The Courage to Surrender—Placing One's Life in the Hands of the Other

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Purpose: *The aim of this study was to investigate how adult patients experience and cope with the anesthesia induction period, that is, before and during total intravenous induction.*
Design: *Grounded theory, based on the Charmaz framework, was used to explore what it is that characterizes patients' thoughts and feelings in this situation and how they handle the time period up to loss of consciousness.*
Methods: *Patients were interviewed using an open-ended method.*
Findings: *The core category: Constructing a foundation for surrendering one's life into the hands of the other illustrates the main concern of the 17 informants. This concern is illuminated by three main categories: Preparing oneself to surrender, trying to retain control, and accepting and surrendering/Refusing to accept and not surrendering. The informants struggled to place their life in the nurse anesthetist's/anesthesiologist's hands in a cycle of circumspection, preemption, and control.*
Conclusions: *In order to enable a dignified surrender, it is essential that the nurse anesthetist/anesthesiologist understands the patient's experience of loss of control.*

Keywords: *anesthesia, grounded theory, constructivism, personal construct theory, qualitative research.*
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ANESTHESIA CARE, with the emphasis on the formation of a relationship between the nurse anesthetist/anesthesiologist and the vulnerable patient, is performed during a brief caring encounter. For that reason, establishing trust in this relationship is of vital importance. There is a lack of inductive studies on how the patient interprets the anesthesia induction period and his/her interaction with operating theatre staff (OTS) in general, and the nurse anesthetist/anesthesiologist, herein called the anesthesia provider (AP), in particular. The aim of this study was therefore to investigate how adult patients experience and cope with the induction period, that is, before and throughout total intravenous anesthesia (TIVA) induction with remifentanil-propofol.

The Grounded Theory (GT) research method applied in this study presupposes little or no preunderstanding of the research area. However, to enable a meaningful discussion of the results, a brief overview of previous research is appropriate. Earlier studies have focused on either the preoperative or the intraoperative phase. According to Palese et al,[1] the perceived quality of care could be improved if the patient received information before surgery about expected perioperative events, thus leading to less fear and anxiety. Preoperative anxiety mainly concerns the anesthesia itself, suggesting that physicians and nurses with specialist education in anesthesia are deemed best suited for handling the patient's thoughts and feelings related to anesthesia and surgery.[2] A common procedure is to provide patient information a couple of days or a day before the scheduled surgery. Besides the medical process, information is provided about the actual anesthesia, the care that will be provided, and the risks involved.[2] Although information is mostly considered to relieve

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Conflict of interest: None.

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preoperative anxiety, one study by Rosén et al[3] suggested the opposite, namely that preoperative information about the risk of pain, anxiety, and discomfort might actually generate discomfort and pain. However, the authors did not specify whether the consequences involved the pre-, intra-, or postoperative period.

Smith and Mishra[4] argued that OTS tend to objectify the patient during perioperative care, especially after induction and during surgery. Smith et al[5] demonstrated that communication at the time of preparation for anesthesia induction is aimed at ensuring that the patient is safe, while clearly signaling to the other OTS present that the actual induction is taking place. Because the patient might still be conscious, the AP tries to avoid or hide technical or other potentially risky parts of the induction process. Smith and Mishra[4] also revealed that patients who perceived negative words or comments before anesthesia experienced more pain and anxiety than those who remembered positive or neutral comments. They concluded that patients should be approached with a calm voice and have their integrity and dignity safeguarded during the induction period.[4]

A review of the literature revealed that most previous research in this area stems from a positivistic perspective on the human being as an object, biological material, or anatomical construction. There is a lack of studies aimed at in-depth exploration of the patient's experience of the induction period. One exception is the study by Susleck et al,[6] who interviewed patients about their perioperative experience 1 to 16 years after the surgical intervention. We know next to nothing, however, about the patient perspective and the process involved in dealing with thoughts, feelings, and concerns until anesthesia-induced unconsciousness occurs. The key research question in this study was: What is the patients' main concern before and during TIVA induction and how do they cope with it?

Design

We chose to work inductively using GT according to Charmaz.[7] By applying a constructivist approach, we acknowledged a paradigm where multiple realities constantly change. It enabled us to grasp the specific and complex world in which the human sees, experiences, and acts. The focus of this study was patients' experiences during TIVA induction. Experiences and data are mutually created between the researcher and each informant.[7] In the constructivist mode, it is possible to theorize the informants' interpretation arrived at during the interview and at the same time acknowledge the researcher's ontological assumptions and preunderstanding.[7] A reflective approach toward one's own and the informant's interpretation is necessary. The strength of this dual approach is the theorizing of the data, leading to a deeper analysis of how meaning and action are constructed by the informants.[7] As a consequence, the constructivist approach results in a deeper understanding of *when*, *to what extent*, and *how* the experience of the induction phase relates to a larger context inherent in the informant's various situations.

Methods

We chose GT with a constructivist approach to gain a deeper understanding of the informants' perspective. We also wished to increase the amount of relevant and descriptive information by enabling the informants to recall their memories and vividly elaborate on their answers. The point of departure was that a humanistic, constructivist approach places the informant's experiences in focus, where the data are mutually created between the researcher and the informant. The main concern was the process of how and why the informants create meaning in the induction period until unconsciousness occurs.

The study was performed in line with the four criteria for good quality in GT research with a constructivist approach as described by Charmaz.[7] These criteria include originality, trustworthiness, resonance, and usefulness. Memos, digital recordings, and verbatim transcription constituted the data collection, which lasted for 14 months. To avoid bias, the informants were never cared for by the researchers. We tried to ensure credibility by allowing three independent persons to judge and comment on the interview guide. Two pilot interviews were also performed, scrutinized, and discussed by the researchers to ensure a good interview technique. A limitation was that all informants were recruited from the same hospital, only reflecting one caring tradition.

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