‘Myth or reality?’ Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices

C FORD

PhD

2019

‘Myth or reality?’ Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices

CLAIRE FORD

A thesis submitted in partial fulfilment of the requirements of the University of Northumbria at Newcastle for the degree of Doctor of Philosophy

Research undertaken in the Faculty of Health and Life Sciences

July 2019

Abstract

The assessment and management of surgical pain are paramount to good quality perioperative care. Regrettably, patients still declare inadequate satisfaction levels within this important area of practice. Holistic preoperative pain planning and education is a useful strategy to address this issue which has never been fully studied in day case surgery. This thesis has used a critical ethnographic research approach to explore and examine preoperative cultural practices and provide insight into what influences and shapes pain planning, management strategies and interactions with day surgical patients. This methodology observed healthcare interactions in the day case unit through a critical lens, underpinned by critical social theory and a transformative paradigm.

Using Carpspecken's (1996) analytical enquiry framework, the preoperative practice of one department was investigated over nine months. Both qualitative and quantitative data collection methods were used, including observations, interviews and timings of interactions. One hundred and twenty-four patients and thirty-three healthcare professionals took part in the study, one hundred and thirty hours of practice were observed, and twenty in-depth interviews with healthcare professionals took place. Data were analysed using reconstructive and statistical analysis, and four main themes were identified as having an impact on preoperative interactions. These four themes were:

- The prioritisation of patient safety over pain management.
- A production line culture which negatively impacted on holistic practice.
- The existence of paternalism and power that affected staff and patient autonomy.
- Unconscious gender and surgery bias, which had a direct impact on the levels and depth of preoperative pain conversations and management strategies.

These were explored further in relation to Bourdieu's (1977) sociological theory of habitus and capital, in an attempt to raise awareness of practice culture and increase transparency, in order to challenge the status quo.

Table of contents

List of tables

List of figures

Appendices

Abbreviations

AAGBI: Anaesthetic Association of Great Britain and Ireland

BADS: British Association of Day Surgery

CE: Critical Ethnography

DBS: Disclosure and Baring Service

DOH: Department of Health

ERAS: Enhanced Recovery after Surgery

HCP: Healthcare Professionals

HRA: Health Regularity Authority

IASP: International Association for the Study of Pain

IRAS: Integrated Research Application System

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

NMC: Nursing and Midwifery Council

NPSA: National Patient Safety Agency

RCT: Randomised Control Trial

REC: Research and Ethics Committee

RSS: Really Simple Syndication

SPSS: Statistical Package for the Social Sciences

WHO: World Health Organisation

Glossary

Ambulatory: related to or adapted for walking

Acute: sudden onset and short course.

Agency: Refers to the level of which an individual has free choice.

Capital: common ideals held within the field that are most valued and can be social, material, cultural or symbolic. This value is linked to capital via social processes.

Catastrophising: exaggerated focus.

Chronic: continuing or occurring for a long time.

Data saturation: this is referred to as the point where no new information can be abstracted from the data.

Etic: Outsider view

Emic: Insider view

Field: the environment which buttresses the practices and habitus of groups of individuals and can be physical or social spaces.

Habitus: principles which influence individuals' choices, behaviour and perceptions.

Inpatient: a person who stays one or more nights in the hospital and receives treatment, lodging, and food.

Neuropathic pain: pain that occurs as a result of the degeneration of the nerves or the nervous system.

Nociceptive pain: pain that results from stimulation of the receptors or protective reflexes.

Perioperative: the period around surgery including before, during and after.

Practices: are the habitus which, although unconscious, is shared by individuals in similar situations.

Preoperative: a period classified from the time the surgery is scheduled until the time the patient is transported from the ward to the theatre operating table.

Psychogenic: originating in the mind, or by emotional conflict

Somatic: relation to the wall of the body.

Standard Deviation: the figure expressing how measurements for a group are spread out from the mean average value.

Structure: refers to the factors which may limit an agent to make free choices.

Triangulation: the validation of information through cross verification from two or more sources.

Visceral: felt in the internal organs of the body.

Acknowledgements

The writing of this thesis would not have been possible without the support of my family and friends and the guidance of my supervision team and colleagues. I, therefore, want to acknowledge my heartfelt gratitude to the following individuals:

- First and foremost, I must acknowledge the patients and healthcare professionals who participated in this study. Thank you so much for allowing me to observe the care you received or the care you delivered. This study would not have been possible without you.
- To my husband Jake and sister Joanne, for their everlasting emotional support and encouragement, as well as, practical support and an endless supply of chocolate and hugs.
- To my wonderful children Charlotte and Jack, you are my inspiration. If you work hard enough, anything is possible.
- To my parents Joe and Sandra, I do this for you.
- To my work sisters Michelle and Laura and my family and friends (you know who you are). I could not have completed this thesis without your love and friendship, not to mention your open ears, broad shoulders and inexhaustible quantity of encouragement.
- To my supervision team and in particular Dr Andrew Melling, for persevering with me, for being patient and persistent.

Author's declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee on the 25th of July 2014, by the National Research Ethics Service on the 27th of October 2014 and by the (NHS) hospital trust Research Department on the 10th of November 2014.

I declare that the word count of this thesis is 83214 words.

Claire Ford

Date: 18/07/2019

Chapter 1

Introduction

1 Introduction

1.1 The study

This PhD thesis developed as a result of my career in the perioperative environment and more specifically my role, as a nurse and a student midwife, in managing patients' pain. I became fascinated with how healthcare professionals (HCP), working within an organisational culture such as the NHS, safeguard patients against pain, especially during the surgical care continuum. My interest also grew, as I have witnessed both excellent and unsatisfactory practice in terms of pain preparation and management.

Due to the nature of surgery, the potential for tissue injury and the initiation of nociceptive pain responses is unique and often unpredictable; consequently, perioperative analgesia should be arranged preoperatively, using pain planning which encompasses individualised and comprehensive pain screening (Chow *et al.,* 2012; Pinto *et al.,* 2012a). However, while contemporary practice acknowledges this, comprehensive preoperative assessments within day-case surgery are often inadequate (D'Arcy, 2012). The reasons for this are complex due to the competing forces of agency (the extent to which one is free to make a choice) and structure (the external social, political and economic influences that may limit choice) (Bourdieu, 1977). Consequently, perioperative care does not take place in a vacuum, and preoperative practices of individual HCPs may vary considerably (Stomberg, Brattwall and Jakobsson, 2013). In a bid to understand perioperative practices further, research studies, such as those from Lauzon-Clabo (2008) and Jones and Durbridge (2016) have explored the underlying and influencing culture of perioperative departments. Nevertheless, these and other articles (which will be explored within the literature review, c*hapter two, page 53*) have been centred on postoperative pain management, inpatient care, and

intraoperative patient safety; therefore, a gap remains within preoperative knowledge about day surgery patients.

Within this thesis, I will explore the culture around preoperative pain planning and management for day case surgical patients, by observing the working practices of HCPs, within the preoperative clinical areas of one NHS hospital trust. Whilst, I recognise that there may be a number of reasons why preoperative pain planning may not occur, this thesis by adopting a critical ethnographical methodology, situated within a transformative paradigm, will focus on providing new knowledge and insight into how issues, such as power (related to both agency and structure) influence preoperative pain planning for day case surgical patients. Using Carspecken's (1996) critical enquiry, these practices will be viewed through a critical lens, framed by Bourdieu's 'theory of practice' (1977; 1986; 1998, 2002), to extrapolate the culture that impacts on healthcare practice and patient care.

In this chapter, I will provide a comprehensive overview of the study, a detailed exploration of the background information that informed my rationale and a synopsis of the key concepts used, in order to provide a contextual foundation. I will also address the research question, aims and objectives, outline the thesis structure, and articulate what supporting documentation will be included in the thesis and how it will be presented.

1.2 Context

Context and phenomena are symbiotically linked and cannot be isolated from each other (Bate, 2014). As such, it is impossible to examine or understand the complexities of a phenomenon, such as pain, or the entity that is culture, without exploring the temporal and spatial context in which these exist. Furthermore, if researchers are short-sighted, the overall credibility and validity of the research may be detrimentally affected (Bate, 2014).

Thus, to understand the culture impacting on preoperative practice, the background, environment, time, place and subject meaning, need to be understood (Thomas, 1993; Carspecken, 1996).

In this thesis, this will include providing a contextual background history of culture, critical social theory, pain, day surgery, and preoperative assessment processes, as well as an overview of contemporary UK pain management practices, perioperative culture, and factors that impact on patients' pain levels. I acknowledge at this point that due to limitations in word count and resources it is not possible to examine all the aspects that can influence pain practices. Consequently, this thesis will not address issues of religion, sexuality, ethnicity, and nationality, as these factors were not always determinable. Additionally, while patient age was extrapolated from the surgical lists, age was not a dominant theme within the findings and will not be examined within this thesis.

1.2.1 Culture

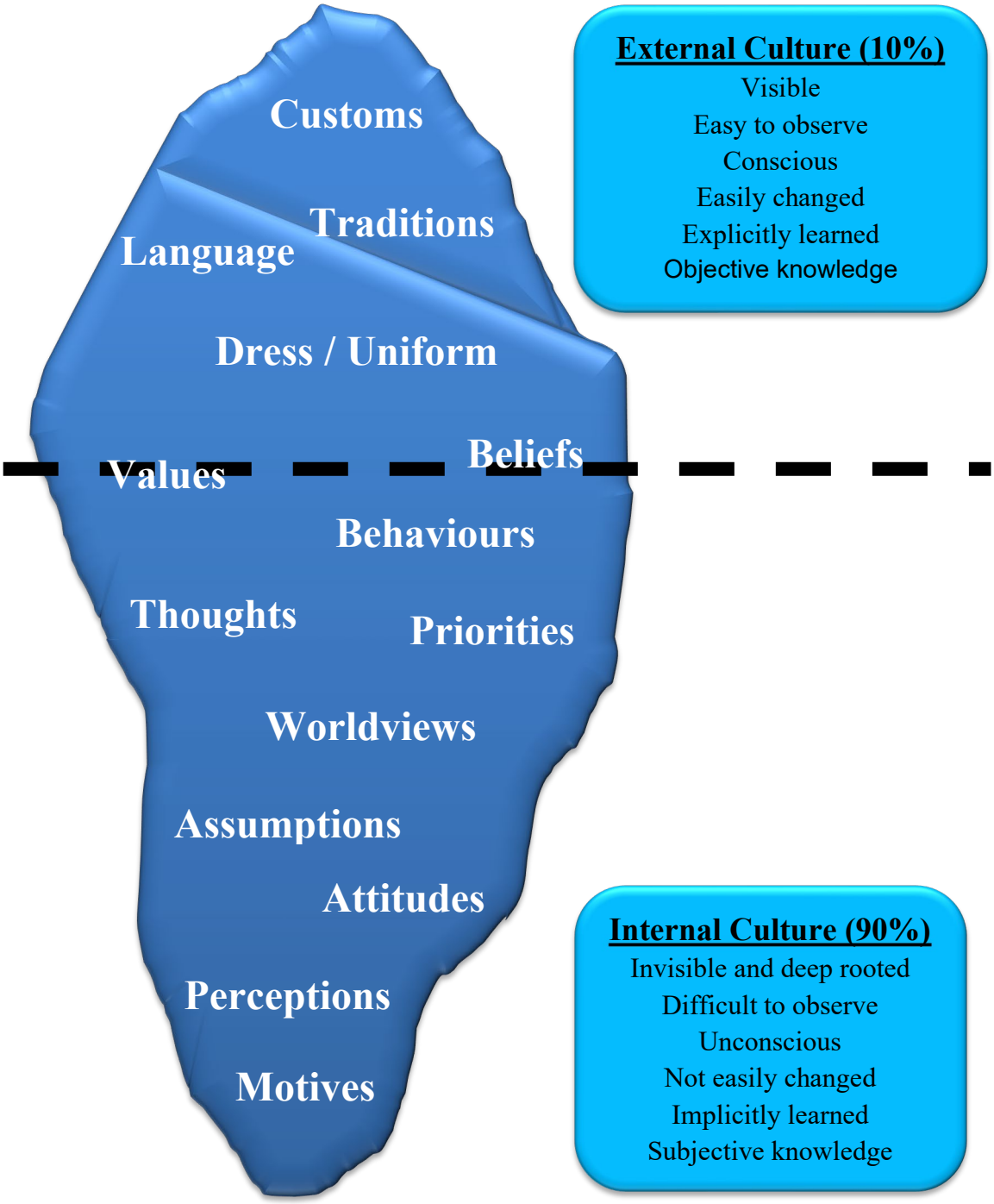
Within the 19th century, a connection and symbiotic relationship were made between culture and the human condition (Inglis, 2004). In this regard, culture is often referred to as the shared social action or behaviour of a specific group that is created, learnt and shared through the process of social interaction, and as such is often deemed the norm (Thomas, 1993; Lee and Zaharlick, 2013). Thus, culture is the entity which enables meaning within the interactions between individuals and is often used to explain human behaviour and the complex interplay between the real world and language (Inglis, 2004; Blommaert, 2015). This entity can be found within any sociological setting and occurs once the individuals within that setting attain some degree of understanding, regardless of whether this is reached after a prolonged length of time or accomplished after a brief and fleeting moment

(Bloomaert, 2015). Consequently, culture is time specific, unique to a given set of people and arises under a specific set of conditions, and therefore morphic and subject to change (McSherry, 2010; Bate, 2014).

When trying to observe culture, there must be a level of appreciation of the current sociological, political and humanistic undercurrents that may impact on this specific group of individuals. Additionally, when first entering or observing a culture, the "cultural portrait" (Bloomberg, 2012, p.32) of that specific sphere may be initially misrepresented, as the surface image presented may contribute to false assumptions being primarily generated (Skeggs, 2015). Culture must, therefore, be viewed beyond the initially presented surface image by observing what is at first unseen. In this sense, culture resembles an iceberg, consisting of two surfaces, the external and internal (*see figure 1, page 24*) and in order to truly see the culture the internal aspects of the entity must also be observed (Hall, 1976). The cultural aspects associated with the surface of the iceberg are usually conscious, easily changed and thus subject to the demands of the organisation or current and national drivers. Whereas, the elements below the waterline are in contrast, usually unconscious and difficult to change as they are not clearly visible, even to the members of the cultural group (Plaister-Ten, 2017). This is important, as it is the internal, hidden and subconscious elements (constituting 90% of the overall culture) such as values, beliefs and assumptions, that are most influential on behaviour and the action of individuals (Dickson and Grimwood, 2010; Moen, 2010).

Therefore, this thesis will examine preoperative practice in order to understand how the internal and external culture influences pain planning and management for day case surgical patients.

Figure 1: The Cultural Iceberg (adapted from Hall, 1976)



1.2.2 Critical ethnography

For this thesis, an ethnographical approach is warranted as this methodology allows an entire cultural group to be observed and investigated within its natural setting (Bloomberg, 2012). However, the hidden aspects of culture and the tensions between agency and structure may be difficult to research using conventional anthropological methodologies (Thomas, 1993; Cook, 2005). To research the submerged aspect of the culture of the perioperative department, there is a need to utilise theory and a research design which will enable the uncovering of these veiled facets. Therefore, a critical theoretical orientation has been adopted using a critical ethnographic methodology.

The origin of critical ethnography can be traced back to the 1970s with research from the University of Birmingham in the United Kingdom, and while its methods may be similar to traditional ethnographical approaches, they vary in relation to the overall aims of the research (Holmes and Smyth, 2011). This methodology is heavily grounded in the theoretical perspective of critical social theory (Thomas, 1993; Carspecken, 1996; Wang, 2013) which attempts to create a picture of culture, with a view to examining wider social differences that may lead to personal transformation (Holmes and Smyth, 2011; O'Mahony *et al.,* 2012).

1.2.3 Critical social theory

Critical social theory was developed in the 1920s and 1930s. It arose from a group of Frankfurt school scholars including Adorno and Horkheimer, who were dissatisfied with scientific Marxism and the constraints of traditional social sciences (Seidman, 2013). However, in contemporary research, critical social theory is more synonymously linked with second-generation critical theorists from the 1960s and 1970s, such as Habermas,

Foucault and Bourdieu (Stewart and Usher, 2007). Cuff, Sharrock and Francis (2006, p. 5) refer to these as the 'synthesisers', as they have attempted to merge conflicting theories. However, regardless of how their ideologies are formulated, what is fundamental to critical theorist is that their aims are centred on revealing inequalities in power, not only within society but also those practices associated with institutions (Stewart and Usher, 2007). Thus, critical social theory is a suitable theory to base the research aims and outcomes upon, as how control is enacted, will undoubtedly impact on work practices and therefore influence the planning and management of patients' pain (Costley, Elliott and Gibbs, 2010; Ladva, 2015).

As the theory selected will influence what can be learnt about the culture (Lee and Zaharlick, 2013; Punch, 2014), a specific critical social theory was not selected before commencement of the research study. Consequently, the decision to align the findings to Bourdieu's (1977) underpinning theoretical ideologies did not take place until the final stage of analysis, and this was chosen at it strongly resonated with the findings. A more in-depth exploration of Bourdieu's theories will be discussed in *chapter three, page 91.*

1.2.4 Pain

As well as providing background information on culture, it is appropriate to offer some contextual information on pain, as well as an overview of the various categories of pain that are currently utilised in clinical practice. When asked what the word 'pain' means, one will often hear a variety of responses. Some may relate pain to an actual physical injury, while others may identify it with experienced emotional events, such as bereavement. Thus, pain can be interpreted within multiple contexts, which can be influenced by life events or associated with painful memories and is, therefore, a unique active process,

exceptionally complex, and extremely subjective (Buglass, 2007; Mackintosh, 2007). Pain while manifesting itself multifactorially, is also a ubiquitous and universal phenomenon, and as such, is experienced by most individuals during their lifetime (Rejeh and Vaismoradi, 2010; Zis, Sokolov and Chaudhuri, 2016). Within a healthcare context, pain is one of the most common patient problems and for many individuals can be the worst feeling they have experienced (Pasero, 2015; Xue *et al.,* 2016).

Since pain has a widespread impact and reach, philosophers, scientists, and HCPs have attempted to gain a greater understanding of the biological, behavioural, and philosophical aspects associated with this phenomenon (Main *et al.,* 2008). Accordingly, knowledge of pain processes has changed considerably over the last five hundred years (Asmundson *et al.,* 2014). Transforming from Plato's hypothesis that pain is a sensation linked to illness (Battaglia, 2016). Hippocratic beliefs that pain is associated with body fluid imbalance. Aristotle's hypothesis that pain and pleasure are purely emotional experiences, and Renaissance religious beliefs that pain is linked to evil spirits or a punishment from God (Linton, 2005; Mann and Carr, 2009b). Finally, to the modern understanding that pain involves the body, behaviour, and conscious mind (Toates and Davey, 2007). It was the 17th-century French philosopher Descartes, who is often credited with making the primary link between the body and the brain (Asmundson *et al.,* 2014; Rodriguez, 2015), by creating the 'biomedical model' of pain, which demonstrated that pain was not only a natural body defence to tissue damage but also a sensory experience (Moayedi, & Salomons, 2016).

Since Descartes, the theory of pain has continued to evolve, and since the 17th century, several influential theories have emerged, including the specificity, intensity and pattern

theory (Moayedi and Davis, 2013). In 1965 Melzack and Wall conceptualised and pioneered a new model of pain, referred to as the 'gate control theory' (Main *et al.,* 2008). They hypothesised that neurons within the superficial dorsal horn of the spinal cord could modulate the flow of signals from the stimulation of peripheral nociceptors (sensory neurons) through the central nervous system to the brain, thus effectively increasing or decreasing the amount of pain experienced (Old, Nicol and Malcangio, 2016; Todd, 2016). They further postulated that the gate control was influenced by psychological and physiological factors and accordingly have been accredited with taking the first step in recognising the symbiotic relationship and the interactive and interdependent nature of these factors (Main *et al.,* 2008). This psychophysiological theory and its underlying principles have widespread applicability and have consequently laid the foundation for some of the additional altered models that have been developed over the last fifty years (Asmundson *et al.,* 2014; VanMeter and Hubert, 2014).

One such model is Engel's 'biopsychosocial model' which has taken the gate theory one step further and is one of the recognised models of pain used today (Vigeyen, Crombez and Goubert, 2007). This model reinforces the uniqueness of individuals' pain experiences and reaffirms that pain often results from the culmination of a myriad of factors that are biological, social and psychological in origin (Engel, 1980). These can include stimulus intensity, genetic predisposition, economic and environmental factors, cultural beliefs, and individual pain perception and coping mechanisms (Juneja and Jaggar, 2009; Mann and Carr, 2009b; Turk and Melzack, 2011). Ronald Melzack has also advanced and extended the gate control theory of pain, in order to address the original theories inability to explain phantom limb pain (Keefe, Lefebvre and Starr, 1996). This has resulted in the creation of the 'neuromatrix' theory of pain, and a greater understanding of the role of supraspinal

influences and brain function on pain perceptions (Keefe, Lefebvre and Starr, 1996). This supplementary theory proposes that the multidimensional experience of an individual's pain is a result of a unique neurosignature (nerve impulse pattern in the brain) that can be produced by genetic and sensory influences, triggered by sensory stimuli and also when stimuli are absent (Melzack, 2001; Melzack, 2005; Melzack and Katz, 2013).

The growth of knowledge around neurological processing has also increased within recent years, as links have been made between physical and social pain. Eisenberger *et al.* (2003: 2004) and Macdonald and Leary (2005) suggest that social distress can be manifested as physically painful sensations, due to an overlap in the regions of the brain associated with nociceptive input and sociocultural distress; thus, reactions to rejection intercede with elements of the pain matrix. However, Riva, Wirth and Williams (2011) and Iannetti *et al.* (2013) highlight that despite this overlap, physical and social pain sensations are different in terms of how they are experienced and managed and that due to their subjective nature, judgements of orientation should only be made in the presence of self-reports by the individual experiencing the pain.

1.2.5 Definitions of pain

In an attempt to aid HCP, individual comprehension and self-reports of this complex phenomenon, various definitions of pain have emerged (Mann and Carr, 2009b; Tornsey and Fleetwood-Walker, 2012). Definitions of pain are necessary not only for medical professionals and scientists but also for patients. These allow patients to make sense of the physical and emotional pain sensations that they are experiencing and to communicate these feelings in a way which enables them to be contextually categorised (Smith and Torrance, 2012). Rodriguez (2015) states that the first worldwide accepted definition of

pain is from The International Association for the Study of Pain (IASP), which declares that it is “an unpleasant sensory and emotional experience associated with actual or potential tissue damage” (Merskey and Bogduk, 1994, p.209). However, the levels of pain felt are not always directly linked to the amount of trauma (Rodriguez, 2015) and to reflect this view the IASP (2019) is in the process of creating a new definition of pain, which is currently proposed as “an aversive sensory and emotional experience typically caused by, or resembling that caused by, actual or potential tissue injury”. In addition to the overall definition, categories of pain have been created and include type (nociceptive, neuropathic and psychogenic), site (somatic and visceral), and duration (acute or chronic) (Rosser, 2014; Rodriguez, 2015).

Nociceptive pain processes which are conveyed through to consciousness, involve the passing of information through primary afferent fibres to the cerebral cortex (Solaro and Uccelli, 2016). This incorporates the stimulation of pain receptors ‘nociceptors’ which are activated by tissue damage from either chemical, physical or thermal trauma (Juneja and Jagger, 2009; Cox, 2012). Conversely, neuropathic pain occurs as a direct result of an abnormality in the sensory processing in the central and peripheral nervous system (Old, Nicol and Malcangio, 2016) and is experienced by approximately 6% of the population (Colvin and Carty, 2012). Somatic pain refers to the sensations that originate in the skin, bone, and muscle, involve the sensory nerves and is a large part of the body’s natural defence mechanism (VanMeter and Hubert, 2014); whereas visceral pain is a sensation which is felt in the organs, transmitted via the sympathetic fibres, and linked to conditions such as irritable bowel syndrome and dysmenorrhoea (VanMeter and Hubert, 2014). Historically, visceral pain was often associated with the term ‘hypochondriac’ which was used to describe patients with vague upper abdominal pain (Maybin and Serpell, 2012),

and is experienced by most individuals at some point in their lives (VanMeter and Hubert, 2014).

Acute pain is defined as pain that is brief and serves a protective purpose and function to inform the body that it has been injured (Toates, 2007; Turk and Melzack, 2011). Acute pain is predominantly nociceptive in physiological terms, typically originates from biological factors, involves sensory processes, and is treated very effectively with analgesics or other medical interventions (Edward, Smith and Hawthorn-Thwaite, 2004; Hobson, Wiffen and Conlon, 2015). It can also be psychological in origin, as damage may result from an emotional event or psychogenic stimuli (Tornsey and Fleetwood-Walker, 2012). Contrastingly, chronic pain persists past the initial healing stage, usually three months, and serves no protective purpose (McGann, 2007). It is also associated with an array of changes to the peripheral and central sensory pathways and thus largely neuropathic, typically connected with chronic disease and usually treated alongside psychological measures due to its extremely subjective nature (Hagger-Holt, 2009; Mann and Carr, 2009a; Nimmo and Dickson, 2012; Smith and Torrance, 2012; Tornsey and Fleetwood-Walker, 2012).

In an attempt to understand the complexities of pain, researchers have successfully unlocked some of the secrets behind this phenomenon, have identified and classified some of its component parts, and have effectively devised dependable definitions (Main *et al.,* 2008). However, despite this deeper awareness, pain remains an extremely complex mechanism, and there is still some way to go before this universal sensation is truly and comprehensively understood (VanMeter and Hubert, 2014).

1.2.6 Pain and the National Health Service (NHS)

Pain is one of the main reasons for individuals seeking healthcare advice and one of the most significant health problems facing the modern NHS (Plaisance and Logan, 2006; Clarke *et al.,* 2009). Chronic pain now accounts for over 4.6 million general practitioners' (GP) appointments (Boyd, 2013) and is as prevalent and as detrimental to the quality of life as conditions such as cardiovascular disease and diabetes (Carr and Watt-Watson, 2012). Consequently, due to the widespread and multifarious nature of pain, it should be classified as a disease in its own right (Turk and Melzack, 2011).

For this reason, reducing the risk of developing pain should be seen as a patient safety issue, and must be measured in line with other quality improvement initiatives (Carr *et al.,* 2013). Moreover, alleviating avoidable pain and suffering should also be a central consideration in the HCP's act of caring; not only is it humanitarian it is morally correct (Colvin and Power, 2007; Department of Health (DOH), 2008). Pain prevention and management, which are synonymously linked with satisfaction and care activities are therefore high on the NHS agenda and a priority for ensuring high-quality care, especially within perioperative services as surgical patients are particularly vulnerable (Idvall, 2004; DOH, 2010; Hanna *et al.,* 2012; Zinn, 2013). Accordingly, in 2001 the Joint Commission announced new standards advocating for pain to be monitored similar to how vital sign are monitored, and this led to the launch of the American Pain Society's 'pain as the fifth vital sign' campaign (Baker, 2018; Jones *et al.,* 2018). However, whilst there is an acknowledgement that pain prevention and treatment should be taken seriously, a culture 'intolerant to pain and tolerant to drug use' (deShazo *et al.,* 2018, p. 595) (which in the US contributed to the opioid epidemic and the death of 200,000 Americans) must not dominate the way in which HCPs manage and respond to patients' pain. Consequently, the Joint

Commission revised their recommendations in 2009 and caution is now advised in relation to the ritual prescribing of opioids and a more holistic and tailored approach to the management of pain needs is now recommended (Rummans, Burton and Dawson, 2018).

1.2.7 Pain and surgery

Pain can be caused by a variety of mechanisms, and surgery is one of the most common and widely experienced (Ward, 2014). In the past, surgery was regarded as an extremely dangerous endeavour, and the risks to patients were often significant. Within the twenty-first century, surgery has become relatively safe and even complex surgeries are now routinely performed, largely in part due to a culture of safety that has grown over the last two decades. Thus, pain has become one of the highest fears that patients experience preoperatively with as much as 70% of surgical patients often expecting substantial pain postoperatively (Colvin and Powell, 2007; Perkins and Ballantyne, 2010).

As surgery invariably involves tissue and nerve damage, the initiation of inflammatory responses and the stimulation of nociceptive receptors, many would suggest that pain is a predictable consequence of surgery (Perkins and Ballantyne, 2010; Tornsey and Fleetwood-Walker, 2012; Deumens *et al.,* 2013). However, pain is individually experienced and felt in varying degrees of severity, even for patients who undergo identical surgical procedures (Meyr and Steinberg, 2008). Thus, perioperative pain can be challenging to manage and treat effectively, as predicting the extent of surgical patients' postoperative pain is often problematic, and it may not be possible to eradicate surgical pain on every occasion (Brennan, Carr and Cousins, 2007; Cox, 2012; Voshall, Dunn and Shelestak, 2013; Hunter *et al.,* 2016).

The ineffective treatment of perioperative pain can lead to increased financial burden on NHS resources as more extended hospital stays, increased analgesic requirements,

decreased workforce productivity, rehabilitation requirements and a delay in the return to normal functioning add to economic strain (Polomano *et al.,* 2008b; Clarke *et al.,* 2009; Lindberg *et al.,* 2013). As a result of inadequate pain management and perioperative preparation, there has also been an increase in litigation (Wilhite, 2011) and pain is often used by NHS hospital trusts, as a way of measuring the quality of service as poor pain management is linked to higher levels of dissatisfaction (Karia and Ibrahim, 2017). Thus, patients are no longer passive participants in their care (The Association of Anaesthetists of Great Britain & Ireland (AAGBI) and The British Association of Day Surgery (BADS), 2011b). There has also been a rise in the number of individuals claiming incapacity benefit for chronic pain, with estimates totalling approximately four billion pounds per annum, within the UK (Boyd, 2013). Therefore, as surgery has global implications it is imperative and a "business necessity" that we treat perioperative pain effectively (Chapman, Stevens and Lipman, 2013; Saver, 2013, p1). This is even more important for day surgical patients, as 80% of surgical procedures within the UK are now carried out as day cases (AAGBI & BADS, 2011a).

1.2.8 Day case surgery

Day surgery, otherwise known as same day and ambulatory surgery, is defined as a surgical procedure undertaken on a patient who was admitted and discharged on the same day (AAGBI & BADS, 2011b; O'Neill, Pennington and Nightingale, 2014). Day surgery can be traced as far back as the 1900s when surgical procedures were first documented in children and infants within outpatient clinics (Nicoll, 1909). Since then there has been a steady increase in the number of procedures carried out as day cases, with the figures rising significantly in the 1980s (Smith and Hammond, 2011). Due to advances in surgical techniques, and the political and organisational drive for ambulatory surgery, minimally

invasive procedures are now being classified as routine within most NHS surgical settings (Gilmartin, 2004; Toftgaard, 2009; Older, Carr and Layzell, 2010; Karia and Ibrahim, 2017). Consequently, day case surgery is being introduced for a broader spectrum of complex surgical specialities; transforming the face of surgery from inpatient to day case (McCloud, Harrington and King, 2014). This is in part, due to the significant economic savings associated with reducing overnight stays, driving an upward trend in converting surgeries to a more ambulatory pathway (Schug and Chandrasena, 2015).

Unmanaged postoperative pain for day case patients has major implications for perioperative services, as it could lead to a significant population of patients who must either manage their postoperative pain and analgesic requirements themselves, or rely on family members for assistance (Older, Carr and Layzell, 2010; Mottram, 2011; Berg, Arestedt and Kjellgren, 2013). Pain is, therefore, one of the most common complications after day surgery and patients who do experience high levels of pain once discharged, often feel abandoned (Mattila *et al.,* 2005; Schug and Chandrasena, 2015). It is only when patients are readmitted for uncontrolled pain or seek unplanned assistance from medical professionals within primary care that a more precise picture starts to emerge (Mattila *et al.,* 2005; Polomano *et al.,* 2008a; D'Arcy, 2012). This is disconcerting, as perioperative care and perioperative nursing is a recognised speciality, with clear guidelines that include various sophisticated and innovative avenues in analgesia delivery (Older, Carr and Layzell, 2010; Kerrin, 2016). Additionally, both patients and staff sometimes fail to comprehend that although day case surgery may be considered commonplace, care planning can be compounded by complexities and variables that may impact effective perioperative pain management (Older, Carr and Layzell, 2010; McIntosh and Adams, 2011). As such, it is naive to think that surgery equals recovery in terms of length of time (Berg, Arestedt and Kjellgnen, 2013).

1.2.9 Fear and anxiety

Preoperative fear and anxiety have been shown to have an exacerbating influence on the levels of pain experienced, as the anticipation of postoperative pain can be immensely frightening (Bailey, 2010; Gürsoy *et al.,* 2016). Patients may also be extremely fearful of the unknown elements of surgery and the association with loss of control, as they place their bodies and lives into the hands of others (Lagerström and Bergbom, 2006). As a consequence, multitudes of factors have the potential to increase anxiety levels to such degrees that fear manifests itself in physiological responses. While perioperative physiological responses can also be attributed to other causes, anxiety and fear need to be recognised and considered as they have the potential to impede healing and recovery (Grieve, 2002).

Some of the physiological manifestations can include tension, irritability and increased activity in the autonomic system (Aytekin, Doru & Kucukoglu, 2016). Adrenergic systems are initiated and the stimulation of release of acetylcholine, catecholamine and adrenaline resulting which could lead to hyperalgesia and over-sensitisation of the nociceptors (Tokmak *et al.,* 2015). Patients who do experience preoperative psychological distress, due to fear and anxiety, thus often have a heightened receptivity to noxious and psychogenic stimuli, which further intensifies their levels of postoperative pain, distress, and overall satisfaction (Buvanendran and Kroin, 2007; Layzell, 2008; Koneti and Jones, 2013). Additionally, anxiety can have detrimental effects on the maintenance and induction of anaesthesia, increase the need for intraoperative anaesthetic drugs, and can exacerbate complications in stress responses (Ebirim and Tobin, 2011; Gürsoy *et al.,* 2016). Moreover, levels of fear can rise to such intensities that it causes some patients to postpone their actual surgery (Apfelbaum *et al.,* 2003).

1.2.10 Catastrophising

One of the key arbitrators between preoperative anxiety and postoperative pain is catastrophising (Pinto *et al.,* 2012b). This is defined as the exaggeration of an imagined threat, which often greatly surpasses the actual physical threat of pain and results in a magnification that can increase the feelings of postoperative pain that are experienced (Deumens *et al.,* 2013). The connection between pain severity and catastrophising is authentic, and in order to take steps towards decreasing postoperative pain, this phenomenon must be recognised (Khan *et al.,* 2011). It is therefore crucial that HCPs understand how catastrophising is demonstrated in patients, in order that physiological interventions (distraction therapy, music therapy and massage etc.) can be incorporated into care planning and administered as adjuncts to analgesic management (Pinto *et al.,* 2012b; Ravindran, 2014).

1.2.11 Genetics and gender

During the last few decades, there have been some significant advancements in the understanding of the genetics of pain; however, this science is still in its infancy and has only taken the first tentative steps towards ultimate discovery (Mogil, 2012). What has been uncovered will help tailor patient care, due to the deeper comprehension of how genetics is linked to predisposing factors, pharmacokinetics, metabolism and biological variances between males and females (Paice, 2007; Mogil, 2012; Ravindran, 2014).

The link between anxiety and levels of pain have recently been shown to be different between males and females, both at a biological and social level, as some females have been found to experience higher levels of anxiety than men, declare pain more than their male counterparts and are more sensitive to painful situations (Matthias and Samarasekera,

2012; Chapman, Stevens and Lipman, 2013). These variances could in part be due to hormonal influences on pain sensitivity, gender-related expectations on pain, religious and ethnic influences and psychological conditioning; as men may perceive that declarations of pain are signs of weakness (Berkley, 1997; Wiesenfeld-Hallin, 2005; Paller *et al.,* 2009; Mitchell, 2012 and Bartley and Fillingham, 2013). Therefore, sex (the biological differences between males and females) and gender (differences between what it is to be male (masculine) and female (feminine) that are socially produced) can be used as a possible indication of who may be at increased risk of inadequate pain control postoperatively (Schug and Chandrasena, 2015). It is important that HCPs, especially those who have contact with patients preoperatively, should consider gender differences to ensure that care is personalised more appropriately and that preoperative anxiety is limited (Mitchell, 2012).

1.2.12 Holistic care

Holistic care is a model of caring which is underpinned by the philosophy of holism, and advocates treating patients as a whole entity (mind, body and spirit) rather than focusing on their illness or symptoms (Selimen and Andsoy, 2011). This has relevance when caring for patients in pain, as individuals are similarly influenced by the social context of their past and present experiences (Craig and Fashler, 2014). Pain responses can, therefore, be prejudiced by the social etiquette of the environment, as individuals learn from the people around them and often demonstrate learned pain behaviours, such as pain expressions and coping strategies (Linton, 2005). Due to these experiences and the associated cultural conditioning, individuals possess unique pain autobiographies; thus, pain treatments need to be matched explicitly to that individual's needs and preferences rather than adopting a blanket approach to care (Schumacher *et al.,* 2002; Tornsey and Fleetwood-Walker, 2012;

National Institute for Health and Care Excellence (NICE), 2014). Perioperative pain, which is multidimensional, should therefore be managed using multimodal approaches (pharmacological and non-pharmacological), which have been shown to have a positive effect on the amount of pain relief achieved at lower doses of analgesia (Deumens *et al.,* 2013; Pasero, 2014).

1.2.13 Preoperative assessment

To provide holistic care, HCPs must communicate with patients in order to understand their specific needs. Preassessment appointments, which are now integrated into most NHS hospital trusts go some way to enabling this, as they play an essential role in providing patients with the preoperative preparation that is vital to optimise resources and ensure the safe effective and efficient quality of care (AAGBI, 2010a; AAGBI and BADS, 2011a). Preoperative assessments are also uniquely placed to assist with the efficiency of surgical practices and operating lists, by undertaking patient screening, and using predetermined protocols, to help identify patients who would be unsuitable candidates for surgery (Hilditch *et al.,* 2003; Pearce, 2004; Harvard Medical School, 2012; O'Neill, Pennington and Nightingale, 2014). Consequently, this assessment is an essential step in the perioperative care continuum and has been instrumental in reducing the number of cancellations, decreasing delays on the day of the surgery, and limiting the associated costs (Carr *et al*., 2006; Hardy, 2012; Pritchard, 2012; Martin, 2016).

In many cases, patients will not only have a preassessment consultation, primarily with a nurse (Doherty and Stevenson, 2016) but also a preoperative visit in the hours prior to surgery. This allows the anaesthetic staff more time to prepare patients for the anaesthesia,

analgesia and pre-emptively address any potential issues (Lagerström and Bergbom, 2006; AAGBI, 2010b).

1.2.14 Pain planning

Pain is an aspect of surgery that many patients are anxious about, and as such, they place pain information as a high priority (Kastanias *et al.,* 2009). Therefore, the preoperative period could be an opportune period to plan pain management strategies, as it can allow for an extensive evaluation and extrapolation of the patients' current and past pain experiences and offer patients the opportunity to discuss their concerns about pain interventions (Dunwoody *et al.,* 2008; Meyr and Steinberg, 2008; Fincher, Shaw and Ramelet, 2012). Likewise, due to the complex nature of some individuals' pain experiences and pain histories, it can also enable HCPs adequate time to make appropriate referrals to specialist pain teams or to liaise with the multidisciplinary team if additional support is required (Spice, 2008; Harvard Medical School, 2012).

Despite this, it is suggested that pain is often forgotten and at times only debated when the anaesthetists visit patients immediately before surgery, especially for patients whose medical histories are complex, as there is a tendency for the focus of the interaction to be centred on assessment of risk (Tooth and McKenna, 2006; Sweitzer, 2008). This raises questions about the extent to which acute and chronic pain are explored during preassessment appointments; as patients with comorbidities and complex pain histories repeatedly report lower levels of satisfaction with their care (Dykstra, 2012; Pinto *et al.,* 2012a; Rivera *et al.,* 2012). This suggests day case preassessments should not be uniform and predeterminates for developing postoperative pain complications, such as gender and anxiety, should be examined in-depth in order to allow for individualised perioperative

analgesia to be arranged preoperatively (Dunwoody *et al.,* 2008; Croissant and Shafi, 2009; Althaus, 2012; Koneti and Jones, 2013; Saver, 2013; Mower, 2015).

1.2.15 Preoperative pain practices

All healthcare professionals practice the bioethical principles of nonmaleficence and wherever possible should abide by the Hippocratic Oath. Pain and suffering should, therefore, be minimised, especially when both healthcare staff and patients are aware that it will be intentionally inflicted (Nursing and Midwifery Council (NMC), 2018). Healthcare practitioners, including nurses and anaesthetic staff, need to adapt and update their practice and use appropriate techniques to ensure that patients are provided with the maximum opportunity to undergo surgery with minimal stress and discomfort (AAGBI & BADS, 2011b). In order to achieve this, HCPs should recognise that pain is a major concern within perioperative care which needs to be placed high on the patients' and perioperative teams agenda (RCOA and AAGBI, 2006; Hayes and Gordon, 2015).

However, as a result of the complex nature of perioperative care and pain planning, preoperative practices of individual HCPs may be obstructed by a barrage of environmental, inter-organisational or intra-departmental constraints, cultural influences, and contextual factors, all of which can impede the holistic assessment and management of pain (Gregory and Waterman, 2012; Mitchell, 2012; Stomberg, Brattwall and Jakobsson, 2013).

1.2.16 Perioperative culture

The word culture has found an increasing focus in health and social care, especially since 1990, in part due to the failings in standards of healthcare delivery and patient safety that

have been widely publicised in recent decades (McSherry, 2010). Thus, in modern society there is a demand for people to understand why individuals act in certain ways, within specific situations; why groups interact in the manner in which they do and why organisations practice in the style they do (Skeggs, 2015). This can include learning through viewing the culture of nations, larger communities or small social groups (Willis and Elmer, 2011). Within healthcare, there have been many levels and areas of practices which have been viewed in a bid to understand, share knowledge and reform the culture of the group and team (Skeggs, 2015). Within perioperative care, the cultural framework which consists of multiple groups working together can be deemed as an organisational sub or micro-culture situated within the prevailing culture of the hospital trust, which is a subculture of the NHS (Liamputtong, 2009; Wicker, 2010). It is often this subculture that has the most influence on the patient's journey, as it consists of individual beliefs, assumptions and values and is situated at the clinical coalface (Manley, 2004; Moen, 2010). This is not to say that the frontline delivery of care is unique to each area, as some practices are universal. Consequently, the work culture of departments or wards can be influenced by the individual practice environment, but also national and global policy, and wider societal norms (Mann and Carr, 2006; Layzell, 2008; Strong and Van Griensven, 2014).

Previous cultural studies within perioperative care over the last twenty years have focused on care standards, safety, teamwork, power and autonomy (McSherry, 2010). One of the top priorities within perioperative care is that every unit should foster a culture of safety (Patil *et al.,* 2017), as it is an area of clinical practice renowned for being a high-risk environment (Jones and Durbridge, 2016). The interest in safety and healthcare is also a major concern for every healthcare organisation across the world (WHO, 2017) and could

be reactionary due to adverse events (Jones and Durbridge, 2016). Within the UK, the safety movement has gained momentum due to reports, such as Berwick's (2013), highlighting the need to address failures in systems, environments, team working, and remove the toxic repercussions aligned with previous blame cultures and practices.

Cultural studies within the perioperative arena, have also unearthed issues relating to teamwork and power. Fear and bullying have been shown to contribute to a negative working culture and unsafe working practices, as staff within the perioperative arena often feel unable to challenge colleagues' poor practices (The Royal College of Surgeons (RCOS), 2015). These feelings of disempowerment are often reinforced by the use of power, control and fear of repercussions. This is not unique to staff as there is also a significant shift in power between the patient and the healthcare professional during the actual surgical procedure; thus a dichotomy also exists between patient autonomy and choice, and medical paternalism and risk (Humphreys, 2005; Minchom, 2006; Tomassini, Bernasconi and Giudice, 2008).

1.2.17 Personal perspective

The advantages of examining clinical practice within this area have the potential to yield information which would be beneficial, not only for those working within perioperative care but also on a more individual and personal level. As a qualified nurse, specialising in perioperative care and as a trained midwife, I had the privilege of witnessing both extremes of the human journey, from birth to death. Therefore, throughout my practice, the one common and continuous symptom I witnessed and dealt with was pain. I observed how some expectant mothers, anxious about the levels of pain they may experience in childbirth, have, with the assistance of the midwife, learned how the pain could be

managed, treated and in some cases even accepted. In my experience, this was at times, in contrast with how surgical patients were prepared for the postoperative pain they could experience and more specifically with how the anticipated pain was planned and managed. I am fascinated that despite how similar some aspects of the experiences of birth and surgery are, HCPs prepare surgical patients and expectant mothers in very different ways. Additionally, not only have I witnessed the contrasting approach to care from the position of an HCP, but I have also experienced childbirth and have undergone surgical procedures myself, under both day case and inpatient pathways. I have also supported close family members who experienced various degrees of postoperative pain following day case surgery. Consequently, my interest in this subject is not only founded upon a professional interest in the topic areas but also from personal experience of current healthcare practices.

1.3 Unanswered questions

These personal and professional experiences, in addition to the background literature, have therefore been the driving force behind the direction of this thesis. When examining the literature on this subject, the following questions have not been fully addressed:

1) To what degree do healthcare professionals prepare day case surgery patients for the postoperative pain?
2) To what extent do nurses and anaesthetists discuss pain within real-world preoperative interactions?
3) To what degree do personal values and beliefs influence the preoperative culture?
4) Within the preoperative culture, what power dynamics and political undercurrents exist within this environment and how do they impact on preoperative pain planning?

1.4 Research question

When undertaking any research project, researchers need to frame the proposed study by identifying what will be studied and why (Lee and Zaharlick, 2013). As there is are a range of unanswered questions, one overriding question needs to be asked to provide a focus for the study. This research question will attempt to encapsulate the unanswered questions which have arisen from personal experience, and a review of the literature and background knowledge surrounding preoperative pain planning and perioperative culture. A research question is paramount as it not only defines the investigation but can also provide direction and act as a frame of reference when conducting, analysing and writing the thesis (O'Leary, 2014). The research question has been condensed to the following:

"How does the underpinning culture of the perioperative department impact on pain and its priority within preoperative practice for day case surgical patients?"

1.5 Research aims and objectives

In addition to the research question, clear aims and objectives must be addressed as a means of clearly articulating what is to be researched (Parahoo, 2014).

Aims:

1) To examine the current practices of a preoperative surgical department within one NHS hospital trust.
2) To ascertain the level of preoperative pain planning that is currently undertaken by the HCPs who have contact with day case surgical patients.

3) To explore the extent to which the culture of the department influences the individual practices of the HCPs and how these practices impact the care that day case patients receive about pain planning and preparation.

Objectives:

1) To look beyond the external cultural surface and explore factors which underpin practice.
2) To challenge the status quo, and examine how control and power impact on preoperative pain planning practices for day case surgical patients.
3) To develop insight into the views and opinions of HCPs caring for day case surgical patients and how they perceive current care is delivered.

1.6 Research project

The research topic is heterogeneous because it relates to pain, which is a complex phenomenon, and surgical procedures, which are performed within clinical environments, by multi-professional and inter-professional teams whose practices may vary considerably and be influenced by a multitude of variables. To answer the overarching research question, which centres on the culture of preoperative pain planning within one NHS hospital trust, a critical ethnographic methodological approach has been adopted (Edmonds & Kennedy, 2013). Additionally, to optimise the understanding of the complexities that existed within the individual HCP preoperative practices; a wide-ranging interpretative approach is employed, which utilises a variety of methods for collecting, analysing and interpreting the data. This approach is used as a means of collecting data from various sources but also to enable triangulation of the data (Lee and Zaharlick, 2013). The overall approach is interpretive to challenge and change practice; therefore, a transformative

paradigm underpins the philosophical viewpoint used. This paradigm, which can also be referred to as the criticalist paradigm, is underpinned by critical theory and is ideally suited to make sense of the inequalities that can exist within social interactions and illuminate the phenomenon or cultural underpinnings under investigation (Madison, 2012). Critical ethnography and transformative paradigms are explored in greater depth within chapter three.

Due to the level of intricacies that exist within the research phenomena, the research project was initially divided into stages. Strategic planning was necessary to ensure that the research tasks were manageable and achievable while attempting to answer the research question. Firstly, a qualitative inductive observational exploration of the preoperative practices of HCPs involved in preoperative care was undertaken. This allowed for cultural immersion within preoperative working environments and assisted with the uncovering of some of the complexities, which influenced the effectiveness of preoperative pain management and planning for day case surgical patients.

Secondly, a non-experimental quantitative collection of data was undertaken and rather than being conducted independently, was simultaneously collected and encapsulated within the observational field notes from the various preoperative assessments/consultations being observed within stage one. This correlational approach provided concurrent statistical data, which was integrated into the findings to provide a comprehensive analysis of preoperative pain management and planning for day case surgical patients.

Thirdly, practice documents, such as preoperative, pre-assessment, day case and theatre records, were examined to assist with the analysis of preoperative practices. Moreover and

lastly, semi-structured interviews were conducted with some of the HCPs whose practice was observed. This was carried out in an attempt to gain a deeper understanding of their values and beliefs, as well as the cultural and political influences which informed their practice and interactions with day case surgical patients. Additionally, these interviews allowed for further expansion of some of the emergent themes from the observations.

1.6.1 Distinctiveness of research project

The originality and distinctiveness of this study were demonstrated through the gap in knowledge identified from a review of the literature on pain management, preoperative assessment and healthcare practice culture for day case surgical patients. This study was also unique as it examined pain practices using a combination of data collection and analysis methods, which increased the distinctiveness in terms of research design. Due to the distinct design and methodological approach of this research, the study will provide unique insight as it examines preoperative pain practice from a critical ethnographical viewpoint, a methodological approach which is relatively new within healthcare research. Additionally, in an attempt to answer the research questions being asked, it will increase the overall knowledge and awareness of real-life preoperative practices for day case surgical patients: it will also reveal a deeper understanding of how values, beliefs, power, and political and cultural influences impact on nurses' and anaesthetists' preoperative practices.

1.7 Construction of the thesis

As the research methodology used for this study is critical ethnography, which advocates the use of researcher reflexivity, extracts from a reflective diary will be intertwined within the thesis itself, in an attempt to increase transparency. These excerpts will be presented

within individual boxes and will be in an italic font. At varying points throughout this thesis, diagrams and figures have also been used to further illustrate the research thesis construction, the research process and the research findings. A list of the tables, figures and diagrams, and their corresponding page numbers can be found above the contents table. Participants' verbatim quotations are similarly used to help illustrate both the analysis process itself as well as strengthen the research findings. These will be in italics and written within a narrowed page margin to ensure that they are separated from the supporting discussion around theory and the surrounding literature. For further perusal, examples of some of the research documentation will be included in the appendix.

The remainder of the thesis is structured as follows:

- Chapter Two examines the theory and literature that surrounds perioperative pain planning and management, perioperative cultural practice and will additionally be used to provide a comparable baseline for the research thesis findings and conclusion.
- Chapter Three outlines the methodological consideration of the thesis. This includes a detailed description of critical ethnography, a rationale for its use and the theoretical orientation which underpins it. Within this chapter, a summary is provided for some of the theoretical perspectives which have been instrumental in shaping the thesis; these include a selection of critical theories and Carspecken's approach to critical enquiry.
- Chapter Four explores the overall research process in detail. This includes the design and the methods employed to undertake data collection and analysis, both of which follow the conceptual framework created by Carspecken (1996). As a consequence of the reflexive nature of this conceptual framework, the symbiotic

relationship between reflection and the research process will be illustrated with the use of extracts from a research journal.

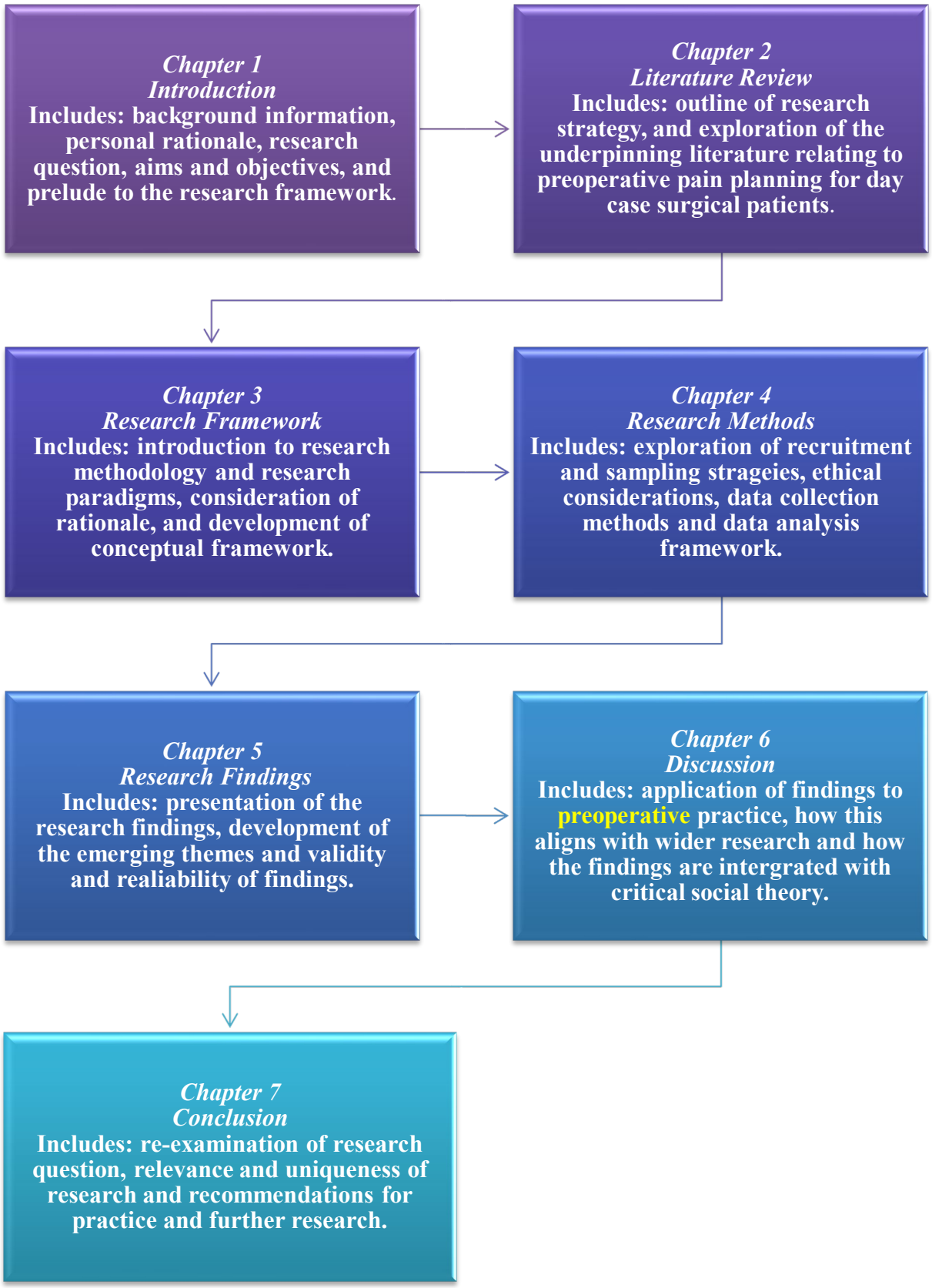
- Chapter Five presents an overview of the findings of the research from both the qualitative and quantitative data, culminating in the articulation of the extrapolated themes from the research data.
- Chapter Six examines how the findings, through the links with wider research, theoretical concepts and the underpinning critical social theory, can aid in the alteration of the status quo within preoperative practice for day case surgical patients.
- Chapter Seven provides a conclusive argument for the thesis, from concept, through its design, to the overall delivery and the answering of the original research question. It will conclude with a list of recommendations for practice and suggestions for further research.

For additional information on the structure of the thesis, see figure 2, page 51.

1.8 Summary

In this chapter, an introduction to the topic which underpinned the research thesis was provided, as well as, a detailed personal and professional rationale for choosing to examine preoperative culture and pain planning for day case surgical patients. The overarching research question was defined, and the research aims and objectives were demarcated. The contextualisation and complexity of pain and culture were presented, and the overall research approach, regarding methodology and paradigm, have been outlined. The following chapter will delve deeper into the supporting literature that already exists on the thesis topic.

Figure 2: Structure of the thesis



Chapter 2

Review of the literature

2 Review of the literature

2.1 Introduction

The aims of this thesis are to explore preoperative pain planning practices within one NHS hospital trust and examine how the culture of the preoperative department impacts on the care that day case surgical patients receive. As already stated in chapter one, pain is a complex phenomenon and how it is perceived, experienced, assessed and managed can be influenced at both a micro and macro level. Additionally, culture is multifaceted and unique to a specific place and time (McSherry, 2010). Therefore, before commencing the research project, it was essential to acquire a broad and detailed understanding of the current knowledge surrounding the topics of pain, culture and perioperative care. Consequently, within this chapter, a range of literature will be reviewed; this will not only provide a springboard for the research project, but may inspire and enlighten the research journey and demonstrate any potential gaps or limitations (O'Leary, 2014).

The literature review commences with an examination of the incidence of postoperative pain and what factors may impact on the levels of pain that patients experience. These are essential fundamentals to explore, as they assist in highlighting the difficulties in current practice and reinforce the rationale for the overall thesis topic. The review of the literature then moves onto preoperative preparation and critically explores the evidence behind the use of preoperative assessments, and the need for patient education, empowerment and partnership. The practice of HCPs involved in the care of day case surgical patients is then explored in an attempt to uncover some of the reasons behind HCPs' pain planning and management decisions. Finally, preoperative care for day case surgical patients will be critiqued within a cultural context.

I must also acknowledge at this juncture that while patient care is at the heart of all HCPs' practice and patients' voices are important, due to limitations in terms of resources and time, the cultural perspectives of patient participants were not explored within this thesis. Therefore, as HCP's practice was the focus of this study, a specific review of the literature examining patients' experiences of surgery was not undertaken and patients' views were only incorporated if they were part of wider studies examining postoperative pain, preoperative preparation and HCPs' practice.

2.2 Literature review: methodology

Searching academic literature is not a straightforward process (Parahoo, 2014); therefore, a structured plan and approach are required to ensure that the task remains focused. The earliest challenges faced, were identifying the search terms that would yield the most relevant information, then selecting which sources of information to access and what tools to use. To accomplish this, I attended educational teaching sessions offered by Northumbria University. These proved to be invaluable in terms of narrowing the search terms and navigating computerised systems. The literature search was conducted via electronic bibliographic databases provided by CINAHL, Web of Science, Medline and PubMed. In addition, an inclusion criterion was developed to focus the search on contemporary sources of information which would most accurately address the research questions (Aveyard, 2014). The inclusion criteria was as follows:

- In order to ensure that sources were contemporary and up-to-date, the literature time frame used was between 2002-2019. Seminal sources of literature that were influential, presented an idea of great importance or were repeatedly referred to within the literature were also included and a rationale for their use was provided.

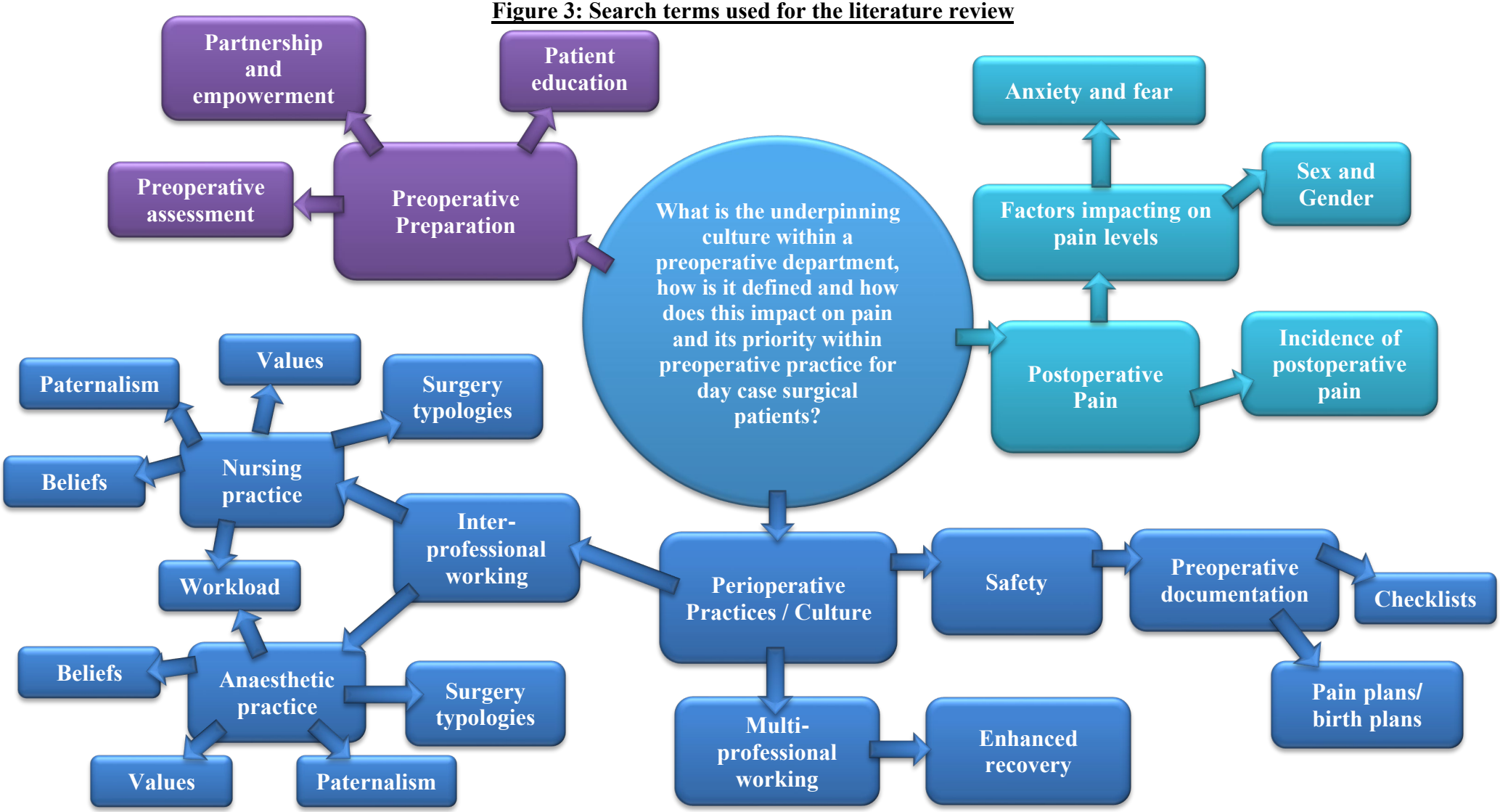
- National and International sources were included, although these needed to be accessible in English.
- Sources needed to be available and accessible via Northumbria University or the associated Interlibrary loan service.
- Acceptable sources of information included journal articles, textbooks, theses, dissertations, government publications, legal and professional publications, books, and conference papers.

As well as inclusion criteria, specific search terms were identified which would further assist with reviewing the literature. The main research terms were 'perioperative culture', 'perioperative pain practices', 'postoperative pain' and 'preoperative preparation'. With the use of Boolean operators, additional search terms, such as 'nurse', were used in addition to those above, in order to narrow down the sources and ensure they were relevant to day case surgical procedures. See *figure three, page 57*, for a detailed diagram of the search terms used in the literature review.

The literature review was conducted at key stages throughout the research project, as searching the underpinning academic literature and relating it to the thesis is an iterative process (Gray, 2018). A literature review was undertaken upon commencement of the project, continued during data collection and analysis, and throughout the writing of the thesis. Being methodical and maintaining a systematic approach to the literature search were beneficial as they assisted with increasing the overall rigour of the literature review (Hewitt-Taylor, 2017). Additionally, as the PhD process would take approximately five years, re-examining the literature review at various intervals ensured that new research matching the original search terms were also included (Pautasso, 2013).

The initial search provided more than 450 potential sources, but after consideration of the abstracts, the sources were narrowed to 233. While this is not an exhaustive list, the key texts were found and reviewed. The themes from the literature will now be explored in greater detail.

Figure 3: Search terms used for the literature review



2.3 Postoperative pain

2.3.1 The incidence of postoperative pain

Many studies continue to report high levels of postoperative pain which supports the view that postoperative pain management is, at times, suboptimal (Leegaard, Naden and Fagermoen, 2008; Polomano *et al.,* 2008a; D'Arcy, 2012; Schug and Chandrasena, 2015). Apfelbaum *et al.* in 2003 conducted a national survey of 250 postoperative patients in the United States of America (USA), to ascertain the levels of pain experienced. Results demonstrated that 86% of patients experienced levels of postoperative pain that were classified as moderate, severe and extreme and that fear of pain was the highest cause for concern in 56% of those surveyed. Although this study was conducted in the USA, population demographics and healthcare practices are comparable with the UK. Additionally, while the effect of recall bias must be taken into consideration when analysing data generated from memory, the researchers attempted to limit the impact of this by ensuring that patients were contacted within 12 months of their surgery. It has also been suggested that due to the nature of how postoperative pain can be experienced and impact on activities of living, some patients have the capacity to recall painful events accurately.

Chung and Lui (2003) conducted a similar study in China. They concluded in their research examining postoperative pain that approximately 85% of the 294 patients who completed their postoperative questionnaire experienced pain postoperatively. The authors also suggested that concerns can be raised regarding the level to which healthcare professionals value pain management, as only 48.6% of patients were cared for by healthcare providers who reinforced the importance of pain relief. These problems are not only associated with historical research, but also contemporary studies. Tocher *et al.*

(2012) explored patients' experiences of pain management postoperatively and found that 68.9% of the 2269 patients surveyed had experienced pain at some point across their hospital admission. Of these patients, 26.3% had pain most of the time, and 38.4% classified their pain as severe. Another study by Eriksson *et al*. (2013) found that 76% of their 157 patient participants reported moderate to severe pain on the first day postoperatively and more importantly, that this pain impacted on their recovery and well-being by reducing their ability to take part in self-care activities. Massad *et al.* (2013) echoed these findings, stating that 72% of the 275 patients they surveyed experienced moderate to severe pain, which rose to 89.3% upon movement and this impacted on their ability to take part in rehabilitation activities. These findings were comparable to results from a study involving 123 elective orthopaedic patients, where severe and moderate pain affected 60% of patients and subsequently caused sleep deprivation and interfered with a return to normal activities (Lindberg *et al.,* 2013).

While the sample size for some of the studies above is small, the findings from these are consistent with previous reports, and therefore a collective body of evidence exists which suggests that a high number of postoperative patients experience pain after surgery. These studies also demonstrate that postoperative pain is not an isolated problem confined to western society, but is a global and contemporary complaint which has implications for postoperative recovery and well-being across the world. This holds relevance within perioperative care, as high levels of acute postoperative pain have been shown to detrimentally affect physiological and psychological recovery (Gan *et al.,* 2004). Furthermore, if pain is mismanaged and inadequately treated, it can lead to chronic pain manifestation and other complications, such as tachycardia, immune system susceptibility and remodelling, and sensitisation of the nervous system (Finney, 2010; Hayes and

Gordon, 2015; Penprase *et al.,* 2015). Consequently, effective pain management should be an essential component of surgical care (Lee, Ray and Dunn, 2001; Patil *et al.,* 2017).

Aspects of practice that were not explored in some of the above studies included the impact of pain over time, and day case surgery is isolation. These issues were addressed in a recent Swedish study examining postoperative pain after forty-eight hours, seven days and three months. The study concluded that 53 of the 118 patients contacted after forty-eight hours experienced pain, and whilst this may be an expected outcome following surgery, results at day seven, show that 42 out of 110 were still in pain and 15 of the 46 patients asked at three months, continued to suffer (Rosén *et al.,* 2010*).* The trajectory of postoperative pain over time was also investigated in an earlier study by Horvath (2003), who claimed within their descriptive correlational study assessing postoperative recovery across 224 participants, that pain on day two post discharge was the most significant predictor of delayed recovery. Again, while the number of participants for this study was small, additional studies involving day case surgical patients reported comparable findings. Wu *et al.* (2002) made similar observations that out of all the symptoms that could be experienced post-discharge, pain was the symptom which occurred with the highest frequency. Cox and O'Connell (2003) and Segerdahl *et al.* (2008) also found within their studies examining outcomes following day surgery, that pain was the most common complaint after discharge. In a study by Brattwall *et al.* (2011) pain was found to be such a problem that 9% of the 355 patients surveyed needed to contact a HCP for pain management advice and 20% of patients were still experiencing pain four weeks after the initial surgery.

Karia and Ibrahim (2017) conducted a recent mixed method study to specifically examine the levels of pain experienced by day case surgery patients once discharged from hospital. They found that 42% of the 95 participants experienced moderate to severe pain, which rose to 57% after the first twenty-four hours post discharge before eventually declining to 28% on day three. They concluded that these results demonstrated that patients' pain increased in the hours after discharge, a finding which had not previously been reported. They conjectured that one explanation for this could be that recovery and ward staff were very effective and efficient at ensuring short-acting analgesia were administered, but once discharged these analgesics lost their effectiveness, so patients were left with increasing levels of pain that they had to self-manage. This assumption was reinforced by further data within the study, which confirmed that 2 patients needed to be readmitted and 13 needed to contact their GP for postoperative pain control management. This strengthens the earlier suggestion that the actual impact of the high levels of pain that patients experience as part of their recovery process are not being witnessed by the surgical team, as they are no longer directly involved in patients' postoperative care. It can be said that postoperative pain remains pervasively problematic for this group of patients (Schoenwald and Clark, 2006; Richards and Hubbert, 2007; Massad *et al.,* 2013; Melzack, 2014). This is compounded by the fact that as a result of the increased number of day case surgeries and the inability to accurately measure and ascertain the level and severity of patients' postoperative pain, the actual picture and extent of the problem are hidden and unknown (Williams, Ching and Loader, 2003; Perkins and Ballantyne, 2010). Managing pain is only one strategy currently employed within clinical practice. Preoperative pain planning (including anticipating pain levels) and patient preparation can also be effective strategies for managing postoperative pain and are seen as essential elements of perioperative care (Burrows and Taylor, 2009; Chow *et al.,* 2012; Pinto *et al.,* 2012a).

2.3.2 Factors that may impact on pain levels

Surgery typology has often been used as a factor in determining the risk of developing acute postoperative pain (Kalkman *et al.,* 2003). However, as the severity and duration, and the physical and psychological impact of pain are uniquely experienced, the risks of developing perioperative pain can be extremely varied and complex (Cox, 2009). Therefore, two patients undergoing the same surgery may experience different levels of pain. Factors that could contribute to the variation in pain perceptions include anxiety and fear, which are present in a significant number of patients preoperatively (Ebirim and Tobin, 2011).

In an article by Pritchard (2009), fear and anxiety were suggested to affect approximately 80% of surgical patients. Clarke *et al.* (2009) similarly stated, in an article reviewing strategies to reduce postoperative pain following orthopaedic surgery, that many patients experienced preoperative fear and anxiety; consequently, HCPs needed to allow for exploration of these risk factors preoperatively. These views were echoed in a study by Sadati *et al.* (2013) which found that preoperative anxiety levels were high, with 56% of the 100 study participants demonstrating high levels of anxiety before surgery. It is therefore not surprising that research into the psychological factors that influence postoperative pain have been studied at great length; with the majority concluding that there are a correlative connection and direct relationship between preoperative anxiety and predictors of acute postoperative pain (Walmsley, Brockopp and Brockopp, 1992; Kain *et al.,* 2000; Kalkman *et al.,* 2003; Abbott, Tyni-Lenné and Hedlund, 2010; Karaman *et al.,* 2016). Carr, Thomas and Wilson-Barnet *(*2005) correspondingly highlighted that this link became intrinsically stronger when individuals were already susceptible to physiological influences, and also in cases when patients' high levels of preoperative anxiety were

overlooked or discounted (Vaughn, Wichowski and Bosworth, 2007). Reducing anxiety in the preoperative period should, therefore, be a serious concern for HCPs (Grieve, 2002; Bailey, 2010; Karaman *et al.,* 2016).

This was not a new revelation. In the late 1800s, John Snow was one of the first anaesthetists to appreciate the value of spending time talking to patients before surgery (Frost, 2005). Snow realised that this valuable adaptation to practice could have a beneficial influence on a patient's level of anxiety and postoperative pain. This suggests that the preoperative anaesthetic visit can, therefore, play a significant role in the reduction of anxiety, especially for patients who are undergoing surgery for the first time (Matthias and Samarasekera, 2012). Preoperative visits from non-anaesthetic staff have also been shown to have a positive effect on reducing levels of anxiety. A study by Sadati *et al.* (2013) drawing on observational research, examined 100 preoperative visits conducted by nursing staff and concluded that incorporating discussions on what would take place during the surgical pathway reduced levels of patients' anxiety.

The above argument is reinforced by Pinto *et al.* (2012a), who claim within their study examining gynaecology surgery, that illness trajectory is also a major factor for increasing the levels of fear and anxiety experienced preoperatively, and nurses can play a significant role in identifying patient anxiety before the surgery. Additionally, a more recent study by Tokmak *et al.* (2015) investigating the effect of anxiety and pain during diagnostic and exploratory procedures, highlights that anxiety can be increased further by concerns over results of investigative procedures. Patients' fears and worries can thus cover a broad spectrum of concerns, from worries over family pets and household tasks, to fears over altered body image. Thus, nurses need to spend time examining the actual underpinning

origins of patients' anxieties during the preoperative period in order to implement strategies to help reduce the level of anxiety experienced before the surgery takes place (Westerling and Bergbom, 2008). However, a preoperative visit may not always result in a reduction in patient anxiety, as the attitude of the staff member and the content of the interaction may also have a significant bearing on the potentially beneficial aspects of this preoperative interaction. Soltner *et al.* (2011) found in their single-blinded single-centre study of 136 patients, that continuity of care (same member of staff conducting visit and undertaking intraoperative care) significantly improved satisfaction levels ($P<0.001$) and staff member empathy was also associated with a reduction in patient anxiety. Consequently, while it is important that patients are visited preoperatively by healthcare professionals, it can be inferred that it is the content and quality of the preoperative interactions that have the most impact on reducing anxiety and pain levels.

Unfortunately, due to increased organisational workloads and time pressures, HCPs have limited time to spend with patients (Gilmartin, 2004; Hawes *et al.,* 2016), and there is a fear that the quality of interactions is being affected and that the holistic and psychological needs of patients are not being met (Pritchard, 2009; Heaney and Hahessy, 2011). This can be more difficult to address within day case surgery, as patients may feel unable to express their fears to HCPs in the immediate period before surgery. In part, this could be due to the impending nature of the surgery, and the fact that they may have just met the member of staff for the first time, but also as a result of the clinical environment, which may not always be appropriately situated for conducting private conversations (Lagerström and Bergbom, 2006).

As briefly mentioned in chapter one, biological sex and gender can also impact on the pain levels experienced and how pain is expressed. Anxiety and fear and their links to pain perception are therefore extremely pertinent when coupled with patient gender (Matthias and Samarasekera, 2012; Mitchell, 2012). For this thesis, the terms used 'gender' is used to represent both the distinction between the biology of the male and female sex as well as the state of being a male or female from a more social and cultural perspective. I acknowledge and appreciate that there are other gender categories, but it would have been extremely difficult to ascertain what the patient defined as their specific gender, without extensive and unnecessarily intrusive questioning around their gender identities. Hence, only male and female classifications are utilised. Gender, rather than ethnicity, religion and sexuality, has been examined within this thesis, as the classification of male or female is easily identifiable in the medical notes, and can be determined visually (in the majority of cases) without patient documentation. Additionally, gender is a variant within sociological research which is commonly associated with power, as everyday life is arranged and constructed in a way which consistently separates males and females (Holmes, 2009).

There are a large number of studies which have examined the differences in pain perceptions between males and females, not only from a biological standpoint but also from a psychological perspective. Unruh (1996) conducted a systemic review of research studies examining gender variations in pain and concluded that women reported pain of longer duration than men, declared more severe levels than their male counterparts and were at higher risk of developing chronic pain syndromes. Another prominent article by Berkley (1997) explored the literature examining gender differences in pain, and the author concluded that when an experimental somatic pain stimulus was delivered, females declared higher pain ratings and displayed lower pain thresholds and less tolerance to

noxious stimuli than males. However, the author commented that while the changes in somatic stimuli were small, there were differences in communication, coping strategies and hormones which also needed to be taken into consideration. These findings were mirrored in another literature review by Paller *et al.* (2009), who stated that there was a large body of research indicating that women experienced greater pain-related stress, heightened sensitivity and a higher level of catastrophising than men.

Contemporary literature continues to discuss the existence of differences in pain perceptions between males and females. Bartley and Fillingim's (2013) review of clinical and experimental findings from a range of literature examining how gender can impact on pain, stated that pain is more prevalent in women than men that women report it more than their male counterparts and that females exhibit the signs of pain more than the opposite sex. The conclusion that women are affected more than men was also shared by Tocher *et al.* (2012), who found that 64.4% of the 2269 patient participants in their research study experiencing severe and enduring postoperative pain were women. In light of the fact that the total female population of the study was 52.5%, this finding was considered significant. Chapman, Stevens and Lipman (2013) also examined patient-related outcomes across 473 participants and revealed that "worst pain" and "adverse effects from pain" were reported in a higher number of cases of women than men. They recommended that as the difference was only marginal, a change in protocol was not required, and that gender and sex was not to be used a sole predictor of pain. However, they did advocate that awareness of gender differences in pain perceptions needed to be taken into consideration when assessing and managing pain.

In addition to pain, the link between gender and anxiety levels may also need to be considered, as the levels of anxiety experienced preoperatively can also be an exacerbating factor in females. In a study by Carr *et al.* (2006) women reported high levels of anxiety well before admission to hospital for gynaecology surgery. The authors proposed that this could be due primarily to the psychological aspects of the surgery type: gynaecology surgery, for example, being frequently interconnected with fertility and childbearing. Seyedfatemi *et al.* (2014) also concluded in their study examining 191 patients' levels of comfort preoperatively, that women reported more anxiety than men. This study examined variants such as religion, marriage and education, which could also have had a corresponding impact on the levels of anxiety experienced. This reinforced Chapman, Stevens and Lipman's (2013) recommendations that gender alone may not be a sole forecaster of pain and anxiety. However, there is no denying that divergence exists (biologically and socially) in pathophysiology, pathogenesis and manifestation of pain. Therefore, it is necessary for HCPs to consider the role of gender when assessing pain, communicating with patients and prescribing analgesics (Rokyta and Yamamotova, 2013).

2.4 Preoperative preparation

2.4.1 Preoperative assessment

While the main purpose of the preassessment is to ascertain appropriateness for surgery (Pandeva and Shafi, 2011), it can also be the ideal platform for patients to discuss their fears, concerns and anxieties, which can be at a heightened state during the preassessment appointment (Gilmartin, 2004; AABGI, 2010a; Fincher, Shaw and Ramelet, 2012; Doherty and Stevenson, 2016). In addition to ensuring that the patient is emotionally prepared, it is also an opportune moment to make sure that the patient is adequately equipped for recovery (Beck, 2007; Meyr and Steinberg, 2008; Pritchard, 2012). The preparation for

recovery and return to normal functioning should incorporate family support, treatment goals and discharge planning, which especially for day surgery, should commence at the preassessment appointment (Mottram, 2011; Chow *et al.,* 2012). However, due to variations in preassessment clinic protocols, delivery methods (telephone, internet, postal, face-to-face) and time limitations resulting from organisational constraints, not every patient feels that they have had the opportunity to discuss their fears (Gilmartin, 2004). To assist with the designing of day surgery services, a study by Lewis *et al.* (2009) was undertaken to explore which medium of delivery patients would prefer (telephone, internet or face-to-face and when they would want the interaction to take place in the preoperative period. The authors canvassed the views of 138 patients and found that if given a choice, 84% would prefer a preassessment appointment which incorporated face-to-face contact, with a healthcare professional from the department where the surgery would take place. Whilst it could be suggested that as the authors were employed by the hospital trust, they may have a vested interest in this result, the opinions voiced by the participants were comparable to other studies.

HCPs conduct preoperative assessments in which they listen to patients' concerns, document patients' requests and provide information well in advance of the surgery (Jackson, 2009). This in turn permits a suitable period for contemplation (Niemi-Murola *et al.*, 2007). They are therefore key gatekeepers and in a prime position to positively influence a patient's surgical pathway (Gillanders, 2012). This view is shared by Fraczyk and Godfrey (2010) who examined levels of satisfaction with day case preassessment services in the UK. In their 275 patient study they concluded that preoperative assessment must be a reciprocal process, which must also allow for the exchange of information from the patient to a healthcare professional. While the sample was limited to one hospital and

not statistically generalisable, the study did go some way to raising awareness of preassessment practices specifically for day case surgical patients.

2.4.2 Preoperative education

Another benefit claimed in the literature relates to pre-surgical instruction and preparation, which has been found to have a positive bearing on postoperative recovery (Kotrotsiou, Roupa and Papathanasiou, 2004; Hardy, 2012). This can be achieved by providing education to patients which can aid in the reduction of anxiety, increase their ability to cope with the pain, encourage early mobilisation and enhance feelings of satisfaction (Lagerström and Bergbom, 2006; Guo, East and Arthur, 2012; Matthias and Samarasekera, 2012; Sayin and Aksoy, 2012; Kol, Alpar and Erdo, 2013). These views have been echoed in a more recent study by O'Donnell (2015) examining preoperative education in day case elective laparoscopic patients. This study concluded that less pain was experienced for the patients who received educational interventions, resulting in fewer analgesics being administered, fewer side-effects and quicker recovery times. However, there were only 24 participants in this pilot study, and this small number prevents any statistically significant conclusions from being made.

A recent systematic review and meta-analysis by Ramesh *et al.* (2016) reviewing journal articles from 1995 to 2015, including 14 randomised controlled trials (RCT), concluded that while preoperative education was shown to have reduced patients' anxiety, it did not significantly affect pain or length of stay. Even though the review examined a range of articles, it was focused on inpatient cardiac surgery, and the overall quality of the evidence was low, given that the education media used within the studies was varied and only 4 articles examined the effects of education on pain. The absence of a statistically significant

reduction in pain scores was also found in a randomised controlled trial by van Dijk *et al.* (2015) where 477 patients were provided with either a preoperative education film or a hospital information film. Nevertheless, additional encouraging findings of the need for education were found. Patients who watched the preoperative education film had more knowledge and lower barriers to pain management than the control group. Both of these factors had a positive impact on patients' postoperative pain management, as they had a greater awareness of the pain assessment tools that would be used to ascertain their postoperative pain, experienced reduced anxiety and were less fearful of opioids.

Preparation and information provision can, therefore, be considered beneficial, but the extent to which this has positive effects on patient experiences can be impacted by the length of the interaction and HCP's training and perceptions. In a study by Fraczyk and Godfrey (2010), although 80% of the 275 participants thought that the preassessment consultation had prepared them for surgery, some were concerned that the discussion was focused more on what the healthcare professional thought the patient wanted to discuss, rather than on the patients' own agendas. Similar findings were found by Lee and Lee (2013), who examined preoperative teaching conducted by nurses to reduce patient anxiety. They sent a questionnaire to 86 nurses to ascertain nurses' perceptions and practice of preoperative teaching. The results indicated that while 91.9% of the nurses preferred to carry out face-to-face teaching and information sharing, time and tight preoperative schedules were ranked as being the most crucial factor impacting negatively on their ability to provide adequate information. Additionally, some nursing staff perceived the information-providing element of their roles as a minor consideration of the overall patient care. These opinions may have been a consequence of the faster-paced healthcare system, which can result in less opportunity for contact, and reduced time to provide

education and divergence between patient and nurse goals (Sjoling *et al.,* 2003; Bailey, 2010). Literature by Field and Adams (2001) and Brown, McWilliam and Ward-Griffin (2006) concur that in today's healthcare system, education often comes second to patient care, nurses regularly fail to espouse client education and patients frequently only learn about pain control measures from non-healthcare professionals.

Similarly, preoperative education is not standardised or clearly defined within preassessment processes, and is often an afterthought, ad hoc and dependent upon the expertise and education of the nurse (Fitzpatrick and Hyde, 2006). The NMC (2018) stipulates that to provide information and education, nurses must possess the current evidence-based knowledge and be adequately trained in health education activities. The nurse must also possess a variety of communication skills, as education and information should be delivered in a language that suits individual need and ought to be offered in a way that reduces levels of anxiety (Berg *et al.,* 2006). What must also be considered is that the retention of information by patients can be impeded by fear and anxiety, especially in patients with low health literacy, as they often fail to ask for clarification and assistance to preserve self-respect and dignity (Humphreys, 2005; Dihle, Bjølseth and Helseth, 2006). Forsberg *et al.* (2015) further state in a study evaluating the care of 170 patients, that patients want the information personally tailored and surgery-specific. It has therefore been suggested that preoperative assessments conducted be anaesthetists and nurses should incorporate education which can be provided to carers and family members, especially for day case surgical patients, as this could have an additional positive correlative effect on reducing postoperative pain within the acute period (AAGBI and BADS, 2011a; 2011b; Grondin, Bourgault and Boluc, 2012; Jackson, 2012b; Key and Swart, 2017).

2.4.3 Agency, empowerment and partnership

Preoperative education could also succeed in achieving enhanced satisfaction and overall positive psychological recovery, by encouraging patient engagement (Walker, 2007). Patients who have been provided with education are more aware preoperatively, feel empowered and possess a greater sense of agency, which reduces their stress, and increases their positive attitude (Johansson *et al.,* 2005). Preoperative fear and anxiety, which can result from lack of agency, control and understanding, is therefore reduced if HCPs provide patients with more information, aid in their empowerment and allow them to play a greater role in their care (Walker, 2007; Dunwoody *et al.,* 2008; Cousins, 2009; Patil *et al.,* 2017).

Pain levels can also be positively affected by increased levels of empowerment, which is a benefit suggested in a recent study by Collette *et al*. (2016). They conducted a controlled interventional study examining the effect of empowerment on pain levels following 91 gynaecology oncology surgeries and found that patient empowerment significantly reduced postoperative pain (P=.01), particularly on the first day of recovery. As the sample size was small for a study of this design and only included women, a broader study including men would be warranted in an attempt to corroborate these results further. However, the authors' recommendations that patients have the right to be involved in their care is supported by a wide range of sources. It would, therefore, seem reasonable to state that patients should be treated in an environmental culture which fosters patient partnership and offers them the opportunity to exert influence over their own care (Weiner, 2003; The American Society of Anaesthetists Tack Force on Acute Pain Management, 2004; Finney, 2010; Hanna *et al.,* 2012; Levitt and Ziemba-Davis, 2013; Andersson, Otterstrom-Rydberg and Karlsson, 2015). This can, of course, be challenging at times, as some patients may

refrain from making a decision or taking control, preferring to remain passive in their care, continuing to be informationally ignorant and disempowered (Davies and McVicar, 2000; Oshodi, 2007). Mitchell (2000) explored psychological preparation for patients undergoing day surgery and concluded from the results that because individuals require varying levels of information, preoperative preparation must be tailored to suit the needs of the patients. The author expanded this view further by creating three information pathways for the passing of information depending upon the patients' level of self-efficacy. Education and information should therefore be personalised and adapted to allow for patients who have an external locus of control and low self-efficacy as they believe they have no control over outcomes (Tooth and McKenna, 2006; Shelley and Pakenham, 2007).

2.4.4 Pain plans

Davis *et al.* (2014) surveyed 68 patients to explore and examine what information patients require during the preoperative periods. This study revealed that one of the most frequently stated needs was information on how pain was to be managed. One strategy identified incorporating education and patient partnership was the use of pain plans. This was proposed by Martin, Kelly and Roosa (2012) who examined how pain outcomes could be improved by using a multidisciplinary and documentary approach. They formulated and evaluated a pain management plan, in the form of written charts, accessible by all HCPs, as well as the patients themselves. They concluded that patients felt less anxious about pain and more empowered when these written charts were used. Unfortunately, within the literature, there is limited information and research specifically examining the use of pain planning documentation preoperatively.

One area of healthcare which has successfully demonstrated the value of documented pain plans however, is obstetrics (Anderson and Kilpatrick, 2012; Whitford *et al.,* 2014). Birth plans, which were formally introduced in the UK within the 1980s, have been shown to improve the effectiveness of communication as they prompt pain management discussions prior to labour and are therefore a useful tool to raise awareness of pain expectations (Hidalgo-Lopezosa *et al.,* 2013). They are also a reliable and effective means of encouraging an open dialogue, which takes into consideration the women's personal preferences (Welsh and Symon, 2014). It is suggested by Whitford *et al. (*2014) in their study examining the use of birth plans, that these plans, rather than impacting on the levels of pain experienced (which can be varied), can have the beneficial effect of enabling women to feel a higher sense of agency and control during labour and birth; a period within the childbirth continuum where women may not be in a position to clearly express their pain management preferences to each healthcare professionals, especially when medical intervention is required. In an attempt to evaluate more than one perspective, this study examined not only the opinions and perceptions of 42 women, but also 24 maternity staff. This resulted in a more balanced view of the use of this document and raised awareness of some of the barriers to adequately using this document, such as time. If used appropriately, birth plans can be an excellent example of how to tailor pain planning, as women during childbirth experience pain at varying levels and the requirements for analgesics vary widely depending on the extent of medical intervention required during the labour process (Impey & Child, 2012). The use of birth plans is therefore supported as they enable the facilitation of partnership working and 'provider-patient communication' regarding labour and birth expectations, as well as increased understanding of the patient's psychological milieu (Bailey, Crane & Nugent, 2008). These plans (which are kept in the patient records) should not just be a tick box exercise, as this has the potential to lead to

idle assessment and management of the women's pain and a skewed analysis of the women's true wishes (Nolan, 2011). It would seem, therefore, that lessons can be learned from the world of obstetric practice about how pain planning is documented.

2.4.5 Preemptive analgesia

Within the realms of preoperative preparation, the administration of preemptive analgesia has been introduced within the UK and in some hospital trusts, is considered routine practice (AAGBI and BADS, 2011a). However, the concept of providing pain control before surgery is not new and was first recognised by George Crile in the 1910s, but despite this early inception, throughout the subsequent decades, it was slow to transcend practice (Penprase *et al.,* 2015). Now, preemptive analgesia incorporates educating patients about the benefits of taking prescribed medications before surgery as well as administering said medication (AAGBI and BADS, 2011a). This would generally include a range of analgesics from paracetamol and non-steroidal anti-inflammatories, to opioids depending upon patient and surgery specifics and have been shown to have a positive effect on reducing peripheral and central sensitisation (Penprase *et al., 2015*). Moore *et al.* (2011) recently examined the effect of preemptive gabapentin by undertaking a randomised controlled trial with 46 participants undergoing abdominal surgery. It was concluded that pain scores after 24 hours were significantly lower for those who had been prescribed preemptive analgesia. While the number of participants in the aforementioned study can be considered low for an RCT, the findings are echoed by Al-Azawy *et al.* (2015) who conducted an RCT with sixty participants, exploring the effect of premedication for reducing pain intensity. They concluded that analgesia administered before surgery reduces pain intensity and increases overall patient satisfaction, especially when it is undertaken in conjunction with patient education. Similarly, a study by McCloud, Harrington and King

(2014) examining preemptive pain management protocols from 100 patient audits and 9 in-depth qualitative interviews, concluded that pre-emptive strategies not only reduce the need for postoperative breakthrough pain relief requirement but improve postoperative self-care and overall recovery.

2.5 Perioperative practice and culture

Despite clear recognition that education and patient empowerment significantly improve patients' health experiences, a gap exists between pain treatment and optimal successful management (Gan *et al.,* 2004; Richards and Hubbert, 2007). There could be many reasons for this, from both an agency and structure perspective. Therefore, for this thesis, it is essential that the current literature on perioperative culture and individual practice is examined and explored further.

2.5.1 Safety culture

A fundamental ethical principle within healthcare is that HCPs do no harm (Jackson, 2012a). Despite this, safety culture has only become a prominent feature within the healthcare industry since the 1990s. It has grown in terms of theoretical understanding, due to raised public and media awareness in the wake of recent public enquiries such as the Francis Report (2013), which brought patient safety to the forefront (Fisher and Scott, 2013). One of the most current influential sources of information regarding safety management, is the white paper by Hollnagel, Wears and Braithwaite (2015). It provides a comprehensive overview of how our understanding of harm and the complex nature of healthcare practice and patient safety has shifted. The authors claim that there has been progressive movement in considering how safety lessons can be learnt, from unpicking single characteristics (technological or human failure) which have created an error (the

Safety-I view) to a deeper appreciation that care is more complex and an error can, more often than not, never be attributed to one isolated cause (the Safety-II approach). In essence, rather than viewing harm from a black and white perspective, they advocate a move towards also embracing all that is grey, as success is a result of the complex interplay between human performance and the spontaneous reactions and adjustments that are needed to match the unique situation. For patient safety culture to be most effective, both approaches, therefore, need to be adopted (Hollnagel, Wears and Braithwaite, 2015).

When examining the literature, there is a wealth of information and research on the benefits of adopting a safety culture within the perioperative department, as all surgical procedures have elements of risk associated with them (Gillespie *et al.,* 2013). Latest figures from England suggest that there is still an unacceptable number of errors, with 496 serious incidents being recorded in 2018/19 (NHS Improvement, 2019). However, due to the high level of iatrogenesis in surgery, patient safety poses a significant global problem (Bleakley, Allard and Hobbs, 2012) and the World Health Organisation (WHO) (2019) claim that almost 50% of adverse events in patients who are in hospital are related to surgical care. Consequently, as patient safety is "at the heart of quality care" (Fisher and Scott, 2013, p.6) a culture of safety should be paramount, fully embraced and something that every member of staff within this environment needs to strive for (Crichton, 2008 Rawling, 2012; Huang, Kim and Berry, 2013; Reckless *et al.,* 2013; NHS Improvement, 2017).

The WHO in 2009 recognised that there needed to be a more cohesive global strategy to increase patient safety during surgery. This was achieved by observing the common issues and risks within perioperative departments, including infections, anaesthetic practices and

communication, and implementing a simplified and systematic process for reducing these errors (Gilmour, 2012; McArthur, 2012). This process was called the safe surgery initiative, and one specific element which was found in the literature related to the use of documentation and checklists. These checklists have been shown to improve outcomes in surgery and reduce morbidity and mortality, by standardising care, strengthening safety processes, aiding memory recall and supporting open communication (Fisher and Scott, 2013; NHS England Patient Safety Domain, 2015; WHO, 2019). They have also been produced in a range of languages and can be adapted and tailored to meet the specific needs of healthcare institutions. This has led to integration and implantation of the WHO surgical safety checklist, which is now considered mainstream practice, into the majority of perioperative departments within the UK and across the globe (National Patient Safety Agency (NPSA), 2009; Lord, 2014; WHO, 2019).

Regrettably, as safety was the main driver for the checklists creation, pain planning and management were not addressed within this document. As such, there are no global standardised documents associated with pain planning and management. This is despite the fact that pain documentation can be utilised to increase the visibility of patients' pain, assist with uniquely tailored pain care plans and enable the transfer of information to all HCPs involved in the patient's care (Abdalrahima, Majali & Bergbomc, 2008).

2.5.2 Teamwork culture

The actions of individuals and the ways in which professionals relate to one another are also of paramount importance within perioperative care. The NMC (2018) states that nurses and midwives must work cooperatively with teams and others as care is not delivered by one healthcare professional alone (Reeves *et al.,* 2010). Therefore, teamwork

has gained increased attention from researchers and policymakers, as how practitioners communicate and work with one another is central to increasing a safety culture (Reeves *et al.,* 2010; Gillespie *et al.,* 2013). Moreover, in order to ensure that patients' pain is managed effectively, it may be necessary to work with other professionals. Consequently, it has been suggested that perioperative care is most effective when there are 'expert teams' rather than 'teams of experts', as changes in cultural practices cannot be influenced and shaped by one professional alone (Bleakley *et al.,* 2006; Watt-Watson, Siddall and Carr, 2012).

Teams are more than a collection of staff who work within the same department, but an assembly of staff with specific qualities and characteristics, that set them apart (Goodman and Clemow, 2010). Two approaches to teamwork that are referred to within the healthcare literature are multiprofessional and interprofessional. These approaches are sometimes used interchangeably but are very different in terms of their characteristics and qualities. The interprofessional approach is discussed later, however, multi-professional relates to a diverse group of professionals who may be involved in a patient's care, who often work within parallel hierarchal lines and have high levels of autonomy but may not directly collaborate or communicate with one another (Goodman and Clemow, 2010; Körner, 2010).

One area of perioperative care that has seen multidisciplinary working thrive is the 'enhanced recovery after surgery' (ERAS) care pathway (Rooth and Sidhu, 2012). This is now one of the most up-to-date anaesthetic practices, and many hospitals have integrated this approach for a wide majority of their more complex surgical procedures (Lombardi, Berend and Adams, 2010; AAGBI and BADS, 2011b; Kehlet, 2011; Hayes and Gordon,

2015). This approach is employed in an attempt to improve recovery from a quality, safety, patient satisfaction and cost perspective, through the use of multimodal and multiprofessional approaches (DOH, 2010). Additionally, it enables care to be delivered throughout the perioperative care continuum with a view to reducing physiological stress responses and anxiety, increase social and emotional preparation, recovery expectations and promotion of normal activities, such as eating, drinking and mobility (Husted *et al.,* 2011a; Husted *et al.,* 2011b; Jackson, 2012b; Lucas *et al.,* 2012; Rooth and Sidhu, 2012; Saver, 2013; Fecher-Jones and Taylor, 2015; Crosson, 2017). Despite the fact that AAGBI and BADS (2011b) claim that these enhanced recovery approaches are an adaptation of practices originating from day surgery, these multi-professional and multimodal approaches have primarily been reserved for more invasive and complex surgeries, and therefore there is a concern that procedures which are minimally invasive and classified as routine, are being marginalised and overlooked (Foss and Bernard, 2012).

Multiprofessional teams can go some way to assisting with pain planning and management; however as the level of collaboration within multi-professional working is limited, repetitions or omissions of care can often occur. Therefore, it may be more appropriate within the perioperative department to work inter-professionally, as it is not the sole responsibility of the nurse, or the anaesthetist to open up the pain conversation (Rosser, 2014). It is the responsibility of all staff working within the perioperative services to ensure that patients' pain is minimal and well managed, in order to accelerate the rehabilitation of bodily functions and escalate the rate of recovery (Mann and Carr, 2006; Breivik and Shipley, 2007). Phillips (2017) likens the perioperative care team to a symphony orchestra in order to highlight the importance of not only the final result, which is usually a safe and successful surgery but also that the end result would not be possible

without the unique talents of each member of the team, and that these members need to work harmoniously. Thus within perioperative care, there has also been a move from multi to inter-professional working (Bleakley *et al.,* 2006; Cousley and Martin, 2016).

Interprofessional working involves staff from various professions not working independently to achieve one goal, but collaboratively, cohesively and collectively with a higher degree of communication than multiprofessional working (Goodman and Clemow, 2010; Körner, 2010). It is therefore fundamental for good effective practice (Rose, 2011) and is an approach to team working which was first recognised in 1978 as being central to safe and effective care (WHO, 1978). Furthermore, in an attempt to improve the postoperative pain outcome of patients, many hospital trusts have employed acute pain teams, incorporating nurses who work alongside anaesthetists, to augment personalised perioperative pain plans (Tung *et al.,* 2012; Duncan and Haigh, 2013). However, even though professionals are often working to achieve the same goal, tribalism, stereotyping and professional barriers sometimes exist within the workplace, and these must be overcome if effective care is to be achieved (Molyneux, 2001). In some cases, hierarchy and power can hinder effective communication within the perioperative environment, as some staff may be reluctant to speak up and voice opinions (Atwal and Caldwell, 2005). The lack of respect for professional boundaries may also lead to daily conflict, which further reduces multidisciplinary team effectiveness (Coe and Gould, 2008; Gardezi *et al.*, 2009; Unruh, Strong and Van Griensven, 2014). Consequently, there is a plethora of literature examining some of the factors which can influence HCPs' practice, from both a structure and an agency perspective. Some of these studies will now be explored in greater detail to highlight some of the cultural practice around pain and surgery.

2.5.3 Anaesthetic practice

HCPs caring for day case surgical patients are themselves unique individuals, each with varying levels of agency, and this may have a bearing on interactions with patients. It can also be said that most interactions that occur within healthcare settings involve a degree of power (between agency and structure) and this can influence relationships, decision making, knowledge transfer and communication (Mahon and McPherson, 2014). In an attempt to explore patient satisfaction within day surgery, Williams, Ching and Loader (2003) asked 107 patients to complete questionnaires which examined specifics such as pain management, decision making and education from a qualitative and quantitative perspective. Whilst care was rated at a minimal level of good the qualitative data revealed that some participants felt that the quality of communication skills demonstrated by medical staff was poor and this was of concern, especially during day case surgery. Participants from the study also stated that the preoperative visit by the anaesthetist was usually brief, that there was a lack of sensitivity displayed, and that medical staff appeared uncaring and unfeeling, all of which impeded the transfer of information and reduction of preoperative anxiety (Williams, Ching and Loader, 2003).

Shoqirat (2013) echoed this opinion in their study exploring patients' experiences of pain management. This study utilised focus groups and involved 31 participants. It found that patients were not well informed, did not feel valued, and were treated in a mechanistic way. This automatic and impersonal approach may have occurred as, historically, the type and amount of analgesia were very much dependent upon the procedure and therefore anaesthetists and other HCPs became culturally conditioned, to group patients' levels of perceived pain by surgical typologies (Kim *et al.,* 2005; Klopper *et al.,* 2006; Lauzon-Clabo, 2008). It was also suggested that paternalism could be found in perioperative

practice, as perioperative pain management remained predominantly medically controlled, with most anaesthetists taking control of patients' pain treatments (Powell *et al.,* 2004; Burrows and Taylor, 2009). In a study examining the barriers to anaesthetists using regional techniques for analgesia, Boyd *et al.* (2006) stated that clinical preference and time played a significant role in decision-making processes, as the discretion for which type of anaesthetic and analgesic to be utilised was ultimately placed squarely on the shoulders of the anaesthetist and this was primarily influenced by time in 38% of the 46 anaesthetist participants. Coll and Ameen (2006) who conducted a postal survey with 785 participants, supported this view, suggesting that anaesthetists did not always have adequate time embedded within their workload or theatre list, to allow for an extensive assessment of daycare surgical patients.

Time, and the structural constraints imposed by the organisation can therefore be a factor in limiting the level of agency, as preoperative visits often fail to provide patients with adequate time to make an informed decision (AAGBI and RCOA, 2008) and some patients do not even see the anaesthetist until they are actually in the operating theatre (Kazi, 2010). To address this, theatre lists and operational scheduling should be altered to ensure that the preoperative visit takes place (AAGBI, 2010a): especially, as the preoperative visit is, for most patients, the first opportunity for them to speak to the actual anaesthetists who will be responsible for their perioperative care (Frame, 2015). However, Bailey, Crane and Nugent (2008) suggest that routine and ritualistic practice, which is sometimes in opposition to the policy, can often remain the dominant practice within some cultural environments.

This ritualistic practice can also be reinforced by the anaesthetists own personal beliefs and views, and therefore anaesthetic staffs' experiences and opinions have a significant role to play in how they deliver care and make clinical decisions (Unruh, Strong and Van Griensven, 2014). These views can be positive and may reinforce partnership, or conversely, they may have a detrimental impact on the quality of care. Breivik and Stubhaug (2008) state that some anaesthetists believe that acute pain is short-lived and will resolve over time and that this significantly influences how they treat and manage acute postoperative pain. Additionally, due to fear of opioid addiction, litigation and respiratory depression, some medical professionals avoid prescribing opioids and pass over the responsibility for pain management to others; this can include not only the nurses who traditionally spend the most time with patients but also the patients themselves (Brockopp *et al.,* 1998; Layzell, 2008).

2.5.4 Nursing practice

Nurses are the frontline force of the NHS, and as such are ideally situated to assist patients with goal setting and pain management strategies (Carr, Layzell and Christensen, 2010; Rejeh and Vaismoradi, 2010). Nevertheless, while recognising patients' individualities, we must also acknowledge that nurses' practices can also be influenced by the practice environment and unique values and beliefs (Mann and Carr, 2006; Layzell, 2008; Strong and Van Griensven, 2014). Through the use of ethnographic research methods, Lauzon-Clabo (2008) concluded through observations of practice on two postoperative units, that nurses' treatment of pain was directly influenced by colleagues' cultural beliefs, work ideals and the social context of the ward. Hence, healthcare practitioners conform and alter their practice, often as a result of the persistent nature of repetitive practices (Mee, 2013).

One area where this has been demonstrated within anaesthetic and nursing research is in relation to surgical typologies (Mann and Carr, 2009a). Past experiences have been shown to dictate nurses' assumptions, and experienced nurses will often inappropriately define their patients' pain in terms of illness trajectory, diagnosis and disease aetiology. This, in turn, results in patients' levels of pain being underestimated, as nurses compare their pain with previous patients (Kim *et al*., 2005; Klopper *et al*., 2006; Lauzon-Clabo, 2008). Even patients themselves often make comparisons between their levels of pain with patients who have had the same or similar surgeries (Wikström *et al.,* 2014). Therefore, it is erroneous to treat patients identically after indistinguishable surgeries, as no two people experience pain in the same way and it may be misguided to assume that postoperative pain should be equal to the extent of the tissue damage inflicted (Özalp *et al*., 2003; Mann and Carr, 2006; Marton and Ambrose, 2007; Vigeyen, Crombez and Goubert, 2007). More importantly, nurses may hold other personal beliefs, values, perceptions and biases, which may be in contrast to patients, and this can often lead to misinterpretation of patients' accounts of pain (Arber, 2004). Thus, the context of care has a major role to play in patient pain management and can have an adverse bearing on the management and assessment of patients' pain (Young and Davidhizar, 2008; Unruh, Strong & Van Griensven, 2014). Mann and Carr (2009a) claim that inappropriate attitudes and beliefs can impede care, as nurses who inherently believe suffering is negative, will strive to alleviate pain at all costs. While those that believe pain is positive and that suffering in silence is noble will ignore patients pain, inferring that it must be endured as it builds character and ensures psychological growth (Brockopp *et al.,* 1998; Buglass, 2007). Therefore, some nurses, and consequently patients, are conditioned to believe that pain is a natural consequence of surgery and should be expected (Layzell, 2008; Mann and Carr, 2009a; Rejeh and Vaismoradi, 2010).

In a recent study by Mackintosh-Franklin (2014), they examined whether nurses' responses had a bearing on how they managed patients postoperative pain. They deduced from 16 nurse interviews, that nurses normalised pain, claiming that pain was to be expected. This theme was evident in all participant interviews and can, therefore, be seen as a substantial finding, which in turn could have a bearing on emotional desensitisation and reduced empathy towards patients. The authors also found that the pain management strategies used for all participants were very medical, and focused mainly on pharmaceutical interventions rather than non-pharmacological approaches to pain management, such as music and distraction therapy. Another interesting finding in relation to pain management was in a study by Schreiber *et al*. (2014), who explored the attitude of nurses and how they assessed and managed patients' postoperative pain. One of the main findings was that patients who were suffering from less physical signs of injury were often not attended as well as patients with visible physiological conditions. This suggests that surgical typologies and nurses' assumptions of the physical trauma associated with specific surgeries, have a direct bearing on their pain assessment and management approaches.

These beliefs are often heavily reinforced by organisational practice and the culture of the working environment (Manley, 2004; Fitzpatrick and Hyde, 2006). In terms of the influence of structure on nurses' sense of agency, Gregory and Waterman (2012) and Wikström *et al.* (2014) found within their studies examining nurses' pain assessment and management practices, that due to competing demands for time and the complexities of the specific clinical practice environment, nurses needed to prioritise care. This impacted on their clinical assessment and management of patients' pain, as they often found themselves in the position of not having the time to explore pain with their patients fully. More importantly, it was found by Manias, Bucknall and Botti in their 2005 research study

involving the observation of 52 nurses as they managed patients' postoperative pain, that nurses were overtly aware of time pressure, but despite this knowledge, still stated that discussing all pain options was unachievable within the constraints of their practice schedule. However, a study by Rejeh and Vaismoradi (2010) exploring patients' perspectives of pain management, stresses that organisational constraints and workload demands, which are often highlighted as being negative impact factors on nurses' ability to manage perioperative pain, should no longer be used as an excuse. Therefore, nurses must take personal responsibility for the care they provide despite their perioperative cultural work practices (Mee, 2013).

Another aspect of practice that impacts on patient care is the level of knowledge that underpins nurses' practice, especially regarding pain assessment tools, analgesia and pain management (Young, Horton and Davidhizar, 2006; Finney, 2010; Berg, Arestedt and Kjellgren, 2013). A report by Keogh (2013), highlighting the areas of concerns within a failing hospital, stated that there is a real concern that some staff are not practising with up-to-date evidence. This is echoed in a study by Al-Qadire and Al-Khalaileh (2014), who concluded after investigating nurses' knowledge and attitudes regarding postoperative pain management, that nurses' lack of knowledge and previous exposure to pain education was a barrier to effective pain management. This study, which included 211 nurses from 4 different hospitals, also exposed a discrepancy between attitudes and practice, as nurses, while recognising that the patient was the authority on their pain, would encourage them to tolerate the pain, or would regularly administer placebos.

Lack of knowledge and education have also been reported to be contributory factors to patients receiving inadequate levels of analgesics (Macintyre and Schug 2007). It has been

found by a wide variety of research studies that both medical and nursing staff regularly administer less medication than prescribed, and titrate drugs ineffectually, often as a result of lack of knowledge and education (Schafheutle, Cantrill and Noyce, 2004; Manias, Bucknall and Botti, 2005; Mann and Carr, 2009a; Rognstad *et al.,* 2012; Tse and Ho, 2014). To address this problem, it may be appropriate to review pain education within healthcare institutions, as implementing an educational programme can enhance the effectiveness of perioperative pain management and may be useful in increasing not only knowledge but also changing attitudes (Briggs, Whittaker and Carr, 2009; Abdalrahim *et al.,* 2011).

2.6 Summary

We have seen, through examining the literature, that a holistic preoperative assessment and anaesthetic visit have been shown to be valuable interactive communication opportunities to initiate and encourage discussion around some of the issues that may impact on patients' levels of pain (Fincher, Shaw and Ramelet, 2012; Matthias and Samarasekera, 2012). These have the potential to pre-emptively reduce some of the risks associated with increased development of postoperative pain, by addressing psychological well-being through pain exploration and education, while enabling and encouraging patient empowerment and levels of agency (Guo, East and Arthur, 2012; The Health Foundation, 2013). Yet, due to the extreme multifaceted nature of pain and how it currently exists within a patient population with complex healthcare needs, there is an increased requirement for HCPs to carry out preoperative assessments that are more comprehensive, in order to ascertain patients' experiences of pain (Dewan, Zhang and Xia, 2012; Grondin, Bourgault and Boluc, 2012).

Additionally, while there is an abundant array of literature on the culture of the perioperative environment (*see diagram 3, page 57*), these are primarily focused on intraoperative care and ERAS for major surgeries. The research studies examining the values, beliefs and attitudes of HCPs are also, in part, about postoperative pain management and therefore, there is a real concern regarding the extent to which nurses and anaesthetists discuss pain preoperatively with patients undergoing day case surgery (Dykstra, 2012). Therefore, in order to improve current practice, there needs to be an exploration of the contextual, cultural and organisational complexities of providing perioperative care for day case surgery patients (Grant, Sueda and Kaneshiro, 2010).

Chapter 3

Research Framework

3 Research framework

3.1 Introduction

Pain planning and management is a complex process that can be influenced by both the patient and the practices of the HCPs caring for them during their perioperative care continuum. However, attempting to understand what occurs in practice and underpin the reasons why, are not straightforward. Due to the multifaceted nature of enquiry, this chapter will provide a justified rationale for the choice of methodology and articulate how the research framework is constructed and formulated. It begins by providing background information on paradigms and methodology, before moving onto the reasons for adopting a transformative paradigm and a critical ethnographic methodology. Critical ethnography is then examined in detail, and the conceptual and theoretical frameworks are explored in greater depth. A diagram illustrating the overall research paradigm is included and can be found on *page 95 (figure 4).*

3.2 Research paradigms

Throughout the research process, researchers need to be cognisant of the way in which they see the world (Creswell, 2014). This worldview not only needs to be understood, but also defined and articulated to others and this can be achieved through the recognition and verbalisation of the philosophical assumptions held by the researcher (Mertens, 2012). These philosophical assumptions which underpin the research paradigm include ontology, epistemology, and methodology. Ontology relates to the theory of social entities, the study of being and the nature of what constitutes reality (Mertens, 2010; Walliman, 2016; Gray, 2018). Epistemology is outlined as the relationship between the researcher and reality, and how the specific version of the reality under investigation is known and accepted in the context of the study (Mertens, 2007; Punch, 2014; Walliman, 2016).

Methodology relates to the methods that are employed in order to investigate the reality under examination (Punch, 2014).

Due to the evolutionary nature of human existence, there has been considerable debate over the last fifty years, between social scientists about research paradigms and the associated philosophical assumptions (Scambler, 2002; Calhoun *et al.,* 2012). There has also been a significant movement regarding the thinking around how reality is constructed within a social context, with the recognition of new philosophies that have birthed from the traditional opposing paradigms of positivist and interpretive. These new paradigms can often supersede or are overlaid onto existing paradigms, so multiple versions frequently coexist (Costley, Elliott and Gibbs, 2010). For critical ethnography, the debate is still ongoing as there is not one true paradigm aligned with this methodology.

When examining examples of critical ethnographers, an array of paradigms are demonstrated, and it is impossible to describe all the philosophical assumptions of every critical ethnographer, as individual perspectives change over time (Foley, 2002). Additionally, the exact paradigmatic approach is not always clearly evident in the research, as many authors do not explicitly define their epistemology and ontological stance, which adds to the confusion and debate. However, two of the paradigms that are often associated with critical ethnography studies are interpretative and transformative.

3.2.1 Interpretative paradigm

Interpretivism is the philosophical stance of seeing the social world as inherited by humans and as such, there is a belief that the associated interactions between individuals can only be fully understood when they are investigated within the real-world context in which this

interaction takes place (Parahoo, 2014). For this thesis, the phenomenon of preoperative pain planning and management needs to be examined via the medium of observing the culture of the clinical environment, and how this culture influences the pain planning interactions. More importantly, this needs to be viewed through a philosophical lens that appreciates that real-world practices are unequal; thus, the interpretative view does not go far enough to help explore issues in power.

3.2.2 Transformative (criticalist) paradigm

This approach arose in the 1980s and 1990s from post-positivist researchers, who felt constricted by the structural laws of their research paradigm and thus in an attempt to encourage individuals to think differently and examine social inequalities, utilised critical theoretical perspectives, with a view to challenging the status quo (Creswell, 2014; Romm, 2015). The transformative paradigm moves the interpretive paradigm forward by sharing some of the ideals from critical theory (Parahoo, 2014). Combining both interpretive and critical theory approaches enables findings from the research data to represent reality as closely as possible, while additionally examining the dynamics of power (Mertens, 2012). As such, a transformative paradigm using critical theory is, therefore, a progressive paradigm, with philosophical assumptions that social structures are reproduced by actions that are often constraints by other (ontology), that knowledge is not neutral and thus often used to maintain status quo (epistemology) (Costley, Elliot and Gibbs, 2010). As a result, a critical theoretical approach is often associated with research grounded in examining social inequalities (Benton and Craib, 2011) as it challenges the taken for granted ways of knowing and asks not what, but why, and who benefits? (O'Leary, 2014).

3.2.3 Paradigm rationale

When considering some of the other ontological and epistemological approaches, a research epistemological stance focusing solely on post-positivism would not be congruent with this study, as it does not complement studies examining power. Additionally, a constructivist approach, which encourages participants to construct knowledge from their own experiences, will not assist with changing the status quo, as individuals are not always aware of inequalities that impact on their lives. Consequently, in an attempt to address the research question and really understand the undercurrent of power and inequality, the practice needs to be investigated using a more transformative paradigm, utilising a criticalist theoretical standpoint. The research paradigm is fully illustrated in *figure 4, page 95.*

3.3 Methodology

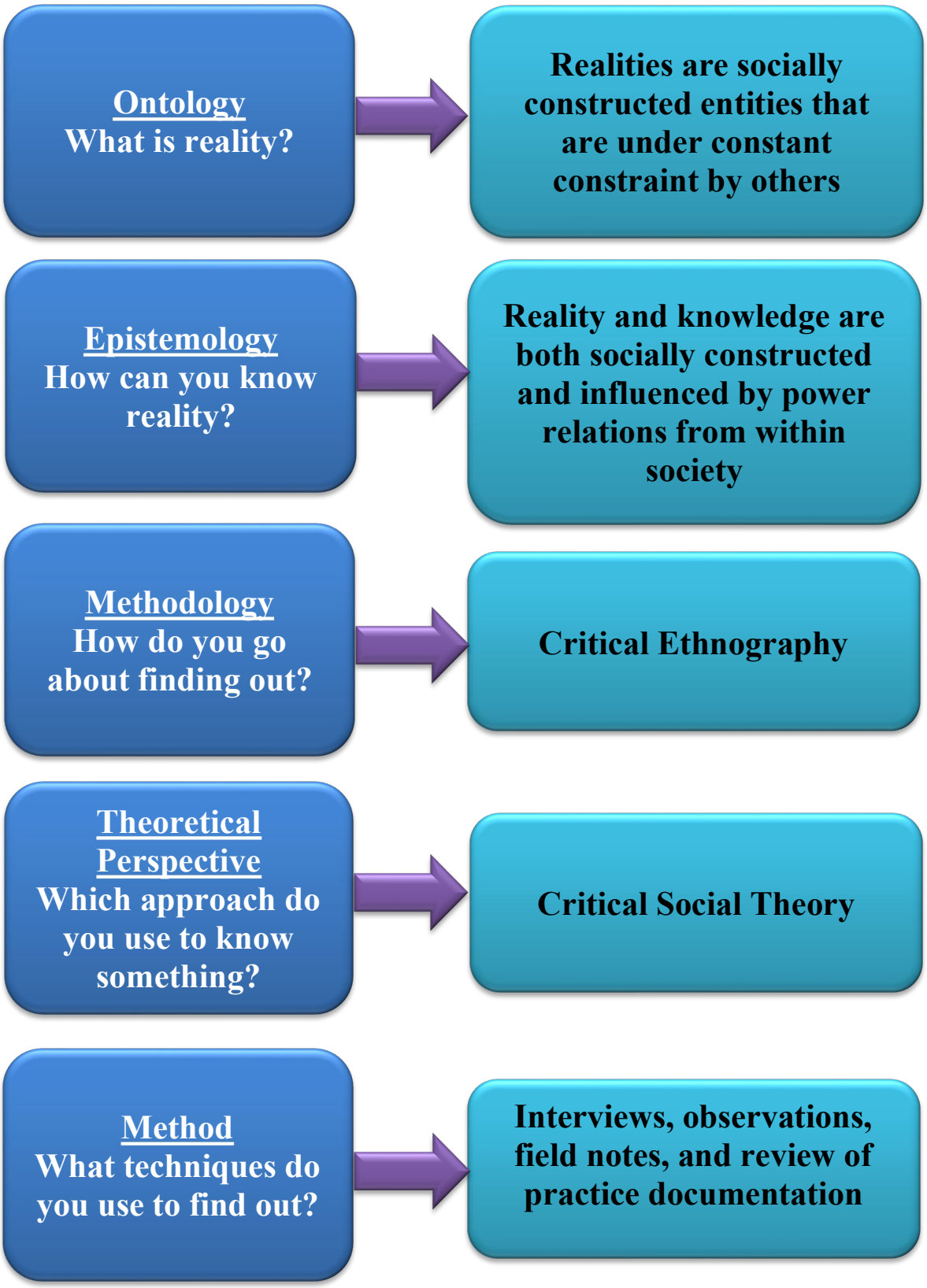
As demonstrated in the diagram above, after confirming the ontological and epistemological stance, it is also necessary to identify the methodological approach that is to be adopted. While the theory is the inspirational muse, it is the methodology which acts as the real conduit for a safe and successful research journey (Madison, 2012). Therefore, once a transformative paradigm is chosen, the option for the choice of methodology is narrowed further, by virtue of the philosophical orientation (O'Leary, 2014; Gray, 2018). The methodological options considered include ethnography, phenomenology, mixed methods, action research, case study and grounded theory.

In order to explore and examine the aims and objectives, with limited bias and the use of inductive reasoning and processes, a preconceived hypothesis is not warranted. Whilst grounded theory may be a suitable strategy to adopt, it is often grounded in the views of

the participants (Creswell, 2014). Correspondingly, due to the need to understand the meaning behind the observed culture and examine relationships within a specific realm of practice, phenomenology is not suitable as this research needs to go beyond describing the phenomenon from the participants' perspectives (Kahn, 2011).

Neither is action research the best approach to adopt as this is more closely suited to studies that include the participants and as one of the aims of the study is to observe and explore the unconscious practice of participants, participatory methodologies are not appropriate (Punch, 2014). Whilst using a case study methodology may have been an option for this study, as observation and context are inherent within the approach, this methodology is more suited to providing a thick description and often requires the researcher to spend extended periods of time within the field (Green and Thorogood, 2014). Lastly, while mixed methods are being increasingly used to understand complex social issues, the focus of this thesis is to examine culture and therefore the primary driver for the research methodology must be ethnography (Creswell and Poth, 2018).

Figure 4: Research paradigm



3.3.1 Ethnography

Ethnography from 'ethno', meaning people or folk and 'graphy', relating to the study of something (Punch, 2014). This method originated in the early 20th century, with traditional social anthropology, which was created and advanced by well-respected researchers, such as Bronislaw Malinowski and Margaret Mead, as a means of studying cultures and societies that were not their own (Madden, 2017). Both Malinowski and Mead spent most of their research career studying Oceanic cultures, by and large, as a direct result of the consequences that emerged from Britain's colonisation of other countries. Thus, this form of investigating the social world became very popular as it enabled the researcher to acquire cultural knowledge of other colonies, by observing, exploring and analysing ways of living and working (Lee and Zaharlick, 2013).

As the world has evolved, so too, have the research techniques that are used to try and make sense of this new realm, and ethnography is no different (Parahoo, 2014). This methodology has undergone significant change over the last seventy years and is no longer limited to exploring the past, or the culture of far off places, but now also embraces examination of contemporary culture, which can be within the researcher's back garden and very familiar, or related to cultural organisations which are inherent within modern society, such as education and health (Punch, 2014). Therefore, in the 1970s the term ethnography was expanded to include qualitative studies where observation of organisational or sociological structures, within researchers' own culture and practice are undertaken (Flick, 2014; Gray, 2018). As such, ethnography is now a popular naturalistic and interpretive methodological approach within nursing and can reveal insights into the work practices of a variety of healthcare environments (Atkinson, Delamont & Housley, 2008; Baumbusch, 2011; Green and Thorogood, 2014).

For this research, I concluded that ethnography was the most appropriate methodology to observe the real-world practices of nurses and anaesthetists. It allows for exploration of how healthcare practices are shaped by beliefs, habits, traditions, values and experiences, and how these are interrelated and moulded by the cultural knowledge of the working environment (Green, Skukauskaite and Baker, 2012; Edmonds and Kennedy, 2013). Moreover, this methodology can be beneficial when the research questions are vague, broad and multi-dimensional, and may additionally allow for the uncovering of new and unexpected practices, which can then be explored and locally explained (Madden, 2017). The approach historically involved the researcher spending a prolonged period of time immersed in the culture and environment being researched, watching and building relationships with the participants, to construct thick descriptive sociocultural data (Lee and Zaharlick, 2013; Silverman, 2014). However, these can also be conducted over a shorter period of time, focus on one particular element of society rather than the group as a whole, and can provide more than a descriptive account (Madden, 2017). Thus, ethnography is wide-ranging, and many subdivisions of the methodology have emerged, including autoethnography and critical ethnography (Costley, Elliott and Gibbs, 2010).

3.3.2 Critical ethnography

Due to varying ethnographic approaches, the philosophical and theoretical orientation will assist the researcher when choosing which ethnographic methodology to utilise (Parahoo, 2014). For this thesis, critical ethnography has been chosen, as this approach symbiotically integrates critical theory with traditional ethnography. This will yield more than a descriptive account and will enable recommendations for how social power inequalities can be addressed (Silverman, 2010; Batch and Windsor, 2015; Ross, Rogers and Duff, 2016).

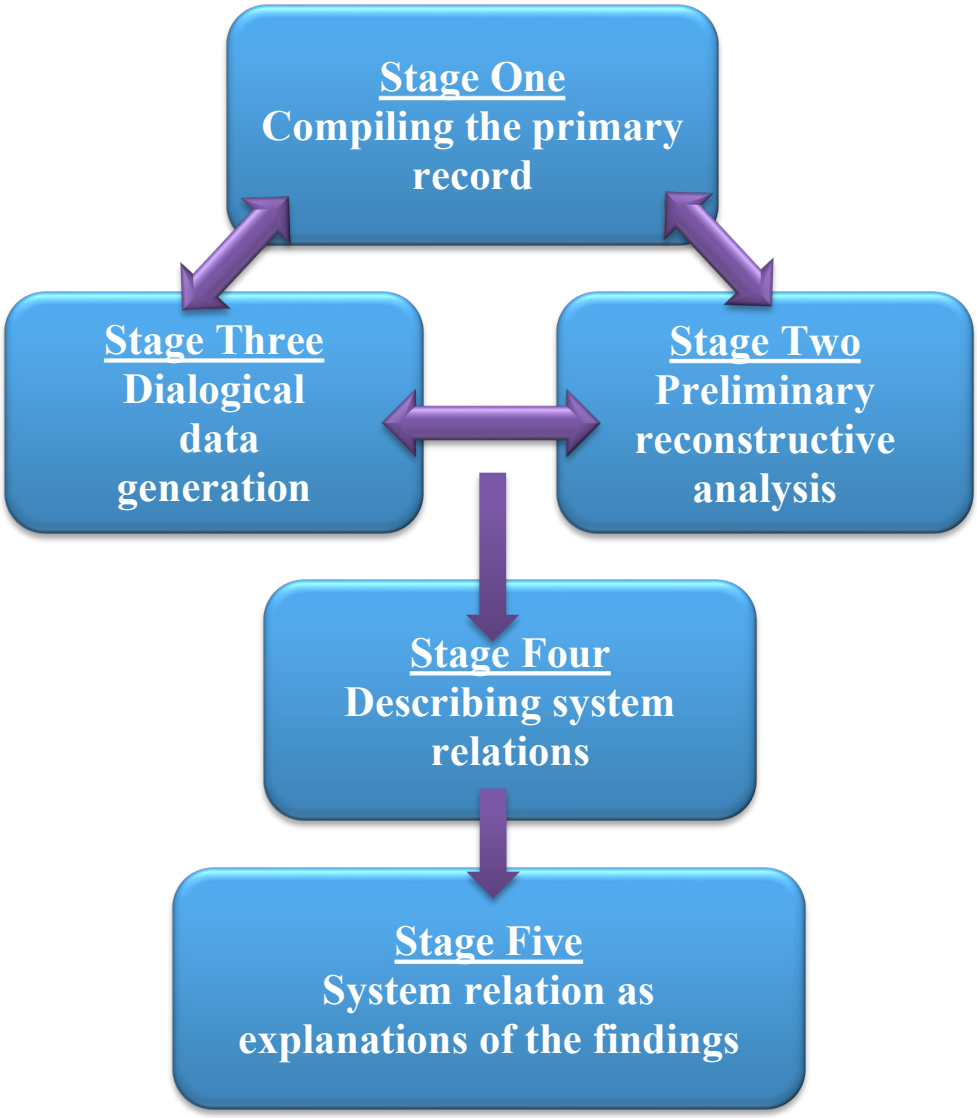
The origins of critical ethnography can be traced back to America and the Chicago School of Sociology, where, following the civil rights movement, traditional anthropological ethnographers became disillusioned with political oppression and the treatment of minority groups (Cook, 2005). Critical ethnography is thus often used when studying cultural practices with a profound political agenda (Benton and Craib, 2011), research which involves marginalised groups within society, or when challenging the status quo (Barton, 2001; McCabe and Holmes, 2014; Dove and Muir-Cochrane, 2014). As culture is a concept that is not static but dynamic and complex, the change element of critical ethnography can be varied in terms of size and impact, from political activity to influencing policy amendments (Foley and Valenzueal, 2008).

The researchers credited with bringing this methodology into the forefront of cultural research are Jim Thomas and Phil Carspecken (Cook, 2005). As a result of their ground-breaking work, this methodology is now being used by nurse and midwifery researchers to examine a range of healthcare issues, including health promotion (Cook, 2005) cultural shifts within midwifery (Hughes, Deery and Lovatt's, 2002), dementia (Bourbonnais and Ducharme, 2010) and communication in acute settings (Batch and Windsor, 2015). Critical ethnography is therefore, an appropriate methodological approach to use for this research study, as it allows for a critique of preoperative clinical practice within a social, cultural, and organisational context (Manias & Street, 2000; Edmonds & Kennedy, 2013). It also incorporates elements synonymous with transformative paradigms, allows a more reflexive approach, and aids in the uncovering of implicit and hidden patterns of working, while additionally examining power and relationships in an attempt to affect change (Manias & Street, 2000; Madison, 2012; Leedy & Ormond, 2013; O'Leary, 2014).

3.4 Development of conceptual framework

Due to the complex nature of the research topic and the healthcare environment that is to be examined, a conceptual framework is required. One of the most prominent critical ethnographic frameworks that has emerged over the last twenty years is Phil Carspecken's five-stage critical qualitative research approach (Holmes and Smyth, 2011) (*see figure 5, page 101*). It is a framework that sets out the process for doing fieldwork and analysis and includes practical suggestions on how to take field notes, how to conduct interviews, generate monological data and undertake analysis using a reconstructive, and reflexive process (Carspecken, 1996). The framework has been noted for its standards, rigour and transferability (Burnette, 2015) and provides some structure and flexibility for a novice researcher (Robertson, 2015). Additionally, it is underpinned by ideas from eminent critical theorists such as British and German sociologists Anthony Giddens and Jürgen Habermas and is often used by researchers who subscribe to the critical theory perspectives (Smyth and Holmes, 2005; Grbich, 2013). Therefore, Carspecken's five-stage critical qualitative research framework has been chosen for this study, and this will be discussed in greater detail in *chapter four, page 114*.

Figure 5: Five-stage research process adapted from Carspecken (1996)



3.4.1 Reflexivity and researcher bias

As well as the practical application of the structured approach to the data collection and analysis, another aspect of Carspecken's conceptual framework relevant and necessary for ethnographic research, is reflexivity. Reflexivity is the process of examining feelings and motives and throwing light on how these influence decisions and actions. Within the realm of healthcare, personal, reflexive skills and processes are now considered standard practice, as they allow staff to recognise their own strengths and limitations in order to improve care standards. These attributes are also necessary within research, not only to ensure good

research standards but also because researchers inherently have an agenda. As such, a high level of self-awareness, transparency and reflection need to be defined and incorporated into the overall research design. This is not only ethical but a practical necessity (Danchev and Ross, 2014). Critical ethnographers need to be critical in a variety of ways, one of which is being critical of themselves and their subjectivity (Deforge *et al.,* 2011; Silverman, 2014). It is also suggested by Phillips and Pugh (2010), that it can be difficult to guarantee that observations remain unbiased when the researcher is familiar with the clinical area, the staff and the perioperative pathway; thus, efforts must be made to make transparent any preconceived ideas or assumptions (Parahoo, 2014). As nursing is inherently a profession which requires a degree of reflexivity, nurse researchers often find the transition to ethnography a natural process, due to transferable reflexivity (Ross, Rogers and Duff, 2016). As a result of my training, I became familiar with carrying out my professional practice under the intensive scrutiny of colleagues and critically reflecting upon my own clinical practice.

This previous awareness was beneficial for this project, however in order to achieve reflexivity, there needed to be the incorporation of a robust and tacit reflective account of the research journey. This was achieved with the use of a diary, which is a useful way to document any preconceived ideas and bias (Larkin, 2013). It assisted me with the keeping of a running monologue of my thoughts and understanding throughout the research process. It also proved to be a useful tool for balancing any subjective and objective interpretations, especially during the analysis stage. Throughout this thesis, reference will be made to this diary and excerpts will be used to ensure the reflexive process is transparent.

3.4.2 Relationships, reciprocity and power

It is essential that within this study, adequate consideration of the potential power imbalance from the researcher perspective is taken into account. This refers to the power that the researcher may hold over the research design, the influence they may have on the questions being asked, how the data is collected and how they subjectively interpret participant voices. Researchers must, therefore, be aware of their own biases and assumptions, especially when power relations are asymmetrical (Mahon and McPherson, 2014). At the commencement of data collection, this imbalance can be more strongly aligned to the participant, as the researcher is in a subordinate position, having no knowledge of the culture and practice environment (Lee and Zaharlick, 2013). However, a shift in power in favour of the researcher can become stronger during the analysis and interpretation of the data. Therefore, researchers need to be cognisant of the change in the dynamics of the participant-researcher relationship.

In order to reduce power inequalities and bias within critical ethnography and more specifically Carspecken's five-stage model approach, there needs to be some incorporation and integration of reciprocity (Vandenberg and Hall, 2011). For this research study, this was encouraged by the use of member checking and triangulation. Member checking, otherwise referred to as informant feedback or respondent validation, is a process of exploring the credibility of results and is often used as a validation technique (Birt, Scott and Cavers, 2016). Triangulation can be carried out in a wide variety of methods, from theory triangulation, data triangulation and methodological triangulation (Maltby *et al.,* 2010). Both member checking and triangulation were used extensively in this study, and the details of both processes will be discussed in *chapter four, page 114.*

3.5 Theoretical orientation

As well as a conceptual framework, research needs to be supported by a theoretical foundation, as theory is an inherent quality needed for research. However, rather than being the cornerstone, it may be embedded throughout the research as theoretical assumptions, either in the framing of the research questions, or interwoven within how the questions are answered (Green and Thorogood, 2014). Critical ethnography which is underpinned by a critical interpretative paradigm, employs critical social theory to extract ideology from the action and is therefore critical theory in action (Madison, 2012; Dove and Muir-Cochrane, 2014).

3.5.1 Critical social theory

Critical social theory was established by the Frankfurt School of Sociology in Germany, by thinkers such as Theodor Adorno and Max Horkheimer, who were disillusioned with the domination of capitalist, communists and fascist systems during the 1930s. Its origins stem from some of the ideologies of Karl Marx, who synthesised French socialism, German philosophy and Scottish political economy in order to make sense of how material capitalism, and the unequal balance of power between those who have and those who have not, was detrimentally impacting the functioning of civilisation. He strongly believed that in order to improve civilisation, force was needed, as a change within the very structure of the social world would not occur spontaneously. He is therefore often referred to as being a revolutionary socialist, due to his strong beliefs in social reform through the means of revolt. However, whilst Adorno and Horkheimer embraced Marx's premise of emancipation, they were more focused on the elements of social capitalism, rather than material capitalism.

During the anti-Semitic period of the 20th century, Adorno and Horkheimer, being Jewish Germans, fled to the USA, and thus the Frankfurt school moved to America in the 1930s. Throughout their career, they were particularly interested in how cultural commodities such as films, magazines and radio, were used as a means of fascist control. The scholars associated with the Frankfurt school, including Horkheimer and Adorno, referred to their work as critical theory (Cuff *et al.,* 2016). This was formulated within the realm of sociology, the study of human society and social problems, through the examination of the development, function and structure of the constructed social world (Elliott, 2014). It was heavily motivated by the presence of power within social interactions and thus had an underlying interest in emancipation (Blaikie, 2007; Buchanan, 2010).

The Frankfurt school returned to post-war Germany in the 1950s, where critical social theory ideologies continued to evolve from the traditional Neo-Marxist origins, to more contemporary theories that were developed thanks to modern critical theorists such as Jürgen Habermas and Pierre Bourdieu. Critical social theory has therefore moved beyond Neo-Marxist perspectives and has now transitioned towards a more critical, political and feminist ideology. The critical theories used within critical ethnography are therefore not only a reflection of the research question, but also of the times in which the research is undertaken (Holmes and Smyth, 2011). Additionally, critical social theory is wide-ranging, and there is an abundant assortment of theoretical standpoints that could be employed. More importantly, when examining which theory to prescribe to, first-time researchers can often find this process difficult, as the terminology used by researchers is often inconsistent and in some cases, even contradictory (Gray, 2018).

Carspecken's (1996) research design is underpinned by a critical social theory perspective derived from the works of Jürgen Habermas's 'theory of communicative action' (1984), and this influenced Carspecken's development of stage two of his framework, referred to as reconstructive analysis. For this thesis, as well as incorporating Habermas's theory of communicative action as part of stage two of Carspecken's framework, the critical theoretical perspectives of Pierre Bourdieu are also utilised in an attempt to assist with the theory to practice integration, especially during stages four and five. The decision to align the findings with Bourdieu however, did not occur until all of the data was collected. This allows for a more open data collection and analysis process and enables the data to influence the theoretical perspective, rather than imposing a predetermined theory which could cloud the interpretation of what is observed (Lee and Zaharlick, 2013; Silverman, 2014).

When using critical ethnography, it is acceptable to use more than one theory, as it is often the case that researchers use one theory to assist with the collection of data and analysis and another to help explain the findings of the study to others (Thomas, 1993). The approach to draw on multiple critical social theory perspectives is also encouraged by Carspecken, a self-proclaimed pragmatist who promotes the use of eclectic research techniques. Therefore, for this research study, stage two (reconstructive analysis) is influenced by Habermas and stages four and five (what Carspecken refers to as structural analysis), draws upon the work of Bourdieu.

What both of these critical social theories have in common, besides the core drive to discuss power, is the awareness and appreciation of the interconnectivity of agency and structure. What is often debated within the realm of sociology, is the extent to which

individuals are free to make choices and how freedom is limited by structural forces from government, family, society and institutions. In other words, socialisation versus autonomy and micro versus macro perspectives. For most sociologists today, structure is believed to play a more prominent role in choices than free will; however, Habermas and Bourdieu believe that structure and agency have equal weight.

3.5.2 Theory of communicative action

Jürgen Habermas, a German sociologist and a previous research assistant to Adorno, was interested in how the media (newspapers, television and radio) were used as weapons of the political and educational elite. However, working now under the influence of new social movements that were popular in Europe and USA in the 1960s, he wanted to reinvigorate traditional critical theory by incorporating language and communication (Elliott, 2014). One of his best-known pieces of work is 'the theory of communicative action'. This focuses on the belief that communication involves a culturally established understanding and achieved consensus between two or more individuals, not from visual perceptions or speech, but from the process of 'reaching an understanding among members of a life-world' (Habermas, 1984, p. 286). It therefore goes beyond capitalism by addressing reason, social action and moral philosophy. It concentrates on the capacity of language to transform society and how understanding is reached via the dialogue between those who speak and those who listen (Habermas, 1984; Buchanan 2010; Holmes and Smyth, 2011; Long, 2017). Within this, Habermas also recognises that society exists on both a macro and micro level and thus, advocates dualistic perspectives for exploring society as subjective reality and also complex unconscious structural entity (Habermas, 1984; Cuff *et al.,* 2016). His philosophies have been hugely influential in Carspecken's use of critical enquiry during the process of reconstructive data analysis, in particular, about

how truth is claimed from a subjective, normative and objective perspective ((Holmes and Smyth, 2011; Sandberg, 2014). Consequently, his underpinning theoretical perspective is utilised during the primary analysis of this study's data and helps inform the findings. The use of the theory will be explored in greater detail in *chapter four, page 114*.

3.5.3 Theory of practice

Pierre Bourdieu, another post-structural French social theorist, is described by Cuff *et al.* (2016) as a synthesiser of critical social theories, as he brought together and merged previous social theories. He was instrumental in inspiring the rebirth of critical social theory, especially within the educational and healthcare arenas and was very critical of the status quo. His main theoretical concepts of 'habitus', 'capital', and 'field' have become central to many social science research studies examining inequality.

3.5.3.1 Field

Society consists of multiple spaces, or fields, which relate to a self-sustaining environment which perpetuates the habitus of specific groups. It achieves this through the use of formal and informal norms and rules, or doxa, which are specific to the sphere of action (practice), and are thus relational in nature. These fields and the power that can be found within and between other fields, structure human behaviour and this is often reinforced by particular forms of symbolic capital, which is used to place an individual and assign them to a particular position (dominant or subordinate) with the field. Within this study, as the wider field can be constituted as the perioperative department, the culture found within the 'sub-field' associated with preoperative care environments will be discussed, as it is the subculture found in this narrowed field that has the most influence on patients' journeys (Moen, 2010).

3.5.3.2 Habitus

Throughout his career, Bourdieu attempted to transcend the dichotomies of objectivism/subjectivism, and structures/actors by symbiotically combining constructivism with structuralism through his use of habitus (Moody, Pfaff and Virk, 2012). Habitus refers to the set of principles which frame individuals' actions, depending on the culture and the environment that individuals are situated in, and is usually determined by external structures and internal experiences. Bourdieu (1977) uses the term 'habitus' to represent the overall embodiment of individuals ingrained transposable dispositions, which are internalised and expressed through repeated practice. Thus, habitus structures the way in which people interact, work and play (Elliott, 2014) and is used as a way of explaining real-world interactions; more importantly, how social structures aligned with inequalities such as gender, can predispose an individual to perceive their world view in a particular way.

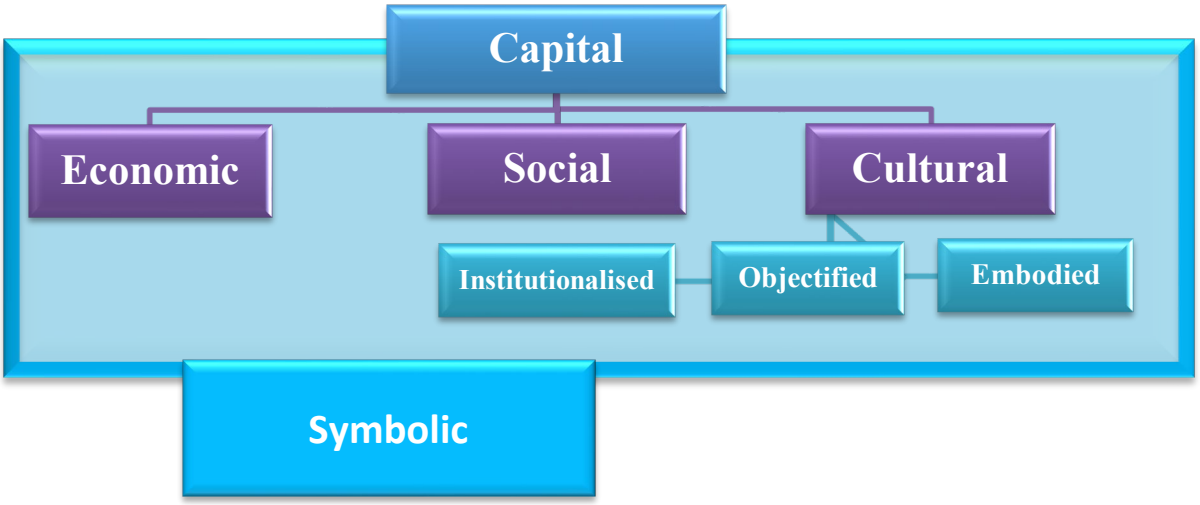
3.5.3.3 Capital

Bourdieu, like Marx, recognises the importance of capitalism and economic power as well as how capital can be formulated by other non-economic means (Bourdieu (1986). Capital is, therefore, a collective set of ideals that are valued and desired within a specific group, and these are often context specific and incorporate economic (what is owned), cultural (knowledge and education), social (resources based on connections) and symbolic (respect, reputations) elements (Bourdieu, 2002; Skeggs, 2015; van Krieken *et al.,* 2016).

Firstly, economic capital, which is readily convertible, is associated with money, assets and other forms of currency and is often thought of as being most influential and essential to the social world (Bourdieu, 1986). Secondly, social capital, which can be inherited or

earned, is founded on the obligations and connections forged, created and maintained and is, therefore, most often associated with whom you know, not what you know. Prestige can be increased by obtaining more capital or being connected to people who have more capital. Thirdly, cultural capital can be defined as what you have and what you know, and these have been further separated into three subtypes, including embodied, objectified and institutionalised (Bourdieu, 1986). Embodied capital incorporates qualities that are associated with the mind and body and can include skills, tastes and mannerisms. Objectified capital encompasses material belongings which have been deemed to possess cultural significance, such as cars, paintings and books. Institutionalised capital is aligned with the symbols of competence and authority, such as University acquired qualifications, work experience and professional titles (doctors). Lastly, symbolic capital, which encapsulates all three of the aforementioned categories, relates to honour and internal and external recognition (s*ee figure 6, page 111*). These subtypes have always been and remain relevant within the realm of healthcare, as HCPs may vary their practice and interactions, depending on their preconceived opinions and/or how the patient's present themselves. Bourdieu (1986) postulates that socioeconomic success can be associated with all forms of capital and the more one possesses, the more one can attain, as greater social capital can open doors to more capital generating possibilities such as education and official accreditations. It can, therefore, buy you a higher place in society and can also be associated with your position within the social world. He also states that within society, it is usually those who possess a high level of capital (mainly social, but also cultural and economic) who are more productive, respected and recognised (Bourdieu, 1986).

Figure 6: Bourdieu's types of capital



3.5.3.4 Symbolic violence

The mechanistic system of 'symbolic violence' (the domination of subordinated groups by the dominant class, to naturalise the status quo) is the process by which the reproduction of the established social order remains (Bourdieu, 1977). Coercion is aided through consent of the dominated to the dominators and is often as a direct result of the suppressed access to resources and instruments of knowledge by the dominant individuals (Crossley, 2005). Symbolic violence is therefore closely aligned with power and the unequal distribution of all forms of capital. However, this often takes place in more subtle forms and is usually associated with gentle, hidden exploitation when overt, brutal exploitation is impossible (Bourdieu, 1977). As well as the exploitation of man over man, Bourdieu was also interested in how, as a result of masculine domination, females were often considered 'lower' in society. But more importantly, how this gendered version of the world which is so ingrained and hidden within the habitus of the social world, self-perpetuates the continuing existence of the status quo (Bourdieu, 2001).

3.6 Summary

As already alluded to, choosing a philosophical standpoint, paradigm, supporting methodology and theoretical orientation has not been without its difficulties. Throughout this chapter, attempts have been made to explore the reasons for the choice of paradigm, methodology and theoretical framework, and to make connections as to how these can contribute to answering the research question.

Firstly, a transformative paradigm enables the findings to be used as a means of challenging the status quo. Secondly, critical ethnography examines the culture of clinical practice through a critical lens, with a view to shedding light on the implicit behaviours that can be found within healthcare interactions. Lastly, the critical theories of Bourdieu allow for the findings to be aligned with social capital and its associated inequalities in power.

Choosing the methodology, however, is only one facet of the research continuum. What also needs to be considered is how the data will be collected and analysed. This will now be explored in greater detail in *chapter four, page 114*.

Chapter 4

Research Methods

4 Research methods

4.1 Introduction

"How does the underpinning culture of the perioperative department impact on pain and its priority within preoperative practice for day case surgical patients?"

In order to address the research question above, multiple stages of research, data collection and analysis methods were utilised. Within this chapter each stage and specific element will be described and discussed. This will commence with an overarching view of the planned approach followed by the recruitment strategy and sampling technique. Ethical considerations and confidentiality will then be discussed, as well as how the data was collected, from both a qualitative and quantitative perspective. Finally, an overview of Carspecken's five-stage approach, the incorporation of observations of practice, interview techniques, and the data analysis procedure will be described. This includes how the analysis process is underpinned by critical theory from Habermas. The theories associated with Bourdieu will be aligned with the discussion in *chapter six, page 243*.

4.2 Research process and stages

The question at the centre of this study was related to a multifactorial phenomenon. Thus, to provide a comprehensive answer, an open-minded approach was adopted, which incorporated the culture of the clinical environment being examined, with dual exploration, encompassing both quantitative and qualitative methods (Liamputtong, 2009). This is an approach often used by ethnographers as a means of uncovering deeper and stronger information, and providing supplementary and validatory data (Maltby *et al.,* 2010; Edmonds and Kennedy, 2013; Lee and Zaharlick, 2013; Tilley and Long, 2014).

Additionally, it can be argued that this is the best approach to adopt when trying to generate rich areas of data; especially when examining and exploring a clinical problem through observing, listening, talking, analysing, reflecting, writing, rethinking and describing cultures (Kahn, 2011; Green, Skukauskaite and Baker, 2012; Lee and Zaharlick, 2013). To optimise the understanding of the complexities of preoperative practice, a multimodal approach using Carspecken's five-stage critical enquiry model (*see figure 5, page 101*) was employed for this thesis. This approach, which utilised a structured framework, also enabled and encouraged the use of a variety of methods for collecting, analysing and interpreting the data, in order to capture multiple perspectives (Carspecken, 1996) (*see figure 11, page 145*).

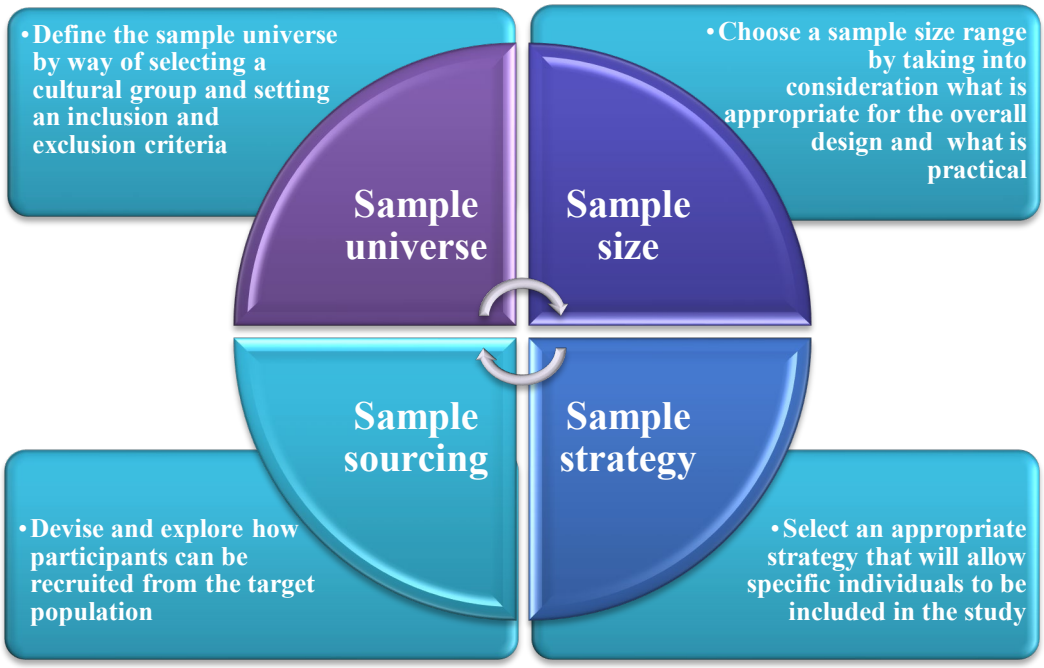
Stage one involved unobtrusive observations of the participants, and writing intensive notes on what was witnessed. Stage two incorporated a primary level of analysis of the witnessed interactions by reconstructing the data. Stage three allowed for more in-depth exploration of meaning, by conversing with the participants. Stage four continued with the analysis of the data for the chosen clinical site, looking more specifically for examples of correlations between sites, participants and the researcher's reconstructions with those from other researchers. Finally, stage five enabled deeper level analysis and generation of the findings to theory. The individual stages will be discussed in detail later in this chapter, commencing with data collection and followed by the data analysis stages.

4.3 Recruitment and sampling

Visualising and planning how the data could be collected in practice was essential, as, without data, there would be no study. However, as well as considering how to collect research data, it was also essential to consider who would hold the answers to the research

question, how these individuals might be contacted, and what information should be provided to potential participants prior to the study. As cultural groups within an organisation can be large, it is often impossible to study every individual; researchers therefore need to formulate a sampling strategy (Schensul and Lecompte, 2013). This is a central component of qualitative research methods and for this study, a four-point approach, devised by Robinson (2014), was utilised (*see figure 7, page 116*). Using this flexible and cyclical approach contributed to the overall validity and rigour of the research study, as the sampling strategy was clearly articulated, followed a robust process and enabled a high level of transparency (Robinson, 2014).

Figure 7: Four-point sampling approach (adapted from Robinson, 2014)



4.3.1 Sample universe

Only one site was chosen as the focus of this research, due in part to limitations on time and resources. Whilst focusing on one location may be considered a limitation in terms of the impact on data transferability, for ethnographic studies, single sites still allow for the generation of findings which will enhance knowledge that may be of use within the wider

social world (Creswell, 2014). For this study, in order to maximise the quality and quantity of data collection opportunities, it was important to consider carefully which hospital site would be most beneficial in terms of ease of access, logistics, work environment familiarity and surgical productivity. There also needed to be broader exploration and consideration of the overall purpose of the study, in order to ensure that the validity and reliability of the study were not compromised (Daniel, 2011). Therefore, a site I was professionally familiar with was chosen, as I had knowledge of the working environment and practices, an awareness of the type of surgical procedures undertaken as day cases and understanding of the general skills mix within the perioperative department.

When conducting ethnographical research or any research using observational data collection methods in an area where the researcher has previously worked, there needs to be some consideration of the impact of researching participants who are known to the researcher (Creswell and Poth, 2018), as the researcher is primarily an insider. The reflective diary extract below demonstrates that upon commencement of data collection, I was initially fearful about the validity of my position as a researcher and not a clinical member of staff; and even whether I would be welcomed back onto the department. As the research was being conducted in a hospital trust where I had previously practiced, I had to consider that my perceptions of previous professional relationships may have been false, and colleagues may not have valued my return.

Reflective Diary Extract - 5th December 2014

"I have seen several members of staff that I used to work with. Some of them seemed wary and asked (in what seemed like a defensive manner) "what are you doing here?". While I see myself as an insider, do they see me as an outsider?"

The anxieties relating to my new role as a researcher had relevance, as workplaces are complex and dynamic, with status positions that are ever-changing, and insider researchers may be viewed with suspicion and not welcomed (Costley, Elliott and Gibbs, 2010). Larkin (2013) states that when researchers transition from an inside practitioner to an outside researcher, this can sometimes result in an imbalance within the power dynamic of the relationship. This can create tension, as familiarity with previous roles may lead to participants feeling that they have to say certain things in order to ensure favour. I, therefore, made every attempt to reinforce my role as a researcher and nurse, whilst also ensuring that I communicated in a non-threatening manner, by using positive nonverbal communication skills, common language and a friendly disposition.

Reflective Diary Extract - 5th January 2015

"Upon arrival this morning, the staff were really busy. I am finding it really hard not to roll up my sleeves and help out, especially when there are so many nursing duties and responsibilities. The drive to assist the team is very strong!"

I also found it challenging, as an established practitioner but a relatively new researcher, to ignore my inherent intuition to provide care. Instead I had to continually remind myself that I was in a clinical setting as an observer researcher. Therefore, there was always an internal dialogue, as I constantly reminded myself of my current role. This confusion with traditional roles can be seen as a natural trade-off when examining cultural practices

Reflective Diary Extract - 5th December 2014

"Is my current and previous knowledge negatively impacting on my observations? I need to clarify everything, to make sure that what I believe is happening is actually occurring. Don't presume, get it confirmed by the participants".

associated with previous clinical practice (Spradley, 1979). Another consideration of my position as an insider, was in relation to my possession of knowledge of the topic area, and that this might influence the research direction, data collection methods and findings. When inexperienced researchers examine a social world that is known to them, some data may not be recognised as being significant to the findings, due to the previously embedded tacit knowledge (Spradley, 1979). Although I did possess some knowledge, which was vital to help with access to the site and to recruit participants, my previous practice experience was restricted to intraoperative care. Thus, my knowledge of preoperative assessment and day surgery practice routine were limited, resulting in some level of ignorance of the unspoken cultural practices within the day surgical unit. Insider knowledge, such as language however, can be an asset to a study, especially those dealing with complex issues within healthcare environments (Costley, Elliott and Gibbs, 2010), as this knowledge often removes the need for an extended time in the clinical area, something which can be difficult to negotiate within busy clinical environments (Liamputtong, 2009; Danchev and Ross, 2014). My existing knowledge proved to be beneficial, as it removed complications associated with blind immersion and my knowledge of the physical space enabled me to spend more focused time observing the interactions themselves rather than trying to become familiar with the environment and protocols.

4.3.2 Sampling strategy

Once decisions on the site, participant criteria and estimated sample size were made, it was necessary to formulate a strategy for selecting the participants (Robinson, 2014). Due to the nature of some clinical environments it is sometimes impossible to create a specific sampling framework prior to the research commencing, especially as it may be difficult to identify the members of that specific group (Daniel, 2011; Schensul and LeCompte, 2013).

Thus, due to the emergent nature of this research design, and the lack of knowledge of the number of staff that could be potential participants, it was not possible to formulate a structured sampling framework prior to commencing the study. Ascertaining potential research participants and identifying who the key informants were, could only be possible once immersion into the clinical environment was underway. Additionally, there was no prior information regarding which patients would be present in the department during the dates and times that were scheduled for data collection. What could be considered prior to the commencement of the study, was what sampling techniques could be utilised to ensure that the sampling was achievable, realistic and appropriate.

As the data collection was conducted in a series of stages and also incorporated various methods, two sampling techniques were adopted. Creswell and Poth (2018) assert that it is sometimes necessary to embrace more than one approach and that researchers need to be flexible; thus, I used opportunistic strategies and purposive sampling. Purposive sampling is defined as being a non-random way of making sure that specific participant groups, found within the research area, are invited to be voluntary participants in the project (Robinson, 2014). Using this sampling technique allowed me to approach participants who had the necessary knowledge, expertise and insight, to best answer the research question and provide most data on the cultural practices relating to the chosen phenomena under exploration (Plowright, 2011; Silverman 2014; Creswell and Poth, 2018). Additionally, this technique has been used successfully within nursing research and critical ethnography, as it assists in providing the largest variability in terms of staff grade, gender, length of service, demographic variation and information to answer the research aims, rather than being used as a means of ensuring generalisability (Gulati *et al.,* 2011; Gray, 2018).

Disadvantages of this approach can include researcher bias, as the researcher's judgment alone decides who is a suitable participant, especially when compared with quantitative sampling techniques such as random or probability sampling. However, this issue can be removed if the researcher's decisions are carefully considered, transparent and based on specific criteria.

The second sampling technique used was opportunistic, otherwise known as convenience sampling, which is one of the most frequently used sampling methods in nursing research (Bloom and Trice, 2014). This was employed in the later stages of recruitment, as it allowed for a more extensive net to be cast and enabled me to take advantage of many unexpected moments and opportunities to gather data (Fetterman, 2010; Schensul and LeCompte, 2013; Creswell and Poth, 2018). Limitations, in terms of unequal representation, were reduced by ensuring that a comparable number of interactions were observed. For example, I tried to ensure that a similar number of observations were undertaken for each of the four surgical specialities.

4.3.2.1 Inclusion and exclusion

On commencement of recruitment, parameters were put in place relating to the attributes that participants must possess, before being invited to participate. This was not only to protect the participants themselves, but also to ensure that the most suitable individuals from whom to elicit information were utilised. By incorporating specific inclusion and exclusion criteria *(see table 1a, page 122)*, the homogeneity of the sample was increased, which helped ensure that the study remained contextualised within a specific clinical area (Robinson, 2014).

As preoperative interactions were being observed, both staff and patients needed to provide consent. Consequently, two independent lists of exclusion and inclusion criteria were created; one for staff and one for patients. Staff participants needed to be registered HCPs, employed by the NHS hospital trust, involved in the care of preoperative patients or conduct preoperative assessments and consultations. The patients meanwhile, needed to be over the age of 18, have the capacity to make an informed decision regarding whether to participate, and be scheduled for a day case surgical procedure within a finite period of time. The exclusion measures used for this study therefore, limited the possibility of undertaking research on vulnerable individuals, whilst the broader inclusion criteria attempted to maximise the size of sample universe and increase the potential for the selection of the most appropriate participants.

Table 1a: Inclusion and exclusion criteria (staff and patients)

Staff or Patient	Inclusion/Exclusion criteria
Staff	• Staff must be registered HCPs • Staff must be employed by the NHS Hospital Trust • Staff must be involved in either the care of preoperative patients or conduct preoperative assessments/consultations
Patients	• Patient's must be over the age of 18 • Patient's must have the capacity to make an informed decision regarding whether to participate • Patients must be scheduled for a day surgical procedure within a specific timeframe

4.3.3 Sample sourcing

Robinson (2014) suggests that a strategy is needed to source volunteer participants and ensure they receive adequate information prior to recruitment. As consent was required from staff and patients, this process proved to be rather challenging and complex, as I did not have direct access to patients prior to their preoperative assessment or surgery.

Therefore, key gatekeepers were essential, as the recruitment of potential voluntary participants, especially patients, was only possible with the assistance of a member of staff working with the hospital trust.

4.3.3.1 Gaining access

When conducting research, it is necessary to consider what preceding contact is needed and what steps must be taken to gain suitable access (Lee and Zaharlick, 2013). Okumus, Altinay and Roper (2007) state that there are three categories of access: formal, personal and emotional. The formal process involves liaising with the organisation and agreeing on specific terms of the research interaction. The personal process can be obtained through the use of existing contacts and by liaising with managers and positional gatekeepers, while emotional access involves engaging with potential participants and building rapport (Okumus, Altinay and Roper, 2007). Throughout this research process, all three types of access were carried out, with particular attention given to emotional access, as there was a requirement to ensure that a trusting relationship was developed between myself, the hospital trust and its employees.

To gain access to the clinical areas and ensure that the purpose of the study was fully disclosed to all potential participants, it was necessary to first liaise with the principal gatekeepers and stakeholders within the hospital trust, to provide detailed information regarding the study. This is a strategy often employed within organisations as it allows other members, external to the actual study, to assist with the recruitment of participants (Robinson, 2014). Once consent and access were granted, it was possible, with the assistance of the lead clinicians (the operating service manager for the perioperative department and the head anaesthetic consultant) and key gatekeepers (contact centre

administrator for day surgery, ward sister and lead nurse for preassessment), to identify which HCPs and patients could be potential participants.

4.3.3.2 ***Recruitment process***

I liaised with a member of staff whose responsibility it was to send correspondence to patients scheduled for day surgery, and received agreement that along with information about their day surgery, patients would also be sent an 'invitation to participate letter' (*appendix 2, page 320*) and 'participant information sheet' (*appendix 4, page 325*). These were subsequently mailed to patients, prior to their preassessment clinic appointments and scheduled surgery. This provided patients not only with information about the study, but also with time to fully consider their involvement. They could then choose to contact me directly, or meet with me on the department prior to their appointment, if they wished to discuss the study or needed further clarification. Consequently, on the day of their scheduled preoperative appointment or surgery, I was then able to approach those patients listed on specific surgical lists, to ascertain whether or not they would like to volunteer to participate in the study. In order to ensure that they were fully informed I addressed any additional questions they had before providing a consent form for those willing to participate to sign (*appendix 9, page 335*). All consent forms and invitation letters were created from standardised University approved research documentation templates. These documents clearly defined the specific elements of the study, such as the right to withdraw, the purpose of the study, the benefits of the study to the participants, any potential known risks, confidentiality, the complaints process, as well as documenting the signature of the participants and researcher (Creswell and Poth, 2018).

For hospital trust staff, emails with the 'invitation to participate' letter (*appendix 1, page 319)* and 'participant information' sheet (*appendix 3, page 321*) were distributed. The commencement of this process occurred simultaneously for the potential patient and staff participants. After a period of time, the potential staff participants were contacted and asked if they would like to volunteer for the study. Those that came forward were offered a meeting where further information was provided. Once the participants had time to consider their level of involvement, they were then provided with consent forms (*appendix 7, page 333 and appendix 8, page 334*) to sign. To assist with recruiting, advertising was also used to ensure that as many staff in the department as possible were aware of the study. Robinson (2014) proposes that this can be done in a variety of ways, including advertising, through printed documents and face-to-face presentations. As I was conducting research within a large department, several methods were used, including leaflets, face-to-face information giving and oral presentations, which are often used to capture a broad audience (Curtis and Curtis, 2011). The processes for recruiting staff and patients have been illustrated below (see *figure 8, page 126 and figure 9, page 126*).

Figure 8: Sourcing the sample - Staff

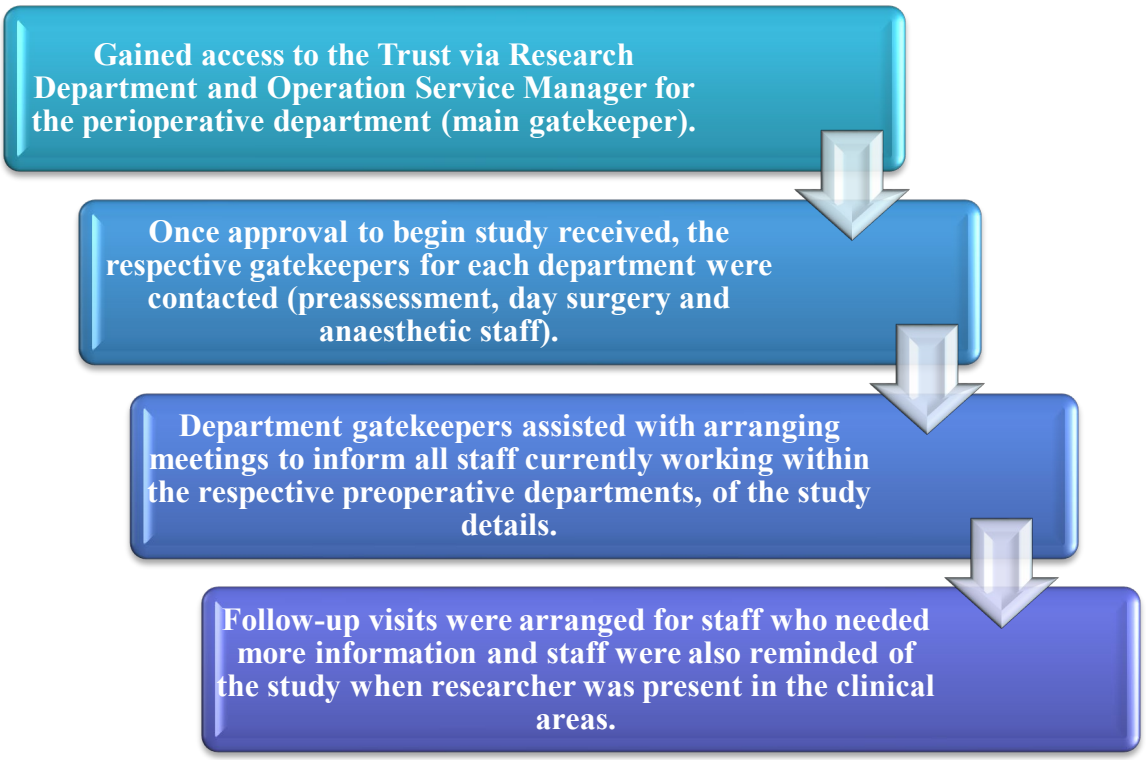
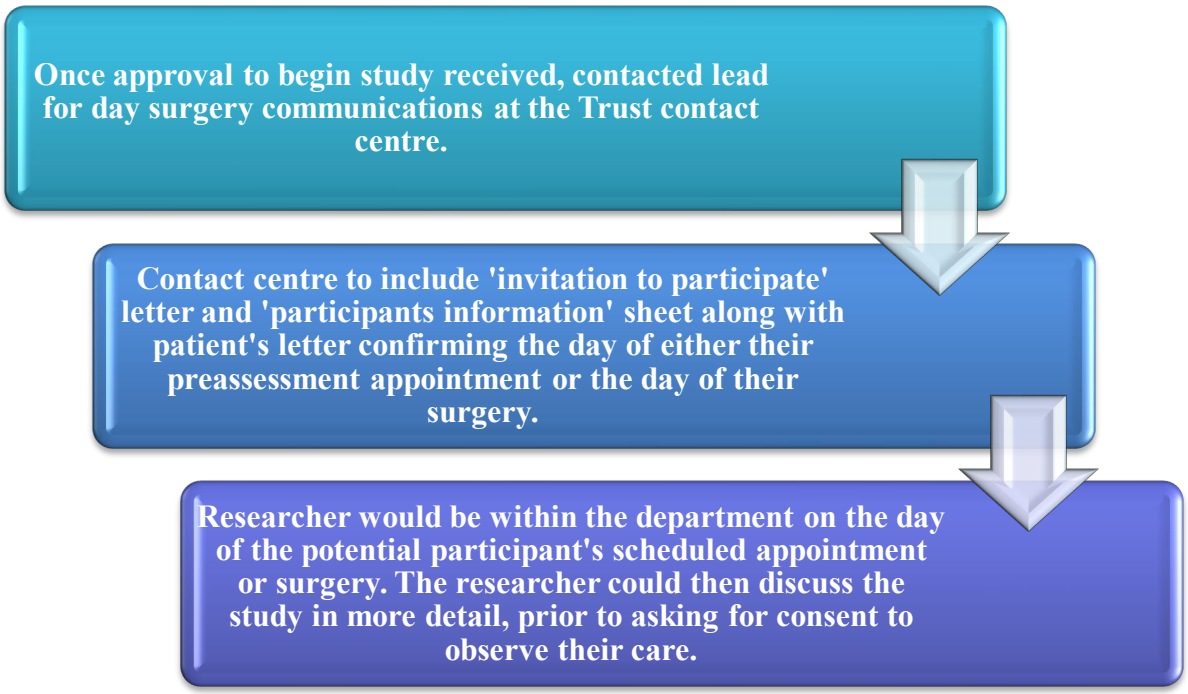


Figure 9: Sourcing the sample - Patients



The realities of researching in clinical practice areas meant that recruiting participants was not straightforward. Ensuring that anaesthetists and nursing staff were aware of the research and that a researcher would be within the department was an ongoing process. Additionally, observing a specific preoperative interaction and ensuring that all research participants (staff and patients) had provided consent was, at times, problematic. If a patient on a specific surgical list had not provided consent, but the HCP had, the interaction could not be observed and vice versa. Furthermore, if a different anaesthetic member of staff arrived to cover the surgical list as a replacement for the previously consented anaesthetic member of staff, the interactions (which the patients had already consented to) could not be observed, unless the replacement staff member also agreed to become a participant. Therefore, it became a logistical challenge to ensure that the HCP and the patient had both agreed to participate.

I was able to negate this obstacle by being more selective about which HCP to follow and when. Initially, this was not achievable, as the number of participants was limited, but, as the number of staff participants increased, more flexibility was possible, which additionally ensured that a broad range of staff was observed and that patient care, under a range of surgical specialities was witnessed. Consequently, the recruitment process, while initially slow, soon gained momentum as the staff became more familiar with my presence and my methods.

Recruitment also proved to be more of a challenge when attempting to observe the daily working practices of the preassessment department. Due to unsuccessful attempts to recruit following the first presentation to the preassessment staff, a second meeting was arranged with the department gatekeeper, and the invitation to participate was redistributed to

include a more extensive selection of staff. Therefore, the final sampling size was not achieved without significant effort and some negotiation in terms of the breadth and reach of the original sampling strategy. A process which is sometimes required to obtain a suitable sample size (Green and Thorogood, 2014).

4.3.4 Sample size

It can be argued that the adequacy of sample size can be relative to the context of the overall research design. A sample of one participant can be sufficient for a case study methodology, while samples sizes of hundreds may be required for quantitative research. Thus, deciding what sample size is the most appropriate, is often based on the judgement of the quality of information against the research questions (O'Leary, 2014). For this study, there were several considerations that needed to be addressed before deciding on the necessary number of participants that needed to be recruited to ensure that sufficient varied and rich data was provided. One consideration was in relation to remaining faithful to the overarching context of the research, while also working with a number that was practical (Robinson, 2014). Therefore, as part of the ethical considerations for this study, an intended minimum target of four qualitative face-to-face interviews and fifty preoperative consultations were set. It was estimated that these numbers would allow for different HCPs' practices to be viewed and would assist with revealing multidimensional perspectives of the same phenomenon (Parahoo, 2014); in this case, preoperative consultations.

Robinson (2014) states that proposing an approximate sample size based on minimum numbers is acceptable, but there also needs to be some level of flexibility, and further re-evaluation of sample sizes may be required. Thus, for this study, sample sizes were

continually reviewed, and it was necessary to recruit additional participants to ensure a comparable number of preoperative visits were observed for patients undergoing specific surgical procedures.

The actual sample size was only determined once the data collection process ended. The criteria to judge when to cease data collection is referred to in qualitative research as data saturation (Gray, 2018). For this study, data saturation was determined as being reached when no new data themes were forthcoming, from either the repeated structured observations of preoperative anaesthetic visits or staff participant interviews, (where a set of topic questions was asked). *Table 1b, page 129* and *figure 11, page 145* illustrate the achieved sample, which is represented by the number of participants. Two patient participants' data sets were later removed from the study, as their care was transferred to an inpatient surgical pathway, and this only transpired during the anaesthetic consultation.

Table 1b: Achieved sample size

Staff or Patient	Observations	Interviews
Anaesthetic Staff	21	9
Nursing Staff	12	11
Patients	127 – 2 = 125	0

4.4 Ethical consideration

During every stage of the sampling process, a conscious review of ethical issues, such as approval processes, informed consent and confidentiality were necessary (Robinson, 2014). These were not only fundamental to the sampling process but also something which every researcher should be cognisant of throughout the entire research continuum (Richards, 2015).

4.4.1 Approval

Research Ethics Committees (REC) are crucial and play a central role in the research process (Danchev and Ross, 2014). As this research project was being conducted within a healthcare environment, ethical approval was required from all the respective organisations (O'Leary, 2014). These included: The University's REC, the Healthcare Regulatory Authority (HRA) and the hospital trust's Research and Development (R&D) team. The application process was therefore conducted sequentially, and ethical principles, which were considered while constructing and formulating the research study proposal, were clearly expressed within each individual application processes. Approval was first granted by the University on the 25th July 2014, and subsequent applications were made to the HRA via the Integrated Research Application System (IRAS) and the hospital trust R&D department, with final authorisation being granted by IRAS on the 27th October 2014 and the hospital trust on the 10th of November 2014 (*see Table 2a, page 130*).

Table 2a: Details of ethical approval

Institution	Application number	Date approved
Northumbria University's Research Ethics Committee	RE-HLS-13-140217-53021b8ce05e9	25th July 2014
Healthcare Regulatory Authority	14/WM/1203 – IRAS Project ID 155251	27th October 2014
Hospital Trust Research and Development Team	0164	10th of November 2014

Continuous, ongoing liaison with the hospital trust's R&D team was essential for completion of the required documentation. This included the research passport application, occupational health clearance, Disclosure and Baring Service (DBS) clearance and a research contract. The research was funded by Northumbria University, as part of a PhD

programme of study, thus, no conflict of interest existed, and neither the participants nor I, benefitted financially from the research project.

4.4.2 Informed consent

Informed consent is a fundamental part of healthcare delivery. It is also crucial within research, as it allows the opportunity for participants to absorb all study information. This has both ethical and practical implications as it ensures informed consent but also reduces the risk of withdrawal at a later stage (Farrimond, 2013). Therefore, a period of time was provided for potential participants to read and consider the study information, before asking them if care/practice could be observed. For consent to be fully informed, there also had to be identification and consideration of any potential risks, discomforts and adverse effects, along with full disclosure of the anticipated benefits and incentives of taking part (Passer, 2014). For transparency, these were outlined in the invitation to participate documentation, sent to potential staff and patient participants.

As well as informed consent, it was crucial to maintain a trusting relationship, to promote the principles of participant autonomy and to ensure participants did not feel coerced to take part (Danchev and Ross, 2014). This can sometimes be difficult when gatekeepers are required to assist with recruitment, as staff may feel pressured to participate (Farrimond, 2013; Green and Thorogood, 2014). Thus, every participant was advised that taking part was voluntary and that there would be no negative impact on their care/practice if they did not wish to take part. This dialogue continued at every subsequent interaction and was beneficial in ensuring consent was fully informed (Holloway and Todres, 2010; Danchev and Ross, 2014). Additionally, participants were made aware that they could withdraw at any stage and that if they withdrew, all the data collected about them for this study would

be destroyed as confidential waste. This was reinforced by the use of a 'debrief information' sheet (*appendix 5, page 329 and appendix 6, page 331*); an excellent way to discuss further stages of the research process, assist with closure and address any concerns that the participants may have, post data collection (Farrimond, 2013; Passer, 2014).

4.4.3 Confidentiality and anonymity

Maintaining participant confidentiality and anonymity are essential when undertaking research, thus, every measure was taken to ensure that both staff and patient information and personal data were not identifiable.

Confidentiality and anonymity are two separate concepts, but both are crucial for ensuring the trustworthiness of the study (Danchev and Ross, 2014). Protecting participants' confidentiality should involve taking appropriate measures to secure raw data, restricting physical and online access and limiting permitted admission (O'Leary, 2014). For this study, confidentiality was maintained through the following processes: when recruiting patient participants, personal information regarding the patients' names, addresses and surgery was never disclosed by the staff member working within the contact centre, and therefore patient names and details of scheduled surgery were only revealed to the researcher on the day that data collection was being undertaken. Additionally, when dealing with electronic information, all data files were password protected and securely stored on my University computer. In relation to data that was present in hard copy, such as field notes and consent forms, these were stored in a locked filing cabinet, in a locked office on University premises.

Anonymity is an aspect of confidentiality, which specifically relates to the act of ensuring that someone's identity is never revealed (Saunders, Kitzinger and Kitzinger, 2015). When collecting and analysing data, it is not always possible to achieve total anonymity, especially if the researcher is aware of a participant's identity (Passer, 2014). Therefore, maintaining the integrity of data while limiting the level to which someone's identity may be revealed inadvertently, was an essential and continuous undertaking. This was aided by the use of unique identifiers, which were used for patients and staff, in order to protect their identity. Additionally, as only select numbers of clinical staff carried out the duties that were under focus, only staff categories were used when linking the unique identifiers to participants' direct quotes. This limited the possibility of participants' vignettes being ascribed to certain members of staff.

4.5 Data collection

As the only researcher, I needed to consider carefully how the various elements of preoperative practice could be observed, while also limiting the time spent and minimising the impact on daily practice. Consequently, in order to reduce researcher bias and enable the collection of a variety of data within a limited time period, eclectic and multimodal approaches to data collection were utilised (Carspecken, 1996; Creswell and Poth, 2018). These were in line with critical ethnography and enabled examination and exploration through observing, listening, and talking (Lee and Zaharlick, 2013) and were conducted in stages, following Carspecken's five-stage approach (Carspecken, 1996). These will now be described in detail, commencing with the stages of data collection before moving onto the stages of analysis.

4.5.1 Stage one – data collection (the primary record)

Data generation began in the day surgical unit in December 2014 and the preassessment unit in July 2015. Within both departments, this commenced with the collection and creation of a primary record, the stage of Carspecken's process wherein the first observational data is collected. Carspecken (1996) suggests that in order to study the culture of any group of individuals, it is imperative that researchers spend time observing the routine and interactions of the group, and document what is being witnessed. This data is monological, as the researcher speaks alone and is primarily passive and framed in the constraints of the observer's perspective (Capone, 2009). Whilst it can be suggested that this can create data which is subjective, this stage was essential. As full immersion in the preassessment and preoperative areas and actively documenting the environment in terms of facilities and functionality, allowed me to become familiar with the environment. This was necessary in order to provide a contextual frame through which the practice could be observed. Being present in the field, albeit in an observational capacity, also enabled broader and more in-depth knowledge to be acquired (Holloway & Todres, 2010), which was more beneficial than learning by purely reading about the environment alone (Kahn, 2011).

Watching and listening can aid in the uncovering of daily work practices and routine, which, for this study, was achieved by using unobtrusive observations. Unstructured and open observation is a technique often employed in qualitative research studies and is the prime research method used in ethnographical studies as it offers a unique opportunity for researchers to explore and attempt to understand a given situation (Curtis and Curtis, 2011; Gregory and Waterman, 2012). For this study, once familiarisation with the wider clinical area was established, the observation activities were focused and prioritised on the

preoperative assessments and anaesthetic consultations with day case surgical patients. These interactions were repeatedly observed, allowing for 'inductive reasoning', a process which has the potential to reveal a vast array of information about cultural practice (Hek and Moule, 2006; Leedy, & Ormond, 2013; Punch, 2014). Repeated observations of some specific aspects of practice were essential, as participants could alter their practice depending on the clinical situation and circumstance (Costley, Elliott and Gibbs, 2010; Price, 2013). To limit the effect of this on the reliability of the data, it was, therefore, necessary to witness a wide array of interactions over an extended period of time, across a variety of surgical specialities and incorporating staff from across the department.

While being present in the clinical areas was important, observations also needed to be recorded to allow for further analysis. Carspecken (1996) suggests that this can be achieved through the use of field notes. These are an essential element of ethnographic studies and are defined as an idiosyncratic record of what is occurring through the observational gaze of the researcher (Madden, 2017). Primarily these can be unstructured, completed while observing practice, or completed later using a data sheet or journal (O'Leary, 2014). For this research project, a combination of unstructured and structured field notes was utilised, and this enabled data collection to become focused after initial immersion in the clinical environment.

One of the limitations of using observational data collection methods is the 'effect of the observer on the observed', otherwise known as the 'Hawthorn effect' which can never be totally avoided (Parahoo, 2014, p. 335). Within healthcare research, this could refer to HCPs altering their usual practice as a consequence of being observed. Therefore, care was taken to limit the ability of the Hawthorn effect to alter the participants' behaviours, by

building rapport, using unobtrusive positioning and the avoidance of direct contact. For the initial observations, this was assisted by the use of a small notepad, which is an approach favoured by Madden (2017), as it is less unwieldy, and the notes can be expanded upon at the end of each day, once away from the area. This size was also beneficial as it was small enough to be carried and concealed on my person, which ensured the data remained secure. I also used a research book as an additional prop, so, it would appear at times that I was making notes whilst reading from the book, rather than recording what was just observed or witnessed or heard. I used this strategy in order to limit the impact that the direct observations and constant note taking could have on the staff; it also ensured that the field notes could be written anywhere, as the documentation areas (central nursing station) was limited in terms of space and accessibility.

For the repeated observations of the preoperative anaesthetic visits and the preassessment appointments, data was recorded with the aid of a structured field notes template (*appendix ten, page 336*), which enabled the simultaneous collection of qualitative and quantitative data. To assist with the process Creswell and Poth (2018) advocate the use of an observation protocol, which incorporates aspects such as the physical settings, reflections, particular interactions and the researcher's reactions and thoughts. However, due to the emergent nature of the research study design, it was not possible to formulate a structured template for the anaesthetic visits prior to immersion in the field. This was therefore created once familiarisation with the clinical area and daily practice had been established. Additionally, it was necessary to observe practice and create some data to preliminarily analyse, in order to extrapolate the primary themes and specific aspects of practice that needed to be focused on for repeated observations. This initial analysis and data reduction were required prior to returning to data collection activities, as analysis, which is a

continuous process, often becomes more complex as the level of data increases (Walliman, 2016).

The structured field note of the various preoperative assessments and anaesthetic consultations also enabled the capture of data that could be quantifiable for later analysis. Quantitative observations have successfully been used within ethnographic studies, particularly within field notes, which are often used as a basis for recording numerical data to help understand healthcare professional practice (Curtis & Curtis, 2011). With the template for this study, this was achieved by incorporating closed questions and questions where a wide range of responses could be stipulated. The choices were then later condensed to variants and categories with a designated number, in order to be numerically transformed. This recasting allowed the raw data to be altered in order to make the analysis process more manageable (Acton *et al.,* 2009). Thus, within the structured field notes, specific variables needed to be clarified to assist with this process and increase the level of validity and reliability. This was achieved by reviewing the observed field notes obtained from the first two days and then creating a structured field note template that was subsequently piloted, tested and revised over the following days. The variables needed to be exhaustive (other or N/A) or mutually exclusive (yes or no) (Schensul and LeCompte, 2013), to allow for both qualitative and quantitative data to be captured. These variables included personal reflections, patient biographical data such as age and gender, details of the scheduled surgery and time data relating to the specific questions being asked, the

Reflective Diary Extract – 15th December 2014

"Decided that it was not appropriate and would negatively impact on observations of preoperative visits to watch interaction and write notes in such a confined space. So structured field notes must be completed immediately after observing the interaction."

clinical assessments being undertaken, and the length of time spent on pain planning and management.

During the collection of this data, the observation of practice became more intimate in terms of physical space, as the preoperative anaesthetic visits were conducted next to patients' beds, and behind closed curtains. Again, being conscious that my presence might create a Hawthorn effect, I stayed on the periphery of the reduced physical area. I did not take notes, and I limited the amount of non-verbal communication in order to reduce any undue influence on the anaesthetists' usual practice or the patients' responses to the questions.

As well as maintaining structured field notes, observations and audio recordings of the preoperative anaesthetic visits were undertaken, as this was the primary interaction where pain planning and management were discussed. More importantly, recording the conversation on a digital device allowed for the timings to be verified, ensured greater accuracy when transcribing participants' narratives, increasing reliability and therefore the validity of data collection (Carspecken, 1996). However, the audio recording equipment needed to be fit for purpose (Punch, 2014). For example, the recording of ambient noise could negatively impact on the subsequent transcription and analysis of the data (O'Leary, 2014; Gray 2018). Therefore, the final device purchased was portable and capable of filtering ambient noise, as it possessed directional microphones. Recordings were only undertaken after both staff and patient participants signed the relevant consent forms, which detailed that the interaction would be observed and audio recorded. As observations of practice were solely focused on preoperative interactions before entering the operating theatre rooms, I acknowledge that any subsequent conversations between patients and

HCPs were not observed and that it is possible that pain planning and management discussions may have taken place during the final interaction in the anaesthetic room. However, due to limitations in terms of time, potential issues around infection prevention and privacy and dignity, the intrusive nature of the observations and my own previous experience and knowledge of the conversations that occur during the anaesthetising period, I decided to omit this from the data collection period.

Another method of data collection used in stage one involved a critical examination of the practice documents used by the nursing and anaesthetic staff as part of standard preoperative care. These included pre-assessment documentation, day case documentation, theatre, anaesthetic and prescribed medication records. Ethnographers have the ability to utilise a broad range of resource and data collection methods, and while they may examine what is happening by watching, they can also use documents which can provide written evidence of the language and words used by participants (Holloway and Tordes, 2010; Creswell, 2014; Gray, 2018). Patient notes were therefore examined, in order to provide biographical, surgical, and medical data. The information reviewed in each case was standardised to include only sections of notes which would provide information that directly related to topic areas and questions on the structured field note template. This ensured the quality of data collection, and assisted with data analysis. It also ensured the confidentiality of patients' information unrelated to the study. By combining document analysis with interviews and observational field notes, triangulation was possible and added to the overall validity of the research, as it allowed the examination of 'real-world' practices from a variety of data perspectives (Silverman, 2010; Flick, 2014). This technique also allowed both qualitative and quantitative data to be cross-correlated,

enabling examination of what the clinical staff claimed as truth, against what was witnessed practice (Boswell, 2014).

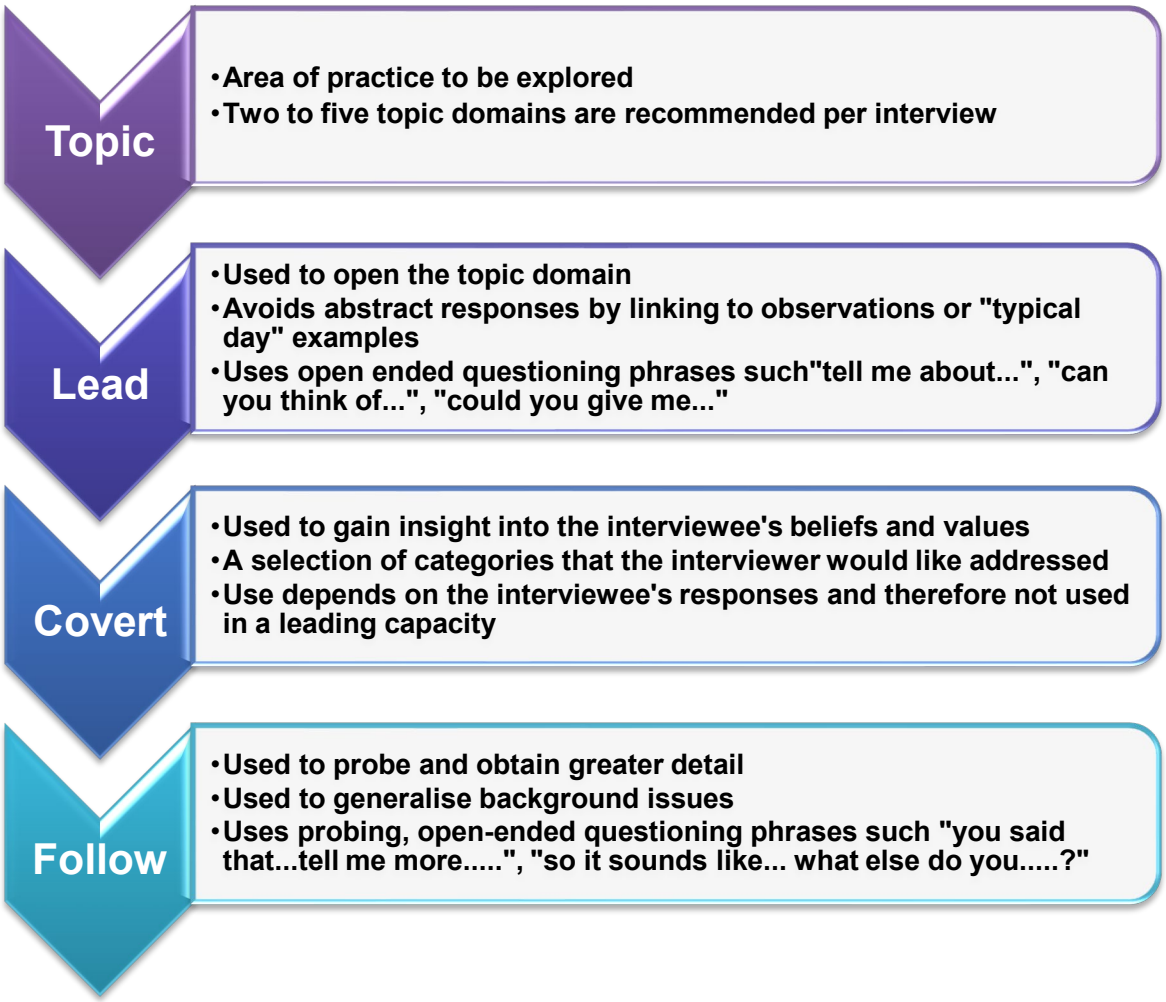
4.5.2 Stage three - Dialogical data generation

Once practice had been repeatedly observed and the documents had been examined, the data collection process broadened out to include information of a more dialogical nature. Clarifying conversations (which unlike ordinary conversations, have a clear agenda) and one-to-one interviews were utilised, in order to illuminate the department narratives and confirm what was observed in practice, against what was said between participants (Rubin and Rubin, 2012; Parahoo, 2014). The combination of observations and interviews is often used in ethnographic studies to elucidate meaning (Green and Thorogood, 2014), as the way healthcare staff interact with the world is socially constructed by their beliefs and formulated by their experiences, both of which can shape their clinical practice (Costley, Elliott and Gibbs, 2010; Parahoo, 2014). Interviews were therefore used to provide the participants with the opportunity to share their opinions on pain and how it is managed preoperatively, and this additional insight helped to inform and triangulate the data that was collected as part of the observational and document analysis process.

The interviews were semi-structured, conducted face-to-face, audio recorded and undertaken, with HCPs who provided consent to have their practice observed. The interviews were undertaken towards the end of data collection for each department, to ensure that a vast array of practice could be observed prior to dialogical data generation. This also assisted with the interview recruitment process, as due to the passing of time, staff became more accepting of my presence within the department. Due to time-lapse between the observations and interviews, recall of interactions may have been limited;

however, as the interviews were largely focused on gaining their views, opinions and perceptions of preoperative process, accurately detailed recall of each specific interaction observed was not needed. As a semi-structured and flexible approach was used to elicit participants views and opinions on a selection of topics, it was necessary to prepare an interview framework (*appendix 11, page 337*), and this was based on Carspecken's four-stage flexible interview approach (Carspecken, 1996). This consisted of four main areas: specific topic area, lead open-ended questions, covert categories, and follow up questions *(see figure 10, page 141)*. Using this framework proved to be extremely beneficial, as spending time considering the most suitable approaches and questioning techniques to use, ensured a more focused interview.

Figure 10: Open-ended approach (adapted from Carspecken, 1996)



In order to foster trust, it was also essential to build rapport during the interview process (Rubin and Rubin, 2012). This was achieved using a responsive and interview-friendly approach, that commenced with a gentle introduction question; this allowed the participants to talk about their career journey. While this question was not explicitly related to the main topic area, this informal introduction is a beneficial approach to take when conducting interviews and provides an opportunity for the participant to relax and helps put the interviewee at ease (Larkin, 2013; Green and Thorogood, 2014; O'Leary, 2014).

The questions used during this initial lead phase were open-ended, which was an appropriate method to use in order to elicit a wide variety of responses interviewees (Rubin and Rubin, 2012). It also enabled interviewees to reply in a way they desired, and they could expand on the questions, disagree, or even relate their answer to a personal agenda. The framework also acted as a guide to ensure that the topics reflected more precisely, the observations and duties of the HCPs being observed. Consequently, separate frameworks were constructed for the anaesthetic staff, the ward nursing staff and the preassessment nursing staff.

During the interview, non-verbals were kept to a minimum in order to lessen positive or negative messages, as verbalising yes or nodding during the interview may increase misunderstanding (Larkin, 2013). The interviews were also carried out at the convenience of the HCP, on NHS premises, and in a private space which was familiar to the participant.

Reflective Diary Extract – 10th March 2015

"I have just undertaken my first interview and I was surprised how difficult I found it. I definitely need to spend more time probing and shouldn't be afraid to ask them to explain why and how".

The length of the interviews varied between forty-five to ninety minutes, which is an acceptable length of time, as a phenomenon is unlikely to be explored in less than thirty minutes (Parahoo, 2014). However, interviews can be difficult, and researchers need to develop their interview skills by using reflective practices (Green and Thorogood, 2014). I, therefore, independently reviewed each interview and documented my impressions in my reflective journal. This allowed amendments and corrections to my technique to be made before conducting the next interview.

What was also undertaken during the interview process was member checking. This is a technique often used by ethnographers in an attempt to increase the credibility of the findings (Kahn, 2011). It is acknowledged that there are disadvantages associated with this technique, such as different members having diverse views on the same data, or disagreeing with the research interpretations (Creswell and Poth, 2018). Nevertheless, member checking was incorporated as it was central to Carspecken's critical enquiry and process of reconstructive analysis, and a strategy often used as a way of evaluating field notes and perceptions of observations, by asking any participants for clarification and verification (Hardcastle, Usher and Holmes, 2006). For this study, the process of generating and reconfirming ideas and concepts extrapolated from the observations, were undertaken by interacting with staff and asking questions while observing practice, asking the nursing staff to read field note examples, and encouraging anaesthetic staff to review some of the quantitative statistical data and transcriptions from their anaesthetic consultations.

4.6 Data analysis

Whilst data collection is essential, it is the data analysis which will enable the researcher to generate findings, and in order to do this, they need to delve into the raw data and try to make sense of it (Parahoo, 2014). This is sometimes more difficult with ethnographic research, as the sorting and coding of data are often more onerous, due to amount and variety of the collected data; thus, it was necessary for me to develop an overall data analysis plan *(see figure 11, page 145).* This consisted of several stages of analysis involving familiarisation with the crude data, transcribing the audio recorded data, coding, re-coding, interpretation of the qualitative data and examination of the quantitative data in order to demonstrate patterns within the practice observed. This section will describe the data analysis process in more depth, ensuring that each remaining stage of Carspecken's five-stage process is clearly explained and examples are provided in order to assist with the discussion of the sorting, coding and theme generation processes.

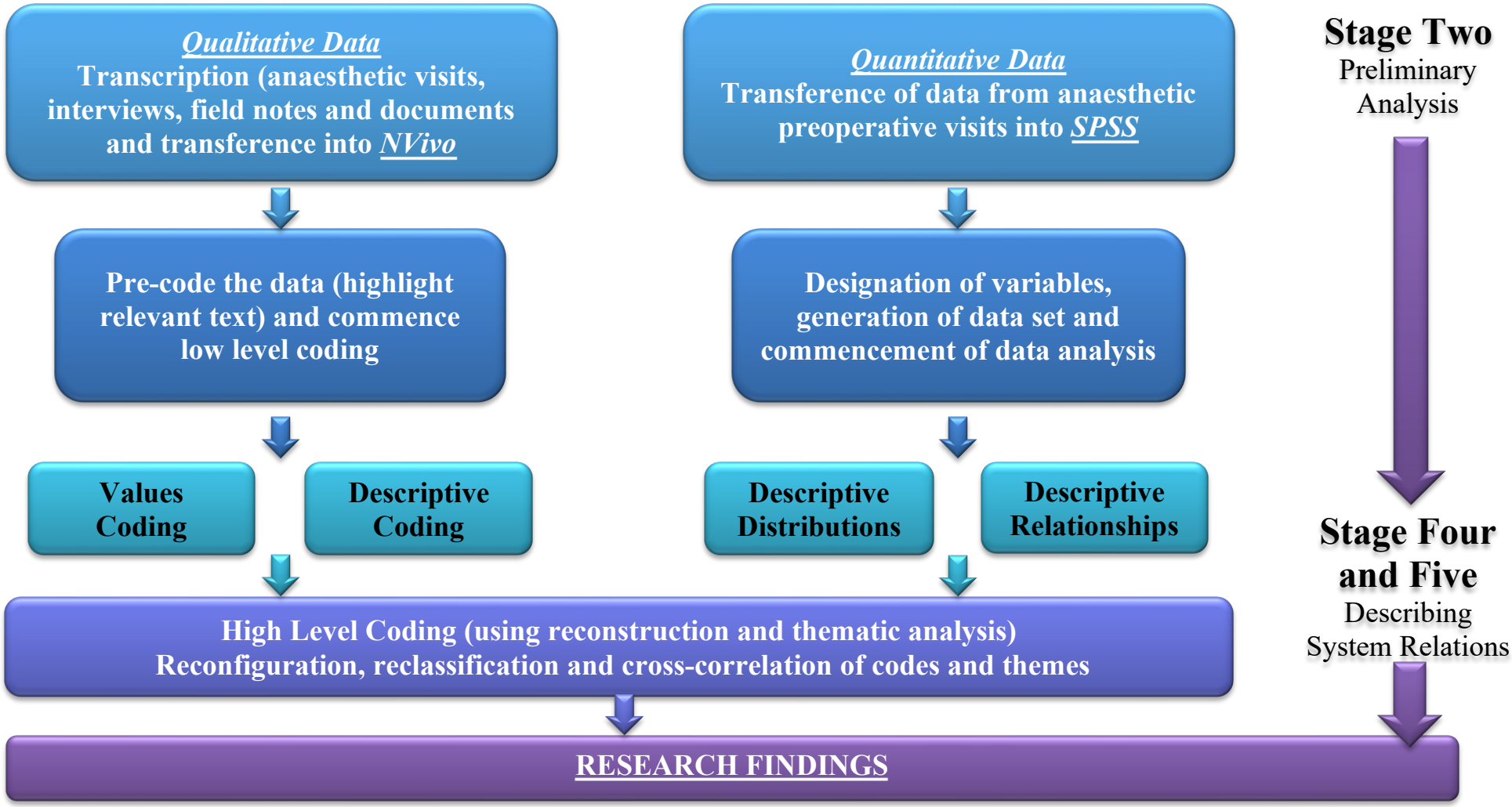


Figure 11: Data analysis diagram

4.6.1 Stage two – Preliminary reconstructive analysis

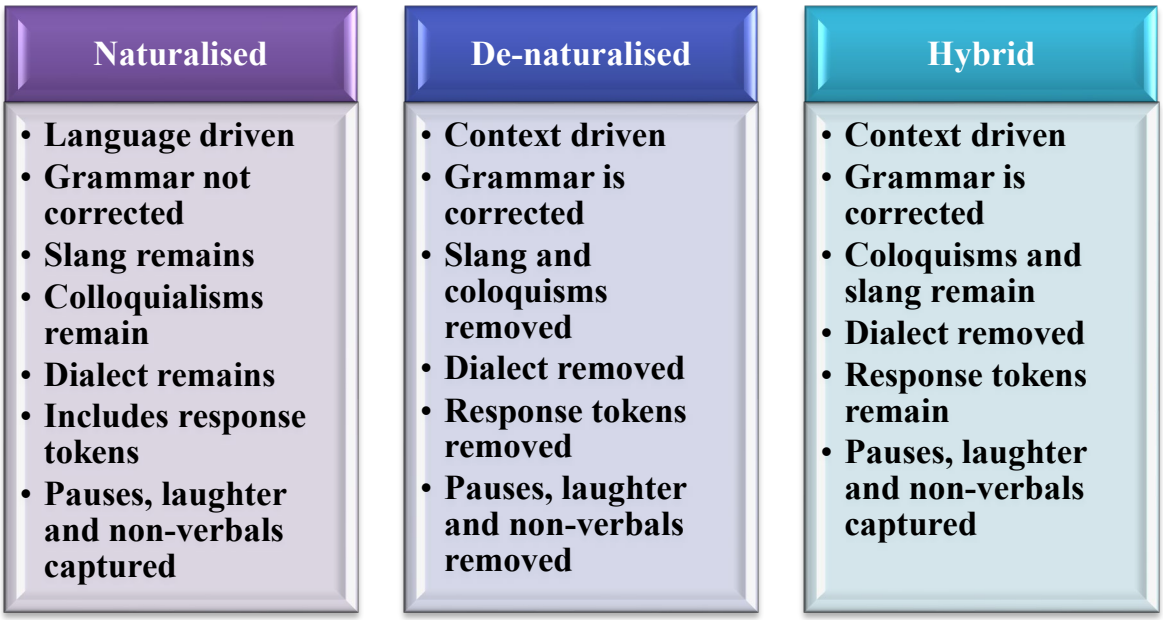
This stage of the critical ethnographic process incorporates the analysis of the data while contemplating issues that may appear unconsciously and may underline the behaviour and cultural practice (Capone, 2009). Thus, reconstructive analysis is the process whereby the researcher can look for the hidden and deeper meaning associated with actions and social interactions that are not initially articulated by the verbal language of the participants (Capone, 2009). It is a cyclical process (Carspecken, 1996); thus, results were revisited and revised, especially when additional data was generated during stage three. However, initial meaning reconstruction, which incorporates elements of a repetitive review of the raw data and the generation of hierarchical codes (Burnette, 2015), can only be achieved once the audio data has been transcribed.

4.6.1.1 Transcription

In order to examine the raw data and commence analysis, it was necessary to transfer the interaction data via narratives (digital audio recordings) to a word file, for ease of examination (Grbich, 2013). This process is called transcribing, and is the first step in the analysis process (Rubin and Rubin, 2012). However, before it can begin, there needs to be some consideration of who will transcribe the data, how it will be described and to what depth. As the only researcher, with no access to additional funding, I transcribed all of the data. Whilst this was practically necessary it was also advantageous, as it enhanced my overall research skills and enabled me to become very familiar with the raw data and identify nuances (Bolden, 2015; Clarke, Braun and Hayfield, 2015; Richards, 2015). As there are no shortcuts to transcribing, this proved to be a long process (Green and Thorogood, 2014; Gray, 2018). Nevertheless, the length of time taken to undertake this

task increased the level of deep immersion, which improved validity and reliability (Harding, 2013) and increased the overall ease and speed of coding and analysis. Deliberation of how the audio data would be transferred into written words was also undertaken, as the type of transcription depends on the analysis method used and the underpinning theoretical stance (Rubin and Rubin, 2012). How the spoken words are recorded into a transcribed arrangement, can be categorised along a sliding scale, with two opposing domains (naturalised to denaturalised), and the actual transcription process used can rest anywhere along this continuum (Oliver, Serovich and Mason, 2005). *Figure 12, page 147,* illustrates the characteristics of these methods of transcription.

Figure 12: Methods of transcription (adapted from Oliver, Serovich and Mason, 2005)



For this research study, although de-naturalised transcription is a process often used within ethnographical studies (Carspecken, 1996), a hybrid transcription process was adopted. I chose to utilise this process as the coding method was not predetermined and therefore took into consideration the transitions, silences, repetitions and tenses within the data. This

also ensured accuracy and allowed for a coding technique to be applied at a later stage (Bazeley & Jackson, 2013).

As conversation and discourse are seldom spoken in correct English (Green and Thorogood, 2014), using the hybrid transcription method also enabled aspects of the naturalised transcription process to be adopted, which offered more detail about the meaning behind the spoken word. As power can be implicit within the narrative of interaction, it was important to ensure that any colloquial or slang word representing power should remain. However, in order to ensure that the context was not overshadowed by the peculiarities of an account littered with nuances of accent and obscurities (Flick, 2014), aspects of de-naturalised transcription were also embraced. *Figure 13, page 148,* provides an example of how the three approaches to transcription altered the transcribed account.

Figure 13: Example of transcription approaches

The illustration uses an excerpt from Participant One's interview

Naturalised

- **Aye, I do (nods head). Erm....I think if I had been, ye knaa, younger mebbee, ye knaa, aa'd hev mebbe studied at summat else.**

De-naturalised

- **Yes, I do. I think that if I had been younger, I would have perhaps undertaken further study.**

Hybrid

- **Yes I do [nods head]. Erm...I think that if I had been younger, I would have maybe studied something else.**

In order to maintain a level of uniformity when transcribing the audio recorded data and to ensure continuity, a transcription convention table was created (*see table 2b, page 149).*

Table 2b: Transcription conventions

Meaning	Convention
Pause in speech	……..
Names and Locations	XXXX
Inaudible words or phrases	???
Section of extract omitted	[….]
Laugher, gesture or non-verbal actitivy	(*laugh*) / (sniff)
Interviewer speaks	I:
Participant speaks	S: (Staff) P: (Patient)
The hyphen is used to donate a word that has been interrupted	-
Word was spoken more, loudly than others in the sentence	CAPITALS

As a level of thematic analysis had already been conducted within the clinical setting as part of the creation of the structured quantitative field notes, it seemed appropriate and logical to continue with the analysis of this data first, extending it further, to incorporate the qualitative data from the transcripts of the preoperative anaesthetic consultations. Undertaking transcription and analysis simultaneously was a valid method to adopt, as transcription is not a separate process, but part of the overall data analysis procedure (Ravitch and Riggan, 2012). Additionally, transcriptions of each subsequent audio recorded interaction were undertaken immediately following the observation of practice. This led to a greater appreciation of the interview process and assisted with the development of my interview technique. Throughout the findings section of this thesis, a selection of vignettes from the tape-recorded interviews and preoperative anaesthetic visits will be used to demonstrate the evolvement of the analysis process and provide examples of the data themes and subsequent findings. These will appear in italics, within speech

marks, and will only be represented by the unique participant identifier, which is shown in *table 4, on page 168*.

4.6.1.2 ***Coding***

When creating the analysis plan (*see figure 11, page 145),* it was necessary to choose a design which remained faithful to the underpinning methodology of critical ethnography (Grbich, 2013) but also ensured that the data reduction process was feasible, reliable, and interactive (Capone, 2009; Holloway and Todres, 2010). Thematic analysis was utilised, as it was a method of analysing and reducing data which allowed for inductive inferences to be used, in an attempt to look for patterns and links, locate themes and relationships, and generation of hierarchical codes (Crang and Cook, 2007; Gibson & Brown, 2009; Green and Thorogood, 2014; Miles, Huberman and Saldaña, 2014; Saldaña, 2016). This approach has been used successfully within healthcare research, and is a technique often used for qualitative data (Silverman, 2014) and critical ethnographic studies (Hilton *et al*., 2001; Groenkjaer, 2002; Hughes, Deery and Lovatt, 2002; Pesut and Reimer-Kirkham, 2010).

One of the underlying features of thematic analysis, which was interwoven within Carspecken's (1996) meaning reconstruction, was the use of a coding process. Coding is defined as being a heuristic process, which serves as an aid to learning and a means of grouping together and identifying themes (Madison, 2012; Harding, 2013; Miles, Huberman and Saldaña, 2014). It can be applied to various data types including observations, field notes, documents and interviews, and is cyclical rather than linear due to its multidimensional nature (Saldaña, 2013). There are two main types of coding: priori, which is more deductive and derived from pre-existing knowledge, and empirical, which is

more inductive (Gibson and Brown, 2009). These are not mutually exclusive, and for some research methodologies, researchers may use more than one, merge the coding styles, or use sequential coding methods in order to analyse the data (Harding, 2013).

For this study, the type of analysis and coding method chosen and how they were applied, logistically and practically, were guided by the research methodology. Consequently, the themes that emerge should be relevant to the researcher's ontological position and accordingly framed within culture and power. Eclecticism, which is a conceptual approach utilised within Carspecken's (1996) critical enquiry, encourages creativity, alternative ways of thinking, and deriving ideas from a broad range of sources (Braun and Clarke, 2006; Flick, 2014; Saldaña, 2016). As such, a combination of coding approaches was applied to the data, including low and high-level coding and descriptive and value based coding (see *figure 11, page 145).* The adoption of this staged coding process enabled all of the data to be examined, with some data being roughly categorised during part of the low-level coding process and then more detailed examination as part of the high-level coding elements of analysis (Carspecken, 1996).

The first stage of the coding process was to pre-code the data. This involved proofreading the completed transcripts in order to correct any errors and reduce the possibility of data misinterpretation. This process also assisted in ensuring a more accurate level of interpretation and abstraction of the content. At that stage of the analysis, interesting passages, words, phrases and quotes worthy of attention were highlighted in order to assist with the process of low-level coding. This involved close and repeated reading of the transcripts, in order to allow for categorisation of sections of the data into corresponding codes (Bazeley & Jackson, 2013). These were then labelled in relation to the content and

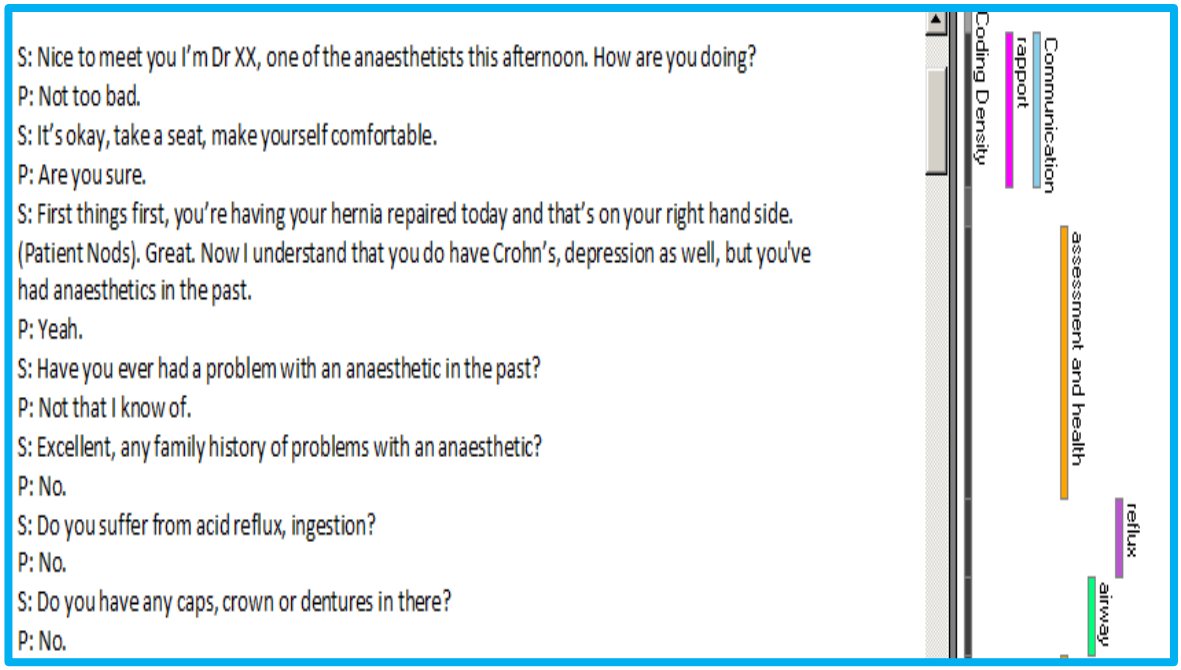
subject matter of the specific data, before moving to more in-depth and detailed analysis. Carspecken (1996) claims that low-level coding requires minimal abstraction as the codes themselves remain very close to the primary data and are thus more objective in nature, depending upon the level of meaning reconstruction that takes place. The codes created related to topics and themes and incorporated either words, paragraphs or pages of data (Saldaña, 2013). Additionally, in order to ensure that the reasoning behind the coding decision was not lost, a coding memo was created for each corresponding code, to reduce potential inaccuracies and confusion, as more than one code could be applied to specific sections of the data (Clarke, Braun and Hayfield, 2015; Richards, 2015).

During the low-level coding process, data were also analysed with the use of descriptive and value coding. Descriptive coding is a coding method referred to as an elemental method, used for field notes and large amounts of data and is a useful technique for novice researchers (Saldaña, 2016). It is often used when research is conducted within social environments and allows for the summarising of simple topics that can be found within a passage of data (Miles, Huberman and Saldaña, 2014). Describing coding is very similar to the reduction coding techniques used within quantitative studies (Richards, 2015) and can include the summarisation of data using a word or phrase, usually a, noun (Saldaña, 2016) or information about the topics discussed or participants' information (*see figure 14a, page 153*). Therefore, descriptive coding was an appropriate strategy to employ to assist with the triangulation of the qualitative and quantitative data.

Values coding is a technique, which is described as an effective method of data analysis, often used for interviews and is congruent with the research questions examining values, beliefs and attitudes (Miles, Huberman and Saldaña, 2014; Saldaña, 2016) (*see figure 14b,*

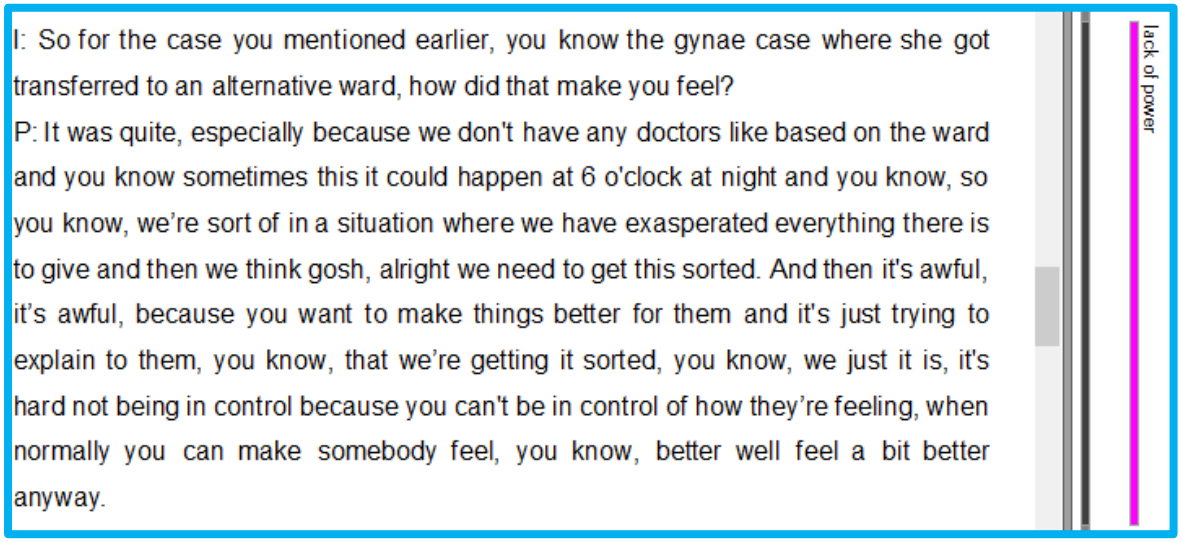
page 153). Values coding was therefore also employed with high-level coding processes and confirmed during pragmatic horizon analysis, which allowed examination of the codes through various perspective lenses, increasing reliability and reducing bias.

Figure 14a: Example of descriptive coding from preoperative consultation



S: Nice to meet you I'm Dr XX, one of the anaesthetists this afternoon. How are you doing?
P: Not too bad.
S: It's okay, take a seat, make yourself comfortable.
P: Are you sure.
S: First things first, you're having your hernia repaired today and that's on your right hand side. (Patient Nods). Great. Now I understand that you do have Crohn's, depression as well, but you've had anaesthetics in the past.
P: Yeah.
S: Have you ever had a problem with an anaesthetic in the past?
P: Not that I know of.
S: Excellent, any family history of problems with an anaesthetic?
P: No.
S: Do you suffer from acid reflux, ingestion?
P: No.
S: Do you have any caps, crown or dentures in there?
P: No.

Figure 14b: Example of value coding from participant interview

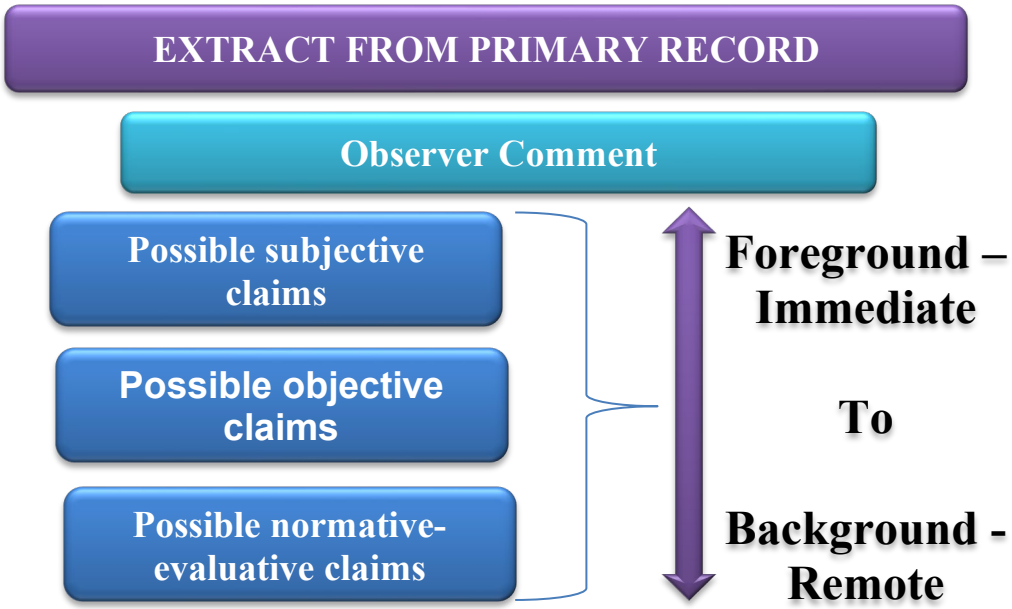


I: So for the case you mentioned earlier, you know the gynae case where she got transferred to an alternative ward, how did that make you feel?
P: It was quite, especially because we don't have any doctors like based on the ward and you know sometimes this it could happen at 6 o'clock at night and you know, so you know, we're sort of in a situation where we have exasperated everything there is to give and then we think gosh, alright we need to get this sorted. And then it's awful, it's awful, because you want to make things better for them and it's just trying to explain to them, you know, that we're getting it sorted, you know, we just it is, it's hard not being in control because you can't be in control of how they're feeling, when normally you can make somebody feel, you know, better well feel a bit better anyway.

4.6.1.3 Pragmatic horizon analysis

As part of high-level coding (which requires a higher level of abstraction) and meaning reconstruction, the determination of meaning and truth claims needed to be embedded (Carspecken, 1996). I achieved this by incorporating pragmatic horizon analysis (*see figure 15, page 154*) to increase the validity of the research findings, as a variety of perspectives and possibilities had been thoroughly examined before deciding on the final code.

Figure 15: Pragmatic horizon analysis (adapted from Carspecken, 1996)



Using this technique enabled a specific aspect of practice to be explored and the possible objective and subjective viewpoint to be scrutinised from a background and foreground perspective and allowed conclusions to be drawn as to what was more immediate, in terms of claim and what was more remote (Carspecken, 1996; Burnette, 2015). This process is essential in research examining power, as inequalities are often not overtly displayed or articulated in participants' responses (Mahon, 2011). Therefore, there needed to be a process where the culture and meaning behind the participant interactions could be reconstructed, and this was achieved using Carspecken's pragmatic horizon analysis,

which draws strongly from Habermas‘s theory of communicative action (Smyth and Holmes, 2005). This is founded on the premise that all human interactions involve language and that the meaning of what is said about reality can be interpreted in a plethora of ways, depending upon the context of the environment and the political and economic undercurrents that may exist and drive the interaction (Seidman, 2013).

As a result, what is verbalised by an individual can be challenged in terms of validity, and legitimacy needs to be confirmed by exploring the meaningfulness and truth of the content, as well as the authority and sincerity of the speaker, before finally reaching a mutual agreement (Habermas, 1984; 1988). Within cultural groups, consensus views on validity claims are often clearly defined and determined, especially if individuals share common values and beliefs; these are referred to as cultural established understanding (Habermas, 1984). However, these can be brittle, and views on validity can be altered, due to organisational demands, peer group pressure or if the landscape is misinterpreted (Habermas, 1984; Stewart and Usher, 2007; Seidman, 2013). Consequently, for analysis of the observed and recorded data, validity claims for this study needed to be explored, in order for a conclusion to be drawn about the version of events.

I achieved this by examining objective, subjective and normative validity claims. Objective claims are associated with third-person perspectives and are often validated with the use of repeated observations. Subjective claims, meanwhile are related to the individual's first-person perspective, and an internal world where the normative claims of the social world are the accepted social norm (Long, 2017). Thus, the data needed to be examined through a process of rationalisation and justification of actions, through reference and linking to existing normative contexts (Habermas, 1984).

Horizon analysis and meaning reconstruction used as part of high-level coding can be beneficial, especially as some researchers may be fearful over the level of potential ambiguity with the coding processes (O'Mahony *et al.*, 2012). Additionally, this process can limit the potential for any misunderstanding of the meaning behind other practitioners' words, or body language (Holloway and Todres, 2010). The interpretation of the data away from the field, can be a further step for ensuring validity, as the researcher will not be overly influenced by the environment, and will have adequate space and time to reflect about what they have seen and how this relates to the research question (Grbich, 2013).

The ideas and findings generated from the pragmatic horizon analysis can be cross-checked when interacting with participants during continued data collection processes (Hardcastle, Usher and Holmes, 2006; Stewart and Usher, 2007). The analysis of data is not a separate entity but an integral, integrated and extended aspect of the data collection process (Miles, Huberman and Saldaña, 2014). This is reinforced by the fact that stage two of Carspecken's approach was both a data collection and analysis stage.

This was a strategy I used in an attempt to gain supplementary views and perspectives and confirm participants' interpretations of practice. It involved examination of the data and deconstruction of the details; in essence breaking down the rich monological data in order to assist with the uncovering of any biases or power imbalances (*see table 3a, page 157 and table 3b, page 157*). This information was then used and incorporated into the high-level coding and concurrent analysis of the data within stages four and five.

Table 3a: Sample of pragmatic horizon analysis from the primary record (field note)

Primary record data: Field notes in relation to an observed conversation between two members of staff. ***The staff member stated, "they don't normally give OxyContin for that, it's just normally given to orthopaedic patients, it's just an ablation, not a major thing. She will not wake up post-surgery". This was in relation to a preoperative analgesia request from an anaesthetic member of staff for a gynaecological patient.***		
Observer comment	A staff member is openly questioning the analgesic regime and suggesting that day case gynaecological patients do not experience as much pain as orthopaedic patients.	
Possible subjective claims	**Foreground** 1) This patient is weak. 2) The prescribing staff member lacks education.	**Background** 1) Gynaecology procedures are not painful. 2) Prescribing staff member must be inexperienced or junior.
Possible objective claims	**Foreground** 1) This will delay their discharge.	**Background** 1) I'm never going to get home on time.
Possible normative – evaluative claims	**Foreground** 1) Postoperative pain management is directly linked to a specific type of surgery. 2) Staff favour rigid and repetitive practice.	**Background** 1) Gynaecology patients don't need that much analgesia compared to orthopaedics. 2) Staff knowledge is inadequate.

Due to the amount of data that was generated, a software package (NVivo) was used to assist with the process of analysing the qualitative raw data. Using computerised programmes could increase effectiveness and efficiency when there is a significant amount of data and can often support coding designs with complex levels of analysis (Bazeley & Jackson, 2013). Therefore, it was a useful programme to use for the amount of data that needed to be analysed and enabled all the data from field notes, documents, interviews, observations and reflection diaries to be placed into folders for ease of access; this was invaluable when looking for themes and vignettes that represented the various codes (Richards, 2015).

Table 3b: Sample of pragmatic horizon analysis from the primary record (visit)

Primary record data: Structured field note - anaesthetic visit. *"S29: Okay, do you take any painkillers normally?* *P36: No* *S29: Is there any painkillers that you can't take?* *P36: No.* *S29: No. Erm, nothing upsets your stomach or anything like that?* *P36: No."*		
Observer comment	This was discussed during a section of the interaction where the anaesthetist was ascertaining current health status and current medications. A broader conversation in relation to pain relief only occurred towards the end of the interaction when the staff member told the patient about what would happen when they were in the operating room.	
Possible subjective claims	**Foreground** • Staff member is trying to ascertain what analgesics the patient usually takes	**Background** • Staff member is trying to include the patient in the decision-making process
Possible objective claims	**Foreground** • Staff member is worried about side effects and drug reactions	**Background** • Staff member is trying to avoid unnecessary harm and possible litigation
Possible normative – evaluative claims	**Foreground** • Patient safety seems to be prioritised over holistic patient-centred care which includes patient empowerment.	**Background** • Discussion is more patient safety-focused rather than an open and bi-directional conversation which involves patient choice.

4.6.2 Stages four and five – conducting systems analysis

One aspect of critical ethnography that is distinctly different from classic anthropology studies is how themes from research findings link to broader structures of power that exist within a culture. Stage four and five, therefore, involved a close examination of the data, in order to abstract common themes and create a descriptive account of how the relationships between the data and coding themes were aligned (Carspecken, 1996).

During these stages, culture was not socially constructed through the views of one person, but instead created through the close examination of the relationships and social systems

that existed within the culture under observation (Lee and Zaharlick, 2013). This was achieved by exploring how the data codes were associated with broader socio-political aspects and making connections with theory and findings from previous research (Smyth and Holmes, 2005; Hardcastle, Usher and Holmes, 2006).

The first process within stages four and five was to bring the low and high-level codes together in order to generate a hierarchical template, which Carspecken (1996) states can only be achieved after stages one, two and three have been completed. To examine the thematic concepts and conceptual identities, thematic maps were utilised, as these are a useful way to visualise emergent themes in a creative and artistic manner, and assist in streamlining thought processes and theme generation (Harding, 2013; Saldaña, 2013; Clarke, Braun and Hayfield, 2015). By using this approach, the macro-sociological theory that is found will be derived inductively from the data and will fit the research question, rather than trying to use the findings to fit a specific predetermined macro-sociological theory (Smyth and Holmes, 2005). Additionally, this proved to be a beneficial approach to adopt for this study, as it ensured that there was a standardised approach to theory development across the qualitative and quantitative data. This also provided a basis upon which the findings could be illustrated, as hierarchical trees *(see figure 36 page 228)* were used in order to assist with the articulation of the findings.

In order to increase validity and reliability, a process of triangulation was undertaken which involved cross-correlating the codes from all types of primary data, especially during the generation of high-level codes, meaning reconstruction and horizon analysis. This was important as high-level codes require support from other sections of the primary record (Carspecken, 1996). Therefore, once a high-level code was generated, the

quantitative and qualitative primary data were examined, in order to find instances of supporting data to strengthen the rationale for the code. Triangulation, therefore, enabled evidence from a variety of sources to be combined within coded themes, which is a useful widely accepted validation strategy for applying equal relevance to all forms of data (Flick, 2014; Creswell and Poth, 2018).

The process described was intensive and time-consuming; however, being organised and methodical in the overall approach ensured that the largest amount of data could be analysed and examined. This constant comparison can also allow for greater exploration of any similarities or differences and rival or contradictory instances, in order to gain a more realistic and accurate representation of the data (Creswell and Poth, 2018). It is a technique often used in qualitative studies and can increase the strength of the findings (O'Dwyer and Bernauer, 2014; Aagaard *et al.,* 2016). In terms of increasing reliability, Carspecken (1996) also suggests that stages four and five should continue to include participants in the process of member checking. However, Hardcastle, Usher and Holmes (2006) state that during stages four and five, this is not always possible due to time constraints, work structures, and participants' lack of understanding of social theory. This was the case with this thesis, therefore, the final stages of analysis were examined by a member of the supervision team in order to increase rigour. The stages of qualitative analysis have been discussed in depth; what follows is an account of how the quantitative data were analysed.

4.7 Quantitative data analysis

In relation to the quantitative data from the anaesthetic visits, the length of time spent discussing specific topics and the numerical information from this data also needed to be analysed, and this was undertaken with the use of a software programme called SPSS. One

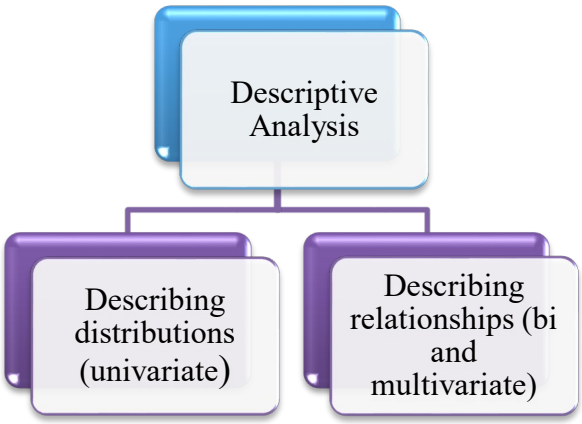
of the first steps when undertaking quantitative data and analysis, especially when using software packages, is to create a data set in order to read and extrapolate statistical meaning easily (Salkind, 2014). This was generated from the observations, audio recordings and timings of the preoperative anaesthetic visits. As there was a large amount of raw data with varying characteristics, the data needed to be separated and categorised according to the variables that would be used for the analysis process. Variables are used as a means of describing characteristics or behaviours and attributes that vary between participants; thus, before analysis, there needed to be an understanding of the types of variables and how these could be analysed and examined (O'Dwyer and Bernauer, 2014). The variables that were predominately used for creating the dataset were nominal (surgery type, the gender of staff and patient), interval (age) and the ratio (timings of interactions in seconds) (Gray, 2018). Once the dataset was created, it was then possible to begin the analysis process. Within quantitative research, there are usually three main ways to analyse the data, descriptive, correlational and experimental (Parahoo, 2014). This research study utilised descriptive means, not only in terms of sample demographics, but also descriptive in relation to the responses from the data collection.

4.7.1 Descriptive statistics

Descriptive statistics allows for articulation of the quantitative findings in a way which examines features and the main characteristics, without having to read the entire dataset. Within some research studies, descriptive statistics provide all the information that is required on the specific group under investigation to answer the research question (Salkind, 2014). Within descriptive statistics, two main methods can be utilised to describe the attributes of the individual culture being researched, and this will be determined by the

types of data collected and the research question (O'Dwyer and Bernauer, 2014). These include univariate distributions and describing relationships *(see figure 16, page 162).*

Figure 16: Types of descriptive analysis (O'Dwyer and Bernauer, 2014, p193.)



For this study, the quantitative data was used as a means of describing the specific cultural group and was not used to infer anticipated patterns within the larger population; therefore, it was appropriate to use descriptive statistics alone. Additionally, in order to examine all aspects of the data set, both distributions and relationships were examined.

4.7.1.1 Distributions:

Descriptive analysis using univariate distributions is an effective way of examining patterns within the data and using simple abstraction methods to present these patterns in a format which is easily understandable (Gray, 2018). Researchers can use multiple ways to articulate their findings, which includes frequencies (percentages and absolute numbers), central tendencies (mode, median and mean), and dispersion (range, deviations). Frequency distributions are the most commonly used method to display data of one or more variate (Gray, 2018). These can be true, or grouped if the data is too large or patterns are too convoluted, and usually are visually displayed in the form of graphs, charts, histograms and polygons (O'Dwyer and Bernauer, 2014). Dispersion analysis is extremely beneficial when examining the range of values from the lowest to the highest, and was

essential when examining the overall data set in order to assist in revealing possible outliers, which may need to be removed, as they could have a negative impact on the data findings (Field, 2013). As previously mentioned, two cases were removed from the data set, as it transpired during the recording that the patients were not suitable for day surgery. Due to this discovery and the more complex nature of the preoperative assessment, these interactions took longer and if included would have impacted on the data. With these outliers removed, the central tendencies and the single values (mode, mean and median) used to assist with the articulation of the findings (Field, 2013) were more representative of the true data for day surgery patients.

4.7.1.2 Relationships:

In order to explore potential relationships between variables it was possible to use comparison analysis. This was achieved by measuring one variable (i.e. length of time spent discussing pain) with another (i.e. length of preoperative assessment) to see if there were any potential associations. For this study a Spearman's correlation coefficient was used, which is a statistical measure of the strength of a relationship between two variables. This has the ability to prove or disprove correlations, however as some relationships can occur by chance, there are limitations to this method and results can be misinterpreted (Field, 2013). Consequently, within this study, comparison analysis was used to assist with the illustration of qualitative findings and was not used in an attempt to make any inferential statistical claims.

4.8 Summary

When undertaking qualitative research, there is a plethora of possible perspectives and interpretations of events that can be extrapolated from the raw data. Thus, within this chapter, the steps taken have been comprehensively articulated in order to ensure that the decisions made are transparent to the reader. The chapter opened with a detailed discussion of the research process and stages, before examining the rationale for the recruitment strategy employed for both the qualitative and quantitative aspects of the study. There followed an in-depth examination of the ethical considerations taken in terms of gaining approval, choosing and accessing the site, recruiting participants, and maintaining confidentiality and anonymity. The logistical process of data collection and the underpinning theoretical justification were then discussed, which followed Carspecken's (1996) five-stage process for critical enquiry. The chapter concluded with a widespread explanation of the analysis process for both the qualitative and quantitative data. The data analysis process involved a variety of steps *(see figure 11, page 145*), therefore the level of detail for this section of the chapter was comprehensive but also essential, in order to fully understand why the chosen methods and processes to induce meaning from the data were used.

The findings will now be explored *(see chapter five, page 166*), and these will be illustrated with the use of graphs and charts along with the use of participant vignettes.

Chapter 5

Research Findings

5 Research findings

Within this chapter, I will present the findings from the field notes, patient case notes, the observations and timings of practice, the reflections and the participant interviews. The discussion of how these findings relate to the theory and the research aims and overarching question will be undertaken in *chapter 6, page 243*.

The findings will be presented in a variety of ways, including diagrams, tables, charts, and participant excerpts. In order to ensure consistency, continuous presentation styles will be used throughout this chapter. Diagrams will use a standardised colour scheme and may also demonstrate some linear or hierarchical relationships between the represented data elements (*see figure 17, page 170*). Extracts, which are direct quotes from the patients or staff members, will have a prefix of their unique identifiers (S1-S33 for staff and P1- P100 for patients). This prefix will be highlighted in bold text (*see the example on page 174*). Direct quotes will be within speech marks, will be indented towards the centre of the page and will have a smaller line spacing than the standard text of the thesis (*see the example on page 174*). Field notes will be presented using an italic font, indented, with the date, place and situation highlighted in bold text (*see the example on page 198*). Reflections will continue to be presented within a text box. Before the findings are presented, an overview of the participants will be provided along with a detailed exploration of the datasets used for the quantitative and qualitative analysis processes.

5.1 Introduction to site and participants

The perioperative department used as the focus for this study was part of a large NHS hospital trust in the North East of England. The larger perioperative department encompassed five sub-departments, including operating theatres, recovery, preoperative

assessment, anaesthetics, and day surgery. All observations were performed on patients having day surgery, the surgical procedures were classified within an orthopaedic, general, gynaecology, or urology specialism.

The study participants consisted of both staff and patients, therefore two datasets were created. I will initially describe the characteristics of the staff dataset, this will be followed by a description of the patient dataset. 33 staff members provided consent to take part in the study; 12 were nurses and 21 anaesthetic staff. Some consented to have their practice observed, some agreed to take part in an interview, and some participated in both aspects of data collection (see *table 4 page 168)*. All possible grades of anaesthetic staff were included in the study, ensuring a wide variety of expertise and experiences were captured during the observations and interviews. From the 21 anaesthetic staff members that consented, 9 were at consultant grade, 4 were employed as physicians assistants, and 8 were graded as juniors, trainees or registrars (henceforth, referred to as juniors). As alluded to earlier in the thesis, in order to limit the possibility of specific participants being identified, the biographic and demographic details disclosed within this thesis will be limited to gender, staff designation and (for the anaesthetic staff only) anaesthetic grade.

All the nurses who participated were female, this is representative of the staff working in this area, in the hospital trust. In relation to the anaesthetic staff, there was a mixture of male and female staff included in the study (71% male and 29% female). This mix is very similar to that found across England, where 68% are male (Royal College of Anaesthetists, 2016). A total of 103 patients consented to their anaesthetic visits being timed, observed and recorded and their medical notes being examined. 24 additional patients also provided consent for their preassessment appointment to be observed.

Table 4: Participant details – staff

Unique Identifier	Staff Designation	Gender	Consent provided for observation of practice	Consent provided to take part in interview
S1	Nursing Staff	Female	YES	YES
S2	Nursing Staff	Female	YES	YES
S3	Nursing Staff	Female	YES	YES
S4	Nursing Staff	Female	YES	YES
S5	Nursing Staff	Female	YES	YES
S6	Nursing Staff	Female	YES	YES
S7	Nursing Staff	Female	YES	YES
S8	Nursing Staff	Female	YES	YES
S9	Nursing Staff	Female	YES	YES
S10	Nursing Staff	Female	YES	YES
S11	Nursing Staff	Female	YES	YES
S12	Nursing Staff	Female	YES	
S13	Anaesthetic Staff	Male	YES	YES
S14	Anaesthetic Staff	Male	YES	YES
S15	Anaesthetic Staff	Female	YES	YES
S16	Anaesthetic Staff	Female	YES	YES
S17	Anaesthetic Staff	Male	YES	YES
S18	Anaesthetic Staff	Male	YES	YES
S19	Anaesthetic Staff	Male	YES	YES
S20	Anaesthetic Staff	Male	YES	YES
S21	Anaesthetic Staff	Male	YES	YES
S22	Anaesthetic Staff	Male	YES	
S23	Anaesthetic Staff	Male	YES	
S24	Anaesthetic Staff	Female	YES	
S25	Anaesthetic Staff	Female	YES	
S26	Anaesthetic Staff	Male	YES	
S27	Anaesthetic Staff	Male	YES	
S28	Anaesthetic Staff	Female	YES	
S29	Anaesthetic Staff	Male	YES	
S30	Anaesthetic Staff	Male	YES	
S31	Anaesthetic Staff	Male	YES	
S32	Anaesthetic Staff	Male	YES	
S33	Anaesthetic Staff	Female	YES	

The preassessment appointments were not recorded as the staff did not consent to this, however the unstructured field notes from the observations were used as part of the qualitative data analysis. Of the 103 original anaesthetic consultations observed, 2 were omitted from analysis as the patient's admission status was changed from day case surgical

patient to inpatient. Another observation was excluded due to the audio recorder failing to record the consultation. As a participant population, patients were over 18 years of age, undergoing an elective day surgery operation, had the capacity to consent and were English speaking. Further biographic and demographic data from the patient participants were collected as part of the semi-structured field notes, and this will be discussed in greater detail later in this section.

5.2 Introduction to data

Data collection took place between Monday to Friday on multiple days over an 8-month period. This incorporated morning and afternoon surgical lists, as well as the unique shift patterns on the day case surgical unit and preassessment department. 130 hours of practice were observed, which generated a large amount of data, including unstructured and semi-structured field notes, audio recordings and reflective researcher diaries. This data together with the interview transcripts and review of documentation provided the data used for analysis (*see figure 17, page 170*). This data were organised, categorised and placed into specific datasets, in preparation for quantitative analysis via SPSS and qualitative analysis via NVivo.

The dataset created for NVivo mirrored the categories stated in (*figure 17, see page 170*) and consisted of corresponding folders. From these folders, the specific documents were accessed, and the various stages of coding and analysis were undertaken. The SPSS dataset (*figure 18, page 171*) was categorised in line with the patient biographic, demographic and surgical information and the six main discussion themes identified when constructing the semi-structured field note template (*see figure 19, page 171)*.

Figure 17: Data collected and used for analysis

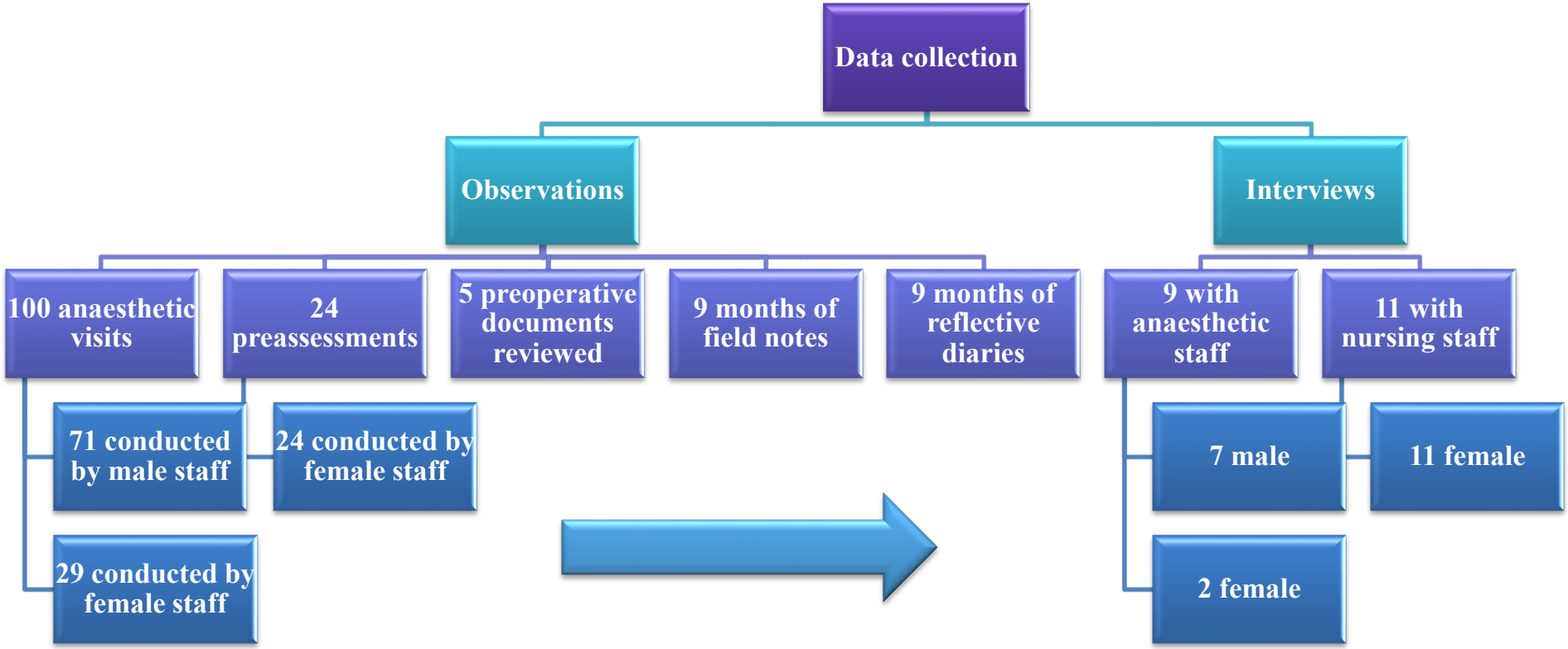


Figure 18: Dataset categories used for SPSS

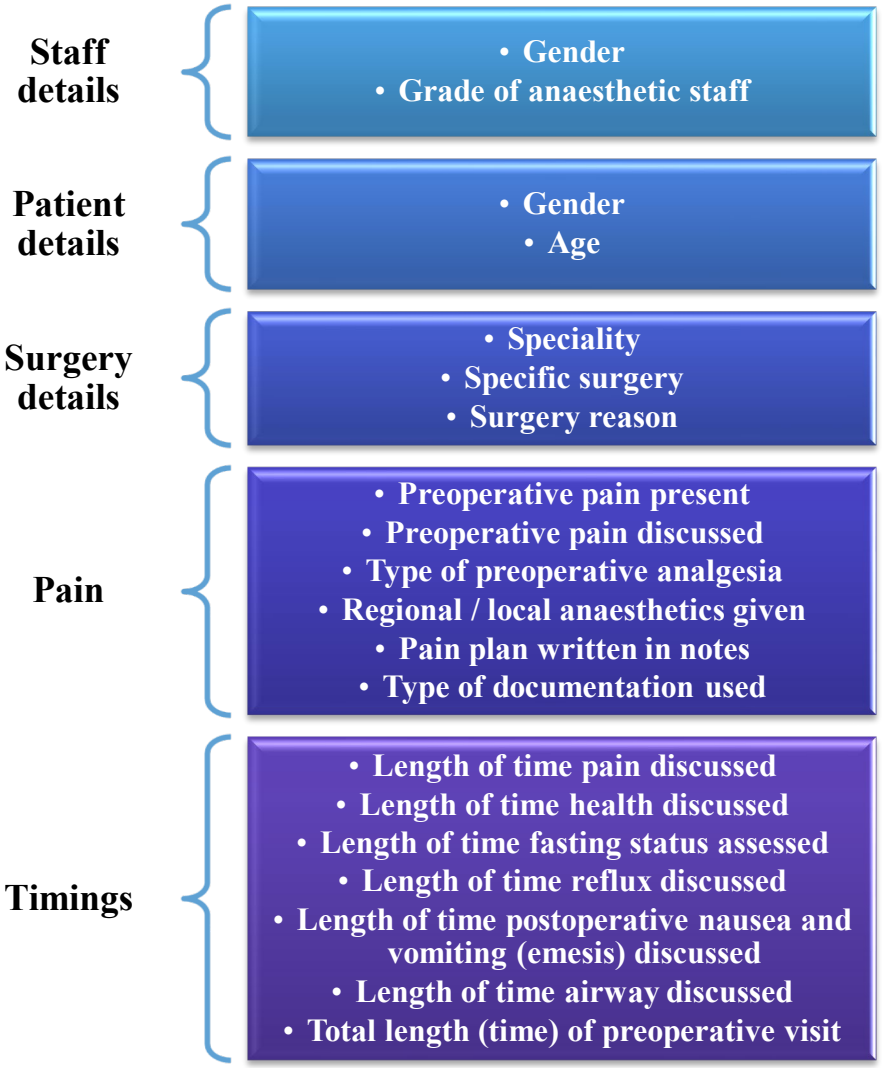


Figure 19: Main themes discussed at preoperative anaesthetic visits

The 100 interactions included in the SPSS dataset were representative of the four main types of day surgery procedures undertaken within the department (*see figure 20, page 172).* Within the surgical specialities, the subcategories were varied, ensuring that a wide variety of surgical procedures were included in the study (*see appendix 12, page 344*).

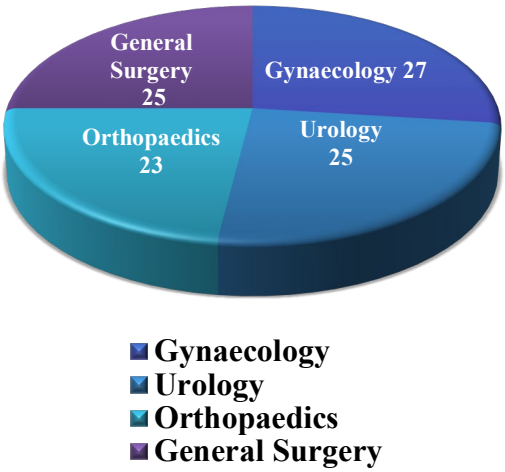


Figure 20: Anaesthetic visits- surgical speciality

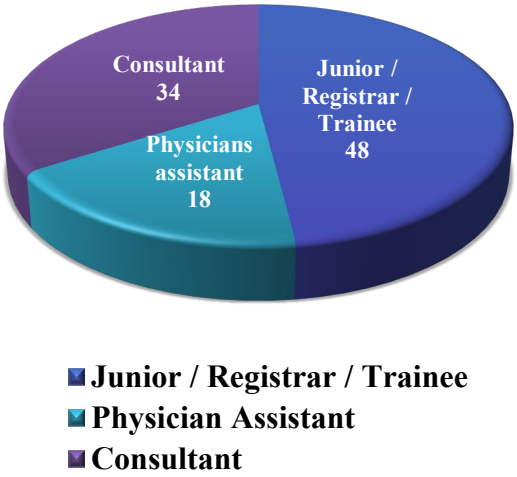


Figure 21: Anaesthetic visits- anaesthetic grade

Ensuring that an equal number of anaesthetic staff grades were observed was difficult to control, quite often the staff member scheduled for the surgical list would change. Despite planning and prior preparation, a greater number of visits observed were conducted by the junior anaesthetic team (*see figure 21, page 172*). This may have been due to the overall demands of the anaesthetic department and consultants' workloads. Overall, due to the prolonged period of immersion, I was able to observe 21 members of the anaesthetic team, and many on more than one occasion. As a result, both common and routine elements of practice, as well as individual preferences and styles, were witnessed and abstracted as part of the data collection process.

5.3 Introduction to findings

In line with stage 4 and 5 of Carspecken's framework, the findings will be presented in thematic groups, rather than individual qualitative and quantitative categories (Carspecken, 1996). This compliments triangulation of data, as participants' vignettes, numerical and statistical data, field note and researcher reflection journal extracts will be used throughout this section, to illustrate the findings. Four main themes arose from the data: 'patient safety', 'productivity', 'power and hierarchy' and 'unconscious bias'. These themes, which arose from the inductive data collection and analysis processes, have been illustrated in *figure 42, page 243.* When discussing the findings on the four themes, a general overview will be presented initially, before any links to other themes and pain planning are made.

5.4 Patient safety

Throughout all elements of the data analysis process, patient safety was an aspect of care, and a concept in terms of data analysis which was evident in staff attitudes, beliefs and the culture of the clinical area. Staff placed a great deal of importance on patient safety; this was observed in the preoperative visits, the examination of the practice documentation and the analysis of the responses given during the anaesthetic interviews. Indicators relating to patient safety were discussed in 100% of observed preoperative assessments and 100% of anaesthetic visits. In addition and as demonstrated by S21 and S14 below, when staff were asked during the face-to-face interviews, what they would consider being their main priority when interacting with patients preoperatively, patient safety was very prominent.

> **S21:** "So, my priority is always safety! Is it safe to proceed? And then disappointingly, it's logistics".

and:

> **S14:** "As an anaesthetic person my main priority is to get them from where they are on the ward, safely through the procedure, and back to the ward. So, their safety is paramount".

The priority attached to patient safety was not isolated to anaesthetic staff alone; many nurses identified this as fundamentally important.

> **S5:** "My main priority is to get them through their operation safely!"

and:

> **S6:** "(Sigh) safety that's what I want. We're obsessed with their safety….. Patient safety's huge."

It is true, that asking participants directly about their priorities provided a clear opportunity for staff to discuss patient safety, which was often at the forefront of these conversations. However, the importance assigned to this factor, by staff, was also demonstrated in the preoperative visits, where it featured prominently.

5.4.1 Developing the overarching concept theme of patient safety

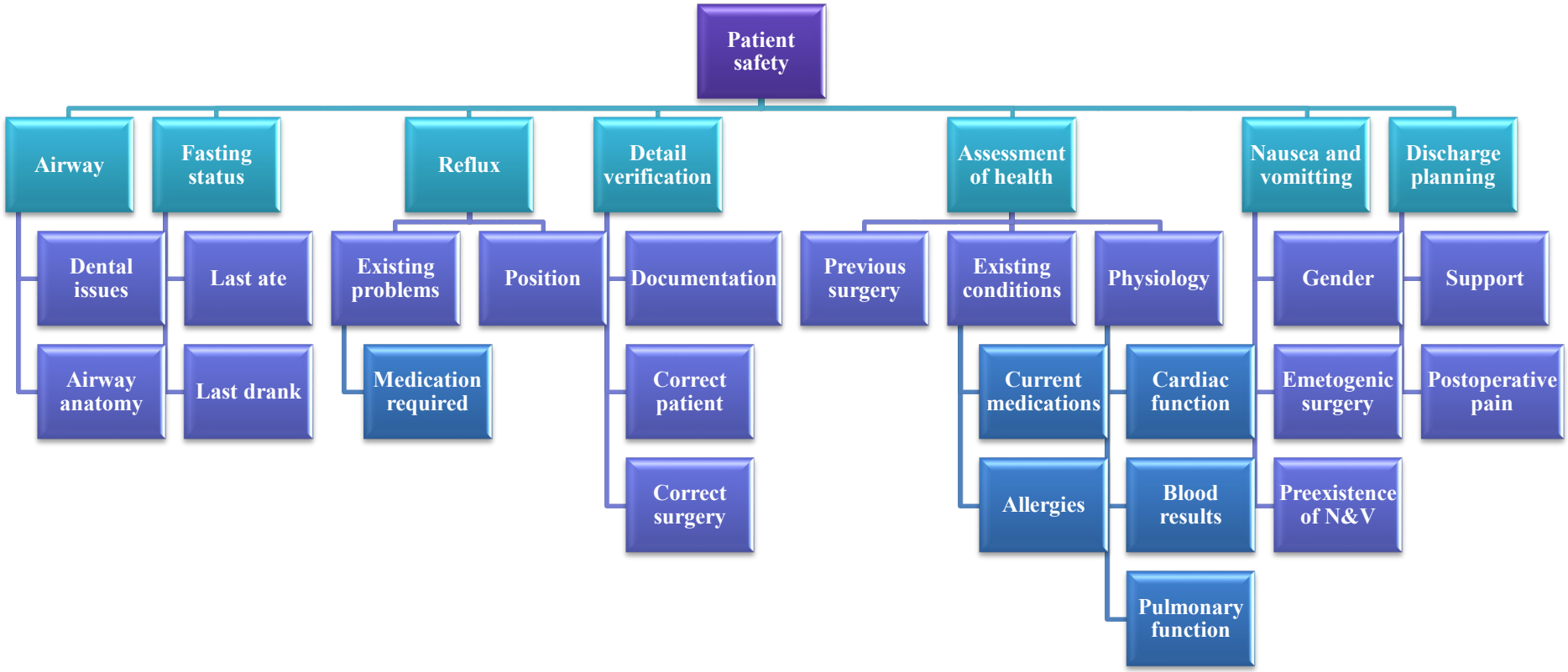
Subtopics of conversation between anaesthetic staff and patients have been interpreted as contributory indicators and led to the generation of patient safety as an overarching concept theme. This was achieved via reconstructive analysis which involved reviewing validity claims through the objective (third-person), subjective (first-person) and normative perspectives, before creating the high-level codes and drawing a conclusion about the version of events. The analysis tree for patient safety is illustrated in *figure 22, page 181* and includes five of the subtopics incorporated into the semi-structured field observation template. Whilst, 'airway', 'fasting status', 'reflux', 'nausea and vomiting' and 'assessment of health' are included as part of the analysis tree, 'pain' was not.

During the analysis (*see example of reconstructive analysis table 3b, page 157*), it became clear that whilst pain was discussed, the connections to patient safety were limited to adverse reactions and side effects of analgesia, rather than in the context of pain assessment, management or planning as an actual patient safety issue.

> **S25:** "Are you okay with paracetamol?
> **P27:** Yes.
> **S25:** And what about ibuprofen and your asthma?
> **P27:** Erm... yeah it's fine.
> **S25:** You can take them?
> **P27**: Yeah."

Pain was therefore not incorporated into this overarching theme. In addition to the five codes mentioned above, two additional codes were identified as being core indicators within the overarching concept of patient safety, 'discharge planning' and 'detail verification'. These will now be examined in greater detail to help illustrate the connection to patient safety.

Figure 22: Patient safety – analysis tree



5.4.2 Identifying discharge planning and detail verification as core indicators of patient safety

For the nursing staff, patient safety was often indirectly referred to when discussing roles and responsibilities. This is demonstrated by one nurse below, who stated on two separate occasions that a safe discharge was one of their main roles.

> **S3:** "My main role I would say is caring for patients. It is my main role.
> **I:** Uhuh.
> **S3:** Assessing them preoperatively, caring for them when they return from theatre and then, like I say, ensuring safe discharge. That would be my main role.
> **I:** So, if you prioritise between the three that you have mentioned, which one do you think is the most important?
> **S3:** I think the most important, for myself as a qualified nurse, is the care postoperatively and ensuring safe discharge."

The validity claim associated with the concept of discharge is therefore aligned with patient safety and not with pain (pain-free discharge), or efficiency (timely discharge).

Identity and surgical verification were commonly undertaken during the initial stages of all interactions, and the following extracts illustrate how this was incorporated into the preoperative visit.

> **S26:** "Can I just check before we start, what you're having done? You have to tell me I'm afraid.
> **P32:** The banding and I think there was the erm….. What did he call it?
> **S26:** Botox.
> **P32:** Yes, injection of Botox".

and:

> **S23:** "Now, can you confirm your name and DOB for me, please.
> **P6:** XXXX
> **S23:** Okay, so what are you here for?
> **P6:** Hernia thing.
> **S23:** Arh, it will be a keyhole operation, is that correct?
> **P6:** Yes".

This often led to a discussion of the patient's current health status, cardiac and pulmonary function, comorbidities, medications and allergies.

S12: "Have you got anything wrong with your heart or lungs that you're aware of?
P57: Not that I'm aware of.
S12: And would you be able to climb two flights of stairs?
P57: Yes.
S12: This is my test of how fit you are, and you've passed my fitness test. (Laugh).
P57: Good. (Laugh).
S12: Do you have any other health problems that you're aware of?
P57: No.
S12: Fab. And you're not on any regular medications?
P57: No.
S12: And you've got an allergy to Elastoplast.
P57: Yes.
S12: Are you okay taking things like Ibuprofen?
P57: Yes."

As demonstrated by the excerpt above (S12), the potential area of the interaction, which could be aligned with pain was situated within a conversation context associated with ascertaining safety. As the question "are you okay taking things like Ibuprofen" was part of a wider risk assessment to ascertain any adverse events to the administration of medication. It was not a validity claim, framed within a detailed discussion about pain (current, previous or expected) and therefore was classified as a patient safety discussion rather than a pain discussion.

5.4.3 Assessment of health as a core indicator of patient safety

The investigation into the patient's health and medical history could be extensive and at times, incorporated a conversation around health promotion. The examination of the patient's health could also be brief, depending upon the agenda and unconscious biases of the anaesthetist (which could be influenced by workload and patient/surgical stereotyping) and the power dynamics between the staff and patient. Both of these themes (which will be examined in greater detail later in this chapter) are illustrated in the abstracts below and demonstrate the interwoven connection between the themes. They also highlight the

diversity that existed across the 100 observed preoperative visits, especially in relation to timings, depth and content.

> **S16:** "You have had anaesthetics before without any problems, and you are fit and well?
> **P45:** Yes.
> **S16:** And you don't smoke?
> **P45:** I do smoke.
> **S16:** You do smoke, oh, right! (Pause)
> **S16:** Well, old enough to try and stop.
> **P45:** (Laugh)
> **S16:** Have you thought about stopping?
> **P45:** I tried once and went four days, and I just thought I couldn't do this. I don't smoke many.
> **S16:** It was in doctors that they first found out smoking caused health problems you know.
> **P45:** (Smiles)
> **S16:** You're not allergic to anything that you know of?
> **P45:** No.
> **S16:** And you're not on any medicines?
> **P45:** (Shakes head)
> **S16:** Great, you get a 1, which is top marks from the anaesthetic point of view."

and:

> **S22:** "Right then, so you look fit and well. Is that the case?
> **P4:** Yeah.
> **S22:** Great, I'm going have a quick look at your preassessment (looking at preassessment documentation) it tells me…. You're scheduled for a loop biopsy. Okee Doke. So, you take no medicines, no allergies, you get out and about do everything you want to do…… Brill. No heart, chest or tummy troubles. And the only thing they could find to put on this is you wear glasses/contact lenses. I wouldn't have bothered putting that on.
> **P4:** (Laugh)
> **S22:** Erm, okay. Otherwise, fit as a lop."

While the interactions above are very different, in terms of conversational direction, (S22's conversation was unidirectional), the content and information being ascertained were the same and aligned with an assessment of health and patient safety.

5.4.4 Confirmation of the core indicators of patient safety

The indicators relating to patient safety were also confirmed when the staff were asked during the interview to describe the usual routine of their preoperative visit. Asking this

question allowed for a degree of member checking to be undertaken, which strengthened the interpretation of the observed interactions and assisted in verifying validity claims and subsequent coding categorisations. The example below is a typical representation of the responses received to this question and it reflects what was observed during the 100 preoperative visits.

> **P18:** "When I normally go to see a patient, I firstly ask their name and introduce myself by giving them my name……and then I take a history from the patient. So, I would ask them about, you know, their medical history, any past medical history. I would ask them specifically about cardiovascular disease, respiratory disease, diabetes, high blood pressure, epilepsy, things that I feel might be relevant to me when giving an anaesthetic.
> **I:** Uhuh.
> **P18:** Medicine allergies, fasting status, dental work, loose teeth, caps, crowns, and previous anaesthetics, and then I would have a discussion about the anaesthetic."

The excerpt just cited demonstrates a scripted style of discussion, where the initial concerns of the HCP are to address issues of patient safety (identity, health assessment, medication, allergies and then anaesthetic safety concerns such as fasting, airway, reflux and nausea and vomiting).

Due to the individual needs of a patient, the length of time discussing the five leading indicators (health assessment, reflux, fasting, nausea and vomiting, and airway) varied considerably between the interactions observed. Assessment of health was discussed in 100% of the audio recorded anaesthetic visits and ranged from the shortest time of 18.4 seconds to the longest time period of 416.9 seconds (*figure 23, page 181*). The mean time spent discussing health across all the 100 anaesthetic visits was 91.3 seconds (sd ±64.4, median 70.4). The assessment of health was the aspect of the preoperative visit that demanded the most time across all specialities (*figure 24, page 181*).

Figure 23: Frequency histogram - time discussing health

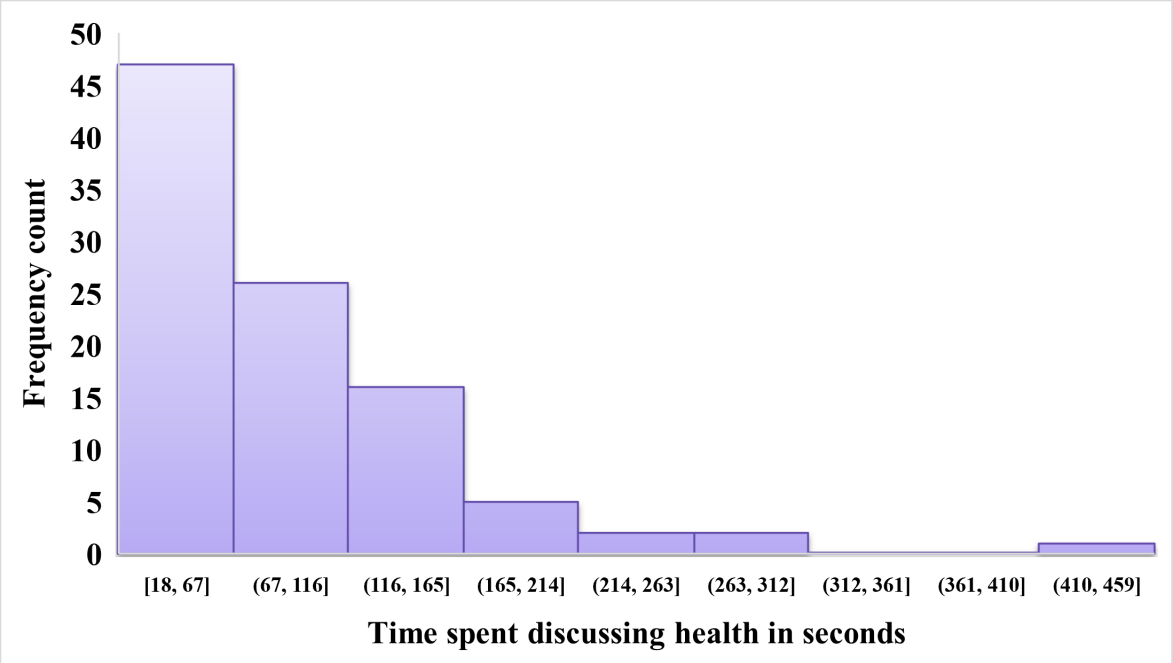
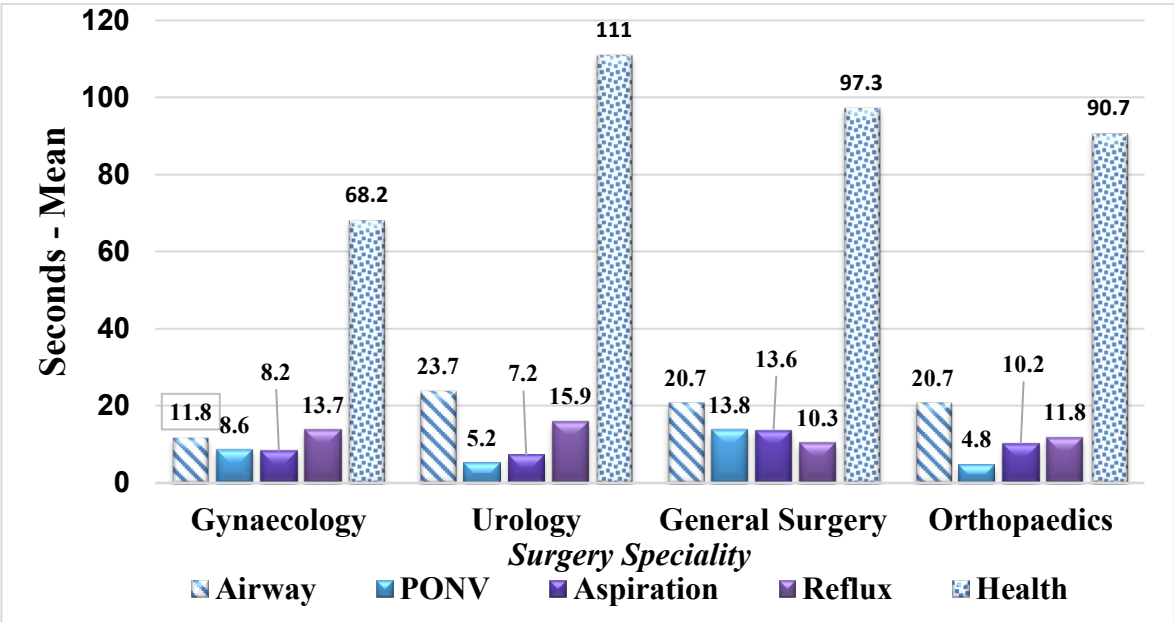
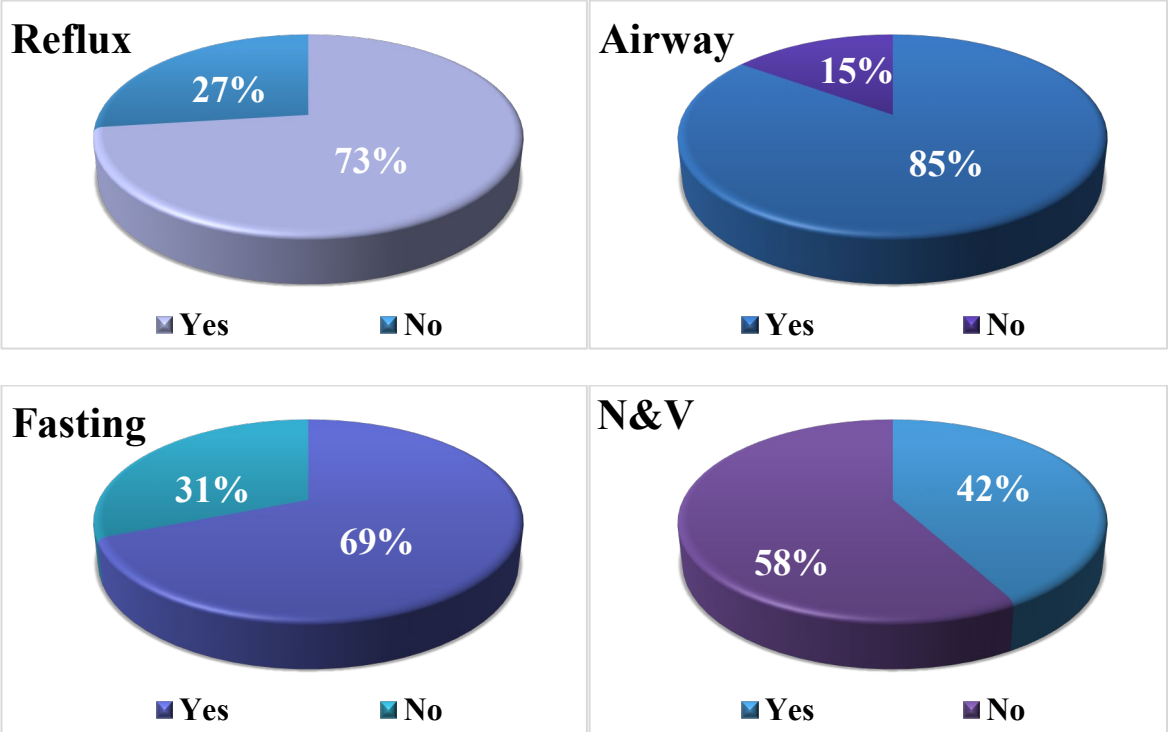


Figure 24: Mean time (in seconds) spent discussing 5 key patient safety indicators – surgical speciality



As well as health, questions relating to reflux were asked in 73% of visits, airway was assessed in 85% of visits, fasting status was ascertained in 69%, and nausea and vomiting (N&V) risk were assessed in 42% of the preoperative visits (*figure 25, page 182*).

Figure 25: Discussion of specific indicators during preoperative visits



Extracts, illustrating the relationship of these four factors to patient safety can be found in *appendix 13, page 345.*

5.4.5 Patient safety and pain

When exploring the relationships between patient safety and pain, two main factors became apparent. This first relates to the timings associated with the preoperative visits and the second to the content of the discussions with patients. The priority, in terms of what is discussed during the preoperative anaesthetic visits, becomes clearer when patient safety is compared alongside pain and the overall length of the anaesthetic visit (*see figure 26, page 183*).

5.4.5.1 Timings of discussions

Across all four surgical specialities, more time is spent examining the various elements of patient safety, than is spent discussing, managing and planning for perioperative pain. It is

clear that pain is considered to be only a small part of the preoperative anaesthetic discussion, with more importance being placed on patient safety. This pattern is repeated when examining these variables from an anaesthetic staff grade point of view (*figure 27, page 183*).

Figure 26: Mean time (in seconds) spent discussing pain vs patient safety – surgical speciality

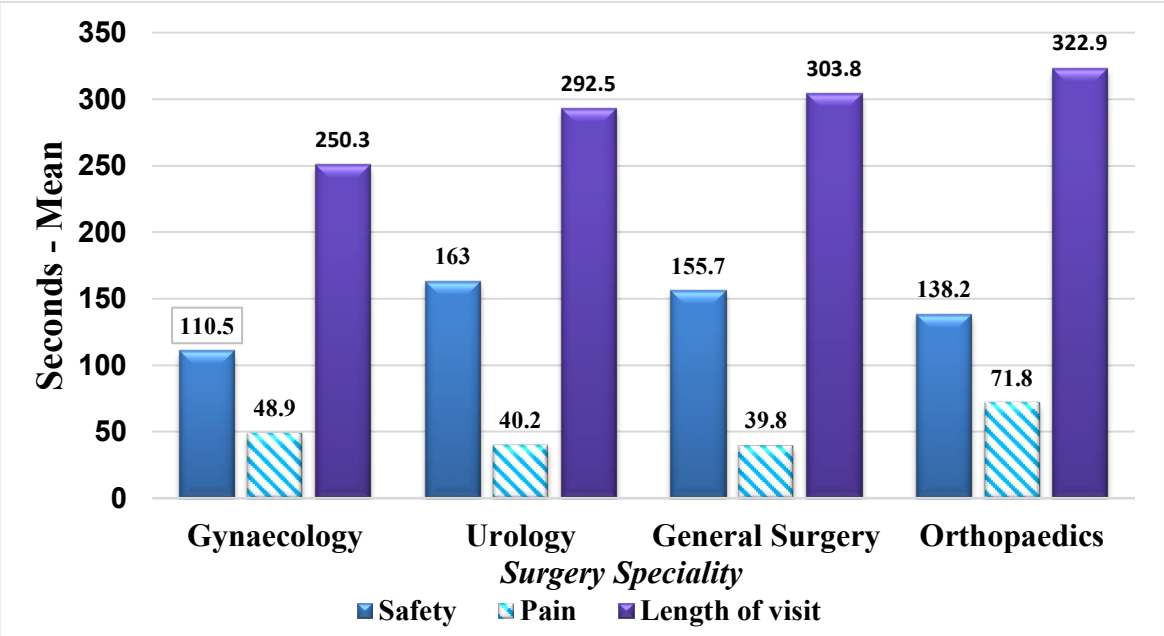
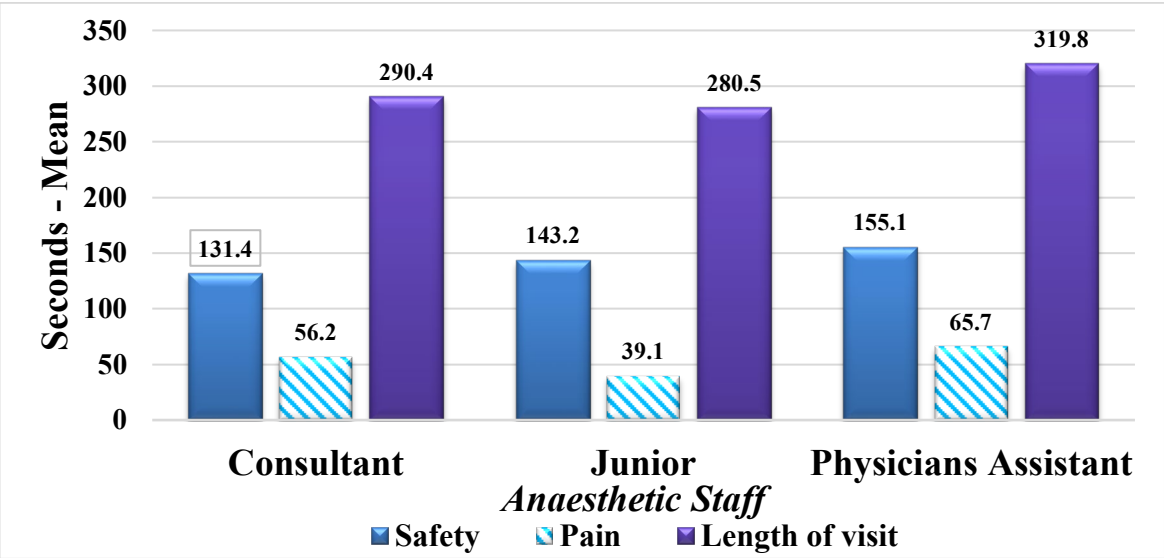


Figure 27: Mean time (in seconds) spent discussing pain vs patient safety – anaesthetic grade



The mean time spent within the preoperative visits ascertaining issues relating to patient safety is varied between all grades of anaesthetic staff, but there appears to be a positive correlation between the lengths of visits and the time spent discussing patient safety. In order to corroborate this finding, a Spearman's correlation coefficient across the 100 preoperative visits was undertaken to measure the strength and direction of any potential association between these two variables. This confirmed that there was a strong positive correlation between the length of time spent with the patient and the amount of time allocated to addressing patient safety issues, which was statistically significant (*see table 5a, page 184).*

Table 5a: Spearman's correlation

		The overall recorded time of the preoperative visit	The recorded time spent discussing patient safety	The recorded time spent discussing pain
The overall recorded time of the preoperative visit	Spearman's Correlation Sig. (2-tailed) N	1.000 100	.749** 0.000 100	.350** 0.000 100
The recorded time spent discussing patient safety	Spearman's Correlation Sig. (2-tailed) N	.749** 0.000 100	1.000 100	-.104 0.301 100
The recorded time spent discussing pain	Spearman's Correlation Sig. (2-tailed) N	.350** 0.000 100	-.104 0.301 100	1.000 100

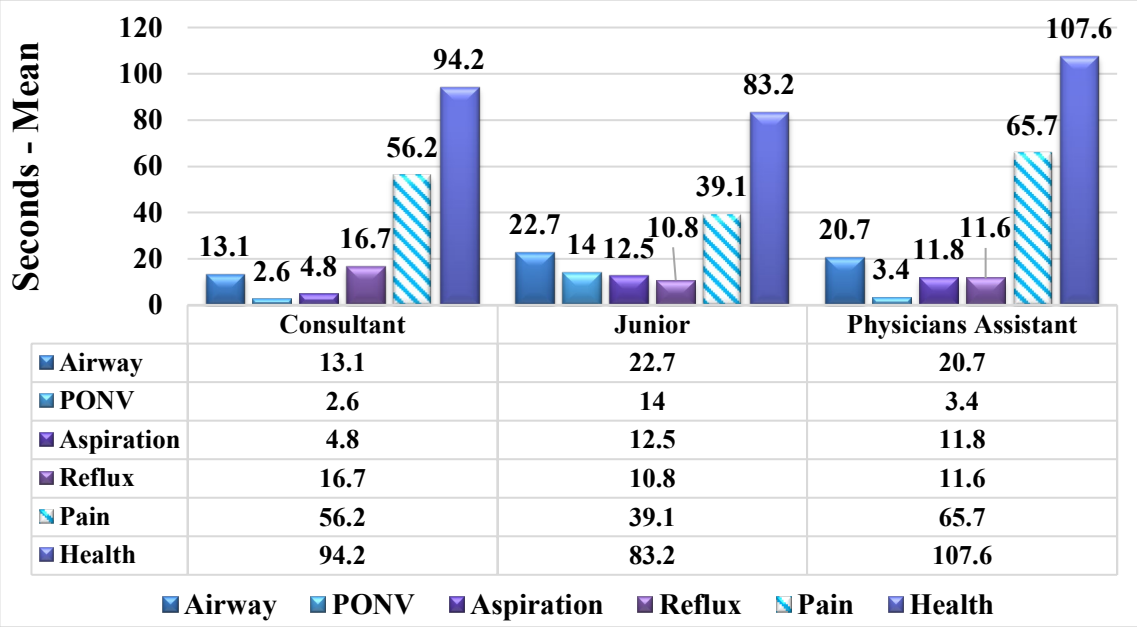
** Correlation is significant at the 0.01 level (2-tailed).

A positive relationship was also found between the length of time spent discussing pain and the overall length of the visit. However, I would suggest that this is an expected result, as anaesthetic visits with limited discussion on patient safety issues and pain would result in shorter overall interactions.

When examining the patient safety indicators in greater depth (*see figure 28, page 185*), differences between the anaesthetic grades of staff and the level to which they prioritise specific elements of the visits began to emerge. The junior members of the anaesthetic staff

spent less time overall with the patient, and spent less time discussing pain, but spent the most amount of time discussing patient safety issues.

Figure 28: Mean time (in seconds) spent discussing 6 key areas (anaesthetic grade)



The findings from the quantitative data demonstrate that consultants, while still placing a priority on patient safety, spent less time assessing airway and nausea and vomiting than either the junior grades or physicians assistants. When analysing the quantitative data in greater detail, what can be seen is that juniors were only involved in the assessment of patients who were requiring other methods of analgesia (regional blocks and local anaesthetic) in 2 visits, whereas, the consultants discussed these techniques in 7 visits (*figure 29, page 186186*).

For the 14 observed visits that did incorporate a discussion on the use of these analgesic techniques, the average time taken for the overall anaesthetic visits (398 v 274) and the time taken to discuss pain (102 v 41) was considerably longer than the remaining 86 visits (*see figure 30, page 186*).

Figure 29: Regional or local analgesia discussed

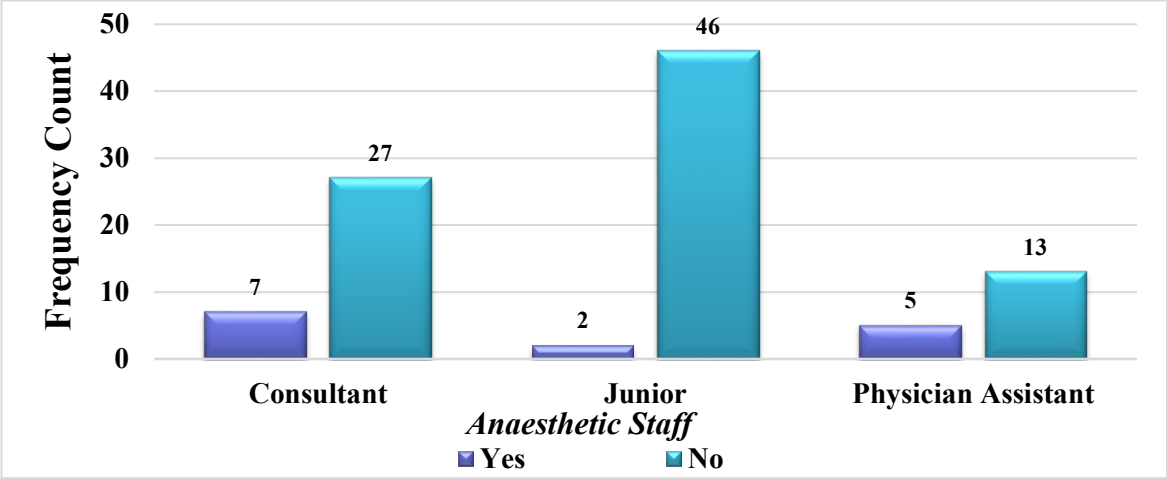
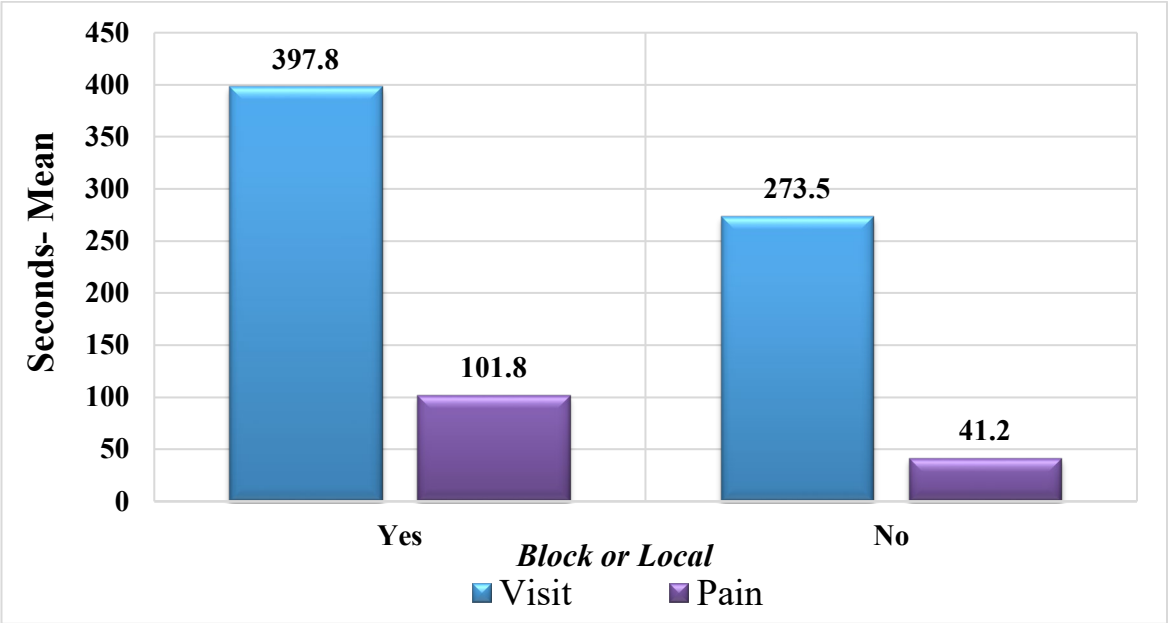


Figure 30: Mean time (in seconds) of anaesthetic visit (regional or local analgesia)



As part of the reconstructive analysis process, the quantitative data from the preoperative anaesthetic visits were shared with the members of staff who took part in an interview and thus were subject to a level of member checking. A selection of participants' explanations for the data results has been included to support the interpretations of the data.

One of the first suggestions proposed was that these advanced analgesic techniques are more complex and have a higher level of risk associated with them; therefore, more time needs to be taken with the patient to ensure fully informed consent is achieved.

> **S20:** "And there is an element of consent now, which has become increasingly important, not only telling them what anaesthetic technique you will be using, but also consenting them for the risks of that, and it might be that there are various alternatives so you might be discussing those."

and:

> **S21:** "From regional anaesthesia, you have to talk about the risks of everything, so there's having an awareness of the risks and having a discussion with colleagues about the risks."

The added level of skill required is another reason why some members of staff believed that juniors did not undertake visits where a regional block was an option. Consequently, this may have contributed to the shorter recorded times for junior anaesthetic staff members, as their inexperience may have limited their access to simpler cases. However, whilst they spent less time discussing pain, they did spend more time assessing the patient safety issues aligned with airway, reflux, nausea and vomiting and fasting status. One reason proposed was that due to the raised profile of patient safety in current healthcare culture, the education and training of anaesthetic staff has changed, with these aspects being more prominent.

> **S13:** "And it looks like anaesthetic registrars are the only ones who are talking about postoperative nausea and vomiting, which is interesting. I think that possibly reflects that we are kind of trained, the modern training is that postoperative nausea and vomiting are important".

and:

> **S16**: "I think when I qualified you didn't discuss anything with the patients. I think it wasn't so much the norm and I think the juniors now are better."

Another consideration is that due to trainees' junior status, their levels of confidence may be lower than the more experienced consultant anaesthetic staff.

> **S15:** "Assessing airway (laugh). Assessing aspiration risk, gosh registrars are doing very well there, I think I will have to shadow some registrars and

see. I think if they are junior, they tend to do the basics much more thoroughly, which we have become quite casual about (laugh)."

The findings that consultants spend less time discussing some of the indicators of patient safety are also reinforced when examining the extracts from the transcripts of the preoperative visits. As the overall assessment of airway, nausea and vomiting, reflux and aspiration by consultants, and content of the conversation was often brief in comparison to some of the junior staffs' assessments.

Airway:

Consultant:
S22: "Alright. Okay, so any caps, crowns, or loose teeth?
P2: No."

and:

Junior:
S13: "Have you got any false teeth, caps, crowns?
P14: No.
S13: And if you open your mouth for me, as wide as you can and stick your tongue out, that's great. And if you get your bottom jaw and put it past your top jaw, yep. And if you put your head all the way back for me. Is that as far back as it goes? Yep and then put your chin on your chest for me. Fab okay."

Reflux:

Consultant:
S16: "Do you ever get acid coming up into your mouth or when you lie down?
P45: No."

and:

Junior:
S23: "You have reflux, yeah?
P25: No.
S23: When you lie down, do you feel like acid coming in your throat, is that cured with your PPI?
P25: Yeah.
S23: So you don't have reflux anymore?
P25: No.
S23: So that's cured. And have you had your medication, your omeprazole?
P25: Yes.
S23: When did you have it?
P25: I had it this morning".

While the data suggests that juniors are consistently assessing patient safety, what can also be seen for this grade of anaesthetic staff is that they spend the shortest amount of time discussing pain with patients; therefore, a correlation may exist between the length of time spent discussing pain and the length of time spent addressing potential patient safety issues. Spearman's correlation coefficient indicates a negative relationship between these two variables (*see table 5a, page 184)*, although when all participants are included this relationship is not significant. However, when this is repeated for the junior grades in isolation, the relationship continues to be negative, but this is now statistically significant (*see table 5b, page 189*).

Table 5b: Spearman's correlation - juniors only

		The overall recorded time of the preoperative visit	The recorded time spent discussing patient safety	The recorded time spent discussing pain
The overall recorded time of the preoperative visit	Spearman's Correlation Sig. (2-tailed) N	1.000 48	.758** 0.000 48	-0.035 0.12 48
The recorded time spent discussing patient safety	Spearman's Correlation Sig. (2-tailed) N	.758** 0.000 48	1.000 48	-.430** 0.002 48
The recorded time spent discussing pain	Spearman's Correlation Sig. (2-tailed) N	-0.035 0.812 48	-.430** 0.002 48	1.000 48

**. Correlation is significant at the 0.01 level (2-tailed).

While pain was discussed in 100% of the anaesthetic visits, the time spent on this specific element varied, from patient to patient across specialities. The shortest pain discussion was recorded at 2.9 seconds, the longest 265.2 seconds, (mean =49, sd ±44.9, median 35.4 seconds). These timings were verified with the use of the audio recordings but were also cross-checked with a member of the supervision team, who undertook a secondary check on a random sample of 10 audio recordings. The variation is not only evident between

surgical specialities (this will be explored later in this chapter) but also between anaesthetic grades, as we have already seen in *figure 28, page 185.*

The timings associated with preoperative visits were not the only element of data which contributed to the interpretation of the information during the reconstructive analysis process. The second factor which influenced the results was the words spoken during the preoperative visit and the contextual underpinnings of the pain conversations. The quality of the pain exchanges was extremely varied both in terms of depth and content. Often the shorter the conversation, the more trivial and the lengthier the interaction, the more detailed in terms of information exchange (this will be explored in greater depth, later in the chapter when examining power, hierarchy and productivity). The examples below illustrate the diversity in terms of the depth of conversation. These extracts all relate to pain management.

Time (3.38 seconds)
P24: "Okay.
S28: We'll try and get you as comfortable as we can before you wake up."

Time (8.2 seconds)
S17: "I'll give you a little bit of painkiller erm during the anaesthetic, and if you need something for discomfort afterwards then we'll give you whatever you need.
P12: Yep."

Time (30.4 seconds)
S14: "Okay, whilst you're asleep, I'm going to give you some painkillers.
P100: Right.
S14: To try and keep you comfortable for afterwards.
P100: Yes.
S14: Okay and XXXXX will put some local anaesthetic in to try and keep that area numb okay.
P100: Yeah.
S14: While you're in hospital we'll give you some painkillers written up for you in recovery in case you wake up, and you're sore, and we'll give you painkillers for that.
P100: Yeah.
S14: And what we'll do is write you up for some painkillers for you to take home okay.

P100: Uhuh.
S14: And that's for the first 2 -3 days to keep you comfortable.
P100: Yeah.
S14: You're not on any painkillers at the moment, so we don't need to start off with anything particularly high level.
P100: Right.
S14: We'll just give you basic analgesia like codeine, paracetamol and ibuprofen to take home for the first 2-3 days, just if you need it".

The contrast between S28 and S14 in terms of length and content is clearly visible. The interaction between S28 and P24 lasted only 3.38 seconds, was unidirectional and used minimising words such as 'comfortable', resulting in a superficial and limited pain discussion. Whereas the interaction between S14 and P100 was over 25 seconds longer, more detailed in terms of information provision and used words such as 'painkillers' and 'numb' which provided a clearer picture of what the patient could expect in terms of pain sensations during the postoperative period. However the conversation between S14 and P100 was still largely unidirectional and the most positive pain conversations (*see the example between S21 and P78 below*) not only prioritised pain within the discussion but were also more inclusive of patients' views and opinions.

Time (265.2 seconds)
S21: "What problem have you had with it, do you have pain?
P78: Yeah extreme pain.
S21: Yes.
P78: Both my elbows dislocate, it's hereditary and I've been like this since birth.
S21: Oh right.
P78: And when I was nine, we didn't know until I was nine, and they said to come back when you're 18 and we'll fix it but back when I was 18 they said no, it should have been done when I was 9. Until now I haven't had a doctor that would touch me.
S21: Right.
P78: But they're really bad, arthritis in my left that's why he is doing that one first.
S21: Okay, so you've got it both sides okay.
P78: Left is my worst and I'm left-handed as well.
S21: Okay. And normally you control pain with?
P78: It's not controlled at the minute, but tramadol, ibuprofen and paracetamol.

S21: You have tramadol at home, ibuprofen and paracetamol. And you're okay taking ibuprofen and paracetamol?
P78: Yeah I'm fine, yeah, but it doesn't touch my pain. None of them do.
S21: Okay.
P78: So I hope that you will give me something that will really help.
S21: So erm…what we need to do is give you an anaesthetic so you can have the operation and ensure your pain is limited for as long as possible afterwards, so what I would certainly recommend for this is put some local anaesthetic around the nerve that supplies sensation to your arm.
P78: Alright.
S21: Okay. So that would numb up your arm.
P78: You're putting me to sleep right.
S21: You'll have an anaesthetic….
P78: Cos I don't want to hear him chopping the bone (laugh).
S21: What... this injection that we do will be done before you go off to sleep.
P78: Right okay.
S21: We find that using an ultrasound machine so we can find the nerves, see them put a little needle through the skin and then the local anaesthetic goes around the nerves.
P78: Right okay.
S21: And that will numb up your arm. It will mean that during the operation you're not getting sensation from the operation and if you're asleep and your bodies not getting the sensation so you don't need as deep an anaesthetic. And so you're waking up fresher cos you're not needing strong painkillers.
P78: Okay.
S21: You're less likely to be sick as a result of the strong painkillers that can make you feel like that.
P78: Right.
S21: And err yeah it gets you up and about sooner and faster. Once your arms heavy, so you won't be able to move it with the local anaesthetic it'll be numb for a period of time….
P78: Days or hours?
S21: Oh hours yeah. I'd expect it to be numb pain-free hopefully for most of tonight but you might find that it starts to come back through the night.
P78: Right.
S21: This way you've got, you know, it reduces the pain. Well takes it away. And….
P78: I've never been pain-free with this arm. I don't know what it's like not to have pain.
S21: Yeah just concentrate on the other side.
P78: That's kind of sore as well.
S21: So it will wear off and you will have some pain there but it's the initial stages really that is the worst with pain when you're waking up, so if we can get over that. The pain will come back, we'll give you some painkillers but basically, you're on everything that we would want you to be on. Paracetamol, ibuprofen and tramadol are the three main regular ones that we would give you.
P78: So you won't give me anything on top of that?

S21: No we will give you some oramorph as well.
P78: Alright.
S21: As an extra, just you know, take the others regularly….
P78: Yeah.
S21: ….take them and then you'll have some oramorph as an additional sort of thing just to get you over the top of it. Don't take too much of it, cos you can you know. Every two hours you can have some but it can build up a little bit so make sure you're not gulping it away.
P78: No I won't.
S21: But you know it will just help you with that extra bit of pain, there's no way of getting around that soreness, hopefully with this block it will get you through the worst of it. Pain-free. Okay".

The length of the exchange was not the only factor which impacted on the quality of pain discussions, this was sometimes dependent upon the anaesthetic staff's agenda, which could be influenced by other priorities. This was demonstrated in a number of anaesthetic visits, when the pain interaction was primarily focused around medication tolerance, allergies, and availability, especially for discharge.

S23: "Are you okay with paracetamol?
P29: Yes.
S23: Are you okay with Ibuprofen?
P29: Yes.
S23: And are you okay with codeine?".

and:

S25: "So, we'll give you some painkillers to take home with you, so you can take paracetamol and ibuprofen together regularly. Erm... have you got any of those at home?
P17: I think so.
S25: Just because they'll charge you, the only thing is they'll charge you £8 for a pack of paracetamol, whereas if you can buy them from a chemist, it'll cost you 20p.
P17: Yeah, I'm sure I have got some at home".

The finding that pain was not a high a priority was also due to the fact that some staff often held preconceived ideas that pain was not an issue within the majority of day case surgical patients and that there were no current issues in terms of practice or patient satisfaction rates. This is illustrated in the extract below (S19) when discussing day surgery patients and pain during their participant interview.

S19: "The anaesthetists have now got the results from our patient perspectives questionnaire and that's looked at almost one thousand two

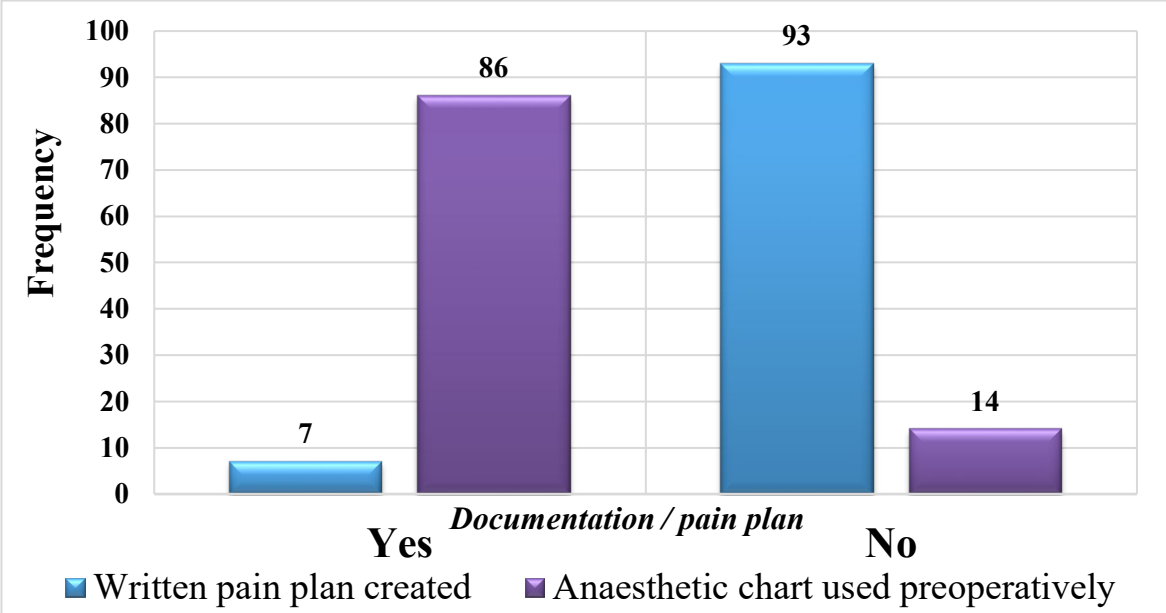
> hundred patients and the data from that is really outstandingly good. So I think looking at this evidence, not that I want to be complacent, but I think we're doing pretty reasonably. I'd like to think".

Further examples from the perioperative setting appearing to relegate the importance of pain were found during the examination of the departmental documentation used preoperatively for all elective day case surgical patients. The documentation included the 'day surgery document', 'anaesthesia and recovery record', and 'preoperative assessment clinic document'. The day surgery document consisted of 4 pages and required staff to complete 36 separate questions or nursing assessments. After reconstructive analysis and consideration of the normative claims, out of the 36 questions on the day surgery document, I interpreted 27 as being related to patient safety and only 2 directly related to pain. Using the same criteria to analyse the two remaining documents, revealed that the areas that needed to be completed by the healthcare professionals were again centred around patient safety. The preoperative document comprised 39 sections requiring information spanning across 4 pages. Only 3 questions provided an opportunity for the nurse to discuss pain with the patient, albeit limited and still under the remit of patient safety, as discussed earlier (current medication and past medical history). No questions were found that would elicit a more in-depth exploration of pain coping strategies, current pain types and pain scores. When exploring the field notes from the observations of the preassessment interactions, pain was not discussed in any capacity in 3 out the 24 patient preoperative assessments.

The preoperative section of the anaesthetic and recovery chart also revealed that all 47 sections highlighted for preoperative completion related to the patient safety indicators previously mentioned. Aside from the theatre checklist on the first page, which was largely questions based, this document provided free space, which the anaesthetists could populate

with further information. However, the headings remained centred on safety, and a freehand written pain plan or additional note specific to pain management and planning was only completed in 7 of the 100 preoperative visits observed. In 14 visits, no information of any kind was populated on the anaesthetic document preoperatively (*see figure 31, page 195*).

Figure 31: Anaesthetic document used preoperatively and written pain plan



The availability of the patient notes may have been a contributory factor to the anaesthetic document not being completed prior to the surgery, as these were not always accessible. When asked during the interview if the missing patient notes impacted on their ability to conduct a preoperative assessment, many replied that although it may slow the process, it would not prevent the assessment from taking place, and the questions they would ask would be linked to the areas needing to be explored on the preoperative documentation.

> **S19:** "Oh, it doesn't affect me; it doesn't bother me at all. I just say "oh your notes are missing. Did you go to the pre-op assessment?" They say "yes" or "no", and I say "well, unfortunately, I going to have to ask the same questions?" So, I put a little bit of a jokey thing on it and just make sure that I'm still going through all the stuff."

When the anaesthetic documentation and the inclusion of a written pain plan was discussed during the anaesthetic interviews, several staff participants commented on how they adapted the anaesthetic document to support their patient interactions.

> **S18:** "Generally I would write on the anaesthetic form A, P, I and C, or a variation of that, depending on what they say, just as an aide memoir for me, so that I know what I was going to give them afterwards, when they come to theatre a few hours later, and I'd forgotten everything that they had just said (laugh)."

and:

> **S20:** "I think the documentation is sufficient. There is a lot of free script for the anaesthetist to write, a lot of free space for us to put free comments in."

The excerpts cited above illustrate how the documents could be used flexibly and that some staff felt it was adequate; however, it was not used by all staff (*see figure 31, page 199*). During the interviews, it emerged that the document was in the process of being updated in order to assist with fully informed consent verification.

> **S16:** Not really no. The pre-op assessment is actually very useful….it can help highlight things that you need to talk about".

and:

> **S14:** There are improvement being made at the moment…..they are re-vamping the anaesthetic chart".

and:

> **S15:** "The anaesthetic chart is getting changed, it is not ideal, we were talking about this the other evening in terms of things that we discuss with patients and informed consent. I don't know whether you know but there has been a very recent ruling about this".

The fact that staff were actively seeking to have the document changed suggests that they were aware that it was currently not fit for purpose and that staff placed patient safety as a high priority, as the changes discussed were associated with patient safety issues. The quote above referring to a recent court ruling, also suggests that S15 was conscious of patient safety regulation and policy. During the interviews with nursing staff (*see S14 and S15 above*), it also became apparent that the documents within the department were used as a way of ensuring that all questions relating to safety were addressed.

> **S1:** "I think we all have our own like way of going through the paperwork….but ways which we know will miss nothing when we are going through all the questions with the patients. It's just like a safe process.
> **I:** So do you tend to follow the script as it is set out on the paperwork?
> **S1:** Yes, I follow all the script. I'll just do that sheet first, then that sheet, then that sheet, I'm very orderly in my paperwork (laughter)".

The extract above illustrates that nursing staff often rely on standardised forms in order to assess and admit patients and maintain patient safety. This was further illustrated during discussions about documentation with the preassessment nurses. These discussions demonstrated that pain, in terms of priority was often only discussed towards the end of the preassessment process once the document was almost complete.

> **I:** "So with regards to pain, what would you normally say?
> **S9:** It's normally at the end of the assessment. You would ask them if they have any painkillers at home. And you know the standard, ibuprofen, paracetamol, if they can take it".

The drive for patient safety was also observed during preoperative assessments carried out by the nursing staff, where litigation concerns were observed in relation to anxieties about documentation completion.

> ***Structured field note – Preoperative assessment number 1***
> *"Staff member seemed to be very concerned about litigation- getting the patient to sign that they will have someone looking after them at home".*

5.4.6 Summary

When examining all of the data, it became clear that within this department there existed a culture of the prioritisation of safety over discussions about preoperative pain planning and management. This was not only demonstrated via the quantitative data, which demonstrated that more time was spent discussing issues related to patient safety. But also, from the interviews where patient safety was stated as being a priority and the documentation, which primarily focused on risk, safety and informed consent.

5.5 Productivity

The ability to prepare patients for the pain they may experience during the perioperative care continuum was influenced by the overall productivity demands of the perioperative department. This finding emerged as a contributory factor to the resultant timings of the preoperative anaesthetic visits and the preoperative consultations. It was also a cause of concern for some staff, and a topic often discussed during the observations of practice and interviews. The indicators which contributed to the development of productivity as one of the main findings included 'process flow', 'surgical list numbers' and 'accessibility issues' *(figure 32, page 199*).

5.5.1 Identifying process flow and surgical list as core indicators of productivity

Whilst observing the general routine on the day surgical ward, it became clear at a very early stage, that at specific times of the day, there were increased periods of productivity. This showed itself in terms of patient flow, from admission, theatre and recovery, and return to the ward for discharge, and staff flow which at specific periods was increased. The following extracts from field notes illustrate how the levels of activity were perceived during these periods.

> ***Field note – December AM - day surgical ward***
> *"Immediately, at the commencement of the working shift, there was already a large number of patients on the ward. The overall buzz on the ward was one of energy, busyness, and ordered chaos".*

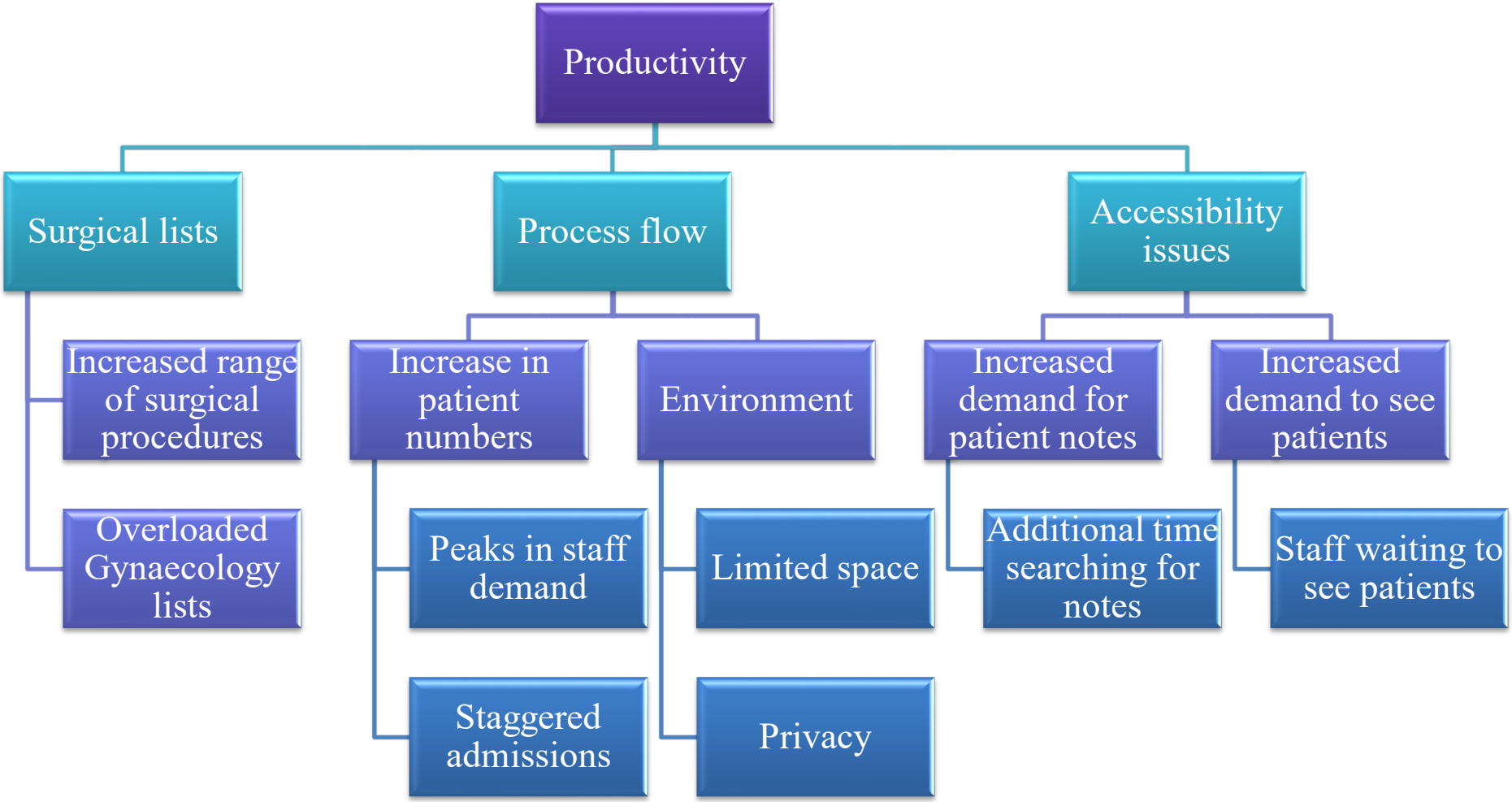
and:

> ***Field note – January AM - day surgical ward***
> *"Very busy upon arrival to the department. The nurses are arriving to start their shift, and already, the waiting area is full of patients, some even standing, so nurses had to hit the ground running".*

and:

> ***Field note – January PM - day surgical ward***
> *"All afternoon, patients in the waiting area ready to be admitted; however, no beds available (no discharges). Four patients back from theatre and with the large influx of admissions ward is really busy, and it seems a bit frantic for staff".*

Figure 32: Productivity – analysis tree



This perception of an extremely busy clinical setting was confirmed through conversations with staff while undertaking direct observations of practice and during participant interviews. Staff were asked about the usual ward routine when reading field notes as part of member checking.

> **S2:** "Within our routine, we would checklist obviously the first on the list, then that usually takes on a normal day from about 7:30 till about 9:30 before everybody is checked listed, and then we kind of catch our breath and catch up again on our workload and try to see where we are."

and:

> **S19:** "I would maybe get the patient in earlier so that the day surgery nurses aren't running around so madly, because I think that would help and you know stop maybe those pinch points where we are all struggling to see the patients in such a short period of time".

The feeling of heightened activity was also enhanced by the environment, as within the clinical areas of the ward, there was a lack of physical space, especially at the nurses' station. This was often the hub of a great deal of activity, and as it was not the most spacious area, often felt overcrowded. This is demonstrated in the below field note extract.

> ***Field note – December AM - day surgical ward***
> *"There a large number of professionals coming into the department to speak to patients and their bags and jackets are being left at the nurse's station, adding to the overall feel of chaos. There was, therefore, a large footfall on the ward, with patients, relatives, and staff (porters, surgical teams, anaesthetic staff, students, healthcare assistants, physiotherapy staff and nursing staff) all needing access to patients, notes and the rooms. The nurse's station is becoming overcrowded".*

Physical space was also a topic many staff commented on when asked what they would like to see changed on the department, as additional space was often suggested as a means of assisting with the process flow of patients on the department.

> **S5:** More space, more rooms so… for example at 11:30 when you've got afternoon patients coming in, we've got somewhere to checklist them straightaway. Because at the moment we've got patients coming in and out of rooms, we're check-listing them and then they go back to the waiting area, then the anaesthetist wants to see them, so they are back and forwards, and patients are waiting a long time in the waiting area".

Some staff clearly enjoyed the busy and sometimes hectic environment in which they worked, in particular referring to the 'fast' turnover of patients and this positively impacted on their overall feelings of job satisfaction.

> **I:** "So what do you like about being a nurse on the day unit?
> **S5:** I like the quick pace of it, erm…. the fast turnover and every day when you come in it's starting again from scratch, it is brand-new….and it just feels like you're making a difference to people".

and:

> **I:** "So what do you like about being a nurse on the day unit?
> **S1:** I like the fastness.
> **I:** What do you mean by that?
> **S1:** Erm…The quick turnover, the meeting of the different people, no day is the same, every day is different and that is what I like".

However, whilst some enjoyed this aspect of working on the ward, some staff also commented on how the overall productivity on the ward had increased, which not only impacted on the pace of work, but also on the number of patients being admitted and discharged on the ward.

> **S3:** "The workload when I came 10 years ago was much quieter than it is now. I would say we used to have maybe 15 to 20 patients per day then; now it has doubled. So, the activity has increased threefold since I have come".

and:

> **S6:** "Well, I'll tell you now the numbers have changed. The numbers are massive now. We used to be lucky to have 4 or 5 in the morning and 4 and 5 in the afternoon….. But it does, it makes me very frustrated. Plus, I'm completely conscious all the time that they are pressured".

The high level of productivity, the increased process flow and demand for notes and patient time, sometimes negatively impacted on the patient's experience. Patients' reactions were captured whilst observing the routine of the ward and are illustrated in the following field note extract.

> ***Field note - February AM - day surgical ward***
> *"Staff advised me that the ward was particularly busy due to staff shortages. As a result, the patients were moved en masse, which the staff stated would increase workload efficiency. While the patients were being moved, one patient said: "I feel like we're being herded like cattle".*

Perceptions of how the increased level of activity was impacting on care were also discussed within the interviews or was directly commented on by the patients themselves during the patient and staff interactions. These responses to the increased level of activity suggest that elements of care were perceived by patients to lack compassion and care, as they felt like a product and not valued.

> **S16:** "So its usual routine, we wheel you down to theatre, go through the checklist, go into the anaesthetic room, wire you up, leads on your chest to monitor your heart, blood pressure cuff on your arm and peg on your finger, a small needle in the back of your hand. Something through that, off to sleep, it takes about ten minutes, you know the routine.
> **P94:** Just like a cattle market (laugh)".

and:

> **S4:** "I have heard comments, patient comments, saying "oh it's like a conveyor belt" and they're horrible to hear because you do not want people to feel like they are on a conveyor belt".

The words used by the staff and patient in the above two extracts are good examples of how productivity or a factory mentality was perceived to be the practice on the ward. This sometimes frustrated staff as the care delivered was not person-centred.

> **S4:** "And I think there are some days where, you know, you go home with a heavy heart almost because you know you haven't been able to and it's not cos the wants not there. It's just because there has been a lot of people trying to get to a person at the same time all with very probably the same priority at the end of the day. I've often apologised to the patient when everybody's left, cos you feel bad for them, it's a bad enough day to start with and then to be bombarded with a lot of people coming through the door".

5.5.2 Access to notes and patients as core indicators of productivity

As well as increased activity and limited space, there was also a high demand for access to patients' notes, and due to the lack of space, these notes could not always be written at the nurses' station. This often resulted in notes being situated in several locations on the ward, which meant that staff often needed to spend additional time locating these notes prior to visiting patients preoperatively.

Field note – December AM - day surgical ward
"Many professionals wanted access to patients' notes, some of which were kept in a central trolley or in trolleys for the bays. If the notes could not be found in the trolleys, staff would then need to go and ask other staff members if they had the notes. They were often passed around from staff member to staff member".

Access to the patient notes was also commented on by staff during interviews and is something which often impacted on their working routine, in terms of time, and interactions with patients.

> **S18:** "The anaesthetic booklet, contains a checklist for theatres and there is always a bit of kerfuffle because this booklet needs to be passed from various people to various people, so other people need to do their own bits of paperwork. And that I guess does create some time delays quite often, in that you know somebody might have taken the notes somewhere else, so you are looking for the notes, or you're looking for the booklet or things like that".

and:

> **S9:** "Sometimes not having the notes available when you're seeing the patients. It's a real bugbear; I hate that, because obviously you're going off the hoof and it's horrible, I just don't like that".

Access to notes was not the only issue mentioned by staff during interviews, as access to patients was often difficult, with the nursing, anaesthetic and surgical teams all needing to speak to the patients preoperatively. This sometimes resulted in staff competing to speak to patients.

> **S15:** "And then just when you want to see the patient you are interrupted by different people who are wanting to do different things…. and I know every other professional feels the same way. The surgeon thinks "oh the anaesthetist is in now, now I can't concentrate on what I want to talk about" and you feel the same."

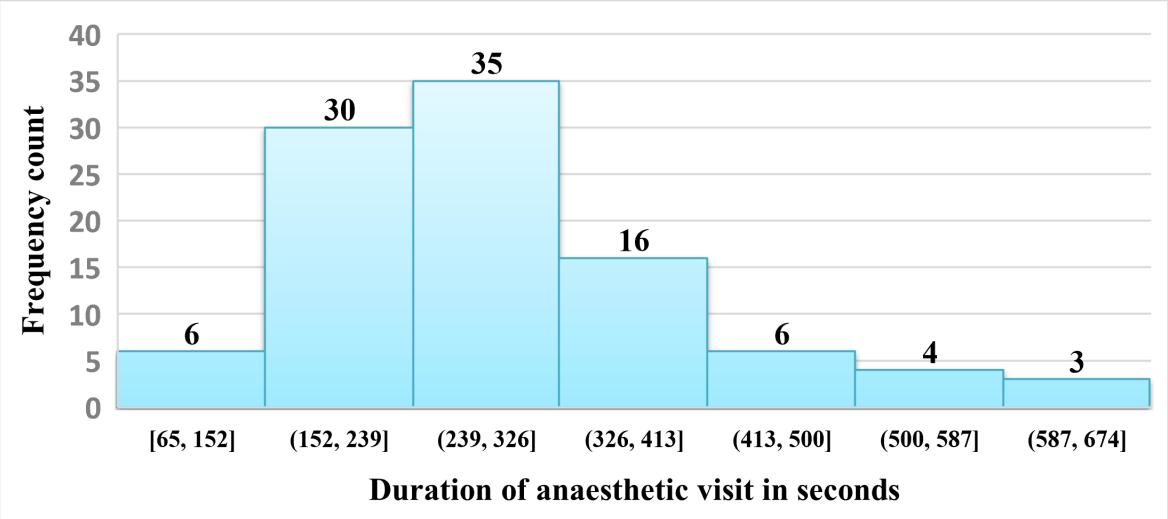
and:

> **S4:** "So there is, on occasion, where I've walked into either behind the curtains or one of the suites, and there have been 100 people in there, all fighting for the patient's attention and I have had to take a step back and just think, "wow", that's not going to help anybody".

5.5.3 Productivity and pain

It was clear from the data that due to increased workloads, time (especially during peak periods) was in high demand, and this had an impact on healthcare interactions. The shortest time spent with a patient was 65 seconds, the longest time was 648 seconds, the mean time was 291 seconds (sd±116, median 278), (*see figure 33, page 204*).

Figure 33: Frequency histogram – duration of anaesthetic visits



On several occasions time appeared to impact on overall duties within the department and impacted upon patient interactions.

> ***Field note – March PM - day surgical ward***
> *"It was 14.00 before the anaesthetic member of staff turned up and they were in an obvious hurry. They openly admitted that the assessment would be very quick, as they were running really late".*

and:

> ***Field note – March AM - day surgical ward***
> *"The beginning of the day started a little late, and as a result patients were bombarded with staff trying to see them and many were not taken onto the ward and their allocated beds until 07.40 am".*

This view was also expressed by staff participants during interviews, and when examining the quantitative data, as the below extracts from S5 and S14 illustrate.

> **S14:** "And when looking at the data (reading numerical data), if you look at the average GP appointment, it's meant to be six minutes, and I think the anaesthetic appointments are less than that. So maybe we need to

> spend a bit more time as a whole, just making sure that the patient has all the information that they need and that all that planning is in place".

and:

> **S5:** "It is frustrating that you can only spend a certain amount of time with the patient, and you do feel like you're rushing through everything".

As mentioned at the beginning of this chapter, the main themes are interconnected, and this can be seen in relation to productivity and patient safety. As time was limited staff's main priority was patient safety, this was something that they were acutely consciously of and regularly referred to during interviews.

> **S16:** "We have half an hour to see five or six patients…so you have to try and gain their trust, go through all the history, and make sure you are happy that they are safe for an anaesthetic".

and:

> **I:** "So with regards to pain what do you think is your main priority with the patient?
> **S19:** So, I don't specifically, I don't really focus too much on the pain if I'm honest".

Further connections can also be made between productivity and unconscious bias (which will be discussed later in this chapter). Gynaecology lists were perceived by staff to be heavily populated, to the extent that this impacted on their patient interactions.

> **I:** "What would you like to see improved for day surgery patients?
> **S19:** Maybe a bit better list management, so there are not 10 patients on the gynaecology list whom we have to see, maybe better if there were four-day cases and two majors something like that".

and:

> **I:** "You mentioned that in gynaecology overall there is less time.
> **S16:** Yes, it was just a thought; you always feel sort of slightly pressured on a gynaecology list".

The impact of productivity on pain, can be seen through various excerpts from interviews (*see example S9 below*), which illustrate the limited amount of time that the staff could spend discussing individual pain relief requirements with patients. As a result of productivity demands, discussions about pain planning and management were being conducted at the end of the assessment and were often minimal in terms of content.

S9: It's normally at the end of the assessment. You would ask them if they have any painkillers at home. You know the standard ibuprofen, paracetamol if they can take it and that the hospital trust now charges for a prescription. So, I ask them to speak to their local pharmacy, tell them what they're coming in for and that they will recommend pain relief".

It can also be seen within the recorded visits that the amount of time dedicated to discussions on pain was sometimes limited and simplistic, as the following sections of transcripts (which represent the total sum of the entire conversation relating to pain for that specific interaction) demonstrate.

S13: "I'll be there the whole time giving you more pain relief drugs and anti-sickness drugs, but in recovery, if you do have any pain or nausea just let us know and we could fix those things."

and:

S28: "Erm… try and get you as comfortable as we can before you wake up and that will be with a combination of painkillers as well as some local anaesthetic into your knee."

and:

S16: "It's not usually particularly sore, sometimes your first wee stings a little bit.
P44: Yeah.
S16: If you feel sore or sick, ask the nurses, and they'll give you something for that."

While the above examples lacked depth and holistic focus, some of the interactions were more detailed in terms of the information provided and how it was tailored to the specific patient.

S14: "From a pain point of view, it's very difficult to assess how painful it's going to be for you cos you're an individual person. It just depends on your pain tolerance, and it also depends on how stuck down the gallbladder is, so if you've had a recent flare-up sometimes, it's a bit more difficult to remove.
P63: I haven't had one for a while.
S14: Hopefully, it should be okay then.
S14: What I'm going to do is I'm going to give you some IV painkillers, a variety of things to try and attack the pain from all sides; the surgeon will put some local anaesthetic into the port sites and into the gallbladder bed to try and keep you comfortable for afterwards.
P63: Right.
S14: The combination of the two, keep most people relatively comfortable.
P63: Right.
S14: But sometimes you need a little bit extra in recovery.
P63: Yeah.

S14: If you're in the recovery area and you're sore let us know, and we'll give you more pain relief then.
P63: Okay.
S14: We'll also send you home with regular painkillers to help with the first couple of days. Is there anything that you can't take?
P63: Not that I know of.
S14: So we'll probably take you with regular paracetamol, ibuprofen.
P63: I've had them before.
S14: And either codeine or tramadol and possibly a little bit of oramorph for the first couple of days just to see how you are".

The above illustration from S14 explores existing pain symptoms, provides some insight into potential pain expectations following the surgery, and discusses a pain plan, using a multimodal approach. Another example of a more detailed discussion is provided below, where S13 mentions pain expectations and a pain plan which is again multimodal.

S13: "Pop a little tube in the back of your hand, and we use that to give you some strong painkillers that'll make you feel like you've quite suddenly been out on the town. But it's quite a nice feeling.
P51: Yeah.
S13: Erm I'll be there the whole time giving you more pain relief drugs and anti-sickness drugs. Erm... and when XXXX finished, we'll wake you up and take you through to recovery.
P51: Right, that's fine.
S13: In recovery, if you do have pain or any nausea, then just let us know, and we can kind of do something about those things.
P51: Right.
S13: Erm... And in terms of pain relief afterwards, sometimes it can be quite sore and at other times not too much of a problem. Mr XXX will put some local anaesthetic in the side of your… inside to try and numb it up.
P51: Right.
S13: But, erm... we'll just play it by ear if you're sore afterwards we'll give you a bit more stuff.
P51: Right, that's fine.
S13: And the vast majority of patients tend to go home afterwards, it would be very unusual for you to stay in.
P51: Right. That's good.
S13: Erm... and if I get it wrong and I haven't given you enough pain relief drugs and your sore in recovery, then they can give you more of the same, and we will get you sorted out one way or another.
P51: Right.
S13: Erm. Most people are certainly comfy enough to go home the same day, it's very unusual for anyone to stay in because of the pain for this kind of procedure, but it could happen (laugh).
P51: Alright. Thank you."

What can be seen from the examples above is that the more time spent with a patient, the more opportunity there is to provide a more detailed and holistic interaction. This is further corroborated by the Spearman's correlations (*table 5a, page 184234*) previously mentioned, which found that there was a statistically significant positive correlation between length of overall visit and length of time spent discussing pain.

In terms of the process flow of the day surgical unit and the ability to admit afternoon patients, productivity can also be impacted by pain which is not adequately managed. This could also result in some patients being admitted and transferred to other wards. This is reflected in the below extracts where S1 and S13 described examples of when the patient's pain was not well managed. This ultimately impacted on the patients' discharge.

> **S1:** "I had a gynaecology patient not long ago who I wasn't happy to send home. We had literally gone through all the drug chart and I had been back into recovery and spoken to one of the anaesthetists. And, you know, the next step was to give her morphine and as a day case we couldn't send her home…. So, we transferred her straight away".

and:

> **S13:** "And sometimes patients end up needing to have significant doses of morphine and if they are in the morning that tends to be okay, because you get the situation under control and they can go home later on in the day. But if they are on an afternoon list then those patients can sometimes become inpatients".

Therefore, a dichotomy exists as productivity demands in terms of access to patients, access to notes, increased process flow and increased patient numbers have been shown to influence the length of the preoperative interaction and the depth and content of the pain conversations. However, if pain is not managed effectively, process flow and efficiency can also be reduced as patients' discharges are subsequently delayed.

5.5.4 Summary

On examination of all of the data, it appears that a culture of high productivity impacts upon staff workload and the clinical environment. At times this resulted in intense periods of activity, where demand for notes and access to the patient were challenging, creating an environment which some participants likened to a 'conveyor belt'. This resulted in some staff feeling pressurised to carry out all of their roles within a restricted timeframe. At times preoperative interactions with patients were brief, and the content in terms of pain was superficial and not holistic. This was not the case in all preoperative visits, and when more time was spent with patients (*see S21 and P78 page 191*) the resulting pain conversation was more detailed, explored patient pain histories and coping strategies and were tailored to the individual patient. This can be beneficial not only in terms of patient care and levels of satisfaction but also productivity and perioperative organisational efficiency as postoperative recovery and patient discharge can be negatively impacted by high levels of pain.

5.6 Power and hierarchy

Power and the existence of hierarchy influenced the culture of pain planning within the department and was evident from the field notes, interviews, and transcripts of the patient/healthcare interactions. The indicators centred on "staff autonomy", the healthcare professionals' perceived level of responsibility, decision making and sense of "staff hierarchy" within the department. As well as "patient empowerment", the level to which each professional's "medical paternalistic practice" impacted on the information the patient received and the subsequent holistic planning and management of their perioperative pain (s*ee figure 34, page 211).*

5.6.1 Identifying staff autonomy and staff hierarchy as core indicators of power

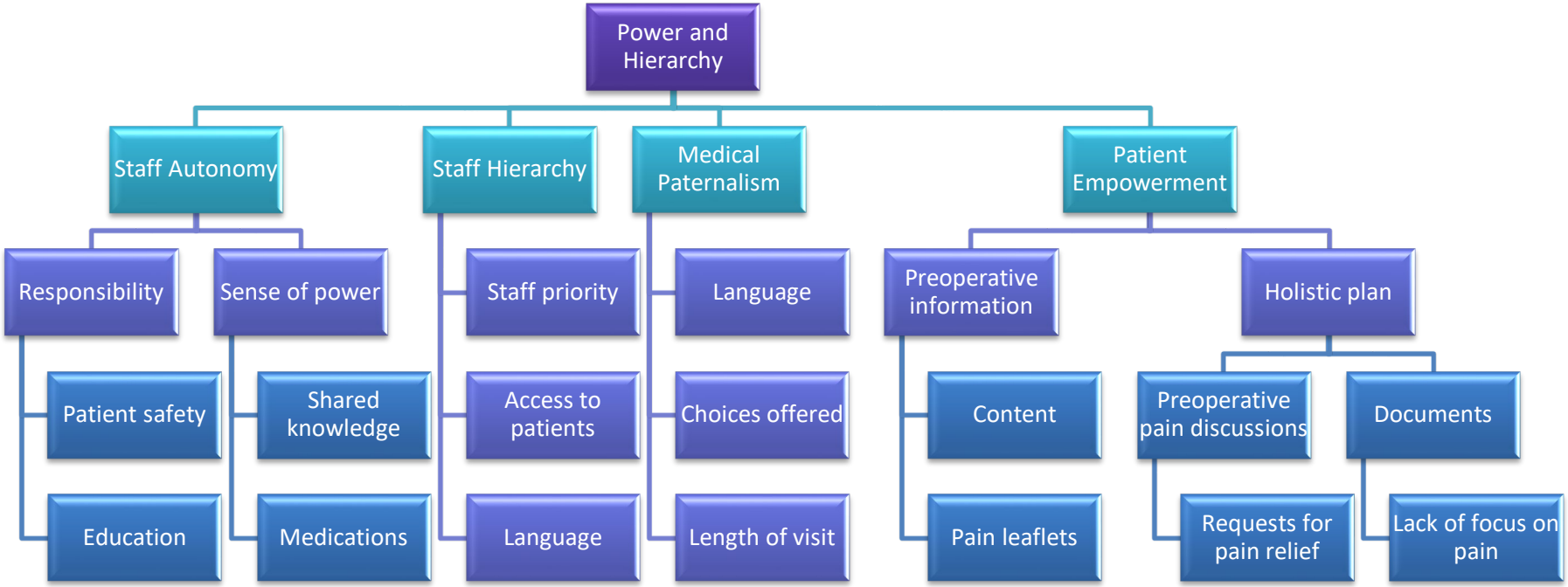
The power that existed within many relationships within the department was a concept which was discussed by several of the participants. This was often within the context of the level of autonomy that the staff felt they currently did or did not possess. For some nursing staff, they felt that the level of autonomy could be increased, especially in relation to their clinical judgements, the administration of analgesics and the ability to immediately manage patients' postoperative pain.

> **S1:** "I would like to see nurses have more of a role in decision-making about what pain relief would be appropriate for the patient. I think that when you're the one looking after the patient, because everybody is so different, you can't say that a patient who is having a gynaecological procedure, "oh she'll just need ibuprofen and paracetamol to go home with". Because some people don't, some people can't manage that and some people don't even need that. Sometimes I think it would be nice for us to be more involved with the pain relief they go home with".

and:

> **S6:** "If we had a little bit more…. or even if they gave us some choices. And trust that we would know."

Figure 34: Power and Hierarchy – analysis tree



and:

> **S3:** "Where it works well is when we've got clear instructions, and then we are left to administer depending upon our assessment of the patient so that definitely helps our level of autonomy."

and:

> **S2:** "Sometimes anaesthetists do not write up things that you think the patient might need. I quite like it when the anaesthetist writes up a variety, so you can use your judgement a little bit…..to see what would be the most appropriate. So sometimes they might just write paracetamol and oramorph and you think well maybe they need something like codeine in-between. So I would say that I like a variety of things written up so I can pick and choose a little bit".

and:

> **S4:** "I have a lot more patients who've had gynae procedures who've experienced quite a lot of…. I wouldn't say unmanageable, but they've had a lot more than they expect to have. One lady had everything from the Kardex that I could give her and again she was a gynae patient, she'd had an ablation and I know, I know that they are quite painful from obviously the ladies who've had them and the information that I have read, and she was very uncomfortable. She didn't feel as if she was going to be able to get up because she was so sore……So I had gone through to ask if I could give her a small amount of oramorph, which seemed to tip the scale for her for some reason. I think possibly if I'd had the oramorph available when she was so uncomfortable, I would have given that first and then gone to find the anaesthetists or gynae consultant, you know, to see could there potentially be a problem".

Autonomy was also a concept which was discussed when addressing the topic of the prescribing of analgesics with the anaesthetic staff. Whilst some stated that they prescribed a range of analgesics for the nurses to utilise (S21), depending on patient need, some also stated that they were often called upon to prescribe analgesics for patients who were not their own (S13) and that other anaesthetic members of staff may not trust the nursing staff.

> **S21:** "I think I don't overprescribe, but I think I make sure there are analgesic options for the nursing staff".

and:

> **S14:** "I think I would edge towards the side of the professionals and their autonomy, the same as I am and I would like them to make the decision to what they think the patient needs".

and:

> **S13:** "What I do tend to get is nurses coming up to me and asking for me to prescribed other people's analgesics (laugh). Cos they know that I am generous with them……. I think maybe other people, I don't know if it's that other anaesthetists don't trust the nurses to make decisions, or if it's just that it's a hassle to prescribe loads of stuff that aren't going to get given anyway and that's why they don't bother".

The opinions cited above suggest that the promotion of nurse autonomy is potentially aligned to power. The anaesthetic members of staff held the power and either decided to share and delegate some level of responsibility or retain it by remaining in control of the overall analgesic delivery. S20 suggested that the limiting of analgesic prescriptions could also be due to concerns over patient safety.

> **S20:** "I guess if you had your management or your safety hat on, if you prescribe a wide range, you are then sending patients home with pots of medications, a lot of which are not necessary".

While delegation may be considered to be an essential element of the role of the anaesthetist, it can also be said that as a consequence there is an unequal balance of power and any cascading of that power is at the discretion of the anaesthetic staff member. Unequal power relationships were also observed during the daily routine and clinical practice in the perioperative department. Power was demonstrated in terms of the hierarchal order and priority of seeing patients, and the participants' perceptions of the hierarchal dominance of one group of professional staff over another; particularly in terms of positional and professional status, the sharing of knowledge and information, and the level of inclusion. This is demonstrated in the field note below, which was recorded after observing a preoperative visit by an anaesthetist, and staff interviews.

> ***Field note – January AM - day surgical ward***
> *"The surgeon came, entered the closed curtain around the patient's bed unannounced and without asking jumped into the consultation. The anaesthetic member of staff stopped what they were doing and conceded so the surgeon could continue getting the consent form signed".*

and:

> **S18:** "I don't think anaesthetists are valued as highly as, well as surgeons, by the hospital trust. I'm not sure they are even thought of as doctors by many patients. That doesn't really bother me. I have to say; it bothers me more that the hospital trust seems to value us less. And I think I'm pretty certain that's true".

and:

> **S15:** "You know that about 60% of patients think that anaesthetists are not doctors and they don't know our medical background, they think we are

technicians. In fact, I even had a midwife asking me if I was a doctor, so it's not just lay people, even some professionals working in the department don't know that."

The excerpts from S15 and S18 illustrate that some anaesthetists felt that the surgical team are recognised as being of a greater professional and positional status than the anaesthetic members of the staff. Further data supports that an imbalance of power was evident on the department, as the nurses expressed concerns over the sharing of knowledge and information across the perioperative care team. Some stated that they were not always advised of changes in an appropriately timed manner or that they would sometimes receive conflicting information, which is illustrated in the extracts from field notes and interviews below.

Field note – February PM - day surgical ward
"The nurse confided in me how pain management could sometimes be difficult as they would often receive conflicting information — stating that surgeons would often come postoperatively and complain that they are providing too much analgesia, while the anaesthetic staff want the patient to have loads of analgesia. Staff member appeared frustrated and said, "we can't seem to do right for doing wrong".

and:

I: Do you tell patients about receiving paracetamol and ibuprofen before the surgery?
S10: "No. Do you know that's what I was saying before, things happen that we don't know about until a later date? And on preassessment we didn't actually know about that until one of the sisters on the day unit had said, "this patient didn't know", well they wouldn't know, because we didn't know ourselves. I just think that people who are meant to give the information should be told first……. I think people tend to forget preassessment and they will tell wards, they will tell managers and everybody else kind of knows. As we are not in the ward, we often get forgotten about. I think we could be more involved even in audit meetings and things like that".

and:

I: So do you have any comments or anything else that you want to say about pain management on this particular unit?
S7: Maybe say once every six months we could meet with the anaesthetists, consultants to discuss pain on the ward and ask us how we feel pain is managed……So a bit more communication between the professional teams."

The excerpt just cited demonstrates that some staff members were cognisant that the power and responsibility for the management of patients' pain needed to be equally shared, and suggested that in order for this to be achieved an open two-way dialogue was needed between all members of the perioperative care team.

5.6.2 Medical paternalism and patient empowerment as core indicators

The interplay between patients and healthcare staff constituted a large part of the data; thus, power was a concept that was additionally present when observing the interactions between the patients and the healthcare staff. This relationship was unequal as patients were told when to arrive onto the department, allocated a bed of the staff members' choosing, and were told where they would be scheduled on the operating list. So patient empowerment was extraneous in terms of the logistics of the surgery and admission onto the ward. In relation to pain, the information that was provided and the level to which the patient was included in the decision-making process was also equally restricted. The anaesthetic member of staff determined not only the order in which they visited patients, but also regulated the length of the visit, and more importantly, they governed the content, flow and level of information that was provided. This was demonstrated as the information exchange within the interactions were largely unidirectional.

> **S23:** "Are you okay with paracetamol?
> **P29:** Yes.
> **S23:** Are you okay with Ibuprofen?
> **P29**: Yes.
> **S23:** And are you okay with codeine?
> **P29:** Yep.
> **S23:** These are your medications for afterwards
> **P29:** Right, okay".

In the above excerpt, typical of many interactions between the anaesthetic staff and patients, the questions being asked are predominately directed at the patient. Consequently, the patient responses are limited and passive, due largely to the use of closed questions by

the anaesthetic staff member. The scope of interaction was, therefore, at the discretion of the staff, and if questions were directed back at them, staff had control of the length and depth of the answers provided to the patient. The following excerpts from two anaesthetic visits demonstrate this limited depth in terms of responses to patient questions; they also highlight the swiftness of movement between questions, that could at time be evidenced by the lack of confirmatory pauses or questions.

> **S28**: "So what we'll do today is a general anaesthetic with some local infiltration of local anaesthetic in and around the nerve. Erm.... to do that I need to put a little cannula in the back of your hand and through that we'll give you some medications that'll drift you off to sleep. I stay with you the whole time. Erm... When was the last time you had something to eat and drink?
> **P86**: 6 o'clock yesterday."

and:

> **S33:** "Do you have any questions for me at all?
> **P80:** Only if he puts a catheter in? I hope I get some decent painkillers cos it's…….
> **S33:** (interrupts) uncomfortable, is it?
> **P80:** Arr, yes! Cos it's at the mouth of the bladder that the problem is. And err the catheter balloon or whatever it rests on it, and it's quite painful.
> **S33:** When did you last eat or drink anything?
> **P80:** 7 o'clock last night and I had some water at 6 o'clock this morning".

The first excerpt cited demonstrates a lack of confirmatory pauses as S28 moves very quickly from providing information on the anaesthetic intervention to asking about their fasting status; thus, not allowing the patient any time to respond to the information provided. The second extract, also demonstrates how perceived power allows the anaesthetist to disregard P80's concerns over postoperative pain, by changing the subject and asking a question based on their own perceived needs and agenda; another example of how patient safety is a priority over patient pain planning and management. This is an example of power being exercised by the anaesthetist over the patient, as they perceive that their own questions, rather than the patient's, have more legitimacy and a higher status in terms of validity claims.

The excerpt just cited is not the only example that demonstrates a lack of a holistic approach when assessing the patient's potential perioperative analgesic requirements.

> ***Field note - December AM – day ward***
> *"Anaesthetic staff did not look at the notes prior to seeing the patient and didn't have their glasses with them either. Patient mentioned that they had longstanding back pain (which was detailed in the notes), but this was not discussed with the patient at all".*

This field note extract highlights that the staff member being observed disregarded the information that the patient provided, and therefore failed to ascertain the patient's full pain history, current coping strategies and potential concerns over how their surgical pain would be managed. This was a common theme across the 100 anaesthetic visits and was substantiated by the quantitative data, as for those patients who were currently taking analgesics (as detailed in the notes), their existing pain and current analgesic requirements were only discussed in 29% of cases. Moreover, when a conversation did take place about their existing pain, the depth of exploration was varied as the following two extracts will demonstrate, despite the fact that both related to the patient's current musculoskeletal pain, which was documented in the patient's notes.

> **S19: [Referring to the patient's notes]** "Nothing really much on there. And not on a lot of medicines, a bit of codeine and paracetamol.
> **P101:** Just when I've got pain.
> **S19:** For your shoulder, yeah!".

and:

> **S30:** "I've looked through your notes and have you got some pain issues at all with your …..
> **P41:** ……It's mainly just a bit, I'm a little bit sensitive when I go to the toilet, it just stings a little bit cos I've had a water infection. It came back quite a few times. It's a lot better now, erm…. But I've got a little bit of blood in my urine.
> **S30:** Right, okay.
> **P41:** It just stings a little bit it's a bit sensitive.
> **S30:** Right, okay. Apart from this, do you have any other pain problems?
> **P41:** No, erm. My neck, aye, sorry I have a lot of problems with my neck.
> **S30:** Right.
> **P41:** It's just for lying down. I'm all right if I've got a pillow.
> **S30**: At the back

P41: I'm fine lying on my back as long as I've got a pillow just to support it cos, I've got like cartilage away on one side of my neck, so there's not a lot of support lying on my side.
S30: So, what do you take for your pain?
P41: I'm on naproxen and pregabalin.
S30: Pregabalin, have you taken your tablets today?
P41: I've taken them this morning.
S30: How much pregabalin do you take 300, 600mg?
P41: 300mg twice a day, but I've taken this morning.
S30: Okay and naproxen.
P41: Naproxen I think it's 500.
S30: 500. Have you taken your naproxen in the morning?
P41: One this morning, yeah".

The power and dominance of the medical professional (whether deliberate, inherent or unintentional), which limited patient empowerment was also observed during some of the interactions (predominately those that did not involve the use of regional anaesthesia) as patients were often not provided with any choice about which analgesics would be used to manage their pain. S18 and S19 confirmed that providing choice was not usual standard practice, suggesting that power and dominance over analgesic choice was deliberate in terms of practice.

S18: "We don't go into that much detail, we just say, you know, we do keep it pretty non-specific, we don't normally give more information about the different sorts of painkillers."

and:

S19: "Oh yeah. No, I don't tend to focus on the pain too much at all. I tend to tell them; I think I tend to tell them that we will give them strong painkillers and then the anaesthetic."

The following extract from field notes also illustrates that when a patient expressed an opinion on specific analgesics, no further discussion took place which would allow for alternative options to be explored. Thus, the data suggests that for some of the interactions, patients were not included in the decision-making process for the pain management strategies that would be used during their perioperative journey.

Field note – December AM – day ward
"One patient didn't want to take paracetamol prior to the surgery, but despite them stating this to the staff member, there was no discussion of alternative medications and the reason why the patient didn't want to take

tablets was never explored. There was, therefore, no in-depth discussion which could have informed postoperative care and pain management after the surgery".

A lack of patient involvement in the decision-making process was also illustrated during preoperative assessments, where discussions on pain were limited. Nurses (S9) and (S11) confirmed that standard pain booklets, which were once provided to patients, were no longer considered routine and that it was only regional block leaflets that were provided to orthopaedic patients. Additionally, due to a change in pricing and prescribing patients now needed to pay for analgesics. Pain conversations were therefore associated with ensuring the patients had analgesics at home.

> **S11:** "We used to have a standard leaflet for pain postoperatively. But I think that expired in about 2009, cos we used to give them one and then, so I usually say to them "make sure you bring some pain relief in with you. Because obviously we used to give it to them, but then they started saying they were going to be charged for it, so we're told that you have to make sure they have got some at home."

and:

> **I**: "You've mentioned leaflets When would you give those to patients?
> **S9:** Well, regional blocks, we don't give that to everybody, but this is pretty good to hand to patients if they require it.
> **I:** Do you have you have any other leaflets with information on pain management?
> **S9:** No."

Medical paternalism, therefore, existed within the department, as decisions were made on behalf of, and not with, the patient. This was not only witnessed during the observations of practice but was also a subject which some professional participants commented on during their interviews.

> **S16:** "I don't say to people would you like the surgeon to put local in. I tend to sort of say that's what we are going to do for you know if they have had a scrotal incision or the like, and I suppose I am making assumptions. I have never thought about it before, but yes, I'm making assumptions that people are quite happy with that because we all know people do feel disempowered when they come into the hospital. So, I suppose I am being a bit paternalistic there".

and:

> **S13:** "Maybe we should kind of pre-empt and help the patient anticipate the kind of pain they will be in afterwards. I guess I make assumptions that they know that they will be in pain afterwards and so it's a slightly throwaway comment "oh in recovery if you've got any pain we can do something about it". Maybe I should be saying "you will be sore, afterwards but you don't need to worry too much about that, we can do things". Yeah, maybe I will do that more in the future".

Paternalistic practice and power were further reinforced by the lack of patient-centric language in favour of paternalistic language and a tone of the conversation that was sometimes dismissive. This is demonstrated in the extract below, where S22 used words and phrases which were dismissive, even patronising, and reinforced paternalistic power over the patient through the use of language. It also reduced any level of empowerment the patient was trying to impart by speaking up about their anxieties.

> **S22:** "It shouldn't be too sore, paracetamol, brufen, and wouldn't even think you need much more than that really.
> **P65:** Just I'm a bit apprehensive cos I've never been under anaesthetic before.
> **S22:** Well, it's not a proper anaesthetic, erm... I'm not sure if that is going to make you more or less.... but don't worry about it."

This paternalistic and patronising language was also demonstrated by the use of specific words which could be considered exclusive and infantilising. S25 and S16 use them in the extracts below, reinforcing to the patient the appropriateness of their passive behaviour, and also demonstrating that the decisions about pain management strategies, were made without the involvement of the patient.

> **S25:** "You are first on the list, and you could be our potentially only customer of the day.....but by the time you go through to recovery and we settle you down".

and:

> **S16:** "When you're asleep my plan is to inject some local anaesthetic in the base of your penis and when you wake up the end will be numb. I was going to say; it's slightly hitty missy so some are better than others and we have had one young lad who went into a panic cos he couldn't find the end of his willy".

5.6.3 Summary

An examination of the data revealed that power and a hierarchical dominance existed within the culture of the perioperative department. For patients, power and dominance over them were demonstrated in terms of paternalistic practices, lack of patient involvement in decision making and unidirectional conversations. While for staff, as many commented upon directly during their interviews, there was often a sense of domination of one type of professional over another, and this was demonstrated by the perceptions of low levels of autonomy, lower professional status, and the restricted sharing of knowledge and information.

5.7 Unconscious bias

The last finding that emerged from this study was the concept of unconscious bias. Essentially how the partialities (of which the participants were sometimes unaware) towards "surgery type" and "gender" influenced pain planning and management decisions and interactions with day case surgical patients. The indicators from the qualitative and quantitative data included "staff and patients attitudes" towards day surgery, "the positive and negative language" used by staff during patient interactions, the "pain perceptions" held by staff due to their level of experience and training, and "gender" inequalities" which were evident in the language used, and the timings of the consultations (*see figure 35, page 223).*

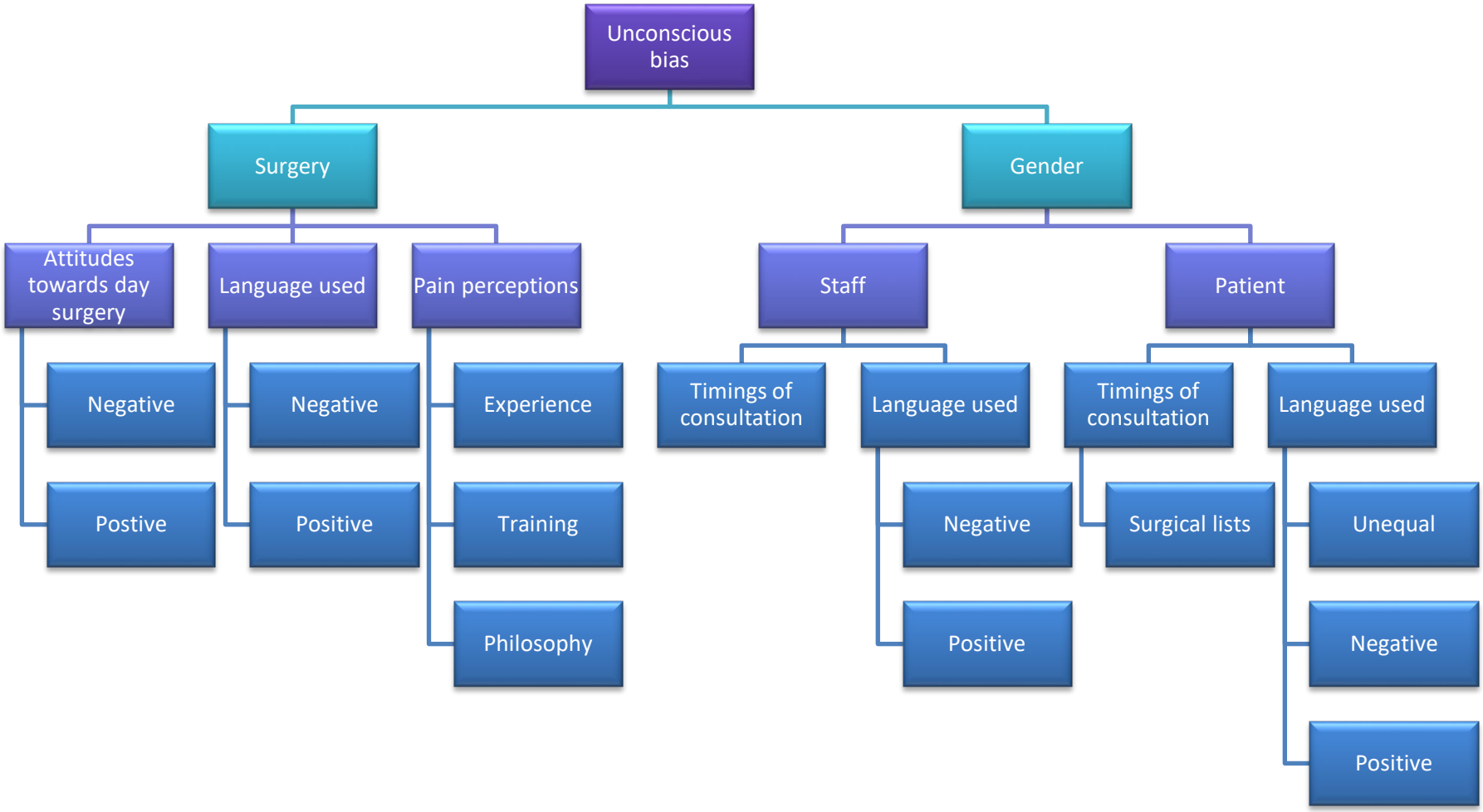
5.7.1 Identifying surgery type (day surgery) as a core indicator of unconscious bias

Day surgery and its position and status within the organisational hierarchy was often subject to unconscious bias. This was witnessed not only during the interactions between staff members but also between staff and patients. These conversations often devalued day surgery with the use of minimising language and sometimes comparing the time taken for the surgery or level of invasiveness, to surgical procedures which required patients to be admitted. The following extract illustrates how S16 deemphasised the surgery in terms of surgical status, by referring to how the procedure is performed in other countries and reinforces negative worth by commenting on the time taken to perform the surgery and the resources that are required.

> **S16:** "Well, this isn't really a particularly big job, you know. And you don't need lots of anaesthetic for this. I mean in some parts of the world you'd just be awake and in clinic anyway so...It's a ten-minute procedure, so it doesn't take very long."

However, in some cases, the comparison to other surgeries was more direct.

Figure 35: Unconscious Bias – analysis tree



S19: "You have had your adrenal glands taken out.
P101: Yeah.
S19: Big surgery!"

and:

S29: "Generally the longest things are the getting there, the getting into the anaesthetic room, the getting into the theatre and recovery room are actually longer than the surgery itself".

and:

S20: "In terms of pain relief, a lot of the day case stuff doesn't need anything doing, cystoscopies, hysteroscopies, these are all…. the next day it's as if they've not had an operation at all".

and:

S17: "Hi. I believe you're coming to see us for a wee bit of surgery.
P13: Yes.
S17: Good, I'll give you a wee bit of painkiller during the operation. Although afterwards there's not an awful lot of pain associated with this kind of so...
P13: No, I wouldn't have thought so; it's not a cut or anything."

The excerpt cited above illustrates how the patient, P13, also viewed the day case surgical procedure as being minor, as they perceived that the surgery (which was within the urology speciality) would not involve damage to external tissues. The minimisation of day surgery, as illustrated by S17, S20 and S29 above is also interconnected to power. Anaesthetic staff (who view their knowledge as superior to patients), make a value judgement on pain expectations associated with the surgery type, and this can be used as a way on imposing an expectation of minimal behaviour from the patient. The minimisation of day surgery was also found in staff interview responses when asked about pain preparation for day surgery patients.

S20: "Well I discuss the post-operative period and what their expectations are, and with day case surgery it's normally a simplistic…."so you might have some pain", "you might feel sick", but from an anaesthetic point of view you do not need to expand on that as much."

and:

S10: "The consultant just tells them about their operation, and often the expectation afterwards is like well it's just a day case, so therefore pain is not involved. I think a lot of day case in the media, is made out to be very simplistic, and very easy, and straightforward. Which it is and it's a good step forward, but they don't think of their discharge when they go home. It is often not thought about".

and:

> **S17:** "I think we don't serve them as well as we could. I think particularly, most of the hospitals in this country don't follow up day case patients as well as the John Radcliffe in Oxford. To be quite frank, we as an anaesthetic department have no idea of their experiences once they go home unless something goes spectacularly wrong and they've come back. So there is a big void in our knowledge. Do they go home and have sickness? Do they go home and have a lot of pain on the first postoperative night? On the second postoperative day? We don't have that data."

In the citations illustrated above, S10 was concerned that the simplistic version of day surgery portrayed in the media could lead patients to have unrealistic expectations of the post-operative pain. This is something which S17 was also aware of, stating that day case surgery patients were at a disadvantage to patients who remain in hospital in the immediate postoperative period. Other attitudes to day surgery led some staff, such as S6, to alter their practice, by ensuring that they treated each patient equally, regardless of surgery type and inpatient/day case status.

> **S6:** "I think from working in theatres. I think that everything I do goes back to that. I have never ever said, somebody is having just, or he or she are just having a haemorrhoidectomy, just a hernia, just a varicose vein, because if anybody has ever worked in the theatre, he or she would realise that there is nothing just about any surgery."

Unfortunately, this approach to equality was not consistent during the preoperative visits that I observed. Staff were often unaware of their negative bias and reinforced this by using language, such as "just", "straightforward", "not major", "minor", "little" and "stuff" to downplay the surgery in their interactions with patients.

> **S22**: "Okay, so this is pretty straightforward stuff. It's not a major procedure shouldn't be too sore afterwards; it should settle down quite quickly."

and:

> **S29:** "Generally the longest things are the getting there, the getting into the anaesthetic room, the getting into the theatre and recovery room are actually longer than the surgery itself."

and:

> **S13:** "Okay, well, I'm the anaesthetist. I'll be looking after you while you're asleep having this minorish operation from our perspective."

and:

> **S19:** "I'm one of the anaesthetic doctors come to have a chat with you about the op today. Erm, going to do a little bit of keyhole surgery and stuff on your right shoulder."

and:

> **S17:** "You've come to see us today for a little bit of surgery."

The excerpts cited above, used words with patients which minimised day surgery procedures, demonstrating that staff had an unconscious bias against this type of surgery. This also reinforced their dominance over the patient, by implying that they have more knowledge than the patient, and created power and control by instilling in patients an expectation of how they should react to the potential pain following the surgery.

5.7.1.1 ***Pain perceptions as a core indicator of surgery bias***

When analysing the data, I also found that within day case surgical procedures, there was an additional layer of bias related to more specific surgical specialities. This bias meant that orthopaedic surgery was treated favourably while gynaecology procedures were treated, in some cases, frivolously. This was demonstrated during observations of practice, interviews with staff, and when undertaking member checking. The excerpts below from field notes and interviews, illustrate some staffs' perceptions that orthopaedics was superior in terms of specialism, income generation and also in relation to the levels of postoperative pain that can result from the procedure.

> ***Field note - December AM – day ward***
> *"One nurse stated, "they don't normally give OxyContin for that?" This was in relation to a preoperative analgesic request from an anaesthetic member of staff for a gynaecology patient. She was talking about how this was not normally prescribed for gynaecology patients preoperatively and in her experience was only given to orthopaedic patients. She even wanted to double-check the prescription, adding that it was "just an ablation" and "not a major thing."*

and:

> **S19:** "I mean it is all to do with resources and money. Orthopaedics make an enormous amount of money and therefore have an enormous amount of

> resources, the general surgeons and the gynaecologist don't make any money at all, in fact, they lose a vast amount of money, so, therefore, the resources aren't really there for them. So yes, I think it is a bit of a resource issue.
> **I:** Uhuh. So are patients disadvantaged at all?
> **S19:** Maybe slightly, I suppose, yeah maybe slightly because the orthopaedic patients do have a lot of education and other services don't have so much because they haven't got the number of nurse specialists, the amount of influence. So yes, I guess in the little way they might be slightly disadvantaged; whether it matters to them clinically or not? Probably not in 99% of cases, maybe 1% of the surgical patients might benefit, maybe 5% might benefit from a little bit more information, you know, engagement preoperatively I would say, yeah maybe so".

and:

> **S15:** "I think in orthopaedics we are so geared to fast-track measures, to ameliorate the pain and get them into physio. That the emphasis is there. I mean this is what I mean, we are an orthopaedic hospital, and there is so much input invested in orthopaedics in the way of information giving and talking about blocks, that it looks much bigger than the emphasis placed on the other specialities I think."

In the extract cited above, S15 suggests that one reason for the unequal balance in terms of information provision and length of time spent with the patient, is due to the fact that the hospital trust view themselves as an orthopaedic speciality service provider. However, while this may be positive in terms of hospital trust identity and marketing, it may not be so advantageous for patients who are undergoing surgery from other surgical specialities.

5.7.1.2 ***Timings of discussions***

Surgical bias was verified when examining the quantitative data for the preoperative visits. The mean average time spent with orthopaedic patients was 72.6 seconds longer than gynaecological patients (*figure 36, page 228*). The finding that gynaecology was the surgical speciality with the shortest amount of recorded time for the preoperative visits was a consistent theme across grades of anaesthetic staff, with the exception of juniors, where gynaecology had the second-lowest result (*see figure 37, page 228*).

Figure 36: Mean time (in seconds) of anaesthetic visits– surgical speciality

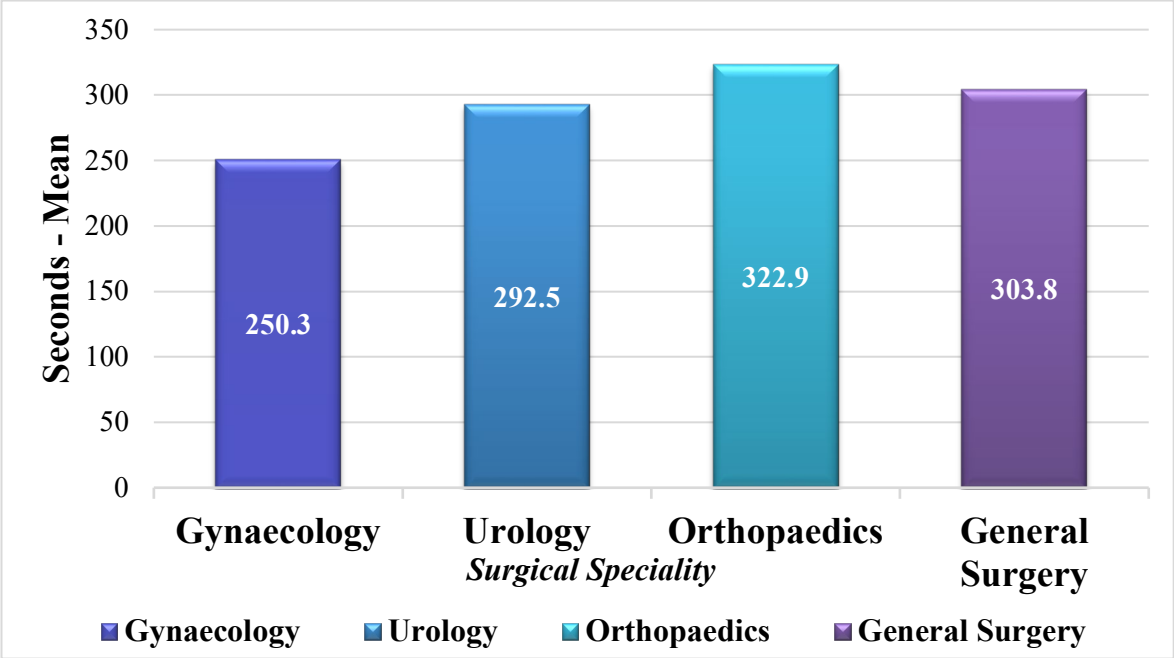
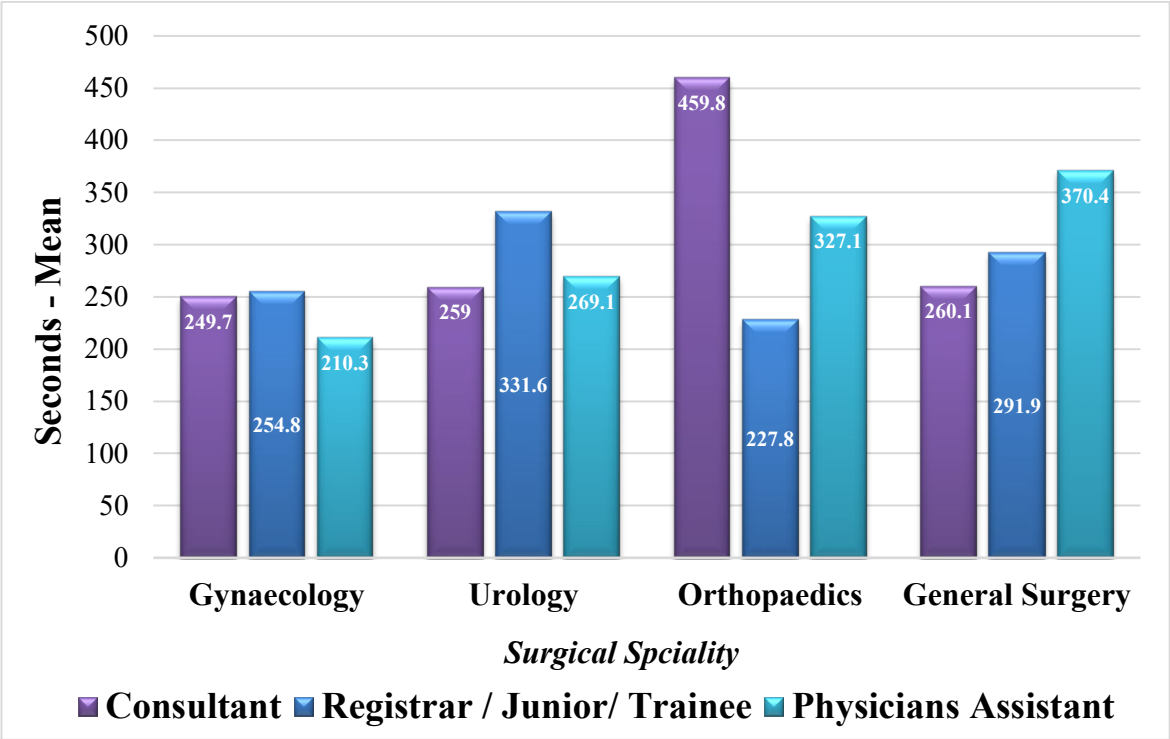


Figure 37: Mean time (in seconds) of anaesthetic visit (staff grade and speciality)



As mentioned earlier, within the section examining productivity, one reason suggested for the shorter time spent with gynaecology patients was the fact that

the size of the gynaecology lists prevented staff from being able to spend an adequate amount of time with each patient.

> **I:** "You mentioned, when looking at the data, that with gynae surgeries there was less time spent as a whole assessing the patient and you hinted at the fact that it may well be because the lists are so busy.
> **S14:** I think as I say part of the issue is, it's perceived as minor surgery, and I don't think we have like a gender bias because we have quite a lot of female anaesthetists and quite a lot of male anaesthetists, so I don't think it's a case of its woman surgery let's not worry about it. But I think a lot of it is seen as quite minor surgery, and therefore people don't feel as though they need to spend as long with the patient, as opposed to orthopaedic procedures that can sometimes be longer, or more invasive".

S14 claimed in the extract above that it was not a case of gender bias, but rather that many routine gynaecology procedures were perceived as less invasive. However, the common denominator within this group was that gynaecology procedures were performed exclusively on women and thus gender needed to be examined in closer detail. When examining and analysing the quantitative data the time spent discussing pain was lower for women across both the urology (47.1 v 30) and general surgery specialities (44.8 v 29), but slightly higher for orthopaedics (70.6 v 72.8) (*see figure 38, page 230)*. A Spearman's correlation coefficient test did not result in any statistical significance in terms of the gender of patient and the length of the visits or time spent discussing pain.

When examining the dynamics and timings related to the gender of staff, the length of the visit was longer when it was conducted by a female anaesthetist, and this was consistent across surgical specialities and anaesthetic grades. Therefore, female staff spent more time with patients than their male counterparts, regardless of surgery speciality or level of seniority (*see figure 39, page 231, and 40, page 245*).

Figure 38: Mean time discussing pain (patient gender and speciality)

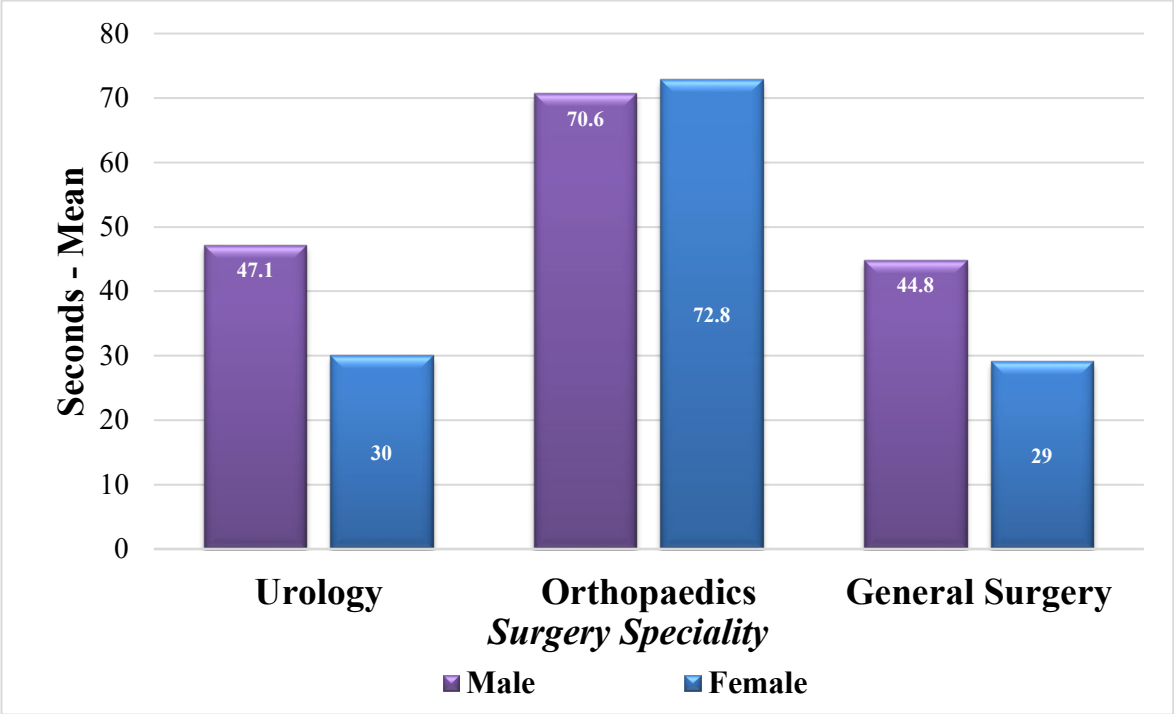


Figure 39: Mean time anaesthetic visit (staff gender and speciality)

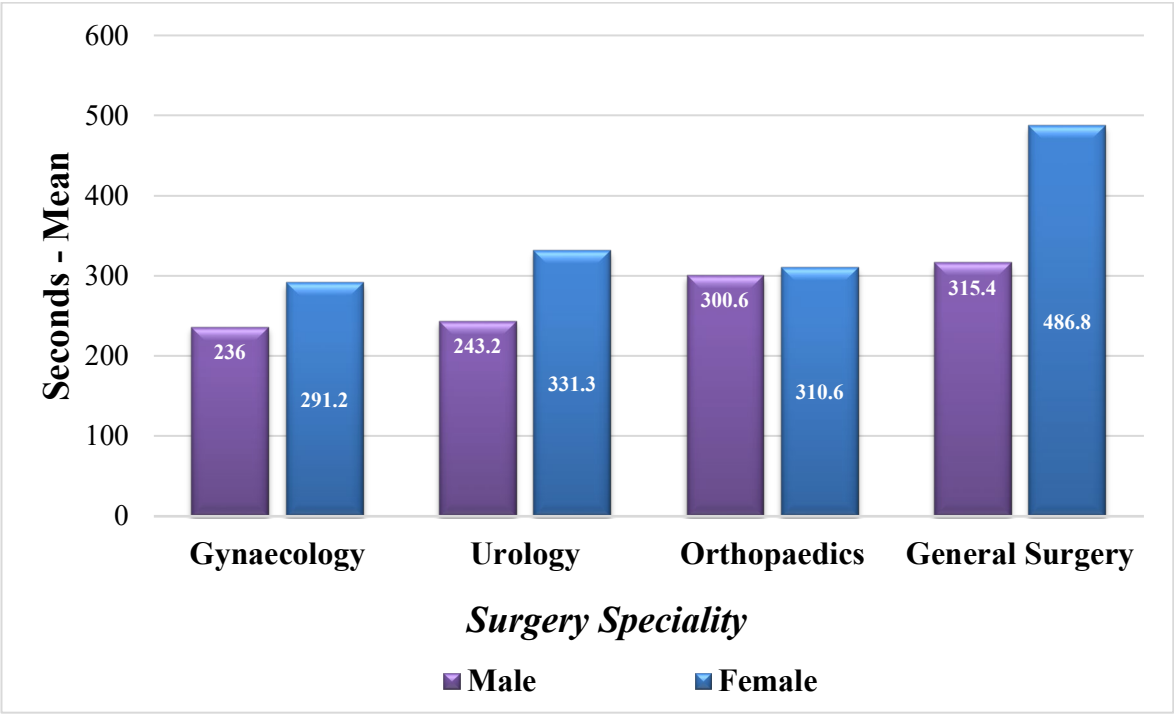
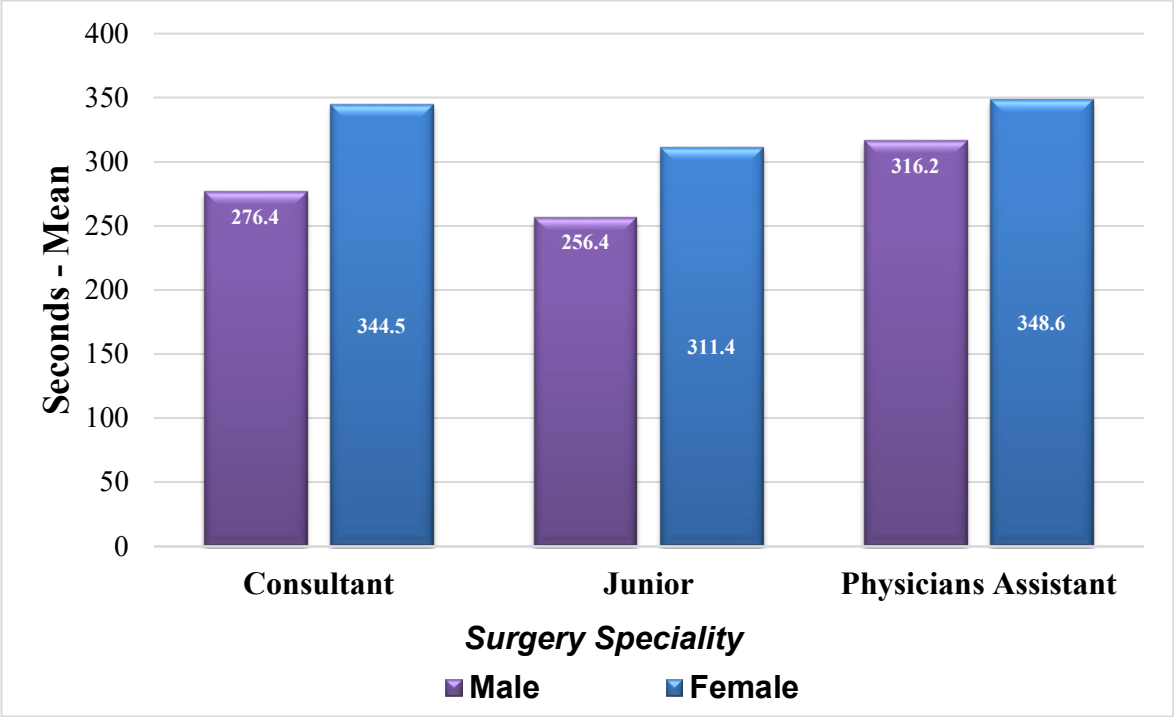


Figure 40: Mean time anaesthetic visit (staff gender and grade)



5.7.2 Gender as a core indicator of unconscious bias

When examining the data relating to the gender of patient and staff, there was an unequal amount of time being spent with female and male patients, for both urology and general surgery and also female and male staff across all surgical specialities, as female anaesthetic staff were spending more time with patients than their male counterparts. The group of patients with the shortest anaesthetist visit times were female patients undergoing a gynaecology procedure, whose visits were conducted by a male member of staff (*see figure 39, page 230).* Although the variation in times were not statistically significant, the findings that female patients were sometimes treated unequally was reinforced when examining the qualitative data, as gynaecological procedures were commonly referred to by staff as being lower in surgical status than other surgeries. As this type of surgery was exclusively performed on women, there is no male data to compare it to, but the

comparison between gynaecology and orthopaedics was often referred to during interviews, as the following excerpts illustrate.

> **S20:** "I think that the majority of gynae surgeries are just minor and trivial. On quite relatively well and non-complex patients; whereas orthopaedic surgery we do as complex orthopaedic surgeries as you get routinely across the region."

and:

> **S19:** "So gynae probably get less chat, but then I guess they are usually fitter women…..it may be that I suspect that the gynae possibly get less just because of the nature of the surgery and the nature of the patient. But and I don't think it's because we don't like women. But if the lists were managed better that would give us more time to see the patients and then get to theatres. Maybe that's why gynae patients have less time spent on them because this is maybe seven patients on the list".

and:

> **S21**: "There's probably a lot quicker gynae surgeries, day case than there are orthopaedic surgeries, but that shouldn't really, well I don't know if that affects the speed and time, and the length of time that you need to spend with the patient. So, it could be that there is a lot more gynae hysteroscopies, ten minutes thing that really isn't that painful, and they are quite often fit young people. So that's maybe the thing, orthopaedics again, the operations are generally longer, but equally you can have just as fit young people, so I think, they all show that sort of pattern, but for some reason orthopaedics is more…..or in gynae do you think that we just don't care about women (laugh)?"

The excerpts above were all from anaesthetic interviews, where participants had examined the quantitative data. As in the case of S14 earlier, S21 and S19 stated that it was not because the staff did not care, or disliked women, but was as a result of the surgical lists being more heavily populated than others and that there was a perception that these surgeries were minor. However, while this could be a contributing factor, the participants referred to above were male members of staff, and this also needs to be taken into consideration in terms of the context of their responses.

This inequality is reinforced when isolating the visits that can be directly compared in terms of surgery types, surgical list, surgeon and anaesthetist (*see table 6 page 234*). The following excerpts from

S28 illustrate that less time was spent discussing pain with a female patient than a male patient, despite the fact that the visits were conducted consequently as the patients were on the same surgical list and were undergoing the same diagnostic orthopaedic procedure.

(Female patient-3.4 seconds)

> **S28:** "We'll try and get you as conformable as we can before you wake up".

(Male patient-14.5 seconds)

> **S28:** "What XXXX will do we'll put some local anaesthetic in and around the knee joint erm just before he starts so it reduces any pain afterwards. Erm... then we'll, I'll give you other medications for pain before you wake up".

This finding was repeated when directly comparing two similar and consecutive preoperative visits conducted by S18, which included discussion of regional blocks for orthopaedic surgeries, as the consultant anaesthetist spent more time with the male patient than the female patient (male patient 137.6 seconds versus female patient 89.9 seconds). Similar results were also found when examining consecutive surgical procedures by junior members of staff across the remaining surgical specialities. S23 spent 123.3 seconds discussing pain with a male patient and only 15.1 seconds with the female patient, despite the fact that these patients were scheduled for the same urology surgery. This was not isolated to male anaesthetic members as a female junior member of staff S24 also spent longer discussing pain with a male patient than the female patient (29.2 versus 15.3 seconds) even though they were undergoing the same general surgery procedure. In total, where a direct comparison could be made in terms of anaesthetic staff member undertaking the preoperative visit, the scheduled surgery, the surgeon and the surgical list, in 5 out of 6 comparable cases, the anaesthetic staff spent more time discussing pain with male patients than female patients.

Table 6: Time spent discussing pain across directly comparable cases

Anaesthetist	Male Patient	Female Patient
S28	14.5 seconds	3.4 seconds
S23	123.3 seconds	15.1 seconds
S24	29.2 seconds	15.3 seconds
S13	14.7 seconds	7.9 seconds
S18	137.6 seconds	89.9 seconds
S25	33.4 seconds	41.1 seconds

In relation to the gender of the staff within the department, there was also an undercurrent of unconscious bias which impacted on females, the evidence for which was demonstrated in two ways. Firstly, as I have already mentioned, female anaesthetic staff spent longer with their patients than their male colleagues and this was consistent across all surgical specialities and anaesthetic grades. The second relates to staff autonomy and power, as all the nurses who participated in the study were female, and 71% of the anaesthetic staff were male, there was a high level of male medically dominated power within the department. This, as previously highlighted, had an impact on the nursing staffs' feelings of autonomy and inclusion in the decision-making process and the sharing of information. An example of how this was demonstrated can be seen in the following field note extract where a female anaesthetic junior, who was conducting a preoperative assessment stopped when a male consultant surgeon entered the patient's closed curtained bay and interrupted the interaction in order to undertake his own assessment.

> ***Field note – December AM– day ward***
> *"In the middle of observing an anaesthetic visit, behind a closed curtain and patient's bedside, a consultant surgeon appeared, without asking permission to enter. There was no apology for interrupting the interaction, or any conversation with the staff member for permission to interrupt. The female member of staff just stopped what she was doing and without saying a word, allowed the male surgeon to undertake his preoperative assessment while she stood waiting at the bottom of the bed. I was also present, with the recording device, and there was not even any acknowledgement of my presence and no apology provided to the patient who was also female. The*

fact that we were all females could be a coincidence. However, the lack of verbal acknowledgement, eye contact and the manner in which the interruption was made is noteworthy."

In terms of this observation, when undertaking reconstructive analysis, it appeared that the consultant surgeon made a value judgment. That being, that his claim to see the patient was of a higher priority than the anaesthetic member of staff. She in turn, legitimised his validity claim, as she did not challenge his display of power. However, as I asserted earlier in this chapter, the hierarchy of staff also had an influence on her practice and therefore power and hierarchy must also be recognised as a potential factor in this case.

5.7.2.1 Language as a core indicator of gender bias

Gender bias was also illustrated in the language that was often used to describe female staff during the preoperative visits and also during the interviews. In the following extracts, nurses are labelled using words which are infantilising, and which negatively reflect on their professional status and worth.

(Patient interactions)

S13: "In recovery, if you do have any pain or any nausea, then just let the girls know, and we can fix those things, or try to fix them for you."

and:

S25: "You could ring up if you want, if you ask the girls they'll give you the direct number for the ward, and you could ring up."

and:

S29: "Just let the girls in there know, and there'll be some more pain medication written up for you."

and:

S32: "Blood pressure, the girls, will take that, so no history of any heart problems?"

and:

S15: "We'll ask you to take the dentures out, and then we put it in your box, we usually, the girls keep a box with your name tag on. So that's even safer because it's got your name tag. And then when you wake up the first thing that the girls in recovery will do, is give you your dentures back okay".

(Interviews)

> **S13:** "It's not uncommon for the girls on the ward to tell me they didn't have time to give the patient the paracetamol preoperatively."

and:

> **I:** "So when you do your pre-op visit do you communicate with any of the staff on the day surgery unit?
> **S19:** Yes and no. I usually have a little joke with them when I come in, just because they are quite bonny girls, I suppose."

and:

> **S20:** "The pre-op assessment girls, within that opening encounter, need to set expectations."

and:

> **S1:** "Challenges, a lot of challenges at times. But a great bunch of girls, great support, couldn't ask for a better team."

As is illustrated in the many extracts above, the word 'girl' is used to refer to the female nursing staff on both the day surgical unit and also in theatre recovery. The word "girl/s", which is defined by Oxford English Dictionary (2018) as primarily relating to a female child, was used on twenty-six separate occasions, yet, the word "boy/s" which is the equivalent term for males, was never used to describe the male staff. "Girl" was also only used when staff were referring to other staff and was never used within the context of describing patients. For patients, the more socially polite and formal term "lady" (Oxford English Dictionary, 2018) was used seventeen times; however, the masculine equivalent "gentleman" was never used. These terms were not spoken solely by the male staff but were also used by the female members of staff across the department. Nonetheless, overall in terms of the underlying suggestion and regardless of who used the word, "girl/s" has the potential to undermine authority, especially when used to describe the professional female staff. S19 also uses the word 'bonny', which adds another layer of bias, by reinforcing the image of a younger female, to staff who are registered qualified professionals. The response to this by S19, was that he likes a joke with the female staff as they are "bonny girls", which not only reflects bias and paternalism, but could also be interpreted as patronising and potentially misogynistic.

Differences in language were also noticed when some staff discussed pain with male and female patients undergoing similar surgeries. S26 often used statements such as "it's obviously a delicate area" or "exquisitely tender" when the surgery was located in and around the anal region of a male patient but did not use these words for female patients.

(Male patient)

> **S26:** "The last thing is to say that sometimes it can be sore, **it's obviously in a delicate area** and you'll have painkillers during the operation and painkillers afterwards and they may put a little bit of local anaesthetic in and around the area. Erm... So that would be the plan. If you can take paracetamol and ibuprofen I would take those regularly just in **case it's sore** and then we'll give you a bit of codeine in case it's **exquisitely tender**... it doesn't normally tend to be...it normally... this is a good sign but sometimes just because...
> **P31:** Yeah sure.
> **S26:** Tend to flare up. We'll give you some painkillers to go home with and hopefully that should be okay".

(Female patient)

> **S26:** "And the last thing to say is that sometimes it can be **a bit sore** after having any operation. If you could take ibuprofen and take paracetamol and we'll give you something else if it's still sore afterwards, we'll give you some codeine to take home. **I wouldn't necessarily take it but it's just in case**.
> **P32:** Yeah.
> **S26:** Have you got paracetamol and ibuprofen at home?
> **P32:** Probably somewhere.
> **S26:** If you haven't it's just they'll charge you £8 to have a prescription from here, you can pick it up from 25p, so I would just get some and take it as directed".

5.7.3 Unconscious bias and pain

The data discussed above, in terms of the language used to describe female staff and when interactions with female patient's, the timing of preoperative visits and the discussion of surgery superiority, contributed to my interpretation that within the department, there existed an underlying unconscious gender and surgical bias which impacted on preoperative interactions. Female surgery appears to have less value than other surgery and the management of female pain appears to be less important. The evidence to support this argument was further strengthened by the use of language and tone, which was often

minimising, in particular when referring to the postoperative pain in female gynaecology surgery.

> **S23**: "Okay. (Looking at notes). No worries, I think that the procedure is not painful so you should be fine."

and:

> **S14:** "This procedure sometimes can leave you feeling a little bit uncomfortable, but it's not usually too painful."

and:

> **S22:** "From our perspective. It'll be kind of like period pains, if that! So, you can take the normal stuff you might for that, like paracetamol or ibuprofen. Erm…we can give you some codeine, but I don't think you'll need it for this, it should settle quite quickly."

and:

> **S22:** "Okay this kind of operation, the ablation it can be a bit like period pain, might be a bit sore like period pain. Things that'll work for period pains work for this so paracetamol and ibuprofen."

The extracts from preoperative visits above illustrate the minimising language used to describe the potential postoperative pain that the women undergoing gynaecology procedures may experience. The association with period pains is worthy of comment, as this phrase was used by male members of staff, who biologically, have never experienced period pains themselves. Additionally, this phrase was used despite the absence of any discussion with the patient about their menstrual cycle and period pain experiences, thus reinforcing a minimalist view of the pain associated with gynaecology procedures and also demonstrating hierarchical dominance in terms of power and knowledge. The male member of staff, despite his gender and lack of personal experience, is claiming that his knowledge of period pains and this procedure are higher in terms of validity claims, than the patient's knowledge and experiences of her own body and menstrual cycle history.

When asked during an interview if they could provide examples of when they have cared for a day surgery patient who was in a great deal of pain postoperatively, many of the staff both nursing and anaesthetic, commented on the fact that they often witnessed

gynaecological patients in more pain postoperatively and this sometimes had an impact on their immediate recovery.

> **S1:** "We had a gynae patient not long ago who I wasn't happy to send home. We had literally gone through all the drugs that were prescribed, and I had to go back into recovery and see one of the anaesthetists, and you know give her morphine".

and:

> **S4:** "Erm…. more recently, I think I find I have a lot more patients who've had gynae procedures who've experienced quite a lot of…. I wouldn't say unmanageable, but they've had a lot more than they expected to have. In the last lady who'd had an ablation…. she had everything from the drug chart that I could give her and I know that they are quite painful from obviously the ladies who have had them and the information that I have read, and she was very uncomfortable. Even to the point where you look at some people, and you think "ooooh" you know. I don't know how uncomfortable they are, but she looked very uncomfortable and had everything, we tried all sorts. She didn't feel as if she was going to be able to get up because she was so sore, which I know from experience, can sometimes help. Erm…but like I say there is some of them, such as the gynae things, cos on the gynae list you can get the ablations which are quite painful and quick procedures but can be painful".

and:

> **S7:** "I would say on a couple of occasions that I know of, and I would say they were more gynae related, sometimes the gynae patients would be in pain. Just trying to think…… tubular occlusions for some reason they tend to have quite a lot of pain, so we are sort of aware before we bring them back that they might be uncomfortable?."

and:

> **S13:** "To be honest, I think sometimes gynae patients might get a slightly raw deal because some people see gynae as less major than general surgery, but at the end of the day if you have an abdominal hysterectomy you have a laparotomy, and it is a major abdominal procedure.
> **I:** Have you noticed this trend everywhere?
> **S13:** Yes, I think so, yeah. Maybe it is that they aren't as sore afterwards, like although they have an abdominal incision, maybe there is less pain associated with having your uterus removed, than having a bit of bowel removed. Or maybe it is a kind of false tradition that we have got ourselves into as anaesthetists. I don't know."

The concern over pain management for gynaecological patients was not limited to postoperative care, as S3 and S8 (field note) also expressed opinions that women undergoing gynaecology procedures were also not well prepared prior to the surgery.

> **S3:** "I'll just give you an example of maybe a patient who's had an endometrial ablation. For our gynae ladies, when I meet them preoperatively, they don't seem to have any expectations of what they are

going to feel afterwards. It's just a case of they think they come in for the surgery, then home and back to work the next day. So, I like to prepare patients for what to expect afterwards, so I do always warn them that they are going to feel maybe cramping pains, which might be awful and they could continue for a few days".

and:

Field note – April – day ward

"During a conversation with S8, and preoperative preparations for patients, they mentioned how in their opinion there was less preoperative preparation for gynaecology patients, probably due to the fact that there was a lack of specialist nurses and that they felt that resulted in 70% of gynaecology patients receiving a poor preoperative workup".

5.7.4 Summary

When examining all of the data, gender and surgical bias (which was predominately unconscious) was present within the culture of the department. This was demonstrated in terms of the unequal view of female patients and staff, reinforced by the language spoken to female patients which included terms and phrases which held negative undertones, and also by the words that were used to refer to female staff. It was also illustrated by the timings of the preoperative visits, which showed inequalities between males and females patients undergoing the same procedure and whose anaesthetic visits had been conducted by the same anaesthetic member of staff. The quantitative data also highlighted that less time was spent with gynaecology patients than any other specialities and that female patients undergoing a gynaecological procedure, whose anaesthetic preoperative visit was carried out by a male anaesthetist, had the shortest amount of time recorded across all specialities. The qualitative responses also showed that gynaecology surgery was viewed as lower in value than other specialities.

5.8 Overall findings summary

This chapter began by introducing the data sets and presenting the findings extrapolated from the data generated as part of the collection process. What can be seen is that the culture across the preoperative department did, in fact, influence the individual practices of the nurses and anaesthetists. And whilst pain planning and management were discussed with the majority of patients, there were large variations in terms of the depth and length of those pain interactions. Through a comprehensive process of reconstructive analysis, four contributing factors were found to exist which had an impact on the HCP decision making and communication skills relating to their pain planning and management for patients' perioperative care. These included HCP prioritisation of patient safety over pain planning management, the drive for productivity and its impact on HCP communication with patients. The existence of unequal power relations and hierarchical structures between staff and patients and how individual unconscious biases increased stereotyping and marginalisation of specific patients undergoing certain surgeries. I suggest that only one of these factors needs to be present in order for there to be a negative impact upon patient care and that if more than one is present the negative impact could be exacerbated further. These findings will now be compared to the wider research and aligned with existing theory, in an attempt to answer the research question and offer recommendations for how these findings can inform practice and alter the status quo.

Chapter 6

Discussion

6 Discussion

In this chapter, I will discuss how the findings relate to the research aims and overarching question. I will also examine how the findings, through links with the existing research and underpinning critical social theory, can aid in positive changes to the status quo within preoperative practice for day case surgical patients. This worldview will be defined and articulated through the alignment, integration and close examination of the existing knowledge and underpinning theoretical perspectives for the four main themes found in the findings, which represent stage four and five of Carspecken's framework. Reference will, therefore, not only be made to the findings from chapter five, but also findings that have been generated in previous research, broader national and international socio-political healthcare drivers, and critical social theories. The discussion will commence with the incorporation of findings with other current research for each theme, before moving on to overall theory integration and the works of Bourdieu (in particular the concepts of capital, habitus and symbolic violence), which were introduced in *chapter three, page 91*. *Table 7, page 243* below illustrates which theory and concept are aligned to the study findings.

Table 7: Alignment of theories to findings

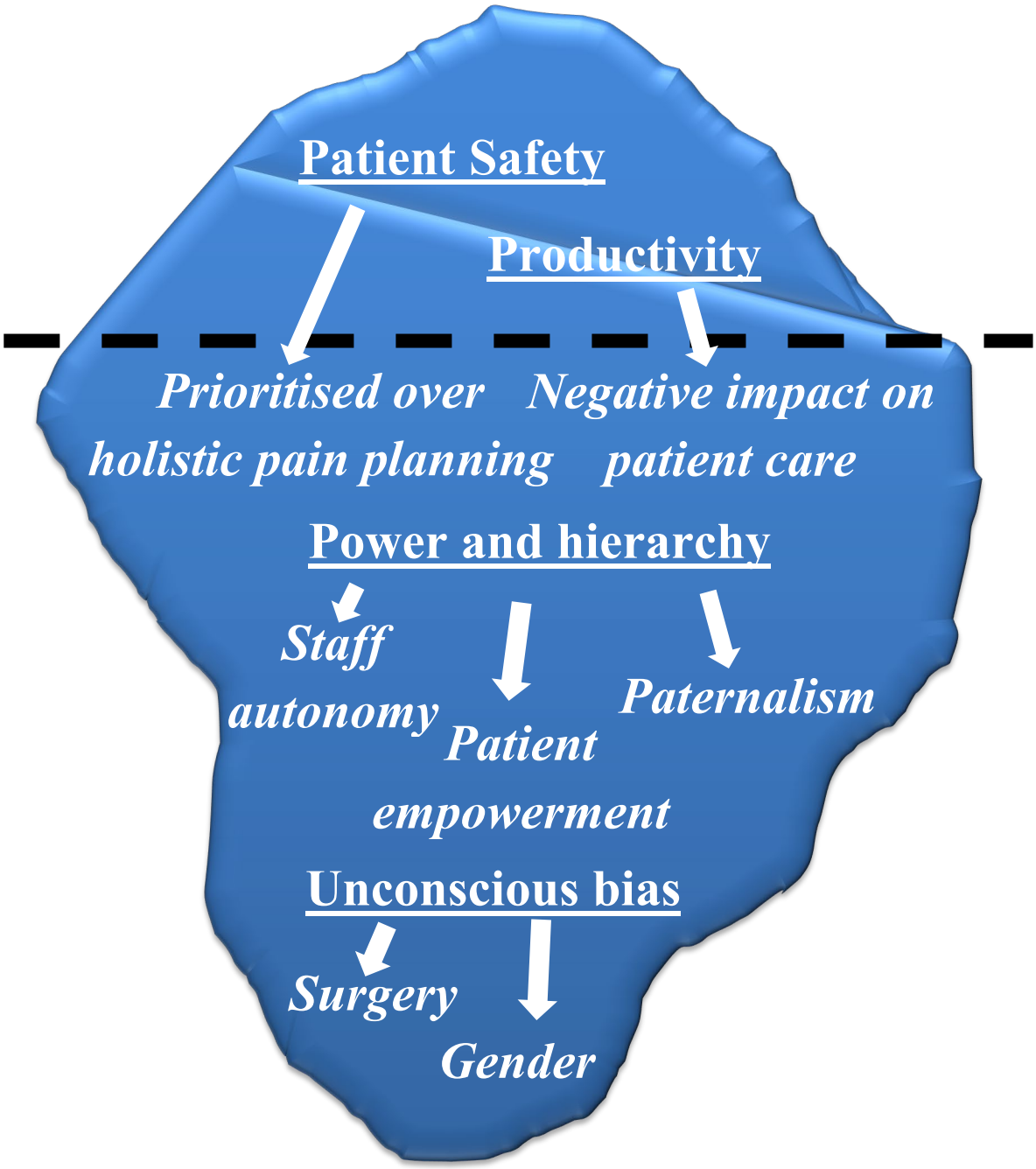
Theory	Patient Safety	Productivity	Power and Hierarchy	Unconscious Bias
Habitus	YES	YES	YES	YES
Social Capital	NO	YES	YES	YES
Economic Capital	YES	YES	YES	YES
Cultural Capital	YES	NO	YES	YES
Symbolic Capital	NO	YES	NO	NO
Symbolic Violence	NO	NO	NO	YES

6.1 Introduction

In chapter one I discussed how culture can be visualised as an iceberg, with only a small section visible and the larger proportion hidden and not easily seen. This is important for healthcare practice, as initial impressions of cultural practice can be misrepresentative of the underpinning habitus driving practice (Skeggs, 2015). The research results presented have examined the elements that influenced practice and contributed to the creation of the preoperative culture, making visible the submersed aspects that represent the largest proportion of the overall iceberg. Before discussing how the findings are aligned with theory and results from previous research, it is necessary to align the findings to their appropriate place within the cultural iceberg (*see figure 41, page 245*).

This helps to illustrate the order of discussion within this chapter, while also visually demonstrating the depth of awareness that the participants themselves possessed. I will begin with the thematic category that was the most visible, 'patient safety', before moving to 'productivity' and 'power', and finally ending with the theme that was the most submerged, 'unconscious bias'. As the diagram illustrates, the overriding themes of patient safety and productivity have been placed above the surface, as these were clearly visible, easy to observe and staff often made reference to these aspects of practice. However, in line with the research methodology and theoretical stance, the intention of the study was to examine the elements of practice that could be found below the surface. As such, it is the underlying influences of patient safety and production line culture that need to be explored, as these were not always overtly part of HCPs conscious practice. The prioritisation of patient safety over holistic pain planning and its negative impact on patient care, have therefore been placed below the line, alongside power and unconscious bias.

Figure 41: Findings represented within the cultural iceberg



6.2 Patient safety

"Globally, one in 25 patients has a surgical operation every year. Complications resulting from an operation occur for a quarter of all these patients. At least half of the cases in which surgery leads to harm are considered preventable.....Ensuring the safety of patients is a high visibility issue for those delivering health care" (WHO, 2017, p2 and p13).

As the above quote illustrates, patient safety is an issue within healthcare that continues to hold significant currency. It is openly deliberated in government, publicised in the media and discussed by staff and patients alike (Ragusa *et al.,* 2016). It is therefore not surprising that patient safety was a theme emerging from this study that had a direct impact on preoperative discussions. However, in terms of increasing knowledge and providing a deeper level of understanding, it is the level of prioritisation and the links between this and the ability to holistically plan and manage perioperative pain that need to be discussed further.

6.2.1 Alignment of findings to existing research

Findings from this study highlighted that both anaesthetic and nursing staff placed a high level of priority on patient safety (*see results page 175 and page 197)*. This affected the length of time spent discussing pain, influenced the position of pain discussions in the overall interactions and impacted on the quality and content of the pain discussions. This practice was further reinforced by the documentation that was used to assist with the interactions, which was primarily patient safety-centric and often guided the direction of the conversation.

Similar opinions relating to the prioritisation of pain within interactions were expressed by Sweitzer (2008), who stated that within the preoperative care environment, pain was often forgotten and frequently only debated when anaesthetists visited patients immediately before surgery. Moreover, even though pain was addressed in the 2009 Helsinki patient safety declaration, it was only referenced in relation to drug contraindications, correct administration and allergies, rather than holistic assessment and patient partnership, and therefore was framed within a strategic priority of reducing risk rather than promoting

patient-centred care (Whitaker *et al.,* 2011). I often observed this when anaesthetic staff asked patients about their current medication and potential analgesic regimes. By reviewing the normative claims and overall context in which these discussions were situated, I concluded that these questions were not used in an attempt to elicit patients' individual pain coping strategies, but rather as a means of ascertaining areas of potential harm and risk, such as side effects and drug interactions (*see results page 175)*. In some cases, even when patients asked further questions or attempted to discuss their current analgesic preferences, anaesthetic staff directed the conversation back towards their own agenda, with the use of directional questions or language which dismissed or minimised their claims *(see results page 215).*

A study by Smith *et al.* (2008) also found that interactions and handovers between anaesthetists and nursing staff were often brief and that the information was primarily based on the patient's clinical condition or problems that could be encountered in the operating room. Participants within this study also stated that at times, nurses needed to ask the anaesthetist for the patient's name, as this was not always volunteered. This indicated that anaesthetic staff reduced patients to specific safety details rather than discussing patients from a considered holistic perspective. These findings were echoed in a research study by Fraczyk and Godfrey (2010) who found that during preoperative assessments, healthcare professionals often focused discussions on aspects of care which they perceived to be important, such as risk, rather than directing the discussion towards elements which were on the patient's actual agenda. This would suggest that in the handover and preassessment processes, patient safety issues were given precedence over holistic patient details, potential reasons for which could include time pressures. Indeed this was corroborated by the findings, as time, or lack it was often referred to by staff

participants in interviews and when observing interactions (*see results (S5) page 205)*. Therefore, within the limited amount of time that the anaesthetic staff had to visit patients prior to commencing the surgical lists, they established and controlled the agenda of the interaction and often placed patient safety at a higher level of priority than holistic pain planning and management.

Lee and Lee (2013) agree that due to time constraints, nurses caring for surgical patients consider the information-providing element of their roles, such as pain discussions, to be a minor consideration in terms of priority. Within this study, these time pressures were associated with the increased organisational drive for productivity and efficiency; thus proving that a direct relationship exists between productivity and patient safety. In fact, many of the findings are interconnected and influenced by other themes. This indicates that the habitus of the department is created from the complex interplay between aspects of structure (the organisational drive and restrictions in terms of surgical start times) and agency (the staff members' ability to control the order and context of the discussion within the allocated period of time). However, holistic pain planning and management, while not deemed a priority for HCPs, is important for patients. Selimen and Andsoy (2011) agree that patients undergoing surgery, experience many stressors and it should be every HCPs responsibility to prioritise not only physical health, but also psychological well-being. For perioperative care, this includes reducing patients' anxieties and fears and providing relevant information on how their pain can be managed (Sadati *et al.,* 2013).

The findings from this study suggest that the documentation used within the department was mainly patient safety-centric. Similar results were found by Abdalrahima, Majali & Bergbomc (2008) who claimed that safety was the main driver for the creation of surgical

checklists. Additionally, Kim *et al.* (2015) state that these checklists are generic and not specifically tailored to address patient issues relating to surgical subspecialties. Documentation was highlighted in a report by Jackson (2012a) as being one of the reasons why hospital trusts failed to meet standards set out by the RCOA. This report also suggests that 90% of day case procedures should have procedure-specific information packs for patients (Jackson, 2012a). Clearly then, these checklists do not holistically address specific patient issues such as anxieties and fears, and they fail to address pain planning and management for varying surgical types, despite the fact that pain documentation should be utilised to increase the visibility of patients' pain. It would seem, therefore, that within this study, the general trend within the department was towards the prioritisation of patient safety over pain planning, although one of the most frequently stated preoperative needs of patients is information on pain management (Davis *et al.,* 2014).

6.2.2 Habitus

Bourdieu (1986) claims that the habitus (or the collection of well-practised habits) of a specific group of individuals can be influenced by capital and how this is viewed, valued, shared, and maintained. Bourdieu postulates that capital is ever-present in real-world social interactions and can be created from subdivisions including economic, cultural, social and symbolic (Bourdieu, 1986). The findings from this study suggest that patient safety is a highly valued commodity, as the habitus of the preoperative department places greater weight on patient safety outcomes and the costs associated with the failures and consequences of incidents involving patients. It is therefore inevitable that holistic elements of care associated with caring for the mind, body and spirit of the patient (Selimen and Andsoy, 2011) can often be left out, in this medicalised environment. This results in a habitus where a blanket approach to pain management is adopted rather than

taking a more individualised approach, where pain treatments are specifically matched to each patient's needs.

While these findings were unique to this research study, links can be made with what is already known about patient safety within healthcare and how this is framed within a window of strategic priority. Due to an increasingly ageing population and patients with complex medical histories, HCP and patient interactions are primarily centred on assessment of risk (Tooth and McKenna, 2006), especially within perioperative care, as there is a high level of iatrogenesis associated with surgery (Rawlings, 2012; Gillespie *et al.,* 2013; Jones and Durbridge, 2016). This high level of risk was often referred to by nurses and anaesthetic staff within the context of policy, regulation and litigation, or witnessed when observing the preoperative interactions (*see results pages 187,196 and 197).* This increased and raised awareness of policy is due in part to recent patient safety initiatives such as the Productive Operating Theatre Improvement Programme, which was created by the NHS Institute for Innovations and Improvement (2009) as a means of improving safety within perioperative care, as two out of three hospital fatalities have been associated with surgical care (Theodore *et al.*, 2013). WHO (2009) also published guidelines on safe surgery in an attempt to reduce harm to patients, and The Helsinki Declaration on Patient Safety in Anaesthesiology, published in 2009, emphasised the role of the anaesthetists in promoting safe surgical care (Whitaker *et al.,* 2011). Consequently, patient safety from a strategic, commercial and organisational standpoint, is being highlighted as being a primary concern for every anaesthetist and HCP working within the perioperative care continuum (van Aken *et al.,* 2011; Patil *et al.,* 2017). In terms of this study and the habitus of the perioperative department, the importance of patient safety was raised from both a structure and agency perspective, as the drive to improve patient safety

is being promoted from within the healthcare organisation and this, in turn, feeds into the tacit knowledge of individual staff, so their own priorities for care become centred on patient safety. However, while I do not dispute the importance of a patient safety culture, I would suggest that a single visioned approach is unnecessary and can detrimentally impact on the holistic assessment and management of pain and other aspects of patient care, such as patient partnership and shared decision making.

6.2.3 Economic capital

Aligning an aspect of care to a capital element is not a new phenomenon. In terms of economic capital and patient safety, this can be affiliated with the monetary costs associated with medical negligence claims, with latest figures from 2017/2018 showing clinical claims have risen to £2.2 billion (NHS England and NHS Improvement, 2019). This can also result in more extended stays in hospital, increased cost of medications and treatments and also the organisational costs in terms of insurance premiums (clinical negligence scheme and liability to third parties schemes). This is not surprising in light of the capitalised climate of the current welfare state, the global increase in medical negligence claims and the perceptions patients now have of themselves as consumers. The economic drive is not only from an institutional standpoint, but also a personal perspective, as the economic cost associated with negligence claims can also be directed to individual practitioners as well as hospital trusts. However, in terms of monetary costs and pain, there are several points for consideration. Pain is frequently cited as being the most common reason for which patients seek medical advice from HCPs (Plaisance and Logan, 2006; Clarke *et al.,* 2009). Therefore, as day case patients are self-caring at home, ineffective pain management is likely to increase the possibility of patients contacting HCPs for medical and analgesic advice. Additionally, if pain is not adequately managed, this could

also potentially increase the length of stay in the hospital, the need for prolonged treatment and result in decreased patient satisfaction rates, all of which could increase financial costs to the NHS and public spending (Polomano *et al.,* 2008b; Clarke *et al.,* 2009; Lindberg *et al.,* 2013). For day case surgical patients within this study, there were also other considerations in terms of delayed discharges and the potential impact this has on process flow, bed space availability and conversion to inpatient admissions (*see results (S1 and S13) page 207)*.

Despite this, it would seem that errors associated with patient safety are still considered a costlier problem than undertreated pain, with the report from NHS England and NHS Improvement (2019) claiming that increases in patient safety could result in a saving of £100 million in care costs each year. Additionally, pain is often an unseen symptom, not always present or predictable, and seen by many patients and staff as inevitable and a natural consequence of surgery (Layzell, 2008; Mann and Carr, 2009a; Rejeh and Vaismoradi, 2010; Mackintosh-Franklin, 2014). Thus, as demonstrated by the findings of this study (*see results (S19) page 193)*, pain is not considered as a serious cause for complaints and therefore not a priority in terms of medical negligence claims, cost-cutting measures and fiscal planning.

6.2.4 Cultural capital

It is not only economic capital that is associated with patient safety, but also the capital that Bourdieu (1986) states is comprised of the social assets of a person. It would appear that higher cultural capital is aligned with a professional culture that embraces patient safety. One such social asset is education. Due to the current focus on patient safety education and human factors training (WHO, 2017), it would appear that a practice which is more

predisposed to ensuring patient safety, is deemed to be more educationally relevant, and current. Meanwhile, knowledge and information on pain management and assessment strategies are not as widely integrated into medical education (Ung *et al.,* 2016). Cultural capital can also be seen in the form of institutionalised capital aligned with the symbols of competence and qualifications, which can be very quickly removed and undermined if patient safety issues are discovered. Recently publicised disciplinary and manslaughter cases, such as that of Dr Bawa Garba, who was convicted of gross negligence and manslaughter in a criminal court, assists in drawing HCPs attention to patient safety issues and remind HCPs that cultural capital can be removed due to the current blame culture that exists within society and the criminal justice system (Dyer, 2019). As a result, there is an increased cultural capital associated with patients' safety rather than holistic pain planning, and the prestige associated with symbolic capital was evident within this study as a patient safety culture was uppermost in the habitus of the department.

6.3 Productivity

> *"The industrialisation of medicine is seen as a malignant phenomenon that negates the individuality of the patient and the creativity of the doctor, turning the former into a production line process and making the latter give up a craft in favour of clinical practice driven by protocols, guidelines and evidence-based medicine" (Iliffe, 2008, p.2).*

The face of medicine has changed over the last century, largely as a result of the increased demand for medical services, but also as a consequence of the continued capitalist culture which exists within the western world and the recent advances in technology and medical research (Rees, 2008). Whilst this may be seen as progress, what needs to be considered, and what Iliffe (2008) alludes to in the above quote, is that HCPs working in a climate of

productivity, need to be mindful of how this production line approach reduces patients to a product, and measurable output.

6.3.1 Alignment of findings to existing research

The results from this study suggest that the drive for productivity and efficiency had a direct impact on the amount of time that HCPs spent with patients, and as a consequence, some pain interaction were reductionist, limited in depth, and lacked holistic focus. This applied particularly to patients on the gynaecology surgical lists, which were by far, the most heavily populated surgical lists that I witnessed whilst on the department. It was suggested by the anaesthetic staff when reviewing the quantitative data, that reasons for this could be that women on the gynaecology list were healthier and younger than patients on other surgical lists and that these surgeries were minor in comparison to orthopaedic and general surgeries (*see results (S19 and S20), page 232)*. The suggestions postulated by the anaesthetic staff, while valid, would appear upon closer examination to reinforce the findings from the reconstructive analysis, that staff held specific and biased perceptions of gynaecology surgery. There is therefore a link between productivity and unconscious bias. This will be explored in greater depth later in this chapter.

In relation to productivity within this study, the process flow of patients and staff was often heightened, (*see results page 200*) there was an increased demand for access to patients and patient documentation (*see results page 203*) and the number of patients on the department had increased, resulting is a faster pace of work and a more rapid turnover (*see results page 201*). The volume of activity within our current NHS has seen large increases, both in terms of emergency and elective surgery, which is one of the clinical areas that has seen increased pressure to improve costs and productivity (Tallis, 2004; Al-Benna, 2012).

This is due primarily to the fact that 29% of healthcare outlays are related to surgical expenditure (Munoz *et al.,* 2010). Consequently, staff are now tasked with the responsibility of increasing efficiency and cost-effectiveness, all with reducing budgets and resources and therefore constrained by organisational targets (Pritchard, 2011; Rawling, 2012).

Despite the fact that some staff participants enjoyed this heightened productivity and faster pace of working, some implied that this could have a negative impact on patients' perceptions of their care. They claimed that patients sometimes referred to themselves as 'cattle' and likened their experience to a 'production line' and a manufacturing process (*see results page 202)*. This was also found in a recent research study by Siu (2015, p. 6) who asserts that patients interviewed felt they were part of a manufacturing system, with one patient stating "*I just feel like a product in the production line of this medicine factory. The doctors are only concerned about finishing their tasks in a short time, and I will be passed to the next step in this production line*". Shoqirat (2013) found similar results that patients did not feel valued and were treated in a mechanistic way. In this study, whilst the views of the patients were not directly explored as part of the interview process, on several occasions during the observations of practice, patients were heard stating that they were "being herded like cattle" or that the preoperative experience was "just like a cattle market" (*see results page 202*). This indicates that these faster-working processes and the increasing industrialisation impelled by incentive payments, normally come at a cost as holistic and compassionate care have become subordinate to productivity (Iliffe, 2008; Ballatt and Campling, 2011).

This view is shared by Sharp, McAllister and Broadbent (2018) who declare that dominant neoliberal discourses of valuing efficiency over effectiveness can be barriers to patient-centred care, as time pressure and increased workloads mean that staff sometimes fail to meet patients' individual needs. Similar findings were found in a study by Carr, Thomas and Wilson-Barnet (2005) who stated that due to high patient turnover, caring and compassion have become institutionalised, with nursing actions becoming robotic and task orientated. These characteristics can also be aligned with the findings of this study. I have already alluded to the fact that the anaesthetic visits were patient safety focused. Key themes declared as core indicators (*see figure 28, page 185*) were routinely discussed in every preoperative anaesthetic visit, which could result in these visits appearing task-focused and repetitive. Due to the nature of the environment and the realities of preparing patients for surgery however, I acknowledge that this can not always be avoided. Within perioperative care, there are certain tasks and roles which need to be performed and specific questions which need to be addressed; consequently owing to limited space and privacy, conversations conducted during the anaesthetic preoperative visits in multiple bedded areas, may be overheard and patients receiving subsequent visits may see these as repetitive and task-focused. However, this in no way undermines or detracts from the need for HCPs to consider the uniqueness of pain experiences and ensure that appropriate pain conversations take place prior to the patient entering the operating room.

Another limitation of the increased productivity witnessed in this study was in relation to the allocation of time. Staff were conscious that some patients could be waiting several hours to have their surgery, which provided the opportunity to speak to them without the associated time constraints. However, to maintain process flow and ensure that the surgical list was not delayed, any preoperative discussion happened in a limited time period before

any of the surgical lists began. Time constraints can impact on the ability of staff to interact with the patients holistically and therefore patient concerns such as anxiety and fear, which many patients experience preoperatively, may not be fully addressed in a clinical environment with rapid patient turnover (Grieve, 2002; Pritchard, 2009; Bailey, 2010; Ebirim and Tobin, 2011; Heaney and Hahessy, 2011; Karaman *et al.,* 2016). The interrelated link to patient safety can be seen again here; not only did productivity limit the time that could be spent with patients (*see results page 205*) but as an added consequence of the prioritisation of patient safety, the time that was utilised, focused on aspects of care that were centred on risk and harm rather than individual needs and preferences. The shortest conversations were also very brief, simplistic and instructive rather than informative, and patients were often passive, responding with single-word answers to questions (*see results page 215*).

The AAGBI and RCOA (2008) also state that preoperative visits often fail to provide patients with adequate time to make an informed decision. In a study by Boyd *et al.* (2006), time limitation was also the primary influence on the decision-making processes for the choice of anaesthesia. Manias, Bucknall and Botti (2005), Coll and Ameen (2006) and Gregory and Waterman (2012) found similar results, concluding that extensive assessments are deemed by participants as being unachievable within the constraints of current workloads. Time was also a factor which Fraenkel and McGraw (2007 p. 616) considered essential to enable patient participation in the decision-making process and cited lack of time as a barrier to effective healthcare, with one participant stating "*a lot of them don't explain things – they don't have time, or they don't take the time*". Gilmartin (2004) also found that the time pressures placed on staff were visible to patients and this resulted in them also feeling pressured and rushed within the consultation, which often

meant they did not feel that they could be open and honest about their fears or ask any additional questions.

Within this study, this was not always the case, as several comprehensive assessments were witnessed, which were holistic and detailed despite the similar time restrictions (*see results (S13) page 207*). This suggests that in addition to time, the beliefs, values, perceptions and assumptions of the individual anaesthetic staff also had an influence on the interactions. This will be discussed later in this chapter as there was also a correlative link between productivity, power and unconscious bias.

6.3.2 Symbolic capital

Findings from this study suggest that within the habitus of the preoperative department, productivity had an influence and impact on pain planning and management activities between HCPs and patients. This was not only in terms of increased patient numbers but also increased process flow and subsequent issues with access to patients and their notes. This is important as there is a significant amount of prestige and recognition associated with this finding, and the link between productivity and prestige is correlational, as more productivity equals greater reputation. This is reinforced by national and global drivers and productivity initiatives, which recognise hospital trust who achieve against targets (NHS Improvement 2019a). These rewards can be financial (economic) but more often are aligned with status, professional recognition and public and media praise associated with symbolic capital, as hospital performance is regularly measured, monitored and published. This may go some way to explaining the reason for the increased number of patient admissions witnessed by the study participants (*see results page 201*). Additionally, NHS reform plans have placed a greater emphasis on the benefits of productivity, resulting in

greater prestige being symbolically interconnected to healthcare practices, which are more efficient and effective.

In this study, the prestige of the NHS hospital trust was commented on by study participants (*see results page 227*) who declared that the hospital was seen as an orthopaedic specialist hospital. This implies that staff believed that an existing level of reputation and respect was already associated with this hospital trust. This also indicates that this finding is aligned with unconscious surgical bias, which will be discussed later in this chapter.

It may also be the case that it is easier to measure and quantify data on productivity than on holistic and patient-centred care, which can be more problematic and time-consuming as it involves liaising with patients and incorporating their views and opinions. Consequently, the symbolic value can be more effortlessly associated with targets and figures aligned with productivity and efficiency, rather than feelings, opinion and perceptions of the quality of perceived care from a patient perspective. This indicates that higher levels of symbolic capital associated with productivity activities could have influenced the habitus of the department. For example, some staff members really enjoyed the rapid turnover of patients and the fast pace of work (*see results page 201*), and thus reinforced the symbolic value of high levels of patients, as it provided them with a sense of job satisfaction.

6.3.3 Social and economic capital

The increased prestige and recognition (symbolic capital) already alluded to can also increase social and economic capital, as the higher levels of one type of capital may correspondingly attract wider social networks and links to individuals with more political,

economic, professional and social power (Bourdieu, 1986). The current NHS is a public service, paid for the UK taxpayer and, as such, an organisation which is heavily associated with monetary cost and value and is now more than ever, operating in a competitive and market philosophy (Churchill, 2007; Iliffe, 2008; Ballatt and Campling, 2011). In this study, a market philosophy was witnessed in some of the interactions with patients, as the staff referred to patients as 'customers' (*see results page 220*). This indicates that some staff considered patients as consumers and purchasers of their services, demonstrating how productivity is deeply embedded in the habitus of this department. Iliffe (2008) and Aranda (2018) suggest that due to the influence of capitalism, there has been a shift in terms of how HCPs and patients perceive themselves, as patients are now considered to be consumers, buying care from a medicine machine and HCP are accountants, continually needing to balance the books. The uniqueness of healthcare interactions has therefore been lost, as a result of the mass manufacturing and production line approach to care (Illife, 2008). This 'Fordist approach', gained popularity in the early twentieth century with the embracing of working practices pioneered by the Ford Motor Company. This can be seen within the findings of this study, as patient care and pain planning were fragmented and simplified, and aligned to standardised protocols. Checklists were undertaken by HCPs who were task-focused, and care took place in an environment which saw huge increases in patient volume. Therefore, the assembly line and consumerist approach, which resulted from the widespread acceptance of Fordism, has not only reduced HCPs vocationalism but also holistic and patient-centred approaches to care.

The association between productivity and economic capital was also demonstrated in this study, as members of staff made reference to the fact that patient numbers had doubled in the last 10 years (*see results page 201*). Although this figure was never verified, such

increases are reflected in data published by the AAGBI & BADS (2011b) who suggest that 80% of elective surgery is now carried out as day case. This indicates that in a bid to reduce surgical costs, more procedures are now being carried out as day surgery. In 2009 the NHS Institute for Innovation and Improvement (2009) instigated 'the productive operating theatre programme'. This aimed to improve efficiency, as part of the NHS productive series, with a view to saving an average hospital £7 million. Some of the areas of focus included session startup, scheduling, session utilisation, and patient turnaround times, all of which were to be statistically targeted. Since its creation in 2009, it has proven to be largely successful, with some hospital trusts saving in excess of £2 million, and efficiency targets for reducing late starts being reduced from 82% to 44% (Theodore *et al.,* 2013). The success of the programme is also reflected in surgical activity figures, with The Royal College of Surgeons of England (2015a) stating that from 2003-2004 to 2013-2014 there was a 27% rise in the number of surgical admissions.

In this study, several staff participants also stated that orthopaedic surgical procedures generated a large amount of income (*see results page 226*). This suggests that for some staff, income generation was aligned with productivity, efficiency and process flow, as the distribution of resources was closely associated with income generation. In this regard, productivity is economically rewarded, which can also be extremely beneficial from a social capital perspective. This is especially so when attempting to recruit high calibre staff, trying to promote positive publicity and when struggling to generate additional funding and savings (Bernstein, 2015; NHS England, 2019). The 'Getting it Right First Time (GIRFT)' methodology created by the Royal National Orthopaedic Hospital, NHS England and NHS Improvement (2019) is an innovation that focuses on productivity. However, the pilot study focused solely on orthopaedic surgical specialities and the

implementation of the workstream that followed, assisted trusts to generate financial opportunities and savings of £696 million. It is therefore not surprising that in the sphere of perioperative care, staff have made a connection between income, productivity and orthopaedics.

6.3.4 Habitus

The habitus of the practice environment, which structured how the HCPs interacted (Elliott, 2014) was determined by not only external structures in terms of efficiency targets, staffing and cost but also internal actions of the HCPs, as staff were aware of time pressures and increased activity within the surgical department. As a consequence, they focused and prioritised aspects of care which they deemed to be most important, rather than those that the patient may have felt were most important. Thus, both agency and structure influenced the habitus of the department, and this was reinforced by repeated and unchallenged practice (Bourdieu, 1977), as both the benefits of social and economic capital aligned with productivity and efficiency were considered best practice.

6.4 Power and hierarchy

> *"Habitus is neither a result of free will, nor determined by structures, but created by a kind of interplay between the two over time: dispositions that are both shaped by past events and structures, and that shape current practices and structures and also, importantly, that condition our very perceptions of these (Bourdieu 1984, p.170)".*

Power can be found everywhere, is present in various guises and exists in all societies and human interactions, even those associated with healthcare (Foucault, 2002; Vandenberg and Hall, 2011). In terms of this thesis, power, as described in Bourdieu's quote above, is

aligned with the habitus of the cultural world and the interplay between individual agency, structural constraints and how these influence relationships and interactions.

6.4.1 Alignment of findings to existing research

Findings from this study suggest that inequalities in power and an unequal balance within the interplay between agency and structure were present between the anaesthetic staff, nursing staff and patients, and in some cases negatively impacted on pain planning activities, and interactions. These instances were associated with staff autonomy, staff hierarchy, medical paternalism and patient empowerment.

6.4.1.1 Staff autonomy

Many nurse participants in the study made reference to the level of autonomy that they felt they did or did not have (*see results page 212*). Primarily, what was found in the data, was that agency power (the personal power associated with free will) was used by the anaesthetic staff, as they could either provide more choice in the medication regime, allowing nurses to use their judgment, or remove choice by limiting what was prescribed. This was also impacted by structural power, as nurses' roles were limited by regulations and professional limitations, as without the additional qualification of pharmacological prescribing, the nurses had restricted free will, in relation to which drug they could use to manage patients' postoperative pain.

These findings have also been found in a study by Wilson (2007) where nurses reported a lack of control over pain management decisions and in particular medications, and thus had limited autonomy which often left them feeling helpless. Consequently, autonomy is considered to be central to healthcare practice, especially for nursing practice, as autonomy is associated with the ability to exercise judgments and make clinical decisions, based on

professional knowledge. Rao, Kumar and McHugh (2016) claim that in hospitals where nurse autonomy is encouraged and found to exist at higher levels, healthcare institutions have a lower risk of death and complications. Similar views were expressed by van Oostveen and Vermeulen (2017), who stated that hospitals need to promote nurse autonomy at higher levels, in order to increase influence on patient outcomes.

In this study, some anaesthetists were happy to provide a range of analgesics on the medication chart, allowing nurses to make decisions (*see results page* ***Error! Bookmark not defined.***). Others, however, were concerned that this would lead to potential postoperative complications (associated with disproportionate amounts of pain) not being escalated to either themselves or the surgical team. This indicates that some anaesthetic staff were not confident in nurses' ability to recognise the signs of postoperative complications and deterioration in patients' conditions. This lack of confidence or respect has the potential to perpetuate hierarchies and prevent the cascade of power from those in authority. MacDonald (2002) suggests that even when autonomy is formally acknowledged and promoted, true professional autonomy will never be realised if the culture of the immediate clinical area is not supportive of nurses' independent judgments. This was also observed in some anaesthetic preoperative visits, where the decisions of the nurses were called into question in front of the patient (*see results page 179*). This suggests that for some staff there was a lack of professional respect, as to openly criticise another professional in front of a patient could be seen as a way of reinforcing their own sense of power and positional status.

6.4.1.2 Staff hierarchy

The NHS is a healthcare organisation and like most organisations, is politically constructed, therefore, interwoven within the very fabric of the institution, exists dynamics of power, which can impact on the overall functioning of the establishment and influence decision making and relationships (Mahon and McPherson, 2014; Batch and Windsor, 2015). Hierarchies of power within professional work have been well documented, especially within perioperative departments where Wicker (2010, p.13) suggests there has been "a long history of a pecking order" with tensions between medical staff and nurses often being recorded (Witz, 1992). Again, this can be seen in the example cited earlier, where an anaesthetic member of staff placed a higher validity claim on their knowledge and was derogatory about the decisions and validity claims of a nurse. Hehir (2010, p. 50) suggests that the dominant culture is "survival of the fittest" and thus healthcare staff must often conform to the dominant practice, which can limit autonomy and lead to an unequal balance of power between the patriarchal medical role and nursing subservience. This is further reinforced through knowledge, which can also be restricted.

Within this study, many nurses felt that they were not always provided with the most up-to-date information (i.e. change in policy or protocol) and that this negatively impacted on their ability to prepare patients preoperatively. This was demonstrated by S10 (*see results page 214*), who was frustrated that she was only made aware of a change in protocol two years after it was initially introduced. She was therefore unaware that on the day surgical unit, oral paracetamol would routinely be given to patients prior to their surgery. As one of her main roles was to provide information to patients preoperatively, she found that this had negatively impacted on her ability to perform this duty to the best of her ability. Breakdown in communication was also examined by Stein-Parbury and Liaschenko (2007)

who concluded that physicians often do not consider nurses' knowledge to be relevant and view their own knowledge as superior, regardless of whether that knowledge is relevant to the clinical situation. Bould *et al.* (2015) also found in a study examining hierarchy within perioperative care, that hierarchy played a dominant role within operating room culture, with the hierarchical gradient being described by participants as 'steep'. This sharp ascent has the ability to negatively impact on the transfer of knowledge not only from nurses to medical staff, as power may impede nurses' ability to speak up, question orders and voice their concerns (Atwal and Caldwell, 2005; RCOS, 2015), but also from medical staff to nurses, as they often do not see the relevance of sharing information with healthcare professionals were are deemed as subservient (Green *et al.,* 2017). This has relevance to this study's findings, as the possession of knowledge by the medical staff, either in terms of analgesic choices or changes to protocols and policies, could be seen as a way of reinforcing the hierarchical dominance of one profession over another. Within this study, it appeared that this was more prominently displayed in terms of the preassessment nurses, who stated that due to their physical location within the hospital, they could easily become forgotten and often missed the cascade of information which other nursing staff on the ward were often party to (*see results page 214*).

The hierarchy between HCPs was also observed when more than one professional needed to speak to a patient. The jostling for prime position was directly witnessed when observing anaesthetic visits (*see results page 216*), but was also referred to, albeit in a light-hearted manner, during staff interviews, during which one staff participant referred to staff 'fighting for patients' attention' (*see results page 203*). This power interplay can sometimes be interpreted as a form of control, associated with fear and bullying, both of which can contribute to a damaging working culture, especially when staff feel unable to

challenge colleagues' practices (RCOS, 2015). However, whilst fear and bullying have been shown to exist within the perioperative arena, with figures from the General Medical Council (GMC) claiming in a survey that 8% of doctors in training said that they had experienced bullying and 14% had witnessed it, particularly in the field of surgery (GMC, 2014; 2015), the examples of power being displayed within this study were more subtle, often unspoken and not regarded by the participants as a form of bullying. While some staff on the department however had high levels of job satisfaction (*see results page 201*), others felt frustrated that their professional status was valued less highly than others, not only by the hospital trust but also patients (see results page 213).

6.4.1.3 Medical paternalism and patient partnership

The use of power was also witnessed in the interactions between HCPs and patients, and often took the form of medical paternalism. Paternalism is suggested by Collinson and Hearn (2003) to be perpetuated within healthcare culture as a result of the influence of the self-justifying notion that doctors can protect patients by way of their authority and standpoint that power is beneficial for all individuals concerned. Parsons (1991) suggests that there had been a prevailing notion within healthcare that individuals who are ill, are not competent, do not possess the knowledge to help themselves, and as such are wholly dependant on the trained professional as their illness and health can only be understood through the subjective view and interpretative gaze of the medic.

Power dynamics are inherent within medicine, as physicians' perceptions and application of knowledge are at the heart of diagnosis and therefore unequal power is unachievable, and patients are traditionally seen as the oppressed group (Harrowing *et al.,* 2010). Within perioperative care, this level of paternalism can often be greater, due to the higher levels of

risk associated with the clinical environment; thus paternalism is still practised within perioperative care, as the discretion for which type of anaesthetic and analgesic is used is predominately medically controlled (Powell *et al.,* 2004; Boyd *et al.,* 2006; Burrows and Taylor, 2009). Within this study, the paternalistic practice was demonstrated in a number of ways, including the use of language and interruptions, the timings of interactions, the pattern of conversation and the sharing of information.

Firstly, HCPs controlled the interactions by regulating the start and end points of the conversations. They, therefore, had complete control over the length of time spent with the patient, and to maintain this control often used interruptions and questions to cut off what the patient was saying (*see results page 217*). This was also confirmed in a study by Greenhalgh, Robb and Scambler (2006) who shared the opinion that time, which was a crucial factor in enabling adequate communication, was usually clinically controlled by HCPs who dictated the length of the interaction. The rhythm of the conversation was also more unidirectional and heavily influenced by the use of closed questions which would restrict the amount of information that the patient could provide (*see results page 215*). Similar findings were found in a study by Sarbandi *et al.* (2017) where interruptions were found to be a way of upholding power and maintaining the direction of the conversation, and often took the form of words such as 'okay'. Doctors were also found within the study by Sarbandi *et al.* (2017) to ignore patient reactions or stop them from elaborating further by using these interruptions as a way of interfering with the patients thought processes. Williams, Ching and Loader (2003) also found that preoperative visits by the anaesthetists were brief, that staff lacked sensitivity and appeared uncaring and unfeeling. This was echoed within this study, as some patients voiced concerns or made remarks about how they were feeling that were not recognised, acknowledged or addressed by HCPs, who

instead asked new questions to change the course of the conversation (*see results page 217 and 217).*

Despite the suggestion that shared decision making and information provision is fundamental to surgical care and that patients should be aware of the choices available to them (Niemi-Murola *et al.,* 2007; Jackson, 2009), findings from this study also revealed that when information about pain management strategies was provided to patients, this was usually brief, lacked depth, was not holistically tailored and further opportunities for discussion were often dismissed and not utilised. These findings are echoed by Mavridou *et al.* (2017), who found that 94.2% of the 225 patients surveyed in their study wanted more information about perioperative pain strategies. In this study, information was provided rather than exchanged, and this limited the capacity for patients to be actively involved in decisions about their care. This lack of interaction and exchange of information was a feature of some of the staff to patient interactions in this study and was demonstrated further as standard pain leaflets were no longer provided to patients who were not to receive regional blocks (*see results page 219*).

Power imbalances were also reinforced through the domination of knowledge and expertise, as often, patients' views were not taken into consideration and in some cases, anaesthetic staff openly admitted that they did not actively offer patients a choice in relation to analgesics (*see results page 218*). In a study by Siu (2015), more than half of the patients felt that they were not involved in the decision-making process. Crispin, Bugge and Stoddart, (2017, p.118) suggest that this can be reinforced by the use of paternalistic language and the commencement of sentences with phrases such as 'what I'm going to do', which limit the exchange and place the patient in a subservient position. This was echoed

within this study by the anaesthetic staff who used phrases such as ‘so what we'll do today is….” (*see results page 220*). Consequently, power from both an agency and structural perspective were demonstrated in this study with the negative impacts of this being witnessed in patient care and staff autonomy.

Another aspect of power that was demonstrated in the clinical setting in this study was related to gender, and the unequal value of surgical types and the language used. The paternalistic practice is perpetuated by the unintentional objectification and stereotyping of patients, and the link between gender and the dominance of males within current medical practice. Thus paternalism, which is associated with male dominance within society, is still present within medicine and often unrecognised as the assumptions in power dynamics between medical staff and patients are profoundly ingrained and hidden (Cooley, 2015; Crispin, Bugge and Stoddart, 2017). Again, this illustrated the complexity and interconnectivity of the findings, as unconscious bias was also found to influence the power dynamics within the habitus of the perioperative department. Gender bias is discussed in more depth later in this chapter.

6.4.2 Cultural capital

It was apparent from the unidirectional conversation witnessed during the preoperative interactions, that medical knowledge in terms of cultural capital, was allocated a significantly higher status than patients. The knowledge demonstrated and the language used by the medical staff often reduced the patients from individuals to their disease, condition, and signs and symptoms, which could only be understood through the view and interpretations of the medical professional (Foucault, 2002). This knowledge had a greater level of cultural capital than the knowledge the patient possessed. The patient's likes,

dislikes and pain experiences were rarely discussed, and the interaction was focused more on obtaining patient safety information and telling the patient about the anaesthetic management plan that the anaesthetists had already formulated, rather than involving them in the decision-making process. The patient was therefore, at the mercy of the physician's knowledge and expertise (Foucault, 2002). Cultural capital is not only associated with the relationship between anaesthetists and patients, but also between HCPs. Again, this was demonstrated in terms of knowledge, which some nursing staff stated was not shared, and autonomy, which was controlled by the medical staff. This can be aligned with the form of cultural capital referred to as institutional capital, which is associated with symbols of competence and authority, such as qualifications and professional titles (Bourdieu, 1986). It appeared that the medical staff's knowledge of analgesics and their status as a medical prescriber placed them in a superior position to that of the nursing staff, who were sometimes seen by the anaesthetic staff as having reduced knowledge and skill. This was not the case for all anaesthetic staff, as discussed in the findings chapter; some medical staff tried to promote staff autonomy and therefore placed a higher level of institutional capital on nurses' knowledge and expertise (*see results page* ***Error! Bookmark not defined.***). However, as autonomy was a dominant theme, it would therefore seem apparent that the institutional capital attached to members of staff with a professional title of doctor, was present within this study, especially in terms of knowledge and information exchange and nursing staff autonomy to make clinical decisions.

6.4.3 Economic and social capital

It can be suggested that aspects of economic and social capital were also demonstrated within the study, especially when power and hierarchy were witnessed between the members of healthcare staff. The additional knowledge and training required to be a

qualified doctor could be seen as having a higher capital status than nurses, not only in terms of economic (salary) but also social (social networks) capital. In this study, this was demonstrated by nurses and junior staff members regularly allowing senior members of staff a higher level of privilege in terms of the order and priority of visiting and communicating with patients (*see results page 216*). Thus, the economic and social capital present within this social realm, influenced individuals' perceptions and views of the material and group worth of their colleagues. Bourdieu (1986) agrees that within society, those who possess a high level of social and economic capital are more respected and recognised, and as a consequence, these forms of capital are often used to place individuals in dominant and subordinate positions within the field (Bourdieu, 1986).

6.4.4 Habitus

Paternalistic practice and the unequal power relationships seen within this study are aligned with economic, social and cultural capital, which either resulted in a decrease in the power and individuality of the patient or impacted on the interactions and hierarchical status between the HCPs. In some instances, the dominance of one individual over another was not always directly exercised, but indirect; thus the habitus of the clinical area resulted from a complex set of actions and subtle interplays of power (Bourdieu, 1998). For patients, power relationships were influenced by the unequal distribution of knowledge or the capital status aligned to the various types of knowledge. Paternalistic practice and power were demonstrated by some of the staff, who reduced their patients to signs, symptoms and often interrupted patients who attempted to elaborate when asked questions or dismissed patients' declarations of fears and anxieties. Whilst these forms of control over the conversation were subtle and not always displayed by every participant, a sense of power still existed within the interactions. As a direct consequence of the nature of the

relationship between anaesthetist and patient, this may be unavoidable, as anaesthetists are solely responsible for airway and breathing, two of the fundamental elements for maintaining life. However, through the process of member checking, some participants began to reflect on their practice and started to discuss the possibility that their practice was paternalistic (*see results page 219*). This reinforced that some HCPs were unaware that they were controlling the content, length and quality of the interactions to such a degree that it negatively impacted on patient care. This is encouraging, as power left unchecked and unchallenged can result in the increased marginalisation of individuals and this has significance within healthcare, as patients, through the presence of their illness and condition, are already disadvantaged. Patients should therefore be treated in a perioperative department which fosters a culture of equal partnership and recognises the importance of patients wishes and views (AABGI and BADS 2011b; Hanna *et al.,* 2012; Levitt and Ziemba-Davis, 2013; Andersson, Otterstrom-Rydberg and Karlsson, 2015).

6.5 Unconscious bias

> *"Male domination is so rooted in our collective unconscious that we no longer even see it. It is so in tune with our expectations that it becomes hard to challenge it" (Bourdieu, 2001).*

Humans are fallible and when it comes to making decisions, can often be influenced by negative or positive biases, either deliberate or rooted at an unconscious level (Kahneman, 2011). Implicit bias, otherwise known as unconscious bias, is the act of decision making based on intuitive and unconscious processes, which often develop and mature through exposure to real-life practices and interactions with others that become reinforced and automatic by repetition and replication (Chapman, Kaatz and Carnes, 2013). These intuitive processes can serve to protect, especially in emergency situations; however, in

complex situations involving multiple individuals, prejudice, stereotyping and discrimination can be undeserved derivatives of these unconscious biases (Frith, 2015). The biases found in the broader population can also exist within the sphere of healthcare practices, and as they are often hidden, unconscious and triggered automatically by the brain, these are often influential in daily healthcare interactions (FitzGerald and Hurst, 2017). These biases are also often reinforced by the persistent nature of repetitive practices, which remain unchecked and unquestioned (Mee, 2013). Within this study, unconscious bias was found to exist within the preoperative arena, particularly biases that were associated with surgery type and gender.

Before these sub-themes are discussed further, it is necessary to reiterate the methodological and theoretical orientation underpinning this study and how Carspecken's (1996) framework integrates the use of critical social theory, specifically Habermas's 'theory of communicative action', as part of the reconstructive analysis. This is warranted as the finding of unconscious bias was the theme that was the most submerged, hidden, and often unspoken. For the majority of interactions, this finding was only revealed when reviewing the underlying subtext, meaning and truth, through the examination of context and validity claims related to overarching themes of the study (Habermas, 1984). Consequently, as stage four and five of Carspecken's framework also incorporates conceptualising the findings from a social systems perspective to discover specific system relationships (Carspecken, 1996) (*see figure 11, page 145*), findings are considered in association with the wider perspective, and reconstructive analysis and validity claims also take into consideration the worldview, both past and present that create and reproduce the habitus of the department. Reference will be made to other contemporary research and historical practices in an attempt to review and reveal the underlying potential truth, which

may be implied rather than clearly articulated. Reviewing historical practice is necessary, as habitus, which is deep-rooted and the tacit knowledge within the field, are invariably shaped and influenced by what has gone before (Bourdieu, 1986).

6.5.1 Surgery speciality

During preoperative interactions, HCPs pain discussions and decision-making were influenced by their existing judgments and preconceptions of day surgery. Some HCPs and patients viewed day surgery as 'less' than in-patient surgery, which required the patient to be cared for in the hospital (*see results page 215*). The false perception that day surgery resulted in minimal pain stimulation, therefore resulted in some patients' fears over pain being dismissed, or their anxieties not being adequately acknowledged and addressed. This was often demonstrated through the use of language and phrases such as "it's a ten-minute procedure, so it doesn't take very long" (S16). Unfortunately, this finding is not unique to this research study.

6.5.1.1 Alignment of findings to existing research

Older, Carr and Layzell (2010) found in their study examing patients' use of analgesia following surgery, that both patients and staff considered day surgery as commonplace and sometimes failed to comprehend that pain planning could be compounded by multiple complexities. Fecher-Jones and Taylor (2015) also established within their research of the experiences of patients following laparoscopic surgery, that patients felt less cared for by nursing staff due to their perception that patients were more independent and self-caring.

Within this study, day surgery was often minimised and downplayed and patients were stereotyped in terms of the healthcare professionals' perceptions of the level of pain that

the surgery would evoke and thus, were treated unequally. This was demonstrated in relation to the amount of preoperative information provided and also the language used when discussing the procedure, which at times seemed dismissive and often trivialised the pain and surgical procedure (*see result page 224*). The link between perceived pain and level of trauma was also found in a study by Schreiber *et al.* (2014) who stated that nurses provided more attention to patients who were suffering from more physical signs of injury. The generation of these intuitive assumptions may in part be due to the success of minimally invasive techniques and multimodal analgesic regimes, both of which have been instrumental in the escalation in the number of procedures that can now be undertaken as a day case. Therefore, some healthcare professionals may now perceive day case surgery procedures, which previously required a length of stay in the hospital, to be less painful than they were. However, pain is uniquely experienced and attempting to equate individuals' specific pain to certain surgeries and levels of tissues damage could be detrimental to patients recovery (Mann and Carr, 2006; Marton and Ambrose, 2007; Vigeyen, Crombez and Goubert, 2007). It is also recognised that day surgery procedures vary in terms of the level of invasiveness and tissue damage. It has already been alluded to earlier in this thesis, that the real extent of patients' pain levels is not genuinely known for day case surgery patients (Williams, Ching and Loader, 2003; Perkins and Ballantyne, 2010). Therefore, there is a real concern that patients could be experiencing higher levels of pain than previously thought, due to the unwitnessed nature of postoperative care for day surgical patients (Karia and Ibrahim, 2017).

There was also a further layer of bias associated with surgery type. As within day surgery, orthopaedic surgery was seen as superior in terms of surgical status (*see results page 226*) and gynaecology was viewed as inferior (*see results page 232)* with HCPs spending, on

average, 73 seconds more with orthopaedic patients than with gynaecology patients (*see figure 37, page 228*). This not only suggests that there exists a bias in terms of the hierarchy of surgery, but that this may be driven in part by gender, as gynaecology surgeries are performed exclusively on women. This will be explored in greater depth later in this chapter.

The Royal College of Surgeons (RCOS) (2018a) does not recognise gynaecology as a surgical speciality, instead it is recognised as a different field of medicine altogether and a speciality in its own right (Royal College of Obstetrics and Gynaecology (RCOG), 2018). This may explain some of the potential bias, as practitioners have less exposure to gynaecology and may not see it truly as a type of surgery. In the overall scheme of perioperative care, it would seem that this separation may be influencing the underlying unconscious assumptions held by staff. The bias towards surgical specialities may also be reinforced by perceived pain expectations associated with tissue damage. Gerbershagen *et al.* (2013) reviewed pain levels from 179 different surgical classifications and claimed that within the top 40 most painful procedures, 22 were associated with orthopaedic conditions. Awareness of this may increase the emphasis on effective pain management in orthopaedics, but conversely, reduce its importance in other types of surgery. Orthopaedic surgery is also very visible as it involves bones and often requires skin incisions and fixation devices which may increase the awareness and perception of increased levels of pain for these type of procedures (Al-Qadire and Al-Khalaileh, 2014). This is often in opposition to what is perceived about gynaecology surgery, as the female reproductive organs are by and large unseen, not often associated with death and not often talked about in society (Aranda, 2018).

Within this study, there was a perception that reproductive organs, specifically female reproductive organs, were not associated with high levels of pain and therefore received less preparation preoperatively. This was mentioned by S3, who suggested that gynaecology patients were inadequately prepared in comparison with other patient speciality groups. What should be considered, is that levels of pain experienced by individual patients are not always directly linked to the amount of trauma or the visibility of illness and injury (Rodriguez, 2015). However, in relation to the findings from this study, patients following specific surgical pathways were deemed by some staff to have stereotypical behavioural traits in relation to expected pain levels that influenced the healthcare professionals' interactions with the patient and impacted on their pain planning and management strategies (*see results page 229*).

6.5.1.2 ***Habitus***

Stereotypical views of patients and severity of surgery are reinforced by the long-held beliefs and assumptions that HCPs hold, as well as the repetitive practices which align symptoms into different categories depending on patient history, physical appearance and treatment compliance (van Ryn, 2002). Repetitive practices are also viewed by Bourdieu (1998) as one of the main factors associated with limiting habitus, as the repetitive processes, while contributing to individuals' increased levels of expertise in a particular arena, can blind the person to other possible options and thus can also limit the practice. Consequently, within healthcare systems, biases can impact on decisions made, especially at an unconscious level, as they are not regularly checked through a process of self-reflection. However, within this study, some staff participants demonstrated that self-reflection had taken place and acknowledged that they were aware that day case surgical patients were sometimes disadvantaged in terms of the hierarchical weight that was placed

on their surgery. They therefore made a conscious effort never to use language during communication with the patient that would devalue the surgery (*see results page 225).* This can sometimes be difficult for anaesthetic staff working within day surgery, as previously held perceptions of the postoperative pain levels experienced by patients can be difficult to alter when they are generated from care that is witnessed through a very narrow view. Additionally, within busy areas such as those found in perioperative departments, there can be a tendency for healthcare professionals to forget that although this surgery is routine for them, it is not routine or minor to the patient (Woodhead and Fudge, 2012).

6.5.1.3 Economic capital

Assumptions and beliefs can be reinforced by the capital status associated with specific elements of practice. In terms of economic capital, within the sphere of this group of perioperative staff, it can be suggested that a higher financial status was placed on orthopaedic surgery, as this fact was referred to by several of the professional participants within this study (*see results page 226*). This finding is reflected in the UK 2017/2018 income generation tariffs for surgical procedures, which sets the costs for minor gynaecological procedures below those for minor orthopaedic surgeries (NHS Improvement, 2016). This factor may contribute to why surgical lists such as gynaecological lists, are believed to generate less income and are more heavily populated than others in a bid to increase profitability and economic efficiency. Additionally, trauma and orthopaedic consultant surgeons are the second most highly paid within the UK, and this is from both private and NHS income (Morris *et al.,* 2008). Economic capital and the higher status of orthopaedics can also be related to the specific costs of pain management in terms of the distribution of material resources and staff, as more surgeries are more routinely performed within this speciality compared to gynaecology (RCOS, 2015a). There

is therefore an awareness amongst perioperative staff and hospital management, that orthopaedics surgical procedures are financially more lucrative. This was demonstrated in this study by lack of distribution of patient pain leaflets, as regional block leaflets were only provided to orthopaedic patients (*see results page 219*).

6.5.1.4 Cultural capital

Verdonk *et al.* (2009) also claim that there is a low prestige aligned with conditions which are not linked to specific major organs (i.e.heart and lungs), or are slow to develop, such as endometriosis. This may be as a consequence of the additional cultural worth that is placed on different types of pain, as visceral pain is traditionally taken less seriously and for many years was associated with the term 'hypochondriac' (Maybin and Serpeth, 2012). Conversely, there seems to be a greater level of cultural status associated with orthopaedic surgeries, probably due to the fact that the pain associated is classified as somatic, and as the adult body is comprised of over 206 bones, orthopaedics is one of the most requested surgeries performed worldwide (Chapman, Stevens and Lipman, 2013). A report by the RCOS (2018b) supports this finding, as in terms of activity, orthopaedics is ranked as one of the highest surgical specialities performed in the UK and orthopaedic surgery is one of the most requested specialities by surgical trainees. In terms of social capital, between the varying specialities some held the view that orthopaedics was more highly respected and regarded within the hospital trust than gynaecology (*see results page 226*).

6.5.2 Gender

As well as surgery type, the gender of the patient was also a factor that influenced preoperative preparation, and this related to not only the gender of the patient but also the gender of the staff. For both urology and general surgery specialities HCPs spent less time

talking about pain with females than males, but slightly more time for orthopaedic surgery. Gynaecology was also the surgical speciality that received the shortest preoperative visits regardless of anaesthetic staff gender and grade. Although these differences are not statistically significant, these findings, when triangulated with the qualitative data, highlighted additional differences in terms of language and attitudes to patients based on gender, which reinforced the reconstructive analysis and findings that bias existed in relation to gender. This finding is reflected in current literature, where it would appear that one of the dominant aspects of bias (both conscious and unconscious) is in relation to gender (Mitchell, 1974; Dowling, 1981; Oakley, 1996; Walby, 1990 and 1997, Doyal, 2005). This area of research has attracted a great deal of attention over the last ten years (Holmes, 2009; Del Boca, 2016), resulting in a multitude of articles exploring how gender bias (both conscious and unconscious) impacts on healthcare practices. Research addressing gender bias with pain planning for day surgery, however, is scarce.

6.5.2.1 Alignment of findings to existing research

Gender Bias is defined as the inclination towards or prejudices against one gender (Oxford English Dictionary, 2018). Within healthcare, this often relates to the fact that one gender is marginalised and treated differently, when compared equally, and within contemporary literature, many claim that females are disadvantaged (Schulman *et al.,* 1999; Lai *et al.,* 2002; Foss, and Sundby, 2003; Alspach, 2012; Gomez *et al.,* 2012). This is due, by and large, to the fact that females are often treated less aggressively than males, and wait longer to be diagnosed, even when their symptoms present the same as those displayed by male patients (Lai *et al.,* 2002; Borkhoff, 2008; Pronina and Rule, 2014; Alspach, 2017). This can result in higher rates of complications, morbidity and mortality for females (Hoffmann and Tarzian, 2001; Alspach, 2017). Foss and Sundby (2003) also claim that

HCPs often describe female patients as demanding compared to their male counterparts and this perception may have an influence on the care they provide. In relation to pain, there is a large body of knowledge which identifies that women experience and declare higher levels of pain than men and are more susceptible to chronic pain syndromes, and thus sex differences need to be taken into consideration (Unruh, 1996; Berkely, 1997; Pallar, 2009, Tocher *et al.,* 2012; Matthias and Samarasekera, 2012; Mitchell, 2012; Chapman, Stevens and Lipman, 2013).

Within this study, several of the nursing staff made reference to the fact that gynaecology patients, and by definition, female patients, received an inferior service compared to those from other surgical specialities (*see results page 239*). Nurse participants also stated that in terms of pain, it was often gynaecology patients who seemed to experience high levels of pain postoperatively and often needed additional analgesics to manage this pain (*see results page 239*). This may be due to the fact that women are more vocal about their pain in comparison to men (Bartley and Fillingim, 2013), alternatively, however, the increased pain witnessed may be as a direct consequence of gynaecological patients receiving fewer analgesics, given that anaesthetic staff perceive gynaecology surgery as less invasive and therefore less painful. Either way, it is gender bias, that whether consciously or unconsciously, impacted on the care that these women received.

These findings echo a study by Pronina and Rule (2014), who stated that pain experienced by women was more likely to be underestimated. This facet of gender bias was also explored in a study examining HCPs ability to recognise facial expressions of pain, which concluded that the HCP was less accurate and slower at recognising pain on women's faces and this may be a reason why females were less likely to receive treatment for pain (Riva

et al., 2011). A retrospective study by McDonald (1994) also found that during the perioperative period, men received more opioids than females. What was interesting about this was that as the patients were drowsy, many were not able to make their pain known. This led McDonald to conclude that during this period, nurses were basing their decision to treat males and females differently on their preconceived assumptions and thus stereotyped the patients, exercising and revealing an unconscious bias against the female patients. For this study, and in relation to nursing staff claiming that gynaecology patients seemed to be in more pain, it could be that the nursing staff, all of whom were female, possessed a greater level of affinity towards women undergoing these procedures and as such, were more sensitive to the women's displays of pain. However, as gynaecology surgical only involves female patients, it is impossible to explore whether the previous hypothesis stated by McDonald is true in this case, as the postoperative care of males and females undergoing similar surgeries cannot be directly compared. Unruh (1996) and Hoffmann and Tarzian (2001) claim that females' pain is often managed through a gendered lens and that their care is not gender-neutral, as their complaints of pain are usually treated as a psychological problem rather than a physical one, and this is in juxtaposition to how men's pain is treated.

Women are more likely to be given sedatives and antidepressants rather than analgesics (Lack, 1982; Calderon, 1990), are 1.5 times more likely to be undertreated than male patients (Cleeland *et al.,* 1994) and to be prescribed less analgesia (Lack, 1982; Faherty and Grier, 1984; Calderon, 1990; McDonald and Bridge, 1991; Wandner *et al.,* 2014). Women's pain is therefore often discounted and attributed to emotional distress or neuroses. Evidence suggests that this is particularly applicable when pain is somatic and associated with the bladder, the reproductive organs and other conditions such as chronic

fatigue syndrome and fibromyalgia which have no specific aetiology; hence the term psychosomatic (Munch, 2004). What is alarming is that HCPs often come to this conclusion without any evidence to support their diagnosis. This is supported by this study, as members of anaesthetic staff associated hysterectomies with less pain than hemicolectomies and as a consequence prescribed fewer analgesics (*see results page 239*), despite the fact that both surgeries would require an abdominal incision.

Further gender biases have also been witnessed when prescribing medications. Enriquez *et al.* (2008) suggest that women with Coronary Heart Disease (CHD) receive fewer aspirin, beta-blockers and statins than men. They hypothesised that this might be due to the fact that HCPs were not aware that more women than men die of CHD every year, and that this ignorance is costing lives. Similar findings were found within studies examining the management of patients experiencing a stroke. Again, female patients were less likely to be prescribed statins, ace inhibitors and aspirin, were discharged with fewer therapies, received less aggressive treatments and waited longer in A&E than their male counterparts (McInnes, McAlpine and Walters, 2008). Gender variances have also been found in studies examining patients with coronary heart disease (CHD). Elderkin-Thompson and Waitzkin (1999) stated that male patients were treated more extensively than females, as doctors often misperceived the seriousness of the condition in female patients, especially in the absence of test results. As a result, they quickly jumped to the conclusion that the females' symptoms were due to emotional or psychological origins, which suggests that this may have been due to negative and misguided stereotyping. This seems to be in alignment with some of the views of the participants from this study, who stated that gynaecological day surgery procedures were usually carried out on young, relatively healthy women who were less likely to experience pain (*see results page 232*).

Gender disparities have been found across a number of healthcare specialities, which echo the results of this study. Schulman *et al.* (1999) were among the first to uncover that gender bias influenced HCPs clinical decision making and to find that women were less likely to be referred for cardiac catheterisation than men. Lai *et al.* (2002) also claimed in their study examining the gender gap in patients with cystic fibrosis, that females were diagnosed significantly later than males (mean averages 12.7 months for females and 8.7 months for males). They hypothesised that due to traditional and gender stereotyping in children, symptoms would have been more visible in boys as they were encouraged to partake in outdoor activities. Findings relating to negative gender bias towards females were also found when examining other diseases such as tuberculosis, chronic obstructive pulmonary disease (COPD), knee replacement surgery and trauma. Where compared to men, women were treated less aggressively, were underdiagnosed, less likely to be referred for treatment and when presenting with critical injuries, were less likely to be sent to a trauma centre (Chapman, Tashkin and Pye, 2001; Thorson and Johansson, 2004; Borkhoff, 2008; Gomez *et al*., 2012). Unequal treatment between males and females undergoing similar procedures was also found in this study in relation to, among other things, the language used. Male genitalia, for example, was referred to as being a sensitive area, whilst female genitalia was not referred to in the same way, despite the fact that the same member of staff interacted with both patients.

Gender has been shown to not only influence the quality of treatment, but can also impact on the effectiveness of communication (Siu, 2015). Street (2002) states that gender can influence significant variations between patient and HCP encounters and can impact on the adaptability of HCPs to successfully interact. In a study by Broom (2008), female patients

were less likely to have their questions answered, or be offered alternative approaches; a stark contrast to their male counterparts. Sandhu *et al.'s* (2009) systematic review of possible variances in interpersonal communication activities found that gender did indeed impact on patient-doctor relationships and concluded that the least patient-centred encounters were those between male doctors and female patients, as they were very medically and task-focused and made presumptions about patients' histories. This was also explored in a study by Siu (2015), examining the treatment of female patients by male staff. Siu (2015) found that women described their experiences as unpleasant and littered with complexities, such as not being taken seriously or understood and being treated with a lack of empathy that impacted negatively on their care. To some degree, this was demonstrated in this study, by the responses of some of the staff participants, both male and female. This applies particularly in relation to the dismissive language and comments made by some members of staff about the pain being "nothing to worry about" or "it's just like period pains" (S22). As the majority of the anaesthetic staff for this study were male, it could be argued that they lacked physical understanding and mental empathy with pain associated with female menstruation and that this may have impacted on their perceptions of surgery involving the female reproductive organs. However, gender bias was also demonstrated by male members of staff when the associated surgery could be performed on both males and females. S26 demonstrated differences in sympathy levels when discussing similar procedures with males and females, and used more empathising words with the male patient when referring to the surgery, the pain and the anatomical area.

Another study by Fochsen, Deshpande and Thorson (2006), examining gender and communication, stated that within their results, male physicians were more dominant over female patients than male patients and they hypothesised that as the study was conducted

in India, the gender variances were following their society's wider cultural patterns of female disempowerment and male superiority (Fochsen, Deshpande and Thorson, 2006). More importantly, these altered perspectives and views are not linked to biological claims or knowledge, but from the gendered norms that have been created within society to maintain gender order (Samulowitz *et al.,* 2018). Additionally, male HCPs were found to be more authoritative in a study by Uskul and Ahmad (2003) and would often use blunt and direct questioning techniques, sometimes showed signs of impatience, blamed the patient and underestimated the patient's abilities. Female staff, meanwhile, have been found to be more empathetic (Nicolai and Demmel, 2007), more patient-centred (Roter, Hall and Aoki, 2002; Bertakis, 2009), less interventionist (Uskul and Ahmad, 2003) and demonstrated increased partnership (Roter and Hall, 2004). Accordingly, female HCPs' interactions with patients have been shown to be associated with longer periods of time, on average over 2 minutes longer than male HCPs (Roter, Hall and Aoki, 2002; Jefferson *et al.,* 2013). Again there are some similarities between the findings in this study and those found previously, especially in terms of the timings, as female anaesthetic staff spent more time with patients than their male colleagues, irrespective of surgical subspecialties and anaesthetic grades (*see figure 43 page 230, and figure 44 page* 231). This could be a result of the inherent nature of women to be warmer communicators and more willing to reveal details about themselves when taking part in conversations (Street, 2002).

6.5.2.2 ***Economic capital***

As well as surgical specialities, comparison with economic worth can also be drawn from an individual's gender, especially in relation to 'labour currency' and 'reproductive currency'. Bose (2015) recognises that generally across the modern world, women are valued as 'less' than their male counterparts and thus continue to be marginalised, albeit to

varying degrees depending on the geographical location. This can be seen in the cult of female invalidism, which was widespread in the 1800s, especially in middle and upper-class patriarchal cultures. Grosz (1994) speaks of how as a form of oppression, women's bodies are secreting, fluid-filled, formless and uncontrollable. This view has continued into the twenty-first century, and even now women are sometimes classified as weak, and are often portrayed in the media as being pale and sickly figures, prone to bouts of fainting and headaches. Within this study, this can be seen in reference to nausea and vomiting, as some members of staff associated higher levels of postoperative nausea and vomiting with women, especially when they were undergoing gynaecology procedures. This could indicate further unconscious stereotypical views of women as weaker.

Medicine's prime contribution to the sexist ideology has been to describe women as sick, and as potentially sickening to men' (Ehrenreich and English, 2011, p32). This has perpetuated the perception that women possess less labour capital, especially within the sphere of science and politics (Rudman *et al.,* 2012). And whilst it can be seen that over the last 40 years, women have made leaps and bounds in relation to entering the labour force, their contribution to the family income is still sometimes seen as 'pin money', and their salaries are often significantly lower compared to their male colleagues (Yeandle, 1999). Gender pay gaps are still an issue and it can be argued even today that women are not paid equally, especially in the realms of science, technology, engineering and mathematics, where a mean pay gap in favour of men of 26% currently exists (Innovate UK, 2018). Within the NHS, the pay gap is currently16.1% (NHS Digital, 2019). Although some of this may be due to female staff working family-friendly hours and therefore avoiding any on-call and shift pattern boosts to income.

In relation to reproduction currency, for centuries women's worth was often reduced only to their ability to serve men and provide offspring (Ferguson, 1984). Women were seen as passive recipients and merely the carriers of men's offspring as men cast out life and force it into the female form, making the uterus seem inferior, as seminal fluid is seen as the active agent (Grosz, 1994). Despite the success of the feminist health movement in 1970 to increase awareness of gender equity and equality, the healthy body is still gendered (Moore, 2010). Women's bodies are therefore, still often sexualised and objectified and relegated to the task of sexual pleasure and reproduction. There are echoes of this within this study, specifically when S19 referred to nursing staff as 'bonny girls'.

There is also a longstanding history of attributing women's health issues to mental health disorders, in effect reducing the credibility of conditions, particularly within the realms of gynaecology and obstetrics. In 1900 BCE, Egyptian healers determined that hysteria was a direct result of a misplaced uterus. This supposed link between the womb and mental health conditions is further reinforced by language, as the term 'hysteria' is derived from the Greek word for uterus, and translates as 'wandering womb' (Tasca *et al.,* 2012). This is not an isolated incident, as most of the other words associated with the female reproductive system and pathology are aligned with negative connotations. Oestrogen (Greek-oistros) means 'insane desire' and pudendum (Vulva) comes from the Latin word pudere and means 'to be ashamed of'. The devaluing of female gynaecological complaints continued into the 1800s where women were often placed in asylums for being hysterical or forced to have hysterectomies. Thankfully, the word hysteria was removed from the mental health diagnostic definitions in 1980. However, it was only 40 years ago that texts books were still claiming that physiological problems in reproduction were associated with psychoactive forces, with many claiming nausea in pregnancy was linked to feelings of

sexual frigidity, infertility was due to women's ambivalence about childbearing, women who experienced difficulties in labour were immature and disturbed, and that menstrual pain was associated with psychiatric issues (Munch, 2004). I would suggest that a remnant of this stereotypical view has continued to unconsciously permeate through the habitus of this field, resulting in female clinical conditions being regarded as "less than" and that this perpetuated the unequal treatment of female patients. This was demonstrated within this thesis by the dismissive language regularly used with women when discussing potential postoperative pain, which was often likened to period pains and patients were told just to take what they would take for a headache, which minimises the postoperative pain that the patient may experience and could also suggest that the individual's previous pain has been related to more emotional stimuli. It was also demonstrated by some staff participants when comparing the levels of pain between procedures on the uterus and bowel, wherein the uterus was valued as less painful to remove than sections of the bowel *(see results page 239*).

6.5.2.3 Social capital

Social capital relates to the "aggregate of the actual or potential resources which are linked to possession of a durable network…..or members of a group", (Bourdieu, 1986, p.248). In relation to healthcare, unequal social capital exists as the workforce is gendered, with most nurses and nurse educators being females. Despite this, patriarchal dominance can still be seen in the current NHS workforce, as positions of power and those in authority are primarily held by men (Broom, 2008). Patriarchal medical dominance is not a new phenomenon, as historically, even when the art of healing was traditionally practised by women, religious institutions often vilified women healers, who were seen as witches (Witz, 1992). In the 1400s, medical physicians also repressed women healers, by

petitioning the government and claiming that women should be restricted from practising medicine. It was, therefore, through the professionalisation of healing, that it became an accepted masculinised practice and women were removed from making decisions about care treatments and instead assigned to the caring for the sick. To some limited extent this can be seen in this study, as nursing staff (who were all female), stated that they had lower levels of autonomy that often restricted their decision-making capabilities and required them to seek assistance from the medical staff (who were predominantly male) when they felt patients needed more analgesics.

This leads to the question, are there still inequalities between males and females within the medical profession? For centuries, it was very difficult for women to enter the medical profession, as their social network was restricted, especially in relation to educational institutions and professional careers. Elizabeth Garret, one of the first women physicians in the 1860s, was bombarded with obstacles and organisational barriers, which resulted in her case being instrumental in the changes to the Medical Act of 1876. However, a hundred and forty years on, women are still restricted in terms of social and career networking opportunities. McCarthy (2016, p.344) still talks of how females were 'excluded from the camaraderie and career networking of the theatre change rooms, as the doctors' room was for men'. Garner and Bowbrick (2015) agree that even today, male doctors, rather than female doctors, are more likely to be invited into the theatre by senior colleagues. These attitudes contribute to the narrowing of women's potential to make greater connections that could increase their economic and cultural capital. Within this study, this disparity can still be seen in the variation of gender among healthcare professionals. The participating nursing staff were all females, yet females only accounted for 28.6% of the anaesthetic staff. Bourdieu (2002) agrees that unconscious gender divisions are often established

between social positions, especially between doctors and nurses. In a recent report by the RCOS (2018a) figures from 2015 suggest that only 11% of consultant surgeons are females, and female surgical trainees only account for 30% of the population. Figures within the speciality of anaesthetics are similar, with the census from 2015 showing that 68% of anaesthetic consultants were male, and 32% were female (RCOA, 2016). These figures are lower than those recently stated by the GMC (2019) who state that females represent 46% of doctors on the medical register, and within this figure there are more females GPs and doctors in training than males. I would suggest that this could be in some way due to the fact that surgery and anaesthesia are still seen as a patriarchal dominated profession and this male dominance leads to women being discouraged from entering the profession by virtue of limiting their connections and networks.

6.5.2.4 Cultural capital

Social and economic capital, however, are not the only drivers behind some of the research findings, as cultural capital and, more specifically the education, training, knowledge and professional titles associated with being a nurse and an anaesthetist, impacted on the unconscious bias found within the habitus of the preoperative department. Firstly, a lower cultural capital status was associated with being a nurse, and more specifically being a female nurse. This applied specifically, to how power was reinforced by the use of infantilising language, such as the use of the term 'girls' for qualified professional female nurses and how the medical dominance of males impacted on female nursing staffs' feelings of exclusion from decision making processes and the sharing of information. Unfortunately, this was not restricted to male staff referring to females staff as 'girls', as I witnessed female staff referring to other female staff as 'girls' in the same way. This would suggest that the habitus of the department was being replicated and reinforced by all staff

members, regardless of gender, and that this ultimately reinforced the status quo. Whilst the word 'girls' itself is not derogatory, the way in which it is used can be seen as such, and within this study, it was often used to refer to staff who were 'lower down' the hierarchy in discussions with patients. The use of the term 'girl' to describe adult women was the focus of a recent research study by Hout (2013), who states that infantilising language undermines women's worth in society and the power demonstrated linguistically, attempts to deny adulthood, and all that comes with being an adult. Infantilisation is a process of discrimination in which the individuals are ascribed a childlike status resulting in false perceptions of their abilities being generated (Redwood and Heaslip, 2010). It is often used as means of devaluing individuals and in relation to females, is a means of reinforcing stereotypical views that women are less competent, less hireable, even if they have the same education and skill level. Therefore, it can be said that female nursing staff were being infantilised and undermined, by the simple use of the word 'girl'; transforming the picture of the trained and qualified female nursing staff to a more immature and childlike status, devaluing both the embodied capital (knowledge) and the institutional capital (position and title) of the nurse. The power demonstrated by using such language appeared to be unconscious, as staff (both females and males) were unaware of the impact of using this language and used it routinely when speaking to patients. It was interesting to note, that no member of male staff was ever referred to as boy, or lad, or gentleman, but always by their title or name, demonstrating that a higher level of respect was given to male staff than female staff. This could be a consequence of the working environment in day surgery, which was more heavily populated with female staff and led to a 'group of girls' mentality. However, the balance is often reversed within the operating theatre and therefore it can also be suggested that a large group of men could be referred to as 'boys', but this was not the case within this study. Neither could the age of the staff be a factor, as

both professions consisted of staff of all ages, so whilst there was a lack of matriarchal displays of power, patriarchal dominance was clearly present. However, it could also be that the use of the word 'girl' had become normalised over time and with constant usage, removing any negative connotations associated with the underlying infantilisation. Alternatively, it can be suggested that this normalisation, is itself an example of how symbolic violence (explained in the following section), reinforces the status quo and the power inequalities on the department.

6.5.2.5 Symbolic violence

Patriarchy is defined as the power of the father over women and young men (Witz, 1992) and symbolic violence refers to the domination of subordinated groups to naturalise the status quo (Bourdieu, 1977). I have already discussed the reduction of women in terms of education and knowledge. I would also suggest that symbolic violence, a non-physical display of power by a dominant group (Bourdieu, 2002), is also used as a means of maintaining male superiority and the status quo associated with the role and status of nurses within the medical hierarchy, for example when using infantilising language. This symbolic violence, can perpetuate false assumptions and can reinforce unconscious bias, which in itself, may limit the opportunities for women to increase their symbolic (reputation), cultural (knowledge and training), economic (salary) and social (networks and social opportunities) capital. In terms of the symbolic violence aligned with female patients, this can be seen when women are only treated the same as men when they act like men. This is referred to as the 'Yentl syndrome' and occurs when female health concerns are not recognised and treated until the female displays male-typical signs and symptoms (Healy, 1991; Merz, 2011). Consequently, for women to be treated fairly, they have in the past needed to present more like men. It is only when they display the typical symptoms

associated with certain conditions (which were all based on the understanding of the male physiology) that they are then treated like a man and given the appropriate care (Johnson *et al.,* 1996). To some extent, this was demonstrated within this study, as female staff behaved like their male colleagues and also adopted the term 'girls' when referring to female staff, in order to comply with male patriarchal attitudes in an attempt to gain respect.

This form of symbolic violence, not only limits female patients access to appropriate care, but it is born out of the continued dominance of research to be gender-blind, as the female voice is often underrepresented in research (Ehrenreich and English, 2011; Polit and Beck, 2012b) and gender is not considered relevant (especially when participants are males and the findings are applied to the female population (Foster, 1989; Verdonk *et al.,* 2009). Findings from this study would therefore suggest that further research into preoperative preparation is necessary, in order to examine in greater detail the variances when discussing pain with males and females undergoing similar procedures.

6.6 Summary

This chapter has explored how the results and findings of this thesis are aligned with wider research and the underpinning critical social theory. What can be seen within this study, is that whilst pain is discussed with the majority of patients prior to their surgery, the length, depth, and quality are significantly varied and influenced by the habitus within the department. This habitus places higher economic capital on elements of care associated with patient safety and paternalistic practice, as well as the financial costs attributed to increased productivity and efficiency and the fiscal measures aligned with specific surgical services which are more lucrative, such as orthopaedic surgery. I also suggest that there is

an unconscious economic undercurrent associated with day surgical procedures, specifically those surgeries involving gynaecological conditions and gender, with a lower status being assigned to females and female surgeries. This may be a controversial view, however during this research, gynaecological surgical lists were more heavily populated and this surgery speciality was valued as less than other surgical types; consequently, gender must also be associated with this finding as all gynaecology patients were, of necessity, female.

This element of the habitus of the department was further strengthened by the additional unequal cultural, social and symbolic worth attributed to staff biases (conscious and unconscious) and assumptions, which had a direct impact on the pain interactions between patients and staff. Bias was also witnessed against day surgery in comparison with in-patient care, which was deemed as being more painful, invasive and severe in terms of levels of acuity. This often meant that minimising language was used with day surgery patients which could potentially linguistically programme them to display minimising behaviours postoperatively.

As well as biases, power and a hierarchical dominance were also found to influence the care of patients, as paternalistic practice and the use of minimising language and unidirectional conversations resulted in limited patient involvement in decision making. Care was also impacted, as some staff stated that their practice was restricted through the control of information and the inability to prescribe analgesics, which created lower levels of autonomy and feelings of lower professional status. The next chapter will explore how lessons can be learned for future practice and will propose some recommendations for practice and future research.

Chapter 7

Conclusion

7 Conclusion

7.1 Introduction

The first chapter established that preoperative preparation is essential for all patients who are undergoing a surgical procedure (AAGBI, 2010a; AAGBI and BADS, 2011a). As pain is one of the main fears experienced by surgical patients (Ward, 2014; Gürsoy *et al.,* 2016), preoperative preparation should therefore include ascertaining previous pain coping strategies and underlying anxieties, and ensuring patients have all the information on the various analgesic options available to them (Althaus, 2012; Koneti and Jones, 2013; Saver, 2013; Mower, 2015). This information will not only ensure that they are fully informed, but can also assist in pain planning and management strategies which are tailored specifically to the patient in order to increase the effectiveness of analgesic approaches (Tornsey and Fleetwood-Walker, 2012; National Institute for Health and Care Excellence (NICE), 2014). This approach can also increase patient satisfaction and reduce potential postoperative complications associated with high levels of postoperative pain. Within this chapter, I will revisit the research question and aims, and will examine through the exploration of the findings, to what extent, and in what way pain is discussed with day case surgical patient prior to their surgery. I will also discuss the strengths and limitations of this study and will present several recommendations for practice and policy, future research and education in an attempt to potentially challenge the status quo.

7.2 Thesis summary

The personal and professional reasons for examining and exploring preoperative pain practices for day case surgical patients were outlined in *chapter one, page 20*. These were primarily as a result of my personal interest in the topic, but also as a consequence of

examining the background literature on the topics surrounding pain, preoperative care and day case surgery, and ascertaining that several questions were not fully addressed and understood.

7.2.1 Revisiting research question, aims and objectives

As a consequence of these potential gaps in knowledge, the following research question was created.

"How does the underpinning culture of the perioperative department impact on pain and its priority within preoperative practice for day case surgical patients?"

In order to explore the varied elements of practice, this research utilised an ethnographic approach, which allowed a cultural group associated with preoperative practices to be observed and investigated within its natural setting (Bloomberg, 2012). Within this thesis, culture has been referred to as the behaviour of a specific group, shared and replicated through the process of social interaction. It is usually time and context-specific and not always fully understood, as 90% of cultural practice is hidden and influenced by elements from the individual's subconscious (Hall, 1976; Lee and Zaharlick, 2013; Bate, 2014). In order to uncover these practices, I incorporated eclectic data collection and analysis methods, which enabled me to observe the direct interactions of HCPs working on a preassessment and day surgical unit within a NHS hospital trust. These observations were situated within a transformative research paradigm, which enabled examination of how power functions inadvertently control, reinforce and replicate the status quo (Madison, 2012). This was achieved with the use of critical ethnography and critical social theory, which assisted in uncovering the culture (both external and internal) of the department and

enabled examination of how the habitus of the practice environment impacted on pain planning practices for day surgery patients. Moreover, the use of Carspecken's (1996) critical enquiry framework and Bourdieu's 'theory of practice' (1977; 1986; 1998, 2002), aided the uncovering of new knowledge and insight into how issues, such as power (related to both agency and structure) influenced preoperative pain planning for day case surgical patients. Using these approaches also allowed for several aims and objectives to be explored in an attempt to address the research question. These included:

Aims and objectives:

- To examine the current practices of a preoperative surgical department within one NHS hospital trust.
- To ascertain the level of preoperative pain planning currently undertaken by the HCPs within this hospital trust who have contact with day case surgical patients.
- To explore the extent to which the culture of the department influences the individual practices of the HCPs and how these practices impact the care that day case patients receive around pain planning and preparation.
- To look beyond the external cultural surface and explore factors which underpin practice.
- To challenge the status quo and examine how control and power impact on preoperative pain planning practices for day case surgical patients.
- To develop insight into the views and opinions of HCPs caring for day case surgical patients and how they perceive current care is delivered.

7.2.2 Contribution to new knowledge

By attempting to answer the principal research question this research has provided knowledge which has the potential to improve patients' perioperative pain experiences and

positively impact on their levels of anxiety and pain satisfaction. In addition, due to the lack of previous research in preoperative pain planning and the contextual influences on preoperative practices, this study has contributed new knowledge in a variety of ways. The research design itself was unique to this realm of practice. It used a combination of data collection and analysis methods and a process not previously associated with research examining preoperative pain planning for day case surgical patients. Additionally, as the findings of this study have been aligned with Bourdieu's 'theory of practice' (1977; 1986; 1998, 2002), a deeper understanding of power and inequalities has been uncovered. More specifically, how economic, social and cultural capital and the value or worth placed on patient safety, along with productivity, paternalistic practice and unconscious bias, can influence pain planning practices.

7.2.3 Research findings

As discussed in *chapter five, page 166,* four key themes emerged (*figure 22, page 176*), which were found to have an influence on preoperative pain planning discussions between patients and HCPs and on pain management and planning decisions made by HCPs. These included:

1) Patient safety - a strong patient safety culture pervaded the perioperative environment, to the detriment of patient-centred, holistic pain planning.
2) Productivity - a culture of productivity driven by organisational demands and reinforced by the associated capital aligned with the capitalist and Fordist approaches to care. Adversely influenced the length of time clinicians spent with patients and also how the patients and staff saw themselves within the care continuum.
3) Power and hierarchy - imbalances in power and hierarchical structures exist within the perioperative department, and these have impacted on the levels of autonomy felt by

staff. In addition, they also limit the patient-centred partnership approach to pain interactions.

4) Unconscious bias- some HCPs working within the preoperative department demonstrated an unconscious bias towards certain types of surgery and patient and staff gender. This had an impact on the way in which these professionals communicated with patients, in terms of the language that was used, the agenda and topic of conversation, the time spent with the patients and the amount and type of information which was shared with the patient, in order for them to be involved in their care. This was also observed in the communication among HCPs, and the words they used to describe each other.

In answer to the questions posed at the beginning of the thesis, data analysis from this study suggests that whilst pain was discussed with the majority of patients preoperatively, the depth and quality of the exchanges varied considerably. Clinical decisions made by HCPs in relation to what they discussed, how long they discussed it, in what order and the language used, was very much influenced by power and more importantly an unequal distribution of power between staff and patients. Habitus both restricts practice and is in turn impacted by the practice of those within it, who confirm and reproduce the status quo (Bourdieu, 1986). Consequently, the habitus of this department was impacted and also influenced HCPs values and beliefs, albeit unconsciously, which caused a level of stereotyping of patients' pain depending on the gender of the patient and the surgical speciality. Additionally, in terms of patient safety and risk, day surgery patients, especially gynaecology patients, were not sufficiently prepared for the possible pain as detailed and holistically tailored pain discussions were limited and not considered the routine practice.

7.3 Strengths and limitations of the study

7.3.1 Strengths

This study has several strengths, not only in terms of the research methods and the techniques employed (which will be discussed in greater detail later in this chapter) but also in terms of the positive implications and increased awareness of HCPs' biases and practice that will result from the new knowledge that this study will provide. Reflective practice is something which all HCPs employ, but the level and depth of the reflection that is undertaken may not always result in light being shone on the areas of practice which remain hidden to the individual. In such cases, these practices can be revealed when they are observed and uncovered by others (Blommaert, 2015). One of the main strengths of this study was in relation to the identification of unconscious surgical and gender biases. This is extremely important as staff may be unaware of the levels to which they treat patients unequally, depending upon the type of surgery they are scheduled for and their gender. By drawing attention to this, staff will have the opportunity to consider the findings and reflect upon their own interactions with daycase surgical patients. Another strength, especially in light of the drive for efficiency is that increased productivity has the potential to negatively impact on patients' satisfaction, staff workload and the time that can be spent with patients. The quality rather than the quantity of the interactions, therefore, becomes even more significant, in order to ensure that patients are true partners in their care and that their care is holistically tailored to suit their individual needs.

7.3.2 Limitations

There are also limitations to this study. Firstly, it was conducted in one hospital trust covering one day case and one pre-assessment unit, with a single researcher. Therefore, it can be said that the sphere of practice observed was small and revolved around practice

which took place in a specific time and place and therefore very context-specific with findings which may not be universally generalisable (Gray, 2018). I agree that what was found within the thesis may not be found in every surgical department, however several parallels were found within the existing body of research. Consequently, whilst this study is not generalisable, findings can be compared with what is already known and can provide additional important insights into preoperative pain planning practices for day case surgical patients. Secondly, as I was the only researcher, with limited time and resources, I was not able to consider age, religion, sexuality, ethnicity and nationality and therefore acknowledge that other elements could also have contributed to HCP individual practice. I also recognise that subsequent conversations between anaesthetic staff and patients were not observed once the patient entered the operating theatre, therefore further conversation around pain management, if it took place, was not captured. However, in light of the nature of the tasks undertaken in the anaesthetic room, I would suggest that findings would be similar to what was observed in the day surgery ward and prioritising of care would be centred on patient safety issues rather than individual pain planning. Thirdly, as a large body of evidence already existed on the views of day surgical patients, I only focused the interviews and observations of practice on HCPs; thus, the views and beliefs of the patients were not explored as part of the data collection process. Preoperative care from a patient's viewpoint would have added a further perspective which may have altered the interpretation of the findings. Fourthly, during the time of the data collection and observation, the department was using paper-based processes. Therefore patient notes were not always available and this may have impacted on the anaesthetic staffs ability to create a pain plan. Additionally, as all members of staff needed access to the same notes, the information may not have been the most up-to-date when I examined the notes. Fifthly, the nursing team on the day surgical and preassessment unit were a longstanding female

team of nurses and therefore no male nurses' views were explored as part of the data collection and analysis process. Whilst this is not unique to this NHS Trust, as the nursing population is female-dominated, male nurse perspectives could have been beneficial. Lastly, I also recognised in *chapter four, page 114* that as an insider, my existing knowledge and understanding may have influenced my observations of practice. However this was potentially reduced through the use of reflexive research practices, research diaries and ensuring clear transparency in relation to the research methods and analysis processes.

7.3.3 Ensuring quality and rigour

As the overarching methodological assumptions of the research were qualitative in nature, it was appropriate to ensure high levels of credibility and transferability in order to ensure trustworthiness (Polit and Beck, 2012a). Credibility refers to believability and reliability of the research account and transferability is a measure often used to assess the quality and rigour of the research and encompasses the levels to which the research findings can be transferred to other settings (O'Leary, 2014). However, I also recognise that there were elements in the study that were quantitative in nature, thus there needed to be some consideration of validity. Validity refers to the process of employing strategies that minimise any potential issues in data collection and analysis (Creswell, 2014). The following steps were therefore taken in order to increase the overall trustworthiness of the study and increase the standards of rigour throughout all five stages of the research process Some of the main validation strategies are highlighted below (*see table 8, page 308*) and these were repeated across several stages of the research framework, i.e. triangulation and member checking.

7.3.3.1 Credibility

- Only data, which related directly to the research question was observed, recorded and measured, and was only used in a manner appropriate to answer the research questions.
- As I was familiar with some of the HCPs, time was taken prior to the commencement of the study to clearly set out the rules in relation to working relationships and distinctions between my researcher role and my previous clinical role, in order to reinforce the research/observer position.
- In order to increase credibility and ensure fair representation, multiple perspectives of data were collected, using both qualitative and quantitative data capture methods which were then further triangulated during the analysis process. This enhanced the depth and richness of data, reduced systemic bias and was consistent with the overarching conceptual framework and underpinning paradigm.
- A reflective diary was maintained throughout the study and any preconceived ideas were recorded, in an attempt to reduce levels of bias. This is beneficial for novice researchers, as it enables them to review their work critically and will add to the rigour and robustness of the study (Walker, Read and Priest, 2013).
- A member of the supervision team was asked to check examples of coding and analysis in order to establish my levels of critical analysis and bias.

7.3.3.2 Transferability

- For this study, the methodology, philosophical orientation, paradigm and methods were all congruent with the overall purpose of the research. This was articulated throughout the thesis in order to ensure transparency and replicability.

- As there was a high level of contextual detail contained in the study, judgments can be made as to whether the findings can be transferable to other practice setting and patient groups. In order to assist with possible transferability, background and contextual information were presented in chapter 1 and 2. It can also be argued that whilst the NHS is a unique institution, surgical practices across the globe adopt similar protocols and guidelines, therefore some comparisons may be made.

7.3.3.3 Validity

- The process of immersion into the practice area promoted the inductive development of the type of data that could be quantified within the structured field notes, and this was standardised for the quantitative data analysis element, increasing the reliability of the data capture.
- In order to increase the dependability of the research findings, a prolonged period of time was spent within the clinical environment and a high number of repeated practice observations were carried out. The extended time in practice also assisted with the building of rapport and trusting relationships, both of which enabled open discussions.
- Efforts were made to ensure that the 'contextual definitions' of the data used within the quantitative data collection and analysis were widely understood and that there was no misinterpreting of the responses in order to increase the validity. This was achieved with member checking, which assisted with the verification of the coding and analysis processes and interpretation of the data, especially for reconstructive analysis.
- In order to increase reliability, replicability and validity, the audio recordings and timings for a random sample of ten audio recorded preoperative assessments/consultations were also repeatedly checked by a member of the supervision team in order to test the accuracy of the timings.

Table 8: Research process and standards of rigour

Stage	Standards for rigour
Stage One - Compiling the primary record	1) Flexible observation schedule 2) Varying observation times 3) Multiple data capture methods 4) Structured field notes 5) Unstructured field notes 6) Prolonged engagement 7) Persistence observations 8) Multi-method triangulation
Stage 2 - Preliminary reconstructive analysis	1) Peer debriefing 2) Prolonged engagement 3) Analysis triangulation 4) Pragmatic horizon analysis 5) Clarifying research bias with reflection
Stage 3 -Dialogic data generation	1) Member checking of data 2) Consistency checks by supervision staff 3) Non-leading interview techniques
Stage 4 and 5 - Discovering system relations	1) Review of culture on more than one site 2) Transcription including the language of interviews and norms of expression 3) Multi-method triangulation 4) Analysis triangulation 5) Peer debriefing

7.4 Recommendations and implications

The results and findings from this study suggest that whilst pain is discussed with patients preoperatively, the prioritisation of patient safety and increased drive for productivity negatively impacts on the ability of HCPs to discuss individual pain requirements and care for patients holistically. Additionally, unconscious bias and medical paternalism also

influence the language used during discussions, and impact on the length of time spent with patients and the placement of pain within the interactions. In order for these findings to assist with challenging the status quo, discourse must take place within education and academic settings. Meanwhile, there needs to be some consideration of how these findings can inform future recommendations for policy and practice.

7.4.1 Policy and Practice

- I do not dispute the significance of a culture which holds patient safety in high regard. However, as HCPs, we also need to consider that being task and risk-focused may increase the possibility of the patient being reduced to less than their whole self. HCPs should therefore recognise that pain is a major safety concern within perioperative care, especially for day case surgical patients, as their postoperative pain is predominantly unseen (Turk and Melzack, 2011; Carr *et al.,* 2013).
- In order to work more holistically, HCPs must be reflective professionally in order to examine their own practice and consider the potential power inequalities that may influence how they communicate with staff and patients. This would not require a re-evaluation of the preoperative care pathway, but only small changes in individual practice, such as recognition and use of holistic pain approaches, which can have a positive impact on patient care.
- Within practice, there also needs to be a review of women-centred surgical services, as within this study, gynaecology surgeries appeared to be valued less than other specialities. Surgical lists were heavily populated and staff often commented that gynaecology patients were disadvantaged. In terms of the unequal time spent with female and male patients, whilst there was no statistical

significance in terms of timings, it was clear that the language used was often different when talking to female patients and when referring to female staff. As there are inherent differences between genders, we should ensure that both sexes have a range of resources that meet their specific needs for health and wellbeing (Doyle, 2002). Examining practice through a gender lens also has the capacity to reveal what is hidden, and in order to refine and adapt practice, gender disparities need to be brought into the spotlight. However, in relation to interpersonal communications and interactions, gender bias can be varied by the context of the organisation, and the political and cultural drivers (Street, 2002). Therefore, in addition to personal reflection and individual adaptations of practice, there also needs to be a political and organisational change. In relation to the study findings, I suggest that gender, and more specifically, surgical specialities, are taken into consideration when undertaking healthcare service audits.

- There was also a level of unconscious bias towards specific surgeries, especially orthopaedics and gynaecology, which appeared to be at opposite ends the surgical hierarchy. Therefore, within practice, there needs to be a review of surgical specialities to determine inequalities in allocated resources and staffing.
- Productivity within the current NHS is always going to be a strategic way to ensure efficiency and financial buoyancy. However, whilst consumerist and production line approaches may be extremely beneficial for process flow, we must not forget that patients have other priorities. Whilst short waiting list times and safety may be high on their agendas, patients are unique and other aspects, such as pain and being party to decision making that affects their care, maybe more important from the patients perspective. Furthermore, compassion and care should be inherent in all practice (NMC, 2018) and this practice should be inclusive of patients feelings and

wishes. This can be achieved at a micro level, by staff taking the time to see their patient as a person, and not a cog in the productive wheel; on a macro level, by the perioperative management team, who must examine alternative ways of ensuring efficiency so that the perioperative care continuum can be as patient-centred as possible.

- As time is a scarce commodity across all aspects of the modern age, it would seem feasible that this would also have translated to healthcare (Strazdins *et al.,* 2011); it can also be said that efficiency is essential for patient satisfaction (Scheriff, Gunderson and Intelisano, 2008). I would suggest however, that patient satisfaction can be measured by multiple factors. HCPs need to be cognisant of time, not only in terms of quantity but more importantly, quality. They can achieve this by ensuring patients are engaged, informed and feel valued, even if the time available is brief, as productivity in the absence of quality can detrimentally impact on patients' levels of satisfaction with their care.

7.4.2 Education

- Paternalistic practice can restrict both patient partnership and shared decision making, in producing a more autocratic care pathway, with the patient as a passive consumer. This can be avoided by allowing patients to take more ownership of their care, especially during the preoperative phase. One way that this inclusiveness can be increased is with the use of patient information leaflets, patients notes and preoperative documentation. An area of care in which patients have a great deal of autonomy is in maternity care, where pregnant women are responsible for carrying their own notes. Pregnant women, through the use of these notes, also detail there own birth plan which usually includes a view of how they would like their pain to

be managed. In addition, they are constantly being provided with antenatal education and information, well in advance of the birth of their child. Lessons for pain management in preoperative care can be learned from these existing practices, especially relating to the benefits of how pain management preferences can be successfully incorporated into the preoperative documentation and how general pain information leaflets should be available for patients to access preoperatively.

- Issues with power were not isolated to the interactions between staff and patients, as staff autonomy and hierarchy were also present within the habitus of the department. Accordingly, there need to be some amendments to the way information is managed within the preoperative care team, as many nurses wanted more autonomy and felt that they were often the last to know when a protocol or policy had been changed. It is therefore necessary to re-evaluate how audit and information dissemination meetings are included in the department to ensure that these are interprofessional. In order to continue to breakdown professional stereotypes and hierarchy between professional groups, it would also be advantageous to promote the benefits and include educational strategies and training which embrace and promote an interprofessional approach to working.
- If HCPs are made aware of any potential bias or assumptions, they can alter their practice to improve equity and equality (Criste, 2003; Verdonk *et al.,* 2009). One way in which these issues can be addressed is through education, and this can take the form of unconscious bias training (Santry and Wren, 2012). This is often used in studies that examine race bias but can also be used to explore implicit biases associated with gender, by exposing hidden prejudices, stereotyping and biases (Alspach, 2017). Healthcare education can also promote greater gender equity and equality by fundamentally re-examining how gender and sex (biologically) are

represented in medical textbooks, as gender bias in favour of males and negative female stereotyping are often found within medical education textbooks (Dijkstra *et al.,* 2008; Metoyer and Rust, 2011; Parker, Larkin and Cockburn, 2017).

7.4.3 Research opportunities

Policies and practice are not easily changed without a robust evidence base upon which to revise and update practice, therefore further research is also warranted and discourse must take place within education and academic settings. As a result of writing this thesis and analysing the array of data collected from practice, several additional avenues of enquiry could be undertaken in order to increase knowledge and understanding. These include:

- Further research exploring preoperative pain planning for day case surgical patients, as there was a high level of negative unconscious bias demonstrated towards day case surgical procedures as a group. Therefore, as 80% of surgical procedures are now carried out as day case surgeries (AAGBI & BADS, 2011a), further research examining other preoperative departments is needed in order to examine comparisons with the findings from this study.
- The potential to expand the research by incorporating patient interviews in order to ascertain patients' perspective of preoperative pain planning interactions and activities. This will also assist in challenging or confirming staffs' perceptions and unconscious biases about pain expectations associated with specific surgery and patient types. The findings from this study could provide more contextual information that can inform HCPs' future practice and also provide patients with a voice through which their wishes and views could be heard.
- Further study, as research is often gender-blind, is warranted into the potential for women to become marginalised, especially in relation to assessing and managing

healthcare problems (Saletti-Cuesta, Tutton and Wright, 2016). This was demonstrated in this study by the timings of the anaesthetic visits, but more importantly, by the language used when interacting with female patients and when discussing or referring to female staff. How the use of language could reinforce negative stereotypical practices is important, as gender bias is often not adequately explored within research and scientific publishing (Del Boca, 2016). This is not only in terms of gender equality but also equity, as both need to be considered when talking about bias and unfair practices. Gender equality is defined as "the absence of discrimination on the basis of a person's sex" to opportunities, the allocation of resources and benefits and services and treatments", whereas gender equity is "fairness and justice in the distribution of benefits and responsibilities between women and men" (WHO, 2002, p. 4). As men and women are biologically different, equity is sometimes more imperative than equality, and therefore further research is warranted into how care from a gendered perspective, can be based on gender differences and not equal treatment (Thorson and Johansson, 2004).

- The results suggested that less time was spent discussing pain with female patients in two of the surgical specialities and less time was spent overall with gynaecology patients. These results were not statistically significant but in combination with the other findings suggest that this is an area worthy of further study in other surgical specialities and in other settings.
- To uncover potential inequalities in care, more research needs to adopt a critical ethnographic approach or other suitable qualitative methodology which seeks to explore hidden assumptions and worldviews.
- In order to consider the influence of ethnicity, age and religion on preoperative pain planning practices, additional research incorporating both staff and patients from a

wider ethnic and cultural background is needed, to highlight other potential biases and power inequalities.

7.5 Dissemination of findings

It is essential that the results of this research are shared with the clinical area that was under investigation and also the wider world of perioperative care. This is necessary in order to highlight potential areas of practice that may need to be improved and also encourage change and challenge practice.

To date the research project findings have been disseminated at a number of conferences in the UK (see list below). I have also been invited to the 2020 British Association of Day Surgery conference in order to present the thesis findings in greater detail.

Conference presentations (past and future)

- British Association of Day Surgery Annual Conference 2020
- RCN Research Conference Sept 2019
- British Association of Day Surgery AGM Conference 2018 (Ford, 2018)
- North East Postgraduate Conference 2016 (won silver prize) (Ford, 2016c)
- Northumbria University Postgraduate Conference 2016 (won gold prize) (Ford, 2016b)
- British Association of Day Surgery Conference 2016 (won silver prize) (Ford, 2016a)
- Northumbria University Research Conference 2015 (poster presentation)

In addition to further conference presentations the study and results will also be disseminated via the following routes:

1. As a completed PhD thesis accessible via Northumbria University Library service.
2. At least two peer-reviewed journal publications. One focused on the overall research study and another on the methodology and use of critical social theory.
3. Perhaps most importantly, as a report of the findings which will be presented to the participating NHS hospital trust, department and individuals involved.

7.6 Summary

Patients commonly experience pain following surgery, as such, how it can be managed and planned for, is an essential aspect of preoperative practice, that should incorporate holistic and tailored pain plans, created in collaboration with the patients. These can only be achieved if patients are fully informed of all of the available options and are empowered to make decisions about their own care. However, the inherent nature of healthcare practices is such that equal power is often unachievable. Additionally, as a result of the complexities associated with pain and how it is manifested and experienced by each individual, it can be difficult firstly, to anticipate and secondly, to manage. While there is an assortment of literature exploring these facets, especially for inpatient surgical procedures, preoperative pain planning practices in day case surgery have not previously been reported in the literature. Therefore, this research provides new insight and an original contribution to knowledge in this field.

This thesis, by embracing a critical ethnographic approach underpinned by critical theory perspectives and aligned to Bourdieu's theory of practice and Habermas’s theory of communicative action, has demonstrated that the preoperative pain planning practices of

HCPs are influenced by views, beliefs and unconscious biases, which are reinforced by repeated practice, which goes unchallenged. These create a habitus, where unequal worth, associated with social, cultural and economic capital, affiliated with patient safety, productivity, hierarchy, autonomy, surgical specialities and gender, influence preoperative pain interactions. Whist the views of the patients were not the focus of this study, the findings, through examination and comparison with the existing body of knowledge, demonstrate that interactions with patients were limited in terms of holistic assessment and pain consideration. Care and compassion were overlooked due to process flow and increased productivity demands on the department. Additionally, the language used by HCPs trivialised day surgery and surgery associated with gynaecology. This could be viewed as acting in a coercive capacity, by instilling a prior expectation of how patients should behave postoperatively. I would, therefore, suggest that through an exploration of the findings, HCPs need to be aware of how unconscious biases, from both an organisational and internal perspective, can impact on their interactions with patients, and how the use of language can reinforce stereotypical attitudes and unequal power relationships between staff and between HCPs and patients.

This study has shown that there need to be numerous changes in the way that day surgical patients are prepared for the pain they may experience within the perioperative care continuum. This can be achieved through small yet significant changes in practice and further research which would involve patients and staff, in order to consider additional ways in which practice can be improved.

Chapter 8

Appendices

8 Appendices

Appendix 1

[UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne NE7
7XA

Date:

Dear ……

INVITATION TO PARTICIPATE IN RESEARCH STUDY

The aim of the PhD research project is to examine preoperative pain planning and management for day case surgical patients. You are being invited to participate in this study because you are a healthcare professional. Additionally, you are employed by NAME OF TRUST, and a key member of staff in the delivery of preoperative care and/or preoperative assessments/consultations. The research is not directly funded by NAME OF TRUST but is supported by the Trust. The research is being conducted by Claire Ford, an employee of Northumbria University, and a PhD research student.

Before you make the decision regarding your participation, it is important for you to understand why the research is being done and what it would involve for you. Therefore, with this letter is an information sheet, which details the research and what you will be required to do if you agree to take part. Please take the time to read this carefully and feel free to discuss it with others.

In 2-3 day's time, Claire Ford (Principal Investigator) will contact you via telephone or email to find out if you are interested in taking part in this research. If you are, Claire Ford will arrange to meet you in order to provide further information and answer any questions that you may have about the study.

If you agree to take part, Claire Ford will provide you with the relevant consent form(s), which you will sign in her presence. If you do get involved, all of the information collected from you will be held in confidence. Also, you will be free to withdraw from the study at any time, without having to give a reason, and without prejudice.

Thank you for taking the time to consider being involved in this study.

Yours faithfully,

Mrs Claire Ford
Principal Investigator

Appendix 2

[UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne NE7
7XA
claire.ford@northumbria.ac.uk

Date:

Dear ……

INVITATION TO PARTICIPATE IN RESEARCH STUDY

The aim of the PhD research project is to examine preoperative pain planning and management for day case surgical patients. You are being invited to participate in this study because you will be having a preoperative assessment/consultation with NAME OF TRUST. The research is not directly funded by NAME OF TRUST but is supported by the Trust. The research is being conducted by Claire Ford, an employee of Northumbria University, and a PhD research student.

Before you make the decision regarding your participation, it is important for you to understand why the research is being done and what it would involve for you. Therefore, with this letter is an information sheet, which details the research and what you will be required to do if you agree to take part. Please take the time to read this carefully and feel free to discuss it with others.

Claire Ford (Principal Investigator) will meet you in person, on the day of your preoperative assessment/consultation, and will be free to provide further information and answer any questions that you may have regarding the study. Additionally, you may contact her, at any time, prior to your scheduled appointment.

If you agree to take part, Claire Ford will ask you to sign a consent form on the day of your preoperative assessment/consultation. If you do get involved, all of the information collected from you will be held in confidence. Also, you will be free to withdraw from the study at any time, without having to give a reason. This would not affect the standard of care that you receive.

Thank you for taking the time to consider being involved in this study.
Yours faithfully,

Mrs Claire Ford.
Principal Investigator.

Appendix 3

UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne
NE7 7XA
claire.ford@northumbria.ac.uk

Participant Information Sheet

'Myth or reality?' Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices.

What is the purpose of the research study?
The aim of this project is to examine current preoperative pain planning and management practices for day case surgical patients. In order to enhance the understanding of preoperative practice, the study will be carried out in several stages as follows: You may be asked, by the Principal Investigator, to participate in more than one stage.

- In the first stage, Claire Ford (Principal Investigator) will spend time within the pre-assessment and preoperative clinical areas. This will enable observation of daily work practices.
- In the second stage, the preoperative assessments/consultations that occur between the nursing and anaesthetic staff and day case surgical patients will be observed.
- The third stage will involve the examination of medical notes, in order to explore data which may further inform preoperative practices.
- In the last stage, healthcare professionals will be invited to participate in an interview(s) with Claire Ford. These will be audio recorded and will provide staff with the opportunity to share their views and opinions on preoperative practices.

Why have I been asked to take part in this study?
You have been asked to take part in this study because you are a healthcare professional, employed by NAME OF TRUST. You also have regular contact with patients undergoing day case surgical procedures and may conduct preoperative assessments/consultations as part of your routine duties.

Do I have to take part in the study?
Taking part in the study is voluntary, and you are the one who has to decide if you wish to participate. Claire Ford will contact you via telephone or email, within in the next 2-3 days to find out if you are interested in taking part in this research study. If you would like to participate, Claire Ford will arrange to meet with you in order to provide further information and to answer any questions that you may have regarding the study. Additionally, depending upon which stage you would like to be involved in, Claire Ford will ask you to sign a corresponding consent form(s), to show that you have agreed to take part. You are free to withdraw from the study, without giving a reason and withdrawal will not affect you in any way. Your decision to withdraw will not be shared with anyone outside the research team.

What will I have to do?
- If you have agreed to participate in stage one, your duties, and responsibilities will not change. However, you may see Claire Ford, within your clinical area for up to a period of 6 months and witness her observing the general day-to-day activities that are carried out within the department. This will include all aspects of the routine working activities, such as meetings and general observations of your daily practice. These observations will be carried out within routine working shifts, and the investigator will not be directly involved in patient care, as she will be present to observe only.

- If you have agreed to participate in stage two, Claire Ford will, over the period of several working shifts up to a period of 6 months, observe you as you undertake preoperative assessments and/or consultations. The researcher will be present, but will not be part of the assessment, as she will be present to observe only. The preoperative assessments and/or consultations will be audio recorded, and Claire Ford will make notes to record the verbal and non-verbal interactions.
- If you have agreed to participate in stage three, Claire Ford will examine the preoperative documentation and patient notes that you have completed and updated. Your presence will not be required for this stage of the study, as the data collection may be carried out after the preoperative assessment/consultation.
- If you agree to participate in stage four, Claire Ford will invite you to participate in an individual face-to-face interview, at a time that is convenient for you. There may be a need to conduct more than one interview, and this will be negotiated between yourself and the investigator. The interview(s) will be audio recorded, will last approximately 45-60 minutes and the investigator will take notes for later analysis.

Are there any disadvantages to taking part?
Claire Ford is aware that due to the nature of the sample size, total anonymity cannot be guaranteed. However, your name will not be disclosed, and any data generated will be labelled by 'profession' and not individual names and grades. You may also experience the potential inconvenience of having to take part in an interview or interviews (these may last up to 60 minutes each) and/or be observed in practice (up to a period of 6 months).

What are the benefits of taking part?
The opportunity to observe day-to-day practices within the preoperative clinical environments, and observe the interactions between patients and healthcare professionals, may help in the uncovering of information regarding preoperative pain practices for day case surgical patients. Additionally, conducting interviews with the healthcare professionals involved may assist in the examination and exploration of some of the cultural, political, and personal factors, which may influence preoperative pain planning, within the context of 'real-world' practice.

What are the exclusion criteria (i.e. are there any reasons why I should not take part)?
In order to be a study participant, you must be a registered healthcare professional, employed by NAME OF TRUST and involved in the care of preoperative patients and/or conduct preoperative assessments/consultations.

Will my participation involve any psychological discomfort or embarrassment?
The investigator does recognise that the observed elements of the study may be anxiety provoking. Therefore, they will spend time, prior to the study, reinforcing their role as an unobtrusive observer. Additionally, every effort will be taken to anonymise your responses, and only information which is relevant to the study will be used.

How will confidentiality be assured?
The investigator has put in place a number of steps to protect the confidentiality of participants, and you will never be identified in any publication, although your words and direct quotes may be published exactly as you said them during the consultation.

How will the data be collected and who will have access to the information that I provide?
The data for this study will be collected using several methods. These include observational field notes, digital audio recordings, and examination of practice documents and patient notes. All of the data that is collected will be labelled with a unique identifier, which will always be used to identify any data that you provide. Your name or other personal details will not be associated with your data, for example, the consent form that you sign will be kept separate from your data. Any

information and data gathered during this research study will only be available to the research team identified within this information sheet, and your name will never appear in any written work.

How will the interview tapes, transcripts, and other data be stored?
All data collected during the study will be stored securely in a locked filing cabinet/cupboard, and office at Northumbria University. Electronic information will also be stored on a password-protected computer and will be kept separate from any other data in a password-encrypted folder.

How will the information be used in the future?
All the information and data gathered during this research project will be stored in line with the Data Protection Act. It will be destroyed, via the appropriate means, one year following the end of the study. During that time, the data may be used by members of the research team, but only for purposes appropriate to the research question. At no point will your personal information or data be revealed, unless forced to do so by the courts.

What will happen to the results of the research study?
The results will be written as part of a PhD thesis, which will be peer-reviewed and will be due for submission by October 2018. Additionally, the findings will appear in a summary report, which will be disseminated to the Trust, the preoperative departments, and study participants. A full copy of the PhD thesis will be made available to participants upon request. It is also intended that the findings of the study, will be published in education, research and healthcare journals, as well as conference presentations.

Who is funding this study?
This PhD study has been funded and supported by Northumbria University, as part of the 'Graduate Tutor' programme.

Who has reviewed this study?
Before any research is being allowed to happen, it has to be checked by a group of people called a research ethics committee. They make sure that the research is fair. This project has been checked and approved by the University Ethics Committee, by the NHS Research Ethics Committee (REC) and the NHS Trust Research and Development Department.

If I take part, can I withdraw from the study at a later date?
You are free to stop taking part in the study at any time. Simply contact Claire Ford to tell her you would like to withdraw. Contact details are at the end of this information sheet. When you indicate your intention to withdraw from this study, Claire Ford will ask you if you would like her to destroy all of the data collected to the point of withdrawal, or whether she can continue to use it in an anonymised form.

Information disclosure
Claire Ford is a Registered Nurse and is governed by the Nursing and Midwifery Council (NMC). She will inform you at the initial meeting of the NMC code (2008), and the NMC raising and escalating concerns regulations (2013).

Thank you for taking the time to read this information.

Complaints
If you have concerns or worries regarding the way in which this research has been conducted. Then please contact Claire Ford or another member of the research team.

Research Team

Principal Investigator: - Mrs Claire Ford,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room M008,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
claire.ford@northumbria.ac.uk

PhD Supervisors: - Dr Andrew Melling,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room B020,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
andrew.melling@northumbria.ac.uk

If you would like to speak to someone outside the research team, please contact a member of the Research and Development Department. Contact details are provided below.

R & D Department : - R & D CONTACT DETAILS

Appendix 4

UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne
NE7 7XA
claire.ford@northumbria.ac.uk

Patient Information Sheet

‘Myth or reality?’ Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices.

What is the purpose of the research study?
The aim of this project is to examine current preoperative pain planning and management practices for day case surgical patients. In order to enhance the understanding of preoperative practice, the study will be carried out in several stages as follows: You would only be asked to participate and consent to stages two and three.

- In the first stage, Claire Ford (Principal Investigator) will spend time within the pre-assessment and preoperative clinical areas. This will enable observation of daily work practices.
- In the second stage, the preoperative assessments/consultations that occur between the nursing and anaesthetic staff and day case surgical patients will be observed.
- The third stage will involve the examination of medical notes, in order to explore data which may further inform preoperative practices.
- In the last stage, healthcare professionals will be invited to participate in an interview(s) with Claire Ford. These will be audio recorded and will provide staff with the opportunity to share their views and opinions on preoperative practices.

Why have I been asked to take part in this study?
It is important that we observe as many preoperative assessments/consultations as possible. Therefore, you have been asked to take part in this study because you will need a preoperative assessment/consultation prior to your surgery, which will be taking place within NAME OF TRUST.

Do I have to take part in the study?
No, taking part in the study is voluntary, and you are the one who has to decide if you wish to participate. Claire Ford will be available on the day of your preoperative assessment/consultation, and if required will meet with you to discuss the study in more detail. This will also provide you with the opportunity to ask any questions. If you agree to take part, Claire Ford will ask you to sign a consent form. You will be free to withdraw from the study at any time, without having to give a reason. This would not affect the standard of care that you receive. Your decision to withdraw will not be shared with anyone outside the research team.

What will I have to do?

- If you are not participating in the study, you may still see Claire Ford within the department on the day of your assessment/consultation. However, she will be observing the general day-to-day activities that are carried out within the department and will not be collecting data which can be directly related to you and your care.
- If you have agreed to participate in stage two, Claire Ford will be present during your preoperative assessment and/or consultation. However, the investigator will not be part of the actual interaction and will there to observe only. The preoperative assessment/consultation will be audio recorded, and Claire Ford will make notes to record the verbal and non-verbal interactions.

- If you have agreed to participate in stage three, Claire Ford will examine your preoperative documentation and notes. Your presence will not be required for this stage of the study, as this will be carried out after the preoperative assessment/consultation.

Are there any disadvantages to taking part?
Claire Ford will be examining the practices of the healthcare professionals who will be involved in your care. However, she is aware that the preoperative period can be anxiety provoking. She will, therefore, spend time prior to the assessment confirming that participation is voluntary, that you can withdraw from the study and can ask her to stop the data collection and audio recording at any time.

What are the benefits of taking part?
The opportunity to observe the day-to-day practices of healthcare professionals and observe the interactions between patients and healthcare professionals may help in the uncovering of information regarding preoperative pain practices for day case surgical patients.

What are the exclusion criteria (i.e. are there any reasons why I should not take part)?
In order to be a study participant, you must be over the age of 18, be able to make an informed decision regarding whether to participate and must be scheduled for a day case surgical procedure at NAME OF TRUST.

Will my participation involve any physical discomfort?
As the investigator will not be directly involved in your care and purely observing the assessment/consultation process and/or day-to-day activities within the department, no physical discomfort should be experienced as a direct result of the researcher's presence.

Will my participation involve any psychological discomfort or embarrassment?
The investigator recognises that information disclosed within the preoperative assessment/consultation may be of a sensitive nature. Therefore, every effort will be made by the researcher to anonymise your responses, words, and will only use information regarding your care, which is relevant to study.

How will confidentiality be assured?
The investigator has put in place a number of steps to protect the confidentiality of participants, and you will never be identified in any publication, although your words and direct quotes may be published exactly as you said them during the consultation.

How will the data be collected and who will have access to the information that I provide?
The data for this study will be collected using several methods. These include observational field notes, digital audio recordings, and examination of practice documents and patient notes. All of the data that is collected will be labelled with a unique identifier, which will always be used to identify any data that you provide. Your name or other personal details will not be associated with your data, for example, the consent form that you sign will be kept separate from your data. Any information and data gathered during this research study will only be available to the research team identified within this information sheet, and your name will never appear in any written work.

How will the interview tapes, transcripts, and other data be stored?
All data collected during the study will be stored securely in a locked filing cabinet/cupboard, and office at Northumbria University. Electronic information will also be stored on a password-protected computer and will be kept separate from any other data in a password-encrypted folder.

How will the information be used in the future?
All the information and data gathered during this research project will be stored in line with the Data Protection Act. It will be destroyed, via the appropriate means, one year following the end of

the study. During that time, the data may be used by members of the research team, but only for purposes appropriate to the research question. At no point will your personal information or data be revealed, unless forced to do so by the courts.

What will happen to the results of the research study?
The results will be written as part of a PhD thesis, which will be peer-reviewed and will be due for submission by October 2018. Additionally, the findings will appear in a summary report, which will be disseminated to the Trust, the preoperative departments, and study participants. A full copy of the PhD thesis will be made available to participants upon request. It is also intended that the findings of the study, will be published in education, research and healthcare journals, as well as conference presentations.

Who is funding this study?
This PhD study has been funded and supported by Northumbria University, as part of the 'Graduate Tutor' programme.

Who has reviewed this study?
Before any research is being allowed to happen, it has to be checked by a group of people called a research ethics committee. They make sure that the research is fair. This project has been checked and approved by the University Ethics Committee, by the NHS Research Ethics Committee (REC) and the NHS Trust Research and Development Department.

If I take part, can I withdraw from the study at a later date?
You are free to stop taking part in the study at any time. Simply contact Claire Ford to tell her you would like to withdraw. Contact details are at the end of this information sheet. When you indicate your intention to withdraw from this study, Claire Ford will ask you if you would like her to destroy all of the data collected to the point of withdrawal, or whether she can continue to use it in an anonymised form.

Information disclosure
Claire Ford is a Registered Nurse and is governed by the Nursing and Midwifery Council (NMC). She will inform you at the initial meeting of the NMC code (2008), and the NMC raising and escalating concerns regulations (2013).

Thank you for taking the time to read this information.

Complaints
If you have concerns or worries regarding the way in which this research has been conducted. Then please contact Claire Ford or another member of the research team.

Research Team

Principal Investigator: - Mrs Claire Ford,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room M008,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
claire.ford@northumbria.ac.uk

PhD Supervisors: - Dr Andrew Melling,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room B020,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
andrew.melling@northumbria.ac.uk

If you would like to speak to someone outside the research team, please contact the Patient Advice and Liaison Service (PALS). Contact details are provided below.

PALS: - (TRUST CONTACT ADDRESS FOR PALS)

Appendix 5

UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne
NE7 7XA
claire.ford@northumbria.ac.uk

Participant Debrief Sheet

‘Myth or reality?’ Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices.

What was the purpose of the project?
The aim of this project was to explore ‘real-word’ preoperative practices and some factors that may influence pain planning and management for day case surgical patients. The results of the study will provide knowledge and information, which may raise awareness of some of the difficulties involved in planning and managing perioperative pain for day case surgical patients and may influence changes within preoperative practices.

What will happen to the information I have provided?
All the information and data gathered during this research project will be stored in line with the Data Protection Act. It will be destroyed, via the appropriate means, one year following the conclusion of the study. During that time, the data may be used by members of the research team, but only for purposes appropriate to the research question. At no point will your personal information or data be revealed, unless forced to do so by the courts.

How will the results be disseminated and how will I find out the results?
The results will be written as part of a PhD thesis, which will be peer-reviewed and will be due for submission by October 2018. The findings will be incorporated into a summary report, which will be forwarded to the Trust, the preoperative departments, and study participants. A full copy of the PhD thesis will be made available to participants upon request. It is also intended that the findings of the study, will be published in education, research and healthcare journals, as well as conference presentations.

Have I been deceived in any way during the project?
The true purpose of the study was declared within the original information sheet. However, at that initial stage, the investigator would not have been aware of the data and findings that would emerge from the observed practice and interviews.

If I wish to withdraw the information I have provided, how do I do this?
You can withdraw from the study at any time. Simply contact Claire Ford to tell her you would like to withdraw. Contact details are at the end of this debrief sheet. When you indicate your intention to withdraw from this study, Claire Ford will ask you if you would like her to destroy all of the data collected to the point of withdrawal, or whether she can continue to use it in an anonymised form. However, once the study has been published, it may not be possible to withdraw your individual data, and therefore we recommend that if you wish to withdraw, for any reason, you do so as soon as possible.

Thank you for taking part in this PhD research study.

Complaints
If you have concerns or worries regarding the way in which this research has been conducted. Or if you have requested, but did not receive feedback from the researcher regarding the general outcomes of the study within a few months after the study has concluded. Then please contact Claire Ford or another member of the research team.

Research Team

Principal Investigator: - Mrs Claire Ford,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room M008,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
claire.ford@northumbria.ac.uk

PhD Supervisors: - Dr Andrew Melling,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room B020,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
andrew.melling@northumbria.ac.uk

If you would like to speak to someone outside the research team, please contact a member of the Research and Development Department. Contact details are provided below.

R & D Department: - R&D contact details for the Trust

Appendix 6

UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne
NE7 7XA
claire.ford@northumbria.ac.uk

Patient Debrief Sheet

‘Myth or reality?’ Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices.

What was the purpose of the project?
The aim of this project was to explore ‘real-word’ preoperative practices and examine some of the factors that may influence pain planning and management for day case surgical patients. The results of the study will provide knowledge and information, which may raise awareness of some of the difficulties, involved in planning and managing perioperative pain for day case surgical patients and may influence change within perioperative practices.

What will happen to the information I have provided?
All the information and data gathered during this research project will be stored in line with the Data Protection Act. It will be destroyed, via the appropriate means, one year following the conclusion of the study. During that time, the data may be used by members of the research team, but only for purposes appropriate to the research question. At no point will your personal information or data be revealed, unless forced to do so by the courts.

How will the results be disseminated and how will I find out the results?
The results will be written as part of a PhD thesis, which will be peer-reviewed and will be due for submission by October 2018. The findings will be incorporated into a summary report, which will be forwarded to the Trust, the preoperative departments, and study participants. A full copy of the PhD thesis will be made available to participants upon request. It is also intended that the findings of the study, will be published in education, research and healthcare journals, as well as conference presentations.

Have I been deceived in any way during the project?
The true purpose of the study was declared within the original information sheet. However, at that initial stage, the investigator would not have been aware of the data and findings that would emerge from the observed practice and interviews.

If I wish to withdraw the information I have provided, how do I do this?
You can withdraw from the study at any time. Simply contact Claire Ford to tell her you would like to withdraw. Contact details are at the end of this debrief sheet. When you indicate your intention to withdraw from this study, Claire Ford will ask you if you would like her to destroy all of the data collected to the point of withdrawal, or whether she can continue to use it in an anonymised form. However, once the study has been published, it may not be possible to withdraw your individual data, and therefore we recommend that if you wish to withdraw, for any reason, you do so as soon as possible.

Thank you for taking part in this PhD research study.

Complaints
If you have concerns or worries regarding the way in which this research has been conducted. Or if you have requested, but did not receive feedback from the researcher regarding the general outcomes of the study within a few months after the study has concluded. Then please contact Claire Ford or another member of the research team.

Research Team

Principal Investigator: - Mrs Claire Ford,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room M008,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
claire.ford@northumbria.ac.uk

PhD Supervisors: - Dr Andrew Melling,
Northumbria University,
Faculty of Health and Life Sciences,
Pre-registration Health Studies,
Room B020,
Coach Lane Campus,
Newcastle upon Tyne.
NE7 7XA.
andrew.melling@northumbria.ac.uk

If you would like to speak to someone outside the research team, please contact the Patient Advice and Liaison Service (PALS). Contact details are provided below.

PALS: - (TRUST CONTACT ADDRESS FOR PALS)

Appendix 7

UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne NE7 7XA
claire.ford@northumbria.ac.uk

CONSENT FORM FOR OBSERVATION OF PRACTICE

Project Title: 'Myth or reality?' Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices.

Principal Investigator: Claire Ford

Please complete the form by initialling the boxes to indicate agreements with the relevant statements. *YES/NO*

1) I confirm that I have carefully read and understand the "Participant Information Sheet" dated …… for the above study. ☐ ☐

2) I have had the opportunity to discuss the study with the Principal Investigator, and ask questions, which have been answered to my satisfaction. ☐ ☐

3) I agree to take part in the study, and I am willing to allow the Principal Investigator to observe my practice and/or the preoperative assessments/consultations, which I conduct with patients. ☐ ☐

4) I hereby confirm that, if I conduct preoperative assessments/consultations, I am happy for them to be audio recorded and for my words to be used within the research. I know that my name and details will be kept confidential and will not appear in any printed documents or within any presentations. ☐ ☐

5) I hereby confirm that I am happy for anonymised excerpts to be used in the study ☐ ☐

6) I understand that I can ask the researcher to cease documenting at any time during the observation. ☐ ☐

7) I understand that any clinical and/or patient documentation that I use as part of the assessment/consultation process may be examined by the researcher and that the data may be used as part of the study. ☐ ☐

8) I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice. ☐ ☐

9) I understand that due to the nature of the study and the sample size, that complete anonymity may not be possible. But I understand that the researcher will endeavour to maintain anonymity when writing reports. ☐ ☐

10) I would like to receive feedback on the overall results of the study at the email address given below. ☐ ☐

Email: ……

Signature of participant..... Date.....…….. (NAME IN BLOCK LETTERS).....……
Signature of researcher..... Date.....…….. (NAME IN BLOCK LETTERS).....……

Please sign and date below in the presence of the Principal Investigator in order to indicate your consent.

Appendix 8

UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne NE7 7XA
claire.ford@northumbria.ac.uk

INTERVIEW CONSENT FORM

Project Title: 'Myth or reality?' Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices.

Principal Investigator: Claire Ford

Please complete the form by initialling the boxes to indicate agreement with the relevant statements. YES/ NO

1) I confirm that I have carefully read and understand the "Participant Information Sheet" dated…… for the above study. ☐ ☐

2) I have had the opportunity to discuss the study with the Principal Investigator and ask questions, which have been answered to my satisfaction. ☐ ☐

3) I agree to take part in the study, and I am willing to be interviewed by the Principal Investigator. ☐ ☐

4) I hereby confirm that I am happy for the interview to be audio recorded and for my comments and/or words to be used within the research. I know that my name and details will be kept confidential and will not appear in any printed documents or within any presentations. ☐ ☐

5) I hereby confirm that I am happy for anonymised excerpts to be used in the study ☐ ☐

6) I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice. ☐ ☐

7) I understand that due to the nature of the study and the sample size, complete anonymity may not be possible. But I understand that the researcher will endeavour to maintain anonymity when writing reports. ☐ ☐

8) I would like to receive feedback on the overall results of the study at the email address given below. ☐ ☐

Email: ……

Please sign and date below in the presence of the Principal Investigator in order to indicate your consent.

Signature of participant..... Date.....……..   (NAME IN BLOCK LETTERS).....……
Signature of researcher..... Date.....……..   (NAME IN BLOCK LETTERS).....……

Appendix 9

UNN and Hospital Trust letterhead]
Faculty of Health and Life Sciences
Pre-registration Health Studies
Coach Lane Campus
Newcastle upon Tyne NE7 7XA
claire.ford@northumbria.ac.uk

PATIENT OBSERVATION CONSENT FORM

Project Title: 'Myth or reality?' Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery preoperative practices.

Principal Investigator: Claire Ford

Please complete the form by initialling the boxes to indicate agreement with the relevant statements. YES/NO

1) I confirm that I have carefully read and understand the "Participant Information Sheet" dated…… for the above study. ☐ ☐

2) I have had the opportunity to discuss the study with the Principal Investigator, and ask questions, which have been answered to my satisfaction. ☐ ☐

3) I agree to take part in the study, and I am willing to allow the Principal Investigator to observe my preoperative assessment/consultation. ☐ ☐

4) I hereby confirm that I am happy for the preoperative assessment/consultation to be audio recorded and for my words to be used within the research. I know that my name and details will be kept confidential and will not appear in any printed documents or within any presentations. ☐ ☐

5) I hereby confirm that I am happy for anonymised excerpts to be used in the study. ☐ ☐

6) I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Northumbria University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐ ☐

7) I understand that I can ask the researcher to cease documenting at any time during the observation. ☐ ☐

8) I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice. ☐ ☐

9) I would like to receive feedback on the overall results of the study at the email address given below. ☐ ☐

Email: ……

Please sign and date below in the presence of the Principal Investigator in order to indicate your consent.

Signature of participant..... Date.....…….. (NAME IN BLOCK LETTERS).....……
Signature of researcher..... Date.....…….. (NAME IN BLOCK LETTERS).....……

Appendix 10

Structured Field Notes

Transcription Number:

Patient Demographic Data: ID:
Age:
Sex: Male / Female
Ethnicity:
Surgical Procedure 1: Diagnostic / Treatment
Surgical Procedure 2: Gynaecology / Orthopaedics / General Surgery / Urology
Details:
Acute pain prior to surgery: Discussed YES/NO In notes YES/NO
Chronic pain sufferer: Discussed YES/NO In notes YES/NO
Details of current pain medication:
Pain discussed during preoperative assessment / consultation: YES/NO

DETAIL (history/planning/management)	**START**	**END**	**TOTAL**
Time preoperative assessment / consultation started			
Time preoperative assessment / consultation finished			
Total time of assessment consultation			
Time spent discussing pain			
Time spent discussing airway			
Time spent discussing PONV			
Time spent discussing health			
Time spent discussing reflux			
Time spent discussing aspiration			

VERIFIED TIMES USING THE AUDIO RECORDING:…….
Pain discussion notes:

Healthcare Professional Data: ID:
Designation: Consultant / Registrar / PA
Location: Day Surgery Unit / Pre-assessment Clinic / Other……...
Types of Paperwork / Documentation used: ANAE / KARDEX / PA
Types of Assessments carried out and the order:
1)
2)
3)
4)
5)
6)
Environment observations :

Communication observations :

Organisational observations:

Reflection:

Appendix 11

Semi-Structured Interview Questions for Preassessment Staff

Thank you for agreeing to participate in the research study. I have designated you a participant number. This is to ensure your privacy and confidentiality.

Participant demographics:

Age: Position: Education: Qualified: Time in preassessment:

TOPIC 1: Personal details

Lead-off question:

Tell me about yourself, your career in nursing and how you came to work in the preassessment department?

Covert Categories:

What do you like and dislike about your job?
Is working within preassessment care what you expected?
What keeps you working within preassessment care?

Possible follow-up questions:

Would you say that you were professionally fulfilled?
Would you like to advance your practice further?
Where do you see yourself in 5 years?

TOPIC 2: Work Practices

Lead-off question:

Tell me about a typical day. Start from the commencement of your shift and tell me about all your activities and duties. Please don't be afraid of going into too much detail as I want to know about everything.

Covert Categories:

What do you think is your top priority with regards to day case surgery patients?
How do you prioritise during the assessment?
Can you tell me about the first time you conducted a preop assessment?
Do you alter your script at all?
What time and in what circumstances would you deviate from your script in relation to pain?
What and who influences your own practice? How has that practice evolved?
What is your experience of preoperative practices elsewhere, either at another hospital or Trust?
What pressures are there in your role?
Do you have a huddle in the morning? Where are patient notes located?
Do you tend to specialise in one type of surgery, i.e. only orthopaedic?
How long would you say preassessment appointments for day case surgeries last?
How much paperwork is there to complete?
What percentage of time is dedicated to seeing patients and how much is for completing paperwork?
If you could have more time what would you prefer?
Do you always keep to schedule with patients?

Possible follow-up questions:

Tell me about your experiences of caring for day case surgical patients and how this has changed?
Do you think your role has expanded and changed over the years?

How has the regime of the environment evolved and what drove the change?
What tools do you use to ensure your preoperative assessments are robust?

TOPIC 3: Pain

Lead-off question:

Can you think of a recent time when after talking to a patient you needed to refer to another member of staff, as you anticipated problems with regards to their pain management?

Covert Categories:

What is your involvement in pain planning preoperatively?
Are there different protocols for different surgeries?
Would you ever liaise with a pharmacist for a day case patient?
Whose responsibilities is pain management and planning?
Tell me what would you normally say to a patient in relation to pain.
Can you predict which patients are going to be in pain prior to surgery?
What would you do differently for a patient with chronic/acute pain?
Would you have to change your practice for these patients?
What problems do you sometimes run into with regard to pain and day case surgery?
What kind of steps do you take in relation to supporting patient's pain during the preoperative period?

Possible follow-up questions:

What other problems have you encountered?
What is your understanding of perioperative pain management?

TOPIC 4: Personal Values and Beliefs

Lead-off question:

I am interested to hear your views and opinions on pain management in general as well as for day case surgical patients. Tell me what you believe is the best way to manage pain?' i.e. analgesics, music, complementary therapies.

Covert Categories:

Do you have a preference for one surgery type over another?
What do you personally believe about pain?
For day case surgical patients – whose responsibility is it to prepare the patients for their surgery and understanding of pain and pain management?
What are your own views regarding preoperative pain planning and management?
What would you like to see improved?
If you had a magic wand, how would you like to see pain dealt with preoperatively?

Possible follow-up questions:

Are there any other specific groups of patients whom you deem as being prejudiced against – alternative regime – focus or lack thereof?

Ending questions

What would you like to see improved for day case surgical patients?
Is there anything else you want to tell me about your role in supporting patients pain planning and management preoperatively?
Would you be interested in participating in further studies examining pain and day case surgical patients?

Semi-Structured Interview Questions for Day Surgery Nursing Staff

Thank you for agreeing to participate in the research study. I have designated you a participant number. This is to ensure your privacy and confidentiality.

Participant demographics: **Age:** **Sex:**
Current position in place of employment:
Educational background:
Total years in practice:
Total years in perioperative care:

TOPIC 1: Personal details

Lead-off question:
Tell me about yourself, your career in nursing and how you came to work in the day surgical unit.

Covert Categories:
Why do you like being a nurse on the day unit?
Why did you choose to work within perioperative care?
Would you say that you were professionally fulfilled?
Would you like to advance your practice further?
Where do you see yourself in 5 years?
What is it about surgery that you like?

Possible follow up questions:
Is working within perioperative care what you expected?
What keeps you working within perioperative care?

TOPIC 2: Work Practices

Lead-off question:
Tell me about a typical day on the ward. Start from the commencement of your shift and tell me about all your activities and duties. Please don't be afraid of going into too much detail as I want to know about everything.

Covert Categories:
What do you think your role should be?
Do you think your role has expanded?
Do you place more priority on pre- or post-op care?
What do you think is your main priority?
How do you prioritise?
What and who influences your own practice?
Does it make your job more difficult if preassessment is not completed or there are some omission and changes?
What kind of steps do you take in relation to supporting patient's pain during the perioperative period?
What is your involvement in pain planning preoperatively?
Are there different protocols for different surgeries?
How has the regime of the environment evolved?

Possible follow up questions:
Tell me about your experiences of caring for day case surgical patients postoperatively and how this has changed?

TOPIC 3: Pain

Lead-off question:
Can you think of a recent time when a patient's postoperative pain was difficult to get under control or when you had concerns over a patient's pain management plan or analgesic regime?
Covert Categories:
How long did it take to get resolved?
What other problems have you encountered?
Can you predict which patients are going to be in pain when they come back from recovery?
What has been the worst case of postoperative pain that you have witnessed?
How did you feel?
What about patients with acute / chronic pain preoperatively?
Would you have to change your practice for these patients?
Possible follow up questions:
What is your understanding of perioperative pain management?
When was the administration of preoperatively paracetamol introduced?

TOPIC 4: Personal Values and Beliefs
Lead-off question:
I am interested to hear your views and opinions on pain management for day case surgical patient. Tell me what you believe is the best way to manage pain?
Covert Categories:
What do you believe about pain?
Do you think other staff and professional should look after the patient's pain?
What are your opinions on opioids?
What are your own opinions regarding preoperative pain planning and management?
What would you like to see improved?
How would you like to see pain dealt with preoperatively?
Possible follow up questions:
When was the dedicated drug Kardex produced for orthopaedics?
Is this reinforcing the typology and prejudice towards orthopaedics?

TOPIC 5: Personal opinion regarding own practice and member checking of field note observations
Lead-off question:
I have copies of some of my field notes, and I would really appreciate your opinion on the content. Please feel free to comment as I value your ideas and thoughts.
Covert Categories:
Do you disagree with my observations?
Would you say they were a true reflection on the normal daily activities?
What has surprised you the most?
Possible follow up questions
Would you be interested in participating in further studies examining pain and day case surgical patients?
Is there anything else you want to tell me about your role in supporting patients pain planning and management preoperatively?

Semi-Structured Interview Questions for Anaesthetic Staff

Thank you for agreeing to participate in the research study. I have designated you a participant number. This is to ensure your privacy and confidentiality.

Participant demographics: **Age:** **Sex:**

Current position in place of employment:

Educational background:

Total years in practice:

Total years in perioperative care:

TOPIC 1: Personal details

Lead-off question:

Tell me about yourself, your career in medicine and how you came to work within anaesthetics?

Covert Categories:

What do you like and dislike about your job/role?

Is working within perioperative care what you expected?

What keeps you working within perioperative care?

Possible follow-up questions:

Would you say that you were professionally fulfilled?

Would you like to advance your practice further?

Where do you see yourself in five years?

TOPIC 2: Work Practices

Lead-off question:

Tell me about a typical day. Start from the commencement of your shift and tell me about all your activities and duties. Please don't be afraid of going into too much detail as I want to know about everything.

Covert Categories:

What do you think is your top priority with regards to patient's perioperative care?

Now if we look preoperatively, what do you say is your main role?

Days can be hectic so how do you prioritise?

Does it make your job more difficult if preassessment is not done or there is an omission in documentation or changes in the patient health?

Can you remember the last time you had to cancel a surgery? How did it make you feel?

Can you tell me about the first time you conducted a preoperative assessment?

What and who influences your own practice?

Checklists and questions – how has that practice evolved?

What kind of steps do you take in relation to supporting patient's pain during the perioperative period?

What is your involvement in pain planning preoperatively?

Are there different protocols for different surgeries?

What are your experiences of preoperative practices elsewhere, either at another hospital or another Trust?

Are there pressures to take a full, thorough history? Can this always be done?

Possible follow-up questions:

Tell me about your experiences of caring for day case surgical patients and how this has changed?

Do you think your role has expanded and changed over the years?

How has the regime of the environment evolved and what drove the change?

What tools do you use to ensure your preoperative assessments are robust?
What practices are different between specialities?

TOPIC 3: Pain

Lead-off question:

Can you think of a recent time when a patient's pain was difficult to get under control, or when you had concerns over a patient's pain management plan or analgesic regime?

Covert Categories:

How long did it take to get resolved?
What has been the worst case of postoperative pain that you have witnessed?
How did you feel?
Did you anticipate a problem may occur?
Can you predict which patients are going to be in pain?
What about patients with acute/chronic pain preoperatively?
Would you have to change your practice for these patients?
How do you come to your decisions with regards to the analgesic regime?
How do you choose which analgesic regime to adopt?
Has your regime ever been questioned by staff/nurses?
What problems do you sometimes experience with regard to pain and day case surgery?
When was the administration of preoperative paracetamol introduced?

Possible follow-up questions:

What other problems have you encountered?
What is your understanding of perioperative pain management?

TOPIC 4: Personal Values and Beliefs

Lead-off question:

I am interested to hear your views and opinions on pain management in general as well as for day case surgical patients. Tell me what you believe is the best way to manage pain? i.e. analgesics, music, complementary therapies.

Covert Categories:

Do you have a preference for one surgery type over another?
Do your own views of pain and surgery type influence your decision on your analgesic regime?
What do you personally believe about pain?
For day case surgical patients – whose responsibility is it to prepare the patients for their surgery and understanding of pain and pain management?
You mentioned earlier analgesics and oramorph and other opioid, what are your opinions of opioids?
What are your own opinions regarding preoperative pain planning and management?
What would you like to see improved?
If you had a magic wand, how would you like to see pain dealt with preoperatively?

Possible follow-up questions:

When was the dedicated drug Kardex produced for orthopaedics?
Is this reinforcing the typology and prejudice towards orthopaedics?
Are there any other specific groups of patients whom you deem as being prejudiced against – alternative regime – focus or lack thereof?

TOPIC 5: Personal opinion regarding own practice and member checking of field note observations

Lead-off question:

I have copies of some of your transcribed preoperative visits, and I would really appreciate your opinion on the content. Please feel free to comment as I value your ideas and thoughts.

Covert Categories:

Do you disagree with my observations?

Would you say they were typical and a true reflection of your usual preop visit?

What has surprised you the most?

Lead-off question 2:

I also have some descriptive data results from my study – initial findings from the recordings and again I would like your opinion.

Is anything in their surprising?

Are they what you would have predicted?

Possible follow-up questions

Is there anything else you want to tell me about your role in supporting patient's pain planning and management preoperatively?

Would you be interested in participating in further studies examining pain and day case surgical patients?

Appendix 12

Anaesthetic visit – scheduled surgery details

Surgery	Frequency
Bone excision	1
Circumcision	3
Cystoscopy + botox injection	1
Cystoscopy + cyst removal	1
Cystoscopy + dilatation	8
Cystoscopy +/- biopsy	10
Digital repair	4
Elbow arthroscopy +/- repair	1
Epididymectomy	1
Examination under anaesthetic / banding / botox injection	1
Hysteroscopy +/- endometrial ablation	9
Hysteroscopy + endometrial ablation + laparoscopic sterilisation	1
Hysteroscopy +/- insertion intrauterine device	2
Hysteroscopy +/- polypectomy	1
Knee arthroscopy +/- repair	7
Laparoscopic cholecystectomy	9
Laparoscopic hernia repair	8
Laparoscopic hysterectomy	2
Laparoscopic salpingo-oophorectomy	3
Laparoscopy	2
Laparoscopy + hysteroscopy + insertion intrauterine device	1
Lesion excision	2
Loop biopsy	2
Needle aspiration	1
Open elbow repair	2
Open hernia repair	5
Open shoulder repair	1
Optical urethrotomy	1
Orchidectomy	1
Open reduction and internal fixation / fracture	1
Shoulder arthroscopy +/- repair	4
Small joint replacement	1
Transvaginal tape	3

Appendix 13

Confirmatory extracts illustrating airway, fasting status, nausea and vomiting, and reflux as patient safety indicators

Airway:

S17: "Okay. I look after your breathing among other things today, so I need to know about your teeth. Do you have any caps?
P13: No, I have dentures; I'll be taking them out and putting them in a pot.
S17: That's very helpful to me actually. Can I have a look at the back of your mouth? That's great and can you show me how far back your neck goes".

Fasting status:

S23: "Okay. When was the last time you had something to eat and drink?
P6: Err 6.30 last night.
S23: Oh, dear, you haven't even had water?
P6: Yeah, I've had some juice.
S23: When was that?
P6: Well, erm...water I had this morning at about 8.30.
S23: And the juice?
P6: That would have been a bit earlier at about 7.30.
S23: And nothing since then.
P6: No.
S23: Okay, good, please don't eat or drink anything until you come to theatre".

Nausea and vomiting:

S12: "Any problems with anaesthetics in the past?
P16: Sickness.
S12: Yeah, okay. And have you had sickness with all of the anaesthetics that you've had?
P16: The last time wasn't as bad, but I had a high dose of anti-sickness.
S12: Yeah, what I'll do about that, is I'll give you, there's kind of three anti-sickness drugs that we tend to use, and I'll give you them all while you're asleep. Cos, the best thing to do is try and prevent it, as otherwise, it can become a bit of a cycle".

Reflux:

S26: "Do you tend to get a lot of acid ingestion or reflux?
P19: Yes, well erm… I do. I take lansoprazole for that, because of the erm….. it's just to reduce the acid because I was diagnosed with erm…. Barrett's Oesophagus.
S26: Yeah, okay. So if you take the lansoprazole does that control the acid that you produce or do you still bring up....?
P19: …..Aye, I still do now and again.
S26: ….Is that every day or is it just with certain foods?
P19: Yes, just certain foods.
S26: So, you wouldn't get it every day?"

Chapter 9

References

9 References

- Aagaard, K. *et al.* (2016) 'Interaction Between Nurse Anaesthetists and Patients in a Highly Technological Environment', *Journal of PeriAnesthesia Nursing*, 32(5), pp. 453-463.
- Abbott, A. D., Tyni-Lenné, R. and Hedlund, R. (2010) 'The influence of psychological factors on pre-operative levels of pain intensity, disability and health-related quality of life in lumbar spinal fusion surgery patients', *Physiotherapy,* 96, pp. 213-221.
- Abdalrahim, M. S. *et al.* (2011) 'The effect of postoperative pain management program on improving nurses' knowledge and attitudes toward pain', *Nurse Education in Practice,* 11(4), pp. 250-255.
- Abdalrahima, M. S., Majali, S. A. and Bergbomc, I. (2008) 'Documentation of postoperative pain by nurses in surgical wards', *Acute Pain,* 10, pp. 73-81.
- Acton, C. *et al.* (2009) *SPSS for social scientists.* 2nd edn. Basingstoke: Palgrave Macmillan.
- Al-Azawy, M. *et al.* (2015) 'Premedication and preoperative information reduces pain intensity and increases satisfaction in patients undergoing ablation for atrial fibrillation. A randomised controlled study', *Applied Nursing Research,* 28(4), pp. 268-273.
- Al-Benna, S. (2012) 'The Impact of Late-Starts and Overruns on Theatre Utilisation Rates', *Journal of Perioperative Practice*, 22(6), pp. 197-199.
- Al-Qadire, M. and Al-Khalaileh, M. (2014) 'Jordanian nurses knowledge and attitudes regarding h pin management', *Pain Management Nursing*, 15(1), pp. 220-228.
- Alspach, J. G. (2017) 'Because Women's Lives Matter, We Need to Eliminate Gender Bias', *Critical Care Nurse*, 37(2), pp. 10-18.
- Althaus, A. *et al.* (2012) 'Development of a risk index for the prediction of chronic post-surgical pain', *European Journal of Pain,* 16(6), pp. 901-910.
- Anderson, C. J. and Kilpatrick, C. (2012) 'Supporting patients' birth plans', *Nursing for Women's Health*, 16(3), pp. 210-218.
- Andersson, V., Otterstrom-Rydberg, E. and Karlsson, A. (2015) 'The importance of written and verbal information on pain treatment for patients undergoing surgical interventions', *Pain Management Nursing,* 16(5), pp. 634-641.
- Apfelbaum, J. L., Chen, C., Mehta, S. S. and Gan, T. J. (2003) 'Postoperative pain experience: Results from a national survey suggest postoperative pain continues to be undermanaged', *Anesth Analg,* 97, pp. 534-540.
- Aranda, K. (2018) *Feminist Theories and Concepts in Healthcare*. London: Palgrave.
- Arber, A. (2004) 'Is pain what the patient says it is? Interpreting an account of pain', *International Journal of Palliative Nursing,* 10(10), pp. 491-496.
- Asmundson, G. J. G., Gomez-Perez, L., Richter, A. A. and Carleton, R. N. (2014) 'The psychology of pain: models and targets for comprehensive assessment', in van Griensven, H., Strong, J. and Unruh, A. M. (eds.) *Pain: a textbook for health professionals.* Oxford: Churchill Livingstone. pp. 35-48.

- Atkinson, P., Delamont, S. & Housley, W. (2008) *Contours of culture: Complex ethnography and the ethnography of complexity.* Lanham: Rowman & Littlefield Publishing Company Incorporated.
- Atwal, A. and Caldwell, K. (2005) 'Do all health and social care professionals interact equally: a study of interactions in multidisciplinary teams in the United Kingdom', *Scandinavian Journal of Caring Sciences,* 19(3), pp. 268-273.
- Aveyard, H. (2014) *Doing a literature review in health and social care: a practical guide.* 3rd edn. Maidenhead: Open University Press.
- Aytekin, A., Doru, Ö. and Kucukoglu, S. (2016) 'The effects of distraction on preoperative anxiety level in children', *Journal of PeriAnesthesia Nursing,* 31(1), pp. 56-62.
- Bailey, J. M., Crane, P. & Nugent, C. E. (2008) 'Childbirth education and birth plans', *Obstetrics and Gynaecology Clinics of North America*, 35(3), pp. 497-510.
- Bailey, L. (2010) 'Strategies for decreasing patient anxiety in the perioperative setting', *AORN Journal*, 92(4), pp. 445-460.
- Baker, D.W. (2017) 'History of the Joint Commission's Pain Standards: Lessons for Today's Prescription Opioid Epidemic', *JAMA*, 317(11), pp. 1117-1118.
- Ballatt, J. and Campling, P. (2011) *Intelligent kindness: reforming the culture of healthcare*. London: RCPsych.
- Bartley, E. J. and Fillingim, R. B. (2013) 'Sex differences in pain: a brief review of clinical and experimental findings', *British Journal of Anaesthesia,* 111(1), pp. 52-58.
- Barton, A. C. (2001) 'Science education in urban settings: Seeking new ways of praxis through critical ethnography', *Journal of Research in Science Teaching,* 38(8), pp. 899-917.
- Batch, M. and Windsor, C. (2015) 'Nursing casualization and communication: a critical ethnography', *Journal of Advanced Nursing,* 71(4), pp. 870-880.
- Bate, P. (2014) 'Context is everything', in Bate, P., Robert, G., Fulop, N., Ovretveit, J. and Dixon-Woods, M. (eds.) *Perspectives on context: A collection of essays considering the role of context in successful quality improvement.* London: Health Foundation, pp. 1-29.
- Battaglia, A. A. (2016) 'Introduction', in Battaglia, A. A. (ed.) *An Introduction to Pain and its relation to Nervous System Disorders.* West Sussex: Wiley Blackwell, pp. 1-16.
- Baumbusch, J. L. (2011) 'Conducting critical ethnography in long-term residential care: experiences of a novice researcher in the field', *Journal of Advanced Nursing,* 67(1), pp. 184-192.
- Bazeley, P. and Jackson, K. (2013) *Qualitative data analysis with NVivo*. 2nd edn. London: Sage Publications Ltd.
- Beck, A. (2007) 'Nurse-led pre-operative assessment for elective surgical patients', *Nursing Standard,* 21(51), pp. 35-38.
- Benton, T. and Craib, I. (2011) *Philosophy of social science: the philosophical foundations of social thought.* 2nd edn. New York: Palgrave Macmillan.

- Berg, A., Fleischer, S., Koller, M. and Neubert, T. (2006) 'Preoperative information for ICU patients to reduce anxiety during and after the ICU-stay: protocol of a randomized controlled trial', *BMC Nursing,* 5(4), pp. 1-7.
- Berg, K., Årestedt, K. & Kjellgren, K. (2013) 'Postoperative recovery from the perspective of day surgery patients: A phenomenographic study', *International Journal of Nursing Studies*, 50(12), pp. 1630-1638.
- Berkley, K. J. (1997) 'Sex differences in pain', *Behavioural and Brain Sciences*, 20(3), pp. 371-380.
- Bernstein, J. (2015) 'Not the Last Word: Orthopaedic Surgery Is Lucrative (But Evidently Not Lucrative Enough)', *Clinical Orthopaedics and Related Research*, 473, pp. 418–421.
- Bertakis, K. D. (2009) 'The influence of gender on the doctor-patient interaction', *Patient Education and Counselling*, 76(3), pp. 356-360.
- Berwick, D. (2013) *A promise to learn – a commitment to act.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf (Accessed: 04/09/2018).
- Birt, L., Scott, S. and Cavers, D. (2016) 'Member checking: A tool to enhance trustworthiness or merely a nod to validation', *Qualitative Health Research*, 26(13), pp. 1801-1811.
- Blaikie, N. (2007) *Approaches to social enquiry.* 2nd edn. Cambridge: Polity.
- Bleakley, A. *et al.* (2006) 'Improving teamwork climate in operating theatres: The shift from multi-professionalism to inter-professionalism', *Journal of Interprofessional Care,* 20(5), pp. 461-470.
- Bleakley, A., Allard, J. and Hobbs, A. (2012) 'Towards culture change in the operating theatre: Embedding a complex educational intervention to improve teamwork climate', *Medical Teacher,* 34(9), pp. 635-640.
- Blommaert, J. (2015) 'Commentary: 'culture' and superdiversity', *Journal of Multicultural Discourses*, pp. 1-3.
- Bloom, K. C. and Trice, L. B. (2014) '*Sampling'* in Boswell, C. and Cannon, S. (eds.) *Introduction to nursing research: incorporating evidence-based practice.* 3rd edn. Burlington: Jones & Bartlett Learning, pp. 179-202.
- Bloomberg, L. D. (2012) *Completing your qualitative dissertation: a roadmap from beginning to end.* 2nd edn. Los Angeles: SAGE.
- Bolden, G. B. (2015) 'Transcribing as research: "Manual" transcription and conversation analysis', *Research on Language and Social Interaction,* 48(3), pp. 276-280.
- Borkhoff, C. M. *et al.* (2008) 'The effect of patients' sex on physicians' recommendations for total knee arthroplasty', *CMAJ: Canadian Medical Association Journal*, 178(6), p. 681.
- Bose, C. E. (2015) 'Patterns of Global Gender Inequalities and Regional Gender Regimes', *Gender & Society*, 29(6), pp. 767-79.

- Boswell, C. (2014) '*Data collection'* in Boswell, C. and Cannon, S. (eds.) (2014) *Introduction to nursing research: incorporating evidence-based practice.* 3rd edn. MA: Jones & Bartlett Learning, pp. 305-330.
- Bould, M. D. *et al.* (2015) 'Residents' reluctance to challenge negative hierarchy in the operating room: a qualitative study', *Canadian Journal of Anesthesia*, 62(6), pp. 576-586.
- Bourbonnais, A. and Ducharme, F. (2010) 'The meanings of screams in older people living with dementia in a nursing home', *International Psychogeriatrics,* 22(7), pp. 1-13.
- Bourdieu, P. (1977) *Outline of a theory of practice*. Cambridge: Cambridge University Press.
- Bourdieu, P. (1984) *Distinction: A Social Critique of the Judgement of Taste*. London: Routledge.
- Bourdieu, P. (1986) 'The forms of capital', in Richardson, J. G. (eds.) *Handbook of Theory and Research for the Sociology of Education.* London: Greenwood Press, pp. 241-260.
- Bourdieu, P. (1998) *Practical reason: on the theory of action*. Cambridge: Polity Press.
- Bourdieu, P. (2001) *Masculine domination.* Cambridge: Polity Press.
- Bourdieu, P. (2002) *The bachelors' ball: The crisis of peasant society in Bearn*. London: University of Chicago Press.
- Boyd, A. M., Eastwood, V. C., Kalynych, N. M. and McDonough, J. P. (2006) 'Clinician perceived barriers to the use of regional anaesthesia and analgesia', *Acute Pain,* 8(1), pp. 23-27.
- Boyd, C. (2013) *Student survival guide: Medicine management skills for nurses.* Oxford: John Wiley & Sons Ltd.
- Brattwall, M. *et al.* (2011) 'Patients' assessment of 4-week recovery after ambulatory surgery', *Acta Anaesthesiologica Scandinavica,* 55(1), pp. 92-98.
- Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77-101.
- Breivik, H. & Stubhaug, A. (2008) 'Management of acute postoperative pain: Still a long way to go!', *Pain*, 137, pp. 233–234.
- Breivik, H. and Shipley, M. (2007) *Pain: best practice & research compendium.* Edinburgh: Elsevier.
- Brennan, F., Carr, D. B. and Cousins, M. (2007) 'Pain management: a fundamental human right', *Anaesthesia and Analgesia,* 105(1), pp. 205-221.
- Briggs, E., Whittaker, M. and Carr, E. (2009) *Survey of undergraduate pain curricula for healthcare professionals in the United Kingdom: A short report.* London: The British Pain Society.
- Brockopp, D. Y. *et al.* (1998) 'Barriers to change: a pain management project', *International Journal of Nursing Studies,* 35(4), pp. 226-232.
- Broom, D. (2008) 'Gender in/and/of health inequalities', *Australian Journal of Social Issues*, 43(1), pp. 11-28.

- Brown, D., McWilliam, C. and Ward-Griffin, C. (2006) 'Client-centred empowering partnering in nursing', *Journal of Advanced Nursing,* 53(2), pp. 160-168.
- Buchanan, I. (2010) *A dictionary of critical theory.* Oxford: Oxford University Press.
- Buglass, L. (2007) 'Assessment of acute pain in adults', in McGann, K. (ed.) *Fundamental Aspects of Pain Assessment and Management*. London: Quay Books, pp. 25-35.
- Burnette, C. E. (2015) 'From the ground up: Indigenous women's after violence experiences with the formal service system in the United States', *The British Journal of Social Work,* 45(5), pp. 1526-1545.
- Burrows, D. and Taylor, E. (2009) 'The role of personal coping strategies in the management of perioperative pain', in Cox, F. (ed.) *Perioperative pain management.* Oxford: Wiley Blackwell, pp. 81-94.
- Buvanendran, A & Kroin, J. S. (2007) 'Useful adjuvants for postoperative pain management', *Best Practice & Research Clinical Anaesthesiology*, 21(1), pp. 31-49.
- Calderone, K. (1990) 'The influence of gender on the frequency of pain and sedative medication administered to postoperative patients', *Sex Roles*, 23(11), pp. 713-725.
- Calhoun, C. *et al.* (2012) 'Introduction', in Calhoun, C. *et al.* (eds.) *Contemporary Sociological Theory*. 3rd edn. pp.1-24.
- Capone, C. (2009) *Voices From the Frontline: Findings and Practical Considerations of a Critical Ethnographic Study.* Doctor of Philosophy. The University of Washington.
- Carr, E. and Watt-Watson, J. (2012) 'Interprofessional pain education: definitions, exemplars and future directions', *British Journal of Pain,* 6(2), pp. 59-65.
- Carr, E. C. J., Layzell, M. and Christensen, M. (2010) *Advancing nursing practice in pain management.* West Sussex: Blackwell Publishing.
- Carr, E. C. J., Thomas, V. N. and Wilson-Barnet, J. (2005) 'Patient experiences of anxiety, depression and acute pain after surgery: a longitudinal perspective', *International Journal of Nursing Studies,* 42, pp. 521-530.
- Carr, E., Brockbank, K., Allen, S. and Strike, P. (2006) 'Patterns and frequency of anxiety in women undergoing gynaecological surgery', *Journal of Clinical Nursing,* 15(3), pp. 341–352.
- Carr, E. C. J. *et al.* (2013) 'Pain: A quality of care issue during patients' admission to hospital', *Journal of Advanced Nursing*, 70(6), pp. 1391-1403.
- Carspecken, P. F. (1996) *Critical ethnography in education research: A theoretical and practical guide*. New York: Routledge.
- Chapman, C. R., Stevens, D. A. and Lipman, A. G. (2013) 'Quality of Postoperative Pain Management in American Versus European Institutions', *Journal of Pain & Palliative Care Pharmacotherapy,* 27(4), pp. 350-358.
- Chapman, E. N., Kaatz, A. and Carnes, M. (2013) 'Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities', *Journal of General Internal Medicine*, 28(11), pp. 1-7.
- Chapman, K. R., Tashkin, D. P. and Pye, D. J. (2001) 'Gender Bias in the Diagnosis of COPD', *Chest*, 119(6), pp. 1691-1695.

- Chow, W. B. *et al.* (2012) 'Optimal preoperative assessment of the geriatric surgical patient: A best practices guideline from the American College of Surgeons national surgical quality improvement program and the American Geriatrics Society', *J Am Coll Surg*, 215(4), pp. 453-466.
- Chung, J. W. Y. and Lui, J. C. Z. (2003) 'Postoperative pain management: a study of patients' level of pain and satisfaction with health care providers' responsiveness to their reports of pain', *Nursing & Health Sciences,* 5(1), pp. 13-21.
- Churchill, L. (2007) 'The Hegemony of Money: Commercialism and Professionalism in American Medicine', *Cambridge Quarterly of Healthcare Ethics*, 16(4), pp. 407-414.
- Clarke, H. *et al.* (2009) 'Strategies aimed at preventing chronic post-surgical pain: Comprehensive perioperative pain management after total joint replacement surgery', *Physiotherapy Canada*, 63(3), pp. 289-304.
- Clarke, V., Braun, V. and Hayfield, N. (2015) 'Thematic analysis', in Smith, J. A. (ed.) *Qualitative psychology: a practical guide to research methods.* London: SAGE, pp. 222-247.
- Cleeland, C. S. *et al.* (1994) 'Pain and its treatment in outpatients with metastatic cancer', *The New England Journal of Medicine*, 330(9), pp. 592-596.
- Coe, R. and Gould, D. (2008) 'Disagreement and aggression in the operating theatre', *Journal of Advanced Nursing,* 61(6), pp. 609-618.
- Coll, A. M. & Ameen, J. (2006) 'Profiles of pain after day surgery: patients' experiences of three different operation types', *Journal of Advanced Nursing*, 53(2), pp. 178-187.
- Collette, A. *et al.* (2016) 'Patient empowerment reduces pain in geriatric patients after gynecologic onco-surgery: Subgroup analysis of a prospective randomized controlled clinical trial', *Journal of PeriAnesthesia Nursing*, pp. 1-9.
- Collinson, D. L. and Hearn, J. (2003) 'Breaking the silence: on men, masculinities and managements', in Ely, R. J., Foldy, E. G. and Scully, M. A. (eds.) *Reader in gender, work, and organisation*. Malden: Blackwell, pp. 75-86.
- Colvin, L. A. and Carty, S. (2012) 'Neuropathic pain', in Colvin, L. A. and Fallon, M. (eds.) *ABC of pain.* West Sussex: Wiley-Blackwell, pp. 25-30.
- Colvin, L. and Powell, L. (2007) 'Pain management and quality in healthcare', in Breivik, H. and Shipley, M. (eds.) *Pain: Best Practice and Research Compendium.* Edinburgh: Elsevier Limited, pp. 289-301.
- Comiskey, C. and Dempsey, O. (2013) 'Analysing data from small and large samples and non-normal and normal distributions', in Curtis, E. A. and Drennan, J. (eds.) *Quantitative health research: Issues and methods*. New York: Open University Press, pp. 348-371.
- Cook, K. E. (2005) 'Using Critical Ethnography to Explore Issues in Health Promotion', *Qualitative Health Research,* 15(1), pp. 129-138.
- Cooley, D. R. (2015) 'Elder abuse and vulnerability: Avoiding illicit paternalism in healthcare, medical research, and life', *Ethics, Medicine and Public Health*, 1(1), pp. 102-112.

- Corrigan, S. (2013) 'Understanding probability', in Curtis, E. A. and Drennan, J. (eds.) *Quantitative health research: Issues and methods*. New York: Open University Press, pp. 333-347.
- Costley, C., Elliott, G. & Gibbs, P. (2010) *Doing work-based research: approaches to an enquiry for insider-researchers.* London: Sage Publications.
- Coulter, A. and Collins, A. (2011) *Making shared decision-making a reality: no decision about me, without me.* London: King's Fund.
- Cousins, A. (2009) 'Education', in Cox, F. (ed.) *Perioperative Pain Management.* Oxford: Wiley Blackwell, pp. 294-309.
- Cousley, A. and Martin, D. (2016) 'The interprofessional team in perioperative care', in Cousley, A. and Martin, D. (2016) *A perioperative model and framework for practice.* London: M&K Update Ltd, pp. 55-69.
- Cox, F. (2009) *Perioperative pain management.* Oxford: Wiley-Blackwell.
- Cox, F. (2012) 'Pain management', in Woodhead, K. and Fudge, L. (eds.) *Manual of perioperative care: An essential guide.* West Sussex: John Wiley & Sons, pp. 238-251.
- Cox, H. and O'Connell, B. (2003) 'Recovery from gynaecological day surgery: are we underestimating the process', *Ambulatory Surgery,* 10(4), pp. 114-121.
- Craig, K. D. and Fashler, S. R. (2014) 'Social determinants of pain', in van Griensven, H., Strong, J. and Unruh, A. M. (eds.) *Pain: a textbook for health professionals.* Oxford: Churchill Livingstone, pp. 21-34.
- Crang, M. and Cook, I. (2007) *Doing ethnographies.* Los Angeles: SAGE.
- Creswell, J. W. (2014) *Research design: qualitative, quantitative, and mixed methods approach.* 4th edn. Thousand Oaks: SAGE.
- Creswell, J. W. and Poth, C. N. (2018) *Qualitative inquiry and research design: choosing among five approaches.* 4th edn. Los Angeles: SAGE.
- Crichton, M. D. (2008) *Safety at the Sharp End: A Guide to Non-Technical Skills.* Farnham: Ashgate Publishing Ltd.
- Crispin, V., Bugge, C. and Stoddart, K. (2017) 'Sufficiency and relevance of information for inpatients in general ward settings: A qualitative exploration of information exchange between patients and nurses', *International Journal of Nursing Studies*, 75, pp. 112-122.
- Criste, A. (2003) 'Do nurse anaesthetists demonstrate gender bias in treating pain? A national survey using a standardized pain model', *AANA Journal*, 71(3), pp.206-209.
- Croissant, K. and Shafi, M. I. (2009) 'Preoperative and postoperative care in gynaecology', *Obstetrics, Gynaecology & Reproductive Medicine*, 19(3), pp. 68-74.
- Crossley, N. (2005) *Key concepts in critical social theory*. London: SAGE.
- Crosson, J. A. (2017) 'Enhanced recovery after surgery—The importance of the perianaesthesia nurse on program success', *Journal of PeriAnesthesia Nursing*, 33(4), pp.1-9.
- Cuff, E. C., Dennis, A. J., Francis, D. W. and Sharrock, W. W. (2016) *Perspectives in sociology.* 6th edn. New York: Routledge.
- Cuff, E. C., Sharrock, W. W. and Francis, D. W. (2006) *Perspectives in sociology*. 5th edn. New York: Routledge.

- Curtis, B. & Curtis, C. (2011) *Social Research: A Practical Introduction*. London: SAGE.
- D'Arcy, Y. (2012) 'Treating Acute Pain in the Hospitalised Patient', *Nurse Practitioner*, 37(8), pp. 22-31.
- Danchev, D and Ross, A. (2014) *Research Ethics for Counsellors, Nurses & Social Workers.* London: SAGE.
- Daniel, J. (2011) *Sampling essentials: practical guidelines for making sampling choices*. California: SAGE.
- Davies, J. and McVicar, A. (2000) 'Balancing efficiency, cost-effectiveness and patient choice in opioid selection', *International Journal of Palliative Nursing,* 6(10), pp. 470-478.
- Davis, Y. *et al.* (2014) 'Patient and family member needs during the perioperative period', *Journal of PeriAnesthesia Nursing,* 29(2), pp. 119-128.
- DeForge, R., van Wyk, P., Hall, J. and Salmoni, A. (2011) 'Afraid to care; unable to care: A critical ethnography within a long-term care home', *Journal of Aging Studies,* 25(4), pp. 415-426.
- Degood, D. E. and Cook, A. J. (2011) 'Psychosocial Assessment', in Turk, D. C. and Melzack, R. (eds.) *Handbook of pain assessment.* New York: Guilford Press, pp. 67-97.
- Del Boca, F. K. (2016) 'Addressing sex and gender inequities in scientific research and publishing', *Addiction*, 111(8), pp. 1323-1325.
- Department of Health (2008) *Better health: Fairer health.* London: Department of Health.
- Department of Health (2010) *Essence of Care 2010.* Belfast: Department of Health.
- deShazo, R. D., Johnson, M., Eriator, I and Rodenmeyer, K. (2018) 'Backstories on the US Opioid Epidemic. Good Intention Gone Bad, an Industry Gone Rogue, and Watch Dogs Gone to Sleep', *The American Journal of Medicine*, 131, pp. 595-601.
- Deumens, R. *et al.* (2013) 'Prevention of chronic postoperative pain: Cellular, molecular, and clinical insights for mechanism-based treatment approaches', *Progress in Neurobiology*, 104, pp. 1-37.
- Dewan, S. K., Zheng, S. B. and Xia, S. J. (2012) 'Preoperative geriatric assessment: Comprehensive, multidisciplinary and proactive', *European Journal of Internal Medicine,* 23(1), pp. 487–494.
- Dickson, C. & Grimwood, K. (2010) 'Shared vision through the team and professional development', in McSherry, R. & Warr, J. (eds.) *Implementing Excellence in Your Health Care Organization: Managing, Leading and Collaborating.* Maidenhead: McGraw-Hill Education, pp. 3-38.
- Dihle, A., Bjølseth, G. and Helseth, S. (2006) 'The gap between saying and doing in postoperative pain management', *Journal of Clinical Nursing,* 15(4), pp. 469-479.
- Dijkstra, A. F., Verdonk, P. and Lagro-Janssen, A. L. M. (2008) 'Gender bias in medical textbooks: examples from coronary heart disease, depression, alcohol abuse and pharmacology', *Medical Education*, 42(10), pp. 1021-1028.

- Doherty, B. and Stevenson, A. (2016) ‘Preoperative assessment and preparation’, in Cousley, A. and Martin, D. (2016) *A perioperative model and framework for practice.* London: M&K Update Ltd, pp. 71-81.
- Dove, S. and Muir-Cochrane, E. (2014) 'Being safe practitioners and safe mothers: A critical ethnography of continuity of care midwifery in Australia', *Midwifery,* 30(10), pp. 1063-1072.
- Dowling, C. (1982) *The Cinderella complex: women's hidden fear of independence*. London: Fontana.
- Doyal, L. (2002) 'Gender equity in health: debates and dilemmas', in Bendelow, G., Carpenter, M., Vautier, C. and Williams, S. (eds.) *Gender, Health and Healing*. London: Routledge, pp. 183-197.
- Duncan, F. and Haigh, C. (2013) 'Measuring and improving the quality of postoperative epidural analgesia for major abdominal surgery using statistical process control charts', *Journal of Clinical Nursing,* 22(19-20), pp. 2748-2757.
- Dunwoody, C. J. *et al.* (2008) 'Assessment, physiological monitoring, and consequences of inadequately treated acute pain', *Journal of PeriAnesthesia Nursing,* 23(1), pp. 15-27.
- Dyer, C. (2018) 'Hadiza Bawa-Garba wins right to practise again', *BMJ*, 362(3510), p.1.
- Dyer, C. (2019) 'Medical manslaughter: independent review calls for root and branch reform of cases', *BMJ*, 365(l410), pp.1-2.
- Dykstra, K. M. (2012) ‘Perioperative Pain Management in the Opioid-Tolerant Patient with Chronic Pain: An Evidence-Based Practice Project’, *Journal of Perianesthesia Nursing*, 27(6), pp. 385-392.
- Ebirim, L. N. and Tobin, M. (2011) 'Factors responsible for pre-operative anxiety in elective surgical patients at a University teaching hospital: A pilot study', *Internet Journal of Anesthesiology,* 29(2), pp. 1-10.
- Edmonds, W. A. & Kennedy, T. D. (2013) *An applied reference guide to research designs: quantitative, qualitative, and mixed methods.* Thousand Oaks: SAGE.
- Edward, R. R., Smith, M. T. & Hawthorn-Thwaite, J. A. (2004) ‘Psychological evaluation’, in Wallace, M. S. & Staats, P. S. (eds.) *Pain medicine and management: Just the facts*. New York: McGraw-Hill Professional, pp. 30-37.
- Ehrenreich, B. and English, D. (2011) *Complaints and disorders: the sexual politics of sickness*. 2nd end. New York: The Feminist Press at the City University of New York.
- Eisenberger, N. I., Lieberman, M. D and Williams, K. D. (2003) ‘Does rejection hurt? An fMRI study of social exclusion’, Science, 302(5643), pp. 290-292.
- Eisenberger, N. I. and Lieberman, M. D. (2004) ‘Why rejection hurts: a common neural alarm system for physical and social pain’, *Trends in Cognitive Science*, 8(7), pp. 294-300.
- Elderkin-Thompson, V. and Waitzkin, H. (1999) 'Differences in Clinical Communication by Gender', *Journal of General Internal Medicine*, 14(2), pp. 112-121.
- Elliott, A. (2014) *Contemporary social theory: an introduction.* 2nd edn. Hoboken: Taylor and Francis.

- Engel, G. L. (1980) 'The clinical application of the biopsychosocial model', *Am J Psychiatry*, 137(5), pp. 535-544.
- Enriquez, J. R. *et al.* (2008) 'Women tolerate drug therapy for coronary artery disease as well as men do, but are treated less frequently with aspirin, β-blockers, or statins', *Gender Medicine*, 5(1), pp. 53-61.
- Eriksson, K., Wikström, L., Lindblad-Fridh, M. and Broström, A. (2013) 'Using mode and maximum values from the Numeric Rating Scale when evaluating postoperative pain management and recovery', *Journal of Clinical Nursing,* 22(5/6), pp. 638-647.
- Faherty, B. S. and Grier, M. R. (1984) 'Analgesic medication for elderly people post-surgery', *Nursing Research*, 33(6), pp. 369-372.
- Farrimond, H. (2013) *Doing Ethical Research.* New York: Palgrave MacMillan.
- Fecher-Jones, I. and Taylor, C. (2015) 'Lived experience, enhanced recovery and laparoscopic colonic resection', *British Journal of Nursing,* 24(4), pp. 223-228.
- Ferguson, K. E. (1984) *The feminist case against bureaucracy*. Philadelphia: Temple University Press.
- Fetterman, D. M. (2010) *Ethnography: step-by-step.* 3rd edn. Thousand Oaks: SAGE.
- Field, A. (2013) *Discovering statistics using IBM SPSS statistics*. 4th edn. London: SAGE.
- Field, L. and Adams, N. (2001) 'Pain management 2: the use of psychological approaches to pain', *British Journal of Nursing,* 10(15), pp. 971-974.
- Fincher, W., Shaw, J. & Ramelet, A. S. (2012) 'The effectiveness of a standardised preoperative preparation in reducing child and parent anxiety: a single-blind randomised controlled trial', *Journal of Clinical Nursing*, 21(7/8), pp. 946-955.
- Finney, L. (2010) 'Nursing care for the patient with co-existing pain and substance misuse: meeting the patient's needs', *MEDSURG Nursing*, 19(1), p. 25.
- Fisher, M. and Scott, M. (2013) *Patient safety and managing risk in nursing.* London: SAGE.
- Fitzgerald, C. and Hurst, S. (2017) 'Implicit bias in healthcare professionals: a systematic review', *BMC Medical Ethics*, 18(1), pp. 1-18.
- Fitzpatrick, E. and Hyde, A. (2006) 'Nurse-related factors in the delivery of preoperative patient education', *Journal of Clinical Nursing,* 15(6), pp. 671-677.
- Flick, U. (2014) *An introduction to qualitative research.* 5th edn. Los Angeles: SAGE.
- Fochsen, G., Deshpande, K. and Thorson, A. (2006) 'Power Imbalance and Consumerism in the Doctor-Patient Relationship: Health Care Providers' Experiences of Patient Encounters in a Rural District in India', *Qualitative Health Research*, 16(9), pp. 1236-1251.
- Foley, D. and Valenzuela, A. (2008) *Critical ethnography.* 3rd edn. California: SAGE.
- Foley, D. E. (2002) 'Critical ethnography: The reflexive turn', *International Journal of Qualitative Studies in Education,* 15(4), pp. 469-490.
- Ford, C. (2016a) *A critical ethnographic exploration of preoperative pain planning for day case surgery patients*. Poster session presented at BADS Annual Conference, Nottingham, United Kingdom.

- Ford, C. (2016b) *Preoperative pain planning for day case surgery patients: an initial analysis of the quantitative data*. Poster session presented at Northumbria University Postgrad Conference 2016.
- Ford, C. (2016c) *Preoperative pain planning for day case surgery patients: myth or reality?* Poster session presented at North East Post-Graduate Conference, Newcastle, United Kingdom.
- Ford, C. (2018) *Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery practices*. British Association of Day Surgery - AGM Conference, Sheffield, United Kingdom.
- Forsberg, A., Vikman, I., Wälivaara, B. M. and Engström, Å. (2015) 'Patients' perceptions of quality of care during the perioperative procedure', *Journal of PeriAnesthesia Nursing,* 30(4), pp. 280-289.
- Foss, C. and Sundby, J. (2003) 'The construction of the gendered patient: hospital staff's attitudes to female and male patients', *Patient Education and Counselling*, 49(1), pp. 45-52.
- Foss, M. & Bernard, H. (2012) 'Enhanced recovery after surgery: implications for nurses', *British Journal of Nursing*, 21(4), pp. 221-223.
- Foster, P. (1989) 'Improving the doctor-patient relationship: A feminist perspective', *Journal of Social Policy*, 18(3), pp. 337-361.
- Foucault, M. (2002) *The Birth of the Clinic*. London: Routledge.
- Fraczyk, L. and Godfrey, H. (2010) 'Perceived levels of satisfaction with the preoperative assessment service experienced by patients undergoing general anaesthesia in a day surgery setting', *Journal of Clinical Nursing,* 19(19/20), pp. 2849-2859.
- Fraenkel, L. and McGraw, S. (2007) 'What are the Essential Elements to Enable Patient Participation in Medical Decision Making?', *Journal of General Internal Medicine*, 22(5), pp. 614-619.
- Frame, W. T. (2015) 'Medico-legal aspects of regional anaesthesia', in Harrop-Griffiths, W., Griffiths, R. and Plaat, F. (eds.) *AAGBI Core Topics in Anaesthesia 2015.* West Sussex: Wiley Blackwell, pp. 54-64.
- Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. *Executive Summary*. London: The Stationery Office.
- Frith, U. (2015) 'Unconscious bias', *The Royal Society*. Available at: https://royalsociety.org/~/media/policy/Publications/2015/unconscious-bias-briefing-2015.pdf (Accessed: 31/07/2018).
- Frost, E. (2005) 'Preoperative evaluation', *Seminars in Anaesthesia, Perioperative Medicine and Pain,* 24(2), pp. 80-88.
- Gan, T. J. *et al.* (2004) 'Patient preferences for acute pain treatment', *British Journal of Anaesthesia,* 92(5), pp. 681-688.
- Gardezi, F. *et al.* (2009) 'Silence, power and communication in the operating room', *Journal of Advanced Nursing,* 65(7), pp. 1390-1399.
- Garner, A. and Bowbrick, V. (2015) 'Suturing the surgical gender gap', *BMJ*, 350, pp. 1-5.

- General Medical Council (2014) *National training survey report 2014: Bullying and undermining*. Available at: http://www.gmc-uk.org/NTS_bullying_and_undermining_report_2014_FINAL.pdf_58648010.pdf (Accessed: 01/04/2019).
- General Medical Council (2015) *Building a supportive environment*. Available at: http://www.gmc-uk.org/Under_embargo_05_03_15_Building_a_supportive_environment.pdf_59988406.pdf. (Accessed: 01/04/2019).
- General Medical Council (2019) *Key statistics from the medical register*. Available at: https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report (Accessed: 17/06/2019).
- Gerbershagen, H. J. *et al.* (2013) 'Pain Intensity on the First Day after Surgery: A Prospective Cohort Study Comparing 179 Surgical Procedures', *Anesthesiology,* 118(4), pp. 934-944.
- Gibson, W. J. & Brown, A. (2009) *Working with Qualitative Data*. London: SAGE.
- Gillanders, D. (2012) 'Psychological aspects of chronic pain', in Colvin, L. A. and Fallon, M. (eds.) *ABC of pain.* West Sussex: Wiley-Blackwell, pp. 73-78.
- Gillespie, B. M., Gwinner, K., Chaboyer, W. and Fairweather, N. (2013) 'Team communications in surgery creating a culture of safety', *Journal of Interprofessional Care,* 27(5), pp. 387-393.
- Gilmartin, J. (2004) 'Day surgery: patients' perceptions of a nurse-led preadmission clinic', *Journal of Clinical Nursing,* 13(2), pp. 243-250.
- Gilmour, D. (2012) 'Swab and instrument count', in Woodhead, K. and Fudge, L. (eds.) *Manual of perioperative care: An essential guide.* West Sussex: Wiley Blackwell, pp. 177-183.
- Gomez, D. *et al.* (2012) 'Gender-associated differences in access to trauma centre care: A population-based analysis', *Surgery*, 152(2), pp. 179-185.
- Goodman, B. and Clemow, R. (2010) *Nursing and collaborative practice: a guide to interprofessional and interpersonal working.* 2nd edn. Exeter: Learning Matters.
- Govender, V. and Penn-Kekana, L. (2008) 'Gender biases and discrimination: a review of health care interpersonal interactions', *Global Public Health*, 3(sup1), pp. 90-103.
- Grant, R., Sueda, A. and Kaneshiro, B. (2010) 'Expert opinion vs patient perception of obstetrical outcomes in labouring women with birth plans', *Journal of Reproductive Medicine,* 55(1-2), pp. 31-35.
- Gray, D. E. (2018) *Doing research in the real world. 4th* edn. London: SAGE.
- Grbich, C. (2013) *Qualitative data analysis: an introduction.* 2nd edn. London: SAGE.
- Green, B., Oeppen, R. S., Smith, D. W. and Brennan, P. A. (2017) 'Challenging hierarchy in healthcare teams – ways to flatten gradients to improve teamwork and patient care', *British Journal of Oral and Maxillofacial Surgery*, 55(5), pp. 449-453.
- Green, J & Thorogood, N. (2014) *Qualitative Methods for Health Research*. 3rd edn. London: SAGE.
- Green, J. L., Skukauskaite, A. and Baker, W. D. (2012) 'Ethnography as epistemology: An introduction to educational ethnography', in Arthur, J., Waring, M. I., Coe, R. and

Hedges, L. V. (eds.) *Research methodologies and methods in education.* London: SAGE, pp. 309-321.

- Greenhalgh, T., Robb, N. and Scambler, G. (2006) 'Communicative and strategic action in interpreted consultations in primary health care: A Habermasian perspective', *Social Science & Medicine*, 63(5), pp. 1170-1187.
- Gregory, J. and Waterman, H. (2012) 'Observing pain management practice on a medical unit following changes arising from an action research study', *Journal of Clinical Nursing,* 21(23-24), pp. 3523-3531.
- Grieve, R. J. (2002) 'Day surgery preoperative anxiety reduction and coping strategies', *British Journal of Nursing,* 11(10), pp. 670-678.
- Groenkjaer, M. (2002) 'Critical ethnographic methodology in nursing research: Issues and solutions', *Contemporary Nurse,* 14(1), pp. 49-55.
- Grondin, F., Bourgault, P. and Bolduc, N. (2012) 'Intervention focused on the patient and family for better postoperative pain relief', *Pain Management Nursing,* 15(1), pp. 1-11.
- Grosz, E. (1994) *Volatile Bodies: Towards a corporeal feminism*. Bloomington: Indiana University Press.
- Gulati, S., Paterson, M., Medves, J. & Luce-Kapler, R. (2011) 'Reflecting on the methodological aspects of a critical ethnographic approach used to inform change for adolescents with disabilities', *The Qualitative Report,* 16(2), pp. 523-562.
- Guo, P., East, L. and Arthur, A. (2012) 'A preoperative education intervention to reduce anxiety and improve recovery among Chinese cardiac patients: A randomised controlled trial', *International Journal of Nursing Studies,* 49(2), pp. 129-137.
- Gürsoy, A., Candaş, B., Güner, Ş. and Yılmaz, S. (2016) 'Preoperative stress: An operating room nurse intervention assessment', *Journal of PeriAnesthesia Nursing*, 31(6), pp. 495-503.
- Habermas, J. (1984) *The theory of communicative action*. London: Heinemann.
- Habermas, J. (1998) *On the Pragmatics of Communication*. Massachusetts: MIT Press.
- Hagger-Holt, R. (2009) 'Psychosocial Perspectives of Acute Pain', in Cox, F. (ed.) *Perioperative pain management*. Oxford: Wiley-Blackwell, pp. 64-80.
- Hall, E. T. (1976) *Beyond Culture.* New York: Anchor Books.
- Hamberg, K., Risberg, G., Johansson, E. and Westman, G. (2002) 'Gender bias in physicians' management of neck pain: a study of the answers in a Swedish national examination', *J Womens Health Gend Based Med*, 11(7), pp. 653-666.
- Hanna, M. N. *et al.* (2012) 'Does patient perception of pain control affect patient satisfaction across surgical units in a tertiary teaching hospital?', *American Journal of Medical Quality*, 27(5), pp. 411-416.
- Hardcastle, M., Usher, K. and Holmes, C. (2006) 'Carspecken's five-stage critical qualitative research method: An application to nursing research', *Qualitative Health Research*, Vol 16(1), pp. 151-161.
- Harding, J. (2013) *Qualitative Data Analysis from Start to Finish*. London: SAGE.
- Hardy, J. (2012) ' Pre-operative assessment of elective surgical patients', *Nursing Standard,* 27(15-17), pp. 59-59.

- Harrowing, J. N. *et al.* (2010) 'Critical ethnography, cultural safety, and international nursing research', *Internal Journal of Qualitative Methods,* 9(3), pp. 240-251.
- Harvard Medical School. (2012) 'Advances in preoperative risk assessment and management', *Curr Probl Surg,* 49(1), pp. 11-40.
- Hayes, K. and Gordon, D. B. (2015) 'Delivering quality pain management: The challenge for nurses', *AORN Journal,* 101(3), pp. 327-337.
- Healy, B. P. (1991) 'The Yentl syndrome. (editorial)', *The New England Journal of Medicine*, 325(4), p. 274.
- Heaney, F. and Hahessy, S. (2011) 'Patient satisfaction with an orthopaedic pre-operative assessment clinic', *International Journal of Orthopaedic & Trauma Nursing,* 15(2), pp. 82-91.
- Hehir, R. J. (2010) 'Managing different cultures: adversity and diversity in the perioperative environment', in Smith, B., Rawling, P., Wicker, P. and Jones, C. (eds.) *Core Topics in Operating Department Practice: Leadership and Management.* Cambridge: Cambridge University Press, pp. 49-56.
- Hek, G. & Moule, P. (2006) *Making sense of research: an introduction for health and social care practitioners.* 3rd edn. London: SAGE.
- Hewitt-Taylor, J. (2017) *The essential guide to doing a health and social care literature review.* London: Routledge.
- Hidalgo-Lopezosa, P., Rodriguez-Borrego, M. A. and Munoz-Villanueva, M. C. (2013) 'Are birth plans associated with improved maternal or neonatal outcomes?', *MCN Am J Matern Child Nurs,* 38(3), pp. 150-156.
- Hilditch, W. G., Asbury, A. J., Jack, E. and McGrane, S. (2003) 'Validation of a pre-anaesthetic screening questionnaire', *Anaesthesia,* 58(9), pp. 874-877.
- Hilton, A. *et al.* (2001) 'The desi ways: Traditional health practices of South Asian women in Canada', *Health Care for Women International,* 22(6), pp. 553-567.
- Hobson, A., Wiffen, P. J. and Conlon, J. A. (2015) 'As required versus fixed schedule analgesic administration for postoperative pain in children', *Cochrane Database of Systematic Reviews* (2).
- Hoffmann, D. and Tarzian, A. (2001) 'The girl who cried pain: A bias against women in the treatment of pain', *Journal of Law, Medicine and Ethics*, 29(1), pp. 13-27.
- Hollnagel, E., Wears, R. L. and Braithwaite, J. (2015) *From Safety-I to Safety-II: A White Paper.* The Resilient Health Care Net: University of Southern Denmark, University of Florida, USA, and Macquarie University Australia.
- Holloway, I. and Todres, L. (2010) 'Ethnography', in Gerrish, K. and Lacey, A. (eds.) *The research process in nursing*. Iowa: Blackwell Pub, pp. 165-176.
- Holmes, C. A. and Smyth, W. (2011) 'Carspecken's critical methodology – A theoretical assessment', *International Journal of Multiple Research Approaches,* 5(2), pp. 146-154.
- Holmes, M. (2009) *Gender and everyday life*. London: Routledge.
- Horvath, K. J. (2003) 'Postoperative recovery at home after ambulatory gynaecologic laparoscopic surgery', *Journal of PeriaAnesthesia Nursing,* 18(5), pp. 324-334.

- Huang, L., Kim, R. and Berry, W. (2013) 'Creating a Culture of Safety by Using Checklists', *AORN Journal,* 97(3), pp. 365-368.
- Hughes, D., Deery, R. & Lovatt, A. (2002) 'A critical ethnographic approach to facilitating cultural shift in midwifery', *Midwifery,* 18(1), pp. 43-52.
- Humphreys, S. (2005) 'Patient autonomy: legal and ethical issues in the post-anaesthetic care unit', *British Journal of Perioperative Nursing,* 15(1), pp. 35-43.
- Hunter, S. A., Martin, R., Weatherall, M. and Galletly, D. (2016) 'Anesthetists and Surgeons Predict Postoperative Pain', *Journal of PeriAnesthesia Nursing*, 33(2), pp. 1-9.
- Hout, C. R. (2013) *Language as a social reality: The effects of the infantilization of women*. Master of Art. The University of Iowa.
- Husted, H. *et al.* (2011a) 'Why still in hospital after fast-track hip and knee arthroplasty?', *Acta Orthopaedica,* 82(6), pp. 679–684.
- Husted, H. *et al.* (2011b) 'Fast-track revision knee arthroplasty: A feasibility study', *Acta Orthopaedica*, 82(3), pp. 438–440.
- Iannetti, G. D., Salomons, T. V., Moayedi, M., Mouraux, A. and Davis, K. D. (2013) 'Beyond metaphor: contrasting mechanisms of social and physical pain', *Trends in Cognitive Science,* 17(8), pp. 371-377.
- Idvall, E. (2004) 'Quality of care in postoperative pain management: what is realistic in clinical practice?', *Journal of Nursing Management,* 12(3), pp. 162-166.
- Iliffe, S. (2008) *From general practice to primary care: the industrialisation of family medicine*. Oxford: Oxford University Press.
- Impey, L. and Child, T. (2012) *Obstetrics & gynaecology.* 4th edn. West Sussex: Wiley-Blackwell.
- Inglis, F. (2004) *Culture.* Cambridge: Polity.
- Innovate UK (2018) *Gender pay gap: Innovate UK*. Swindon: Technology Strategy Board.
- International Association of Pain (2019) *IASP's Proposed New Definition of Pain Released for Comment*. Available at: https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?ItemNumber=9218. (Accessed: 02/11/2019).
- Jackson, I. (2012a) 'Day surgery services', in Calvin, J. R. and Peden, C. J. (eds.) *Raising the Standard: a compendium of audit recipes.* London: Royal College of Anaesthetists, pp. 155-169.
- Jackson, J. (2009) 'One-stop outpatient and pre-operative assessment', *Nursing Management - UK,* 15(9), pp. 24-28.
- Jackson, J. (2012b) 'Preoperative assessment', in Woodhead, K. and Fudge, L. (eds.) *Manual of perioperative care: An essential guide.* West Sussex: John Wiley & Sons, pp. 11-22.
- Jefferson, L. *et al.* (2013) 'Effect of physicians' gender on communication and consultation length: a systematic review and meta-analysis', *Journal of Health Services Research & Policy*, 18(4), pp. 242-248.

- Johansson, K. *et al.* (2005) 'Preoperative education for orthopaedic patients: systematic review', *Journal of Advanced Nursing,* 50(2), pp. 212-223.
- Johnson, P. A. *et al.* (1996) 'Gender differences in the management of acute chest pain', *Journal of General Internal Medicine*, 11(4), pp. 209-217.
- Jones, C. and Durbridge, M. (2016) 'Culture, silence and voice: the implications for patient safety in the operating theatre', *Journal of Perioperative Practice,* 26(12), pp. 281-284.
- Jones, M. R. *et al.* (2018) 'A brief history of the opioid epidemic and strategies for pain medicine', *Pain Ther*, 7, pp. 13-21.
- Juneja, R. & Jagger, S. (2009) 'The Physiology of Pain', in Cox, F. (ed.) *Perioperative pain management*. West Sussex: Wiley-Blackwell, pp. 1-16.
- Kahn, S. (2011) 'Putting ethnographic writing in context', in Lowe, C. and Zemliansky, P. (eds.) *Writing spaces: Readings on writing.* South Carolina: Parlor Press, pp. 175-192.
- Kahneman, D. (2011) *Thinking, fast and slow*. London: Allen Lane.
- Kain, Z. N. *et al.* (2000) 'Preoperative anxiety and postoperative pain in women undergoing hysterectomy: A repeated-measures design', *Journal of Psychosomatic Research,* 9(4), pp. 471-422.
- Kalkman, C. J. *et al.* (2003) 'Preoperative prediction of severe postoperative pain', *Pain,* 105(3), pp. 415–423.
- Karaman, T. *et al.* (2016) 'Evaluating the efficacy of lavender aromatherapy on peripheral venous cannulation pain and anxiety: A prospective, randomised study', *Complementary Therapies in Clinical Practice,* 23, pp. 64-68.
- Karia, K. and Ibrahim, N. (2017) 'Postoperative pain control after discharge from day surgery', *The Journal of One Day Surgery,* 26(3), pp. 18-26.
- Kastanias, P. *et al.* (2009) 'What do adult surgical patients really want to know about pain and pain management?', *Pain Management Nursing,* 10(1), pp. 22-31.
- Kazi, M. I. (2010) 'Cost effective preoperative evaluation', *Journal of Bangladesh College of Physicians & Surgeons,* 28(2), p. 69.
- Keefe, F. J., Lefebvre, J. C. and Starr, K. R. (1996) 'From the Gate Control Theory to the Neuromatrix: Revolution or Evolution?', *Pain Forum*, 5(2), pp. 143-146.
- Kehlet, H. (2011) 'Fast-track surgery—an update on physiological care principles to enhance recovery', *Langenbeck's Archives of Surgery,* 396(5), pp. 585-590.
- Keogh, B. (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf (Accessed: 29/08/17).
- Kerrin, A. (2016) 'Perioperative practice', in Cousley, A. and Martin, D. (2016) *A perioperative model and framework for practice.* London: M&K Update Ltd, pp. 1-10.
- Key, W. and Swart, M. (2017) *Guidelines for the provision of anaesthetic services (GPAS) for preoperative assessment and preparation 2017.* London: Royal College of Anaesthetists.
- Khan, R. S. *et al.* (2011) 'Catastrophising: a predictive factor for postoperative pain', *The American Journal of Surgery,* 201(1), pp. 122-131.

- Kim, F. J. *et al.* (2015) 'Current issues in patient safety in surgery: a review', *Patient Safety in Surgery*, 9(26), pp. 1-9.
- Kim, H. S. *et al.* (2005) 'Strategies of pain assessment used by nurses on surgical units', *Pain Management Nursing*, 6(1), pp. 3-9.
- Klopper, H. *et al.* (2006) 'Strategies in assessing postoperative pain - a South African study', *Intensive & Critical Care Nursing*, 22(1), pp. 12-21.
- Kol, E., Alpar, E. and Erdo, A. (2013) 'Preoperative education and use of analgesic before onset of pain routinely for post-thoracotomy pain control can reduce pain effect and total amount of analgesics administered postoperatively', *Pain Management Nursing,* 15(1), pp. 331-339.
- Koneti, K. K. & Jones, M. (2013) 'Management of acute pain', *Perioperative Management*, 31(2), pp. 77-83.
- Körner, M. (2010) 'Interprofessional teamwork in medical rehabilitation: a comparison of multidisciplinary and interdisciplinary team approach', *Clinical rehabilitation,* 24(8), pp. 745 – 755.
- Kotrotsiou, K., Roupa, Z. and Papathanasiou, I. (2004) 'Pre-surgical instruction and guidance: A study from a Greek surgical clinic', *ICUS Nursing Web Journal,* (19), pp. 3-10.
- Lack, D. Z. (1982) 'Women and pain', *Women & Therapy*, 1(1), pp. 55-64.
- Ladva, P. D. (2015) *All your time, all the time: a critical ethnography in a knowledge-intensive firm*. PhD Thesis. The University of Sydney.
- Lagerström, E. and Bergbom, I. (2006) 'The care given when undergoing operations and anaesthesia - the patients' perspective', *Journal of Advanced Perioperative Care,* 2(4), pp. 183-193.
- Lai, H. C. *et al.* (2002) 'Delayed diagnosis of US females with cystic fibrosis', American Journal of Epidemiology, 156(2), pp 165-173.
- Larkin, V. (2013) 'Encounters in the field, challenges and negotiations in midwifery research', *Evidence Based Midwifery,* 11(3), pp. 99-106.
- Lauzon-Clabo, L. M. (2008) 'An ethnography of pain assessment and the role of social context on two postoperative units', *Journal of Advanced Nursing,* 61(5), pp. 531-539.
- Layzell, M. (2008) 'Current interventions and approaches to postoperative pain management', *British Journal of Nursing*, 17(7), pp. 414-419.
- Lee, C. and Lee, I. F. K. (2013) 'Preoperative patient teaching: the practice and perceptions among surgical ward nurses', *Journal of Clinical Nursing,* 22(17/18), pp. 2551-2561.
- Lee, K. F., Ray, J. B. and Dunn, G. P. (2001) 'Chronic pain management and the surgeon: barriers and opportunities', *J Am Coll Surg,* 193(6), pp. 689-701.
- Lee, M. Y. & Zaharlick, A. (2013) *Culturally competent research: using ethnography as a meta-framework*. New York: Oxford University Press.
- Leedy, P. D. & Ormond, J. E. (2013) *Practical Research: Planning and Design*. 10th edn. New Jersey: Pearson Education Incorporated.

- Leegaard, M., Nåden, D. & Fagermoen, M. S. (2008) 'Postoperative pain and self-management: women's experiences after cardiac surgery', *Journal of Advanced Nursing*, 63(5), pp. 476-485.
- Levitt, F. C. and Ziemba-Davis, M. (2013) 'An exploratory study of patient preferences for pain management during intravenous insertion: Maybe we should sweat the small stuff', *Journal of PeriAnesthesia Nursing,* 28(4), pp. 223-232.
- Lewis, S., Stocker, M., Houghton, K. and Montgomery, J. (2009) 'A patient survey to determine how day surgery patients would like preoperative assessment to be conducted', *Journal of One-Day Surgery,* 19(2), pp. 32-36.
- Liamputtong, P. (2009) *Qualitative research methods.* 3rd edn. Oxford: Oxford University Press.
- Lindberg, M. F. *et al.* (2013) 'Pain characteristics and self-rated health after elective orthopaedic surgery - a cross-sectional survey', *Journal of Clinical Nursing,* 22(9-10), pp. 1242-1253.
- Linton, S. (2005) *Understanding pain for better clinical practice: a psychological perspective.* Edinburgh: Elsevier.
- Lombardi, A. V., Berend, K. R. and Adams, J. B. (2010) 'A rapid recovery program: Early home and pain free', *Orthopedics,* 33(9), pp. 1-3.
- Long, H. (2017) 'Validity in mixed methods research in education: the application of Habermas' critical theory', *International Journal of Research & Method in Education*, 40(2), pp. 201-213.
- Lord, S. (2014) 'How safe is your operating theatre?', *Journal of Perioperative Practice,* 24(6), p. 122.
- Lucas, B., Cox, C., Perry, L. and Bridges, J. (2012) 'Preoperative preparation of patients for total knee replacement: An action research study', *International Journal of Orthopaedic and Trauma Nursing,* 17(2), pp. 79-90.
- MacDonald, C. (2002) 'Nurse Autonomy as Relational', *Nursing Ethics*, 9(2), pp. 194-201.
- MacDonald, G. and Leary, M. R. (2005) 'Why does social exclusion hurt? The relationship between social and physical pain', *Psychological Bulletin*, 131(2), pp. 203-223.
- Macintyre, P. E. and Schug, S. A. (2007) *Acute pain management: a practical guide.* 3rd edn. Edinburgh: W. B. Saunders.
- Mackintosh, C. (2007) 'Assessment and management of patients with post-operative pain', *Nursing Standard,* 22(5), pp. 49-55.
- Mackintosh-Franklin, C. (2014) 'Registered nurses' personal responses to postoperative pain: A descriptive qualitative study', *Pain Management Nursing,* 15(3), pp. 580-587.
- Madden. R. (2017) *Being ethnographic: A guide to the theory and practice of ethnography*. 2nd edn. London: SAGE.
- Madison, D. S. (2012) *Critical ethnography: Method, ethics, and performance*. 2nd edn. California: SAGE.
- Mahon, P. and McPherson, P. (2014) 'Explaining why nurses remain in or leave bedside nursing: a critical ethnography', *Nurse Researcher,* 22(1), pp. 8-13.

- Mahon, P. R. (2011) *From the inside out: A critical ethnographic look at paediatric intensive care nursing and the determinants of nurse retention*. PHD Thesis Doctor of Health. The University of Bath.
- Main, C. J. *et al.* (2008) *Pain management: practical applications of the biopsychosocial perspective in clinical and occupational settings.* 2nd edn. Edinburgh: Churchill Livingstone.
- Maltby, J., Williams, G., McGarry, J. & Day, L. (2010) *Research methods for nursing and healthcare*. Essex: Pearson Education Limited.
- Manias, E. & Street, A. (2000) 'Rethinking ethnography: reconstructing nursing relationships', *Journal of Advanced Nursing*, 33(2), pp. 234-242.
- Manias, E., Bucknall, T. and Botti, M. (2005) 'Nurses' strategies for managing pain in the postoperative setting', *Pain Management Nursing,* 6(1), pp. 18-29.
- Manley, K. (2004) 'Workplace culture: is your workplace effective? How would you know?', *Nursing in Critical Care,* 9(1), pp. 1-3.
- Mann, E. M. and Carr, E. (2006) *Pain management.* Oxford: Blackwell.
- Mann, E. M. and Carr, E. (2009a) *Pain: creative approaches to effective management.* 2nd edn. Basingstoke: Palgrave Macmillan.
- Mann, E. M. and Carr, E. (2009b) *Pain*. 2nd edn. New York: Palgrave Macmillan.
- Martin, D. (2016) 'Peri-anaesthesia management of patient care framework', in Cousley, A. and Martin, D. (2016) *A perioperative model and framework for practice.* London: M&K Update Ltd, pp. 11-21.
- Martin, L., Kelly, M. J. and Roosa, K. (2012) 'Multidisciplinary approach to improving pain management', *Critical Care Nursing Quarterly,* 35(3), pp. 268-271.
- Marton, K. and Ambrose, L. (2007) 'Psychological aspects of chronic pain treatment', in McGann, K. (ed.) *Fundamental aspects of pain assessment and management.* London: Quay Books, pp. 125-140.
- Massad, I. M. *et al.* (2013) 'Postoperative pain is undertreated: results from a local survey at Jordan University Hospital', *Eastern Mediterranean Health Journal*, 19(5), pp. 485-489.
- Matthias, A. T. and Samarasekera, D. N. (2012) 'Preoperative anxiety in surgical patients - experience of a single unit', *Acta Anaesthesiologica Taiwanica,* 50, pp. 3-6.
- Mattila, K. *et al.* (2005) 'Postdischarge symptoms after ambulatory surgery: first-week incidence, intensity, and risk factors', *Anaesthesia and Analgesia,* 101(6), pp. 1643-1650.
- Mavridou, P., Manataki, A., Arnaoutoglou, E. and Damigos, D. (2017) 'A Survey of Patients' Preoperative Need for Information About Postoperative Pain—Effect of Previous Surgery Experience', *Journal of PeriAnesthesia Nursing*, 32(5), pp. 438-444.
- Maybin, S. and Serpell, M. G. (2012) 'Visceral pain', in Colvin, L. and Falcon, M. (eds.) *ABC of pain.* West Sussex: Wiley-Blackwell, pp. 31-36.
- McArthur, L. (2012) 'Care of the adolescent in surgery', in Woodhead, K. and Fudge, L. (eds.) *Manual of perioperative care: An essential guide.* West Sussex: Wiley Blackwell, pp. 271-278.

- McCabe, J. and Holmes, D. (2014) 'Nursing, sexual health and youth with disabilities: a critical ethnography', *Journal of Advanced Nursing,* 70(1), pp. 77-86.
- McCarthy, S. (2016) 'Gender inequality: Unconscious and systematic bias remains a problem in emergency medicine', *Emergency Medicine Australasia*, 28(3), pp. 344-346.
- McCloud, C., Harrington, A. and King, L. (2014) 'A pre-emptive pain management protocol to support self-care following vitreoretinal day surgery', *Journal of Clinical Nursing,* 23(21/22), pp. 3230-3239.
- McDonald, D. D. (1994) 'Gender and ethnic stereotyping and narcotic analgesic administration', *Research in Nursing & Health*, 17(1), pp. 45-49.
- McDonald, D. D. and Bridge, G. R. (1991) 'Gender stereotyping and nursing care', *Research in Nursing & Health*, 14(5), pp. 373-378.
- McGann, K. (2007) 'The anatomy and physiology of pain', in McGann, K. (ed.) *Fundamental aspects of pain assessment and management*. London: Quay Books, pp. 1-9.
- McInnes, C., McAlpine, C. and Walters, M. (2008) 'Effect of gender on stroke management in Glasgow', *Age and Ageing*, 37(2), pp. 220-222.
- McIntosh, S. and Adams, J. (2011) 'Anxiety and quality of recovery in day surgery: a questionnaire study using Hospital Anxiety and Depression Scale and Quality of Recovery Score', *International Journal of Nursing Practice,* 17(1), pp. 85-92.
- McSherry, R. (2010) 'Factors influencing collaborative working', in McSherry, R. and Warr, J. (eds.) *Implementing Excellence in Your Health Care Organization: Managing, Leading and Collaborating.* Maidenhead: McGraw-Hill Education, pp. 97-115.
- Mee, S. (2013) 'Is workplace culture an excuse for poor care?', *Nursing Times,* 109(14), pp. 14-16.
- Melzack, R. (2001) 'Pain and the Neuromatrix in the Brain', *Journal of Dental Education*, 65(12), pp. 1378-1382.
- Melzack, R. (2005) 'Evolution of the Neuromatrix Theory of pain. The Prithvi Raj Lecture: Presented at the Third World Congress of World Institute of Pain, Barcelona 2004', *Pain Practice*, 5(2), pp. 85-94.
- Melzack, R. (2014) 'Foreword', in Van Griensven, H., Strong, J. and Unruh, A. M. (eds.) *Pain: a textbook for health professionals.* Oxford: Churchill Livingstone, pp. vii-viii.
- Melzack, R. and Katz, J. (2013) 'Pain', *WIREs Cogn Sci*, 4(1), pp. 1-15.
- Merskey, H. & Bogduk, M. (1994) *Classifications of chronic pain*. 2nd edn. Washington: International Association for the Study of Pain Task Force on Taxonomy, IASP Press, pp. 209-214.
- Mertens, D. M. (2007) 'Transformative Paradigm Mixed Methods and Social Justice', *Journal of Mixed Methods Research,* 1(3), pp. 212-225.
- Mertens, D. M. (2010) 'Transformative Mixed Methods Research', *Qualitative Inquiry,* 16(6), pp. 469-474.
- Mertens, D. M. (2012) 'What Comes First? The Paradigm or the Approach?', *Journal of Mixed Methods Research,* 6(4), pp. 255-257.

- Merz, C. (2011) 'The Yentl syndrome and gender inequality in ischemic HD', *Cardiology Today*, 14(8), pp. 4-5.
- Metoyer, A. B. and Rust, R. (2011) 'The Egg, Sperm, and Beyond: Gendered Assumptions in Gynecology Textbooks', *Women's Studies*, 40(2), pp. 177-205.
- Meyr, A. J. and Steinberg, J. S. (2008) 'Clinical pain management peri-operative scenarios', *Clinics in Podiatric Medicine & Surgery,* 25(3), pp. 517-535.
- Miles, M. B., Huberman, A. M. & Saldaña, J. (2014) *Qualitative data analysis: a methods sourcebook*. 3rd edn. London: SAGE.
- Minchom, A. (2006) 'Preoperative assessment', *Anaesthesia and Intensive Care Medicine, 7*(12), pp. 437-441.
- Mitchell, J. (1975) *Psychoanalysis and feminism*. New York: Vintage Books.
- Mitchell, M. (2000) 'Psychological preparation for patients undergoing day surgery', *Ambulatory Surgery,* 8(1), pp. 19-29.
- Mitchell, M. (2010) 'A patient-centred approach to day surgery nursing', *Nursing Standard,* 24(44), pp. 40-46.
- Mitchell, M. (2012) 'Influence of gender and anaesthesia type on day surgery anxiety', *Journal of Advanced Nursing*, 68(5), pp. 1014-1025.
- Moayedi, M. and Davis, K. D. (2013) 'Theories of pain: from specificity to gate control', *Journal of Neurophysiology*, 109(1), pp. 5-12.
- Moayedi, M. and Salomons, T. V. (2016) 'Brain imaging in experimental pain', in Battaglia, A. A. (ed.) *An introduction to pain and its relation to nervous system disorders.* West Sussex: Wiley-Blackwell, pp. 227-248.
- Moberly, T. (2017) 'Bullying culture in NHS starts at top, says royal college head', *BMJ*, 356, p.1.
- Moen, C. (2010) 'Organisational culture', in Smith, B., Rawling, P., Wicker, P. and Jones, C. (eds.) *Core Topics in Operating Department Practice: Leadership and Management.* Cambridge: Cambridge University Press, pp. 89-106.
- Mogil, J. S. (2012) 'Pain genetics: past, present and future', *Trends in Genetics,* 28(6), pp. 258-267.
- Molyneux, J. (2001) 'Interprofessional teamworking: what makes teams work well?', *Journal of Interprofessional Care,* 15(1), pp. 29-35.
- Moody, J., Pfaff, S. and Virk, I. (2012) *Contemporary sociological theory*. 3rd edn. West Sussex: Wiley-Blackwell.
- Moore, A. *et al.* (2011) 'Gabapentin improves postcesarean delivery pain management: a randomized, placebo-controlled trial', *Anesthesia and Analgesia,* 112(1), pp. 167-173.
- Moore, S. (2010) 'Is the healthy body gendered? Toward a feminist critique of the new paradigm of health', *Body and Society*, 16(2), pp. 95-118.
- Morewedge, C. K. and Kahneman, D. (2010) 'Associative processes in intuitive judgment', *Trends in Cognitive Sciences*, 14(10), pp. 435-440.
- Morris, S. *et al.* (2008) 'Analysis of consultants' NHS and private incomes in England in 2003/4', *Journal of the Royal Society of Medicine*, 101(7), pp. 372-380.

- Mottram, A. (2011) "They are marvellous with you whilst you are in, but the aftercare is rubbish': a grounded theory study of patients' and their carers' experiences after discharge following day surgery', *Journal of Clinical Nursing,* 20(21/22), pp. 3143-3151.
- Mower, J. (2015) 'Incorporating age-specific plans of care to achieve optimal perioperative outcomes', *AORN Journal,* 102(4), pp. 369-388.
- Munch, S. (2004) 'Gender-Biased Diagnosing of Women's Medical Complaints: Contributions of Feminist Thought, 1970–1995', *Women & Health*, 40(1), pp. 101-12.
- Munoz, E., Munoz, W. and Wise, L. (2010) 'National and surgical healthcare expenditures, 2005-2025', *Annals of Surgery*, 251(2), pp. 195-200.
- NHS Digital (2019) *Gender pay.* Available at: https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/how-we-support-diversity-and-inclusion/our-workforce-demographics-2017/gender-pay (Accessed: 31/01/2019).
- NHS England (2019) *Next steps on the NHS Five Year Forward View: Funding and efficiency.* Available at: https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/funding-and-efficiency/ (Accessed: 19/06/2019).
- National Institute for Health and Care Excellence. (2014) *Patient experience in adult NHS services: Evidence update February 2014*. London: National Institute for Health and Care Excellence.
- National Patient Safety Agency. (2009) *WHO surgical safety checklist.* Available at: http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/?entryid45=59860&p=3 (Accessed: 25 August 2017).
- NHS England Patient Safety Domain (2015) *National safety standards for invasive procedures.* London: NHS England Patient Safety Domain.
- NHS Improvement (2016) *National tariff payment system 2017/18 to 2018/19: a consultation notice*. Available at: https://improvement.nhs.uk/resources/national-tariff-1719-consultation/#documents (Accessed: 01/08/2018).
- NHS Improvement (2017) *Our approach to patient safety: NHS Improvement's focus in 2017/18*. London: NHS Improvement.
- NHS Improvement (2019) *Provisional publication of Never Events reported as occurring between 1 April 2018 and 31March 2019.* Available at: https://improvement.nhs.uk/documents/5269/Provisional_publication_-__NE_1_April_2018_to_31_March_2019.pdf (Accessed: 11/04/2019).
- NHS Improvement (2019a) *Operating theatres: opportunities to reduce waiting lists*. London: NHS Improvement.
- NHS Institute for Innovation and Improvement (2009) *The Productive Operating Theatre*. Coventry: NHS Institute for Innovation and Improvement.
- Nicolai, J. and Demmel, R. (2007) 'The impact of gender stereotypes on the evaluation of general practitioners' communication skills: An experimental study using transcripts of physician-patient encounters', *Patient Education and Counseling*, 69(1), pp. 200-205.
- Nicoll, J. H. (1909) 'The surgery of infancy', *British Medical Journal,* 2, pp. 753-754.

- Niemi-Murola, L. *et al.* (2007) 'Patient satisfaction with postoperative pain management-effect of preoperative factors', *Pain Management Nursing,* 8(3), pp. 122-129.
- Nimmo, S. & Dickson, L. (2012) 'Postsurgical pain', in Colvin, L. A & Fallon, M. (eds.) *ABC of Pain*. West Sussex: Wiley-Blackwell, pp. 37-41.
- Nolan, M. (2011) 'Birth plans: a relic of the past or still a useful tool?', *Practising Midwife,* 4(5), pp. 38-39.
- Nursing and Midwifery Council (2018) *The Code: standards of conduct, performance and ethics for nurses and midwives.* London: The Council.
- Oakley, A. (1996) *Sex, gender and society*. Rev. edn. Aldershot: Arena, published in association with New Society.
- O'Dwyer, L. M. and Bernauer, J. A. (2014) *Quantitative research for the qualitative researcher*. London: SAGE.
- O'Donnell, K. F. (2015) 'Preoperative pain management education: A quality improvement project', *Journal of PeriAnesthesia Nursing,* 30(3), pp. 221-227.
- Okumus, F., Altinay, L. and Roper, A. (2007) 'Gaining access for research: Reflections from Experience', *Annals of Tourism Research,* 34(1), pp. 7-26.
- Old, E. A., Nicol, L. S. C. and Malcangio, M. (2016) 'Recent advances in neuroimmune interactions in neuropathic pain: The role of microglia', in Battaglia, A. A. (ed.) *An introduction to pain and its relation to nervous system disorders.* West Sussex: Wiley-Blackwell, pp. 123 - 147.
- Older, C. G., Carr, E. C. and Layzell, M. (2010) 'Making sense of patients' use of analgesics following day case surgery', *Journal of Advanced Nursing,* 66(3), pp. 511-521.
- O'Leary, Z. (2014) *The essential guide to doing your research project.* 2nd edn. Los Angeles: SAGE.
- Oliver, D. G., Serovich, J. M. and Mason, T. L. (2005) 'Constraints and opportunities with interview transcription: Towards reflection in qualitative research', *Social forces; a scientific medium of social study and interpretation,* 84(2), pp. 1273-1289.
- O'Mahony, J. M., Donnelly, T. T., Este, D. and Bouchal, S. R. (2012) 'Using critical ethnography to explore issues among immigrant and refugee women seeking help for postpartum depression', *Issues in Mental Health Nursing,* 33(11), pp.735-742.
- O'Neill, J., Pennington, B. and Nightingale, A. (2014) 'Principles of perioperative nursing', in Brady, A., McCabe, C. and McCann, M. (eds.) *Fundamentals of medical-surgical nursing: A systems approach.* West Sussex: Wiley, pp. 105-123.
- Oshodi, T. O. (2007) 'The impact of preoperative education on postoperative pain. Part 1', *British Journal of Nursing,* 16(12), pp. 706-710.
- Oxford University Press (2018) *Oxford English Dictionary*. Oxford: Oxford University Press.
- Özalp, G. *et al.* (2003) 'Preoperative emotional states in patients with breast cancer and postoperative pain', *Acta Anaesthesiol Scand,* 47, pp. 26-29.
- Paice, J. A. (2007) 'Pharmacokinetics, pharmacodynamics, and pharmacogenomics of opioids', *Pain Management Nursing,* 8(3), pp. S2-5.

- Paller, C. J., Campbell, C. M., Edwards, R. R. and Dobs, A. S. (2009) 'Sex-Based Differences in Pain Perception and Treatment', *Pain Medicine,* 10(2), pp. 289-299.
- Pandeva, I. and Shafi, M. I. (2011) 'Perioperative care in gynaecology', *Obstetrics, Gynaecology and Reproductive Medicine,* 22(2), pp. 38-44.
- Parahoo, K. (2014) *Nursing research: principles, process and issues.* 3rd edn. Basingstoke: Palgrave Macmillan.
- Parker, R., Larkin, T. and Cockburn, J. (2017) 'A visual analysis of gender bias in contemporary anatomy textbooks', *Social Science & Medicine*, 180, pp. 106-113.
- Parsons, T. (1991) *The social system.* 2nd edn. London: Routledge.
- Pasero, C. (2014) 'One size does not fit all: Opioid dose range orders', *Journal of PeriAnesthesia Nursing,* 29(3), pp. 246-252.
- Pasero, C. (2015) 'Focus issue: Innovations in pain management', *Journal of PeriAnesthesia Nursing,* 30(3), pp. 178-180.
- Passer, M. W. (2014) *Research methods : concepts and connections.* New York: Worth Publishers.
- Patil, V. *et al.* (2017) *Guidelines for the provision of anaesthetic services (GPAS) for intraoperative care 2017*. London: Royal College of Anaesthetists.
- Pautasso, M. (2013) 'Ten simple rules for writing a literature review', *PLoS Comput Biol*, 9(7), e100149.
- Pearce, L. (2004) 'Safe admission', *Nursing Standard,* 19(8), pp. 14-15.
- Penprase, B. *et al.* (2015) 'The efficacy of preemptive analgesia for postoperative pain control: A systematic review of the literature', *AORN Journal,* 101(1), pp. 94-105.
- Perkins, F. and Ballantyne, J. (2010) 'Postsurgical pain syndromes', in Stannard, C. F., Kalso, E. and Ballantyne, J. (eds.) *Evidence-based chronic pain management.* West Sussex: Blackwell Pub, pp.194-203.
- Pesut, B. & Reimer-Kirkham, S. (2010) 'Situated clinical encounters in the negotiation of religious and spiritual plurality: A critical ethnography', *International Journal of Nursing Studies, 47*(7), pp. 815-825.
- Phillips, A. (2006) 'What is culture?' in Arneil, B., Deveaux, M., Dhamoon, R. and Eisenberg, A. (eds.) *Sexual justice / cultural justice*. London: Routledge, pp. 15-29.
- Phillips, E. & Pugh, D. S. (2010) *How to get a PhD: A handbook for students and their supervisors*. 5th edn. Maidenhead: Open University Press.
- Phillips, N. F. (2017) *Berry & Kohn's operating room technique.* 13th edn. Missouri: Elsevier.
- Pinto, P. R. *et al.* (2012a) 'Risk factors for persistent postsurgical pain in women undergoing a hysterectomy due to benign causes: A prospective predictive study', *The Journal of Pain,* 13(11), pp. 1045-1057.
- Pinto, P. R. *et al.* (2012b) 'The mediating role of pain catastrophising in the relationship between presurgical anxiety and acute postsurgical pain after hysterectomy', *Pain,* 153, pp. 218-226.
- Plaisance, L. and Logan, C. (2006) 'Nursing students' knowledge and attitudes regarding pain', *Pain Management Nursing,* 7(4), pp. 167-175.

- Plaister-Ten, J. (2017) *Leading across cultures: Developing leaders for global organisations.* Oxon: Routledge.
- Plowright, D. (2011) *Using Mixed Methods: Frameworks for an Integrated Methodology*. London: SAGE.
- Polit, D. F. and Beck, C. T. (2012a) *Nursing research: generating and assessing evidence for nursing practice.* 9th edn. London: Lippincott Williams & Wilkins.
- Polit, D. F. and Beck, C. T. (2012b) 'Gender Bias Undermines Evidence on Gender and Health', *Qualitative Health Research*, 22(9), pp. 1298-1298.
- Polomano, R. C., Dunwoody, C. J., Krenzischek, D. A. and Rathmell, J. P. (2008a) 'Perspective on pain management in the 21st century', *Pain Management Nursing,* 9(1), pp. 3-10.
- Polomano, R. C., Rathmell, J. P., Krenzischek, D. A. and Dunwoody, C. J. (2008b) 'Emerging trends and new approaches to acute pain management', *Pain Management Nursing,* 9(1), pp. S33-41.
- Powell, R. A., Holloway, F., Lee, J. and Sitzia, J. (2004) 'Satisfaction research and the uncrowned king: challenges and future directions', *Journal of Mental Health,* 13(1), pp. 11-20.
- Price, A. M. (2013) 'Caring and technology in an intensive care unit: an ethnographic study', *Nursing in Critical Care*, 18(6), pp. 278-288.
- Pritchard, M. J. (2009) 'Managing anxiety in the elective surgical patient', *British Journal of Nursing,* 18(7), pp. 416-419.
- Pritchard, M. J. (2011) 'Using targeted information to meet the needs of surgical patients', *Nursing Standard,* 25(51), pp. 35-39.
- Pritchard, M. J. (2012) 'Pre-operative assessment of elective surgical patients', *Nursing Standard,* 26(30), pp. 51-56.
- Pronina, I. and Rule, N. O. (2014) 'Inducing bias modulates sensitivity to nonverbal cues of others' pain', *European Journal of Pain*, 18(10), pp. 1452-1457.
- Punch, K. (2014) *Introduction to social research: quantitative & qualitative approaches.* 3rd edn. Los Angeles: SAGE.
- Quick, J. (2011) 'Modern perioperative teamwork: an opportunity for interprofessional learning', *Journal of Perioperative Practice,* 21(11), pp. 387-390.
- Ragusa, P. S., Bitterman, A., Auerbach, B. and Healy, W. A. (2016) 'Effectiveness of Surgical Safety Checklists in Improving Patient Safety', *Orthopaedics*, 39(2), pp. 1-4.
- Ramesh, C. *et al.* (2016) 'Effect of preoperative education on postoperative outcomes among patients undergoing cardiac surgery: A systematic review and meta-analysis', *Journal of PeriAnesthesia Nursing*, 32(6), pp. 1-12.
- Rao, A. D., Kumar, A. and McHugh, M. (2017) 'Better Nurse Autonomy Decreases the Odds of 30-Day Mortality and Failure to Rescue', *Journal of Nursing Scholarship*, 49(1), pp. 73-79.
- Ravindran, D. (2014) 'Chronic Postsurgical Pain: Prevention and Management', *Journal of Pain & Palliative Care Pharmacotherapy,* 28(1), pp. 51-53.
- Ravitch, S. M. & Riggan, M. (2012) *Reason & rigour: how conceptual frameworks guide research*. London: SAGE.

- Rawling, P. (2012) 'Intraoperative care', in Woodhead, K. and Fudge, L. (eds.) *Manual of perioperative care: An essential guide.* West Sussex: John Wiley & Sons, pp. 135-140.
- Reckless, I. P. *et al.* (2013) *Avoiding errors in adult medicine.* West Sussex: Wiley Blackwell.
- Redwood, S. and Heaslip, V. (2010) 'Equality and diversity in practice development', in McSherry, R. and Warr, J. (eds.) *Implementing excellence in your healthcare organization: managing, leading and collaborating*. Maidenhead: McGraw-Hill Open University Press, pp. 170-186.
- Rees, J. L. (2008) 'Evidence and the industrialization of medicine', *Clinical and Experimental Dermatology*, 33(4), pp. 390-393.
- Reeves, S., Lewin, S., Espin, S. and Zwakhalen, S. M. (2010) *Interprofessional teamwork for health and social care.* Oxford: Wiley-Blackwell.
- Rejeh, N. & Vaismoradi, M. (2010) 'Perspectives and experiences of elective surgery patients regarding pain management', *Nursing & Health Sciences*, 12(1), pp. 67-73.
- Richards, J. & Hubbert, A. O. (2007) 'Experiences of expert nurses in caring for patients with postoperative pain', *Pain Management Nursing*, 8(1), pp. 17-24.
- Richards, L. (2015) *Handling qualitative data: A practical guide*. 3rd edn. London: SAGE.
- Riva, P., Sacchi, S., Montali, L. and Frigerio, A. (2011) 'Gender effects in pain detection: Speed and accuracy in decoding female and male pain expressions', *European Journal of Pain,* 15(9), pp. 981-985.
- Riva, P, Wirth, J. H. and Williams, K.D. (2011) 'The consequence of pain: The social physical pain overlap on psychological responses', *European Journal of Social Psychology*, 41, pp. 681-687.
- Rivera, R. A. *et al.* (2012) 'Preoperative medical consultation: maximising its benefits', *The American Journal of Surgery,* 204(5), pp. 787–797.
- Robertson, E. (2015) '"Como arrancar una planta": Women's reflections about influences of immigration on their everyday lives and health in Mexico'*, Social Sciences,* 4(2), pp. 294-312.
- Robinson, O. C. (2014) 'Sampling in Interview-Based Qualitative Research: A Theoretical and Practical Guide', *Qualitative Research in Psychology,* 11(1), pp. 25-41.
- Rodriguez, L. (2015) 'Pathophysiology of pain: Implications for perioperative nursing', *AORN Journal,* 101(3), pp. 338-344.
- Rognstad, M. *et al.* (2012) 'Attitudes, beliefs and self-reported competence about postoperative pain among physicians and nurses working on surgical wards', *Scandinavian Journal of Caring Sciences,* 26(3), pp. 545-552.
- Rokyta, R. and Yamamotova, A. (2013) 'Sex differences in pain perception and interpretation', *Activitas Nervosa Superior Rediviva,* 55(3), pp. 125 -134.
- Romm, N. (2015) 'Reviewing the Transformative Paradigm: A Critical Systemic and Relational (Indigenous) Lens', *Systemic Practice and Action Research,* 28(5), pp. 411-427.

- Rooth, C. and Sidhu, A. (2012) 'Implementing enhanced recovery in gynaecology oncology', *British Journal of Nursing,* 21(Sup10), pp. S4-S15.
- Rose, L. (2011) 'Interprofessional collaboration in the ICU: how to define?', *Nursing in Critical Care,* 16(1), pp. 5-10.
- Rosén, H. I., Bergh, I. H., Lundman, B. M. and Mårtensson, L. B. (2010) 'Patients' experiences and perceived causes of persisting discomfort following day surgery', *BMC Nursing,* 9(1), pp. 1-8.
- Ross, C., Rogers, C. and Duff, D. (2016) 'Critical ethnography: An under-used research methodology in neuroscience nursing', *Canadian Journal of Neuroscience Nursing,* 38(1), pp. 4-7.
- Rosser, M. (2014) 'Pain', in Rosser, M. (ed.) *Fundamentals of palliative care for student nurses.* New York: Wiley-Blackwell.
- Roter, D. L. and Hall, J. A. (2004) 'Physician Gender and Patient-Centered Communication: A Critical Review of Empirical Research', *Annual Review of Public Health*, 25(1), pp. 497-519.
- Roter, D. L., Hall, J. A. and Aoki, Y. (2002) 'Physician gender effects in medical communication: A meta-analytic review', *JAMA*, 288(6), pp. 756-764.
- Royal College of Anaesthetists (2016) M*edical workforce census report 2015*. London: Royal College of Anaesthetists.
- Royal College of Obstetricians and Gynaecologists (2018) *Careers and Training*. Available at: https://www.rcog.org.uk/en/careers-training/ (Accessed: 01/08/2018).
- Royal College of Surgeons (2015*) Avoiding unconscious bias: A guide for surgeons.* London: Royal College of Surgeons.
- Royal College of Surgeons (2015a) *Surgery in Numbers: England*. Available at: https://www.rcseng.ac.uk/media/media-background-briefings-and-statistics/surgery-andthe-nhs-in-numbers (Accessed: 041/01/2019).
- Royal College of Surgeons (2018a) *Surgery and the NHS in numbers*. Available at: https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/surgery-and-the-nhs-in-numbers/ (Accessed: 25/04/2018).
- Royal College of Surgeons (2018b) *Surgical Specialties.* Available at: https://www.rcseng.ac.uk/careers-in-surgery/trainees/foundation-and-core-trainees/surgical-specialties/ (Accessed: 01/08/2018).
- Royal National Orthopaedic Hospital, NHS England and NHS Improvement (2019) *Getting it Right First Time.* Available at: https://gettingitrightfirsttime.co.uk/# (Accessed: 19/06/19).
- Rubin, H. J. and Rubin, I. (2012) *Qualitative interviewing: the art of hearing data*. 3rd edn. Thousand Oaks: Sage Publications.
- Rudman, L. A., Moss-Racusin, C. A., Phelan, J. E. and Nauts, S. (2012) 'Status incongruity and backlash effects: Defending the gender hierarchy motivates prejudice against female leaders', *Journal of Experimental Social Psychology*, 48, pp. 165-179.
- Rummans, T. A., Burton, C. and Dawson, N. L. (2018) 'How Good Intentions Contributed to Bad Outcomes: The Opioid Crisis', *Mayo Clin Proc*, 93(3), pp. 344-350.

- Sadati, L. *et al.* (2013) 'Effect of preoperative nursing visit on preoperative anxiety and postoperative complications in candidates for laparoscopic cholecystectomy: a randomised clinical trial', *Scandinavian Journal of Caring Sciences,* 27(4), pp. 994-998.
- Saldaña, J. (2013) *The coding manual for qualitative researchers.* 2nd edn. London: SAGE.
- Saldaña, J. (2016) *The coding manual for qualitative researchers.* 3rd edn. London: SAGE.
- Saletti-Cuesta, L., Tutton, L. and Wright, J. (2016) 'The relevance of gender in the care of hip fracture patients', *International Journal of Orthopaedic and Trauma Nursing*, 22, pp. 3-12.
- Salkind, N. J. (2014) *Statistics for people who (think they) hate statistics*. London: SAGE.
- Samulowitz, A., Gremyr, I., Eriksson, E. and Hensing, G. (2018) '"Brave Men" and "Emotional Women": A Theory-Guided Literature Review on Gender Bias in Health Care and Gendered Norms towards Patients with Chronic Pain', *Pain Research and Management*, 25, pp. 1-14.
- Sandberg, F. (2014) 'A reconstructive analysis of the potential for critical learning and change in recognition of prior learning: a Habermasian analysis', *British Educational Research Journal,* 40(4), pp. 682-698.
- Sandhu, H. *et al.* (2009) 'The impact of gender dyads on doctor-patient communication: A systematic review', *Patient Education and Counselling*, 76(3), pp. 348-355.
- Santry, H. P. and Wren, S. M. (2012) 'The Role of Unconscious Bias in Surgical Safety and Outcomes', *Surgical Clinics of North America*, 92(1), pp. 137-151.
- Sarbandi, F. R. *et al.* (2017) 'The effect of physicians' gender and experience on Persian medical interactions', *Discourse and Interactions*, pp. 89-110.
- Saunders, B., Kitzinger, J. and Kitzinger, C. (2015) 'Anonymising interview data: challenges and compromise in practice', *Qualitative Research,* 15(5), pp. 616-632.
- Saver, C. (2013) 'Pain and patient experience: A business partnership', *OR Manager,* 29(6), p. 1.
- Sayin, Y. and Aksoy, G. (2012) 'The effect of analgesic education on pain in patients undergoing breast surgery: within 24 hours after the operation', *Journal of Clinical Nursing,* 21(9/10), pp. 1244-1253.
- Scambler, G. (2002) *Health and social change: A critical theory*. Buckingham: Open University Press.
- Schafheutle, E. L., Cantrill, J. A. and Noyce, P. R. (2004) 'The nature of informal pain questioning by nurses – a barrier to post-operative pain management?', *Pharm World Sci,* 26(1), pp. 12-17.
- Schensul, J. J. and LeCompte, M. D. (2013) *Essential ethnographic methods: a mixed methods approach.* 2nd edn. Lanham: Altamira Press.
- Scheriff, K., Gunderson, D. and Intelisano, A. (2008) 'Implementation of an OR efficiency program', *AORN Journal*, 88(5), pp. 775-776.

- Schoenwald, A. & Clark, C. R. (2006) ‘Acute pain in surgical patients’, *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 22(1), pp. 97-108.
- Schreiber, J. A. *et al.* (2014) 'Improving knowledge, assessment, and attitudes related to pain management: Evaluation of intervention', *Pain Management Nursing,* 15(2), pp. 474-481.
- Schug, S. and Chandrasena, C. (2015) 'Postoperative pain management following ambulatory anaesthesia: challenges and solutions', *Ambulatory Anesthesia*, 2, pp. 11-20.
- Schulman, K. A. *et al.* (1999) 'The effect of race and sex on physicians' recommendations for cardiac catheterization', *The New England Journal of Medicine*, 340(8), pp. 618-626.
- Schumacher, K. L. *et al.* (2002) 'Pain management autobiographies and reluctance to use opioids for cancer pain management', *Cancer Nursing,* 25(2), pp. 125-133.
- Segerdahl, M. *et al.* (2008) 'Clinical practice and routines for day surgery in Sweden: results from a nation-wide survey', *Acta Anaesthesiol Scand,* 52(1), pp. 117-124.
- Seidman, S. (2013) *Contested knowledge: social theory today.* 5th edn. New York: John Wiley & Sons.
- Selimen, D. and Andsoy, I. I. (2011) 'The Importance of a Holistic Approach During the Perioperative Period', *AORN Journal*, 93(4), pp. 482-490.
- Seyedfatemi, N., Rafii, F., Rezaei, M. and Kolcaba, K. (2014) 'Comfort and Hope in the Preanesthesia Stage in Patients Undergoing Surgery', *Journal of PeriAnesthesia Nursing*, 29(3), pp. 213-220.
- Sharp, S., McAllister, M. and Broadbent, M. (2018) 'The tension between person-centred and task-focused care in an acute surgical setting: A critical ethnography', *Collegian*, 25(1), pp. 11-17.
- Shelley, M. and Pakenham, K. (2007) 'The effects of preoperative preparation on postoperative outcomes: the moderating role of control appraisals', *Health Psychology,* 26(2), pp. 183-191.
- Shoqirat, N. (2013) '“Sleepless nights and sore operation site”: Patients' experiences of nursing pain management after surgery in Jordan', *Pain Management Nursing,* 15(3), pp. 609-618.
- Silverman, D. (2010) *Doing qualitative research*. 3rd edn. London: SAGE.
- Silverman, D. (2014) *Interpreting qualitative data.* 5th edn. Los Angeles: SAGE.
- Siu, J. Y. (2015) 'Communicating under medical patriarchy: gendered doctor-patient communication between female patients with overactive bladder and male urologists in Hong Kong', *BMC Women's Health*, 15(44) pp.1-11.
- Sjoling, M., Nordahl, G., Olofsson, N. and Asplund, K. (2003) 'The impact of preoperative information of state anxiety, postoperative pain and satisfaction with pain management', *Patient Education & Counselling,* 51(2), pp. 169-176.
- Skeggs, B. (2015) ‘The idea of class: A measure of value’, in Holborn, M. (ed.) *Contemporary Sociology*. Cambridge: Polity Press, pp. 4-31.

- Smith, A. F., Pope, C., Goodwin, D. and Mort, M. (2008) 'Interprofessional handover and patient safety in anaesthesia: observational study of handovers in the recovery room', *British Journal of Anaesthesia*, 101(3), pp. 332-337.
- Smith, B. H. and Torrance, N. (2012) 'Epidemiology of chronic pain', in Colvin, L. and Fallon, M. (eds.) *ABC of pain.* West Sussex: Wiley-Blackwell, pp. 1-4.
- Smith, I. and Hammond, C. (2011) 'Preoperative assessment and day case surgery', in Radford, M., Williamson, A. and Evans, C. (eds.) *Preoperative assessment and perioperative management.* Cumbria: M&K Publishing, pp. 267-280.
- Smyth, W. and Holmes, C. (2005) 'Using Carspecken's critical ethnography in nursing research', *Contemporary Nurse*, 19(1-2), pp. 65-74.
- Solaro, C. and Uccelli, M. M. (2016) 'Pain in multiple sclerosis: From classification to treatment', in Battaglia, A. A. (ed.) *An introduction to pain and its relation to nervous system disorders.* West Sussex: Wiley-Blackwell, pp. 345-360.
- Soltner, C., Giquello, J. A., Monrigal-Martin, C. and Beydon, L. (2011) 'Continuous care and empathic anaesthesiologist attitude in the preoperative period: impact on patient anxiety and satisfaction', *British Journal of Anaesthesia*, 106(5), pp. 680-686.
- Spice, J. (2008) 'Promoting healthy eating: the role of pre-operative assessment', *Paediatric Nursing,* 20(4), pp. 14-18.
- Spradley, J. P. (1979) *The ethnographic interview.* Belmont: Wadsworth, Cengage Learning.
- Stacey, M. (2002) 'Concluding comments', in Bendelow, G., Carpenter, M., Vautier, C. and Williams, S. (eds.) *Gender, Health and Healing*. London: Routledge, pp. 267-283.
- Stein-Parbury, J. and Liaschenko, J. (2007) 'Understanding collaboration between nurses and physicians as knowledge at work', *American Journal of Critical Care*, 16(5), pp. 470-477.
- Stewart, L. and Usher, K. (2007) 'Carspecken's critical approach as a way to explore nursing leadership issues', *Qualitative Health Research,* 17(7), pp. 994-999.
- Stomberg, M. W., Brattwall, M. and Jakobsson, J. G. (2013) 'Day surgery, variations in routines and practices a questionnaire survey', *International Journal of Surgery,* 11(1), pp. 178-182.
- Strazdins, L. *et al.* (2011) 'Time Scarcity: Another Health Inequality?', *Environment and Planning A: Economy and Space*, 43(3), pp. 545-559.
- Street, R. L. (2002) 'Gender differences in health care provider-patient communication: are they due to style, stereotypes, or accommodation?', *Patient Education and Counselling*, 48(3), pp. 201-206.
- Strong, J. and van Griensven, H. (2014) 'Assessing pain', in van Griensven, H., Strong, J. and Unruh, A. M. (eds.) *Pain: a textbook for health professionals.* Oxford: Churchill Livingstone, pp. 91-114.
- Studer Group (2007) *Best Practices: Sacred Heart Hospital Pensacola, Florida.* Florida: Studer group.
- Sweitzer, B. J. (2008) *Preoperative assessment and management.* 2nd edn. Philadelphia: Lippincott Williams & Wilkins.
- Tallis, R. (2004) *Hippocratic Oathes*. London: Atlantic Books.

- Tasca, C. *et al.* (2012) 'Women and hysteria in the history of mental health', *Clinical Practice and Epidemiology in Mental Health*, 8, pp. 110–119.
- The American Society of Anaesthesiologists Task Force on Acute Pain Management. (2004) 'Practice guidelines for acute pain management in the perioperative setting', *Anaesthesiology,* 100(6), pp. 1573–1581.
- The Association of Anaesthetists of Great Britain and Ireland. (2010a) *Pre-operative assessment and patient preparation: The role of the anaesthetist.* London: The Association of Anaesthetists of Great Britain and Ireland.
- The Association of Anaesthetists of Great Britain and Ireland. (2010b) *The anaesthesia team.* London: The Association of Anaesthetists of Great Britain and Ireland.
- The Association of Anaesthetists of Great Britain, Ireland and The British Association of Day Surgery. (2011b) 'Day case and short stay surgery: 2', *Anaesthesia,* 66(5), pp. 417-434.
- The Association of Anaesthetists of Great Britain, Ireland and The Royal College of Anaesthetists. (2008) *Information management: Guidance for Anaesthetists.* London: The Association of Anaesthetists of Great Britain, Ireland and The Royal College of Anaesthetists.
- The Association of Anaesthetists of Great Britain, Ireland and The British Association of Day Surgery. (2011a) *Day case and short stay surgery*. London: The Association of Anaesthetists of Great Britain, Ireland and The British Association of Day Surgery.
- The Health Foundation. (2013) *Evidence scan: Involving patients in improving safety*. London: The Health Foundation.
- The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland. (2006) *Good practice: A guide for departments of anaesthesia, critical care and pain management.* London: The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland.
- Theodore, C. *et al.* (2013) *Evaluation of the productive operating theatre programme*. London: Matrix Decisions Ltd.
- Thomas, J. (1993) *Doing critical ethnography*. London: Sage.
- Thorson, A. and Johansson, E. (2004) 'Equality or equity in health care access: a qualitative study of doctors' explanations to a longer doctor's delay among female TB patients in Vietnam', *Health Policy*, 68(1), pp. 37-46.
- Tilley, D. S. & Long, J. (2014) 'Qualitative and mixed methods', in Boswell, C. & Cannon, S. (eds.) *Introduction to nursing research: Incorporating evidence-based practice*. 3rd edn. Burlington: Jones & Bartlett Learning, pp. 227-264.
- Toates, F. (2007) 'Describing and classifying pain', in Toates, F. (ed.) *Pain*. Oxford: Oxford University Press, pp. 7-14.
- Toates, F. & Davey, B. (2007) 'Pain: a global health problem', in Toates, F. (ed.) *Pain.* Oxford: Oxford University Press, pp. 1-6.
- Tocher, J. *et al.* (2012) 'Pain management and satisfaction in postsurgical patients', *Journal of Clinical Nursing,* 21(23/24), pp. 3361-3371.

- Todd, A. J. (2016) 'Anatomy of pain pathways', in Battaglia, A. A. (ed.) *An introduction to pain and its relation to nervous system disorders.* West Sussex: Wiley-Blackwell, pp. 13-33.
- Toftgaard, C. (2009) '"Presidential": day surgery development', *Ambulatory Surgery,* 15(1), p. 4.
- Tokmak, A. *et al.* (2015) 'The effect of preprocedure anxiety levels on postprocedure pain scores in women undergoing hysterosalpingography', *Journal of the Chinese Medical Association,* 78(8), pp. 481-485.
- Tomassini, G., Bernasconi, E. and Giudice, G. (2008) 'From research to clinical practice an interdisciplinary project of day surgery anesthesiological course: From preoperative evaluation to patient discharge', *International Journal of Surgery,* 6(1), pp. 36-40.
- Tooth, L. and McKenna, K. (2006) *Client education: a partnership approach for health practitioners.* San Diego: Plural Pub.
- Tornsey, C. & Fleetwood-Walker, S. (2012) 'Pain Mechanisms', in Colvin, L. A & Fallon, M. (eds.) *ABC of Pain*. West Sussex: Wiley-Blackwell, pp. 5-10.
- Tse, M. M. Y. and Ho, S. S. K. (2014) 'Enhancing knowledge and attitudes in pain management: A pain management education program for nursing home staff', *Pain Management Nursing,* 15(1), pp. 2-11.
- Tung, H. *et al.* (2012) 'Effects of a preoperative individualised exercise program on selected recovery variables for cardiac surgery patients: A pilot study', *J Saudi Heart Assoc,* 24(1), pp. 153–161.
- Turk, D. C. and Melzack, R. (2011) 'Prologue', in Turk, D. C. and Melzack, R. (eds.) *Handbook of pain assessment.* New York: Guilford Press, pp. 1-2.
- Ung, A., Salamonson, Y., Hu, W. and Gallego, G. (2016) 'Assessing knowledge, perceptions and attitudes to pain management among medical and nursing students: a review of the literature', *British Journal of Pain*, 10(1), pp. 8-21.
- Unruh, A. M. (1996) 'Gender variations in clinical pain experience', *Pain*, 65(2), pp. 123-167.
- Unruh, A. M., Strong, J. and van Griensven, H. (2014) 'Introduction to pain', in van Griensven, H., Strong, J. and Unruh, A. M. (eds.) *Pain: a textbook for health professionals.* Oxford: Churchill Livingstone, pp. 1-8.
- Uskul, A. K. and Ahmad, F. (2003) 'Physician-patient interaction: a gynaecology clinic in Turkey', *Social Science & Medicine*, 57(2), pp. 205-215.
- van Aken, H., Staender, S., Mellin-Olsen, J. and Pelosi, P. (2011) 'Patient safety in anaesthesiology', *Best Practice & Research Clinical Anaesthesiology*, 25(2), pp. ix-x.
- van Dijk, J. F. M. *et al.* (2015) 'The effect of a preoperative educational film on patients' postoperative pain in relation to their request for opioids', *Pain Management Nursing,* 16(2), pp. 137-145.
- van Krieken, R. *et al.* (2016) *Sociology.* 6th edn. Sydney: Pearson Education.
- van Oostveen, C. and Vermeulen, H. (2017) 'Greater nurse autonomy associated with lower mortality and failure to rescue rates', *Evidence Based Nursing*, 20(2), pp. 56-56.

- van Ryn, M. (2002) 'Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care', *Medical Care*, 40(1 Suppl), pp. I-140-I-151.
- Vandenberg, H. E. R. and Hall, W. A. (2011) 'Critical ethnography: extending attention to bias and reinforcement of dominant power relations', *Nurse Researcher,* 18(3), pp. 25-30.
- VanMeter, K. C. and Hubert, R. J. (2014) *Gould's pathophysiology for the health professions.* 5th edn. Missouri: Elsevier.
- Vaughn, F., Wichowski, H. and Bosworth, G. (2007) 'Does preoperative anxiety level predict postoperative pain?', *AORN Journal,* 85(3), pp. 589-604.
- Verdonk, P., Benschop, Y., Haes, H. and Lagro-Janssen, T. (2009) 'From gender bias to gender awareness in medical education', *Advances in Health Sciences Education*, 14(1), pp. 135-152.
- Vigeyen, J. W. S., Crombez, G. and Goubert, L. (2007) 'Science and psychology of pain', in Breivik, H. and Shipley, M. (eds.) *Pain: Best practice and research compendium.* Edinburgh: Elsevier Limited, pp. 7-15.
- Voshall, B., Dunn, K. S. and Shelestak, D. (2013) 'Knowledge and attitudes of pain management among nursing faculty', *Pain Management Nursing,* 14(4), pp. 226-235.
- Walby, S. (1990) *Theorizing patriarchy*. Oxford: Basil Blackwell.
- Walby, S. (1997) *Gender transformations*. London: Routledge.
- Walker, J. A. (2007) 'Patient information. What is the effect of preoperative information on patient satisfaction?', *British Journal of Nursing,* 16(1), pp. 27-32.
- Walker, S., Read, S. and Priest, H. (2013) 'Use of reflexivity in a mixed-methods study', *Nurse Researcher*, 20(3), pp. 38-43.
- Walliman, N. (2016) *Social research methods: the essentials.* 2nd edn. Los Angeles: SAGE.
- Walmsley, P. N. H., Brockopp, D. Y. and Brockopp, G. W. (1992) 'The role of prior pain experience and expectations on postoperative pain', *Journal of Pain and Symptom Management,* 7(1), pp. 34-37.
- Wandner, L. D. *et al.* (2014) 'The impact of patients' gender, race, and age on health care professionals' pain management decisions: An online survey using virtual human technology', *International Journal of Nursing Studies*, 51(5), pp. 726-733.
- Wang, C. L. (2013) 'Rethinking the significance of 'critical' in critical ethnography of education on the basis of Foucault's philosophy', *National Journal of Education,* (10), pp. 1-19.
- Ward, C. W. (2014) 'Procedure-specific postoperative pain management', *MEDSURG Nursing,* 23(2), pp. 107-110.
- Watt-Watson, J., Siddall, P. J. and Carr, E. (2012) 'Interprofessional pain education: the road to successful pain management outcomes', *Pain Management,* 2(5), pp. 417-420.
- Weiner, K. A. (2003) 'Empowering the pain patient to make treatment decisions', *Home Health Care Management and Practice,* 15(3), pp. 198-202.
- Welsh, J. V. and Symon, A. G. (2014) 'Unique and proforma birth plans: A qualitative exploration of midwives ′experiences', *Midwifery,* 30(7), pp. 885-891.

- Westerling, K. and Bergbom, I. (2008) 'The importance of nursing in perioperative care: a patient's perspective', *Journal of Advanced Perioperative Care,* 3(4), pp. 133-144.
- Whitaker, D. K., Brattebø, G., Smith, A. F. and Staender, S. E. A. (2011) 'The Helsinki Declaration on Patient Safety in Anaesthesiology: Putting words into practice', *Best Practice & Research Clinical Anaesthesiology*, 25(2), pp. 277-290.
- Whitford, H. M. *et al*. (2014) 'Use of a birth plan within woman-held maternity records: A qualitative study with wand staff in Northeast Scotland', *Birth: Issues in Perinatal Care*, 41(3), pp. 283-289.
- Wicker, P. (2010) 'The role of the operating department manager within the context of the organisation', in Smith, B., Rawling, P., Wicker, P. and Jones, C. (eds.) *Core Topics in Operating Department Practice: Leadership and Management.* Cambridge: Cambridge University Press, pp. 2-18.
- Wiesenfeld-Hallin, Z. (2005) 'Sex differences in pain perception', *Gender Medicine,* 2(3), pp. 137-145.
- Wikström, L. *et al.* (2014) 'Healthcare Professionals' Perceptions of the Use of Pain Scales in Postoperative Pain Assessments', *Applied Nursing Research,* 27(1), pp. 53-58.
- Wilhite, C. L. (2011) 'Implications of postsurgical pain mismanagement', *Plastic Surgical Nursing*, 31(3), pp. 121-123.
- Williams, A., Ching, M. & Loader, J. (2003) 'Assessing patient satisfaction with day surgery at a metropolitan public hospital', *Australian Journal of Advanced Nursing*, 21(1), pp. 35-41.
- Willis, K. and Elmer, S. (2011) *Society, culture and health.* 2nd edn. Oxford: Oxford University Press.
- Wilson, B. (2007) 'Nurses' knowledge of pain', *Journal of Clinical Nursing,* 16(6), pp. 1012-1020.
- Witz, A. (1992) *Professions and patriarchy*. London: Routledge.
- Woodhead, K. and Fudge, L. (2012) 'The context of perioperative care', in Woodhead, K. and Fudge, L. (eds.) *Manual of perioperative care: An essential guide.* West Sussex: John Wiley & Sons, pp. 3-10.
- World Health Organisation (1978) *Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.* Geneva: World Health Organisation.
- World Health Organisation (2002) *Integrating gender perspectives in the work of WHO: WHO gender policy*. Geneva: World Health Organisation.
- World Health Organisation (2009) *Patient safety - safe surgery safe lives. The second global patient safety challenge.* Geneva: World Health Organisation.
- World Health Organisation (2017) *Patient safety: making healthcare better.* Geneva: World Health Organisation.
- World Health Organisation (2019) *Safe Surgery: Why is safe surgery important*. Available at https://www.who.int/patientsafety/safesurgery/en/ (Accessed: 11/04/2019).

- Wu, C. L., Berenholtz, S. M., Pronovost, P. J. and Fleisher, L. A. (2002) 'Systematic review and analysis of postdischarge symptoms after outpatient surgery', *Anesthesiology,* 96(4), pp. 994-1003.
- Xue, Z. P., Li, H. Y., Guan, R. T. and Chen, S. (2016) 'Applying healthcare failure mode and effect analysis to patient pain management in the anaesthesia recovery period', *Chinese Nursing Research,* 3(1), pp. 34-36.
- Yeandle, S. (1999) 'Women, men, and non-standard employment: breadwinning and caregiving in Germany, Italy, and the UK', in Crompton, R. (ed.) *Restructuring gender relations and employment.* Oxford: Oxford University Press, pp. 80-104.
- Young, J. L. and Davidhizar, R. (2008) 'Attitude: Impact on pain assessment', *Journal of Practical Nursing,* 58(2), pp. 6-10.
- Young, J. L., Horton, F. M. and Davidhizar, R. (2006) 'Nursing attitudes and beliefs in pain assessment and management', *Journal of Advanced Nursing,* 53(4), pp. 412-421.
- Zinn, J. (2013) 'Surgical patients: A vulnerable population', *AORN Journal,* 98(6), pp. 647-649.
- Zis, P., Sokolov, E. and Chaudhuri, K. R. (2016) 'An overview of pain in Parkinson's disease', in Battaglia, A. A. (ed.) *An Introduction to pain and its relation to nervous system disorders.* West Sussex: Wiley-Blackwell, pp. 387-408.