

Keeping Vigil over the Profession: A Grounded Theory of the Context of Nurse Anaesthesia Practice

Rita S. Schreiber, Marjorie A. MacDonald

Department of Nursing, University of Victoria, Victoria, Canada

ABSTRACT

Background: Nurse anaesthetists in the US have faced continued, repeated challenges to their profession. Regardless, they have met these challenges and have established themselves as major anaesthesia care providers. In this paper we address the research question: How do Certified Registered Nurse Anaesthetists (CRNAs) manage the socio-political context in which they provide care for their patients?

Methods: Grounded theory was used to explore how nurse anaesthetists protect and promote their profession. Purposive, snowball, and theoretical sampling was used and data were collected through participant observation and interviews conducted at a conference of the professional association, an educational program, by telephone, email exchanges, and time spent in operating rooms and an outpatient surgical clinic. Analysis included coding at increasingly abstract levels and constant comparison.

Results: The basic social process identified was keeping vigil over the profession, which explains how nurse anaesthetists protect and promote their profession. It is comprised of three contextual categories: Establishing Public Credibility through regulatory and educational standards, Political Vigilance and taking action in governmental and policy arenas, and Tending the Flock through a continuous information loop between local and administrative/political levels.

Conclusions: From our study of the context of nurse anaesthesia practice, it is clear that CRNAs are dedicated to protecting their ability to provide high quality patient care by maintaining constant vigilance over their profession.

Keywords: Certified registered nurse anaesthetists; Grounded theory; Anaesthesia

BACKGROUND

In 1931, Agatha Hodgins brought together in Cleveland 40 nurse-anaesthetists from 12 states to form the National Association of Nurse Anaesthetists (NANA-later American Association of Nurse Anesthetists- AANA). Within weeks, state organizations began forming, and almost immediately the profession faced its first legal challenge; in California Dagmar Nelson was charged with practicing medicine without a license. After a lengthy court battle, in 1934, the state Supreme Court ruled that nurse anaesthesia was not the illegal practice of medicine, and that anaesthesia performed by a nurse was nursing. This was only the first of many legal and political challenges faced by nurse anaesthetists, thus the need to Keep Vigil Over the Profession has always been present for them.

In an earlier report [1] we presented a grounded theory of nurse anaesthesia practice and its relationship to nursing and nursing knowledge: Keeping Vigil Over the Patient. In this paper we report findings related to the study question: How do Certified Registered Nurse Anaesthetists (CRNAs) manage the sociopolitical context in

which they provide care for their patients?

METHODS

We used grounded theory to explore CRNA practice. As a qualitative, systematic approach, Grounded Theory (GT) is often used to explore social processes in context. GT involves the iterative collection and analysis of data to formulate explanatory theories grounded in the world of participants [2]. GT was originally developed by Glaser and Strauss [3] and refined by others, including Glaser [4], Strauss [5], Strauss and Corbin [6], Schreiber and Stern [7], and Charmaz [8]. Because we were interested in the processes that CRNAs use as they enact their role, GT was the method of choice. We were influenced by Strauss [5,9] in our examination of the contextual influences on situated interaction and CRNA practice.

Consistent with GT methodology, we sought variation in data sources and participant experiences, using multiple techniques. First, we attended the 2006 meeting of the American Association

Correspondence to: Rita S Schreiber, Department of Nursing, University of Victoria, Victoria, Canada, Email: rschreib@uvic.ca

Received: February 2, 2021, **Accepted:** February 17, 2021, **Published:** February 24, 2021

Citation: Schreiber RS, MacDonald MA (2021) Keeping vigil over the profession: a grounded theory of the context of nurse anaesthesia practice. *J Anesth Clin Res.* 12: 1002.

Copyright: © 2021 Schreiber RS, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

of Nurse Anesthetists (AANA), where we conducted participant observation, used purposive and snowball sampling to recruit participants, conducted interviews (n=18), gathered documents, and visited and examined the association's archives. We interviewed key informants about socio-political matters like regulatory and legal issues, scope of practice, billing and reimbursement. Scientific sessions, convention rituals, and mentoring relationships were observed. We also conducted e-mail and telephone follow-up to clarify issues. Theoretical sampling led us to conduct additional interviews with new informants. Most interviews were taped and transcribed verbatim; interviews not recorded were documented in field notes.

Participants' years of CRNA experience ranged from student through 40 years, and participants represented a minimum of 10 states; many had military experience, had worked in several states in both rural and urban settings, and some had worked in locum tenens positions. Eighteen of 41 participants were men.

Based on emerging theoretical concepts, we conducted a site visit to a small city in the American Northwest to explore the context of CRNA practice. We observed anaesthesia practice in an outpatient clinic and in two hospitals, visited an educational program and observed practicing CRNAs supervising students. We gathered data through document review, formal and informal interviews, and observations in clinical settings. Throughout the study we wrote or recorded field notes documenting our observations, interactions, and analytic ideas.

Data analysis

Analysis began with entry to the field and continued concurrently with data collection. Throughout we met and discussed emerging findings and agreed on interpretations and memoing. We assigned increasingly abstract codes and compared incoming data to other data, to concepts, and to emerging categories. We constantly made comparisons among ideas about actions and interactions occurring in the data. Finally, we constructed a theory of nurse anaesthesia practice, Keeping Vigil comprising two major categories. Keeping Vigil Over the Patient, which theorizes nurse anaesthesia practice and is reported elsewhere [1] takes place within a larger socio-political context, Keeping Vigil Over the Profession, presented in this paper.

Rigour

We used widely accepted techniques to ensure rigour, including constant comparison, "negative" case analysis, participant checks, persistent observation, and prolonged engagement in the field [3,10]. We also used peer debriefing within a GT seminar [11]. We listened to the tapes repeatedly, while reading and re-reading the text. Selected participants reviewed the findings and provided feedback to ensure our interpretations were consistent with their experience and understanding.

LIMITATIONS

As in all qualitative research, findings cannot be generalized widely. However, if the findings fit in explaining other situations and circumstances, then they can be said to be theoretically generalizable [12,13]. Participants included only active members and employees of the AANA and it is unclear whether or how well these findings would explain the actions and interactions of non-active members or non-members. Yet, the AANA works to keep members actively

informed and involved, and its membership includes an estimated 95% of nurse anesthetists in the country.

ETHICAL CONSIDERATIONS

The study was conducted in accordance with the Canadian Tri-Council [14] guidelines on human subject research, including informed consent. The study received approval of the Human Research Ethics Committee of the University of Victoria and the Board of Directors of AANA.

RESULTS

In this paper we report on Keeping Vigil Over the Profession comprising three major contextual categories that influence how CRNAs Keep Vigil Over the Patient: Establishing Public Credibility, Political Vigilance, and Tending the Flock. To keep vigil over the patient, CRNAs must also keep vigil over the profession (Figure 1). This vigilance operates in the background of CRNA practice and works to buffer it from ongoing threats. Participants are convinced that without such vigilance, the continuous political and legal challenges launched against them would whittle away at CRNA practice, imposing ever-increasing limits on their scope. This vigilance also operates internally within the professional organization, working to keep the membership informed, cohesive, and speaking with a unified voice.

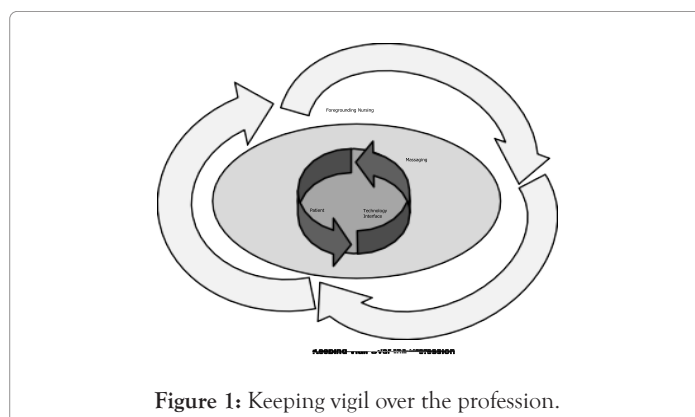


Figure 1: Keeping vigil over the profession.

Establishing public credibility

A primary concern of Hodgins and her colleagues that continues today is the need to establish the credibility of the nurse anaesthesia role in the eyes of the public. CRNAs must not only practice safely, but they must be seen to be practicing safely. Thus, nurse anaesthetists needed to set a high standard and demonstrate the safety and worth of their practice. In practice, they also needed to establish themselves as trustworthy, safe providers of anaesthesia care. They did this by adopting a protected title for nurse anaesthetists, establishing standards of practice and a standardized curriculum, as well as personal-professional credibility.

Adopting a title

Early in its history (1956), AANA members adopted the title Certified Registered Nurse Anaesthetist, or CRNA. This title recognizes the national certification that was already established and enshrined the "nurse" part of nurse anaesthesia, which was and continues to be viewed by practitioners as the foundation and spiritual home of their practice. The following quote is a typical example of the commitment to nursing within CRNA practice and

identity:

I think the reason why nurse anaesthesia is a nursing role is that we are able to combine all that good science stuff along with our nursing stuff. You have an opportunity to take care of someone who is in a huge anxiety part of their life and alleviate that anxiety through just touching them on the shoulder, touching them on the head, telling them "This will be OK, and I'm going to take really good care of you." And to me, that's nursing.

So strong is the commitment to nursing that an attempt at an AANA meeting to drop "nurse" from the title was widely defeated, which is notable in light of the fact that, although affiliated with universities, approximately 40% of CNRA educational programs are still housed outside schools or departments of nursing.

Identifying an agreed-upon title for the role allowed the professional association to mount public relations campaigns about the role and the title, and enabled them to create and distribute recruitment materials to attract students to the profession. By having a professional name that was recognized and accepted by all, the group prevented many of the nomenclature arguments and irregularities within nursing that have dogged the more recent development of the Nurse Practitioner (NP) role in Canada where there is no inter-provincial agreement on title and title protection NPs.

Developing practice standards

Similarly, formation of NANA/AANA created a forum and the means to develop practice standards and establish curricula. Creation and ongoing revision of standards of practice promoted a high quality of care and helped ensure the status of the CRNA role. It further allowed members to define for the public the nature of their care, as well as identify a level of excellence for CRNAs to achieve. CRNAs could enumerate their qualifications to those who might question their preparation to provide safe care.

In addition, NANA/AANA approved educational pro-grams, and laid the groundwork for the accreditation and certification processes that continue today, although AANA no longer accredits nurse anaesthesia programs or certifies CRNAs. In 1975, as a result of challenges by the American Society of Anaesthesiology (ASA) to the U.S. Office of Education, the AANA relinquished these responsibilities to five independent Councils. Since 1975, the AANA has been the sole professional organization that represents all CRNAs in all situations public and private at both state and federal legislative levels. CRNAs could now point to these developments to demonstrate the rigour of their training and their high practice standards. This works today both at the individual level, in establishing personal-professional credibility with

physicians, and within institutions and the nursing community. It also works at the state and national level, in lobbying for legislation and regulation that support a broad scope of CRNA practice.

Establishing educational programs

The creation and adoption of a standardized curriculum for preparation of nurse anaesthetists began in 1935, with a report from the AANA Education Committee. The report contained recommendations regarding subjects to be taught, hours of classroom and clinical instruction, and a minimum number of cases to be administered by the student to get a diploma. The AANA report served the same purpose that the 1910 Flexner Report did for physicians, using educational standards to position CRNAs and their practice in a politically advantageous place. To support members in meeting these educational requirements, AANA sponsored refresher courses between 1947 and 1951.

CONCLUSION

Over time, CRNA educational preparation has been increased. This began with requirements for specific pro-gram lengths, which kept expanding; however, it took a long time for CRNAs to agree on the need for baccalaureate or graduate education. For example, the "1985 Proposal" to mandate a minimum of baccalaureate preparation, failed at the AANA conference that year. Nonetheless, there was a general recognition of a need.

REFERENCES

1. Akinbami BO. Evaluation of the mechanism and principles of management of temporomandibular joint dislocation: Systematic review of literature and a proposed new classification of temporomandibular joint dislocation. *Head Face Med.* 2011;7: 10.
2. Pillai S, Konia MR. Unrecognized bilateral temporomandibular joint dislocation after general anesthesia with a delay in diagnosis and management: A case report. *J Med Case Rep.* 2013;7: 243.
3. Nusrath MA, Adams JR, Farr DR, Bryant DG. TMJ dislocation. *Br Dent J.* 2008;204(4): 170-171.
4. Wang LK, Lin MC, Yeh FC, Chen YH. Temporomandibular joint dislocation during orotracheal extubation. *Acta Anaesthesiol Taiwan.* 2009;47(4): 200-203.
5. Sia SL, Chang YL, Lee TM, Lai YY. Temporomandibular joint dislocation after laryngeal mask airway insertion. *Acta Anaesthesiol Taiwan.* 2008;46(2): 82-85.
6. Ting J. Temporomandibular joint dislocation after use of a laryngeal mask airway. *Anaesthesia.* 2006;61(2): 201.
7. Shakya S, Ongole R, Sumanth KN, Denny CE. Chronic bilateral dislocation of temporomandibular joint. *Kathmandu Univ Med J (KUMJ).* 2010;8(30): 251-256.