



Constructing Recognition of the Others State of Surrendering- A Grounded Theory

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Abstract

Objective: The intraoperative setting is a complex environment, where nurse anaesthetists' are required to handle an intense flow of information. Apart from intraoperative time constraints and pressure to perform, little is known about nurse anaesthetists' concerns prior to administering anaesthesia. Therefore, the aim of this study is to answer the key questions; what are nurse anaesthetists' main concerns prior to and during anaesthesia induction and how do they cope with them?

Methods: Constructivist grounded theory was used to illuminate the context and specific conditions under which the informants performed anaesthesia nursing. Fifteen nurse anaesthetists were interviewed using an open-ended method.

Results: The common denominator for the informants was their active efforts to construct grounds for recognition of the other's state of surrendering associated with anaesthesia induction. The core category; constructing recognition of the Other's state of surrendering, is supported by three main categories; Creating a trusting relationship, Working with the technology and Establishing recognition.

Conclusion: The act of recognition highlights the healthcare organisation's obligation to provide sufficient time for the ethical practice of anaesthesia, which presupposes awareness on the part of anaesthesia staff of their own professional approach.

Keywords: Anaesthesia; Nursing; Grounded theory; Constructivism; Social process; Recognition; Ethics

Introduction

Anaesthesia implies that the patient needs to construct a foundation for surrendering her/his life into the hands of an unknown Other [1]. Accordingly, surrendering requires that the patient has developed sufficient trust in the nurse anaesthetist (NA) and/or anaesthesiologist [1]. Therefore, the assumption behind this study is that a moral approach from the NA where the patient's concerns are recognized is required to create trust on the part of the patient. Despite previous research in this area, we know very little about how external conditions in the intraoperative setting affect the NAs' moral compass and subjective perceptions while administering general anaesthesia. For that reason the aim of this study is to explore in depth what are the NAs' main concerns adjacent to the induction process and how NAs deal with these concerns.

What we do know is that the intraoperative setting is a complex environment where external conditions not only distract from and interrupt patient care but also increase the risk of stress, lack of control and error [2]. A review of previous relevant research indicates that the ability to stand by the patient is more or less restricted by external conditions such as; organisational demands on productivity, time

constraints as a result of the need to adhere to the operating schedule and pressure from co-workers to perform [1,3]. This causes moral distress because of lack of input in decision making and being unable to perform in a manner that the NA believes is morally correct [3]. Such moral distress not only affects the NAs' moral compass but can also lead to a fragmented self-image, feelings of worthlessness and lack of professional integrity, all of which have a negative influence on patient care [3]. Subsequently, moral distress might well result in cutting corners [4] and can be a reason for NAs considering leaving their current employer or actually doing so [3].

In Sweden, anaesthesia can be administered by both NAs and anaesthesiologists, as is also the case in the USA and France. A French health psychology study by Chiron et al. [5] found that anaesthesiologists and NAs developed a strategy of depersonalization and a cynical attitude to protect against stress and cope with the workload [5]. In contrast, a study by Pape & Dingman [6] revealed how the NAs' strategy during the induction process was to "get in their bubble", shielding the patient from the rest of the operating theatre staff and trying to promote her/his sense of being in focus.

Sabatino et al. [7] concluded that the healthcare organisation has an obligation towards staff members to facilitate an ethical environment that not only strengthens professional dignity but also helps protect human dignity in the caring encounter. The NAs' presence at the

threshold of unconsciousness encompasses not only her/his skill but also ethics and knowledge of how to manage the patient's life from induction to emergence [3,5]. Thus, the NA embodies the foundation on which the patient places trust and reliance for her/his self-preservation [1]. The extent to which the nurse stands-by the patient has a major influence on how the latter experiences the former's involvement in her/his care [8]. Because external conditions influence our relationship with others, the nurse-patient interaction requires knowledge of what it is that characterizes the substance of the NA's concerns and how she/he deals with them [7,9].

Objective

The aim is to answer the key questions; what are the NAs' main concerns prior to and during anaesthesia induction and how do they cope with them?

Methods

We decided to work inductively using grounded theory (GT) according to Charmaz [10]. The focus of this study is NAs' professional experience and performance during anaesthesia induction. As we chose a constructivist approach with a paradigm of multiple interpretations of reality, the researcher and each informant jointly documented experiences and data [10]. This approach enabled the researcher to theorise about the informants' interpretation revealed during the interview. At the same time, the researcher's ontological assumptions and pre-understanding were acknowledged [10]. The researcher, who has many years' experience as an NA, adopted a reflective approach towards his own as well as the informants' interpretation. The constructivist approach resulted in a deeper understanding of to what extent and how the experience of the induction phase relates to the larger context of the informants' differing situations.

Ethical Considerations

As the study did not involve patients, ethical approval was not required in accordance with the Swedish Law concerning Ethical Review or Research Involving Humans [SFS 2003:460]. The ethical requirements on information, consent, confidentiality and utility are in accordance with the Helsinki Declaration as of 2011 and the Ethical Guidelines for nursing research in the Nordic countries as of 2011.

Selection

The inclusion criterion was Swedish NAs currently active in the field who had at least two years of work experience. Hence, the selection was performed in a stepwise fashion. First, a point of departure was decided in which we defined the informants and inclusion criteria [10]. The second step comprised focused selection, which was necessary as only NAs with at least two years of work experience were included. This was achieved by recruiting through advertisements at each anaesthesia unit in local, regional and university hospitals in south Sweden. Third, the informants volunteered to participate by contacting the interviewer, who was not employed at any of the hospitals involved. Fourth, theoretical selection was based on the data collected, which also guided the simultaneous analysis and supplementary recruitment of informants [10]. The contextual conditions in Sweden pertaining to anaesthesia nursing, its implementation and specific features are presented in Box 1.

The work context of Nurse-Anaesthetists in Sweden

Swedish occupational title: Registered Nurse with Graduate Diploma in Specialist Nursing – Anaesthesia Care.

The anaesthesia nursing process in Sweden: Nurse anaesthetists independently induce, maintain and complete general anaesthesia (GA), with some support from the anaesthesiologist, depending on the patient's physical status prior to anaesthesia.

Assessment and evaluation of the patient's physical status: The anaesthesiologist evaluates the patient's physical status prior to anaesthesia induction in accordance with the American Society of Anesthesiologists (ASA) classification system.

Implementation of anaesthesia nursing in Sweden:

- To plan and independently administer GA to ASA I-II patients in elective surgery.
- To plan and administer GA to ASA III-VI patients in elective surgery in collaboration with the anaesthesiologist.
- To plan and administer GA to ASA I-VI patients in acute surgery in collaboration with the anaesthesiologist.

Specific features of anaesthesia nursing in Sweden:

- Establish that the patient's airways are clear (e.g. intubation) and maintain the patients physiological state as well as monitoring, regulating, documenting and following up the patient's respiration, circulation, depth of anaesthesia and body temperature.
- Administration of volatile agents, intravenous hypnotics, analgesics and muscle relaxants.
- Documentation and follow up of the patient's blood and fluid requirements as well as fluid treatment.
- To work preventively by setting priorities and taking quick decisions in case of acute adverse events.
- To report, document and make critical evaluation of the peri-operative care.

Box 1: The work context of Nurse-Anaesthetists in Sweden.

In line with Charmaz's [10] constructivism, the researchers developed the categories and theory from the patterns revealed by their theoretical constructions of the informants' subjective experiences. A total of 15 eligible informants (11 women and 4 men) with a mean age of 50.5 years (range 32 – 63 years) and mean work experience as an NA of 18.5 years (1 – 36 years) volunteered to participate in the study. Four were from a local hospital, three from a regional hospital and eight from a university hospital. The informants were allowed to decide the time and place for the interview. None of them were excluded or declined participation after the initial contact. Written consent was obtained and the interviews took place at the hospital where the informants worked. The informants were included by theoretical selection and the process ended when no new sub- or main category emerged from the data [10].

Data collection

The constructivist interview technique was inspired by Charmaz [10] where memory enhancement was achieved by recreating the context in which anaesthesia induction took place and using reflective, open-ended, questions. All interviews were conducted in a vacant operating room at the operating theatre where the informants were asked to think about concerns and actions related to the caring encounter and anaesthesia process. Reflective and open-ended [10] questions were posed that targeted the informants' thoughts, emotions and perceptions associated with the anaesthesia process. The interviews lasted for an average of 48 minutes (range 28 - 73 minutes)

and were recorded with a digital voice recorder and transcribed verbatim after each interview.

Data analysis

We followed the recommendations of Hallberg [11] and Glaser [12] by: a) establishing whether previous studies with a GT approach had been conducted within this particular context and with the same aim, b) performing initial line-by-line coding in accordance with Charmaz [10] in order to identify words (e.g. “responsive”) or phrases (e.g. “I want to be present”) indicating important categories, qualities or contexts related to the research questions, and c) applying focused coding in order to detect and explain the most significant codes. In this phase the three main concerns were illuminated: Creating a trusting relationship, Working with the technology and Establishing recognition. These concerns were based on sub-categories such as; mediating a sense of presence and mediating a sense of comfort. Concurrently, theoretical coding (e.g. attentiveness, advocacy and leadership) helped to conceptualize the relationship between the codes

generated from the focused coding, enabling theorization of the data and successively linking the corresponding sub-category and main category [10]. Memos for each interview were logged, including reflections that emerged during the analysis and coding processes [10]. The constant comparative method [10] was simultaneously applied to data, codes and categories.

Results

The core category: Constructing Recognition of the Other’s State of Surrendering, summarises a process in which the generated GT is presented based on three main categories, Creating a trusting relationship, Working with the technology and Establishing recognition. Additionally, the main categories contain several sub-categories. In conjunction with the GT process, the temporal aspect is anchored in the informants’ thoughts and feelings in relation to the development of professional recognition associated with anaesthesia induction. The outline of the results is presented in Figure 1.

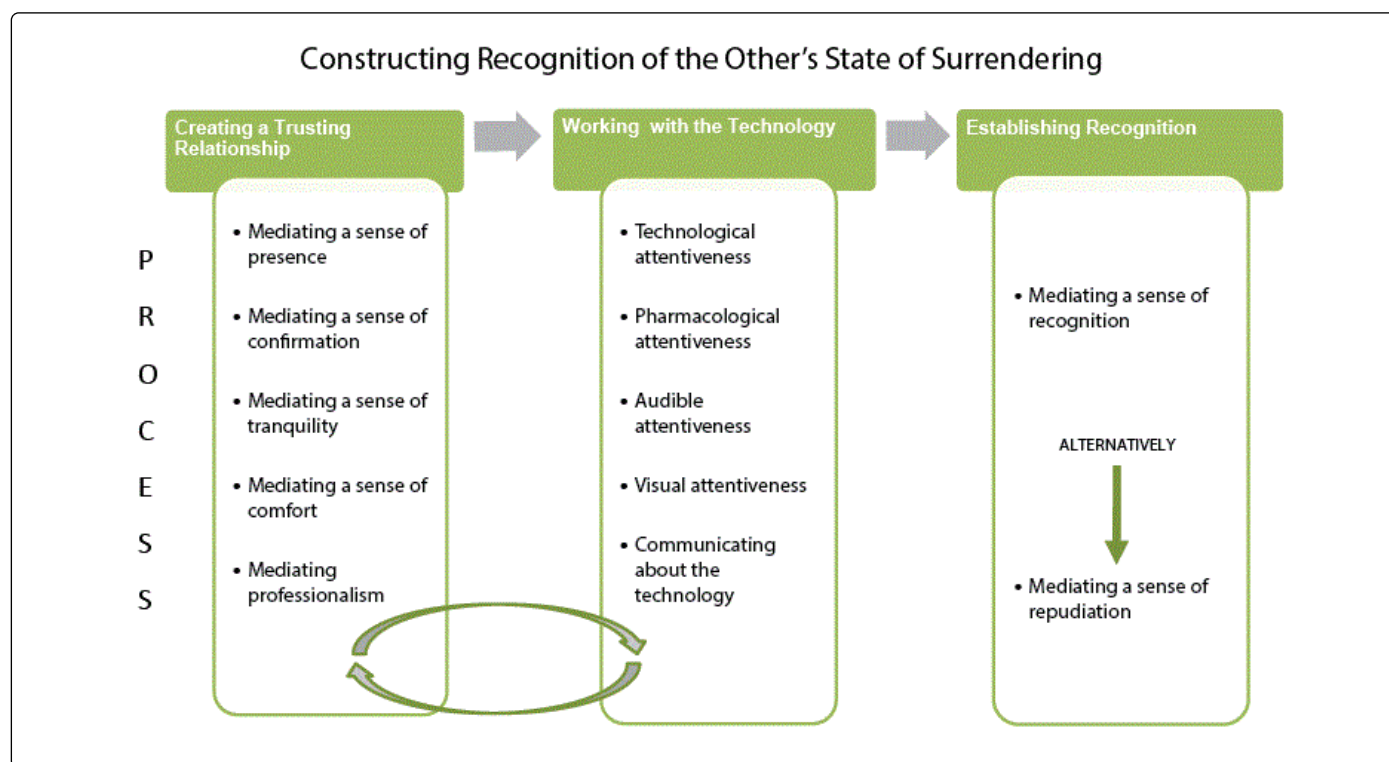


Figure 1: Illustration of the core category: Constructing Recognition of the Other’s State of Surrendering, represents a process with three related main concerns: Creating a trusting relationship, Working with the technology and Establishing recognition/repudiation. The process started when the nurse-anaesthetist first encountered the patient in the operating theatre. Once the process was initiated the phase of creating a trusting relationship overlapped with the phase of working with the technology here illustrated by two circulating arrows in the lower part of figure 1. The sub-categories illustrate how the nurse anaesthetists’ dealt with the main concerns.

The common denominator for the informants was their active efforts to construct grounds for recognition of the other’s state of surrendering associated with anaesthesia induction. The core category comprises the informants’ descriptions of the various phases in the process, while the main categories are linked to the core category and

represent the primary concerns of the informants during the anaesthesia procedure. Recognition was preceded by an effort to create a trusting relationship with the patient.

The informants’ various strategies for creating trust were achieved by means of mediation, e.g. being present and providing comfort. The second main category involved the informants’ attentiveness, representing strategies of working with the technology, which in turn were communicated to the patient and/or the anaesthesiologist. Due to using similar strategies in the process of constructing a foundation for recognition of the patients’ struggle to surrender, the last phase of establishing recognition was binary.

Although the driving ambition of the informants appeared to be an aspiration to ensure the best possible care, and they recognized that the

patients were vulnerable in their state of subjection, they were nevertheless aware that this was not always the case.

“I think that some of my colleagues are cold. They breeze in and say, ‘right, this is what will happen’ and ‘You’ve got to wear the anaesthesia mask for your own sake’. Standing beside her I think to myself, how fortunate I am that it’s not me she’s anaesthetizing” [NA W:10].

Each of the three main categories contains a number of sub-categories that illustrate the different strategies used in the process. In the following text the main categories will be presented with bold headings and sub-categories in italics. Shorter quotations in the main text are presented in double inverted commas. The quotations origin are presented in parenthesis and categorised by profession, gender (W=woman, M=man) and number.

Creating a trusting relationship

During the short period prior to the patient falling into anaesthesia induced unconsciousness, the informants tried to evaluate and bond with the patient. Social skills became a tool for mediating a sense of presence by relating to the patient, while at the same time remaining attentive to her/his body language. One NA said; “I want to be present. I would like to give them a firm handshake, greet them and look them straight in the eye to show them that I will be there for them” [NA W: 4]. In contrast, another NA described how some of her colleagues skipped this strategy as it seemed to require too much effort: “It’s really simple, no big deal, just anaesthetize the patient.. you don’t need any communication whatsoever. Many of us don’t want to bother with it anyway. But at the same time, it is the most important thing” [NA W: 10].

The NAs mediated a sense of confirmation to the patient through eye contact, while at the same time the patient seemed to express acceptance that the anaesthesia should go ahead. Thus; “I hope I’m able to provide safety. ‘We are here’. Acknowledge [the patient]. I see you, and right now you are the most important thing” [NA W:12].

Time constraints during the short caring encounter made some of the NAs more aware of the importance of trust in the patient – caregiver relationship. Frustration was caused by feelings of being unable to deliver optimal conditions for creating trust. However, by adjusting the operating room environment, the NAs managed to mediate a sense of tranquillity to the patient. The operating room environment could also be made less stressful by requesting staff to keep their voices down. Alarms from technical devices such as infusion pumps or the anaesthesia machine were also switched off out of respect for the patient and the situation.

An approach used by all informants directly aimed at the patient was mediating a sense of comfort. The purpose of comfort talk was to promote positive thoughts and feelings of hope in the patients. Other strategies included giving the patients a specific task, such as trying to visualise the ocean or getting them to focus on their breathing. Comfort could also be provided by touch, i.e. placing a hand on the patient’s shoulder while holding the anaesthesia mask or by gently stroking her/his cheek during pre-oxygenation, “..carefully, just enough to let the patient know that someone is there” [NA W:9].

Providing comfort to patients indicates empathy as well as recognition of their state of subjection and is an attempt to maintain their dignity. It is demonstrated here by the NAs’ efforts to create a peaceful environment in the operating theatre and interact with the patient prior to anaesthesia. Mediating professionalism implied acting

as the patient’s advocate and adopting a position of leadership in the caring encounter.

“If I can achieve a situation where I feel that, prior to anaesthesia, the patients are showing complete confidence in me, then that is a true measure of my professionalism. It is one of the most important aspects for a skilled professional and makes the satisfaction obvious” [NA M: 11].

It also involved aspects of planning the nursing care and having various nursing strategies at hand in case an adverse event should occur. Because; “It’s really all about having a Plan B and I believe that this makes one feel confident, that I have everything in place, and I know who to contact if something happens” [NA W:7].

Working with the technology

A crucial part of delivering safe anaesthesia care includes the NAs’ technological attentiveness in the operation of the necessary technical equipment for administering and monitoring anaesthesia. One NA described her technical readiness by saying that; “I really want to make sure that I can prevent airway obstruction, so I always have the stylet, the McCoy Flex-Tip and such by me in order to remove all such risks” [NA W:7].

The hands-on aspect of working with the medical technology involves connecting the monitoring equipment to patients. Such work also entails pharmacological attentiveness, as the intravenous drugs used to initiate anaesthesia can only be administered in conjunction with the monitoring of vital signs. This aspect also includes pre-oxygenation of the patient. One NA declared; “I usually tell the patients that they are going to have oxygen and that I’m going to hold the [anaesthesia] mask over their face. I always ask if it’s okay so they don’t feel that they’re being suffocated” [NA W:3].

The NAs’ response to alarms from technical devices, i.e., infusion-pumps, monitoring equipment or signals from the patient was dependent on their perceptual attentiveness.

Some informants’ described audible attentiveness as concentrated on the patient’s breathing and at the same time listening for signs of distress, whereas visual attentiveness involved the actual monitoring of vital signs, i.e., breathing frequency in addition to the patient’s clinical signs, i.e. skin color.

Communicating about the technology is a step in which the NA informs the anaesthesiologist about any concerns regarding the patient’s physical condition that have to be dealt with prior to induction. Most of the NAs described that they explained to the patient what was going to happen at the start of the induction process.

“When I anaesthetize patients with Propofol I inform them that a strange kind of pain may occur [at the site of i.v. administration] as if they don’t know about this they may be scared just before they go to sleep” [NA W:2].

Establishing recognition

Building a good relationship with the patient prior to induction was considered to be very important, as it generally resulted in a calmer and more harmonious patient during emergence from anaesthesia. It also meant mediating a sense of recognition of the patient’s subjection and understanding its significance for her/his vulnerability. One male and one female informant viewed the anaesthesia preparations from a gender perspective, sharing the opinion that, in general, female

patients are more emotionally concerned about the integrity of their bodies, whilst men are more likely to accept the loss of control due to the cognitive side effects of the anaesthesia drugs during induction. This aspect is important when it comes to respecting the patient's autonomy and "...I believe that women are more emotionally engaged. They are in touch with their feelings in a different way. One knows that one will be undressed, but still retains the wish to be in control" [NA W:7].

Paying attention to the patients' verbal and bodily signals increased the ability of some NAs to adapt their nursing strategies to best suit the patients' needs. This can involve empowering patients by allowing them to participate. Because; "...some [patients] become sort of rigid when they feel the anaesthesia-mask over their face but they relax as soon as I ask 'Would you like to hold it yourself?'" [NA M:15].

By understanding the importance of the anaesthesia process for the patient, some NAs' demonstrated an ability to empathise and described their approach with unpretentiousness as well as humility. One NA stated; "...one has the feeling that they are handing their life over to you, which is quite amazing when you think about it. That people put so much trust in a virtual stranger" [NA M:13].

A recurring theme among the informants was having a sense of responsibility for the anaesthesia process. The NA functions with a high degree of autonomy, which involves not only focusing on specific tasks, such as administering the appropriate dosage of anaesthesia drugs, but also being able to deal with their effects on patients. Applying one's professional knowledge and social skills during the anaesthesia process involves the ability to plan it together with the patient. This requires showing the patient respect, humility and integrity, thereby treating anaesthesia induction as a mutual decision.

"Just as I am about to anaesthetize the patient we should have agreed on everything that is to be done. Our confidence in each other is mutual. Mm... I believe in the patient and the patient believes in me. That feels good!" [NA W:13].

Although some of the NAs' made an effort to create an appearance of genuinely caring for their patients, they were more or less unaware of mediating a sense of repudiation. Instead of acknowledging the patient's subjection and vulnerability, they prioritized intraprofessional recognition by using the patient as a tool for strengthening their own position as both a professional and a person. For two NAs, the importance of prioritizing intraprofessional recognition influenced their emotional state while administering anaesthesia. One of them explained that "...above all I want my colleagues' respect. I can become extremely annoyed and disappointed if I don't get the respect I deserve at that moment" [NA W:12].

Some NAs' strived to obtain absolute control during the anaesthesia process. However, one NA had sufficient self-awareness to grasp why she acted in such a manner during the short caring encounter prior to anaesthesia induction.

"I did not have a lot of self-esteem as a child and I therefore feel that this job compensates for that. I become a little tetchy when I'm anaesthetising because I want all the equipment in order to feel in complete control over the situation" [NA W:7].

A few NAs' saw the patients as an obedient group who must deal with their own concerns and left them to cope with their feelings of anxiety alone. A small number of NAs went even further by avoiding eye contact, shunning communication and feeling frustrated when patients wanted to take part in their own care. One NA used

medication to relieve the patients' concerns and fears, hoping it would make them feel safe, thereby avoiding communication with them; "I give them Alfentanil or Fentanyl so they feel safe, as it enables me to control the situation" [NA W:14].

Discussion

Methodological considerations

We opted to follow Charmaz's [10] evaluation criteria for rigour in constructivist GT studies. Credibility was achieved by including elucidative and descriptive quotations in each main category. Originality was ensured due to the fact that the study describes the basic NA-patient interaction process prior to anaesthesia induction. Resonance is evident in the GT, while the main categories illustrate the richness of the informants' experiences during the induction phase. The study is useful (usefulness), as the findings increase awareness of the social process and various choices available for ethical performance within the anaesthesia nursing profession. The core category; Constructing Recognition of the Other's State of Surrendering, created a new understanding of the process that takes place prior to anaesthesia induction. The main categories; Creating a trusting relationship, Working with the technology and Establishing recognition, represent new concepts that depict the NAs' main concerns and how they cope with them.

Reflection on the results

The implication of this study is the need for an understanding of the social process adjacent to anaesthesia induction, in which the NA and the patient interact. This study reveals a unique inside perspective of how NAs construct recognition of the patients' struggle to surrender. It also provides a new grounded theory aimed at supporting the ethical act of NA-patient interaction. More specifically, the generated grounded theory produced knowledge about the informants' methods of constructing a foundation for recognition of the other's state of surrendering.

As the nursing profession is practised within the frame of face-to-face encounters it can be considered a social process [13]. A process that is in agreement with Honneth's [14] approach to the concept of recognition and Goffman's [13] theory of face-to-face interaction, where the face represents the self-image defined by approved social attributes in the immediate presence of another.

The primary role of NAs is to care for the patient from induction to emergence based on science, professional knowledge and ethical standards. The manner of the NA in the social interaction with the patient influences the latter's expectations of the NA [15]. This means that if the NA does not take a professional approach, she/he will convey nothing but distrust, which may affect patients' expectations [15]. Barriers to implementing and maintaining appropriate ethical conduct will also influence the perception of an NA who is aware of the relationship with the patient during the caring encounter [3].

Creating a trusting relationship is the first step in face-to-face interaction and its importance for the patient's struggle to surrender is immense. As informant NA W:10 pointed out, it is easy to avoid communication but at the same time it is the most important aspect in the encounter with the patient, as it signals the presence of the professional. Presence means standing by the patient [8], although it does not necessarily involve being social as the NA may be unengaged or distracted [16]. In such situations self-absorption and adopting an

approach of anonymity towards the patients become a means of ensuring a smooth work shift. At the same time, the NAs' main concern related to Working with the technology is having sufficient technical skill and attentiveness to provide safe anaesthesia induction.

Recognition of the other as a person involves the NA identifying situations that have an ethical dimension [14], i.e., the caring encounter. Second, sensitivity on the part of the NA is necessary to enable awareness of the ethical components of the situation, e.g., the patient's struggle to surrender. Third, the NA also requires sufficient imagination and capacity to appreciate the significance of the situation from the other's perspective [14,15], i.e., self-awareness. One could argue that the third feature of recognition appeals to the performer's empathic competence, as it requires the skill to see oneself in the other in order to establish recognition [14].

Establishing recognition is the phase in which the majority of the informants became aware of the patient's vulnerability and in response chose an ethical approach by; a) understanding the importance of recognition for the patient, b) respecting the patient's right to autonomy and c) allowing the patient to participate. For instance, asking permission to place the anaesthesia mask over the patient's airways signals respect for the latter's integrity and dignity as well as enabling her/him to preserve self-worth. Therefore, anaesthesia induction is viewed as a mutual decision. Informant NA W:3's approach of communicating information to the patient about the preparatory anaesthesia routines, such as pre-oxygenation, reflects a humanistic [17] approach in which focused nursing is avoided by balancing social and technical skill.

According to Levinas [18], recognising the other means actually seeing her/his state of subjection, the loss of control over her/his own consciousness and struggle to surrender. In the short caring encounter prior to anaesthesia induced unconsciousness, recognition of the patient's state is to "give" [18] in the form of inspiring trust. Thus, recognition becomes an ethical act of establishing solidarity, unanimity and maintaining the patient's dignity [14]. Furthermore, nurses who choose to actively interact with the patient also develop an increased sense of responsibility for their patients [19].

The few informants who, more or less unintentionally, chose to mediate repudiation acted as if in denial of the patients' state of subjection and vulnerability [14]. This approach is the contrary to humanism and normative ethics, as these two aspects imply an understanding of the connection between the patient's vulnerability and the actions of the professional [14,17]. Establishing and maintaining the nurse-patient interaction can give NAs a sense of meaning in their work and help the patient to become more prepared for various nursing interventions [20].

Clinical implications

A. Professional: The NA's caring approach reflects how she/he copes with establishing recognition in the care encounter. For this reason an awareness of the main concerns in this GT study can facilitate a humanistic perspective on nursing care by helping the NA to recognise the patient's state.

B. Ethical: In agreement with Honneth [14], we believe that recognition of the patient's struggle is an act of ethical caring as it necessitates the ability to stand by the patient. This argument is compatible with the rationale of Levinas [21], where access to the other is "straightaway ethical" and recognition of the other implies preventing objectification and reductionism. Consequently, nurses

have a responsibility to act as role models, educating and helping students and novice nurses to achieve a genuinely caring attitude in their professional identity [22].

C. Individual: Self-assessment of one's own qualities would be appropriate before pursuing a nursing career [23], whereas school of nursing admission committees should examine applicants' objectives before admitting them to nursing programmes. This would help those applicants who lack the necessary qualities to discover and follow other professional paths [23]. The patient's modesty and possible diffidence when entering the operating theatre demand an empathic and respectful approach on the part of the NA [24].

D. Clinical: The rapid pace of work and time constraints of the operating schedule undermine the NA's professional obligation to assume true ethical responsibility [3,4]. Although the patient is dependent on the NA's technical skills [23], the obligation also implies the ability to preserve the patient's as well as her/his own dignity [7,19].

The above aspects (A-D) can not be fully met if the nurse fails to establish recognition and, as a consequence, misses out on what the patient has to say, preventing patient autonomy and participation. Such repudiation might lead to the risk of alienating the patient [13].

Study Limitations

A. By using only one source of data in the study there was a risk of incubating a focus on the informants lived experience instead of generating a basic social process. This was a risk that could have been reduced by undertaking interviews and observations at the same time.

B. Because the theory is intended to establish the relationship that exists among data, codes and categories, it is not to be perceived as an absolute truth. Rather, a cautious explanation of a social process in which the concept of recognition reflect the NAs' moral performance towards the patient's strife to surrender.

C. The study is relatively homogenous in terms of gender. Though, the sample is representative of how gender is distributed among Swedish NAs' in southern Sweden.

Conclusion

Establishing recognition of the other's state of surrendering is a moral act and an expression of genuine care that requires an awareness of one's own professional approach. In line with Fligstein [25], we believe that caring involves being open to the patient's concerns, not distracted by self-interest or immovable goals, hence making the patient more willing to trust, co-operate and surrender her-/himself. If the NA is unable to carry out the nursing process it will not only undermine the nursing care of the patient's body and safe anaesthesia but most probably imply an unethical and false façade that mediates repudiation – ultimately approved and sanctioned by the NA's own healthcare institution.

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Author Contributions

AL collected the data and performed the manuscript writing. AL and AF jointly contributed to the study design and data analysis.

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