p.86).

Identifying and addressing ontological and epistemological matters are philosophical but also crucial to research, as they form part of a research paradigm, which is considered in the next section.

3.2.2 Research paradigms

A research paradigm is a set of beliefs guiding action (Denscombe 2021). Paradigms offer a particular view of the world and have influenced the development of research styles and practices, shaping the interpretation and understanding of how research should be conducted (Ross 2012). There are two key paradigms in research: qualitative and quantitative. The quantitative research paradigm draws on positivistic ideas that knowledge is singular, objective, and observable, leading researchers to look for a cause and effect through prediction, test, and observation (Polit & Beck 2021), as highlighted above. As my research is located within a descriptive phenomenological paradigm, it is appropriate that the different experiences of individuals are valued as the knowledge being sought to answer the research question.

3.2.3 Qualitative research

As I am investigating people’s experiences, qualitative research is an appropriate paradigm for the reasons outlined below.

Qualitative research is an approach to finding out more about meaning within the lives of individuals. This can include people’s attitudes, beliefs, motivations, and experiences of different events or activities (Patton 2013). Researchers are interested in gathering information in the form of words and stories, rather than numbers and measurements, to understand more about people. This is often done by interviewing people, although some qualitative researchers may also use methods such as observation, textual analysis (Fairclough 2003) or arts-based practice (Marx and Regan 2021).

In this paradigm, value is placed on meaning within a person's experience or social processes (Schwandt 2015). Participants' meanings can offer valuable insights, so people are selected because they have access to their experiences and understandings that will contribute to a study. Researchers use information collected to think about how the social world can be better understood. This is done through an inductive process as the researcher does not use an existing theory but will draw on their findings and look for patterns, shared ideas, and differences in views. They will use these insights to inform their findings and conclusions. As these findings are based on people's experiences, they are not used to make predictions but offer an opportunity for others to see what their world is like. The value of this paradigm is the ability to find meaning in everyday stories and the complexity of human experience (Bryman 2016).

Qualitative researchers accept that they are humans working alongside humans. Thus, by asking participants to talk about their experiences, they become part of the research process and will influence the response. Therefore, in qualitative research, researchers must be open and share what may have influenced their research. This openness means that research readers can have a more informed view of how the data are created, which is a strength of qualitative research (Patton 2013). In Chapter 1, I introduced myself as a researcher and my relevant clinical experiences to address this for the reader. In Chapter 6, I share a reflexive Chapter which articulates some of my thoughts, feelings and insights into decisions during this research. Having provided an overview of qualitative research, the following section describes the methodologies I considered.

3.3 Methodology

Several research methodologies exist within qualitative research. When I was conducting my research, I considered three key methodologies: Grounded Theory, ethnography, and phenomenology. As this section explores, these approaches can offer different ways of answering questions.

Grounded theory is a methodology researchers can use to understand people's experiences by interpreting the data to generate a theoretical explanation (Patton 2013). When using this approach, the researcher focuses on a process or an action and recruits people with some experience or views on the focus of the research. Rather than wait until the end of data collection to analyse and then form a theory, the researchers use a constant comparative method. This approach was initially developed by Glaser and Strauss (1967) as they wanted to use experimental data to inform theory rather than using the data to fit existing theories. As a method, researchers will use constant comparison to analyse data as it is collected, taking a thematic approach to develop a theory. They will then use this theory to inform how new data will be collected and categorised. As new data are collected, they can change the theory and can be used to address any gaps. This process continues until the point where further data do not add anything new and 'saturation' is reached. The findings help create frameworks for further research and rely on participants' interpretation of their experiences, and the researcher seeks explanations to develop a theory (Polit & Beck 2021). In Grounded Theory, it is common for the selected participants to be independent of each other. For example, they are not necessarily from the same place or do not interact with each other by different means. This independence can give additional strength to developed theories (Creswell 2013). In this research, I wanted to describe what it felt like for perioperative team members to care for the patient during their perioperative journey rather than generating individual interpretative explanations about processes, so it was deemed to be inappropriate for this research.

Next, I considered ethnographic research. This was given more consideration as it is a helpful methodology when considering the impact of cultural issues on the research topic. The various cultures and sub-cultures are well known by those working in the perioperative setting and their effect on patients (Bello et al. 2022). Researchers using an ethnographic approach are interested in sharing how culture informs human experiences (o'Reilly 2011). The perioperative culture denotes attitudes to caring. A vital part of an ethnographic approach is to immerse oneself in the culture to gain insights into what it is to be in that culture. This generates data that describes the behaviour of the whole, the person in the context of the environment, colleagues and others (Gobo 2008). For this reason, it seemed that ethnography would not be best suited due to its focus on culture, as this research is searching for the lived experience of those caring for patients in the perioperative setting.

The final decision was to use phenomenology as it explores the lived experience rather than developing theories (Grounded Theory) or describing and interpreting culture (ethnography). Phenomenology does not put things into categories, attempt to give an explanation or yield theory. It describes the individual's everyday experience and tells in meaningful ways what it is to be a human operating in a specific setting. Specific to this research is the perioperative setting, which is finding ways of understanding what it is to care for patients, in the broadest sense, as an experience in the perioperative setting.

3.3.1 Phenomenological approaches

Phenomenology is both the name of a well-established philosophy and a research methodology (underpinned by the philosophy of the same name (Giorgi 1985)). The methodology enables the researcher to uncover a person's lived experience without using the researcher's own bias, knowledge or beliefs to determine that experience (Koivisto et al. 2002). This lived experience can then be described meaningfully as it is recalled through an everyday experience. Phenomenology describes the yet undescribed, the very things of life itself. Everyday experiences that are known, such as being a parent, playing team sports and/or living with a terminal illness, are examples that are likely to at first seem to be well-understood experiences that have clarity and shared understanding. Yet, it can become confusing when thinking about such topics, as a person can feel what it is for themselves while articulating a clear and meaningful description for others is challenging. What seems clear and easy can become vague as thoughts become hazy, making it hard to see and articulate meaning. The phenomenologist van Manen (2003) writes that it is this very point – that these are such ordinary and everyday experiences – that is why phenomenological attention can give meaningful insights. Thus, to answer the question of what it means to care for the patient in the perioperative setting, a phenomenological study was well-positioned to describe something that has not been described before. Phenomenology was put forward as a return '*back to the things themselves'* (Husserl 2001, p.168). This has manifested through the methodology, as it provides an established framework for approaching primal topics, such as caring for people, whilst offering the precision of specific settings and context.

The origination of phenomenology is accepted as being led by Edmund Husserl early in the 20th century (Giorgi & Giorgi 2008). Husserl's phenomenology was first a philosophical tradition that he developed as a rigorous science, which then developed into a research methodology that could describe phenomena in people's lived experiences (Patton 2013). Overall, phenomenology studies the structure of various types of experience, ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, including linguistic activity (Smith 2018). Each experience will be real for that person, whether a dream or fantasy, such as how a child finds money left behind by the tooth fairy. The experience is real, with the child having a conscious experience of a phenomenon. As people subjectively experience things, they can give the researcher insights into their experience. These insights will help to provide a meaningful description. Whilst each person experiences things differently (as it is unlikely that individuals will experience phenomenon the same way (Ross 2012)), philosophically, Husserl's thinking about phenomenology was that the collective lived experiences of people offer a more general view of a phenomenon, as each person can only experience some parts of the phenomenon, not all (Giorgi 1985, Husserl 2001, Zahavi 2003, Giorgi 2009). According to Husserl (2001, Giorgi 1985, 2009), this does not change the phenomenon – as Husserl sees the lifeworld as the experience of things that exist independently on their own without needing consciousness. Instead, the individual will experience part of the phenomenon; others may experience some similar and some different parts (Zahavi 2003). Phenomenological research uses these philosophical ideas so that projects can bring together the various ways individuals create meaning in their human experience and how these are considered together. This idea was key for Husserl, calling it 'intentionality' (Giorgi 1985, 2009).

Intentionality is that consciousness is always directed towards objects, which means that reality is the nature of both subjects and objects as they appear to consciousness (Morse 1994). The object itself is perceived in the meaning of the experience (Creswell 2013). Husserl believed that philosophically, phenomenology is without presuppositions, requiring an approach that suspends judgements about what is real (Husserl 2001) and that there is an intentionality of objects that are experienced through consciousness (Husserl 2001, Smith 2018). When somebody has an experience, phenomenology looks at the structure of the form of that experience, where the form will typically involve what Husserl called "intentionality". That is, the direction of experience a person has toward things in the world. As this experience is a property of consciousness, it is the experience of or about something. According to classical Husserlian phenomenology, our experience is directed toward—represents or "intends"— things only *through* particular concepts, thoughts, ideas, images, etc. Smith (2018) makes the point that these make up the meaning or content of a given experience. In Zahavi's (2003) translation of Husserl's work, he notes that a person's experience of the object is smaller than the object itself. The object can be experienced in different ways and by other people. This does not negate a person's lived experience, but their experience is only part of the object and its intentionality. Phenomenology is used to access the lived experience of things happening and what that is like for the person. The object (the phenomenon) is understood in terms of the subject (the person) sharing how their consciousness experienced things themselves. Phenomenology aims to describe the general structure of what the experience is of something. This can be based on what one person experiences but philosophically the object transcends that person's experience. This means that drawing on other people's subjective experiences can change the description to reflect more of the phenomenon being studied.

Husserl is accepted as the founder of phenomenology, and his work has developed and grown over time as a research methodology. The first development was authored by Heidegger (a student of Husserl), who built on Husserl's ideas by addressing perceived ontological issues. This form of phenomenology became known as interpretive phenomenology. Ontological ideas around a person being there in the world led Heidegger to see it as too difficult to fully remove the observer when that person is studying others. This led to Heidegger's methodology as a more interpretive phenomenology, as the observer would use the descriptions of others to interpret meaning (Creswell 2013). There have been further developments in philosophical ideas, such as Merleau-Ponty, who looked at how perception is a dialogue between the lived body and the world – you cannot touch somebody's hand without being touched (Merleau-Ponty 2012) and Sartre, who predicated his existentialism on existence preceding essence (Macann 1993). Others have developed research methods, such as Smith's (Smith & Nizza 2022) work with interpretative phenomenological analysis (IPA) or Dahlberg's reflective lifeworld research (Dahlberg et al. 2008), and these can be categorised as falling within the interpretive phenomenological methodology. Husserl's original ideas became known as descriptive phenomenology. Husserl was interested in describing the phenomenon in a manner that remained as close to the lived experience revealed and understood. Giorgi (1985) developed Husserl’s work into his [Giorgi’s] scientific method.

As outlined above, there are several approaches within phenomenology. Although most approaches are interpretive, philosophically speaking, phenomenology is broadly divided between descriptive and interpretive (Creswell 2013). This research uses descriptive phenomenology so that the findings remain close to the phenomenon's essence rather than being too influenced by the researcher’s interpretation. This was important due to the relative lack of qualitative literature and a perceived need to describe the essence of what is happening behind the closed doors of the perioperative setting.

3.3.2 Giorgi’s descriptive phenomenology

In this research, I used Giorgi’s descriptive phenomenological method. In this rigorous approach, researchers collect concrete descriptions of experiences and, through intuitive systematic analysis, develop a meaningful description of the lived experience (Finlay 2011). The method is considered to enable researchers to collect the description of another person’s story as they experienced the event, using their lifeworld to:

> *‘describe and articulate the ‘whatness’ of a phenomenon as it ‘comes to appear’ in experienced happenings.’*
>
> (Todres & Holloway 2004, p.82)

Giorgi (1985) developed his method as he saw a need for something that broke away from the challenges of psychologism. For him, whilst Husserl’s phenomenology addressed many of those issues, he felt that there was a need for a method that was both practical and was able to be positioned within Husserl’s phenomenology. The method relies on remaining strictly faithful to all its components and adopting a ‘phenomenological attitude’ during data collection, data analysis and the findings (Giorgi 2017). It is helpful to clarify that Giorgi considered his approach scientific because of the rigour and the methodological position that this method is descriptive and not interpretative. He asserts this position by claiming and then illustrating that different researchers, if adhering to the same method, will produce the same findings from a data set (Giorgi & Giorgi 2008). Putting forward that the rigour used gives reliability and validity has caused some debate (Beck et al. 1994, Smith 2010, Noble & Smith 2015, Paley 2016) over the methodological difference between descriptive and interpretive phenomenology, with the latter approach putting forward that all phenomenological researchers have to interpret some or all of the stages of the method: from how they collect data to the way that the findings are distinct and different to what participants say (Giorgi 2011). Descriptive phenomenology focuses on establishing a tightly controlled approach that seeks out and remains faithful to a phenomenon by making meaningful assertions through intuitive validation. This honours Husserl’s maxim of a return to the things themselves by bringing together an understanding of intentionality, object and subject (Faulconer 1993). Descriptive phenomenology pays careful attention to the experience of consciousness of a person who is in the world where the experience exists because it is already an experience of a person; that is, the world is given in the experience and not behind it. In Husserl’s phenomenology, this seeking of the experience is epistemological, as he:

> *‘does not presume that the subject and object must come into contact, nor does he ask questions about how they can be related to each other or whether knowledge falsifies its object...the subject needs no bridge to the object.’*
>
> (Faulconer 1993, p.42).

Giorgi does not see this as the case for interpretive phenomenology and, when asserting his position, has been seen as critical of interpretative phenomenology. Giorgi (2011, 2017) has responded by further clarifying his position and detailing the nature of his descriptive phenomenology. For Giorgi, researchers will use examples of lived experiences to build a description of that thing itself and not an interpretation. He remains steadfast that his scientific method is '*strictly based on Edmund Husserl*' (Giorgi 2017, p. 83), pointing out that critics, such as Paley, have been hugely critical of phenomenology in nursing, arguing it is not phenomenology. Giorgi (2017) argues that such criticisms are due to a misunderstanding of the philosophy and method. Giorgi (1985, 2009) is thorough in his philosophical underpinnings and practical application of phenomenology, recognising the value of phenomenology in areas such as nursing. In his writings, Giorgi desires a rigorous scientific approach (that is, a human scientific approach as the valid way of understanding things themselves, not a natural scientific approach but with the methods synonymous with that approach); he recognises the role of the researcher, the limitations of data, and a fundamental inability to describe truth in completeness accurately. In Giorgi's methodology, these positions are accepted and create rigour as the method achieves consistency and accuracy in data reporting. Descriptive phenomenology, as Giorgi eloquently expresses:

> *"is more inchoate; it dares not go beyond what is present. Gaps in the results are filled by obtaining more data, not theoretical speculation."*
>
> (Giorgi 2009, p.127)

Returning to an earlier point, Giorgi (1985, 2009) clarifies that this methodology requires the researcher to adopt the phenomenological attitude. Husserl, as a mathematician, used the term 'bracketing' to convey the phenomenological attitude. Bracketing is also referred to as 'reducing' or 'suspending' and represents the mathematical use of bracketing, whereby the authors acknowledge the existence of [mathematical] ideas but group them together. Bracketing does not remove that part but means that things can be dealt with separately. Giorgi places emphasis on the researcher using this approach to suspend their own ideas, thoughts, conclusions, and interpretations that are independent of the participants. This is a practical step that requires recognition that you are part of the process, and it is about consciously trying to put aside what you think you know to learn something new. The researcher acknowledges that they are present there and will have an influence.

Part of phenomenology is always based on the researcher trying to consciously ground themselves within the participants' experiences whilst suspending their beliefs and biases. This enables the researcher to hear meaning in the participant’s lived experience to gain a deeper understanding of what it is like for the participant. This insight allows the researcher to approach the structures that make up the phenomenon. This attitude continues into the analysis; for example, only doing one analysis at a time and not starting on another until you have completed that analysis. By doing this and giving time to collect thoughts so that each analysis is considered as a new experience by reframing the phenomenological stance, it supports being about to learn something new. Finally, this is extended to the findings where the researcher maintains a close connection to the participants and the phenomenon so that they can remain faithful and true to the lived experience of the phenomenon. This is a challenging attitude but essential to, so far as possible, extrapolate out their current understanding, external ideas and any bias outside of what the participants have described. Adopting this phenomenological attitude by consciously putting aside what one thinks opens the opportunity to learn more. Todres (2007) sees this as a skill of the researcher that gives permission to the participant to provide a thickly textured description of their experiences. Using data, the researcher analyses and synthesises a description of essential structures and variances that describe what it is to live that experience. Such an approach can importantly generate ways of thinking primarily based on what is obtained through the investigation, yielding the descriptive nature of this approach.

Like natural sciences, this method involves collecting and analysing data to produce findings. Unlike natural science, which intervenes by applying control to the phenomenon or environment, this study seeks to understand the phenomenon as actually experienced (Giorgi 2009). The high ecological validity may be why the data can be presented in meaningful ways so that others reading phenomenological descriptions can relate to the everyday human aspects of the phenomenon as experienced by others.

Giorgi's descriptive phenomenological method (Giorgi 1985, 2009, Giorgi & Giorgi 2008) is used in this present study. The method, in simple terms, for this study involves three stages as outlined below:

1. Collect data (see section 3.4 Method) – in the form of concrete descriptions of what the experience was like.
2. Analyse the data (see section 3.5 Analysis) - this is a timely and involved stage that slows the analysis down so the researcher can dwell on, become embodied in and faithful to the data. Giorgi breaks this down further:
    a. Transcribed data are read for a sense of the whole.
    b. The data are re-read and broken down into meaning units.
    c. Meaning units are considered, with sensitivity to the phenomenon being studied, for phenomenologically sensitive expressions.
3. Elicit findings (see Chapter 4) – using phenomenologically sensitive expressions, a description of the phenomenon is made of a gestalt of an essentially irreducible generalised structure of the phenomenon and its more detailed constituent parts. Unlike themes, constituent parts do not stand alone but give more detail to aspects of the general description, and the general description shows the interrelation between the constituent parts.

3.4 Method

3.4.1 Study overview

This study uses Giorgi's descriptive phenomenological method to conduct a cross-sectional study of seven participants to describe what it is like to care for patients in the perioperative setting. This section expands on the steps of the research method.

3.4.2 Sampling, inclusion/exclusion

Qualitative researchers aim to find participants who can offer a rich data source of their human experience about the issue being studied (Patton 2013). Different sampling approaches can help access other qualitative evidence (Benoot et al. 2016). In descriptive phenomenology, maximum variation sampling is a crucial aspect of recruitment, and as it is used in this research, it will now be explored.

Maximum variation sampling is a purposive sampling method (Denscombe 2021). This type of sampling considers the main variations expected in the kind of people with experiences relevant to the research question. Participants can offer the same rich quality of descriptions as a homogenous group, in this case, caring for people in the perioperative setting whilst having the potential to include the unique aspects of a heterogeneous group (different genders, ages and roles). This can illuminate shared patterns from the sample whilst giving validity to the differences that can arise from variations in the group (Patton 2013). More variation and differences will reduce the scope of variation and focus more on general descriptions. However, there can be a challenge at the beginning to know the range of variation (Palinkas et al. 2015). To achieve representation and diversity, supported by my supervisors, I used my judgement as an early researcher and an ODP when choosing the sample of participants for this research. This resulted in selecting participants with a relevant lived experience who also represented variations, such as differences in demographics, extent of experience, educational background, professional role and area of clinical expertise.

It should be noted that in the staff selection, I did not aim to include each profession and job role in the perioperative setting. The aim was to include participants with experience caring for people in each perioperative phase. Maximum variation was achieved by having a range of roles and professions that included participants of different ages and levels of experience and education. To help illustrate this, I offer two examples of variation, demonstrating where participants are sampled to help see what is general to the lived experience and what might be a variation:

1. Participant 1 is an ODP working in anaesthetics, and Participant 2 is an ODP who works in surgery.
2. Participant 3 is a nurse who works in surgery, and Participant 4 is a surgeon.

In both examples, participants would have been exposed to the phenomenon, which could help to describe the intentionality of caring for people in the perioperative setting. To foster this type of sampling method, the following requirements were set out to determine eligibility:

1. At least two years of experience working in the NHS, caring for surgical patients.
2. Experience in caring for patients who are unconscious for at least part of the time they have been with them.

A minimum of two years of experience working in the NHS was set as I wanted people working and employed there who had sufficient exposure to the phenomenon. Participants who had been learners during the two years were excluded from the study. Learners in placement would introduce too significant a variation from the focus, and several studies have looked at students in the operating department (Blomberg et al. 2015*b*, Valeberg et al. 2018, Willassen et al. 2015). Two years was set as the minimum level of experience to equate to participants having competency (Benner 1984).

As this study investigates a specific phenomenon, there is a need to ensure that participants had experience caring for the patient in the operating department. To address this, one of the inclusion criteria was that the participants would have cared for unconscious patients. In operating theatres, staff can care for patients with different degrees of anaesthesia, including conscious patients, patients with conscious sedation (meaning patients who are awake but do not feel discomfort or pain) and unconscious patients (due to sedation or a general anaesthetic). As discussed in Chapter 1, as the term perioperative can be vague, any recruitment could include participants outside the operating department, such as staff from preoperative assessment or outpatients (Williams 2022). Therefore, it was decided that quintessential to the phenomenon was that the patients would need to be unconscious at some point during the care episode.

To summarise, when selecting staff to interview, I had to be mindful of sufficient differences in those experiencing the phenomenon through maximum variation sampling. Specific to this research included staff who would contribute to the whole picture of caring for the patient during the three phases of perioperative care.

3.4.3 Recruitment and access

Within descriptive empirical phenomenology, Giorgi (2009) confirms that three individuals can confirm the essence of a phenomenon. As the purposive sample was taken from the perioperative team, it was important to include enough participants to illuminate the essence of caring for the [unconscious] patient and where there may be variations, for example, between the surgeon and a HCA. A suitable range of staff was included to ensure that the focus remained on caring for the unconscious surgical patient rather than particular staff groups. It was anticipated that 6-10 participants would be necessary. During the study, it was felt that sufficient data had been collected after seven participants had been interviewed. Notably, the seven participants represented the principle of maximum variation sampling, as shown in Table 3.1.

Participant	Job Title	Area of experience	Experience
1	Operating Department Practitioner	Anaesthetics, Surgery, Postanaesthetics	4 years
2	Healthcare Assistant	Surgery	10 years
3	Nurse (SFA)	Surgery	32 years
4	Healthcare Assistant	Postanaesthesia	6 years
5	Operating Department Practitioner	Anaesthetics, Surgery, Postanaesthetics	8 years
6	Consultant surgeon	Surgery	25 years
7	Consultant surgeon	Surgery	18 years

Table 3.1 Relevant demographic data of participants (SFA = surgical first assistant)

It is important to gain the approval and support of those considered to be ‘gatekeepers’ (Holloway & Wheeler 2010) who could help or hinder the study. Another view of gatekeepers is the importance of selecting the gatekeepers to domains of knowledge (Morse & Field 1996); under phenomenological conditions, this is deemed as those that experience the phenomenon.

Following ethical approval for this research (see section 3.4.5 ethical considerations), an application was sent to a large teaching hospital's research and development department for permission to access staff and the premises. Three gatekeepers were identified below when participants were recruited and interviewed for this research. Approval, required by the University, was not needed from the Health Research Authority as the research only included staff.

- The first gatekeeper was the Head of Research at the NHS Teaching Hospital, where permission was needed to research the premises and approval to use staff time for non-clinical activities. An application, including copies of the research protocol (Appendix 1), participant information sheet (Appendix 2), consent form (Appendix 3) and data protection form (Appendix 4), was made to the Head of Research at the hospital to use the premises and staff time. Approval for the research was given with a proviso of limiting the number of participants to 20 (see Appendix 5).
- The second gatekeeper was senior theatre leadership, as recruitment was planned to include displaying posters in the operating department coffee rooms and for senior management to add the opportunity to participate in research as part of the team agendas. Having agreement from the Head of Research gave initial permission, but I also needed senior staff to allow and not obstruct recruitment. I had already informally spoken to the theatre manager about my plans to undertake this research, so I sent a formal email to the theatre manager, copying the general manager to explain the proposed research and organisational approval and permissions that had been given. However, after two months I still had not had a response due to staffing challenges. I arranged for a face-to-face meeting with the theatre co-ordinator and was met with enthusiasm for the research as it was seen as good for patients, good for perioperative practice and would be a good activity for staff to participate in for their own personal development and research awareness. This was an important step as the theatre co-ordinator confirmed that, where possible, they would support staff to be released during their working day to be interviewed.

- Finally, participants are themselves gatekeepers to their experiences. Staff identified for interview were recruited voluntarily and then asked to provide written consent to participate, ensuring an informed, autonomous decision.

When permission was granted, it was agreed that recruitment for the research would be promoted by placing posters in each of the six coffee rooms, and staff were asked to add it as an agenda item in their monthly team meetings. Recruitment was made using participant information sheets (see Appendix 2). First, staff who wanted to be participants had to sign the consent form (see Appendix 3). All staff who volunteered for this research met the inclusion criteria. From the staff who volunteered, I was fortunate in that they had worked in the three perioperative phases: anaesthetics, surgery and postanaesthetics, as shown in Table 3.1. Seeking representation from the whole team would be challenging and not commensurate methodologically.

3.4.4 Interviews

As the methodology for this research was phenomenology, using interviews as the research tool was appropriate. Giorgi’s method (1985, 2009) involves one-to-one interviews that are audio recorded so that the interviewer can concentrate on the discussion and not distract the participant with notetaking. This allows the interviewer and participants to develop meaningful storytelling, that is, descriptions of participants' experiences as they experienced them. The interviews will be described in a general way first, followed by more specific aspects.

Interviews took place in a comfortable room, without distraction/noise, lasting between 36 and 59 minutes. Rooms were based on the hospital grounds should staff be needed; however, they were not within the operating theatre suite to allow staff more privacy and confidentiality from colleagues. The private room offered a relaxed, neutral atmosphere that was important for participants to feel free to share their stories. It was important that participants did not try to give answers they thought the interviewer wanted but were facilitated to tell their own stories in their own way.

During interviews, the interviewer was able to seek clarification and examples so that thickly textured descriptions of caring for patients in this setting were gained. It is recognised that the interviewer plays a role in gathering valid data, reflecting the person's lived experience (Rumary et al. 2023). To support this, the interviews were unstructured and took place in a relaxed atmosphere. Using unstructured interviews can generate rich data as participants are free to answer at length, providing in-depth and detailed information (Holloway & Wheeler 2010). In creating a relaxed atmosphere, I aimed to support freedom in participants telling their stories in their own words. I aimed to create a physically and psychologically safe space that meant that I could work together with the participants to make the interview more phenomenological. As the researcher, I am looking to know the patient's world, and this requires a balance between the subjective world of the participant and the researcher trying to know it (Sholokhova et al. 2022). The skill of the researcher includes being able to support participants to feel safe in sharing their personal experiences. Phenomenology seeks to uncover the lived experience, which can be a space where the participant lives but has been not articulated or brought into their conscious or cognitive thought (Zahavi 2003). Whilst this pre-reflective space is not yet conscious (Petitmengin 2007) that does not mean it is seeking unconscious experiences but experiences that will become pre-reflective (Høffding and Martiny 2016). The reciprocity that takes place in a phenomenological interview supports the participant to move from general experiences and explanations to specific, singular lived experiences (Høffding and Martiny 2016). Whilst the interviewer has a general idea of what they are exploring, for example, a research question, the interview is kept open to allow the participant to choose what they want to share (Zahavi 2015).

When interviewing participants, they may become aware of experiences that they have not shared before or that they were not aware of. This requires an empathic approach so that whilst the participant and the interviewer try to reach a resonation in understanding, the interviewer is aware that topics may become emotive for the participant (Varela and Shear 1999). To help protect the participant, the information sheet (see Appendix 2) raises the possibility that participants could become uncomfortable or upset. I recognise that the formal system for gaining ethical approval was not an endpoint and ongoing support was needed. In addition, I carry a professional duty (statutorily bound to my HCPC registration) to promote safety and welfare (HCPC 2016, 2023) as well as an ethical duty (Beauchamp and Childress 2019) as a researcher. It should be noted that the participant information sheet also highlights that there can be meaningful benefits for participants in becoming more aware of their experiences and understanding themselves differently. It is important when exploring participant's experiences and digging into their personal world that they feel safe, supported and free to make choices in sharing their experiences. However, Whitney and Evered (2022) feel that there is still an unspoken risk to the researcher, participant and research for subjects when participant and/or researcher distress is not anticipated. To support researchers, they developed a tool to help guide researchers navigate difficult situations. As an experienced health care practitioner, I had the advantage of having experiences of supporting people who are anxious, distressed or are finding things difficult. However, the interviews were straightforward in that the participants remained comfortable during the discussion. Finally, in the unstructured interview, the participants, who were all healthcare workers, could choose what they wanted to disclose, the intensity and the pace of the interview (Corbin and Morse 2003).

In line with common practice, I aimed to put participants at ease by removing any power perceptions, reaffirming confidentiality/anonymity, and using language that was relatable and accessible to the participant. Following formalities, participants were asked the same question about their lived experience. This question was used to evoke thoughts, and then stories, of experiences that are near the phenomenon. Interview skills include being mindful that participants may try to answer questions in a way they perceive the researcher wants questions to be answered or using active listening skills to really hear what the participant is saying and to drill down further into their experiences. This differs from listening to participants and then using my interpretation or understanding (particularly because of my insights into perioperative practice as an insider) to form questions and ask participants to discuss topics I chose. These approaches helped to support the participants in accessing and communicating their lived experiences of the phenomenon. Having presented the general aspects of the interviews, I will now move on to the specific aspects considered.

Interviews took place in a small, comfortable room that was separate from the operating department so that we would not be disturbed and the participant would not feel distracted by seeing work-related activity taking place (Holloway and Galvin 2016). The room was furnished with a low coffee table and two comfy two-seater chairs at ninety degrees to each other. There was a large window, that did not have direct sunlight, providing a comfortable level of lighting. The carpeted floor textured lowered ceiling and comfy sofas absorbed sound well making it easier to hear and have a comfortable conversation as echoes were absorbed (Grimley and Love 2018). The participant was welcomed and invited to take a seat. After I thanked the participants for their time, I reminded them that:

1. They had given consent to have the interview audio recorded. I checked for permission again prior to the interview and then started the audio recorder, checked the battery level and that it was recording before placing the recorder on top of the coffee table.
2. They were free – without prejudice – to withdraw at any point, and the data would be erased until the transcribed data became anonymised.
3. Anything said would be anonymised/confidentiality maintained.
4. I was required to disclose any information that suggested unsafe care that had not subsequently been managed appropriately.

Participants were then asked to confirm their job and role title, how long they had been working in theatres, their primary area of practice, and any other perioperative phases in which they had commonly worked.

When the participants agreed that they were ready to begin the interview, then I began by asking participants the same initial question:

"Tell me what it's like for you to care for the kind of people you care for in perioperative care".

The question is phrased in a way that intended to reduce the participants anticipating specifically what the research was 'looking for' but was near to the experience so that they would tell their own stories (Finlay 2011). The question was balanced between being open enough whilst being quite specific in leading them towards the phenomenon being studied. Indeed, as a phenomenological researcher, it was vital that I tried to suspend personal understanding of the topic. If this is not suspended then my personal understanding of the topic may influence what I ask the participant rather than asking them about what they are experiencing. For example, a participant had been discussing patient exposure as follows:

Participant - "*…all the drapes come off and the patients being washed to get all their preparation fluid off. And I'm conscious that patients then need to have their gown pulled down and blankets put back up so that a) they're not freezing to death but b) predominantly that they, their dignity, is regained really.*"

I was very familiar with and pleased to hear what the participant was sharing due to my own beliefs and practices. This resonation led me to want to agree and to tell the participant something about my understanding to pursue my own understanding. However, as a phenomenologist, I needed to hear more about what this experience was for them and what it was like. The question that I asked them pursued this, and the participant was then able to give a deeper meaning – and conflict – to their experience. The participant had over 30 years of experience, and they believed that it was not good to transfer their feelings onto the patient, but they were using their own feeling and their own beliefs to guide their practice as to how best to care for the patient as a human being. The participants [in their interview] did not refer to the patient being unconscious, asleep or in any way ‘absent’ and if I had not suspended my own ideas, then this really interesting and revealing lived experience may not have been shared:

Interviewer - *Okay. So let’s just dwell on that a little bit. For you, you’re in the operating theatre and you feel a patient is exposed unnecessarily…what’s that experience like, for you?*

Participant - I feel, well I suppose you can personalise it and think, ‘would I like that to happen to me’. And the answer is obviously, ‘no’. And so I suppose I transfer my feelings onto to the patient but, and I, but also I think it’s important that, well it’s important that we don’t transfer our own feelings onto patients all the time but I also feel it is part of what we should be doing. You know, we should be thinking about dignity, and personal care, very carefully.

On a personal note, as an academic with a clinical background in perioperative care, I was aware of the potential for participants to want to answer questions in a particular way. After the initial question, the interview was unstructured to allow the participant to talk about their own experiences in their own manner without me asking for anything new. Subsequent questions were reflexively created to clarify things, ask for other examples, or gain a deeper understanding. This kept participants focused on their lived experience of caring for patients in theatres. Questions were kept open rather than closed to help elaborate on what was already said. The goal was to interact with participants conversationally to help facilitate their story from their point of view. The clarificatory questions were, for example, “Can *you say a little bit more about that?*”, “*In your view, how does ‘that’ connect with ‘that’?”* and “What *happened then?*”. Other questions are used to give flow and give permission for them to describe their experience, for example, "*What was that like, when something that you had not anticipated took place?*" and "*So what you have just described, has it had an impact? Has caring changed?*" At times, if participants were unsure of how to describe the complexities, then reassurances were given to their answers with further guidance. To demonstrate this further, below are two examples taken from the interviews I had with participants. The first is when I asked a participant a question based on their story to help them get closer to their lived experience:

Participant – "…It is interesting how that lot - I think, when you first start in theatres - that's really obvious, and then it disappears as you focus so hard on learning something and doing it. And then actually when you become comfortable with that it somewhat comes back in a way.

Interviewer – "Okay, so that's really helpful. Do you think you can think of some, examples of those different phases? So let's go back to the sort of novice part, 'I'm learning the routines' can you think of an occasion that you could share that with me? What that's like for you?

Participant – "I suppose, it was very difficult. You, you, know, first incisions in skin is quite a psychological barrier, and so the first few of those you do are tough."

The second is when insufficient description is given of the phenomenon so questions are posed to steer the participants towards their lived experience of caring:

Participant – "Staff are just there for that day usually and their reason is because they want to get home but the surgeon, they know that patient. They could be seeing them for years and they've got more of a personal interest to make sure that person gets their operation done. So you can see the two different sides to it."

Interviewer – "That's great, that's how you've seen it for anaesthetists and surgeons. What about for yourself, how do you feel you care for a person? Again, what's great is if you have examples or stories about examples where you felt it had impact on your care. That would be great."

Participant – "We had a long list of stuff to get through and lack of staff as well, on a night shift. We're all tired and want to go to bed, you need to get certain procedures done before that surgeon goes home otherwise that person isn't going to get seen to until the next day. So, we did the anaesthetic, went through into the theatre, got the patient set up on the table and the

> operation started. It’s kind of a bit of a rush to get ready for the next case so that we could kind of send for the patient straightaway, I probably didn’t finish of everything for this patient before I got ready for the next patient and the Bair-hugger [heating device] wasn’t turned on.”

When participants had nothing further to add to their description, they were thanked and reminded of their freedom to withdraw from the research until the data were anonymised. Using an unstructured interview allowed for reflexivity, to respond to the participants and their stories rather than the limitations of having prepared questions, criteria or points that need to be addressed. This freedom meant that when the participants shared *that* they had an experience of the phenomenon, then the questions could be asked to seek out *what* that experience was. This included prompts such as, ‘Can *you tell me more about that?’* and ‘Would *you tell me about an occasion when that happened so that I can understand what it was like for you?*’.

Knowing that the interviews were audio recorded allowed the focus to be on the participants and what they were saying. Recordings additionally offered the opportunity to re-immerse myself in the data. The value of the audio recording was not just the words but the tone, intonation, pace and paralanguage that offer a richer description of the experience that can help during the analysis when determining the disciplinarily sensitive descriptions of the data. All interviews were transcribed verbatim, including pauses and all the participant and interviewer’s spoken words (see Appendix 7 for an example).

3.4.5 Ethical considerations

When conducting any form of research, particular ethical issues must be addressed, such as respecting the rights and safety of all participants. Following the guidelines, as this research was undertaken through Bournemouth University and involved NHS staff but not patients, it only required Bournemouth University Ethics Committee approval. Following minor amendments, ethical approval was obtained for the research (Appendix 6) using the Participant Information Sheet (Appendix 2) and Participant

Consent Form (Appendix 3). Updated guidelines from Bournemouth University (2021) have renamed these documents to Privacy Statement and Participants Agreement Form, respectively. In this research, and to avoid confusion, I have continued to use the earlier titles as these reflect what was used with participants and the approval forms.

Anonymity and confidentiality of the data obtained from the participants must also be considered (Clark & McCann 2005). As such, the identity of the participants was known only by me, and I maintained sole access to the interview tapes, transcripts and all data. This was stored and then erased in accordance with the Data Protection Act (2018) and, Bournemouth University's Research Ethics Code of Practice (Bournemouth University 2021) and Code of Good Research Practice (Bournemouth University 2020). This research did not meet the conditions required to be considered to fall under the General Data Protection Regulation (UK Research and Innovation (UKRI) 2020). However, as any identifiable data had been removed and all personal data was deleted at the point of anonymisation, the research would not have contravened the regulation.

Permission was obtained from each participant to audio record the interviews. It was made clear that recordings would be permanently erased after they had been transcribed. Whilst research is open to scrutiny, the anonymity and confidentiality of the data obtained from the participants must also be considered and therefore, the recordings were erased (Clark & McCann 2005). Specific permission was received for this purpose with a reiteration that anonymity and confidentiality will be maintained as part of the permission seeking.

In line with the protocol, participants were informed and freely chose to participate in the study. As NHS staff, the participants were deemed capable of understanding the information given to them and that they could withdraw at any time up to the point where transcripts are anonymised, without giving reason and without any negative consequences. Before the interview, as described in the previous section, the procedure was reiterated, and a judgement was made that the participants sufficiently understood these points and were freely volunteering. Some participants shared that they were interested in the process, which would help them articulate ideas as they prepared for other interviews about their work. Assurance was given to participants that their identity would only be known by me and that only I had access to the interview tapes and transcripts. All data was stored in accordance with the Data Protection Act (2018), and as the data is fully anonymised, it is not required to be compliant with GDPR regulations (UK Research and Innovation (UKRI) 2020). The data were kept on a university encrypted device that had an alpha-numeric password. No hyperlinks were created to the data, and it was not transferred via email or copied onto other devices. The device used for audio recordings was formatted to prevent recovery of data. Consent forms were kept in a locked drawer in a locked office before being shredded after the data were transcribed and anonymised.

In terms of the researcher, it is also ethically important to ensure that the data is valid, reliable and has veracity (Giorgi 1985). This is not just in terms of the interview and the recording but in using a valid and reliable approach to give veracity when relaying the data. It is also ethical to ensure that participants' time and energy are respected by not asking them to complete unnecessary tasks.

3.5 Analysis

3.5.1 Giorgi’s phenomenological method of analysis

Giorgi is clear and insistent on adhering to his scientific method, asserting that researchers using his method will only succeed if they stick strictly to the stages laid out (Giorgi 1985, 2009, Giorgi & Giorgi 2008). The steps are identified below, and the analysis only began when all the interviews had been completed, and the data were transcribed verbatim. Undertaking analysis or seeking to find meaning before data collection is completed may impair the phenomenological attitude of bracketing during data collection. For each transcribed interview, Giorgi's (2009) steps were used. The first three steps are applied to each participant's transcript. The final fourth stage is the point where the analysis of the individual scripts would be used together to consider a more general description of the phenomenon and any variations that may be accounted for, e.g. a particular variation experienced by those performing surgery or something specific linked with professional identity. Giorgi's steps of analysis are considered below, with an outline of how they were applied to this research:

3.5.1.1 Giorgi's 1st analytical step: read for a sense of the whole

Application of this step is for each interview: the purpose of this stage is to reacquaint the researcher with the data. Re-listening to the audio recordings meant I could hear the participants and not just read their words. It was important to refrain from trying to perform or think about any analysis, breakdown or projection at this stage. This was challenging. Giorgi (2009) argues that meaning can be seen going backwards and forwards, so a holistic view of the description is needed so the reader can spend more time on the parts. He highlighted that when reading the researcher should adopt a phenomenological attitude, which means bracketing thought, external frameworks, experience or any referencing that may be used to understand what is being read. Finally, in getting a sense of the whole, at this stage I was not looking to make a global description or sense but rather to gain familiarity with what the person was saying about the phenomenon.

3.5.1.2 Giorgi's 2nd analytical step: determination of the meaning units

Application of this step is for each interview: this is a practical step to help simplify things by making smaller, somewhat arbitrary 'units' that are more manageable. Giorgi (2009) argues that there is too much data generated in a phenomenological interview for the reader to study in one attempt which is why he adds this practical step that does not alter the data and is not analytical in the sense of reducing the data. This step involves the transcribed description being broken down into ‘meaning units’. The pre-determinants of what constitutes a meaning unit are loosely fixed as they should not affect the overall analysis and outcome findings (as Giorgi and Giorgi 2008 demonstrate in their side-by-side comparison of this analysis method where they created different meaning units but their findings were comparable). Broadly speaking, units are blocks of description that the researcher sets so that the text in a block is manageable and typically reflects a section of the story with a specific aspect of the experience. Each time the meaning changed in the text, a new meaning unit was created. Typically, the meaning units are related to blocks of sentences around a singular point of interest but they may be shorter or longer as appropriate. When transforming the meaning units, in the next stage, one meaning unit is usually addressed, but phenomenologically sensitive expressions can span more than one unit. As discussed above, this stage is a matter of convenience, although it did feel like it helped me, as I spent more time with the data during this step. In the previous step, a holistic awareness of the participant’s description developed. This stage allowed me to consider individual aspects of the participant’s responses.

3.5.1.3 Giorgi’s 3rd analytical step: transforming into disciplinarily sensitive expressions.

The third step transforms the participant’s natural attitude expressions into phenomenologically disciplinarily sensitive expressions. Application of this step is for each interview: For Giorgi, this stage is argued (Giorgi & Giorgi 2008, Giorgi 2009) as remaining scientific even though it may initially seem subjective. Importantly, data are collected in the natural setting, and as human experience, have interdependency and intrinsic relations to the person and the world. Meanings are relational, not hypothetical; they have context and referential aspects. Whilst the natural science approach seeks to control the variables while collecting data on a phenomenon, Giorgi aims to transform the data so that the implicit meaning can be distilled into an explicit, meaningful description that is sensitised to the phenomenon. Through this transforming stage, each interview transcript allowed the research data to become meaningful descriptions in their own right.

This stage was completed after all the meaning units were determined for all the participant interviews. If consideration is given to developing ideas about the lived experience, there is a risk of losing a phenomenological attitude. Because of this, during this stage of analysis, these ideas can contaminate how meaning units are determined, as there is a risk that the transcribed data may be interpreted based on these ideas and other aspects of the phenomenon being ignored. This was a difficult stage. It required me to become familiar with the meaning units in several different ways. Each interview's meaning units were read as a whole whilst being aware of the parts. Reading was an active, engaging and thoughtful process that considered whether *that* the phenomenon was being experienced and, if so, *what* the experience of that phenomenon was. Whilst this was undertaken for each participant individually, there was also a developing sense of echoes and shared experiences.

The second stage was to get a degree of generalisation that reduced down to the specificity of the findings to the context or situation. Reducing descriptions through a process of free imaginative variation for both stages required closeness to the data whilst having a more global view of each participant. Finally, in practical terms, I had a more focused and reduced amount of data that were explicit, disciplinarily orientated descriptions that were meaningful in terms of the phenomenon. An example of steps two and three are shown in Appendix 8.

3.5.1.4 Giorgi's 4th analytical step: further transformation of constituents

Step four is the transformation stage to distil further constituents that are '*typically essential in order to account for the concrete experience*' (Giorgi & Giorgi 2008, p.46). The application of step four involved using data from all participants to bring the phenomenon together in a single description. Data were analysed from individual interviews and from a sense of all the interviews. Intuition was used to synthesise a general structure of the experience and constituents of that structure. Constituents are general to the structure (rather than universal to all) and give a more detailed account of the lived experience. The general description brings together the constituents in a format that research users can access. Typically, this means that both the reader and the researcher need a reduced text that describes the phenomenon in a meaningful way to the reader, giving new insights that describe what was experienced but not known well. In their simplicity is a profound depth. During this stage, two techniques of immersing oneself in the data and reduction by abstraction of language were used to articulate the final description. Articulation was developed through immersing myself in the experience of others and constructing this sense of that experience into written words (Giorgi 2009). Immersing myself in the experiences meant reading and re-reading the drafted descriptions before considering the alignment between them, the phenomenon and the experiences. These were also referenced against the transcripts to determine if the participant's experience had been lost or misrepresented. At times, aspects were dwelt on over long periods to distance myself from the participant and consider the phenomenon itself. Giorgi verifies that the final description is not a description of the experiences but of the phenomenon, so it is not in itself a collection of participants' descriptions. In redrafting the descriptions, the articulation of the understanding of the description is born out via the abstraction of language. During this drafting process, there was a desire to reduce the text to account for as much of the experience as possible whilst maintaining sufficient detail to be meaningful to the phenomenon. Some proposed constituents were merged, whilst others were not reducible enough to be considered as part of the phenomenon. Appendix 9 is an example of an early constituent and the related phenomenologically sensitive meaning from the transcripts. You can see that a note was left to consider if this was generalisable enough or whether it was a sub-theme of a different constituent.

It has been important to demonstrate that this research has closely followed each stage of Giorgi's analysis. Giorgi considers his descriptive phenomenological method as scientific (Giorgi 1985, Finlay 2011), and failure to follow the steps could impede any claim that this research is phenomenological, leading to a loss of rigour and validity in the findings. Validity is a term that Giorgi (1985, 1988) uses. Giorgi shows that it has a different meaning from when it is used in quantitative research, as it rather represents what was being observed. Later on, Giorgi (2002) puts forward that validity is not as important an issue as it is in other research methodologies. As mentioned previously, there is also an ethical responsibility to ensure that participant's contributions are valued in terms of staying true to their descriptions and using their gift of time and storytelling to create new findings. Analysing nearly 40,000 words of data was no small task, and Giorgi's method generated around an additional 20,000 words during the stages of analysis - with a further 8,000 words of findings. The large amount of data slowed me down during this stage of the research, meaning that I spent more time with the data. To dwell with the data brings the researcher closer to the data, living with it. Yet, a literary challenge exists in having a sense of the whole 60,000 words. To meet Giorgi's challenge required me to be familiar with the whole meaning whilst having detailed knowledge of, perhaps, just a few words one participant says. Finlay (2011) refers to this as a dance between the closeness and the whole. This takes focus and concentration, making analysis challenging. In addition to the mental agility, this analysis involves using a phenomenological attitude that requires an approach that can be hard work to create uninterrupted 'head space'. Interruptions, lack of capacity and difficulty making phenomenological sense were real barriers to this research. Van Manen (2003) points out that when reading phenomenological findings, people can take a superficial view that what is written seems obvious and simple; with the profoundness, depth and unravelled hidden complexities being missed. As a novice researcher who has completed their first phenomenological research, I can resonate with this experience that readers may not see the effort required to make everyday things more explicit.

3.5.2 Credibility of analysis

Credibility encompasses ideas of '*truth, value or believability*' (Leininger 1994, p.105). For this research, consideration is given to the credibility of both the emic (the lived experience of the participants) and the etic (the researcher's view) of the participants. Credibility is achieved in several ways. Using participant quotes is a powerful method of adding credibility as readers can consider the alignment between what participants are saying, how the researcher is using the quote to substantiate a description and how it aligns with the reader's own experiences and imagination. The quotes can be aesthetically powerful as they can make studies more human, touch the reader, and have meaning as they find new understanding and meaning in themselves. The use of participant quotations in Chapter 4 also shows the meaning-in-context whereby the findings only become part of the general structure when the lived experiences are contextualised within the totality of the data (Leininger 1994).

Generally, qualitative research does not seek generalisability, certainly not in the universal sense. In this phenomenological study, the findings offer a general structure of the phenomenon. The findings are based on the intuit analytical process of the transcribed data. It represents a description based on the participants. The Interpretivist position is that, epistemologically, the data would vary between participants (earlier in this Chapter, it was stated that qualitative research does not seek to be replicable). Part of Husserl's phenomenology is that the experience of the intentionality of the object is being described. This means that a good phenomenological study should, at least in part, resonate with others who have had the experience. To some extent, there can be a resonance with others too, as we are all human beings and can share the humanness of things. This research explores the experience of caring for people in the perioperative setting. However, if the findings do not have some resonation with people's own experiences of caring in other settings, then the description is unlikely to be credible or valid. The purpose is not to create generalisations but deep and meaningful knowing of the phenomenon. Transferability of this would be the degree of generalisation to other, similar settings.

Phenomenological research does not depend on reproducibility but on transparency (Avis 2005). Transparency is the researcher revealing the reflexive decision-making and the mechanics of their research, such as ethics, methods, and researcher positionality. Reflexivity is explored in a more detailed account in Chapter 6.

As phenomenology is concerned with intentionality, it seeks to describe a general structure of the studied phenomenon. For this reason, Giorgi (2009) sees no credibility in member checking by asking participants to verify the findings as they are formed by a researcher adopting a phenomenological attitude and will not mirror the participants described experiences. Whilst some authors believe that all qualitative research benefits from participants checking that findings are credible (Leininger 1994), Finlay (2011) cautions the novice researcher when using participants to validate findings. Credibility for this research is through detailed independent reading of the analysis and findings followed by comparison, debate and discussion with the supervisory team that includes well-published, experienced researchers with expertise in the qualitative research paradigm, descriptive phenomenology and perioperative practice. This co-reading supports critiquing guidance that stretches and deepens the phenomenological analysis and synthesis of findings.

Finlay (2011, p.15-16) puts forward facets that can be used to determine if something is phenomenological. These have been articulated against the study design in Table 3.2:

Finlay's facet of a phenomenological project	**Articulation of facet in this research**
a focus on lived experience and meanings	Method – Interview participants with a phenomenological attitude to seek *that* they have experienced phenomenon and *what* that phenomenon is. Analysis – Immersive analysis of raw data that first hears the participant's voice and then distils out the phenomenon through free imaginative variation to contemplate and find meaning.
the use of rigorous, rich, resonant description	Findings – the general structure and its constituents, whilst remaining true to the data, are constructed with a hard bony scaffold that is textured with softer, more aesthetic flesh (structure and texture). It is an evocation to those who have experienced the phenomenon and insightful to those who have not.
a concern with existential issues	Analysis – consideration of participants, the amalgamation and separation of their experiences and them as a person. Seeking identity to the person and their human condition whilst operating in the surrounding world; free agents with responsibility.
the assumption that body and world are intertwined	Interviews – seeking natural attitudes of participants to seek and hear their pre-reflexive experiences of objects. Not merely the inner self but the experience of the phenomenon as it is lived. Analysis – dwelling on the raw data to consider embodied elements of the lived experience. Findings – the connectivity of the participant to the patient, themselves and others in a complex setting involving the primacy of caring for another.
the application of the 'phenomenological attitude'	Findings - offer verification and confirm rigour in the study. The application of phenomenological attitude in data collection, analysis and findings is tested through authentic, recognisable and meaningful findings.

Finlay's facet of a phenomenological project	**Articulation of facet in this research**
a potentially transformative relational approach	Discussion – how the research informs and changes understanding.

Table 3.2 Articulation of how this research meets Finlay's (2011) phenomenological project facets.

This research aimed to collect, analyse, and describe people's lived experiences in a way that does not pre-determine or use pre-defined ideas to limit findings. Important to this research was using an approach that could describe the world as people are experiencing it. This research has strength in finding depth in everyday stories of the complex human experience (Bryman 2016). This exploration of the human experience can give answers to this type of research question (Holloway 2005). The next Chapter shares my findings.

Chapter 4 – Findings

4.1 Introduction

In this Chapter, I present the findings from this study. They present a novel way of describing how staff care for patients in the perioperative setting. I have used Giorgi's (2009) approach of first presenting phenomenological findings as a general description of the lived experience, which is then followed by the more detailed constituents that make up this essence, namely:

- Constituent 1 – Your patient and you: fictive kinship
- Constituent 2 – Taking custodianship of the body and the person
- Constituent 3 – Knowing what to do
- Constituent 4 – Making decisions for the patient without the patient

In Giorgi's phenomenological method, the findings are written as a description of the general structure of the phenomenon alongside the constituents. The description brings together the human experiences to reveal the phenomenon, in this study, the essence of caring within perioperative settings. As the phenomenon in this research is made up of human experiences of care, it may also have meaning to others who care for patients in other healthcare settings. To the naïve reader, findings can be read as simple and obvious, with the profoundness and complexity of the lived experience being missed (van Manen 2003). In this Chapter, the general description is the whole sum of what describes the phenomenon and shows the interrelationship between the constituent parts. Constituent parts provide more detail, but unlike themes that can be independent, the constituents are interrelated (Giorgi 2009). The general description is therefore, more than the sum of the parts, as the constituents do not stand alone. This means the constituents are not offered in isolation but as part of the general description. Giorgi explains that Husserl referred to these as 'moments', as their interrelation means that they cannot be removed and they do not stand on their own (Applebaum 2012). There is no cause-and-effect relationship as they are part of one and the same description. Therefore, the reader can benefit from considering the findings with this interrelationship in mind. For example, the first and second constituents are not read independently as they have an interrelationship between them. Custodianship is shaped by the efforts staff make to form fictive kinship, and fictive kinship is, perhaps unknowingly, sought by staff as they will take custodianship of the patient. Thus, custodianship is *because of* fictive kinship, as fictive kinship is *because of* custodianship within the context of this phenomenon. This interrelationship extends throughout this Chapter. Phenomenology invites the reader to see how the complexity of this type of care is constructed through everyday experiences.

4.2 Essence of caring for people in the perioperative setting

This description explores the world of caring for patients in the operating department, a place that is unknown to most people. This world, hidden behind closed doors, is a complex, busy and demanding environment that is awash with technology to keep patients safe during surgery. Woven into the primacy of what it is to care for the patient is knowing that the patient cannot look after themselves and that their usual freedoms as a human being are somewhat suspended. Operating departments are staffed by highly skilled teams with a clear focus on keeping the patient’s body safe. When staff are confident that this priority is met, they then care for the patient in more human ways, putting the patient – as a person – at the centre of their role. As priorities change during the patient’s journey, staff can quietly switch back and forth between caring for the body and caring for the person. Staff take care of the patient by accepting the patient as their responsibility. Experienced staff find ways of balancing how they see the body as a person and how they suspend ideas of the body being human when objective caring is needed. Finally, as freedoms return, staff then return the body back to the person.

In the operating department, patients can find themselves in an unfamiliar place that they do not know and that they do not understand. Although patients are likely to be unfamiliar with the alien environment, staff feel very much at home. Patients present in need of help and are welcomed and accepted by staff through a type of socialisation where human-to-human connections are established. With this connection, individual patients, formerly strangers, swiftly become part of the group of people making up the operating department team. This mutually reciprocal adoption develops a fictive kinship where the patient and those caring for them experience a primordial sense of caring and being cared for, in a time of extreme vulnerability. It is then, behind closed doors that the usual human freedoms are handed over as the patient goes through the process of surgery, with unconsciousness removing any final remnants of autonomy. Having lost freedoms, the patient’s last act is to accept that their fictive kin will care for them and their body. In response to this silent offering, staff become custodians of their kin and their body. Custodianship means seeing the body with a degree of objectivity, knowing that it is highly precious and at risk of being damaged whilst in their care. As a custodian of the patient, the level of responsibility for staff is higher than a person caring for themselves; as a person can make their own choices, be that responsibly or with negligence. This places the highest level of responsibility on staff who will know how to care with skill, morals and ownership to protect the person who has lost freedoms, with dignified care. As custodians, decisions about the patient will be made without the patient. Custodianship is transient. Some staff may transfer custodianship to others but ultimately there is an aim to return the body back to the patient.

Having presented the general description, I will now move on to each of the constituents. Participants have been given pseudonyms to give anonymity; they do not necessarily represent the participant’s gender or culture.

4.3 Constituents

4.3.1 Constituent 1 – Your patient and you: fictive kinship

This constituent explores establishing a relationship between participants and their patients. Collectively, participants describe a type of connection that forms between two individual human beings, likely strangers, that is consenting, powerful and trusting, creating a familial type of connection, as Gracie-May shared:

> *"But they still get – whether they are awake or asleep –even if we didn't talk to them, we still give them the care that – if I thought that that was my mum – the care I give my mum is the care that they get. Whoever, whatever, they get the same one hundred percent care whether they're awake or not."* – Gracie-May (HCA)

Participants are sensitive to this connection and the impact this can have, for example Ben describes this as "*It is like making them feel at ease when they come to you. Everyone is nervous."* and Bonnie values her connection, knowing "we're the first people they see when they wake up". The connection formed is more than an acquaintance, customer care or exchanging pleasantries that might involve passing conversations or interactions.

Occasionally, requests are made by patients to be cared for as Ben shares:

> *"you could she* [the patient] *was nervous, she was sweating and talking a lot and shaky…she didn't want me to leave she said like, can you stay there in recovery." – Ben (RODP)*

but it is much more common for there to be unspoken implicit obligations as Sadiyah shares in her experiences:

> *"…you perhaps hold the patient's hand as they are going to sleep or something. It's something that I, that I will attempt to do, if I feel that they are a bit anxious." – Sadiyah (Sister, Theatres)*

The patient trusts that staff will stay with them and be there for them, no matter what happens. That their body will be protected at a time when they cannot look after themselves. In return, the participants work hard to use their skills and expertise to do anything they can to support and help the patient with a caring attitude. Like families, the establishment of this human-to-human connection is not always verbalised. Instead, it can be assumed, anticipated or formed in silence. A more explicit connection is normally offered to the more anxious or emotionally upset patient. In their role, some staff will only care for a patient who is unconscious, and others who meet the pre-operative patient only have a few busy moments to form this connection as they check-in the patient before an anaesthetic. The lack of time or opportunity can make it more challenging and Ben finds this is particularly the case in anaesthetics and is harder for the novice:

> *"There's a lot of pressure like time pressures as well the stress you get quite a lot to begin with but as* [you] *become more experienced you learn that's not as important" - Ben (RODP)*

Connections allow the patient to be adopted into the operating department team as fictive kin. As participants have very little time to make a connection to the patient formally they rely on a range of tools suitable for their situation to quickly accumulate enough human-to-human connection to see the individual as their kin.

Connecting to their patient is integral to participants taking on the care of the patient but connecting also was a pre-requisite and somewhat different to caring itself. For example, participants talk about how connecting leads to both giving care but also to feeling positive that they can safely hand-over care to others and, on occasions, know about their onwards journey. Isaak has noticed this change as he became more experienced:

> *"Because I've always cared, I've always wanted to do the right thing but previously it was more about doing the right thing based on what I had learnt was the right thing, and following procedures. Whereas now a lot of its based on - not more compassion, as I'm still as compassionate as before - but it's more emotionally based. It's hard to describe what I think. I take it more personally now. Whereas before it was a patient that I want to look after, I want to do my best thing for and I will do what I think is the best thing based on learning. Whereas now, its more personal connection… now, I think I have genuine conversions with the patient" – Isaak (senior ODP)*

The sense of establishing human-to-human connections is also evident in the descriptions as something that participants do retrospectively and use to reaffirm their understanding of the kinship that they experienced. With the patient, as a person, often being suspended in time there can be a delay for participants being able to construct meaningful connections. Participants describe connecting to the patient as an ongoing, continuous process. Using previous experiences allows participants to transfer ideas of kinship from previous patients to new patients. This retrospective transference can help participants to make good any shortages in their connection to the patient. This is typically where staff first meet a patient that is unconscious, such as a scrubbed practitioner who uses previous experiences of kinship to understand how they can view an unconscious patient arriving from the emergency department or staff who wait until the patient regains consciousness before they make human-to-human connections. Whilst this does not offer a true sense of kinship, it provides a practical method of creating a meaningful enough relationship between the participant and their patient. Experienced staff are comfortable with this arrangement, having had experience of making more authentic human-to-human connections, so they are willing to accept the substitute when required.

During limited opportunities and short periods of time, the complexities of perioperative care can risk demanding objectivity and a kind of transactional arrangement that supersedes the humanness of patients. Ben describes this challenge as, "*…it sounds like you're dehumanising patients…, it's just like [a conveyor belt]…It's kind of one in one out*". The anticipation that patients submit themselves to whatever surgical onslaught takes place behind those closed theatre doors appears to be overshadowed by a desire that staff have, to establish human connections with their fictive kin.

All the participants spoke about their experiences of how they connected to patients. It was common that participants would refer to patients with possessive adjectives, such as 'my', 'your', and 'their'. This connective aspect of kinship is in part an assumed role of participants, *“It’s just, you want to do what is the absolute best for your patient”* (Isaak, Senior ODP) and is the outcome of the of human-to-human interactions:

> *“I’ve learnt that through other ways…you don’t know anything about anybody unless they tell you. You can’t judge a book. You just gotta be compassionate, you just gotta be caring and do it. Regardless.” – Bonnie (ATP, PACU)*

> *“I just try and find/think, right okay, let’s see where we can, see if they’ve got any hobbies sort of try and think of…if they don’t, I, then they don’t then you won’t so it’s best. So, I just sort of say, “okay”, ‘you’re not too hot?” to get, you know, to get them to react what we are doing.” – Gracie-May (HCA)*

This primacy of needing human-to-human connection is described universally by participants as they find ways of connecting in a range of different and complex settings. There are no standard mechanisms of how participants do this but there is a universal intention made of two components. The first is that when participants first meet a patient they welcome and accept. The second is reciprocation where the patient accepts and becomes part of the operating department kin. Establishing this type of fictive kinship is seen regardless of the participant’s role and therefore at whatever stage they would meet the patient. Each patient becomes part of and completes a type of familial group. The forming and adjourning of this adopted group may be highly short term, knowing that the patient will soon lose consciousness and others may be longer with the patient dipping in and out of consciousness with or without a memory of events. Finally, there is a pressing need to establish human-to-human moments as participants will be caring for patients who are likely to lose their autonomy or freedoms, meaning that the care of the patient – with their vulnerabilities – is taken on by carers acting as their fictive kin. Participants act on this kinship by taking on the responsibility of looking after the patient’s body and making choices for them.

Caring for patients – their body and them as a person – is experienced positively with this kinship being established. This connection for some participants means that they also see themselves as being able to objectively take on technical roles as they are part of the bigger team who will continue to care for that patient as a whole. Isaak, as a senior ODP, works in anaesthetics, surgery and post-anaesthetics and finds that the surgical phase is most likely to lead to this objectivity:

> *"It is harder on the scrub side because you haven't go that, had that connection with the patient with you directly, in most cases. But, yeah it has changed. I think that more thought goes into what we're doing. I find it's more in the anaesthetic role because you've built some kind of relationship directly through booking them in and having a little bit of a chin wag. You do meet interesting people and I think it's just something when you've had a chance to find out about their background or they've been a particular character and have got really endearing characters and you get a little glimpse of that before they go under anaesthetic." – Isaak (senior ODP)*

Connecting to the patient creates a sense of kinship that enables the patient to become part of, and the purpose of, the operating department family. Adopting the patient as kin is a priority for the participants. They use it to describe how they experience caring for the patient. Patients, as individuals, are from wider society with all its diversity. In developing kinship, participants describe a wide range of differences in the people that they care for and how they find a variety of different ways to help them connect to the individual patient. Participants were positive about their experiences as they shared stories about people that they felt they connected to:

> *"I suppose that – as happy and jolly as can be – if I've got a patient that is, you know, crying and has received bad news or whatever, I'm obviously not joking around. I change the way I come across to patients. You have to, like, match how they are kind of thing. But still keep positive, you know." Bonnie (ATP, PACU)*

> *"And it's nice if they are awake throughout the procedure and actually take them back – when you take them to recovery – that's nice as well because you're actually seeing their pathway all the way through. It's…I, just think that personal contact with the patient is important." – Gracie-May (HCA)*

Connections are deeply personal and when formed enable participants to feel that they can genuinely continue to care for the patient. This includes being able to have confidence in handing-over care to others. Participants give equal credibility to the way they connect to patients, regardless of whether the patient is awake or not. Accepting these limitations enables participants to choose methods that they view work best to establish their connection to the patient. This means that participants will sometimes overlap or partially use one or more ways to achieve a connection. These include i) using imagination, ii) talking with patients, iii) finding stories and, iv) making a difference; each of these will be described in more detail below.

4.3.1.1 Using imagination

Participants can imagine ways how they can connect to the individual patient. This heavily relies on thinking of the individual patient as a fellow human being. Extending an imaginary invite is based on human morals and beliefs of caring for the patient as one of their own. This mentally constructed connection is used to help guide them in seeing the patient as a person:

> *"But they still get – whether they are awake or asleep – you know even if we didn't talk to them we still give them the care that – if I thought that that was my mum – the care I give my mum is the care that they get. Whoever, whatever, they get the same one hundred percent care. Um, whether they're awake or not." – Gracie-May (HCA)*

> *"But in the same way that, and those patients go in thinking, 'oh gosh I hope I haven't got a tumour', and each time because they know it's a check one it's, 'oh, I got the all clear'. So, with them having that done under local anaesthetic, you can, you can see that, that, see that patients' face live when 'it's all clear', uh, the relief on their face. And so, you do find it is different in each of the specialities, I suppose really because of the outcome more than anything." – Sadiyah (Sister, Theatres)*

> *"You know, it's treating them as people. It's not, just because they're not aware of what's going on, it doesn't mean you can then dehumanise them, start talking about them as a procedure or*

> *something like this. It's just about treating them, remembering that is a person." – Isaak (Senior ODP)*

Regardless of where participants work, the perioperative environment is about being with the patient, whether they are conscious or unconscious. However, the complexity of the perioperative environment risks obscuring the patient as a person as they can be hidden behind a cloak of objectification, procedure, and illness. This, coupled with time pressures, can make it hard for staff to find and make a human-to-human connection with the patient. To overcome these difficulties, participants use their imagination to find creative ways of overcoming these barriers to form more human-to-human connections. Participants use these connections to either accept or hand-over the care of the patient. Commonly these strategies included: moral guidance, substitution and/or transference (where participants would create stories or superimpose their own experiences) and beliefs:

> *"Because, without compassion, I just don't think you can do this job. I don't think you can. Can you? I don't think anybody in the hospital could do their job without compassion. I think that's what makes a nurse, or a HCA or you know, even porters. The lot. It makes the hospitals…without that we are nothing." – Bonnie (ATP, PACU)*

> *"But things like Orthopaedics, doing knee and hip replacements, you think, 'yeah this is going to benefit the patient', and they'll be pain free and what-have-you." – Sadiyah (Sister, Theatres)*

> *"They are the things you would do at home, if there was, if you were looking after a relative you wouldn't them in a- if they spilt food down a blanket, you wouldn't just leave it there, would you? You would change it." – Isaak (Senior ODP)*

4.3.1.2 Talking with patients

Ben, is an ODP who works mainly in an anaesthetic role, caring for the awake patient before anaesthetic induction. Ben can talk with the patient as a primary method of establishing a human-to-human connection and describes several different experiences. In the first experience below, Ben recounts a time when talking to the patient strengthened their ability to see the patient as a human. This extended kinship beyond their immediate care episode and outside of the operating department; whilst acknowledging that at times the experience can be quite different.

> *"He was awake, he was chatting he was quite a cheerful guy and he wasn't in any pain. So, it was a kind of sense of achievement that he would be going back to the ward…and that…that the surgeon would be going to see him later and he was one of the nicest surgeons. He would kinda get them out of the bed and walk around with him no matter what time of day it is, so you know that he is getting really good care. And he's going to be, he's going to be OK, and we've done some good." – Ben (RODP)*

In the second example, Ben describes the skill of using routine care interactions as an opportunity to also establish a human-to-human connection. Using emotional intelligence enables Ben to know whether a patient wants – or is able – to strengthen that connection through talking or whether he will need to use a different approach.

> *"So, a lot of it does depend on how much you get to know the person in the short amount of time in the anaesthetic room. The patient yesterday was quite a chatty man, and we did go through the checklist and he did interrupt, well not interrupt, but kind of carry on chatting after every question and that's great and you get to know that person a little bit more and what they're about whereas sometimes people are kind of, don't want to talk much and are extra nervous and give you short answers. They don't want to make conversation; they just want to get it over and done with." – Ben (RODP)*

In the third example, Ben describes a time when they were not able to talk to the patient, limiting their connection. Ben found this limited both his ability to fully care for the patient and a feeling that he could not fully return the body back to the patient or hand-over care to others. Ben was left estranged from their adopted kin, to contemplate if their care had actually been detrimental:

> *"I think it also depends on if they are awake when you take them to recovery as well. Cos if they're still unconscious then you don't get to say goodbye…and…it's not…you feel you don't get to build as much a bond with that patient as well. Sometimes if you go round to recovery and that patient is awake and they're in pain or they're being sick or sometimes you can just tell that something is not right*

> *sometimes, can’t you? But you’re not sure what, that doesn’t give you the sense of achievement, I don’t feel. Sometimes you can feel like you’ve done more harm than good.”* – Ben (RODP)

Finally, patients struggling to engage in conversation may limit the use of verbal connection but it does not prevent the attempt to seek connection. Patients that are reticent to talk helps to define the nature and conduct of the kinship, allowing the connection to feel genuine and individualised to that patient:

> *“Whereas some people are the complete opposite, and they want to know every detail that they can and when you check their consent form they can tell you every detail of the procedure that is going to happen and that makes them better feeling they know what is going to happen but some people don’t want that. If you kind of tell them what you’re doing as you’re doing it, so if you’re putting monitoring on: tell them why you are doing it, that helps.”* – Ben (RODP)

4.3.1.3 Finding stories

Participants who work in the surgical team usually begin caring for the patient around the ‘stop’ moment. When somebody calls for the stop moment then all staff in the operating theatre should stop what they are doing and participate in a final safety check. This takes place before the first surgical incision and key patient related information is checked as set by the WHO (2008). It includes things such as correct patient, correct procedure, correct site, use of antibiotics, etc. The whole team will then confirm that they are ready to proceed. All staff become busy as they quickly carry out the ritual preparation of the body so that the surgeon can make the first incision. The preparation reduces the patient to an anaesthetised body, covered by sterile drapes except a visible surgical site. With the patient hidden, participants need to use tools that actively seek ways of seeing the patient as an individual human as they cannot talk to or see the patient. This commonly involves asking the surgeons for information that relates to the patient’s humanness:

> *“I think it depends on what the operation is. Because if it’s something serious, I always try and find out the background information about the patient. You know like now we have a pre-start brief, before we*

> *do surgery, I often find out from the surgeon: 'what's the story behind this?' Something like, even having an amputation or they're diabetic and I also say, 'how did they come to you?' You know, why, why's he suddenly presented to you, why's he left it so long. That sort of thing." – Sadiyah (Sister, Theatres)*

Finding stories about the patient seems to offer a retrospective affirmation of participant's understanding of previous kinships. This is consistent with all surgical outcomes, whether the body is returned to the patient and their family or, unusually, the patient not surviving. As part of kinship, participants find knowing that patients have died, helps to understand further the connection that they had formed.

> *"Quite often I'll ask the surgeons, how did that patient do, that we worked on for eight hours. So, it's nice when they say, "well actually, they're doing really well". You think, amazing, because you, some of the things you do, you think, 'blimey!'. So, it's really good. And then it's a bit sad when you hear that they actually didn't pull through. But it is nice to know." – Gracie-May (HCA)*

4.3.1.4 Making a difference

The final aspect that participants described are the connections that can be made by transferring previous experiences of connecting to patients, particularly where participants had a sense that they had a positive impact by making a difference. Knowing that they made a difference can be used to understand that connecting to a patient will allow them to similarly make a positive impact for their adopted kin. At times this was felt as a brief transaction where participants would experience achievement as a direct result of an action, whilst at other times there was a delay in gratification that was used strengthen belief in how participants actions are benevolent.

> *I enjoy, I enjoy my job. I enjoy looking after a patient that is having an operation. Such a scary experience. Such a daunting experience and I think to be able to help that in some kind of way, to help that person is quite…is quite a privilege, I quite enjoy doing it. – Bonnie (ATP, PACU)*

> *"You know, I think, certainly emergency work has it's challenges but also has a lot of reward as you know that it's immediate and you're*

> *going to sort something out there and then." – Sadiyah (Sister, Theatres)*

> *"Staff cannot be rewarded with additional finance or time but can be motivated by knowing that the extra contributions, in how they care for the patient, are making a difference. Giving information, by way of feedback, supports staff to know that they are making a difference by how they care for the patient." – Rhona (consultant surgeon)*

Isaak, as an experienced senior ODP, describes how his experiences of making a positive impact for patients is prospectively used in conjunction with verbal conversations to establish a deeper kinship. Isaak develops trust and morality in this kinship which leads to a genuine connection with the patient:

> *".... I am actually listening to the patients and allowing them to be understood. I think it's a more valuable and you do build trust then. And I think it's nice to think that they, they will go off to sleep and they will have their anaesthetic and actually be quite relaxed and trust that you're going to do the right thing." – Isaak (senior ODP)*

There were variants within this constituent; with Sadiyah experiencing that her connection to the patient was partly dependent on the type of surgery the patient was undergoing, and Harry describing a variation in that how he connected to the surgical team affecting his connection to the patient. These are described below:

Sadiyah, as the oldest participant, and the one with the most perioperative experience, found that her connection varied depending on the type of surgery the patient was having; with a deeper, more emotional connection when she understood that her patient had a life limiting disease.

> *"…I suppose also that my attitude changes as to whether it's something I know the patient is going to recover from or is going to be potentially life limiting. Because obviously I feel that something that is going to be therapeutic to the patient, I tend to have a different attitude towards, whereas…with something major, I find that I am certainly more, I feel emotionally, more empathetic towards the patient because I feel that it doesn't matter what we're going to do we're not going to cure them and that this maybe the start of a long process for them." – Sadiyah (Sister, Theatres)*

Harry's experiences include working in both the NHS and the independent sector and in large teaching hospitals and small treatment units. Having performed surgery and worked in different teams and organisations, Harry described a variation in his experiences. He found that there is a sense of better care when there is a greater connection to the patient by all the team members. Smaller teams and smaller units also offered this sense of a greater connection that created a more unified approach:

> *"Yes, it's true. I'm not sure. It must be a lot of little things [laughs] rather than any one big thing. But quite what makes it a more caring environment…I suppose, the…it's a little bit…control…so that…everybody knows everything about all the patients [in small units]." – Harry (consultant surgeon)*

Staff work hard to establish fictive kinship, so that the patient who has lost their freedoms, is cared for as family members would care for each other. This human-to-human connection is ethical and deeper than might ordinarily be found between two people as one will temporarily be responsible for the other. Staff find ways to see the patient as a person, regardless of whether they are awake, unconscious, or somewhere in-between. In addition to seeing the humanness of their patient, staff know that they are becoming responsible for the patient and their body. In the next section, I explore how participants are very natural in their way of caring for their patients as custodians of something highly precious.

4.3.2 Constituent 2 - Taking custodianship of the body and the person

The second constituent brings together a kind of stewardship that all practitioners experience whereby the team will care for the patient as they silently surrender their bodies over to theatre staff. Caring for the patient is experienced as a custodianship that is assumed between the patient and members of the team that importantly is with equal and similar measure whether the member of staff had spoken to the awake patient or are limited to caring only for the anaesthetised body. Staff take their custodianship of the patient very seriously, making explicit acknowledgement that the patient is commonly rendered unable to either look after themselves or make choices for themselves. As a custodian, this type of care has a degree of objectivity as it primarily has lower levels of emotion which are balanced out with higher levels of responsibility. Staff take ownership of the body and engage the whole team to adopt an approach of caring for the body. Staff place high value on this type of care but are able, as custodians, to recognise that whilst they do not own the body, they work hard to provide the best care and frequently find ways of giving, what is seen as, *"extra care"* in recognition of not owning the body and preparing it to be returned. This includes things like washing the body of any soiling, lotions or spillages, changing dirty linen, swapping to a suitable mattress or bed and generally preparing the body so that it is clean and comfortable.

It is this type of caring for the patient that sees participants taking on a duty of being custodians, first to protect the body and then finding ways that show genuine and more empathic human caring attitudes. This attitude creates a medium for allowing staff to show generosity and due diligence for what is precious.

Working in anaesthetics, as an ODP, Ben is frequently one of the first points of contact in theatres; a role known as 'receiving' patients. As a task, staff carry out a number of checks but are highly cognisant of the patient as a human person and the emotional load they are carrying. Ben is able to care for this awake patient's needs in a meaningful way by adopting this participant custodian role:

> *"If you tell them you are going to look after them and be there for that procedure and you and the doctors aren't going to leave them you going to be watching over them and looking over them that kind of makes them feel looked after, like they're not just in a room full of strangers that your, that your job is there to care for them. That can really help" – Ben (ODP)*

Whilst other participants, who are in the surgical team, commonly only care for anaesthetised patients, they too experienced being a custodian of the patient. Sadiyah, as a very experienced theatre nurse, describes this as being there for the patient:

> *"I think, I think, for me it is knowing that the patient is there. I'm, I'm there as the patient's advocate and I feel that the transition between – the time between the ward and when they go back to the ward, patients are very vulnerable, and I feel that I can step in and…be there for them and act for them and do my best for them"* – Sadiyah (Sister, Theatres)

Sadiyah strongly identifies to their role of advocating for the patient and yet will not have met or spoken to that person. Many of the participants similarly can make decisions about the person, without the person. This is accepted as an integral component of custodial caring being met through commitment to custodian ownership of the patient's body whilst the person is suspended by the depths of anaesthesia.

Finally, this caring for the body continues into the postanaesthetic care unit. Here, the patient can move in and out of consciousness, and staff will follow with accepting and relinquishing the duty of being the custodian as they the patient regains consciousness and therefore ownership. This custodian attitude is experienced by staff at all levels; and is not exclusive to registrants. Bonnie, as an Associate Theatre Practitioner (not a professional role), also experiences this custodian attitude in her role:

> *"OK, so I'll take an experience from this morning for instance. A patient that came through knee arthroscopy – I don't take airways, in my role – I start off doing all the checks and I listen to the handover from the anaesthetist and….and I do the checks. So, the temperature. Letting the patient know, even you know, whilst they are unconscious letting the patient know that I am taking temperature. Checking the wound. Pulling curtains around. Taking pulses, things like that"* – Bonnie (ATP, PACU)

As custodians, the physical caring for the person is regularly undertaken directly by staff but is also frequently experienced vicariously where staff see themselves as a collective with this shared attitude. This was seen by both medical and non-medical staff:

> *"You know, there have been times where I've spoken out because I felt that something is wrong or have asked them to stop or you know, even surgeons perhaps picking up the wrong, you know, not knowing*

> *which bit of anatomy they are picking up or whatever. You know, I've said, well isn't it this or but that's not necessarily from a nurse's point of view but I do feel that it's grounded in me being a nurse and wanting to care holistically for the patient whilst they're in my care" – Sadiyah (Sister, Theatres)*

> *"And that's in the last few weeks, I've noticed the contrast of trying to do the general anaesthetic there. And I think that we will need to have some people from theatre down and some of them going up to theatre so that they understand that…that care of somebody that's having a general anaesthetic alone, I mean even if you're not operating or doing anything else. Just the sort of psychology…that you're…you're immediately a lot more responsible for various things, in terms of their safety and their well-being because once they've had a general anaesthetic they have no say in anything, so I suppose that, that's been really noticeable in the team, so, I think that's to do with the care of patients under anaesthetic and um, and all the subconscious stuff you do" – Harry (consultant surgeon)*

The second part of this constituent illustrates the human caring attitudes of being a custodian. With the body physically and physiologically safe, then practitioners find themselves focusing on the patient's dignity. This is not passive or merely maintaining but actively promoting care for the dignity of the patient. Participants were readily able to name this aspect or their caring experiences, taking pride in something that most patients simultaneously are worried about but will never know about. Participants are able to relate to the exposure of patients that at times are required during procedures:

> *"and also, it's things like, dignity. You know, as most people are not aware, or they chose not to be aware, that when you're in theatre we have to expose the area that needs to be operated on. And a lot of times patients are exposed for no reason. Certainly, now we do the WHO checklist for time out, you know, we have to check the site has been marked, the area has been shaved and things like that, patients can actually be exposed quite a lot. And I, but, interestingly enough one of the other aspects of the WHO checklist is patient warming. To make sure the patient's not freezing to death, but I also feel the dignity aspect of it. That when we are doing the WHO checklist, there is no reason why we shouldn't keep the patient covered up until we've done those checks" – Sadiyah (Sister, Theatres)*

> *"You know, it's treating them as people. It's no, just because they're not aware of what's going on… [you cannot] start talking about them*

> *as a procedure or something like this. It's just about treating them, remembering that is a person." – Isaak (senior ODP)*

> *"Well, in theory, if you are under an anaesthetic, for example. Exposure. Nobody….you are under anaesthetic, in theory you don't know what - as a patient - what is going on but I think there should still be a certain amount of dignity in terms that there is no need to expose certain areas of patient unnecessarily. And the classic example is a patient who is exposed for the procedure and then the doors are opened and left open inappropriately. And that makes no difference to the patient they have no idea afterwards but that, that's part of a sort of culture, I think, that's trying to maintain some dignity for them whilst not compromising the surgery" – Harry (consultant surgeon)*

This idea of being a custodian of the person's body is refined further when participants talk about how students, novice practitioners and practitioners that have not worked in theatres care for the patient during their perioperative journey. Experienced custodians talk about their own experiences as a novice, and their experiences of watching students or the novice practitioner, they referred to the first phase of being a custodian, that is, describing the challenges of meeting the technical demands of caring for patients. Whereas Ben, in his role as an ODP, talks about their experiences "at the beginning" as being congested by technical demands, Harry, as a consultant surgeon, who also works in non-theatre settings talks about caring for patients in the theatre setting as something that is learnt before it becomes 'second nature':

> *"now because you see a lot more….at the beginning I was busy thinking about a lot of things at once…maybe I didn't pick up on it very well…like maybe I needed people to tell me they were anxious." – Ben (ODP)*

> *"…we've been trying to introduce general anaesthetics to a department that don't normally have general anaesthetics. And that's been interesting because things that are second nature to me - about caring for an asleep patient - aren't to them." – Harry (consultant surgeon)*

Harry works in different clinical settings, where *"they are completely used to awake patients and are really good at what they do"* but when those same staff first started to care for unconscious patients, they were not able to care for the patients in a different way despite something being significantly different. As an experienced custodian, Harry identifies this difference in terms of the patient's unconsciousness: *"I mean, when you've got somebody awake it's not, it's not as important"*, where the patient loses autonomy and the ability to look after their own body and being, *"I mean, pressure points, warmth, er dignity – all these kind of things"*.

Whilst being a custodian is identified universally by the perioperative team, the participants came from different professions and have different roles. These differences led to some variation in the experiences and below are some examples of these variances. They include identifying professional roles as key tenant, being a parent and ideas around gender roles.

Surgeons describe their custodianship, at times, as needing to become solely focused on caring for the body during surgery. Isaak noticed this too, that surgeons switched their priorities, becoming objective in their role to focus on completing procedures:

> *"…their focus is on the procedure and it's maybe easier for them to forget about the nursing side of the role because they're in operating mode and thinking about the procedure more." – Isaak (senior ODP)*

Whereas for the surgeon they rely on others in the surgical team to take on the more human aspects of looking after the person whilst they focus on the body:

> *"I think that the key at the time is that you have to try remain dispassionate because you need to sort the problem out and there's no point sort of, wringing you hands at that stage, you've got to make a decision, can you sort it out yourself?" – Rhona (consultant surgeon)*

> *"So, I think that I hope that if people felt strongly about it that they'd pipe up and say something. And then hopefully I would be able to explain the reasons why for doing it." – Harry (consultant surgeon)*

Professional identity was very important to Sadiyah and used as a tenet of how they identified themselves in their role. As a nurse, Sadiyah describes the personal responsibility they have to care for the patient. The responsibility starts when the patient arrives in the operating theatre and ends when they leave for recovery. Sadiyah self-identifies her caring attitude and feels different to other members of the team; knowing it was something that could *"annoy people"*. Being aware that this view frustrated other members of staff does not stop Sadiyah. With her professional identity, Sadiyah self-mitigates any offence with a personal belief that the custodianship of the patient is more important as they are, *"…only there for the patients"*. Custodianship of the patient places a priority towards the patient and is seen as a positive mechanism by which other professions can be challenged:

> *"I tend to think of that, I feel as a nurse – I suppose it's because I've being doing it for a long time – I was always taught that the patient is your responsibility from the moment that they come to theatre to the moment they certainly go into recovery. And sometimes it can, you know, annoy people. Um, but I'm only there for the patients…– we were doing something laparoscopically and the surgeon picked um…a fallopian tube up and said, oh yes this is the appendix. And I said, "No, no, that's the fallopian tube". "Oh! Yes, yes, yes, yes", he said. "You know, I'm just trying to orientate myself." – Sadiyah (Sister, Theatres)*

The second variation was a participant who described a poignant change in how they experienced being a custodian of the patient after they became a parent. Before being a parent, they saw their role as an interpretation of morals, procedures and learning. As a parent this became *"…more emotionally based"* as they felt they had softened in the way they were with people and being able to open up more as a parent. The experience of taking responsibility for a family member that is unable to look after themselves was important for them. It strengthened the participant's ability to understand what it means to take on custodianship of another human, as fictive kin, in the perioperative setting.

In the final variation, Gracie-May experienced the care for the patient through ideas around more traditional gender-based family roles: *“Even the lads have got a mothering instinct in them. They’ve got a soft side to them.”*.

This section has explored how the patient’s loss of freedom, in the perioperative setting, is responded to through custodianship. In this way of caring staff will look after something that is highly precious and has become their responsibility. As custodians, the participants cared for the patient as they would for a member of their family. This means that they will care for the body by keeping it safe and care for the person by giving them the dignity. The following two constituents articulate the pragmatic nature of how staff, as custodians of the patient who have lost their freedoms, have a way of knowing and choosing how to best care for their patient. Care is typically both for the patient’s body and for the patient in more human ways. The participants have a way of knowing when the focus needs to be directed more towards the body or the person.

4.3.3 Constituent 3 - Knowing what to do

In this constituent, all participants shared experiences of how – as Bonnie puts it: they *“just know how…”* to care for their patients in the perioperative setting. This sense of knowing how to care for their patients is described as an experience of bringing together the three different facets of cognitive knowledge, emotional knowledge, and knowledge from experience. This led to a sense of a natural and rewarding way of caring for the patient where participants just see, just know, and just do.

Eben gives an example of her experiences of caring for a patient where she (1) sees the patient, (2) knows what to do and then (3) cares for the patient in a natural way where they don’t notice being cannulated. In her account she touches on the three facets:

> *“I’m quite good at distracting people and keeping them talking - you could see she was nervous, she was sweating and talking a lot and*

> *shaky…I kept her talking, and she didn't even notice the cannula going in and she was absolutely fine." – Eben (ODP)*

Participants were able to use other ways of assimilating how they know what to do. Isaak gives an example of how a difficult aspect of caring for a patient is trying to maintain patient dignity whilst their body is exposed as part of having an operation. In this example, Isaak weaves together his cognitive knowledge, his emotional knowledge and some personal experience in knowing how to care for the patient. This use of a personal experience, where Isaak recalls being a patient and the thought that he wouldn't want himself to be exposed unnecessarily is used to build on his emotional knowledge of wanting to keep patients dignified:

> *"Just maintaining dignity, part of having an operation is getting exposed and there are the clinical risks, of becoming cold but there's also the dignity. I've had a general anaesthetic and I wouldn't want to think that I was lying there stark naked unnecessarily." – Isaak (senior ODP)*

There are times where participants find that they notice others do not necessarily have a natural attitude in this constituent. That is, other staff do not see or are not able to decipher non-verbal cues, and that participants have to be explicit in helping these staff to see and to know what to do to care for the patient. Harry, as an experienced consultant surgeon, was working in a department where the staff "don't normally have general anaesthetics" that *"things that are second nature to me – about caring for an asleep patient – aren't to them"*. Harry "noticed the contrast" that experienced staff may be *"really good at what they do but they are not used to asleep patients"*. Harry found it difficult to explicitly articulate what this knowledge was, using phrases like:

> *"Just the sort of psychology…that you're…you're immediately a lot more responsible for various things".*
>
> *"and all the subconscious stuff you do which causes a huge issue afterwards for the patient which seems a very minor thing at the time".*

Harry believed that a solution was to support staff by arranging for them to spend time with theatre staff, so they could get to know this process of being able to see, to know and to do to help their understanding of what it means to care for the unconscious patient:

> *"I think that we will need to have some people from theatre down and some of them going up to theatre so that they understand that, that care of somebody that's having a general anaesthetic" – Harry (consultant surgeon)*

Eben also gives insights into their experiences of less experienced staff when mentoring students or newly qualified staff:

> *"I was doubled up with a newly qualified ODP. It's quite hard, teaching them the way….my trainee did, kind of, all the checks. At the same time as kind of doing the HCA role I'm trying to make sure that she is doing everything correctly…it's not that they are doing anything wrong but that they are doing things differently to how you would" – Eben (ODP)"*

For Eben, she finds that working with a newly qualified ODP is challenging when their care for the patient is not as natural. While her mentee cognitively knows how to carry out tasks, Eben finds that their lack of experience and emotional knowledge means that the novice appears unable to see, know, and do. Eben notices the inability to decipher non-verbal cues, and this leads to not knowing how to care for the patient in a natural way:

> *"...watching my trainee to see what she's doing: is she aware of what is going on or is she looking around the room? Um, not paying much attention!"*

Sadiyah, Rhona, and Harry – as surgeons and a nurse – differed from the other participants in having a stronger professional identity, which they used as part of their description of how they experienced caring for patients. For them, their professional identity gave them legitimacy and specific experiences that enabled them to see the patient in a particular way and to know what to do:

> *“That’s obviously the greatest factor for me, I’m a nurse and obviously I’m in the caring profession but also, I’m a carer…I feel that I can bring that aspect of care to them better than someone perhaps, who hasn’t had the nursing background who might look…and things that others might pick up on, I can pick up on different things. So, I think that together we give the patient the best care we can and then the best journey, really, through their episode of care with us.” – Sadiyah (Sister, Theatres)*

> *“To a degree, most surgeons are perfectionists. You know, that’s a good trait - you’d expect them to get it right…I’ve been operating there for 17 years; I do the same operation, I did 17 years ago and I do it exactly the same way and to turn up after 17 years and have them say, ‘oh, I haven’t done a hip replacement before’...it isn’t the same and under those circumstances you are just trying to get through the operation reasonably well rather than treating excellently.” – Rhona (consultant surgeon)*

> *“I think it is very dependent on your own confidence with what you are doing at the time. And not just sort of in an arrogant way but as long as you’re truly convinced that you know how to do the procedure and that, you know, that you are trained and that you believe you are reasonably good at it then, then you don’t have difficulties in doing that.” – Harry (consultant surgeon)*

The operating department is not a natural setting for person centred care in that patients have lost their freedoms and a highly skilled staff make use technology to safely perform surgery on the body. Within custodianship, experienced staff can see through these potentially confusing facets to see the patient and to know what to do. Staff can discern, with a type of knowing, that is experienced as a natural attitude. In knowing what to do, staff can care for the body to keep it safe and for the person to give them dignity. In the last section, the second pragmatic constituent is considered. In this constituent, participants experienced what is means to have custodianship and make decisions about the patient without the patient. The loss of freedoms for the patient in the perioperative setting is experienced as normal for participants. Patients being unconscious is - in itself - not a trigger for how care changes but rather, with the loss of freedoms, there is a whole caring attitude particular to custodianship in the perioperative setting. The next section draws out how staff choose what needs to be done and what they will do to care for the patient. As custodians, this is ultimately making decisions about the patient without the patient. The absent patient is a consequence of the reduction of the operating theatre to deliver safe surgical care. The perioperative setting will have a flux where the patient is unlikely to ever be aware of the decisions that were and were not made.

4.3.4 Constituent 4 – Making decisions about the patient, without the patient

Most surgical patients are unconscious for most of their surgical journey and in addition, whilst only some cannot recall the moments before their anaesthetic, most people are unable to recall what happens after their anaesthetic whilst they come in and out of consciousness for a period of time. Thus, participants care for the patient knowing what they do is unlikely to ever be known. The paradox of making decisions for the patient without the patient is solved by a complex judgement by the carer, that is often reconciled by the wider team to be in the patient's best interest. This leaves caring for the patient as a process of ongoing decisions being made to ensure best interests. Whilst patients are highly at risk of being vulnerable, staff step forward make decisions and act by doing the best they can. Isaak, as a senior ODP who works in all theatre areas, experienced this paradox in a way that feels like his caring attitude involves transferring personal expectations of right and wrong to a higher level than if relying on asking the person:

> *"Like I say, from the slightest detail to big decisions, they'll be none the wiser that you've done that for them and yet it's still, it's a very satisfying job. Knowing that, you know, that you're acting in the, that you put yourself in the position very much more than in a position that you would ask them what they would like" – Isaak (senior ODP)*

Isaak further illuminates this constituent in sharing how his experiences will vary in the three different phases of anaesthesia, surgery and post anaesthesia but a commonality is experienced when reflexively making decisions based on knowledge, experience, and patient response.

> *"But essentially it's, in all of the roles I think you - regardless of what the patient tells you - you're you are using your knowledge and experience of what you're seeing though monitoring, through knowledge of the procedure and through what the patient is saying/doing you make decisions."* – Isaak (senior ODP)

This tacit knowledge is passed down through tradition and the nature of caring for people in theatres is determined by certain priorities that individual practitioners are not willing to compromise on. These practices are rationalised and used to support practitioner's decision making. Ben illustrates this when recalling mentoring a student about prioritising decisions where they wanted to place a warming device (Bair Hugger) on the patient before attaching monitoring and connecting up intra-venous fluids:

> *"There was actually a little bit of a difficult airway yesterday. And I think that threw her off a little bit 'cos she came through and she said, 'I'll go and get the Bair-Hugger'. And I was like, 'ooh um actually [laughs] shall we get the monitoring up and get some fluid connected first? Kind of need to prioritise a little bit here. What we need to do…'. We had a chat about that later and it is fine"* – Ben (ODP)

Similarly, Isaak, as an experienced ODP, uses his tacit knowledge to be able to anticipate what are the best decisions for the patient using any cues available including which colleagues he is working with and the limited information available from the operating list. These decisions made about the person without the person is experienced as an interesting part of the job and has aspects of reciprocal caring.

> *"You would draw from your own experience, your own perception of a situation and obviously your training to make a decision on what that person would want without them having any input. And I think that that is a really interesting part of the job…before meeting a person, decisions are frequently made based on anticipation of what technical care interventions will help.*
>
> *You're deciding what kit to have available before you even really know anything about the patient's history: do you think: I'll find out where the invasive monitoring is? Will I get a particular drug that isn't routinely stocked? Do I need different airway devices? You're kind of decision making even before you've started."* – Isaak (senior ODP)

This sense of making best decisions for the patient without the patient was not as strongly or clearly expressed in the same way by HCAs but is by medical staff who experience a greater sense of responsibility in choosing how to use their skills due to the greater harm that can be experienced by making the wrong choice. For nurses and ODPs the decisions relate to providing personalised care that avoids harm whereas for medical staff they are responsible for the post-theatre care and how surgery is carried out has a more obvious effect.

Caring for the patient, for the surgeon, involves their confidence in their surgical skill. This personal confidence is not about a sense of self-importance but much rather it reflects an internal conversation. Harry, as a consultant general surgeon, seeks conviction that he is being true to himself in his skill to carry out a surgical procedure. During this self-talk, Harry, silently seeks reassurance from a type of knowing that includes accurate knowledge of the procedure required, knowledge that he has been approved through his surgical training and belief that he is reasonably good at surgery. With this type of knowing, the decision to proceed can be made as Harry is able to feel a high enough level of confidence in the absence of any concerns:

> *"I think it is very dependent on your own er, confidence with what you are doing at the time. And not just sort of in an arrogant way but in a…but if you…as long as you you're truly convinced that you know how to do the procedure and that, you know, that you are trained and that you believe you are reasonably good at it then, then you don't have difficulties in doing that." – Harry (consultant surgeon)*

By contrast Harry reflects on previous occasions when he was not so confident as a trainee and felt that decision making was harder. Harry was aware of not being so confident in making surgical decisions when operating on patients. There is variation in how medical staff support patient choice; options are not always given with a belief that a person will agree with their decision. The choices offered to patients can depend on the member of staff who will make decisions on behalf of the patient based on their personal experiences and preferences.

Whilst there is an accepted tradition in practice, participants see that there are various ways of making the same decisions. There is an awareness that colleagues care for people in different ways and by doing things their way. Others accept the variance in individual autonomy as it is considered safe and within policy, but individuals stay committed and advocate their rationalised care practices. Ben experienced changes depending on who they were working with:

> *"So, I spoke to the anaesthetist before hand – there was a changeover of anaesthetist – so the first anaesthetist said we would think about it, and that, that lunchtime there was a changeover and the second anaesthetist was like no, you don't even give them that option it's not safe for them, so you don't even offer that kind of thing. You don't give them a choice and they will go along with what you say." – Ben (ODP)*

There are times when the participants have to make decisions that appear to be contrary to others. For non-medical staff, this was experienced around challenges regarding what was considered unsafe practice. In contrast, for medical staff, it was notable when making choices that their theatre team did not anticipate, notably the decision not to proceed with the surgery. In the scrub practitioner role, Sadiyah sees her role as protecting the patient, even when that includes refusing a surgeon's use of a non-standard practice, even where it may seem innocuous in case it later causes harm to the patient. This is seen as caring for the patient, and staff need to influence how others care.

> *"I was assisting a surgeon, and the surgeon wanted to cut, to cut a swab and I said "no…we don't do that". And he said, "Oh, but…". And I said, "no, we don't do that", and he said, "why not?". And I said, "because it's something we do not do." and although I didn't really want to explain to him, you know, the, why we don't cut swabs, I just felt it was important for me to stand my ground and say, "No, that's not our practice. We do not do that". – Sadiyah (Sister, Theatres)*

As an experienced nurse, Sadiyah finds the confidence to speak up and advocate her decisions that are in the patient's best interests. Still, she recognises that speaking up for the person is complex, involving hierarchies and individuals, despite strategies to give everybody a voice. There is a need for people to speak up and others to listen up, which overcomes personalities. In the participants' stories, it was apparent that people in the scrub role seem to have a pivotal role in the choice of action in difficult situations. Sadiyah shares an illustration of these complexities:

> *"But I think the theatre environment is hierarchical and so therefore the more senior you are the, the, the louder the voice you have. But I feel that sometimes those with the loudest voices – doesn't matter what, what role they have can actually dominate a lot of the time. So, it takes a lot for someone to speak out against them or over them." – Sadiyah (Sister, Theatres)*

4.4 Conclusion

This Chapter presents the findings from the participants that I asked to '*"tell me what it's like for you, to care for the kind of people you care for, in perioperative care".* The phenomenon has been written as a general description of the essence and the constituent parts of the participant's lived experience. Participant's accounts have been used to demonstrate the richness of these experiences and to help the reader connect to and share in their world as they resonate with this lived experience. Van Manen (2003) expects good phenomenological findings to evoke intellectual and emotional responses in the reader. I put forward that van Manen places more emphasis on this than any part of the phenomenological process. If the reader does not experience new spaces being created for thought that did not previously exist or a resonation of emotional connection, then it suggests that the work is not phenomenological. In contrast, Giorgi (2017) places the emphasis on the scientific process as critical to a study being phenomenological. Therefore, I leave the reader to find their own strengths in this presentation of what it means to care for patients in the perioperative setting, behind closed doors.

Chapter 5 - Discussion

5.1 Introduction

In this thesis, I set out to answer the question, ‘What is the lived experience of caring for patients in the perioperative setting?’. From my research, I have found that perioperative care means looking after the patient’s body as a custodian who places the highest level of responsibility on staff who care for patients with skill, morals, and ownership. Staff, as custodians, care for patients to protect the body that the patient hands over, often silently, as they would care for their kin. Connecting as fictive kin allows staff to take on the custodian role of making decisions about how to care for the patient, commonly without the patient being consciously present. Custodianship is transient, and some staff transfer it to others when they hand over the patient to a different team, but ultimately, there is an aim to return the body back to the patient. This way of caring is a natural response to patients who have lost their freedoms.

I have used the findings from this research to propose a new conceptual model of perioperative patient care (see Figure 5.1) that brings together the constituents and general description of caring for patients in this setting. The model demonstrates the dynamic interrelationships of high-quality care experienced by staff when looking after patients who have lost their freedoms.

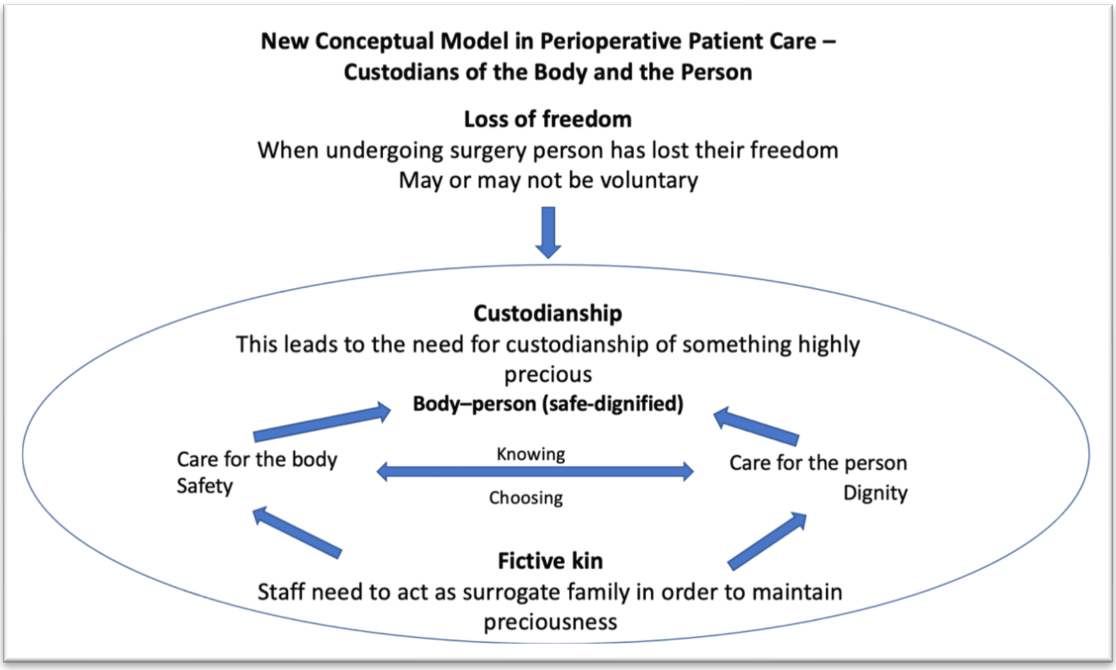

Figure 5.1 Conceptual model of perioperative patient care: custodianship of the body and the person

In this Chapter, I use literature, including publications post-2015, to examine key aspects of this conceptual model. There is some overlap between these aspects, which honours the interrelatedness of constituents (Applebaum 2012) by not artificially presenting them as independent and standalone. These echoes are important and can only be reduced with detriment. The key elements that I will now discuss are:

1. Loss of freedoms – patients commonly will lose their usual human freedoms in the unfamiliar, high-technology environment where they will routinely cede some or all of their body to staff.
2. Custodianship - staff use custodianship to care for the patient's body and for the patient as a person, choosing if they need to prioritise one over the other.
3. Fictive kinship - informs an understanding of how staff make human-to-human connections with the patient and is used by the staff as their guide to know what to do.

Lastly, I will look at this new understanding of caring for patients in the perioperative setting through the lens of the humanisation framework (Todres et al. 2009).

5.2 Suspending humanness - loss of freedoms

My research findings show that high-quality perioperative care develops as staff become sensitised to knowing that their patients will lose their usual freedoms. The unconscious patient has no autonomy or ability to exercise any utility, making them entirely subject to the perioperative staff as their body is taken care of. Simultaneously, in this state, patients become more vulnerable and subject to the risks of harm during their time in the perioperative setting (Gawande 2015, Wu et al. 2019, Roberts et al. 2023) and require others to care for them (RCoA 2019, CODP 2021, AfPP 2023). Whilst the care of the vulnerable patient is staff’s *raison d'être*, they do not explicitly describe or refer to patients in terms such as ‘loss of freedom’ even though it is normal for patients to lose their usual freedoms. Existing literature does not refer to the loss of freedoms in this setting. In this section, I discuss the loss of freedoms by (i) examining literature identifying common sources of how patients typically can lose their freedoms, and (ii) considering what can be learnt from existing literature from other settings where usual freedoms are typically lost.

5.2.1 Loss of freedoms – contributing perioperative factors

The patient’s usual freedoms are lost in several ways; the final and most obvious severing is unconsciousness caused by general anaesthesia (Andrade et al. 2014). My findings show that before the induction of anaesthesia, staff identified areas that could impact patients and risk impairing their freedoms. Literature also indicates that the loss of freedoms is multifactorial, and I will now consider some specific examples.

Patients can be anxious both before arrival and whilst in the operating department. It has been shown that when anxiety is induced, a person’s autonomy is impaired (Kunst et al. 2019). Furthermore, Jones et al. (2009) identified that when a person anticipates an upcoming threat, there can be a negative impact with the reduction of self-efficacy, self-control and focus, suggesting there can be an anticipated loss of autonomy. Carbonell (2014) puts forward that letting patients experience stress, in the knowledge that certain anaesthetic drugs would cause them to forget immediately, is unethical. In addition to this problematic ethical position, regardless of the degree of amnesia, anxiety is known to change physiology (Williams & Jones 1968, Charmandari et al. 2005) and can increase complications such as nausea and vomiting, pain and anaesthetic requirements (Maranets & Kain 1999, Van Den Bosch et al. 2005). Friedrich et al. (2022) reviewed research on preoperative anxiety, finding it was first reported back in the 1970s and that it continues to be recognised as a critical issue as it has been associated with increased morbidity and poor pain control. However, Royston and Cox (2003) point out that it would be helpful if psychologists could conduct patient interviews as this may better define true incidence. Among patients' concerns, Friedrich et al. (2022) and Royston and Cox (2003) identified the loss of control associated with anaesthesia and concerns of things going wrong during surgery that may lead to future impairment. Whereas Caumo et al. (2001) associated surgery with patients being concerned that they might experience a loss of independence or that they may not be able to provide for their families.

Several recent systematic reviews have looked at perioperative anxiety. Abate et al. (2020) conducted a meta-analysis of surgical anxiety, finding that almost half of surgical patients globally report anxiety, with patients being four times more likely to be anxious when worrying about fear of complications. The studies considered anxiety in both anaesthetics and surgery, though not all studies included both. However, other systematic reviews report variation in the prevalence. For example, Oteri et al. (2023) examined 27 studies across twelve different countries of patients undergoing brain surgery and found that anxiety varied between 17-89%. Whereas Bedaso et al. (2022) looked at studies in low- and middle-income countries and found results ranged between 24-88% with a pooled prevalence only 8% higher than Abate et al. (2020) figure of 48%. These studies illustrate the complexity of multiple factors that can embody patients' sense that they have lost their freedoms.

Several other variants of loss of freedom are now considered, which generally arise from patients entering a world of the unknown, including the environment, medical vocabulary and high technology. In my findings, staff were concerned that the operating department's environment, people, language and high technology could intimidate patients. Arakelian et al. (2018) also found that when they interviewed older patients about any worries associated with surgery, they described their feelings of heightened anxiety as they were taken down to the operating department as a realisation of seriousness arose. One of the themes of their findings was how patients identified that they would be in an unknown environment that was 'strange and frightening' (Arakelian et al. 2018, pg. 828). Haugen et al. (2009) undertook a small survey (*n*=119), finding that technical equipment and surgical instrumentation contribute explicitly to increased anxiety for 9% and 6% of patients, respectively. The authors found that ongoing information about the technology and other environmental factors reduced patient anxiety. A number of participants also shared how they would tell the patient about the equipment and the environment in an attempt to reduce patient anxiety. Moloney et al. (2023) considered patient's experiences of robotic-assisted surgery and similarly found that the lack of information was a source of anxiety and reduced confidence about their surgery. Not knowing what will happen and being worried were also considered contributing factors by Arakelian et al. (2018) in their study of older patients having bowel surgery.

Several small studies have trialled how information can reduce anxiety in the form of a pre-operative visit to the operating department. Studies have looked at both physical visits and using technology, such as augmented reality (AR) or virtual reality (VR). Findings give different opinions, with Rizzo et al. (2023) finding an improvement using AR and Bidgoli et al. (2023) showing no difference between patients who made no visit and those who had a physical or virtual visit. Yu et al. (2023) conducted a systematic review and analysed five studies, concluding mixed results on how a virtual tour might relieve preoperative anxiety. They found no effect in three studies and a reduction in two when using VR. The authors concluded that this may be due to the studies that showed a change in anxiety levels had recruited participants where some had previous surgery (which is a predictor of lower anxiety) whereas the others did not.

Another aspect is staff using medical vocabulary, which can leave patients isolated and scared about what might be done to their bodies, feeling that they are losing control of their bodies and leaving their lives in the hands of staff (Arakelian et al. 2018). Gobbo et al. (2020) also found a number of factors that made patients worry, including confusing and complex written information, fear of dying and that the environment was intimidating. During interviews, Arakelian et al. (2018) found that when patients described feeling out of control, this also included when they were in the anaesthetic room and knew that they would be letting the anaesthetic team take control of their bodies; despite making this choice, they were not in control as it relied on trusting staff. Similarly, Ewart (2020) found that some patients describe knowing that they would be letting staff take control of their bodies but that they still experienced a heightened embodied feeling when they realised the actual moment had come when they had to hand over control to someone else.

In conclusion, studies spanning the last thirty years have reported multiple contributing factors that emanate from patients not having enough information or that patients benefit from having more information (Powell et al. 2016, Falco et al. 2018, Gobbo et al. 2020).

5.2.2 Loss of freedoms – exploring other settings

It is helpful to explore the connections and differences found when comparing with other healthcare situations, where usual freedoms can also be considered lost, removed or suspended. In this section, I look at how living with dementia, acquired brain injury and deprivation of liberty safeguarding may reduce or take away a person’s autonomy.

People living with dementia generally experience a deterioration in their ability to comprehend situations and make choices (Bentwich et al. 2018). Bentwich et al. (2018) found that staff show cultural differences in their understanding and applications of support for autonomy and dignity. Further to this, they found that outside of the acute setting, the expectation was to adopt the acute care model approach which accepted that there would be '*concessions on their autonomy …for a limited period of medical care*' (pg. 136). Todd et al. (2021) found in their literature review that staff often use beneficence rather than autonomy to make decisions. This means that when staff find their patient is unable to make decisions, they are using their best judgement of what to do based on what they see as best for the patient. With the loss of patient autonomy in the operating department, the staff similarly will use beneficence to guide their actions. However, Bentwich et al. (2018) point out that this approach can dominate caring attitudes with a focus on clinical problems and not individuals by '*surrendering* [patient's] *personhood for good*' (pg. 136). Todd et al. (2021) agree that further work is needed and consider agency as a vehicle that may address the balance between patients' autonomy and others making decisions on their behalf. Agency is a dimension of Todres et al.'s (2009) humanisation framework, which is looked at in section 5.5.1.

One way patients can be involved in decisions is by making advanced directives. However, very little literature explores this, suggesting it may not be a common practice. A phenomenological study by McKinnon et al. (2020) highlighted the challenge of applying advanced directives whilst the patient was unconscious, as there can be too many variables; leading to questioning of how best to understand the directive in the moment of a specific context. Staff found that they were making decisions in a grey zone of uncertainty, and during interviews, this was experienced as being clouded with a medical paternalistic view.

There is some similarity here to the findings of van der Weide et al. (2023), who found that in daily situations, how people with dementia are supported depends on multiple factors, including staff characteristics, competence and how they interact with the patient and their family. Panday et al. (2022) also found that the quality of communication between staff and patients can influence patient autonomy when they looked at the rehabilitation of people with acquired brain injury (ABI). There is a difference for patients with an ABI who have lost some or all of their autonomy in comparison to perioperative patients in that it is unknown whether a patient with an ABI will experience further loss or a return to their former selves (Panday et al. 2022). Fundamental to perioperative patients is that in all but a minority of high-risk operations, most patients expect to regain both their freedom and faculty and to benefit from their surgery following rehabilitation. Panday et al. (2022) refer to the term relational autonomy as a helpful way of viewing freedoms in the rehabilitation setting as it embraces that autonomy '*…can be directly or indirectly influenced by the clinicians with whom they interact, institutional rules, the physical environment…*' (pg. 5544). As already discussed, this is true for perioperative patients who typically lose their usual freedoms.

Further to this, in my study, staff found that as freedoms return, staff will seek to return the body back to the person. To some degree, there is relational autonomy during this stage in the operating department. Staff use discharge criteria to determine when the patient can be safely transferred to the ward or discharged home (Association of Anaesthetists 2013). Although the requirements are based on medical parameters (Phillips et al. 2011), staff in the operating department often take time to clean the patient, change the bedding and replace patient gowns to remove evidence of blood, any body fluids or surgical fluids, e.g. surgical skin lotion. By undertaking these actions, staff can substitute the patient's decisions with their own when patients cannot make their own decisions.

The final setting explored is when a person has their freedom taken away, usually without their agreement. Patients who become too great a risk to themselves or others may be subject to a Deprivation of Liberty Safeguard (DoLS) (de Jong et al. 2017) when they are ‘sectioned’ under the Mental Health Act (Rooke 2020). Minimising the DoLS for an individual is always desirable, but this can be complicated (de Jong et al. 2017). It is argued that in these situations, the person needs to be limited in what they can do, or that substitution takes place, and others control them (Varelius 2006). In doing so, the patient - vulnerable to potential harm due to a condition and/or situation - is protected as they cannot fully care for themselves or protect themselves (Office for Health Improvement & Disparities 2021). The responsibility may be passed onto staff, or control can be taken, meaning that staff need to exercise judgment even when they are likely to operate with limited resources. Even if control has been authorised, there can be further conflicts, such as staff caring for forensic psychiatric patients that are part of the judicial system, whereby returning liberty – which is desirable - would mean that the patient is returned to a standard prison where they will not receive the same support leaving them vulnerable (Gosek et al. 2020). Douglas et al. (2021) found that caring for patients is more challenging for those who have ongoing reduced freedoms, such as prisoners, as it was challenging to give and follow up care.

In considering different contexts and different patient groups, it can be seen that there are substantial challenges involved in deciding how best to support patients to maintain their autonomy and, when they cannot, what is best for the patient. When reflecting on how autonomy is impacted in the other settings, there seemed to be critical components that can help give structure to the changes in freedom:

- patient choice in losing their freedom
- to what degree is freedom lost
- likelihood freedoms will change, and in what time frame

In the examples considered in this section, the patient is unlikely to have chosen to lose their freedom. In contrast, most patients undergoing surgery accept that they will submit themselves to the staff’s care when they consent to a procedure. There will be exceptions, such as emergencies where a patient may be unconscious on arrival in the hospital. There is sometimes a choice given as to the degree to which patients may lose their freedoms. That is, whether they have a general anaesthetic that would render them wholly unconscious or selecting only part of their body to be anaesthetised. Ewart (2020) shows that during regional anaesthesia, patients experience a point where they become highly aware of a numbed (anaesthetised) limb that they no longer have agency of. Although patients can be conscious, there is not a discussion about transferring agency; rather, it is usually assumed, and patients resign to this inevitability, assuming staff will take care of them.

5.2.3 Respecting patients' freedoms in the operating department

The right to rule one’s own body is a fundamental cornerstone of healthcare (Dalla-Vorgia et al. 2001) and has legal credence (European Union Agency for Fundamental Rights, 2009). Self-rule can be traced back to Hippocrates and Plato through to the current legislation, notably the Mental Capacity Act (2005). The loss of freedom can infringe on this autonomy and the ability to self-govern (Montgomery v Lanarkshire Health Board 2015, Beauchamp & Childress 2019). Control belongs to the patient in their freedom to choose and exercise autonomy, which in the UK is embedded in national frameworks (NICE 2021) and statutory professional standards (NMC 2015, General Medical Council (GMC) 2020, HCPC 2024). Patients may be unfamiliar with many or all of the things that happen behind the operating department doors (McNair et al. 2016), for example in many countries, including the UK, a proportion of patients are unaware that anaesthetists are medical doctors (Arefayne et al. 2022).

The operating surgeon usually consents the patient, and the whole team checks and verifies the consent with the patient as part of the legal (RCSE 2018) and professional requirements (AfPP 2022, Gardiner et al. 2023). However, there has been a growing emphasis on the role of the consent form as a critical part of patient safety (Roberts et al. 2023). Staff use the consent form to identify the patient and for procedural information when checking the patient into the operating department, ‘sign in’ (before anaesthesia commences) and ‘time out’ (before surgical incision) (WHO 2009, AfPP 2022). Using consent forms for a secondary purpose risks devaluing the more human aspects when the consent form is used to raise patient safety rather than verifying the GMC’s (2020) tenet of shared decision-making. Gardiner et al. (2024) show how the rest of the perioperative team plays a part in verifying this consent when the patient enters the operating department. Further research is needed to explore these ideas to understand the balance between consent for safety and autonomy to promote high-quality perioperative care.

In my findings, loss of freedom is more than checking that a signed consent form is verified. Perioperative care involves recognising that when patients go through the doors of the operating department, they will be handing over a degree of autonomy and freedom. Ewart’s (2020) study theorised that trust plays a fundamental part in patients handing over autonomy and staff assuming agency. In my research, staff accept taking on the custodianship of the patient as a way of meeting the patient’s loss of freedom. This is not a transaction. There is no client or customer relationship here where the exchange is proportional to the expectation with any degree of contractual relation. This is often the patient’s last act, allowing others to accept and care for them, and it is discussed further in the next section.

Studies have not examined how the loss of freedom is understood by patients undergoing surgery. However, some studies have explored what patients anticipate. For example, Fritel et al. (2023) found a strong correlation between patients’ views and what surgeons predict their patient’s hopes and fears were. The researchers also noted that the patients found greater satisfaction when, as part of the study, they identified a hope and a fear as they reflected on what was important to them. For example, repairing a prolapse is known to have a high failure rate, and the patients who were aware of this positively affected how they managed their expectations. Patient knowledge in this example gave them greater autonomy and reduced the loss of freedoms. Including the patient in decision-making (GMC 2020) is fundamental to using an evidence-based approach (Sackett et al.1996, Dawes et al. 2005, Gerrish & Lathlean 2015). Not being involved in decisions is reported by Bello et al. (2023) as being a significant cause of perioperative anxiety for patients that can harm their satisfaction. The challenge in the perioperative setting is that many decisions are made about the patient without the patient.

As mentioned above, Fritel et al. (2023) asked patients to identify a hope and fear. Themes of what is important to patients in healthcare settings can help staff to understand the patient experience. This is standard practice in other settings, particularly those involving support for chronic conditions. For example, in palliative care (von Post & Wagman 2019, McCaffrey et al. 2024), medications (Ameer 2021) and rehabilitation (Leggett et al. 2021), where what is most important to the patient is used to determine how best staff can use their expertise. Aligning patient outcomes and quality of life (Higginson and Carr 2001, Fayers & Machine 2016) has given structure to care for patients, particularly in palliative care (Albers et al. 2010, Schildmann et al. 2016, Murtagh et al. 2019). Giving voice to the patient allows them to set their own outcomes so that practitioners can use the best evidence available to guide practice. In the UK, the operating surgeon will have discussed matters with the patient, and, as they have a technical, objective focus on safe surgery, they do not regularly discuss other more human topics, such as what is important to the patient in the operating department. Ewart (2020) similarly found a need to use shared decision-making in the operating department.

Further exploration should be undertaken to investigate how patients can set their care outcomes, be involved in shared decision-making, and determine what is most important for them beyond what is currently agreed upon as part of the consent process. As Ewart (2020) also points out, not all perioperative staff have the skills to involve patients in discussions and those who seem to, have acquired it tacitly.

Therefore, any investigations or changes in practice require appropriate education and support for staff to learn and develop the skills necessary.

It is interesting to note that when staff talk about their care for a patient, they rarely talk about their patients being unconscious. As discussed in Chapter 3, during the phenomenological interviews, I purposefully did not include the term ‘unconsciousness’ or anything similar to prompt participants, only using the words, ideas and phrases they responded with. However, the general lack of explicit reference to the unconscious patients is replaced with an implicit caring attitude that is different and acquired. Staff found it difficult to describe what they did that was caring despite all feeling fully committed to providing good care. The inability to articulate care is found in literature. Gilligan (1982) ascribes that care is based on an involvement of emotional relationships. In contrast, Tronto (1998) sees care as an automatic responsibility, as there is ‘*a habit of mind to care*’ (pg. 127). Similarly, Benner & Wrubel (1989) put forward that care involves an emotional response to suffering that is noticed and recognised as part of an ongoing process of engagement. Morse et al. (1990) identified the lack of agreement of both definitions and components. Further to this, Tronto (1998) identified the challenge of defining care and noted that typically literature tends to:

> *“either overemphasise the emotional and intellectual work, or overemphasise care as work at the expense of understanding the deeper intellectual and emotional qualities”*
>
> *Tronto (1998, pg. 16)*

Tronto gets to the root of what this study aimed to do: re-balance the current perioperative literature that looks at the work of care. She also acknowledges that analysing care can provide a framework for political change (Tronto 1993). Despite the challenges of caring for patients and being able to articulate what that care is, perioperative staff know that others may not be able to care for perioperative patients.

They find that others new to the environment are naïve to what it means to care for somebody who has lost their freedoms.

5.3 *In absentia* – custodianship of the body and the person

Knowing that the patient cannot look after themselves is a critical part of perioperative practice, as staff can then understand what is needed and how to keep the patient safe. In addition to caring for the body, my findings show that experienced staff are skilled in knowing when and how to look to maintain the patient's dignity. This includes caring for the patient when their dignity is reduced, for example, necessary exposure of the patient during medical examination or surgery. Staff make decisions on the level of dignity they want to give the patient and balance this against objective needs to help them choose the level of dignity they will provide. Decisions can sometimes be critical, particularly during life, death or harm. These decisions about the patient are commonly made without the patient. Patients are unlikely to know the details of what will happen to their bodies and how staff will look after them.

Nonetheless, patients accept the inevitability of losing their freedoms as they allow staff to take over their bodies. In his study, Ewart (2020) found that patients accepted this loss, resigning themselves to becoming a clinical procedure that needs to be done. This acceptance is commonly a silent commitment, implicitly hidden in silence. At times, euphemisms can be used, such as, 'How long will the surgery take?' meaning, 'I don't know what's going to happen', or 'I'm worried something will go wrong [and perhaps die] - will you be there with me', or 'will I wake up'? Eriksson suggests that because of Caritas [love], staff will care for the suffering human (Eriksson 1997). This research found that patients bequeathing their bodies to the perioperative staff and those staff accepting the patient is best described as custodianship. The systematic review conducted by Oteri et al. (2023) on patients who had brain surgery found that the level of anxiety was not affected by whether the patient was awake or unconscious.

This finding supports my description that custodianship transcends the patient’s level of consciousness and is where they may have lost some of their freedoms.

Custodianship is a novel way of giving meaning to perioperative care. Custodianship is the condition of being a custodian and is defined as ‘a person who has responsibility for taking care or protecting something’ (Simpson & Weiner 1989). It comes from the Latin *custodia,* meaning guarding or keeping. In the US, a custodian is generally associated with a janitor, taking care of buildings. It can be used as a caretaker, guardian, keeper or patron in other languages. Custodianship also represents a lack of choice and can be associated with the UK Criminal Justice System (CJS). Custodianship in the CJS is commensurate with the seriousness of the offence; imprisonment involves a deprivation of liberty and is perhaps the most onerous and intrusive sentence available (Ashworth & Kelly 2021). These punitive measures are at the opposite end of the settings of this research, as custodianship is not a punishment but rather an act of free choice. This research also argues that the negativity around custodial systems should not limit the humanising potential that custodianship offers. The extra responsibility taken on is to preserve the human within the setting, whether that is a grandparent living with dementia, a person lying unconscious in the Emergency Department or a sibling in the operating theatre. Once the condition of reduced mental capacity occurs, for example, a traumatic head injury or anaesthetic, the person has less choice. Staff have expertise in their professional knowledge, and as custodians, they can and will do things that patients will know nothing about, including preserving their lives and functions as human beings. If a patient has lost freedoms, then without custodianship, there risks being a void: the patient needs somebody with them, their fictive kin (discussed in the next section), to work together and preserve their dignity when looking after their body. Custodianship is key and is now discussed, as it brings together what is lost and what is needed when staff, acting as a surrogate family, ensure the dignity of something highly precious and cared for.

In this research, participants had confidence and naturally adopted custodianship as the caring attitude; as discussed in the previous section, some staff struggle to be custodians when unfamiliar with caring for a patient who has lost their freedoms. For example, learners (medical and non-medical) who focus on the technical, objective aspects of perioperative care need help identifying the patient beyond the objective procedure. Eriksson et al. (2020) also found that qualified nurses (with 1-3 years of experience) who were new to the operating department found significant challenges in understanding and defining their role as a nurse. Jeon et al. (2023) showed that high technology and the patient's unconsciousness raised big ethical questions where the patient was not involved in decisions, and questions over their rights were subject to hierarchy, intra-team conflict and individual practices. Furthermore, experienced staff who work in different areas of healthcare (and are competent in caring for awake patients) do not initially adopt a natural way of caring in this setting. In addition, Blomberg et al. (2015*b*) found that attitudes towards patients changed with the belief that the patient was asleep, with staff saying derogatory things about patients when they were unconscious. Willassen et al. (2015) found that staff in situations where they felt they could not care or were unable to stop inappropriate care could lead to moral distress in the staff. Whilst Benner (1984) is widely accepted as giving structure to the development of mastery in clinical practice, and although she studied intensive care nurses (who also care for unconscious patients), it is unclear what currently helps staff develop an ability to care for patients who hand over their freedoms. This research suggests that embedding my new perioperative care model, custodians of the body and the person, could help new staff and students interpret and guide caring for the patients who lose their freedoms in this setting.

To date, the absence of this type of understanding of perioperative care may have underpinned the two-fold problem in operating departments: (1) the ongoing debate of how perioperative staff care for patients who are unconscious when they require technical expertise and (2) the attempt to use existing language, from other settings, to define or interpret perioperative care. Custodianship can provide direction for staff as it creates a nexus between the two things that staff hold essential: keeping the body safe and dignifying the person, whether awake or *in absentia*. The idea of custodianship offers a meaningful and pragmatic way of describing this complex everyday experience of perioperative staff. The pragmatism of custodianship is the accessibility of the term for everyday use. The description could be easy to understand and offer transferability. Further, it also appears to be a valuable mechanism to move forward the ongoing debates by helping to (1) shape definitions of the perioperative staff role, (2) unshroud misunderstandings of how staff 'care' for patients in the operating department [behind closed doors] and, (3) legitimise the contribution of all members of the perioperative team.

Custodianship is not easy. It places the highest responsibility on staff to protect something of great value to another person but of little immediate direct value to themselves. Temporarily, staff will take control of the patient to look after their body and to care for their dignity. The other side of this attitude to caring is that the additional responsibility coupled with the moral duties of kinship may give some explanation to a debt that accumulates, leading to compassion fatigue. The experience of staffing pressures, demanding operating lists and complicated procedures in a complex environment can all cause stress in keeping the body safe. In addition, Ramage (2023) shows that change, even when evidence-based, can be significantly impeded for perioperative staff due to a lack of time, needing to learn how to use research and the challenge of changing practice rituals. However, Ramage also found that change is supported by positive leadership and a culture of learning.

Finally, I put forward that custodianship is more than valuable, as it represents something extra: extra care, an extra level of giving that staff did not know they had. This makes it worthy of further investigation, for example, to illustrate good examples of how staff perform this role to show humanising practice with the patient and make it more accessible to the novice and inform systems design.

In the following sections, custodianship is explored, as well as how it is used in other settings and circumstances in existing literature. Ideas of what staff are custodians of are then explored, focusing on the patient’s body and the patient's humanness. Using some of the ideas presented from the existing literature, the discussion finishes by considering how staff can juggle the two views of the patient as a body that needs to be kept safe and a person who should be dignified.

5.3.1 Custodianship in existing literature

This section examines the literature to support the claim that describing a patient's care as a custodianship is novel. An informal literature review explored how the terms are used concerning care. A search of the university databases for “custodian OR custodianship” AND “care” has 345 unique records. The terms ‘custody’ or ‘custodial’ were not included in the search as these relate to judicial services, care of children, or unskilled carers (particularly in the US).

No records were found that use the term custodian to describe the care of patients. The literature found was screened by title, and where needed, the abstract was read to determine relevance, and the full article was reviewed for further confirmation or to understand more fully how the term custodian was being used. Despite the void of literature on this topic, this informal literature review does reveal how the term is used and is included to consider similarities and differences to inform this research.

The literature in this section uses the terms custodianship and custodian concerning matters where a charge is given/taken so that there is a responsibility for something/someone not [deemed] able to take care of themselves. Topics in the literature included caretakers/janitors or custodians of information, children, historical items, environment, medication, and traditions/customs, written in order of the number of occurrences. Generally, articles use the terms to give a sense of a protective guardian who looks after the objects or children being cared for. When used with children, this is generally where they have been removed from parent/s and/or children deprived of liberties in the judicial system. There are also references to children who have a disability affecting their mental capacity. When a DoLS is authorised, the literature reveals little differences to similar circumstances if the person was an adult, except their age means that there are additional critical legal duties to safeguard. The examples of custodianship in the literature can be divided into two subjects: something inanimate (non-human) or something human. Inanimate subjects were not initially considered as the proposed perioperative care model concerns a human subject with a loss of freedoms. While the literature offers little immediate insight for this research, some articles provide valuable contributions that I will explore in more detail to consider relevant findings and insights.

Custodianship is a term regularly used in a subject called ‘camp studies’. This subject includes camps as:

> “*…a modern technology of humanitarian aid and population management, a thanatopolitical* [politics of death] *institution, a site of protest and resistance, a metaphor of sovereign exclusion, or a means of colonial expansion, and more*”
>
> (Weima & Brankamp 2022, p.338)

Camp studies started in the late nineteenth century and have recently focused on the modern institution of camps. Whilst initially, camp studies stemmed from concentration camps, since the turn of the twenty-first century, it has embraced other types of camps, such as makeshift refugee camps and institutional refugee camps. However, following the war on terror after 9/11, it has had to include global detention camps (Martin et al. 2020). This has led to authors like Collins et al. (2022) highlighting that terms like custodianship have formed essential structural ideas. Collins et al. (2002) found that by abandoning the historical lens of concentration camps and their control of people outside of typical legislation, they can view the modern, more humanitarian camps using ideas of custodianship to explore these geographical spaces where care takes place. The change in camps prompted Collins et al. (2022) to put forward the need for a new definition that reflects the humanitarian nature of camps, not solely the historical description of concentration camps. Part of the drive to change our understanding of camps is the observation that it is too simple to state that camps are divided into ‘care and control’ (p. 6). Instead, custodianship is a term that:

> “…*correlate[s] with a spatial political technology that is defined by its capacity to seamlessly shift between seemingly distinct forms of governance as circumstances dictate.*”
>
> (Collins et al. 2022, p.2)

When custodianship is used in camps, the care-control framework can offer a way of understanding responsibility for the people. However, the framework does not have an ethical position, meaning that the term can describe the activities taking place in more humane refugee camps or where a ruling body instigates the dreadful atrocities seen in concentration camps or Delta Camp, Guantanamo. As Farooqi (2012) puts forward, the term custodian has a dichotomy, either the supervision of the imprisoned or the watchful care of an individual.

My research findings reflect similar ideas that staff will care in a way that as priorities change, they can quietly switch back and forth between caring for the body and the person. It is critical that custodianship, as described so far, does need to have a dynamic component. The literature on perioperative care I have reviewed does not address this dynamic aspect of care. Instead, it focuses on one or both components; it does not explicitly discuss their integration and separation as a skilfully used tool in high-quality perioperative care. My research found that this is an integral part of perioperative care based on experience and skill and would benefit from further research.

Although I previously stated that I would not explore examples of custodianship for inanimate objects, the cultural anthropology researchers Bendix and Kurzwelly (2021) reflect on the custodianship of human inanimate objects. There are similar questions around care and control when considering custodianship of the human remains in one of the world's oldest collections; the Blumenbach skull collection kept at Göttingen University. There, skulls from across the globe are kept in uniform rows of identical, unremarkable boxes, disconnected from the body, '*likened to the evidence vaults of criminal justice institutions'* (p. 22). These represent the human body and life whilst the humanness is historically lost. Staff that work there are called custodians, and their responsibility is not just to maintain the integrity of the skulls but to preserve the humanness of the collection. There are mixed records of what happened and how skulls became part of the collection, leaving unanswered questions:

> '*What did those bodies do or represent that brought them into custody? What entitled their keepers to treat them as property, severing heads from skeletons and further preparing them for shipment and study?*'
>
> Bendix and Kurzwelly (2021, pg. 23)

Bendix and Kurzwelly provide a thoughtful framing of custodianship that strongly relates to custodianship as identified in my study. The unconscious body that temporarily loses all freedoms and humanness requires skill, morals, and ownership. Although patients are often reduced in the perioperative setting, they are still human. As custodians, there is a purpose to the ownership of the inanimate body: to repair, heal or rehabilitate. However, it is the knowledge of knowing that they are still human and precious that gives a connection. Knowledge of the humanness is necessary for custodianship. Collins et al. (2022) have already pointed out that a human connection is needed. Bendix and Kurzwelly (2021) outline how unpicking the human stories behind the skulls, with the current worldview, could lead to dismantling the collection to return the remains. Similarly, in perioperative care, having insights and knowing the patient should determine and change our worldview in how we care in a more profound, more human way.

The inclusion of skulls in this discussion illustrates the importance of the connection between staff and patients in the perioperative setting, which is more than just being responsible for an object. Whilst the skulls are not living tissue, they do represent humanness, and it is this aspect that means staff can connect to them in a particular way. Custodianship arises from this connection. Several articles have studied the custody of children and kinship and show the strength of this link as research has found value when biological kin take on the custodianship of children (Gibson & Singh 2010, Lee et al. 2021). The connection between kinship and custodianship has made differences in the care of children with a greater likelihood of permanency, and more equality was seen across the sample regarding experiences of different ethnicities. Despite the challenges for kinship carers, such as their relationship with the biological parents, the child benefits more when their carers are kin (Brandt 2004). The research did not explore why biological kinship had a positive impact, but it did affirm that there is strength and ethics when kin connect with the child as they take on the custody. This will be discussed further in section 5.4 when fictive kinship is explored to illustrate how staff relate to patients despite no biological connection.

5.3.2 Custodianship is a learnt caring attitude

Staff caring for the person first must be able to care for the body. As staff develop technical expertise, they can find more space to see the person. People who are new to theatres find it an emotional experience that is both exciting and an anxious time. Operating theatres are an acute area involving skill, knowledge and technology dominated by tasks, problems and high technology (Mitchell & Coppelstone 1990, Freeling et al. 2017). Novices find they need help to see past the objective, and clinical and scientific knowledge is required (Dikmen & Bayraktar 2021). These obscure and hide the person, preventing them from being able to engage in care and, when caring for the patient, being able to see beyond more objective needs. This is supported by Phillips et al. (2015), who found that student nurses need the professional vocabulary to articulate caring for a person despite their inner desire to care for others.

Similarly, student nurses find the operating theatre a difficult experience as they feel worthless and alienated and cannot see empathy (Taylan & Özkan 2022). It may be that the novice does not act as a custodian as they cannot simultaneously care for both the body and the person, or they do not have the experience and expertise to know when and how to switch priorities. However, researchers also found that experienced staff can care for the body but, at times, do not do this in a dignified way (Willassen et al. 2015). Staff not taking on custodianship can lead to uncomfortable reading. For example, a research study in Norway by Valeberg et al. (2018) found differences in the professional groups with nursing staff providing dignified care. In contrast, they found that physicians might not act as custodians of the person, e.g. discussing irrelevant, personal matters in front of an awake patient, a female adolescent with slightly overweight and heavy breasts who was undressed and put in a very vulnerable position on the operating table. The patient, wearing knickers only, was positioned at the operating table in a hands-and-knee position. Many people were in the operating theatre, and the door was not closed. Or a nurse who used an elderly male patient as a 'table', and every time they picked up equipment, it touched his genitals.

So far, consideration has been given to exploring how existing literature helps illuminate the human-to-human connection of custodianship: taking on the responsibilities of caring for the person when they have lost their freedoms. The following section explores how staff take on the custodianship of the patient in the perioperative setting.

5.3.3 Custodianship – a merging of two worlds

My research conceptualises that a perioperative custodianship model is based on the staff caring for patients as custodians of the body and person through a safe-dignifying continuum. As the patient's freedoms are handed over, staff diligently care for the patient and their body. Caring for something precious is taken seriously, with staff using their skills, morals and justice to look after something they intend to transfer to others or give back to the patient. This is important as it is unlikely that the patient will ever know how they were looked after. It is clear that keeping patients safe is a priority, and staff will deliver safe surgical outcomes together. Sometimes, staff, collectively or individually, adopt a more objective attitude of caring for the body. In the findings, staff know the surgical team (in particular, the surgeon) will need to adopt an objective focus, and the surgeon reciprocally relies on the team to balance this out by maintaining a more humanising perspective. Sometimes, staff respond by speaking up when they need to shift the continuum towards a more dignified approach, e.g. keeping the patient covered up. There is a skill with experienced staff of knowing how to change between those modalities. For the novice, this is often observed but not understood as the team silently seems to know what to do, and it is noticed when staff do not adopt this attitude towards caring. Harmony is reached when staff can provide dignified, safe care, but it can be broken when the team have different priorities that lead to dignity loss or unsafe practice. However, finding harmony does not mean a lack of mobility. The custodian model (Figure 5.1) values the relationship between mobility and stability, recognising that there are times when staff will move towards a more dignified or body-focused approach. The continuum between safety and dignity will be determined by how staff integrate three faculties, 'fictive kinship' (discussed in the next section), 'knowing' and 'choosing'. There is an interrelationship between these three.

Further research must investigate factors contributing to these skills and how staff use them as they master custodianship. Knowing and choosing is possible with the staff's experience, skill and professional values, collectively in a team and independently. The choices that staff make should be in response to the patient's priorities, and staff may need to adjust the balance of safety-dignity. Further research is recommended to understand how this lens can be used to interpret activity in the operating theatre, particularly how patients would understand custodianship. There is also further scope for examining other settings where patients lose their freedom to understand the similarities and differences.

5.4 A room full of strangers - fictive kinship

My findings highlight that perioperative staff are comfortable in their 'home' surroundings, feeling assured that they are well prepared with an extensive range of equipment, technology and expertise to care for patients. They also recognise the contrast for the patient who can be uncertain, anxious, scared and ultimately medically reduced to an unconscious state so that the team can get on and safely complete surgical intervention as efficiently as possible. In the operating department, the first time staff meet a patient, the patient can be in various states: awake, consciously sedated, unconsciously sedated or fully unconscious. In my findings, the general response of staff is to try and connect to the patient as fictive kin. Specifically for the awake patient, this is important – that they are welcomed, respected and treated as individuals (Oliveira 2020, Bello et al. 2022) – what has not been evident in the literature is how staff connect to the patient in the other states of consciousness and awareness. My research has found that there is a general sense, in perioperative care, that staff draw from a range of strategies to establish a fictive kinship with the patient. The techniques are explored in more detail in section 4.3.1 and are:

- Using imagination
- Talking with patients
- Findings stories
- Making a difference

Although the proposed perioperative care model places custodianship first, my findings reveal that custodianship is possible *because of* fictive kinship. However, this interdependency is not linear or transactional, and at times, my findings show it is established with little more than imagination. Staff must connect to their patients in the perioperative setting despite the many barriers that make connections hard. Staff work hard to adopt patients as fictive kin to establish a high-level connection beyond being just social. It is essential as they will have the patient's body in their hands, making decisions about how to care for them without them. This type of connection informs custodianship. In this section, I will explore fictive kinship and how it paves the way for staff to become custodians of patients who have lost their usual freedoms. Literature is examined to illustrate how research can be understood through this lens and, reciprocally, how literature can inform the proposed model.

Fictive kinship is an anthropological term founded on the idea that the family is always the primary social group (Helman 2007). Families are typically biologically related, but they also have non-biologically related members. Individuals given the honorary status of being like a family member are fictive kin. Nelson (2013) argues that the term is helpful despite the need for more precision that may be needed for studies that look at specific settings or groups. Currently, no literature uses the term fictive kinship to describe the connection between staff and patients in the health and social setting. This study proposes that fictive kinship is a new way of understanding how staff make human-to-human connections in the perioperative setting. Nordqvist (2019) shows that people engage with people as kin only when they believe they are related; with this belief, they would treat unknown relatives as their kin. She goes on to say that the cultural assumption that kin connects through genealogy, biology and genes does not explain the kinship affinity experience between people, which can be experienced in multidimensional ways. Sociologically, kinship is not a given. Instead, it emerges through a process and is 'brought into being' (pg. 58). Through this process, kinships can be understood as being something that is:

> *'very carefully brought into existence, known and engaged with through various strategic, bodily, practical, personal, affective and familial practices as part of everyday life.'*
>
> (Nordqvist 2014, pg. 280).

The strength of the connection between staff and their patient results from the belief that the staff will become custodians of the patients and will know how to care for them and make decisions for them. This foreknowledge underpins staff engaging with patients as fictive kin. Kinning is the process of becoming kin, a complex and multifaceted event, such as adoption (Nordqvist 2019). My findings reveal that the operating department staff engage in kinning to establish fictive kinship with the patient. Kinning in this setting is also complex and multifaceted, deriving from things such as structures of health (the type of person working in the operating department who will then be allocated to care for the patient), inequalities (such as patients who are anxious, vulnerable, suffering, in need) or personal connection (likeable patients, shared commonality). Some of these aspects will now be explored.

In this study, participants can create a stronger sense of fictive kinship by knowing more about some patients. This process is more than a moral obligation of being employed to provide medical intervention, regardless of the employee's professional title. Whilst there has been some suggestion that the creation of different staff groups, e.g. technical staff, ODPs, and healthcare assistants, have been detrimental to patient care (Timmons & Tanner 2004, Shields & Watson 2007), all participants had a strong desire to make human-to-human connections. This goes beyond making connections with the awake patient in the operating department. Staff know that patients are commonly anxious (Tulloch & Rubin 2019, Ji et al. 2022) and can provide support and comfort through empathetic and supportive conversations (Salzmann et al. 2023). Anxiety is not only unpleasant but may also negatively affect outcomes for surgical patients (Kassahun et al. 2022, Salzmann et al. 2023). However, in the operating department, staff also try to make human-to-human connections when the patient is unconscious, even if they have not met the patient before and know they will not see the patient awake. For example, it is an everyday experience for a scrub practitioner not to see an awake patient, yet they use a range of techniques, as described in my findings, to connect to the patient in a more human way. Therefore, the desire to establish a connection with the patient can be a one-way connection that only yields meaning to the perioperative team.

The staff know that it is difficult to engage in fictive kinship due to the barriers of the healthcare system and requirements for safe surgery. Participants describe being aware of the risk that patients could become lost or hidden in the operating department, with their perioperative journey becoming like a conveyor belt. Patients can become lost, both physically and metaphorically, perhaps most noticeably when they are covered over and hidden in the operating theatre. However, even before arriving in the operating department, patients undergo some degree of reduction from an individual person into a surgical patient. Personal clothing is replaced by donning an unremarkable surgical gown, with anything removable from the body typically being disconnected. Bodies are commonly drawn on with a tattoo of surgical markings, and the preparation for the anaesthetic and surgery routinely will induce sensations of hunger, thirst, anxiety, emotion and concern. In theatre, anaesthetised bodies are hidden under sterile drapes; often, only a surgical site is exposed. Metaphorically, the patient disappears with the demands of a busy operating list taking over. There is, after all, a need for tasks to be completed quickly, and attention is required to ensure that equipment is being prepared, managed and used correctly and that procedures are followed with precision so that patients can have the best outcome. Ongoing high-technology advances, such as robotics, will only increase the technical demand for staff (Russell 2022). The complexity of the operating department means that the patient’s humanness can quickly become lost with the demands of looking after their body. The obscuring or reduction of the patient is the challenge staff have in trying to engage in meaningful kinning.

The nurse theorist Parse puts forward that humans are greater than, and more valuable than, the sum of any reducible constituent parts (Parse 1997). However, as described, perioperative practice generally necessitates a reduction of patients towards objects and procedures. The surgeon will focus on cutting and stitching, the anaesthetist will monitor physiological changes, and the circulator will ensure the correct sutures are available. Knowing the patient as unique requires a unique body of knowledge; the patient is the only one who can know and reveal what is best for them. Making the person expert (HMSO 1999) saw some controversy and split opinion (Shaw & Baker 2004), but it is the basis of evidence-based practice (Gerrish & Lathlean 2015). While patients can be experts in their choices, this does not mean that staff should relinquish their expertise (Hemingway 2013). The problem in the operating theatre is that the patient – who has unique personal and complex structures that give meaning to their life – is regularly absent. Despite staff placing a high value on professional values (Torabizadeh et al. 2019), they commonly have little or no time with an awake patient, and they are unlikely to ascertain the patient’s values and beliefs (Mitchell & Copplestone 1990, Markovic 1997, Hansen-Ketchum 2004). Caring for the patient as a person is a challenge compared to caring for the body.

Finding ways of connecting to the patient takes a lot of work and is the daily challenge staff encounter. For example, it would be expected that staff working in anaesthetics will meet a highly anxious patient who does not particularly want to talk and wants things over and done with (Stamenkovic et al. 2018, Ji et al. 2022, Kassahun et al. 2022) or there is a noticeable loss of humanness when a patient is sedated or anaesthetised which can strip the patient of their freedom to make choices for themselves. These practices are routine and are experienced by staff as everyday events in the operating department staff. As found in the literature review and this study’s findings, staff new to this setting do not understand the nature of caring in this setting. Commonly, the novice finds things unnatural or confusing (Tarrant 2006), and my findings show that this includes experienced ward staff new to the operating department, with caring becoming a more natural, unspoken and intuitive approach after some time. When staff can connect to the patient as fictive kin, perioperative care is experienced as high-quality care, with staff being custodians of the body and the person.

In Nordic countries, the difficulty of connecting to patients was approached with a strategy to increase the time and give continuity by an operating room nurse meeting with the patient before, during and after surgery (Rudolfsson et al. 2003). This approach is known as the perioperative dialogue, based on the humanistic approach in which a perioperative nurse's care supports well-informed patients through their surgical journey (Rudolfsson et al. 2003). Studies of the use of the perioperative dialogue have shown that patients and staff experience a better sense of caring and being cared for, with some specific anxiolytic (reducing anxiety) benefits (Rudolfsson et al. 2003, Lindwall & von Post 2009, Pulkkinen et al. 2016). However, more studies, such as randomised controlled trials, need to examine the degree of impact this has or the resources required. Swenne et al. (2018) found that the perioperative dialogue does not impact other vital factors, such as opiate consumption, postoperative nausea and vomiting, and length of stay. Dias et al. (2022) support these findings in their study of operating room nurses having pre-operative dialogues. Studies need to explore the nature of the human-to-human connection made between staff and patients.

Rudolfsson et al.’s (2003) Grounded Theory study of the perioperative dialogue did find that nurses can see the patient as friends or family. Sundqvist et al. (2018) and Blomberg et al. (2018) found it was important for staff to see the patient’s face using eye contact and physical gestures, and that touch can convey a lot. The perioperative nurses' connection is a personal, ethical responsibility that confirms the patient and ‘*creates a mutual community*’ (Blomberg et al. 2018, pg. 418). Larsson et al.’s (2023) systematic review identified that patients feel safe if they feel they have participated, have control and feel the presence of others. Feeling part of things includes being spoken to directly and being seen as a person who is capable and equal but with individual needs. In my study, the participants did not use the perioperative dialogue as this is not a common practice in the UK. However, they did experience seeking a connection with the patient, describing a range of tools they could adopt and use. In confirming the patient as a person, Blomberg et al. (2019) found that establishing a connection with the patient helped them to be present for the patient. With a connection in place, Blomberg et al. (2018) showed that staff can always have the patient in mind and can go on to care for the patient and preserve their dignity.

In Nordic caring sciences, Eriksson's *caritas*, i.e., human love and charity (Nyström et al. 2021), is theorised as the motive for caring. With this ethic, staff can share this suffering as '*the foundation of common existence has been created*' (Lindwall et al. 2007, pg. 30). In my study, fictive kinship is not established as part of any particular formality or in response to any requirement of sorts. It also does not appear to be part of the taught traits. Instead, fictive kinship seemed to be organised and learnt by observing how others solved the problem of making human-to-human connections. Smith et al. (2005) described how anaesthetic staff could connect in different ways to the patient, but an inexperienced member of staff from the ward, staff would not understand subtle cues when the patient needed staff to be quiet but confidently present and holding a patient's hand when appropriate. Staff describe experiences not necessarily noticed by others (Smith et al. 2005) and appear to want to connect to the patient's humanness naturally. My study shows that staff use a pragmatic approach to understand who they care for by establishing a human-to-human connection with them. For some, Eriksson's Caritative Caring Theory is abstract enough to have universality (Näsman 2020), and further research would help to understand how the human as a suffering being establishes the connection wanting to alleviate that suffering in terms of fictive kinship. As fictive kinship is an integral and interdependent part of the proposed perioperative care model, any integration into perioperative training programmes should benefit staff's development of high-quality perioperative care.

A study by Krupic et al. (2016) found traits of good practice in perioperative staff connecting to patients with dementia. Staff understood that patients with dementia need more time and care that recognises the individual. However, the initial contact point in the anaesthetic room did not need to change, such as requiring additional time. Instead, Krupic et al. (2016) showed acknowledging that somebody had dementia was necessary. The principle can be seen that connection can be made with the time available and, perhaps more importantly, that it could be sustained with familiarity and that all patients require the permanent presence of at least one person, ideally through physical contact, e.g. holding hands (patients with dementia can become distressed if this is broken and in my experience, this is true for the patients without dementia that need to hold your hand). Verbal connection is important, but nonverbal seems more important to patients as they do not want to be left alone (Arakelian et al. 2017). The findings of my study are that staff use a range of strategies to establish fictive kinship, such as reliance on a whole team approach and being able to see if the patient is conscious or seeing their face. As this may be a critical stage in the caring process, further research would benefit any development of models to support education and training in making connections with the patient.

As discussed in Chapter 1, the operating department staff members have various backgrounds, experiences, and qualifications. Some staff may have yet to gain healthcare experience, and only ODPs will have undergone specific lengthy perioperative training. Currently, operating theatre scrub nurses are not required to have a formal post-registration qualification in the UK, which has left staff unsupported in a challenging environment. Radford and Fotis (2018) showed the variety of experiences qualified nurses encounter when starting in the operating department due to a common lack of structure. Therefore, consideration must be given to approaches that will support all perioperative staff, as the studied phenomenon was a general experience of the broader team that is cognisant of the variations of the team’s existing skill base and experiences.

5.5 Humanising the unconscious

In this section, I used Todres et al.'s (2009) humanisation framework as a lens to consider the proposed perioperative care model. First, I will give a brief introduction that looks at the framework and then how the framework can be used to understand the care of patients in the perioperative setting. This will be followed by a discussion of how the framework can inform and be used to understand the three key elements in this Chapter: loss of freedoms, custodianship and fictive kinship.

5.5.1 Using the Humanisation Framework to inform perioperative care

Galvin & Todres (2012) worked together over several years to develop ideas around people's experience of being cared for, particularly the presence and absence of feeling cared for as a human. They were concerned that people felt '*that they do not feel fully met as human persons in the way that care is organised and practised*' (Galvin & Todres 2012, pg. 1). As already identified in this Chapter, the perioperative setting has numerous organisational challenges and practices that can stop a patient feeling fully human. These challenges make their framework an interesting lens to challenge how we humanise the patient in this setting. Galvin & Todres draw from a phenomenological tradition that considers a person being a lived body as a way of knowing and being. Within this tradition, the view is that a person has far richer possibilities than dualism would limit with its quantification of separation (Todres 2007). The possibilities of a lived body with embodied experiences led Galvin and Todres to show that care given to people may meet some care needs [requirements of care] but is not always caring. Caring is experienced by both the person receiving and the person giving and is an embodied lived experience. Todres et al. (2009) developed the humanisation framework as a scaffolding upon which research, policy and practice could benefit health, well-being and education. The framework comprises eight philosophically informed dimensions of humanisation constructed to bring together a value framework for humanising care that would help guide practice and inform research. It is essential that practice, particularly expert practice, continues to inform theory and that theory informs practice (Benner & Wrubel 1989). The framework has been used to understand other areas of health care and education, including care of older people with dementia (Borbasi et al. 2013), pre-registration nursing (Phillips et al. 2015), public health (Hemingway 2012), communication between nurses and patients with aphasia (Pound & Jensen 2018), an exercise programme (Killingback et al. 2021) and in sport (Kavanagh & Brady 2013).

The framework will now be considered for perioperative care. Table 5.1 shows how I have used my research findings to demonstrate how the eight dimensions can be understood in terms that are humanising or dehumanising in the perioperative setting. The table shows the types of activities that can humanise and dehumanise the patient. However, the table must be considered carefully, as not all activities that dehumanise the patient should be seen as examples of poor care. For example, staff focusing on retracting the liver, inserting an airway adjunct, or evaluating the neurovascular supply to a foot all require objectification of the technical components to be undertaken safely. In the custodian model, staff know this is essential to care for the patient and will skilfully choose to objectify a technical aspect. Importantly, this objectification needs to be carried out in a way that does not sacrifice the more humanised ways of caring. Still, because there is a specific care need, staff can prioritise caring for the patient's body, knowing that when the task is completed, they can care for the patient as a person. As custodians, staff provide high-quality perioperative care, individually and collectively, as a team.

Table 5.1 Dimensions of humanisation (Todres et al. 2009): examples of how humanising care can be obscured/enabled in the perioperative setting.

Forms of humanisation	**Forms of dehumanisation**
Insiderness Little is known about the patient as a person, often silenced by anaesthesia. Staff use fictive kinship, patient consent and best decisions as a guide	*Objectification* Focusing on technical aspects can keep the body safe

Agency Usual freedoms are lost Staff become custodians	*Passivity* Body and dignity are dynamically prioritised by staff making decisions
Uniqueness Individuality is lost through bodies being reduced and then hidden Fictive kinship preserves some degree of what is known	*Homogenisation* Bodies are protected based on the best evidence (usually positivistic) Dignity is typically based on ethical and moral attitudes
Togetherness Being on own Fictive kinship adopts patient into family that shares privacy, connectedness and intimacy.	*Isolation* Feeling alienated behind closed doors
Sense-making Waiting, procedure, and business can create conveyor belt perception Knowing what is important for the patient and sharing information	*Loss of meaning* Need for efficient throughput Challenges in accessing surgery
Personal journey Unconsciousness suspends a journey, but there is still a past, present and future. Staff commonly ask about a job/family/where a person lives and offer to sort out surgical needs so the patient can return healed.	*Loss of personal journey* Anaesthesia to support safe surgery Just seeing body in the present
Sense of place Feelings of alienation behind closed doors. Welcomed as fictive kin	*Dislocation* Structural/organisational requirements to protect the body and for privacy
Embodiment Unknown experience, environment and people. Patients challenged to know their place or contribution. Existential concerns around harm and dying. Staff take on responsibility of patient’s embodiment by becoming custodians of the body and the person, keeping them safe and dignified whilst humanness is temporarily suspended.	*Reductionist body* The focus is on keeping the body safe rather than including the person as well

Applying the framework gives a helpful perspective for perioperative staff to evaluate and determine how to shape care so that patients can be ‘*fully met as human persons* *in the way that care is organised and practised*' (Galvin & Todres 2012, pg. 16). The framework can also determine ways of suspending dimensions when there are other priorities, such as the need for a general anaesthetic. Whilst unconsciousness makes it challenging to evaluate the degree of their humanisation, it is not a contributing factor to my perioperative care model. Therefore, any philosophical challenge regarding the humanness of the unconscious is less relevant when accepting the fundamental position that patients cannot be fully human in this setting. Staff can use ways of caring that are more humanising than dehumanising despite the patient's absence. Table 5.1 shows ways that staff can use the custodian perioperative care model to humanise the patient, despite the challenges of the setting. It is recommended that this is explored further, including using the perioperative care model as a way of evaluating the humanisation of patients in the operating department.

5.5.2 Dignifying the patient

Staff generally want to promote the 'absent' patient's dignity when caring for the patient (Mann 1998) even though there are some cultural differences with staff associating care with measures of patient safety (Chellam Singh & Arulappan 2023). Further to this, there are also medically induced challenges, as medicines, illness, and anaesthetics can change the patient, making it harder for staff to qualify what they believe they know about that person. However, every person is unique (Eriksson 2007) – as is their perioperative journey – but during their journey, typical cues will recede and identifying their uniqueness becomes challenging with altered states of consciousness and institutional dehumanisation (hospital number/procedure, gown, removal of items for anaesthetic safety, e.g. false hair, teeth, jewellery, make up). Pulkkinen et al. (2016) found that when staff can identify the patient's uniqueness, the patient has been seen. Whilst this research investigated awake patients, my research findings have shown that staff continue to want to connect to the patient to see them in more human ways, despite knowing the person receiving surgery may not know, or ever be likely to know, how they were cared for.

When the patient becomes part of the theatre family through fictive kinship, staff can find ways of seeing and then caring for the patient as a human. The relationship between staff and the patient can be viewed as an unconditional responsibility with a desire to want the best outcomes. The humanisation framework does not suppose how a connection is formed between two people or why that relationship is formed. It provides a comprehensive way of seeing the whole person more humanly through conversations, interactions, decisions, environment, attitudes, etc. The framework guides what makes people feel more human and how health – in the broadest sense - should be able to embrace the individual. Understanding what makes a person more human can equip staff to identify strategies that value the patient as unique to give them dignity despite being somewhat suspended as a person in the operating department.

5.5.3 WHO surgery safety checklist – the missing human dimension

Whilst the research has found meaning from participants' experiences, further research is needed to explore the extent and nature of fictive kinship and how it informs subsequent care. For example, currently, operating theatre team briefing only notes particular concerns or differences of patients, e.g., high body mass index (BMI) or language differences; most patients are therefore not discussed, and the information shared with the team are moments of safety checks. Other countries have explored and valued the use of the perioperative dialogue (Pulkkinen et al. 2016, Swenne et al. 2018) and theatre staff visiting patients pre-operatively (Dias et al. 2022). These are valuable in reducing patient anxiety and should be considered as a strategy to establish fictive kinship. This should be addressed by investigating the impact of sharing what is important to the patient with the perioperative team as part of the WHO surgical safety checklist.

Using the surgical safety checklist is known to improve outcomes for the patient (Paterson et al. 2024). Despite the evidence that the correct use of the checklist is good for the patient, Ziman et al. (2018) found variations in compliance between the professions. They also found little or no participation from the patient. Furthermore, Paterson et al. (2024) showed that using the checklist was impeded by reduced team participation, hierarchies exerting power and general complacency. These ongoing difficulties in implementing the checklist and genuine engagement continue to present a risk to the patient (Roberts et al., 2023). One of the challenges to the checklist is the diversity of staff in the operating department. Yeganeh et al. (2022), who studied professional relationships and communication in Iran, also found that different staff groups valued teamwork differently, with culture, gender, and hierarchy negatively impacting patient care. Whilst human error continues to be a significant component of never events and harm (Pirouzi et al. 2020), nursing staff place more emphasis on teamwork than physicians, despite the evidence that improved teamwork can reduce burnout and error, such as retained surgical items and wrong site surgery. Having illustrated some of the challenges with the WHO surgical safety checklist, any future challenges would likely meet at least as much resistance.

A further challenge with the dissonance between the staff groups and the challenge of using the WHO surgical safety checklist is the need for a shared understanding of hierarchy and leadership. Arad et al. (2022) studied teamwork during surgery. They found that most staff considered patient safety an individual responsibility, but experienced nurses saw themselves as safety supervisors, identifying themselves as having '*…a huge responsibility. [We] stop dangerous work processes before harming the patient.*' (Arad et al. 2022, pg. 4). It is accepted that good teamwork enables better patient outcomes (Pattni 2018, Arad et al. 2022, Bello et al. 2022). Further work needs to be undertaken to understand how broader aspects of humanisation should be integrated into the complexities of the operating department. Work has already been done to show that humanism in post-graduate perioperative medicine curriculum can increase patient empathy and professionalism, resulting in statistically significant differences in patient anxiety, pain and overall satisfaction (Canales et al. 2019). The growing emphasis on patients making shared decisions (GMC 2020) and the learning from other areas of health care can be used to address the plateau in patient safety (Roberts et al. 2023). My research has shown that high-quality perioperative care is based on the relationship between custodianship and the loss of freedoms. It is recommended that further investigation of this relationship is made by placing a greater, more meaningful emphasis on the patient as a person in the WHO surgical safety checklist. The checklist offers unique opportunities when all the staff come together to stop and consider medically relevant information about the patient to reduce the risk of harm. Currently, there is no formal humanised aspect. Holland and Muir (2021) show that using stories can develop learning and that the subject of those stories will direct learning. Placing the patient as a person at the centre of the checklist will enable staff to see the patient in more human ways that can support fictive kinship. Blomberg et al. (2019) found that introducing the WHO checklist has already reduced the time for the perioperative dialogue. The recommendation is to let patients lead their care by asking them to share what is most important to them.

It can be seen that the operating department can risk the patient being dehumanised due to the requirements of safe surgery. Caring is assumed to be part of being human (Bulfin 2005), and when people are caring, it creates a sense of unity (Locsin 2017). However, with each team member working on individual parts of a surgical ‘assembly line’, further questions need to be explored to understand what staff offer beyond the interventions they are completing. Without a clear understanding then with the increase in high-technology, particularly decision-making robotic surgery and artificial intelligence (AI), the future of humanising the unconscious is uncertain. It raises questions about whether autonomous robots and interactive AI can replace staff, and if not, then what is the added value? The perioperative setting challenges staff to articulate a comprehensive humanising approach when caring for patients. Staff can respond, in part, by becoming fictive kin and acting as custodians. Further research is needed to explore these dimensions in more detail and how effective strategies, such as those offered by this research, can promote the humanisation of care. There will always be a suspension of humanness with anaesthesia, but this should not halt investigation because of any view that perioperative care cannot become more humanising.

5.6 Addressing the research aims and objectives

At this point, it is appropriate that I address how this research's original aims and objectives have been met:

This research has found a new general description of caring for patients in the perioperative staff setting. The description underpins a proposed novel conceptual model of high-quality perioperative care: custodianship of the body and the person.

Staff connect with patients as fictive kin. The connection may be one-way, as some staff will first meet a patient when they are unconscious. Unconsciousness does not alter how staff connect to the patient; rather, because staff know that patients lose their usual freedoms in the operating department, they form this type of connection. Depending on the situation, staff will draw from various techniques that enable them to see the patient as fictive kin. The techniques include using imagination, talking with patients, finding stories and making a difference. Fictive kinship informs a custodian type of caring. As custodians, staff use their professional values, knowledge and skills to provide high-quality care for the patient.

The research offers a new and novel way of understanding how perioperative care transcends the individual as a description of care within the operating department carried out by the collective team and the individual. The phenomenological description gives new, easy-to-use vocabulary to the everyday experiences of staff as they provide remarkable care for the individual patient in a different way than previously understood.

As a way of caring, custodianship seems to have developed organically in response to the patient’s loss of freedom rather than their unconsciousness per se.

5.7 Limitations and strengths of study

This study’s contribution is a new understanding of caring for patients in the perioperative setting that provides easily accessible, pragmatic language. The proposed novel conceptual model can be used to underpin education that supports all staff in the operating department to enable high-quality perioperative care. In addition, there are new opportunities to conduct further research, particularly into how an adapted WHO checklist can become more humanised by allowing patients to be involved in their care, which until now has been missing.

There is potential overlap in this section with the next Chapter, which is my – Reflexive Chapter, as limitations and strengths require reflection. Therefore, I invite the reader to gain a fuller insight by reading this section and the final Chapter.

5.7.1 Limitations

There are always limitations to all types of research (Patton 2013). As the researcher, I wanted to understand more about the human story of caring in a challenging environment that I was familiar with, which led to using qualitative research (Polit & Beck 2021). However, as this was my first phenomenological study, there was the risk that my interviewing or phenomenological attitude would reduce the sensitivity to the phenomenon. However, I was well supported by my supervisory team to ensure that my data, analysis and findings were in line with Giorgi’s (1985, 2009) descriptive approach.

Although I have closely followed Giorgi’s descriptive phenomenology method, limitations are associated with the research approach and how this was applied in my study. These are now explored. The first is that my research is a context-limited study.

As an approach, phenomenology intrinsically focuses on a specific topic within a particular context. Thus, my findings are limited to the data collected from staff working in the perioperative setting in England. The second limitation is that, intrinsic to the phenomenological approach, this study is not an individualistic or profession- or perioperative-phase-specific perspective. The study pursues the meaning of caring in the perioperative setting, and the findings provide a general description of that meaning. Thirdly, unlike other types of qualitative research, there is a specific limitation as the findings are not given to participants to confirm credibility (Cresswell & Cresswell 2018). Good phenomenological research should resonate with participants (van Manen 2003, Giorgi 2009), but it is a general description of the phenomenon using participants lived experiences, not a description of their lived experiences. The phenomenon of study transcends the individual experience, and as identified in the second limitation, the phenomenon is not individualistic. Whether there is value in the truth of my findings is limited until shared with readers and subjected to their critique.

Further limitations are specific to how I used the research approach in my study. There is a gap between data collection and the final submission of this thesis, which has been around nine years. Data is usually contemporary, and changes, such as an increase in international recruiting for staffing, could mean that the data no longer reflects the context-specific data I collected. Secondly, maximum variation in sampling includes a range of participants that have had experiences of the phenomenon but is always limited to the participants that a study samples. There will be different lived experiences that may reveal variations of other shared ways of understanding the phenomenon. Finally, the process of free imaginative variation was not recorded during this study. As there is no record of this process, there is a limitation to the transparency of the analysis of the data, as it is just theoretical and not open to critique. Transparency allows greater insight into the analytical phase and the researcher's impact on influencing the findings. Direct quotes support the authenticity but are limited to sharing what the author chooses to share.

The quality of this research has been considered by looking at the rigour, relevance, resonance and reflexivity as put forward by Finlay (2011) as a way of thinking about phenomenological research. I will now touch on each of those elements, directing the reader to other sections when relevant.

Rigour – This research has adhered to the descriptive phenomenological method described by Giorgi (2009). The study has been open to review by my supervisors and colleagues. In addition to this, I have presented at internal university and faculty conferences. Findings have also been shared with students (pre- and post-registration). Before my research, it was not easy to describe to others the important things taking place behind the closed doors of the operating department beyond medical intervention. I was surprised at the response of an experienced group of post-registration students who had worked for many years in the operating department. After they had read my general description, they sat quietly, waiting for me to prompt further discussion. My surprise was that they did not have comments or critiques; they were happy to accept that what they had read was obvious and comfortably resonated with their experience. My other notable response came from an academic colleague who reflected on how much it made them want to return to practice. As mentioned in this thesis, van Manen (2003) says that a good phenomenological description can be read naively, missing the depth and intricacy, but can also touch on intellectual and emotional responses.

Relevance – Dobrow et al. (2017) point out that relevance is not synonymous with impact but relies on time to be compared to other things. Therefore, at this stage, it is hard to determine relevance. However, using my research, I have had an abstract accepted for an oral presentation at a national conference; the Association for Perioperative Practice and a scientific panel blindly accepted my abstract to present at the European Operating Room Nurses Association (an organisation representing 24-member countries).

Resonance – Again, this will be judged with time but also by the reader. As this study looks at the human experience, the reader should be able to resonate with aspects of this study whether they have experience in the operating department or not. Another layer of quality in research will be how others who have experiences in similar settings will also find resonation. For example, a healthcare practitioner may not have been in the operating department but can resonate with custodianship, loss of freedoms and forming human-to-human connections through fictive kinship. Finally, the reader can find resonation with the participant quotes in Chapter 4, demonstrating good use of the phenomenological method.

Reflexivity – My personal awareness, decisions, insights and approach are explored further in Chapter 6.

5.7.2 Strengths

There was a personal interest and drive in wanting to undertake this research, as described in section 1.3. A personal drive is seen as an advantage (Maxwell 2012) as it can provide a commitment to completing the study. In addition, as part of my evaluation of this descriptive phenomenological study, I used Finlay's (2011) proposed facets of a phenomenological study. Table 3.2 was included to demonstrate how my study was structured and carried out in line with her framework. I now consider the strengths – by recognising the challenges of data and findings:

Data – In this study, I used open interviews to allow the participants to answer questions how they wanted to. Unstructured, open interviews can reveal new, unanticipated things that have not been prompted, providing rich, thick data worth knowing as it tells the human story (Todres 2005, Ross 2012). Interviews gained access to knowing more about the phenomenon. The participants included a range of operating department staff to help understand some of the common or variable components of a general description of the phenomenon that can resonate with a broader group of staff. The phenomenological attitude requires bracketing what is already known, personal beliefs and understanding (Finlay 2011, Creswell & Creswell 2018). However, it is accepted that, in practical terms, it is impossible to remove all thoughts (Zahavi 2003, Giorgi 2009). The study drew on experienced participants as phenomenological research needs to investigate people who have had the experiences and had good perioperative acumen (Todres 2005). Lived experiences of the phenomenon offered my data collection with rich descriptions of concrete events of their experiences. Generally, staff drew on recent stories suggesting that these were fresh in their memories, less likely to be processed and offered a degree of accuracy (Holloway & Wheler 2010). It also indicates that these are everyday experiences rather than a skew of notable memories. Sample size, and more importantly, knowing when there is sufficient data, is the subject of an ongoing debate both philosophically and practically (Morse 1995, Morse 2000, Fusch & Ness 2015, van Rijnsoever 2017). It is difficult to say when further interviews would not yield something new or different (Patton 2013). Data was believed to be sufficient after seven interviews. However, one of the practical drivers can be the extensive workload involved (Choy 2014, Creswell & Creswell 2018), which can risk influencing an early decision to stop collecting new data. There will always be a degree of truth in this, and the findings are presented openly in this context and are not claimed to be universal.

Findings – The findings of this study include two novel ways of describing perioperative care through fictive kinship and custodianship. Further, loss of freedoms is not generally in the literature about the perioperative setting or healthcare. The lack of their use in existing literature indicates that these findings are not drawn from existing knowledge and beliefs.

Finally, it is difficult to judge whether the length of time that this study has taken (over ten years) has been a strength or a limitation of the study. The formal literature review considered literature up to the point of data collection to inform the study, and there may have been studies that could have been included in my post-study informal literature search. The extended time has provided the opportunity to think about my research and, as a practising and consulting practitioner, to reflect on and grow in my understanding of this topic as I observe and participate in operating department practice. The length of the study could attribute the novel findings as a reflection of dwelling on the data.

5.8 Recommendations

Based on my findings and discussion, the following recommendations arise:

Recommendations for practice:

- To use the custodian perioperative care model to inform, educate and train staff to understand and develop high-quality perioperative care.
- To modify the WHO surgical safety checklist to include an overarching statement of what is most important for the patient.
- To use the custodian perioperative care model as an evaluative tool to understand the quality of perioperative care and inform improvement strategies.

Recommendations for future research:

- To explore the extent and nature of fictive kinship and how it informs subsequent care.
- To explore the impact on developing and improving staff skills in kinning.
- To investigate factors contributing to the mastery of custodianship and how patients can understand the decision-making of their custodians. There is also further scope for examining other settings where patients lose their freedom to understand the similarities and differences.
- To evaluate the impact of using the custodianship perioperative care model in education programmes.

Chapter 6 – Reflexive Chapter

Qualitative research recognises and values the researcher as part of the research (Holloway 2005). In this Chapter, I share with the reader aspects of my part in this research study and how I worked at holding onto Giorgi's scientific process of adopting the phenomenological attitude. Sharing my reflexivity is important as it is considered an intrinsic feature of qualitative research (Avis 2005).

6.1 How did it feel to find my research question?

There was no single point where I found my research question—instead, I view it as an ongoing iterative process. By this, I mean that I can only know I have found the right research question when I know I have found an answer. As discussed in section 5.7.1, time is needed to determine if a good answer has been found.

Looking back at my research journey, I began with wanting to understand why I would experience a sense of excellence in the care of a patient in one theatre and only an average experience in another. Thus, my more grassroots question of what care was in the operating department became my research question. I felt confident with this as I noticed that my working title, 'humanising the unconscious', typically raised the interest of colleagues and fellow students when I shared it with them. However, 'unconsciousness' was dropped as it would mean that I was sharing my ideas with the participants by telling them that the unconscious patient was part of their experience of caring. As noted in my findings, participants rarely refer to patients as being unconscious, and this is the type of moment that I felt that I had found the right research question. My research question revealed a more general phenomenon, as it can include caring for awake, sedated or unconscious patients.

There was a long time between starting my data collection and nearing the completion of my analysis. During this time, as I was trying to suspend thoughts and understanding of perioperative care (which was challenging as a perioperative educator) as part of the phenomenological bracketing, I became immersed in the data. Being lost in a phenomenological attitude was most noticeable when I emerged from 'the other side'. In trying to figure out what I was doing with all the findings, I did a bit of a 360-degree turn: I was thinking about custodian care and what it is when I realised everything went back to the research question of what it is to care for patients. I again felt as if I had found my research question. I had yet to see the whole phenomenon as I was labouring over the phrases, components, and constituents, which is something Finlay (2011) recognised as a challenge in phenomenology, describing it as a dance between the parts and the whole.

6.2 What was it like doing phenomenology?

Being phenomenological is hard work. My background is positivism, and I am very comfortable running an experiment to collect observable data that is objectively interpreted to yield research findings and confirm facts. The closest such an experiment would get to being interested in the subjective human interest would be writing a null hypothesis in an attempt to remove any researcher bias. I was fascinated the first time I heard about phenomenology, particularly that a research project can be called scientific through a rigorous application of Giorgi’s method. As a scientific study, it is considered to be repeatable, and another researcher can find the same meaning if they seek precisely the same phenomenon (Giorgi & Giorgi 2008). There then seemed to be tension when using a scientific approach to find meaning by a subjective researcher studying another subjective individual. This was, and is, the focal point for an ongoing tension.

Giorgi (1985, 2009) put forward his method and, following criticism, argues powerfully that he can be descriptive due to the clarity of his method and adopting a phenomenological attitude of bracketing (2011, 2017). Giorgi and his wife tested the method by independently reviewing data that, whilst their transforming steps (see section 3.5.1 on Giorgi's phenomenological method of analysis) were different, the final descriptions were comparable (Giorgi & Giorgi 2008). However, the premise of needing to 'test' phenomenology underlays the tension that, somehow, as a researcher, I become the instrument despite all my subjectivity. Within this position, I felt uncertain. It reminded me of Hans Christian Andersen's Emperor's New Clothes, where any discrepancy in the appearance of phenomenology would be attributed to the researcher not being rigorous enough, failing to approach near enough to the meaning or not holding to the phenomenological attitude.

My first experience helped me understand what being an interviewee is like. Early in my research, my supervisor, Professor Les Todres, suddenly announced in a supervisory session that he would interview me phenomenologically. Professor Todres is a hugely inspiring role model, vocally intelligent, deeply philosophical, and mesmerising. I share this to identify the relationship between the interviewer and the participant, which made me feel intimidated and an imposter. I felt put into a position where I needed to prove myself on several levels. They are in no particular order and include: Were my study ideas going to be judged as being at the doctorate level? Would Professor Todres be interested in my study? Would my profession be seen as valuable and doing something good? My overall concern was to have the correct answers, and in realising this concern, I anticipated my challenge was that in wanting to be phenomenological, I would answer the question in a way I thought the researcher wanted. I did not think of this as a power difference typically described by others (Anyan 2013) but rather the juxtaposition of an interviewer, participant and the unknown. I needed the interviewer's skills to help me find the phenomenon.

For my part, I shared a recent story. When working in the operating department, I noticed that the anaesthetist and patient were struggling following several failed attempts to insert a spinal needle into the intrathecal space. I abandoned my 'usual' spot supporting the anaesthetist and swapped places with the HCA. I moved to be with the patient and stood in front of them, holding their shoulder with one hand and their hand with my other. While I was in mid-flow of sharing this experience, Les interrupted with a smile to tell me that this was now phenomenological as he could hear *that* I had an experience. I was now telling him *what* that experience was. I continued my story whilst quietly feeling surprised that I had been phenomenological. My supervisor, who had stepped out of their interviewer role, said there was a phenomenon that should be explored here. Somehow, it all seemed simple; I had just told a story. Through this experience, I understood that an essential part of the interviewer's skill was to offer reassurance and confidence to participants when they tell their stories. My participants all started their interviews, needing clarification of what they were supposed to be saying. Some needed ongoing reassurance that just telling their story was really helpful. Les also demonstrated how to look for an experience and to notice when the participant was sharing one so that they could be supported to share the richness of what it was. Whilst it can involve some probing and digging deeper, there is satisfaction for both interviewer and interviewee when it is found.

The second experience was after I had completed my first interview. My supervisors seemed pleased with the data I had collected. Les affirmed that this was because I had interviewed well and had been phenomenological. He confirmed that it was the interviewer's skills to find what was phenomenological. Whilst I was sceptical of praise, I reflected on the interview experience. It was hard work and tiring, and I knew a lot of data was being generated. Zavattaro (2020) describes similar experiences in their autoethnographic study and likens the interview to a black box where everything comes into that moment. It felt like there was only one opportunity to get it right, and any mistake would be irreversible and a moment lost. In pursuing a hunt for the phenomenon, I was concerned that that one lost moment would miss the phenomenon. However, this somewhat naive view did sustain my focus. During the interview, I was aware of the constant internal dialect of trying to listen whilst being reflexive to pursue the phenomenon.

Throughout my study, I was aware of the need to ‘be phenomenological’. In order to adopt the phenomenological attitude, I found that I would engage in self-talk to remind myself that I needed to be phenomenological. As a novice researcher, I would question myself whether the constant personal inner talk was because I was new to this research approach or because it wasn’t a natural attitude. Inner guidance included phrases like, ‘be phenomenological…are you being phenomenological….I am *listening,* but am I *hearing* what they are saying…is this phenomenological? I found maintaining a phenomenological attitude during interviews was particularly challenging. To support participants during the interview, I tried to make them feel as comfortable as possible by engaging in conversations as naturally as possible. Natural discussions would be difficult if I asked to pause between answers so that I could think about what the participant said before asking the next question. I found that I developed a responsive mechanistic approach to interviews that focused on exactly what participants were saying and rejected my internal related to what I thought about their responses. During the interviews I relied on gathering the data, relying on the audio recording to gather the data. This enabled me to metaphorically ‘shelve’ any thoughts of needing to analyse the data to find meaning at this stage. By suspending this type of thinking, it gave me more opportunity and space to immerse myself in what was being said. Immersing myself meant not bringing ideas and thoughts with me but staying really focused on what they were saying and waiting to hear that they had had an experience.

Reflexive issues were considered in my thinking. I did not keep a reflexive journal of my thoughts and now see this as an omission, and in future, I would keep an ongoing journal. However, I shared my thinking and reflections during supervision, which was recorded and notes made. This articulation was essential to my reflexivity, helping strengthen my research skills and providing an opportunity for talking, which was used to improve my thinking. During the analysis stage, this was particularly important as part of developing skills in using free imaginative variation for my analysis. Conferring my self-talk during supervision initially helped me to perform the dance of moving between being close to the data and then far away enough to understand how a phenomenon was being experienced through the participant's consciousness as part of a larger, more abstract and irreducible description. This gave me the confidence to be able to dismiss, merge and create the constituents that were essential and transcended the individual experience.

The key to reflexive issues was the awareness of my suppositions and pre-suppositions and the need to bracket them. To illustrate the approach used, I will now outline a general and then a specific example of how I approached the challenge of suspending my suppositions and pre-suppositixons. Developing expertise in Operating Department Practice as an academic clinical practitioner is essential to my employment. During my first participant interview, I quickly noticed that I was experiencing a lot of self-talk and that 'I already knew what they were talking about'. This made sense as it is my subject area. Still, I reasoned that this did not feel phenomenological as I would just listen to things that I already knew. I would just be going through a routine of getting participants to tell me what I expected so that I had data to substantiate my pre-suppositions. I found that I could give myself permission to step back and hear what others were saying, and I could frame it as others were saying things because *that* was their experience with the phenomenon. In my self-talk I was then able to remain focused on pursuing what the experience was.

A specific example of adopting a phenomenological attitude during data collection and analysis is the topic of unconsciousness. Before I started my PhD, my pre-supposition was that the nature of caring in the Operating Department was because patients are unconscious. The work of Todres & Galvin (Todres et al. 2009) influenced me to consider how to 'humanise the unconscious'. This idea initially influenced my thinking, and I considered studying 'the lived experience of caring for the unconscious patient in the perioperative setting'. However, as already discussed, I took 'unconsciousness out', which changed the phenomenon I was studying. During interviews, my self-talk included not introducing this as a topic, which I sustained through the interviews. However, when I was over halfway through the data analysis, I had a specific thought about unconsciousness. As I actively engaged in the phenomenological attitude, my self-talk wanted to suspend this thought as I realised that I might again return to seeking meaning in humanising the unconscious. However, at this point, I suddenly realised that the participants had not talked about unconsciousness, bar one of two mentions of the patient being asleep. This was a surprising moment that I had not expected to find: that the staff did not talk about having an unconscious patient.

Furthermore, I constantly reminded myself that I should be bracketing. 'You must bracket...are you bracketing?...is what I am doing, bracketing?' was loudly playing on repeat in my internal dialogue. Thoughts of bracketing [or not] kept me second and perhaps third-guessing my reflexive instincts during the interview. Was I hearing what the person was saying and living their experience, or was it my interpretation, bias or desire to make things fit? I found that bracketing was not about passively suspending thought but demanding vigorous self-talk. Not just listening but also hearing what the participants say. Supervision was essential in supporting and affirming my internal reflections and guiding my active interviewing skills. It is easier to know what being phenomenological actually means once you are helped to clarify what experiences are and are not phenomenological.

6.3 Findings

My final reflexive point concerns a later stage in the research and is a point in time that helped to affirm that I have been phenomenological in this study and my findings.

I found the analysis stage incredibly demanding for two reasons. (1) analysis is challenging, as I had a spread of 40,000 words of raw data and a further 20,000 words that I wrote as part of Giorgi's approach to analysis to draw out what was sensitive to the phenomenon and (2) the headspace required to fit all of this in. The latter challenge was a personal one that led to this study being extended over a much longer period than anticipated. To support me in developing skills and confidence in analysing data and synthesis of findings, my supervisors directed me to look at a published personal account of the phenomenological analysis by Suddick et al. (2020). This was incredibly helpful as I found some harmony as the shared insights were highly relatable. The demand and the mental insult are skilfully illustrated, with strategies for comprehending such vast data and meaningfully making sense of the whole and the parts. While the paper refers to hermeneutic phenomenology, I resonated with the experiences, though my strategies could have been more creative. Table 6.1 demonstrates that I attempted to use colour coding, but I found the process of colour coding was more helpful than the finished product.

Table 6.1 Colour coding data into constituents

2.11 Technical skills can be carried out by different roles/grades without a difference to the patient. 2.11 At times care of a person is undertaken by somebody that is less senior but it is on the basis that immediate help is
2.12 There is a comfort in having skilled help to take on difficult technical tasks. 2.12 When caring for people there is a comfort in having defined boundaries of how people can care for a person, for example managing artificial airways.
2.13 As a healthcare assistant, when caring for a person, there is a sense of feeling fully supported by more senior people so that at no moment do they feel out of depth or unsure in how they should best care for that person.
person means waiting, even if they have a high pain score, and that is accepted as a normal experience because of the business.
2.15 Privilege…to care for people that are suffering…are able to help through being there when the patient first wakes up needing reassurance about how they feel and then how their surgery went. There is a real need to confirm that things are normal, such as feeling discomfort but that they can be managed.
2.16 Some of the suffering that a person experiences is normalised by those that care for them, such as headaches and sore throats. Reassurance is given that everything is normal and in order.
2.17 Caring for a person in the postanaesthetic room means repetition. A person commonly wants reassurance, reorientation, confirmation and their uncertainties answered. Rrepeatedly.
2.18 The experience of caring for a person can vary between gender; men being more aggressive and immediate and woman being more tearful when they wake up from their anaesthetic.
2.19 Whilst on most occasions the person wakes up without event, and their care focuses on them wanting to confirm that things are finished, sometimes the person will need additional care as they awake confused.
2.20 Caring for the waking person, can mean that the anaesthetic drugs change how people might normally behaviour, this includes people being sworn at and on one occasion, due to the confusion, an attempt to be kissed.
talking about taking their kids swimming and then consciousness is regained; the person needs constant reassurance and explanation. Generally caring for the waking person goes well within these objectives but sometimes it is found to be quite difficult.
2.21 There is a need to understand what it is to care for the anaesthetic person. This understanding is helped with wider experiences to see the patient's journey beyond the walls of theatre, including preoperative admissions and postoperative ward care.
2.22 Being involved, as part of the team, can make you feel like you are making a difference to that person's life.
2.23 Being aware that the person has offered they body and that they may have had an unpleasant operation, one that

The process of phenomenological bracketing continued into synthesising my findings with constant self-talk of wanting to hear the participants' voices and not my own. Although Giorgi's analysis leads to developing phenomenologically sensitive meaning, I needed to keep returning to the verbatim transcribed interviews to re-immerse myself in what the participants were saying. By adding this as an additional stage, I had more confidence in not being lost in all the data and that Giorgi's stages were not distancing me from the phenomenon. My concern that a distance was being created was based on being a novice researcher new to Giorgi's steps, despite reassurances from my supervisors. In using this process, I was able to suspend my perspective and see something new about the phenomenon that could transcend the individual moment and offer meaning that was both general enough for the operating department staff and was concrete and detailed enough to inform a model.

6.4 Insider-outsider issues: Merton's insider principle

Researchers must construct knowledge carefully, aware of themselves and what they are studying, to reveal something meaningful. Creswell & Creswell (2018) assign significance to this relationship - between the researcher and participant – putting forward that it is part of how the epistemological assumption is defined. As a researcher researching a participant's experience, then epistemologically - the knowledge gained and its validation–will depend on this relationship. This relationship can be structurally defined as whether the researcher is an insider or outsider. According to the prominent sociologist Merton (1972), the insider is seen as a member of a group and has a '*specified social status*…[whereas]…*outsiders are non-members*' (p.21). The insider will have '*privileged access to particular kinds of knowledge*' (p.11) that the outsider does not. The outsider is not necessarily a pejorative as they can access and validate knowledge with degrees of detachment from the social structure.

Acknowledging an understanding of these different positions means that I can recognise the advantages and challenges of both positions. As a researcher, I am an outsider, not employed in the participant's organisation. In addition, participants may not fully trust an outsider researcher and, therefore, not fully share all of their experiences. However, I have some insiderness as an ODP who knows about the operating department and is familiar with staff in my region due to my academic role. As an insider, I could understand what participants were saying during interviews. However, adopting my phenomenological attitude meant I had to reposition myself towards being like an outsider to ask questions and not assume an understanding of what was being said. Being an insider helped to give participants access and work with senior staff to recruit and use resources. Knowing how and who to contact can be challenging, particularly in theatres with restricted access for non-authorised staff.

As an insider, I did not have to contend as much with unknowns as I was familiar with the type of staff and the type of things that they said. This meant that I could concentrate on listening and hearing participants, and there was some liberation in having the opportunity and permission to ask staff questions without assuming a shared understanding. Asking participants if I could share some of their accounts felt quite personal. I reflected on my interview experience and was aware that as an experienced ODP and an academic who has trained and worked with many of the regional perioperative staff, there was a risk of intimidation that might skew the data. I used some of my skills from clinical practice during the interviews to notice the participants and take a therapeutic approach of reassurance, offering quiet confidence that they were okay and could share what was private and personal. Outsiderness felt like when I took a more objective view of what I was hearing, and during analysis, it felt like I was trying to listen to what participants were saying. Of course, in phenomenology, they are not saying the phenomenon is bigger than a single moment, but my findings needed to be true for each moment.

6.5 Final thoughts

I am proud of the findings demonstrating the skilled caring attitude of staff looking after vulnerable patients who cannot look after themselves. Caring for people truly is a privilege, but it is also complex, and the perioperative setting only adds to that complexity. I am grateful to my supervisors and participants as they freely gave, and whilst they are somewhat hidden, they manifest in the best parts. Similarly, perioperative staff are hidden and rarely acknowledged, but I am proud to be part of the good things that happen behind closed doors.

I look forward to continuing this work in a post-doctoral capacity to develop and evaluate an educational approach to using the new perioperative custodianship model and to promote integrating the patient's humanness alongside the WHO surgical safety checklist by including the patient identifying what is most important to them. However, I will first re-engage with the love of my life and my best friend, Emma. Second, I am told that my ignored job list has become very long.

Throughout this research, I can only understate the role of my supervisors, CE-H, LT, MH, and VH, in their mentoring, affirmation, patience and belief in my humanness.

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APPENDICES

Appendix 1 - Research protocol for NHS Hospital approval

Research Protocol

A phenomenological study of the lived experience of caring for the person during their perioperative journey

Introduction

This research looks to gain descriptions of theatre staff.

Methods

This phenomenological research adapts Giorgi's methodology (1985, 2009).

1. Participants will be recruited through Participants Information Sheets placed in the theatre environment, namely notice boards/coffee rooms, and senior staff will be asked to inform staff at team meetings. Participants who sign the consent form will be recruited where they meet the entry criteria.
2. Data will be collected through one-to-one audio-recorded interviews in a relaxed atmosphere through unstructured interviews. The consent form includes seeking permission to audiotape the interviews.
3. The Patient Information Sheet/consent form outlines the interview process. During the interview, participants will be asked to describe their experience of caring for the surgical patient. I will start with the question, 'Tell me what it is like to care for the type of people that you care for in the perioperative environment'. Where insufficient answers are given or the participant relays phenomena, further questions will be posed to gather more data. Subsequent questions will direct participants to further describe an experience they may mention.
4. The audio recorded interviews will be transcribed verbatim with the exception that any identifying or confidential information will not be included. At the point a transcription is anonymised, the participant will be unable to withdraw from the research.
5. Transcribed data will then be presented using Giorgi's steps of analysing phenomenological transcripts: division into meaning units, meaning unit analysis, situated structure statement and general structure statement (Giorgi 1985). This structured methodology enables data to be described, reduced and search for essential structures/intentionality.

Sample

This purposive sample from the whole perioperative team is anticipated to need to be 6-10 participants in number.

Participants who are staff will have been informed and freely chosen to participate in the study. As NHS staff, the participants will also have the capacity to understand information given and that they can withdraw at any point.

The participants will be individuals selected to reflect the members of the perioperative team. Whilst it is challenging to define a perioperative team, the selective criteria will be for an experienced practitioner that cares for the unconscious person as part of their role.

Interview Schedule

Interviews are anticipated to be 30-90 minutes. It may necessary to schedule another meeting to conclude the interview.

A comfortable room, without distraction/noise will be needed. This will be located at the Hospital.

Participants will be reminded prior to the interview that

1. they have given consent to have the interview audio recorded
2. that they are free – without prejudice – to withdraw at any point and the data erased, up until the transcribed data is anonymised
3. that direct quotes to be used in the thesis will be shown to the participant prior to inclusion
4. that anything said will be anonymised/confidentiality maintained
5. that as I am a registered professional, I may be obliged to share information that suggests unsafe care has not been managed appropriately within the organisation or by external bodies

Participants will be asked to confirm their work title, how long they have been working in theatres, what their main area of practice is together with other common areas of practice.

I will then begin the interview by asking participants to share an occasion where they particularly felt that they gave good care.

Subsequent questions will be unstructured with the intention to gain data that describes their experience of caring for patients in theatres.

Questions will be made to gain clarification – rather than closed questions – to focus on elaborating on what they have already said. The goal is to interact with them in a conversational way, in order to facilitate their story from their point of view. Client centred interview skills are brought to bear and cannot be anticipated and specific requests to clarify cannot be anticipated. The clarificatory questions are, for example, can you say a little bit more about that, in your view how does ‘that’ connect with ‘that’, and what happened then. Other questions are used to give flow and give permission for them describing their experience.

Participants will be thanked and then reminded of their freedom to withdraw from the research up until the point data is anonymised.

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Appendix 2 - Participant Information Sheet

An invitation to share your experience of what Perioperative Care is like…

Dear Colleague/s,

You are being invited to take part in research that will contribute to a PhD project being undertaken at Bournemouth University. Below is some information that will help you decide if you want to participate or not. Please contact me if you have any questions or want to discuss further.

Who is organising this study?

The research is being organised and led by myself, John Tarrant, as a part time PhD student at Bournemouth University. This research is independent of my employment in clinical practice. The research project has been approved by Bournemouth University's Ethics Programme Team and the Trusts' R&D Department.

Title of the research project

Behind closed doors: the lived experience of caring for people during their perioperative journey.

What is the purpose of the project?

The research aims to better understand your experiences of caring for patients in the perioperative setting. It aims to encompass all members of the perioperative team, with at least two years of theatre experience, so that new perspectives can be gained to inform education and working practices.

Can I participate?

To participate you need to have had at least two years of experience in caring for surgical patients. It is important to the project that the patients you care for have been unconscious for at least part of the time you have been with them.

Do I have to take part?

Participation is completely voluntary; my intention is to better understand your experiences of caring in the perioperative environment. If you are interested, then return a completed consent to myself. Paper copies are available or you can email me for an electronic copy. You will be able to withdraw from this project at any point, without notification or explanation; this is your right. There will be no negative consequences. You can request to have your contribution withdrawn up to the point where the data becomes anonymised. After anonymisation it cannot be extracted out of the collected data.

What do I have to do? / What will happen to me if I take part?

If you are happy to participate then you will need to complete the consent form. When this is completed I will invite you to participate in an informal, confidential interview that will be carried out on a one to one basis at a time that is convenient to you. You will be asked to share your experiences of caring for surgical patients in the theatre. Some experiences may have been stressful and interviews will endeavour to be managed appropriately. You are free to withdraw at any time and without giving any reason. Interviews should last, on average, 60 minutes but may vary around 30-90 minutes. Interviews will be carried out on the hospital site and circumstances may mean that interviews would need to take place on more than one occasion.

Interviews will be recorded so that I can concentrate on what you are saying rather than taking notes. I will be the only person that has access to the audio recordings and after the interview I will transcribe the audio for analysis. They will only be accessible using an alpha-numeric password known only to myself and the audio tracks will be deleted once transcription, anonymisation and audio analysis has been completed.

What are the possible disadvantages and risks of taking part?

Participants may wish to share experiences that have been stressful and/or emotional. You may decline to discuss significant events or terminate the interview without reason. Effort will be given to ensure the interview is managed appropriately.

What are the possible benefits of taking part?

Sharing meaningful experiences may enable personal reflection and insights to be gained. These could be used to inform practice.

Will my taking part in this project be kept confidential?

Your interviews will be recorded and then transcribed to a word document. These will be kept secure in accordance with the Data Protection Act (1998) and the research project has been registered with the Trusts' Data Controller Register. As previously outlined, the recordings will be transcribed by myself, so that no one else will have access to the data and they will only be accessible via a alpha-numeric password known only to myself. Audio recordings will then be deleted after they have been transcribed and the audio analysis is completed.

Data will be treated confidentially and strict anonymity will be given to yourself, organisations, patients and colleagues that you may refer to in the interview. Quotations from the interview will only be included in the study where you have given permission.

As a Health & Care Professions Council registrant I may be duty bound to act upon disclosure of practice that is not commensurate with the regulators. Whilst it is unlikely that any such practice will not have already been managed, it is important that this is made clear prior to any disclosure.

Who is organising/funding the research?

This project is the basis of my PhD project at Bournemouth University. The research has not been funded but the fees for the PhD are underwritten by Bournemouth University.

What will the results be used for?

Data will be used to inform the research for my doctoral thesis. The research may also be used for sharing with others through activities such as presentations, publication and conferences.

Contact for further information

Please post/email your details to the following address:

John Tarrant, Faculty of Health & Social Sciences, Bournemouth University, Room R604, Royal London House, Christchurch Road, Bournemouth, BH1 3LT

01202 962121 || tarrantj@bournemouth.ac.uk

Supervisor contact details

Should you wish to contact my supervisor to discuss any issues, he can be contacted as follows:

Dr Martin Hind, Royal London House, Floor 1, Bournemouth University, Christchurch Road, BH1 3LT

07548359184 || mhind@bournemouth.ac.uk

Independent Contact

If for any reason you wish to contact the university – such as make a complaint – then the Deputy Dean for Research and Professional Practice can be contacted as follows:

Professor Vanora Hundley, Faculty of Health & Social Sciences, Bournemouth University, Royal London House, Christchurch Road, Bournemouth, BH1 3LT

01202 965206 || vhundley@bournemouth.ac.uk

Once the consent form has been signed by all parties, participants you should receive a copy of the signed and dated participant consent form, the participant information sheet and any other written information provided to the participants. A copy of the signed and dated consent form will be kept securely with the project's main documents until the point when transcripts have been anonymised.

Many thanks in anticipation for your consideration and time.

Appendix 3 - Participant Consent Form

Full title of project:

Behind closed doors: the lived experience of caring for the person during their perioperative journey.

Name, position and contact details of researcher:

John Tarrant, Senior Lecturer in Perioperative Care (Bournemouth University), R604, Royal London House, Bournemouth University, Christchurch Road, BH1 3LT. t 01202 962121 || m 07734 962126 || e tarrantj@bournemouth.ac.uk

Name, position and contact details of supervisor:

Dr Martin Hind, Royal London House, Floor 1, Bournemouth University, Christchurch Road, BH1 3LT. t: 07548359184 || e: mhind@bournemouth.ac.uk

Please Initial Here

I confirm that I have read and understood the participant information sheet for the above research project and have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free to withdraw up to the point where transcripts are anonymised, without giving reason and without there being any negative consequences. In addition, should I not wish to answer any particular question(s), I am free to decline.	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	
I agree to take part in the above research project.	

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Once this has been signed by all parties participants should receive a copy of the signed and dated participant consent form, the participant information sheet and any other written information provided to the participants. A copy of the signed and dated consent form will be kept securely with the project's main documents until the point when transcripts have been anonymised.

Appendix 4 - RBCH Data Protection Form

The Royal Bournemouth and Christchurch Hospitals

DATA PROTECTION ACT 1998

DATA CONTROLLER REGISTER

Use this form to summarise details about each collection of (or system containing) person-identifiable data. Include details of all manually held and computerised personal data involved. Use a new form for each collection/system.

For help in completing this form, please contact:
Bournemouth & Christchurch Hospitals: Lizzie Woodward: 01202 962378

Department	Bournemouth University	Location	Faculty of Health & Social Studies
Name of person completing form	John Tarrant		
Project title	Behind closed doors: the lived experience of caring for the person during their perioperative journey		

REC Approval	YES ☐ NO ☐ N/A ☒
If YES, REC Reference No.	

	Details of the system and ownership	
	Who is collecting the data?	John Tarrant
	Where is the data being held?	Digital Audio Recorder Password Protected University Computer

	Details of the data processing	
	Is the data held on a computer, manually or both?	Computer
	If computerised, what IT systems will be used to the capture the data e.g. Excel, Access, Electronic CRF or other data base?	Digital Audio Recorder, transcribed into Word document
	Is any of the data processed externally? i.e. does an outside bureau or agency or other NHS organisation do some or all of the data processing?	NO
	If the data is processed externally please give the name of the company, university or other NHS organisation that processes it.	N/A
	Does a written contract or an agreement exist with the company or NHS organisation?	N/A

	Information recorded and disclosed				
		Recorded		**Disclosed**	
	Patients name	~~YES~~	NO	~~YES~~	NO
	Initials	~~YES~~	NO	~~YES~~	NO
	Address	~~YES~~	NO	~~YES~~	NO
	Hospital number	~~YES~~	NO	~~YES~~	NO
	Date of birth	~~YES~~	NO	~~YES~~	NO
	Post Code	~~YES~~	NO	~~YES~~	NO
	Telephone number	~~YES~~	NO	~~YES~~	NO
	Age	~~YES~~	NO	~~YES~~	NO
	Sex	~~YES~~	NO	~~YES~~	NO

	Source of Data Please indicate which of the following you will be using		
	Paper records	~~YES~~	NO
	Hospital computer not attached to the network	~~YES~~	NO
	Hospital computer attached to the network	~~YES~~	NO
	Home or other personal computer not attached to the network	~~YES~~	NO
	Home or personal computer attached to the network	~~YES~~	NO
	Laptop, palmtop or hand held computer	~~YES~~	NO
	University computer	YES	~~NO~~
	Computer disk, CD or memory stick	~~YES~~	NO
	Audio tapes	YES	~~NO~~
	Digital camera	~~YES~~	NO
	Images including x-ray	~~YES~~	NO
	Details required for the organisation to register with the Information Commissioner		

	For what purpose is the data collected and held? E.g. health administration, personnel, employment, contractors, health research, accounts, crime prevention etc. (e.g. is the data collected for the purpose of treating the patient?)	Research	
	About whom is the data collected and processed? E.g. patients, complainants, relatives, staff, contractors, suppliers, etc.	Theatre staff	
	What sort of data is collected and held? E.g. health details, employment details, finance details, personal views, trade union membership, other personal details.	Personal experiences of working in theatres	
	To whom may the data be disclosed? E.g. other NHS depts or sites, social services, government, voluntary agencies, relatives, legal representatives, survey/research organisations.	PhD Thesis, publication, conference, inform curriculum	
	How often will the data be shared or disclosed.	All data is anonymised, no other data shared	
	Can you confirm that you keep a record of disclosures and associated reasons?	YES	~~NO~~
	If you are collecting data directly from the patient will you obtain written consent from the patient for the information stored and processed?	n/a	
	If you are collecting data directly from the patient will you ensure the data is not used by anyone else for other purposes?	n/a	

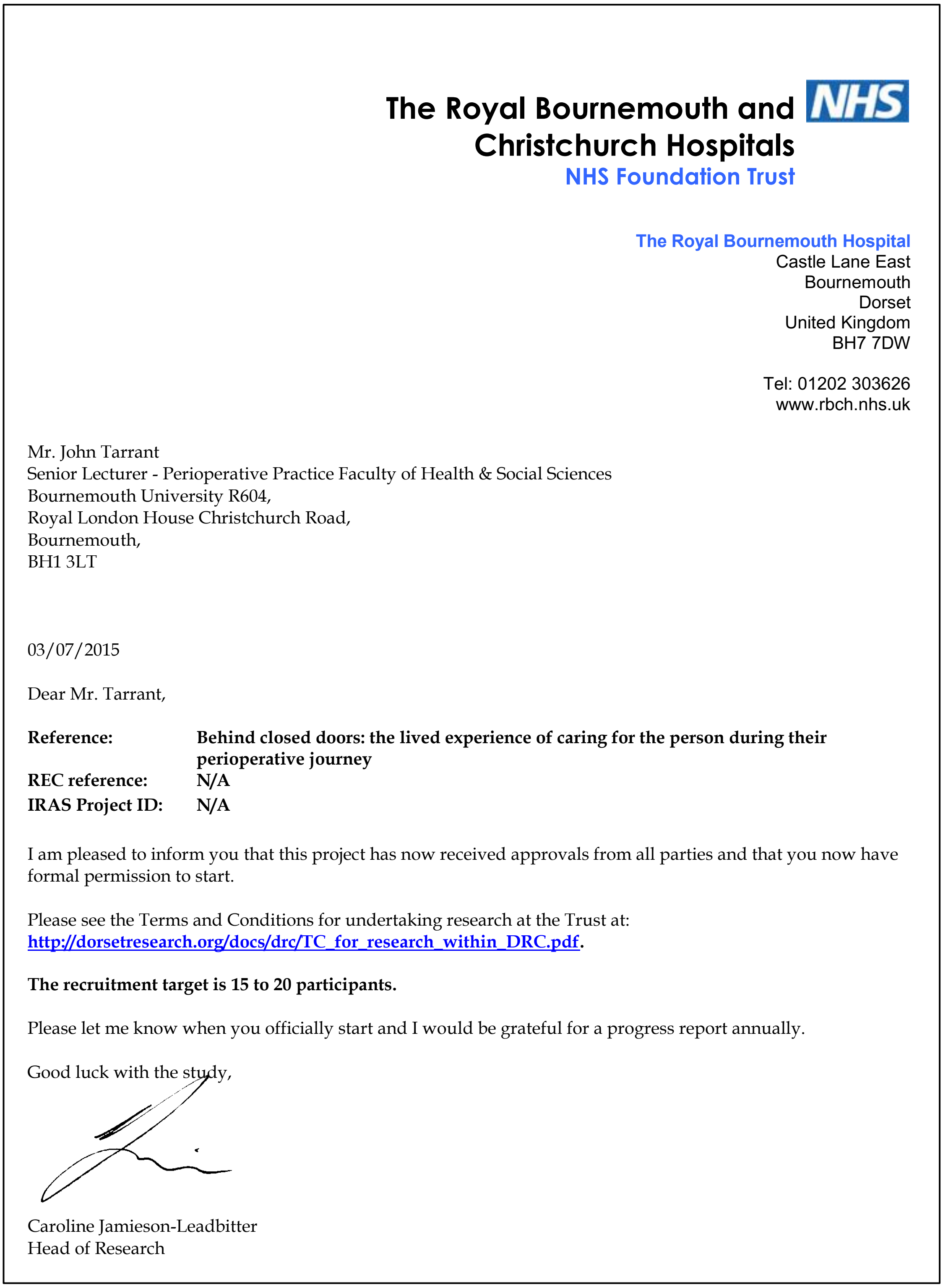
	Data Quality and Security		
	If you collecting data directly from the patient will you have a method of checking data accuracy?	n/a	
	If the data is to be published, state where and if it will be completely anonymised?	Tbc – yes, completely annonymised	
	How will the data be held? – personal laptop not attached to a network, laptop attached to network or other?	University computer	
	How is personal and sensitive data destroyed?	Electronically deleted	
	When sending sensitive and bulk personal data by post is it sent via Royal Mail Special Delivery or a Courier service?	n/a	
	Are staff aware of the security guidelines regarding e-mail i.e. sensitive and confidential data must be send via encrypted e-mail e.g. NHS.net	YES	~~NO~~
	Are staff aware of the Safe Haven policy?	YES	~~NO~~
	What contingency arrangements are there to cover loss of records?	Data storage has backup system	
	If data is being submitted electronically is it being done using secure send or the N3 network?	n/a	

	Compliance with Data Protection (DP) principles		
	If you are collecting data directly from the patient or member of staff have they been informed that it is being used?	YES	~~NO~~

	Have the patients or members of staff given their consent to all processing and disclosure?	YES	~~NO~~
	Have measures been taken to ensure that those to whom the data is disclosed will process it appropriately?	YES	~~NO~~
	Are there routine audits of how the data is managed?	YES	~~NO~~
	How is the data kept accurate and up to date?	n/a	
	Is the data archived in line with NHS guidelines?	YES	~~NO~~
	Can patients or staff access their personal data within the 40 day limit set by the DP Act?	YES	~~NO~~
	Is it possible to prevent processing that can cause damage or distress? i/e/ If a person does not want to have their data processed can their request be met without detriment to the service provided?	YES	~~NO~~
	Are their procedures in place within the department to control security and access to personal and sensitive data?	YES	~~NO~~
	Are departmental staff aware of their responsibilities under the DP Act?	YES	~~NO~~
	Is data to be transferred outside the European Economic Area? If so to which country	No	

Completed by the Data Protection Officer Initials: ……………………………………
Name of Data Protection Officer ………………………………………………………………
Signed: ………………………………………………………………………………………
Register Reference Number: ...……………………………………………………………...
Date: …………………………………………………………………………………………….

Appendix 5 - Research Approval Letter (NHS Hospital)



The Royal Bournemouth and
Christchurch Hospitals
NHS Foundation Trust

The Royal Bournemouth Hospital
Castle Lane East
Bournemouth
Dorset
United Kingdom
BH7 7DW

Tel: 01202 303626
www.rbch.nhs.uk

Mr. John Tarrant
Senior Lecturer - Perioperative Practice Faculty of Health & Social Sciences
Bournemouth University R604,
Royal London House Christchurch Road,
Bournemouth,
BH1 3LT

03/07/2015

Dear Mr. Tarrant,

Reference:	**Behind closed doors: the lived experience of caring for the person during their perioperative journey**
REC reference:	**N/A**
IRAS Project ID:	**N/A**

I am pleased to inform you that this project has now received approvals from all parties and that you now have formal permission to start.

Please see the Terms and Conditions for undertaking research at the Trust at: **http://dorsetresearch.org/docs/drc/TC_for_research_within_DRC.pdf**.

The recruitment target is 15 to 20 participants.

Please let me know when you officially start and I would be grateful for a progress report annually.

Good luck with the study,

Caroline Jamieson-Leadbitter
Head of Research

Appendix 6 - Bournemouth University – approved research ethics proposal

Research Ethics Checklist

Reference Id	5754
Status	Approved
Date Approved	06/05/2015

Researcher Details

Name	John Tarrant
School	Health and Social Care
Status	Postgraduate Research (PhD, MPhil, DProf, DEng)
Course	Postgraduate Research
Have you received external funding to support this research project?	No

Project Details

Title	A phenomenological study of the lived experience of the perioperative team when caring for the unconscious surgical patient
Proposed Start Date	01/06/2015
Proposed End Date	30/11/2018

Summary (including detail on background methodology, sample, outcomes, etc.)

Background - The perioperative environment is an acute area of health care that is often perceived as a task orientated conveyer belt that exists behind closed doors. Yet this highly complex and pressurised area relies on highly skilled individuals working closely together to care for the unconscious surgical patient. Within this environment are numerous variables that can affect excellence in perioperative practice. Perioperative care is a paradox. It involves the poorly explored phenomena of caring for a human being that has no autonomy, cognition or individuality. The individual does not know, and is unlikely to ever know, what care they received. Perioperative staff are bound legally, contractually, professionally and morally to deliver care that individuals would both consent to and feel 'cared for'. This correlation is currently unknown. The study will consider the lived experience of individuals of the perioperative team that care for the unconscious surgical patient that is the phenomena of caring for the unconscious surgical patient. Perioperative staff are key to the delivery of perioperative care. However team make-up is fluid and varies. The Operating Room commonly houses clinical staff that are regulated by three different regulators and some staff are non-regulated. Error continues to remain on the national agenda (NHS England 2014) due to the persistence of 'never events' occurring, perioperative practice is largely focused on seeking evidence based medicine/practice for efficacious anaesthetic and surgical intervention that benefits patient related outcomes. However, clinicians are now becoming more aware of emerging changes in practice around the so-called non-technical skills. Technical expertise is not necessarily considered as absent: clinicians know what to do. However, where error or failure occurs it is more often people knew what to do, but it was not done (Reason 1991)! Yet this moving emphasis on how Human Factors are integrated into practise leaves a need to explore how clinicians 'care' for 'people' rather than 'administer' to 'unconscious objects'. Whilst clinical staff may consider it integral to their role to care for people, there is a lack of literature, within perioperative practice, that explores what this means. Care emerges as synonymous with tasks, despite individuals believing that there is something more, highlighted by the strong feeling that care should be performed by registered health care professionals rather than unregistered health care assistants. In order to search for the how clinical staff experience caring for patients, a qualitative approach is necessary. This will enable staff to determine their experience rather than correlate it to the researchers own taxonomy or nomenclature. The current lack of literature in this area steers the methodological approach towards searching for the phenomena of caring in the perioperative environment.

Methodology - Giorgi's approach to phenomenology will be adapted. Participants will be recruited from a large NHS Trust and following consent, data will be collected through one to one recorded interviews. Participants will receive an outline of the interview process prior to the event and will be asked to describe their lived experience of caring for the unconscious surgical patient. Further questions will direct participants to further describe an experience they may mention. Recorded interviews will be transcribed and research findings will be presented using Giorgi's steps to existential phenomenology: division into meaning units, meaning unit analysis, situated structure statement and general structure statement (Giorgi 1985). This structured methodology enables the research process to describe, reduce, search for essence/s and to focus on intentionality.

Sample - Participants will have been informed and freely chosen to participate in the study. As NHS staff, the participants will also have the capacity to understand the information given them that they can withdraw at any point. The participants will be individuals selected to reflect the members of the perioperative team. Whilst it is challenging to define a perioperative team, the selective criteria will be for an experienced practitioner that cares for the unconscious person as part of their role. The team will be selected from a 'main theatre' in a large teaching hospital. Therefore careful selection of staff to ensure that the sample includes various roles so that the focus is on the phenomenon and not the staff groups. This overlap of different professions performing roles will enable further insights into how people care for the unconscious surgical patient as both commonality and variances will be seen. Within descriptive empirical phenomenology, Giorgi confirms that 3 individuals can confirm that the lived experience is an essence rather than pertaining just to the individual. As the purposive sample will be taken from the whole perioperative team it will be important to include enough participants to determine their experience/s can be used to illuminate an essence of caring for the unconscious person and where this maybe a variation, for example between the surgeon and the care worker. Therefore a suitable range of staff will be included to ensure that the focus remains of the phenomena of caring for the unconscious surgical patient rather than particular staff groups. It is anticipated that 5-10 participants will be necessary but the sample number will also be determined when saturation is found.

Outcomes - Current description rests on the task-orientated nature that exists in this environment but is not yet described with any richness that resonates. This is a significant gap in knowledge that may be counter-intuitive due to the lack of influence on education, training and service design. Little is known about the experience of individuals, working in a perioperative team, to care for the unconscious surgical patient. Research findings will help to underpin education, training and service design. This will help to inform current agendas around improving safety by developing an understanding how humans interact within care systems. In addition to this, little is written about the philosophical model of care for the unconscious surgical patient; with the current emphasis on tasks to enable life support. Further there is an absence of phenomenological studies of perioperative workers as a whole and only limited studies from other countries on working in the perioperative environment. This study takes a novel look at the individuals that make up the whole team with an expectation to be able to describe in new ways how people care for the unconscious surgical patient as part of a team.
This will enhance our understanding in new ways of strategies to education and enhance perioperative staff in their care of others. This research looks to provide new knowledge about how concepts of humanisation could be further understood by the challenges of clinicians caring for the unconscious human. These steps will result in new knowledge that will contribute to an understanding of care provision; enabling a more strategic approach to future education, training and service design.

External Ethics Review

Does your research require external review through the NHS National Research Ethics Service (NRES) or through another external Ethics Committee?	No

Research Literature

Is your research solely literature based?	No

Human Participants

Will your research project involve interaction with human participants as primary sources of data (e.g. interview, observation, original survey)?	Yes
Does your research specifically involve participants who are considered vulnerable (i.e. children, those with cognitive impairment, those in unequal relationships—such as your own students, prison inmates, etc.)?	No

Does the study involve participants age 16 or over who are unable to give informed consent (i.e. people with learning disabilities)? NOTE: All research that falls under the auspices of the Mental Capacity Act 2005 must be reviewed by NHS NRES.	No
Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited? (i.e. students at school, members of self-help group, residents of Nursing home?)	Yes
Will it be necessary for participants to take part in your study without their knowledge and consent at the time (i.e. covert observation of people in non-public places)?	No
Will the study involve discussion of sensitive topics (i.e. sexual activity, drug use, criminal activity)?	No
Are drugs, placebos or other substances (i.e. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	No
Will tissue samples (including blood) be obtained from participants? Note: If the answer to this question is ‘yes’ you will need to be aware of obligations under the Human Tissue Act 2004.	No
Could your research induce psychological stress or anxiety, cause harm or have negative consequences for the participant or researcher (beyond the risks encountered in normal life)?	No
Will your research involve prolonged or repetitive testing?	No
Will the research involve the collection of audio materials?	Yes
Is this audio collection solely for the purposes of transcribing/summarising and will not be used in any outputs (publication, dissemination, etc.) and will not be made publicly available?	Yes
Will your research involve the collection of photographic or video materials?	No
Will financial or other inducements (other than reasonable expenses and compensation for time) be offered to participants?	No
Please explain below why your research project involves the above mentioned criteria (be sure to explain why the sensitive criterion is essential to your project’s success). Give a summary of the ethical issues and any action that will be taken to address these. Explain how you will obtain informed consent (and from whom) and how you will inform the participant(s) about the research project (i.e. participant information sheet). A sample consent form and participant information sheet can be found on the Research Ethics website.	

Please see the attached documents: Participant Information Sheet + Consent Form Ethics Check Question - Study requires the cooperation of a gatekeeper. It is important to gain approval and support of those persons considered to be 'gate keepers' (Holloway 1991) who could help or hinder the study. Therefore, those staff identified for interview, that will be recruited voluntarily, will be asked to provide written consent to participate ensuring an informed autonomous decision. Since this study is founded on collected data from those that are working in the perioperative environment, the participants will need to be recruited from NHS staff. Permission will need to be sought from gatekeepers (The NHS Trust) in order to recruit (through posters and visits) and to conduct interviews (on the premises and during the working week).

Without permission of the gatekeeper, recruitment and interviews will be jeopardised. Another view of gatekeepers is the importance of selecting the gate keepers to domains of knowledge (Field & Morse 1985); under phenomenological conditions this is deemed as those that experience the phenomena. It would be ethical to the intentions of the study to ensure that suitable participants are recruited requiring some purposive selection criteria. These have been included in the Participant Information Sheet 1 (see attachments) and include setting a minimum level of experience that will equate with what Benner (1984) found to be a competent practitioner. Additionally, I have used my own observations of staff in clinical practice to anticipate people that have a repository of rich description of their experiences; I will raise awareness of the recruitment for this research project with selected individuals. The current senior Matron for surgical services will be contacted to seek permission to access staff. Participants will be recruited by sharing the PIS/consent form to clinical leads with a request to distribute to staff/raise at team meetings. The PIS/consent form will also be left in perioperative staff rooms.

Ethics Check Questions- Your research involves the collection of audio materials- Collected audio materials will be used solely for the purpose of transcribing/summarizing. Both of these questions are addressed in the prose below: As the methodology for this project is phenomenology, the use of interviews as the research tool is appropriate.

Giorgi's method (2009) involves one to one interviews that had audio recording so that the interviewer could concentrate on the interview and not distract the participant with note taking. Meaningful data needs to collect data in the form of people telling a meaningful story of their experiences - as they experienced them - stories of their experience of caring for unconscious surgical patients. As it is recognised that the interviewer plays a role in being able to gather good data, that is, data that reflects the persons lived experience in a meaningful way it is ethical to ensure that the data is valid, reliable and has veracity (Giorgi, 1985). This is not just in terms of the recording and relaying that data with veracity in a valid and reliable fashion. It is also ethical to be able to capture that lived experience from the participant so that the consequential processes of recording and relaying data can be true. Thus data for the study needs to be gathered in a relaxed atmosphere through unstructured interviews; these can generate rich data as participants are free to answer at length providing in depth and detailed information (Holloway & Wheeler 1996). Indeed, it is key that myself as the researcher does not influence any answer that the participant may give. Where insufficient answers are given or the participant relays phenomena, further questions will be posed to gather more data. Audio recordings will also allow me to re-immerse myself in the data. Not only in the recorded vocabulary but the tone, intonation, pace and paralanguage that gives colour to a potentially others black and white gamut. Permission will be obtained from each participant to tape the interviews together with any written notes will be gained prior to interview. It will be made clear that recordings will be permanently erased after they have been transcribed and audio analysis completed and that they will only be accessible using an alpha- numeric password known only to myself. Whilst research is open to scrutiny, the anonymity and confidentiality (Clark & McCann 2005) of the data obtained from the participants has also to be considered and therefore the recordings will be erased. As this research project is part of my Doctoral studies, it will be necessary to include the one participant's transcribed interview. Specific permission will be gained from the person with a reiteration that anonymity and confidentiality will be maintained, as part of the permission seeking, the person will be able to see the full copy of the transcript. The identity of the participants will be known only by me including access to the interview tapes and transcripts and all data will be stored in accordance with the Data Protection Act (1984).

Final Review

Will you have access to personal data that allows you to identify individuals OR access to confidential corporate or company data (that is not covered by confidentiality terms within an agreement or by a separate confidentiality agreement)?	No
Will your research involve experimentation on any of the following: animals, animal tissue, genetically modified organisms?	No
Will your research take place outside the UK (including any and all stages of research: collection, storage, analysis, etc.)?	No

Please use the below text box to highlight any other ethical concerns or risks that may arise during your research that have not been covered in this form.

No other ethical concerns or risks are anticipated but should they emerge during the research then reapplication for ethics would be considered. In a similar fashion, should any changes be necessary to the methodology or method then an ethics application would also be made.

Attached documents

Participant Information Sheet_Final.docx – attached on 05/05/2015 14:36:09

Consent Dorm.docx – attached on 05/05/02015 14:36:09

Appendix 7 - Sample of transcribed interview

Interviewer – *“OK, the sort of starting question that I ask everybody is, if for you, you could tell me some stories and description of what it is like for you to care for people in theatres, so tell me about your world in theatres. What's it like caring for people?”*

Participant – “So me, as a consultant surgeon, normally my typical day operating would be seeing patients first thing in the morning, consenting them for the surgery and then I really meet them again when they are asleep and coming into theatre. So….and then at the end of the day we try, if possible, to talk to people at the end of the day and then um, and then that’s the end of it. And actually now, we tend not to routinely follow patients up so, we most of the time won’t see them in clinic again or potentially ever after that day.”

Interviewer - *“Yeah, ok, so you’ve seen that change which is also quite interesting. Um, for you then um, how’s that connection then with the person as a surgeon - and bearing in mind that you’ve seen that change - perhaps think about some examples of people that you’ve cared for um and how that meaning or didn’t have meaning?”*

Participant - “Yeah, its….it’s always the, the more continuity - you know the patients and the doctors prefer it if, um, seeing somebody, treating them and seeing them afterwards and all the continuity is a thing that is, you know, prob- there is less of these days. Um, so, following up patients we don’t routinely do now. But, yeah, it was a good bit of routine informal feedback. Because you got a constant stream of, er, how people felt it about it. But in terms of the day of the surgery, one of the challenges we’ve got a the moment is really long waiting lists. So when you see somebody you then haven’t seen….they barely recognise you and you don’t recognise them; you haven’t seen them for many months. Whereas, when you’ve got quite short waiting lists, it’s you know, somebody you’ve already…you recognise, you know.”

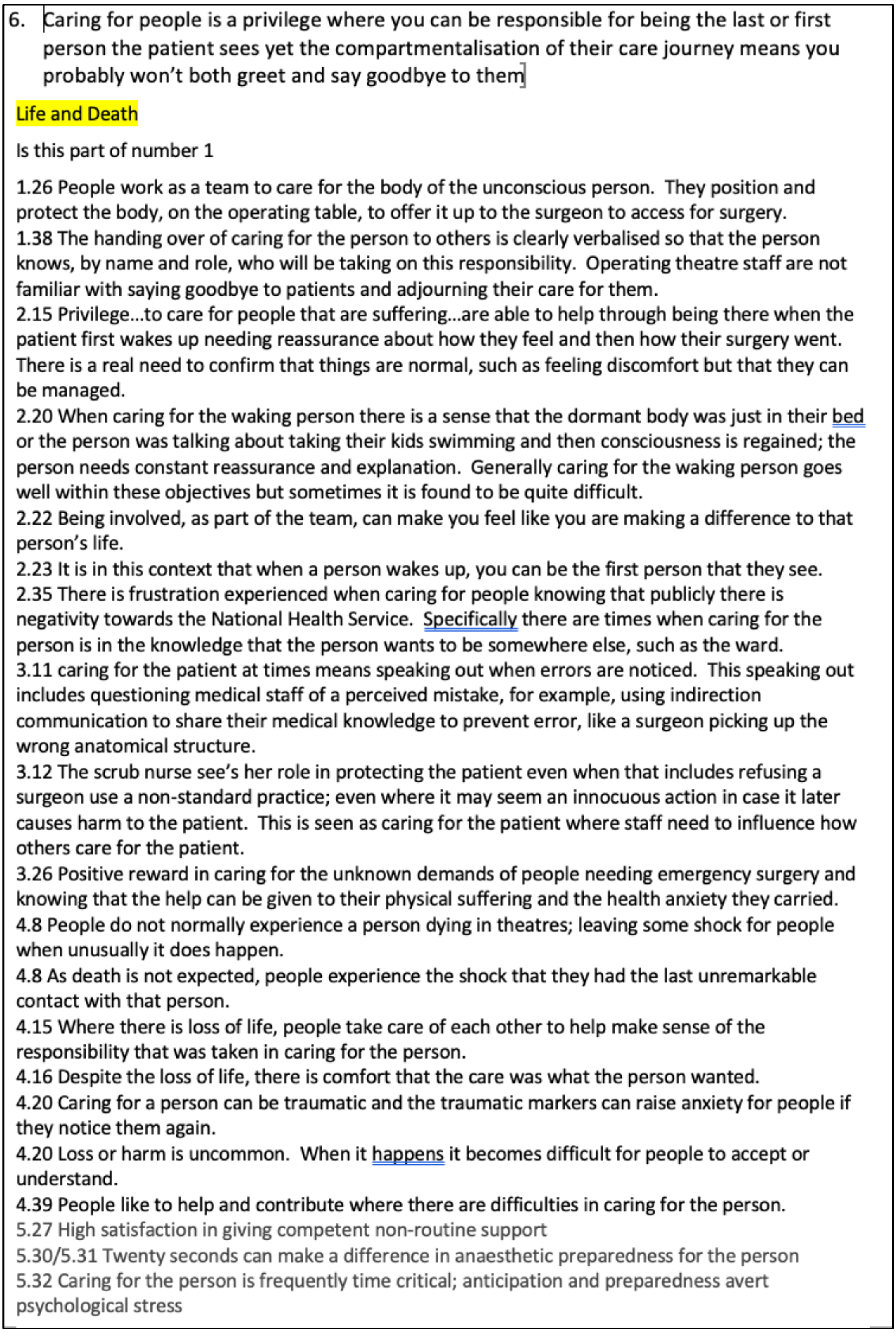
Appendix 8 - Transformation of the participants' natural attitude expressions into phenomenologically psychologically sensitive expressions

Units of Meaning (Transcript)	Transforming into disciplinarily sensitive expressions	Relation to phenomenon of: caring for people in theatres
1. So, me, as a consultant surgeon, normally my typical day operating would be seeing patients first thing in the morning, consenting them for the surgery and then I really meet them again when they are asleep and coming into theatre.	Identifies himself as a consultant surgeon. On a typical day when P_7 is going to operate the first thing he does is to see the people he has planned to operate on. P_7 highlights that it is at this moment he consents those people. Prior to surgery P_7 will not speak to them again, meeting them next in the operating theatre where the person is fully anaesthetised & ready for their procedure	7.1 Consent is gained on the day of surgery. After this the surgeon and patient will not have any further conversations as the patient will next time be unconscious.
2. So….and then at the end of the day we try, if possible, to talk to people at the end of the day and then um, and then that's the end of it. And actually now, we tend not to routinely follow patients up so, we most of the time won't see them in clinic again or potentially ever after that day.	At the end of the working day, where possible, P_7 tries to talk to the people he operated on. This moment is the last time he will see them. Historically P_7 would have likely met them again in a clinical but the routine care pathway does not include a follow-up.	7.2 limits on consultation time with the patient means routine follow up is rare
3. Yeah, its….it's always the, the more continuity - you know the patients and the doctors prefer it if, um, seeing somebody, treating them and seeing them afterwards and all the continuity is a thing that is, you know, prob- there is less of these days. Um, so, following up patients we don't routinely do now. But, yeah, it was a good bit of routine informal feedback. Because you got a constant stream of, er, how people felt it about it.	P7 prefers a continuity when seeing the patients, he is caring for. For P7, this continuity includes seeing the patient before their treatment, treating them himself and then seeing them afterwards. P7 generalises this as a preference of both doctors and patients but knows that there is less continuity in healthcare now. When seeing patients after their treatment, P7 received a stream of constant useful informal feedback from treated patients about how they felt afterwards. However, patients are now not routinely followed-up now and this informal feedback is not accessed in other ways.	7.3 both patients and carer prefer a type of care that has more continuity; this is becoming more rare.

Units of Meaning (Transcript)	Transforming into disciplinarily sensitive expressions	Relation to phenomenon of: caring for people in theatres
4. But in terms of the day of the surgery, one of the challenges we've got at the moment is really long waiting lists. So when you see somebody you then haven't seen….they barely recognise you and you don't recognise them; you haven't seen them for many months. Whereas, when you've got quite short waiting lists, it's you know, somebody you've already…you recognise, you know.	At the time of interview, P7 was aware of very long waiting lists. Patients that P7 had met to plan surgery then had to wait many months; this long wait meant he did not recognise the patient and that the patient barely recognised him. By contrast, short waiting lists helps P7 to recognise the patient as somebody that he knows.	7.4 Long waiting lists leads to a stranger-like relationship emerging, with the surgeon struggling to recognise the patient. 7.4/7.6 Short waiting lists in the independent sector support familiarity, helping carers know the patient
5. Yeah, I think, er…the system as well, so we now have, predominately two of us that work together and share the waiting list: so the patient may have been seen by each other and then operated on by the other person.	P7 now shares a waiting list with another consultant surgeon. This sharing means that a person may be seen by a different consultant to the one that then operates on them.	7.5/7.6 Shared carers reduces continuity of care
6. Um, I think it…it is difficult, and actually I see the reverse in private practice for example, we'll have just one consultant there'll be a short waiting list, see somebody and then see them as a follow up. And um, and er I think it is probably far easier on both sides. Cos you see them immediately and recognise them from a couple of weeks ago. They see you and feel more comfortable because you're the one that saw them in clinic.	P7 finds that having long waiting lists with more than one consultant makes things difficult. P7 also works in private practice and using this experience he is able to define this difficulty further by comparing another healthcare system. In this private healthcare system, P7 has a short waiting list where he is the only consultant. By contrast, P7 finds this system far easier for both himself and patients. A waiting list of a few weeks means that P7 between meeting patients for their first consultation and then for their surgery, he is able to recognise the patient and this recognition is mutual as patients see the consultant that they met in clinic. Patients are given comfort by seeing the same doctor for their initial clinic and surgery.	7.6/7.7 patient finds comfort if they recognise surgeon

Appendix 9 - Example of an early constituent forming following individual transcript analysis.

This constituent was later deemed to be more appropriate as part of other constituents.



6. Caring for people is a privilege where you can be responsible for being the last or first person the patient sees yet the compartmentalisation of their care journey means you probably won't both greet and say goodbye to them

Life and Death

Is this part of number 1

1.26 People work as a team to care for the body of the unconscious person. They position and protect the body, on the operating table, to offer it up to the surgeon to access for surgery.
1.38 The handing over of caring for the person to others is clearly verbalised so that the person knows, by name and role, who will be taking on this responsibility. Operating theatre staff are not familiar with saying goodbye to patients and adjourning their care for them.
2.15 Privilege...to care for people that are suffering...are able to help through being there when the patient first wakes up needing reassurance about how they feel and then how their surgery went. There is a real need to confirm that things are normal, such as feeling discomfort but that they can be managed.
2.20 When caring for the waking person there is a sense that the dormant body was just in their bed or the person was talking about taking their kids swimming and then consciousness is regained; the person needs constant reassurance and explanation. Generally caring for the waking person goes well within these objectives but sometimes it is found to be quite difficult.
2.22 Being involved, as part of the team, can make you feel like you are making a difference to that person's life.
2.23 It is in this context that when a person wakes up, you can be the first person that they see.
2.35 There is frustration experienced when caring for people knowing that publicly there is negativity towards the National Health Service. Specifically there are times when caring for the person is in the knowledge that the person wants to be somewhere else, such as the ward.
3.11 caring for the patient at times means speaking out when errors are noticed. This speaking out includes questioning medical staff of a perceived mistake, for example, using indirection communication to share their medical knowledge to prevent error, like a surgeon picking up the wrong anatomical structure.
3.12 The scrub nurse see's her role in protecting the patient even when that includes refusing a surgeon use a non-standard practice; even where it may seem an innocuous action in case it later causes harm to the patient. This is seen as caring for the patient where staff need to influence how others care for the patient.
3.26 Positive reward in caring for the unknown demands of people needing emergency surgery and knowing that the help can be given to their physical suffering and the health anxiety they carried.
4.8 People do not normally experience a person dying in theatres; leaving some shock for people when unusually it does happen.
4.8 As death is not expected, people experience the shock that they had the last unremarkable contact with that person.
4.15 Where there is loss of life, people take care of each other to help make sense of the responsibility that was taken in caring for the person.
4.16 Despite the loss of life, there is comfort that the care was what the person wanted.
4.20 Caring for a person can be traumatic and the traumatic markers can raise anxiety for people if they notice them again.
4.20 Loss or harm is uncommon. When it happens it becomes difficult for people to accept or understand.
4.39 People like to help and contribute where there are difficulties in caring for the person.
5.27 High satisfaction in giving competent non-routine support
5.30/5.31 Twenty seconds can make a difference in anaesthetic preparedness for the person
5.32 Caring for the person is frequently time critical; anticipation and preparedness avert psychological stress