THE EXPERIENCE OF PATIENTS UNDERGOING KNEE SURGERY WITH LOCAL OR REGIONAL ANAESTHESIA: AN ETHNOGRAPHY

by

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ABSTRACT

This ethnographic study is concerned with the surgical experience of patients within the social context in which it occurs: the operating theatre. Traditionally, the focus of the operating theatre has been on conducting safe, efficient surgery with unconscious patients. However, as the volume of surgery performed under local or regional anaesthesia increases, this focus is shifting. Care of awake patients in the operating theatre is now a prominent feature of modern perioperative practise, and support for the conscious patient has become a major responsibility for all perioperative staff. The aim of this thesis is to understand the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. Through such an understanding the nature of the relationship between the conscious patient and the rest of the perioperative team can be established and the most important factors that influence the perioperative experience of this patient group clarified.

An ethnographic approach has been used to gather data which enables an understanding of the relationship between the conscious patient in an operating theatre and the rest of the perioperative team. Data was gathered through preoperative and postoperative interviews with seven adult patients scheduled for knee arthroplasty or knee arthroscopy under local or regional anaesthesia. One other patient was interviewed preoperatively but not postoperatively. In addition to the patients, three surgeons, one anaesthetist, one anaesthetic practitioner, one scrub practitioner and a recovery practitioner were also interviewed, making a total of 22 interviews. Participant observation was also conducted in four locations in the hospital; day surgery theatres and main theatres during surgery, the preoperative clinic referred to as 'joint school' (where seven consultations were observed) and the fracture clinic where a further seven consultations were observed. Collectively, these areas reflect those visited by patient participants during their surgical journey.

The study generates an authentic ethnographic account of the patients' experiences of knee surgery with local or regional anaesthesia. A thick description, drawn from the views of patients and perioperative staff, has been produced which supports theoretical interpretations of the behaviour and relationships enacted in the context of everyday life in an operating theatre setting. Data analysis was through a constant comparative approach which followed the six steps of grounded theory methodology (Glaser and Strauss, 1967). Perioperative staff caring for the patient during this time typically adopt a medical or scientific perspective towards the patient's body, whereas patients view this experience from a lived perspective. Four themes identified as trust, capital, embodiment and the clinical gaze were identified through the data analysis. These themes relate to the strategies patients and staff utilise to bridge the gap between their different perspectives. An understanding of which can contribute to ways of interacting with and caring for surgical patients in the perioperative environment.

GLOSSARY OF TERMS

Anaesthetic Room	A room usually adjacent to but separate from the operating theatre. In the United Kingdom (UK), anaesthetic rooms are the standard site for induction of anaesthesia.
Arthroplasty	The surgical reconstruction or replacement of a joint.
Arthroscopy	A minimally invasive surgical procedure where a small endoscope is inserted into the joint to diagnose and sometimes treat damage within joints. (Also known as arthroscopic or keyhole surgery.)
Emic Perspective	The emic perspective means to view the world as a member of that culture views it.
Enhanced Recovery Programme	The enhanced recovery programme encourages patients to be an active participant in their own recovery process. The aim is to work closely with the patient, their family and other healthcare professionals to aid a speedy recovery from the operation, as well as a safe and timely discharge. The aim of the enhanced recovery programme is for patients to be well enough to return home sooner after their surgery.
Etic Perspective	The etic perspective represents an outsider or stranger’s view of that culture.

General Anaesthesia	General anaesthesia brings about a reversible loss of consciousness and analgesia in order for surgeons to operate on a patient.
Intraoperative	Occurring, carried out, or encountered during surgery.
Joint School	This is a patient focussed education programme which gives patients and their family the opportunity to speak to the hospital staff and find out everything they want to know prior to hip or knee replacement.
Laying Up Room	A room usually adjacent to but separate from the operating theatre where surgical instruments are prepared and 'laid up' or set out on trolleys in a sterile manner in preparation for surgery.
Local Anaesthesia	Local anaesthesia is used to numb the nerve supply in a specific part of the body to prevent pain signals being transmitted to the brain during surgical procedures.
Operating Department Practitioner (ODP)	The ODP works predominantly in the operating department alongside surgeons, anaesthetists and nurses, caring for patients throughout the perioperative journey. This begins with the anaesthetic, continues throughout surgery and finishes with the recovery of the patient.
Orthopaedic	The surgical speciality dealing with acute injuries, congenital and acquired

	disorders and chronic arthritic or overuse conditions of the bones, joints and their associated soft tissues, including ligaments, nerves and muscles.
Perioperative	The perioperative phase (also referred to as the intraoperative phase), involves the surgery itself. It starts when the patient is wheeled into the operating theatre and ends when the patient is transferred to the post anaesthetic care unit (PACU).
Postoperative	The postoperative phase is the period immediately following surgery. This period is typically recognised as the time spent in the post anaesthetic care unit (PACU) until discharge home or back to the ward area.
Preoperative	The preoperative phase begins when the patient is admitted for surgery and ends when the patient enters the operating department for surgery.
Recovery	The recovery room (also known as the Post Anaesthetic Care Unit or PACU) is the area within the operating department where patients are taken immediately following their surgery. Patients in this area typically have 1:1 care until they are considered to have sufficiently recovered from their surgery to be discharged to the ward.
Regional anaesthesia	The injection of local anaesthetic near a cluster of nerves to numb only the area of

	the body that requires surgery. For example, spinal and epidural blocks involve interrupting sensation from the legs or abdomen by injecting local anaesthetic medication in or near the spinal canal. Patients having a regional anaesthetic may remain awake or may be given a sedative. Other regional anaesthetic blocks can be performed for surgery on the extremities, blocking sensations from the arm or leg.
Scrub Area	A room usually adjacent to but separate from the operating theatre where the surgical scrub takes place.
Sterile Field	A sterile field is an area kept free of microorganisms to protect the health and safety of a patient during a medical procedure, especially surgery. This area is aseptic; all items in the sterile field are sterilized and should not contain microorganisms.
WHO Surgical Safety Checklist	A simple tool designed to improve communication and teamwork by bringing together the surgeons, anaesthesia providers and theatre team involved in the patient's care to confirm that critical safety measures are performed before, during and after an operation.

ACRONYMS AND ABBREVIATIONS

American Society of Anaesthesiologists	ASA
College of Operating Department Practitioners	CODP
Department of Health	DH
Enhanced Recovery After Surgery	ERAS
Friends and Family Test	FFT
General Data Protection Regulation	GDPR
General Medical Council	GMC
General Practitioner	GP
Health and Care Professions Council	HCPC
National Health Service	NHS
Nursing and Midwifery Council	NMC
Office for National Statistics	ONS
Operating Department Practitioner	ODP
Oxford English Dictionary	OED
Patient Advice and Liaison Service	PALS
Patient Experience Team	PET
Post Anaesthetic Care Unit	PACU
Royal College of Physicians	RCP
Royal College of Surgeons	RCS
World Health Organisation	WHO

INTRODUCTION

The National Health Service (NHS) has traditionally operated on the basis of an established model of professional and social authority. Within this model, medical and other health professionals are expected to exercise judgement on behalf of the patient, drawing upon the expertise and knowledge of their profession. The principles of evidence based medicine and evidence based practice have formed the foundation of modern healthcare and the allocation of limited healthcare resources (Greenhalgh et al, 2014). However, as the life expectancy of the population increases, so too does the prevalence of patients presenting with multiple long term conditions (WHO, 2010). This results in the need for more complex choices between an increasing number of treatment and support options, so that evidence from single focus randomised controlled trials is becoming less definitive (Health Foundation, 2012). In this context, patients' goals and preferences need to be given greater weight, especially where the traditional evidence base has limited relevance to what the patient regards as important.

Throughout this thesis, I have referred to the 'patient' or 'patients' rather than alternatives such as service user, consumer or client to describe those persons undergoing medical or healthcare treatment. Although this term carries with it some connotations related to a medical model of healthcare, patient is a recognised term that relates to someone who is being attended to by a medical or other health professional. The General Medical Council (GMC, 2019) refers to people treated by a doctor as patients, the Nursing and Midwifery Council (NMC, 2018) refers to people, patients and service users, whereas the Health and Care Professions Council (HCPC, 2014) refers to service users. Deber et al (2005) found that consumer and customer were terms particularly disliked by people receiving healthcare or medical treatment, with patient being the preferred description. The use of service user has also been criticised as being a detached term not related specifically to healthcare, whereas client carries with it connotations of lawyers or prostitutes (Simmons et al, 2010).

Since the turn of the 21st century, a range of government initiatives have attempted to reconfigure the relationship between the patient and medical or other health professionals. Using the patient experience as a driver for improvement determined the approach to quality in the NHS Next Stage Review (DH, 2008) and was emphasised in the NHS Constitution (DH, 2009). Since the introduction of the Health Act in January 2010, healthcare commissioners and service providers have had a legal obligation to take the NHS constitution into account in every decision and action, which includes the need to focus on the patient experience (De Silva, 2013). The White Paper, 'Equity and Excellence: Liberating the NHS' (DH, 2010) suggested that further emphasis should be placed on improving patient experiences of healthcare and the NHS Outcomes Framework (domain 4) makes clear the provision of a 'good experience' of care for patients is a central goal for the NHS:

> *"NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from 'real time' data techniques"* (DH, 2011 pp.17-18).

By recognising the patient experience as one of the three pillars of quality in healthcare; alongside clinical effectiveness and patient safety (Institute of Medicine, 2001), the aim is for patients to be enabled to challenge the expertise and authority of medical professionals (Coulter and Collins, 2011). Data relating to the patient experience is therefore justified in that it highlights strengths and weaknesses in safety and clinical effectiveness through a focus on improving the patient experience, which in turn contributes to improvements in the other two domains (Berwick, 2009). However, the intrinsic value of the patient experience should also be recognised because humane, empathetic patient care is the minimum that patients should expect (Doyle et al, 2013).

The principle of 'no decision about me without me' (DH, 2010 p.3) was introduced to give patients ownership of clinical decisions in a more equal therapeutic alliance with clinicians. Patient involvement in care decisions has been shown to improve satisfaction with services received, and increased knowledge and understanding of personal health status can also increase adherence to chosen treatments (LaVela, 2014). This approach is intended to empower individuals to make choices about their own healthcare, including whether to have diagnostic tests, and what type of treatment is most appropriate for them.

Although the terms 'patient experience' and 'patient satisfaction' are often used interchangeably in the NHS, these should not be treated as synonyms (Rockville, 2017). Experience is predominantly a cognitive assessment of what happened and how it happened, while satisfaction is how it made the patient feel (LaVela, 2014). In other words, patient experience depends upon whether something that should happen in a healthcare setting (such as clear communication with a provider) actually happened or how often it happened. Satisfaction relates to whether a patient's expectations about a healthcare encounter were met. Therefore, two patients receiving the exact same care, may give different satisfaction ratings simply because of differing expectations.

Orthopaedic surgical success has traditionally been measured either in terms of a lack of complications, or specific objective clinical parameters: such as range of motion, knee stability and radiographic results (Hamilton et al, 2013). These objective clinical outcomes do not necessarily contribute to a positive patient experience or correlate with postoperative physical function (Milner et al, 2003). Other routine outcome measures such as the Knee Society Clinical Rating System (Insall et al, 1989) and Harris Hip Score (Harris, 1969), are more subjective, as they are based on the surgeon's assessment but represent an initial move towards an holistic assessment of the patient rather than focussing exclusively on the implant. The drawback of these surgeon-based outcome measures is they begin with the assumption there is agreement between the views of patients and clinicians. This has been shown not to be an accurate reflection of the reality (Wylde et al, 2009). Significant differences have been found between doctors' and patients' perceptions, especially when related to subjective quality of life domains such as emotions and social functioning (Janse et al, 2004). This discrepancy between patient and surgeon perceptions could reflect the differing priorities of the two groups. Surgeons may judge the success of surgery on joint alignment and stability, whereas patients may evaluate outcome in terms of vitality and ability to return to valued leisure activities.

In 2012 the then Prime Minister (David Cameron) announced the introduction of the 'Friends and Family' test (FFT) by the Department of Health. This was a simple assessment of the patient's experience by way of one question:

> *"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"*

From 2013 onwards, patients have been asked to provide this feedback which is then made public in order to provide information about services and patient care based on population feedback (DH, 2012). However, this is a hypothetical question which assumes a choice but does not give an indication of the alternatives the patient should use as a comparison. Whether the patient would prefer to have no treatment, travel 50 miles to the next hospital or pay to undergo treatment privately is not made clear. The FFT supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. What is less clear is whether the patient is assessing nursing care, medical treatment, cleanliness of the hospital, quality of the food or a combination of these factors. Although the FFT offers timely, continuous and local-level data, the suitability of this to impact quality improvement has been questioned (Robert, 2018). Comparisons of Trusts and wards on the basis of the proportion of respondents answering they would be 'likely' or 'extremely likely' to recommend the department/ward takes no account of differences between the Trusts/wards, the reasons for admission, or treatment outcomes. A ward providing treatment that has a high success rate or which results in a reduction of pain will score more highly than one dealing with more complex issues where the effect of treatment is not evident at the time of discharge; even if care standards are otherwise identical between the two wards. These issues relating to validity and representation make comparisons between time and location difficult, and it has been suggested the lack of qualitative detail with which to contextualize results, means the FFT is not fit for purpose (Marsh, 2019). Instead, it is argued the inclusion of 'softer' less quantitative data could serve a different purpose; disrupting assumptions rather than counting occurrences (Edwards et al, 2015). From April 2020, the FFT question will be changed to:

> *"Overall, how was your experience of our service?"*

It is intended that when combined with supplementary follow-up questions, the new FFT will provide a more reliable mechanism to highlight both good and poor patient experience which can subsequently be utilised for quality improvement purposes.

Operating theatre environment

The operating theatre is a unique environment, which is both highly specialised and technological. There is a need for perioperative staff within the operating theatre to combine patient care with technological ability while retaining the centrality of the patient to this work (Bull and Fitzgerald, 2006). For the patient the operating theatre is an alien environment, as although their surgical procedure will have been explained to them, the nature of the activities that make up this work remain unknown. In contrast, practitioners are well versed in the technologically driven perioperative routines of care that make up this work. This may focus attention away from patients, resulting in a degree of dehumanization, stress, fear, and ambivalence (Kleinman, 1988; Barnard and Sandelowski, 2001).

During the perioperative period, patients have distinct requirements that need specialized care. Scheduled surgery is essentially a planned trauma that affects the whole person, during which time the individual depends entirely upon others. Issues of identity and agency are significant when considering patients' experiences of the operating theatre. For many patients, the thought of being conscious during this time when bodily control is lost and sensations are altered is both frightening and stressful. Since agency is a human capacity and process to act and make choices (Hardin, 2001), it has the tendency to shift along a continuum during illness. When individuals do not or are unable to fully enact agency during the course of illness, the way they define and understand themselves shifts. Perioperative staff caring for the patient during surgery normally adopt a medical or scientific perspective towards the patient's body, whereas patients view this experience from a lived perspective. For staff, the extraordinariness of medical technology becomes ordinary and familiar in ways that may deter practitioners from recognizing that patients are undergoing an unfamiliar, traumatic, and life altering event (Lapum et al, 2010).

Enhanced recovery after surgery

The concept of enhanced recovery after surgery (ERAS) was first described by Kehlet (1997). The idea behind ERAS was to introduce a series of preoperative, perioperative and postoperative interventions such as the use of regional anaesthesia, preoperative carbohydrate loading, early mobility, and early oral nutrition to reduce postoperative physical and psychological stress, thereby accelerating postoperative recovery (Nicholson et al, 2014; Carli, 2015). Early studies conducted in colorectal surgery indicated such a multimodal approach could provide effective pain relief and facilitate early patient mobilization so that hospital stay was reduced from eight days to two days without any reported nausea, vomiting, or ileus (Bardram, 1995). The introduction of ERAS programmes in patients undergoing total knee arthroplasty have been shown to significantly reduce perioperative morbidity and mortality (McDonald et al, 2016). However, multiple aspects of perioperative care are altered in the implementation of these programmes and not every ERAS programme implements the same interventions, making it difficult to ascertain which components of the programme are most important in achieving optimal outcomes.

Benefits of local or regional anaesthesia

Much of the population faces a surgical experience at some point in their life, and as all western countries are experiencing growth in the number and proportion of older persons in their populations (ONS, 2018) this is likely to have a direct impact on the future of anaesthesia and surgical care. The type of anaesthetic used for many orthopaedic surgical procedures, including hip and knee arthroplasty, open reduction and internal fixation of hip fractures and more minor surgery such as carpal tunnel decompression now involves a local or regional rather than general anaesthetic. This anaesthetic technique is advocated as a part of the ERAS programme and has been associated with early mobility (McDonald et al, 2016) and early discharge (Frassanito et al, 2020). The main difference between the two techniques is that with a general anaesthetic the patient is rendered unconscious, whereas with a regional anaesthetic the patient is conscious but the area being operated on is made numb through the use of a local anaesthetic agent. Regional anaesthesia can be divided into two types: central anaesthesia which involves injecting local anaesthetic around the spinal cord either in the sub arachnoid space (spinal) or the potential space outside the dura (epidural), and peripheral nerve blocks which involve injecting local anaesthetic around the various nerve plexus (groups of interconnected nerve fibres that connect the nerves of the spinal cord with the peripheral areas of the body). Many anaesthetists regard regional anaesthesia as the most efficacious anaesthetic technique for numerous procedures, especially for those elderly orthopaedic patients that have pre-existing comorbidities such as hypertension, ischaemic heart disease, chronic obstructive pulmonary disease or renal impairment. As the prevalence of people living with comorbidities increases with age, it is anticipated that an increasing number of patients with comorbidities will present for orthopaedic procedures such as hip or knee arthroplasty (Podmore et al, 2018). The relative safety of regional anaesthesia means that many orthopaedic patients who would previously have been denied an operation, because of the dangers associated with a general anaesthetic in the presence of these comorbidities, are now able to have surgery.

Other benefits that have been associated with regional anaesthesia include shorter hospital stays and more effective use of hospital beds (Bergman et al, 2012). A meta-analysis of randomized controlled trials also suggested that regional anaesthesia is associated with both a reduced initial mortality rate and lower incidence of deep vein thrombosis in comparison with general anaesthesia in hip fracture patients (Urwin et al, 2000). However, this represents only one part of a complex perioperative experience and in order to assess patient outcomes fully, it is necessary to look beyond the traditional outcome measures of morbidity and mortality and to recognize that measures of patient experience are equally important indicators of outcome quality.

Few studies address patient satisfaction in relation to joint arthroplasty. Those that do, describe the majority of patients as being satisfied with surgical outcome even though consistent reports of 10 to 20% dissatisfaction with joint arthroplasty persist (Baker et al, 2007). Various factors have been suggested as influencing patient satisfaction with arthroplasty, including postoperative pain or joint stiffness (Hamilton et al, 2013). However, some patients report poor clinical outcomes in relation to pain and function but report good levels of satisfaction with their surgical outcomes and vice versa (Hu et al, 2019). Furthermore, various factors such as meeting patient expectations, staff politeness, the surgeon's communication skills and surgical waiting times have all been suggested as influencing overall patient satisfaction (Mira et al, 2009).

Impetus for the study

My interest in conducting this study stems from a desire to develop an understanding of how the patient's experience of regional anaesthesia and surgery can be better understood in the perioperative context. The patient's experience of being conscious during local or regional anaesthesia and surgery has not been examined adequately and remains a little understood area of clinical practice. This knowledge will help to address the challenge to not just perform routine based perioperative care, but to acknowledge every patient's individuality and the uniqueness of their surgical experience. The reasons for undertaking this study stem from my personal experiences of working as an operating department practitioner (ODP) in the perioperative environment and of educating others to work in that environment. As the operating theatre has historically been linked with the unconscious patient, the perioperative practices associated with the conscious patient have remained under scrutinised. Orthopaedic surgery is increasingly being conducted with a regional anaesthetic (Chit Ying et al, 2001) and so I felt there was a need to understand the context of the lived experience of orthopaedic patients remaining conscious in the operating theatre. In addition, an understanding of this experience may identify the skills, attitudes and behaviours that staff need to ensure the patients perioperative experience is a positive one. In short, more knowledge and a clearer understanding of how people experience orthopaedic surgery whilst conscious with a regional anaesthetic may therefore lead to being able to offer improved perioperative care to these patients.

Aim and purpose of the thesis

The aim of this thesis is to understand the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. Through such an understanding the nature of the relationship between the conscious patient and the rest of the perioperative team can be established and the most important factors that influence the perioperative experience of this patient group clarified. Therefore, the purpose of the thesis is to reposition the patient at the centre of the surgical process and as the focus of the work of the operating theatre. In order to provide an understanding of the patient's experience of remaining conscious in the operating theatre while undergoing knee surgery with a local or regional anaesthetic, I posit the patient as not just a passive recipient, but an active participant in the surgical process.

Research questions

The research questions arose from my experience as an ODP, which led me to wonder about the nature of the relationship between the conscious patient in the operating theatre and the rest of the perioperative team.

1. How do patients undergoing knee surgery with regional anaesthesia make sense of their place in the perioperative environment?
2. What strategies do patients utilise to influence their experience of having surgery with regional anaesthesia?
3. What strategies do perioperative staff utilise to influence the patients experience of having surgery with regional anaesthesia?
4. To what extent can ethnography aid an understanding of the diverse experience of a patient undergoing regional anaesthesia and surgery in a perioperative setting?

Overview of the methodology

This research project sought to gain an understanding of the patient experience of undergoing surgery with regional anaesthesia through a qualitative ethnographic research design. Qualitative research is particularly appropriate when little is known about a topic, as the researcher begins with no preconceived ideas (Stern, 1994). Patients scheduled for a total knee arthroplasty or knee arthroscopy were selected because of the planned regional anaesthetic. The prevalence of regional anaesthesia as the technique of choice for this type of surgery is increasing and has been further encouraged through the development of several healthcare policies both in the UK and abroad (Memtsoudis et al, 2019). These orthopaedic surgeries provided an opportunity to study awake patients in the operating theatre during surgical procedures which ranged between 20 minutes for an arthroscopy and up to 1 or 1.5 hours for a total knee arthroplasty. In order to gain an understanding of the social context in which this experience took place, an ethnographic approach was adopted which followed preoperative, perioperative, and postoperative perspectives to gather information from a variety of sources before, during and after surgery. The aim of the ethnography was to understand the patient experience within the social context in which it occurs. Repeated observations, conversations, and in-depth interviews have enabled the views of patients and perioperative staff to be gathered to facilitate an understanding of the behaviour and relationships that are enacted in the context of everyday life in an operating department setting. As there are numerous perceptions of the relationship between the conscious patient and the rest of the perioperative team during regional anaesthesia and surgery, it is in understanding the multiplicity of these viewpoints and their interactions that allows for a holistic understanding of the patient experience. A more detailed discussion of the methodology is provided in chapter 2.

In summary, the inclusion of patient experience as a central theme in healthcare policy in the United Kingdom is an ongoing trend in healthcare policy and practice which aims to encourage patients to participate actively in their care, treatment and the services they use (DH, 1989; 2003; 2006; 2008; 2009; 2010; 2012a; 2012b; 2015). The development of this theme has ensured that patient experience is now placed firmly at the centre of the healthcare agenda in an attempt to develop a therapeutic alliance between the patient and medical or other health professionals. The potential benefits from the use of a regional anaesthetic technique both in the perioperative period and its potential to influence postoperative outcome measures is of increasing interest to both clinicians and healthcare providers alike. However, limited information currently exists on how the patient views themselves or their participation in this crucial perioperative period.

Structure of the thesis

The thesis is presented in seven chapters:

Chapter one – Contextualising the study and literature review

This chapter provides an overview of the theoretical background of the study. Beginning with an examination of Bourdieu's theory of practice, the concepts of habitus, field and capital are introduced in relation to the patient in the operating theatre (1.1). How these relate to Foucault's social construction of reality and the role of power in maintaining the culture of the operating theatre are then discussed (1.2). Drawing upon Goffman's concepts of the 'total institution' and 'presentation of the self in everyday life', the creation and maintenance of 'front' and 'back' stage areas are then considered in relation to the patient in the operating theatre setting (1.3). Ethnographic studies that have been carried out in healthcare settings and in particular those conducted within the operating theatre are discussed in order to provide context for this study (1.4). Finally, literature relating to the sociology of the body, especially as it is related to health and illness is examined to demonstrate a gap in the understanding of what meaning patients attribute to their perioperative experiences (1.5).

Chapter two – Methodology

This chapter provides details of the methodology and methods used to address the research questions. To begin with, an overview of the assumptions made about what constitutes knowledge of the reality being studied and the appropriate methods for building knowledge of this reality are given in relation to the paradigms that dominate within surgery (2.7). This leads to an examination of the constructivist ontology and interpretivist epistemology of the study which contrasts with the positivist approaches more commonly applied in this setting. The production of thick description (Geertz, 1973) through observation and ethnographic interview and its concomitant interpretation have been the central tenets of this study. This is discussed in relation to the use of grounded theory as a means of raising description to abstract categories and theoretical interpretation (Corbin and Strauss, 2015) to generate theory from research 'grounded' in data. The ethnographic mosaic (Palmer 1928, Blackman 2010) approach of the study is considered in relation to the Chicago School of Ethnography and in particular the use of participant observation, as this determined the type of questions asked, the way the research was conducted, the type of data collected and the nature of the findings. The Research Methods are presented as the research strategies used in the study. The pre – peri – post operative approach to data collection is justified and the setting, recruitment of participants, issues of access and process of data analysis are described (2.1) and finally, ethical considerations are addressed (2.5).

Chapter three – Trust

This chapter examines trust as a theme identified through an analysis of the data. The discussion begins with an examination of what is meant by trust and the part trust plays in relationships within a modern western society. The difference between trust and faith is explored, which leads to a consideration of the concept of faith and what this means for participants in the study setting (3.1). The patients use of faith as a strategy for dealing with limited agency in the perioperative setting and to address uncertainties regarding the possible outcomes of surgery is discussed. The extent to which patients are happy to place their trust in the various agents involved in their care, such as the institution (3.2), professions (3.3) and individual practitioners (3.4), is considered. Given the uneven power dynamic and asymmetric distribution of knowledge in the patient/doctor relationship, the need for the doctor to trust the patient is also discussed in relation to the opposing views from which the doctor and patient approach the medical encounter (3.5 and 3.6).

Chapter four – Distribution and currency of capital in the operating theatre

The second theme discussed following an analysis of the data is capital. This chapter draws upon the work of Bourdieu and specifically his concepts of social and cultural capital with particular reference to how these forms of capital can be applied by both staff and patients in the medical setting (4.1). My role as ethnographer in the setting is also discussed here in so far as it led to a reflection on the capital that was available to me at various points in the field work and how this influenced and was influenced by relationships in the field (4.2).

Chapter five – Embodiment and disembodiment in the operating theatre

This chapter examines how patients make sense of their embodiment in the operating theatre with a partially anaesthetised body during what Goffman (1961) refers to as the ‘repair cycle’ (5.9). By drawing on Leder’s (1990) principle of *dys*-appearance; where the body appears in focus but in a *dys* state (generally during periods of pain or physical discomfort), the term *dystance* is introduced to explain the abnormal feeling experienced by patients who have a local or regional anaesthetic. The concept of dystance is used to reflect how the feeling of an abnormal apartness from the body is experienced and considered by the patient. How a dystanced body leads to the surgical team assuming agency for the anaesthetised part of the patient's body is discussed along with how patients use such dystancing to come to terms with their perioperative experience (5.4). Finally, the need for staff to maintain a backstage area (Goffman, 1961) in the perioperative environment and the effect seeing behind the scenes can have on the patient perspective is considered (5.8).

Chapter six – The clinical gaze

This chapter examines Foucault's concept of the clinical gaze (1976) and the implications of this for current surgical practice. The development of the clinical gaze in the course of medicine and healthcare is discussed in relation to patients becoming framed as 'objects of knowledge', the evolution of the medical record and the effect of this on the objectivity and subjectivity of the patient during their perioperative journey (6.1 and 6.2). The multiplicity of clinical gazes created through the use of modern technologies in contemporary clinical practice is considered in relation to patient consultations and the surgical experience of participants in the study (6.3). Strategies patients use to come to terms with viewing themselves in a biomedical setting and the approaches employed by both patients and medical staff during this time in the distribution and maintenance of patient agency during the surgical experience are examined (6.4 and 6.5).

Chapter seven – Conclusion and Recommendations

The concluding chapter evaluates the main findings of the PhD study. The empirical evidence is discussed and concluded in three broad areas: the awake patient in the operating theatre (7.1), patient strategies (7.2) and staff strategies (7.3). Each section aims to provide sound conclusions based on the empirical evidence derived from the research. The value of ethnography as a research methodology is discussed (7.4) highlighting how it may facilitate future research in the operating theatre and contribute to an understanding of the patient experience. The conclusions in this final chapter provide an original view of the patient's experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. This contributes to existing knowledge with an aim of clarifying the most important factors that influence the perioperative experience of this patient group.

CHAPTER ONE: CONTEXTUALISING THE STUDY AND LITERATURE REVIEW

1.0 Patient experience

The purpose of this literature review is to critically examine the context from which my ethnographic study emerged. In order to establish the extent of previous research, to provide a background and to develop an argument for the necessity of the study, literature was sought which focused on knowledge about the experience of patients within the operating theatre. Previous research has focused primarily on patients' experiences during general anaesthesia or on particular aspects of the patient experience of undergoing surgery such as anxiety (Susleck et al, 2007), information provision (Mitchell, 2008) or nursing care (Karlsson et al, 2012a). Relatively few studies have examined the nature of the patient's perioperative experience (Jensen et al, 2004; Jlala et al, 2010; Fredrickson et al, 2012; Karlsson et al, 2012b). Some studies have targeted clinically distinct patient groups or discrete aspects of patient satisfaction within the context of regional anaesthesia and surgery (McCarthy et al, 2004; Capuzzo et al, 2005; Schoenfelder et al, 2011). However, these studies are limited by their narrow focus. Most have also drawn on positivist quantitative epistemologies and data derived from self-completed fixed choice questionnaires which lack flexibility and provide limited context to the responses. Little evidence exists related to how patients that are having surgery with a regional anaesthetic feel about their perioperative experience or how they view themselves or their participation in this crucial surgical period.

The few studies that have examined the patients' perspective of the perioperative experience have used a phenomenological approach and have consistently identified 'control' as an emergent theme (Mauleon et al, 2007; Susleck et al, 2007; Bergman et al, 2012; Karlsson et al, 2012a). However, the context in which this theme is emergent in each study differs from control of pain (Mauleon et al, 2007; Bergman et al, 2012) to control of the body (Bergman et al, 2012; Karlsson et al, 2012a) and control of time (Mauleon et al, 2007; Susleck et al, 2007). During the perioperative experience, the patient's autonomy needs to be maintained as much as possible and this centres on the patients' ability to choose, decide and take responsibility for him or herself. It has previously been noted that patients who are listened to, treated respectfully, and shown concern, feel more secure because they feel they are able to retain a sense of control and play an active role in shaping their situation (Karlsson et al, 2012a).

The need to care for an increasing number of conscious patients having surgery with a regional rather than general anaesthetic is leading to a change in the nature of patient care in the perioperative environment. Whereas anaesthetists once assumed full responsibility for patients during anaesthesia, the increase in the use of regional anaesthesia means that support for the conscious patient is becoming a major responsibility for other perioperative staff such as nurses and ODPs. Literature providing an explanation of the theoretical background of key concepts utilised within the study will be discussed first. Next, ethnographies conducted within a medical setting and in particular a perioperative environment will be considered to establish the contextual background and tradition to which the current study belongs. Finally, there will be an examination of literature that discusses embodiment and the body in relation to social theory.

1.1 Bourdieu

Bourdieu's theory of practice (1977, 1988, 1990, 1991, 1998) utilises the terms Habitus, Field and Capital to make up the three central concepts necessary for the analysis of culture. Bourdieu's theory of practice attempts to overcome the opposition between objectivist and subjectivist interpretations of the social world. The suggestion here is that objectivism often uses subjective observations and understandings that are not made explicit; whereas subjectivism often neglects to take account of objective structures and social conditions that contribute to subjective decision making (Rhynas, 2005 p.181).

1.1.1 Habitus

In order to overcome the incompatibility of objectivism and subjectivism, Bourdieu developed the concept of habitus to create a theory that represents the practices and experiences of a social group:

> *"These two moments the subjectivist and objectivist stand in dialectical relation. It is this dialectic of objectivity and subjectivity that the concept of the habitus is designed to capture and encapsulate"* (Bourdieu, 1988 p.782).

The habitus, which consists of embodied dispositions and thought patterns, overcomes the subjective – objective dichotomy by inscribing subjective, bodily actions with objective social force so that social meaning is attributed to even the most seemingly subjective individual acts (King, 2000). Habitus is used to explain how objective reality, as measured by the statistical chances of success, becomes internalised into a structure of dispositions and aspirations to provide an implicit sense of what could or could not be achieved (Calhoun, 1995). This in turn, generates a set of objectively determined practices which are experienced as free choices.

> *"The concept of habitus can be defined as a series of dispositions. It also designates a way of being or habitual state (especially of the body) and in particular, a predisposition, tendency, propensity or inclination"* (Bourdieu, 1977 p.214).

Habitus can be determined or influenced by social factors such as class because the collective historical experience has engendered a class ethos – a sense of the field of objective possibilities or limits to reasonably achievable ambition. Bourdieu quotes Durkheim to clarify this point:

> *"In each of us, in varying proportions is yesterday's man; it is yesterday's man who inevitably predominates in us, since the present amounts to little compared with the long past in the course of which we were formed and from which we result. Yet we do not sense this man of the past, because he is inveterate in us; he makes up the unconscious part of ourselves. Consequently we are led to take no account of him, any more than we take account of his legitimate demands"* (Durkheim, 1938 in Bourdieu, 1977 p.79).

Behind the concept of habitus lies the principle of a knowledge without consciousness; 'an intentionality without intention' and a practical mastery of the perceived world-order which allows anticipation of the future without even needing to imagine it as such. This view regards agents as neither totally free nor as mere puppets of objective social laws. Instead, individuals incorporate a practical sense of what can and cannot be achieved, based on intuitions gained through past collective experience, into their habitus to form a structure of dispositions which reflect the field of objective possibilities open to them at a particular historical moment.

Habitus is formed through the process of socialization at a young age and is essentially a set of intuitive, or doxic, dispositions that inform the way individuals behave in various contexts, and which remains relatively stable over time (Shilling, 2012). In the operating theatre, habitus structures everyday practices such as how medical or other healthcare professionals interact with each other or with patients and also how patients interact with medical and healthcare professionals. Medical staff (in particular the consultants) are the dominant personnel within this environment and so are able to determine how things are said and done in the operating theatre. This control or 'discipline' (Weber, 1947) has developed over many years. Bourdieu argues that when a habitus or way of being becomes so entrenched and correspondingly the ways of reading and interpreting what is going on are so solidified that it is beyond question or reflection, it becomes a doxa. Doxa refers to the prevailing orthodoxies or modes of thinking that lead to accepted solutions for an array of problems. Kuhn (1970) refers to these constructs as paradigms; which may in some instances solve problems, but in others act to prevent problem solving. Because problems are viewed through pre-established narratives, conditioning, classification systems and past experiences, problem solving is approached from behind conceptual and cultural clutter which has been socially accepted and normalised from childhood to the point it is taken for granted as a universal position or truth.

> *"Unlike scientific estimations, which are corrected after each experiment in accordance with rigorous rules of calculation, practical estimates give disproportionate weight to early experiences: the structures characteristic of a determinate type of conditions of experience, through the economic and social necessity which they bring to bear on the relatively autonomous universe of family relationships, or more precisely, through the mediation of the specifically familial manifestations of this external necessity (sexual division of labour, domestic morality, cares, strife, tastes etc.) produce the structures of the habitus which become in turn the basis of perception and appreciation of all subsequent experience"* (Bourdieu, 1977 p.78).

In short, doxa act as a set of blinkers which limit the way the world and its opportunities can be viewed and this in turn develops the habitus which determines choices made and actions taken.

1.1.2 Field

Individual agents do not act in isolation, but rather social life takes place within objective social settings governed by particular sets of social relations, to which Bourdieu refers with his concept of field. Fields are the social and institutional arenas in which individuals express and reproduce their dispositions and where they compete for the distribution of different kinds of capital (social, cultural, symbolic). Although fields are relatively autonomous from one another, they can always be regarded as the site of struggle between the dominant and dominated. By exercising their symbolic power within a field, certain groups are able to ensure the field is structured in such a way as to maintain their privileged position (Calhoun, 1995). However, the resources being competed for are not always economic or material. Rather, numerous different fields exist, and success within each of these fields results from the capital that an individual possesses. Consequently, individuals experience power differently depending upon which field they are in at that given moment, so context and environment are key influences on habitus.

Surgical habitus which embodies the guiding principles and values of surgeons, develops through years of supervised practice and cultivates the techniques and behaviour of surgery. Lave and Wenger (1991) describe this learning as an integral and inseparable part of social practice which leads to a legitimate peripheral participation in communities of practice. Learning, thinking and knowing are regarded as being formed through relations among individuals in activity in, with and arising from, the socially and culturally structured world. This view is essentially that of a situated learning activity which reflects how apprentices learn their trade and progress to 'full participant' status. However, patients do not have this progression. The social world in which patients find themselves for the duration of their operation is within this community, but without progressing through the necessary stages, full membership is unobtainable. Instead, patients remain outsiders who are not afforded the privileges associated with being a full member of the community of practice in this particular field.

1.1.3 Capital

Capital, as Bourdieu uses the term, refers to specific qualities that an individual possesses which enable success to be ensured within a given field. Those in possession of the greatest amount of capital are by virtue of this fact dominant within the field in which that capital is valuable and are able to structure the field in such a way which serves to reinforce their dominance. Bourdieu identifies three fundamental forms of capital which depend upon the field in which they function. Under certain circumstances each form can be acquired, exchanged, and converted into other forms. Because the structure and distribution of capital represents the inherent structure of the social world, an understanding of the multiple forms of capital helps to explain the organisation and functioning of the social world. The notion of capital is expanded beyond the economic conception of direct monetary value for Bourdieu, to include ‘immaterial’ and ‘non-economic’ forms of capital: specifically cultural and symbolic capital. Cultural capital is the cultural knowledge that serves as the currency that enables an individual to navigate a culture and alters the experiences and opportunities available.

Cultural capital may be institutionalised through academic qualifications, which:

> *“are to cultural capital what money is to economic capital. By giving the same value to all holders of the same certificate, so that any one of them can take the place of any other, the educational system minimises the obstacles to the free circulation of cultural capital which result from its being incorporated in individual persons”* (Bourdieu, 1977 p.187).

Three forms of cultural capital have been identified, each of which may be exchanged for economic capital under certain conditions. When social fields bestow value directly upon a specific bodily form, activity or performance, they are effectively creating a category of embodied capital. This embodied capital takes the form of long lasting dispositions in the mind and body which become a part of the person’s habitus. Although embodied capital can be increased by investing time into self-improvement in the form of learning, as this becomes integrated into the individual and forms a part of the habitus it cannot easily be transferred.

The objectified state of cultural capital takes the form of cultural goods such as pictures, books, dictionaries, instruments or machines, which can be appropriated materially through economic capital but also symbolically via embodied capital. Objectified cultural capital refers to the owned material objects which might relate to educational pursuits (books and computers), jobs (tools and equipment), clothing, accessories and even the type of food which is purchased and prepared (Bourdieu, 1984). These objectified forms of capital signal to others what kind of (and how much) cultural capital is possessed, which in turn contributes to the continued acquisition of it and also acts to indicate class. Cultural capital can also be seen to exist in an institutionalized state; academic qualifications and degrees which create a:

> *"certificate of cultural competence which confers on its holder a conventional, constant, legally guaranteed value with respect to power"* (p.248)

are prime examples of this, along with job titles, religious titles, political offices, and other social roles like husband, wife, mother and father.

Finally, Bourdieu identifies social capital, which he defines as:

> *"the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition"* (p.248).

Through membership of a particular group, with the sharing of a surname, class, tribe, school or party, members are afforded the backing of collectively owned capital. The amount of social capital is reliant upon the size of the network and the amount of capital (economic, social or cultural) possessed by each of the individual connections or the whole network of connections. An individual's social capital is determined by the size of their relationship network, the sum of its cumulated resources (both cultural and economic), and how successfully (quickly) the individual can activate these. These social networks must, according to Bourdieu, be continuously maintained and fostered over time in order for them to be called upon quickly in the future. Within the operating theatre, the patient has limited opportunity to activate their social network, whereas for medical and theatre staff, social capital may be a combination of individual interpersonal relationships and formalised through trauma networks or other interdisciplinary alliances (Loss et al, 2018).

All types of capital can be derived from economic capital through varying efforts of transformation. However, while cultural and social capital are fundamentally rooted in economic capital, these can never be completely reduced to an economic form. Instead, Bourdieu stresses that social and cultural capital remain effective because they conceal their relationship to economic capital.

The currency of capital relates to currency in both senses of the word. As well as representing value or worth, capital needs to be current in order to retain its value. It is not the immediate value of the metal or paper making the coin or note that provides value, but the usefulness or ability to exchange this currency for goods or services. No form of capital is universally regarded in terms of value. The traveller who tries to spend Sterling in New York will find this currency is not accepted, whereas in London it is valued and desirable. Similarly, knowledge is only reflected in status as long as that knowledge is current and regarded as valuable in a specific set of circumstances. The mechanic is the bearer of cultural capital through his knowledge of how to fix a broken-down vehicle, which to the stranded motorist is a valuable commodity. However, this knowledge is less valuable to a surgeon about to perform a knee replacement on the mechanic than it is to the surgeon who has broken-down and is stranded at the side of the road. Similarly, a surgeon's knowledge of how to perform a knee replacement is worth less to the mechanic who has been called upon to fix the vehicle than it is to the mechanic about to have a knee replacement. In this example, the currency of capital must be such that it is accepted as valuable within a particular set of circumstances.

Accepted forms of capital also change over time so that what is regarded as valuable does not remain static. Although Francs were once the currency of France, they no longer have value; having been replaced by the Euro. Equally, the value of embodied capital may change over time as demand for certain forms of skilled labour declines or as changes in fashion affect the value attributed to specific physical forms of talk, dress and deportment (Wacquant, 1995). Therefore, production of a valued bodily form among a group or class does not guarantee its continued value. As fields within society change so may the forms of capital they reward. As one form of cultural capital is lost, other types of capital can be gained to compensate. Age may be associated with a loss of embodied cultural capital, but this is often compensated for through an increase in economic capital or extended social connections and social capital. In short, capital needs to have currency in that it needs to be accepted as valuable in the here and now. Further discussion of the distribution and utilisation of capital in relation to this study can be found in chapter four.

1.2 Foucault

Bourdieu regards power as being created and re-legitimised through an interplay of agency and structure (Shilling, 2012), whereas Foucault sees power as ubiquitous and beyond agency or structure. Context and environment are seen as key influences on Bourdieu's concept of habitus, in that the social or institutional arena (field) individuals are in at any given moment results in an alteration of how power is experienced and it is the doxic interrelationship between field, habitus and capital that gives rise to social action. However, Foucault (1982) argued that power and knowledge are inseparable. Power is manifested in established structures, cultural belief systems, practices and sources of knowledge. In other words, power goes beyond the capacity of individuals into social structures and institutions. Foucault (1984) further argues that reality is socially constructed through multiple dominant discourses informed by science, laws, policy, practices, codes of behaviour and education. For Foucault, knowledge provides an instrument those in power can wield for their own ends (Hacking, 2002). In the operating theatre the dominant discourses of technology, medicine, skill and competency are communicated and sustained through its culture. Capital in this field comes in the form of competence and expertise, with the value of a member's contribution to the team measured by the amount of knowledge and competence they possess, with power distributed accordingly.

The patient in the operating theatre is an embodied corporeal being subjected to the processes of power relations (Smart, 1995). Thus an embodied patient is both an object of knowledge and a target for the exercise of power (Rabinow, 1984), open to inescapable influence and transformation by other forces which affects their ability to act in certain ways (Patton, 1989). These subtle coercions of the body exist within a political field with associated power relations which ensure the patient acts in ways:

> *"totally imprinted by history"* (Foucault, 1984 p.83).

Patients do not have emancipatory knowledge as there is a lack of power, position and awareness of the social/power systems within the operating theatre. Consequently, patients act as they are directed, in ways dictated to them. The relationship between power and knowledge can be regarded as one of mutual dependency (Kendall and Wickham, 1999). Knowledge can direct or control power, but whereas power can be exercised without knowledge, knowledge cannot be integrated without the power to do so. Power is therefore a series of relations between forces, not something wielded by masters, but an attribute of forces, each of which has the capacity for resistance to affect and be affected by other forces. Power should not be regarded as essentially repressive, as it is not something that is possessed, but something that is exercised. Resistance to power is therefore seen by Foucault as a part of the exercise of power.

Within the operating theatre, relations of power, knowledge and the body are focused on the technologies of power and their interrelationships with the emergence of knowledge which has the individual as the object of scrutiny. For Foucault, the reorganisation of medicine resulting in the ‘birth of the clinic’ led to the development of the clinical gaze and

> *“the myth of a nationalized medical profession, organized like the clergy, and invested, at the level of man’s bodily health, with powers similar to those exercised by the clergy over men’s souls”* (Foucault, 1976 p.31).

The argument being that the birth of the clinic constitutes an expansion of medical power, as the clinical gaze is directed not only towards the patient’s body but also towards the patient as a social being. Further discussion of the clinical gaze, in relation to this ethnography and the implications for current surgical practice can be found in chapter six.

1.3 Goffman

For Goffman the body is not produced by social forces, as it is for Foucault. Rather, the meanings are determined by shared vocabularies of body idiom which are not under the immediate control of individuals. Body Idiom can be regarded as a conventionalised form of non-verbal communication which constitutes aspects such as dress, bearing, sound level and physical gestures (Shilling, 2012). The shared vocabularies of body idiom allow people to be categorised and graded hierarchically according to the information displayed. Consequently, these classifications exert an influence over the ways individuals seek to manage and present their bodies.

1.3.1 Presentation of the self

Goffman (1959) distinguishes between social spaces in which aspects of a particular performance are in progress. The ‘front’ region is the area where the activity occurs in the presence of other people: an ‘audience’. Here some aspects of the activity are emphasised while others, that may discredit the fostered impression of the activity, are suppressed. A backstage area is a region in which the illusions and impressions of a performance are produced and constructed, but also where the impression fostered by the performance is actively contradicted as a matter of course. Examples of this include restaurants, where the kitchen is physically separated from the seating area and the customer is not party to the process of preparing the meal; and backstage in a theatre, where the special effects are manufactured and actors are routinely out of character. Although the majority of backstage areas are spatial and physically separated from the front region, the backstage area can also be temporal, such as when the audience has yet to arrive and the stage is used for rehearsal. Goffman's distinction for the temporal change in stages generally rests upon the physical presence or absence of the audience. Within the operating theatre the patient may be both simultaneously present and absent through the use of anaesthesia. The complexity of this position highlights a limitation of Goffman's regions metaphor in explaining the organisation of work in settings involving local, regional and general anaesthesia (Hindmarsh and Pilnick, 2002). Furthermore, the use of regional anaesthesia particularly reveals the importance of analysing the embodied conduct of practices and skills associated within perioperative teamworking, when examining the organisational activities of the operating theatre.

1.3.2 Total institutions

In the process of being admitted for surgery, patients are admitted to what Goffman (1961) describes as 'a total institution'. A central feature of a total institution is the breakdown of barriers that ordinarily separate sleep, work, and play. While the degree to which this applies to any individual varies according to the type of surgery, length of stay, and postoperative care requirements, all aspects of life are conducted in the same place and under the same authority. In order to be admitted into the institution and be officially designated the role of patient, the individual undergoes a rite of passage involving procedures such as: history taking, weighing, assigning a number, storing personal possessions, changing into a hospital gown and being allocated a bed. This is not experienced by other groups within the institution such as staff or visitors and is the process Goffman (1961) refers to as 'leaving off' and 'taking on', with the midpoint characterized by physical nakedness. 'Leaving off' entails the dispossession of property which forms an important part of the process for the patient because individuals invest emotional capital in their possessions. Through the removal of possessions, individual social signifiers are detached and the cues that identify a person with a particular social group are removed. The most important of these may be one's own name, as being allocated a number and losing one's name can be seen as a curtailment of the self.

By the time a patient enters the operating department, any symbols of self have been removed and replaced by identifiers which are specified by the institution (gowns, name bands etc). This limits the ability of the patient to demonstrate their true self identity or convey additional social information about themselves. The result being the patient is regarded as belonging to that group which is patients, as opposed to the other groups that exist in this environment, such as theatre staff, anaesthetists, surgeons, managers, administrators and the like. By being seen as 'with' that group, individuals are assumed to have the social identity of that group.

Characteristically, in total institutions, the inmate is excluded from knowledge of the decisions taken regarding his or her fate. In the case of surgical patients, the decisions are presented to the patient but may be done in such a way as to present a 'fait accompli' with the decision making process being restricted from the patient to such a degree that they in fact have very little input into this process. The patient typically does not know the terms or alternative options that have not been explained, with the result that evidence is presented by clinical staff in such a way as to pre-determine the patient's choice about their treatment. Upon admission into the total institution, the inmate is stripped of the stable social arrangements relied upon in their home world. This raises the concern that emphasis is placed on the clinician – patient consultation which ignores the power imbalances that suppress the patients voice, the patient's ongoing self-management and the importance of the patients wider social networks.

1.4 The ethnographic tradition in the operating theatre

One of the earliest ethnographies to be carried out within a medical environment was Becker et al's (1961) 'Boys in White' study which focused on the development of medical students as they passed through medical school. Although conducted over half a century ago, this ethnography is discussed here in the context of being a major work that has given rise to ethnography being utilised as a valid methodology within medicine. These authors were interested in how the perspective of medical students changed during the process of undergoing medical training, because:

> *"Science and skill do not make a physician; one must also be initiated into the status of physician; to be accepted, one must have learned to play the part of physician in the drama*

> *of medicine. As in other dramas, learning the lines is not enough. One must learn what others expect of him and how they will react to his words and actions"* (p.4).

By utilising an ethnographic methodology, Becker et al were introducing a qualitative approach into the positivistic world of medicine which was (and to some extent, still is) more comfortable with the statistical evidence provided by quantitative methods. Even the stated aim of the study:

> *"The problem was to discover what medical school did to medical students other than giving them a technical education. It seemed reasonable to assume that students left medical school with a set of ideas about medicine and medical practice that differed from the ideas they entered with, ideas they could not have had in advance of the concrete foretaste of practice that medical school gave them"* (p.17).

is presented almost as a hypothesis which could be tested in a way akin to positivistic study designs.

In addition, Becker et al (1961) attempted to derive some quantitative analysis from their field observations. This was conducted under the guise of an attempt to check the validity of inferences concerning the existence of students' 'shared perspectives', and the content of these perspectives. Field-note items were enumerated in accordance with a number of criteria. A distinction between recorded 'statements' and 'activities' was made, activities were described as either 'group' or 'individual', and statements were recorded as being 'made to observer alone' or 'to others in everyday conversation'. Becker et al also differentiated between statements that were volunteered and those that were prompted, elicited or directed by the observer. Hence all the data bearing on a particular theme could be enumerated and classified according to these criteria.

This approach is of limited value, as the precise focus of observation and recording may change as the research develops. Such a shifting focus may be unintentional, but equally may be a deliberate part of the research strategy. During participant observation, the researcher is always forced to be selective in the events and activities that are attended and may therefore decide to concentrate on different aspects of the talk and action at different times. Since these changing periods of emphasis will not necessarily be for the same duration, the summation of records of events may be distorted by such shifting emphasis. Becker et al may have enumerated their data in this way in order to provide a statistical justification for an audience indoctrinated in a positivistic paradigm and therefore not familiar with a qualitative ethnographic approach such as the one used.

The major focus of explorations into the cultural aspects of the operating theatre have typically been concerned with the work of surgeons and to a lesser extent anaesthetists. The efforts of the nurses, ODPs and auxiliary staff who work alongside surgeons and anaesthetists to make up the perioperative team are either not mentioned or are seen as peripheral to and supporting the work of surgeons or anaesthetists. In terms of providing substantial evidence regarding the cultural environment in relation to the patient's experience of the operating theatre, there is a paucity of literature. Much of the literature reviewed has also been written from a professional viewpoint which privileges this perspective and excludes those with little or no experience of the operating theatre. Although there have been several ethnographic studies examining the culture of the operating theatre, Fox (1992), Cassell (1991), Cassell (1997) and Moreira (2004) have all focused on the surgeon, while Hindmarsh and Pilnick (2002) and Goodwin (2009) concentrated on the anaesthetist or anaesthetic team. Other ethnographic works that have examined the patient experience have done so from the perspective of an embodied experience rather than the involvement of the patient in the culture of the medical environment (Young, 1997 and Prentice, 2013).

Fox (1992) regards the patient as an area of potential conflict between the dominant medical professionals in the operating theatre. The authority of the surgeon is examined as being afforded through the use of rituals. This view regards rituals as effecting status transition in their subjects, but also as validating the status of those who institute the rites. Just as weddings validate the authority of the religious order to define the social status between a couple, rituals of surgery, such as the maintenance of asepsis, validate the authority of the surgeon to move a patient from a dangerous social state of illness to the safe state of one who has been healed. During this process:

> *"The rhetoric of anaesthesia constitutes the surgical patient as a subject in a way that no other healing speciality, including surgery itself, can, and assists in supplying surgery with its authority to heal"* (Fox, 1992 p.46).

The relationship between the surgeon and anaesthetist is described as a 'highly stylised courtesy' which demonstrates different but equally legitimate rights over the patient who is treated as an object. Fox concludes that these two medical professions hold differing though equally legitimate definitions of the patient. The surgeon is interested in the illness of the patient, because the operation signifies a desirable decrease in the illness of the patient. However, the anaesthetist is interested in the fitness of the patient, because the operation signifies an undesirable decrease in the fitness of the patient. These oppositional views can be seen to derive from the relationship each has with the patient.

What Fox fails to recognise is that the realms of authority are not exchanged (as he suggests) when the anaesthetist notes a deterioration in the patient's fitness. Authority is not assumed by the anaesthetist directly, but is given to the surgeon to take action. This is despite the anaesthetist being able to diagnose the problem and with it the necessary course of action. This negotiated authority is more akin to the teamwork seen in contemporary operating theatres, where the surgeon acknowledges anaesthetic concerns regarding the deteriorating patient and takes action. If the surgeon ignores the anaesthetic concerns, the anaesthetist does not intervene through direct action, but rather acts as a check against what may otherwise be a despotic surgical authority. If the surgeon fails to act to restore the patients compliment of fitness, the anaesthetist can either wait for further deterioration and try again or seek a second opinion from another (possibly more senior) surgeon.

Unlike patients that have been silenced through general anaesthesia, conscious human agents clearly have the potential to influence surgical discourse. Fox (1992) suggests the interactions between surgeons and awake patients can be understood in the context of a meeting of experts. The patient is an expert by means of ownership of the body and the surgeon is an expert through professional status. Surgeons are therefore not the only experts and to maintain their position of authority must deal with contrary definitions of how patients are categorised along with the extent of surgical success. Because of the insult it causes, simple definitions of surgical success are often not immediately available but depend instead upon socially accepted and shared perspectives on how success is to be judged. However, despite expertise being distributed among several parties, each with their own perspective, this relationship is not an equal one. Because surgery depends not only on the physiological process but also on a social process of the reclassification of a person into the category of being 'healed', the legitimacy of surgery brings with it the power to define how the outcome of these activities are judged; through measures such as five year survival rates. Fox (1992) concludes:

> *"the social meaning of surgery is that its power is constituted through rhetorics about healing. The problem with the rhetorics of surgery is not that they enhance surgery, but that in doing so they deny other possibilities"* (p.130).

Given the importance and centrality of the patient to the work of the operating theatre, it seems unfair that the patient voice is not heard and the ways patient rhetoric about healing differs from that of the surgeons is not fully considered.

Cassell undertook two ethnographic studies of surgeons in hospitals in the USA. The first, 'Expected Miracles' (1991) focuses on the surgeons, their performance in the operating theatre and their characteristics. In attempting to provide an objective account of the surgeons, Cassell provides context through participant observations and interviews with the surgeons themselves. However, the stated belief that successful surgery is a 'miracle' implicitly constitutes the surgeons as miracle workers and reveals a bias that once again places the surgeon at the centre of the process with everyone else (including the patient) as peripheral.

Cassell's second ethnographic study 'The woman in the surgeon's body' (1997) continues this trend with the surgeon placed at the centre of the surgical experience, albeit with a focus on the experiences of female surgeons. In this ethnography, Cassell found the lives of female surgeons to be more complex and less well supported than their male colleagues. Although more able to combine compassion with good surgical technique than the male surgeons, there was less recognition afforded to their abilities. What is clear from 'The woman in the surgeon's body' (1997) is that women surgeons face what Bourdieu (2001) calls a 'double bind' for women: if women behave like men, they risk their 'feminine' attributes and implicitly question men's power, if they behave like women, 'they appear incapable and unfit for the job' (2001 p.68). Powell and Sang (2015) have suggested that although women may hold female capital and cultural capital, this is not the same as, nor is it convertible to, male capital. Underlying this ethnography is a definite sense that Cassell has left some experiences of the female surgeons undiscussed. This may be an example of what Blackman (2007) terms 'hidden ethnography' where any emotional response on the part of the ethnographer is omitted so that an element of secrecy surrounds the fieldwork and accounts provided. There is certainly an undercurrent in this study of participants having experienced inappropriate and misogynistic behaviour which has not been explicitly discussed. In the context of the current #metoo movement, this implied element of the social experiences of female surgeons may yet come to the fore.

Beginning from the premise that surgery is a 'body contact sport' (Bosk, 1979 p.210), Cassell examines surgery as both uniquely physical and distinctively embodied. Through a focus on the bodies involved in surgery, in particular those of the surgeon and the patients, the emphasis is on the embodiment of the surgeon when the body of the surgeon is a woman and despite being a part of the physical interaction, the patient is regarded as a passive recipient:

> *"The surgeon makes brutal contact with the body of the patient, piercing the flesh, violating body integrity. The patient's body is irreversibly altered"* (p.31).

This is something of an oversimplification, as the patient is presented with available options and must actively consent to surgery before it can take place. While Cassell recognises the need to examine how embodied differences and similarities can be understood, embodiment here is discussed as the way in which an individual's body is inhabited and experienced and the way in which these surgeons' bodies incorporate and express social information. This is justified because

> *"A disembodied discussion of the social construction of difference ignores the depth, persistence and power of difference. To understand it we must explore the embodied nature of existence and identity"* (p.39).

Although this is discussed in the context of the experience of female surgeons, it is a point that applies equally to patients. Cassell's argument is that embodied knowledge is often perceived as biological; as a set of facts about indisputable body differences, even though body differences are not self-evident and may be endowed with numerous cultural meanings. Even gender does not exist in and of itself, instead it is produced during interaction and is therefore negotiated or constructed. This fits with Bourdieu's concept of habitus, which simultaneously shapes the body at the same time as being expressed by the body so that social structure and practice are expressed in and by the body.

Moreira (2004) examined the coordination of the operating theatre, focusing specifically on the socio-technical organisation of surgery. Moreira identified three bodies present in surgical practice: the patient ensemble, which is described as the sets of people and things constructed in preoperative activities; the surgeon body, which is a combination of the surgeon and apparatus in the operating theatre; and the body world inhabited by the surgeon. Here, the patient's body is seen as forming part of a much wider ensemble that includes input from the social world of relatives and history, and also the medical world of blood tests and scans. The culmination of this ensemble is the medical record which is constructed by multiple agents but is kept by the institution as a verified version of the patient – a coming together of the parallel multiplication of the patient's body. However, this approach once again limits the patient to the peripheries of surgery as something only seen in the context of being part of a wider ensemble constructed around the surgeon:

> *"spatial organisation converts the diversity of resources arranged in preoperative activities into one integrated, centralized socio-technical apparatus – the surgeon-body"* (Moreira, 2004 p.110).

The assertion that spatial organisation is centred around the surgeon-body in the operating theatre seems naïve and ignores the role of the patient as the focus of this work. While Moreira suggests:

> *"The team negotiates how to position the patient to better satisfy the needs of the surgeon"* (ibid, p.118).

This could equally be interpreted as satisfying the needs of the patient as without a patient, there can be no surgical activities and nowhere to cast the clinical gaze.

Hindmarsh and Pilnick (2002) focused more specifically upon the organisation of medical practice within anaesthesia. Although this was not a traditional ethnographic study, the research utilised ethnomethodology and conversational analysis to examine fourteen days of audio visual recordings of everyday work in one hospital's anaesthetic rooms. The work of the anaesthetists and the social spaces in operation are examined using Goffman's (1959) terms. However, as Hindmarsh and Pilnick (2002) demonstrate, in the operating theatre it is often not the patient's physical presence that determines when the stages change, as the patient is present throughout, but the consciousness of the patient. When the patient is awake, the region is 'frontstage', but when the patient loses consciousness through a general anaesthetic, this area then becomes 'backstage'. If the patient remains conscious throughout the surgery, as in local or regional anaesthesia, the boundaries are less clear and staff must find other ways to create a backstage area. When the patient is sedated and the distinction between wakefulness and unconsciousness is ambiguous, staff must determine when the area is frontstage and when it is backstage and act accordingly. Hindmarsh and Pilnick's (2002) study shows how a backstage for collaboration between medical staff can be produced fleetingly in the course of apparently pure frontstage work with the patient.

1.5 Sociology of the body

Modern western culture has an intricate view of the body, which although considered as one object among others, is assigned a singular status as the locus of a subjective consciousness (Merleau-Ponty, 2001). Biomedicine tends to refer to the body in physical terms, based upon the Cartesian model of subjectivity as a mind/body split (Doyle and Roen, 2008). The operating theatre has its own rituals that are in many ways extensions and intensifications of biomedical epistemologies, practices and symbolic elements. These involve the transformation of a life world into an object that can be manipulated through the distillation of the patient into a small depersonalised, objectified body part (Hirschauer, 1991). Limited literature has been found examining how this stance of objectification is experienced in relation to the patient as the objectified party.

Bourdieu’s analysis of the body as a bearer of symbolic value and form of physical capital implicitly contains a view of the body as a biological and social phenomenon. However, this does not examine the importance of biological processes to human embodiment in any detail. The term ‘embodiment’ here is used to refer to the lived body; the body being in the world as the site of meaning, experience and expression (Bradby, 2009). Bodies both shape and are shaped by society and the social relations of which they are a part. Bourdieu provides a view of the human body as an unfinished phenomenon which is in a constant process of becoming while living within society. The concept of embodiment provides a link between the structure and agency of the body, where the biological or physical are sociologically significant because they provide signals for identity construction which act as limiting factors on social action (Gabe et al, 2004). Physical factors such as age, gender, social class and ethnicity, underline the importance of the corporeal on biography, self and identity. Bourdieu suggests there has been a multiple commodification of the body in modernity. The body has become a bearer of value to the degree that it constantly enters into cultural and social markets which bestow value on prestigious bodily forms whether or not people are engaged in formal work (Fraser and Greco, 2005). In this sense there is every reason why the body should become increasingly important to the persons sense of self-worth or identity. Young (1997), regards the human body as a universal symbol system because all societies attempt in some way to socialise members. Put more simply, every society tries to ‘educate its bodies’ (Isenberg and Owen, 1977). However, the body and its environment are often presented as a dichotomy, with the body, nature and biology perceived as stable and unchanging phenomena, in contrast to the social environment and history, which are regarded as realms of life subject to constant change. However, this view takes limited account of the body as a phenomenon formed by the social influences that have helped develop it. As Merleau-Ponty (2001) recognised:

> *“The world I inhabit is from the outset an ‘intersubjective’ one. The language I possess was taught to me by others: the manners I have I did not invent; whatever abilities, techniques or talents I can claim were nourished by a social inheritance – even my dreams are rooted in a world I never created and can never completely possess”* (p.103).

Much of the literature relating to embodiment within the operating theatre focuses on the surgeon and the surgeon’s body at the centre of the operating theatre environment. Moreira (2004) regards the patient as a part of an ensemble, while Hirschauer (1991) focusses on the transformation of the surgeon’s body to include equipment, representations and skills in the form of the ‘Surgeon-body’. Callon and Rabeharisoa (1999) have suggested:

> *“the operation itself is but one moment, albeit crucial, in a continuous reconfiguring dynamic of bodies and persons in presence”* (p.58).

This thesis focuses on that ‘crucial moment’ while accepting the embodied actions that take place within the operating theatre incorporate actions and resources contributed by various people in different places often over a prolonged period of time. The argument in this thesis is that an understanding of the embodied experience of the patient can contribute to an appreciation of the strategies employed by the patient to make sense of the unique environment of the operating theatre.

The patient is by their very nature an outsider: what Simmel (1950) terms ‘a stranger’. That is a member of a group which is ‘other’ in comparison to the natives of the operating theatre. The patient is a stranger in the land of the operating theatre and as Simmel (1950) notes, strangers are not really conceived as individuals, but as strangers of a particular type. What becomes relevant then is not just the relation to the individual patient, but the relation to the group of others that is ‘patients’. Even the patient that is awake and retaining agency is treated as an outsider in this environment. As Simmel explains:

> *“The stranger is by nature no ‘owner of soil’ – soil not only in the physical, but also in the figurative sense of a life-substance which is fixed, if not in a point in space, at least in an ideal point of the social environment. Although in more intimate relations, he may develop all kinds of charm and significance, as long as he is considered a stranger in the eyes of the other, he is not an ‘owner of soil’”* (p.402).

Participation in this environment is based on a situated negotiation and renegotiation of meaning in the world. These systems of relations arise out of and are reproduced and developed within social communities, which are in turn a part of systems of relations among people. The concept of legitimate peripheral participation obtains its meaning not in a concise definition of its boundaries, but in its multiple generative interconnections with persons, activities, knowing and world (Lave and Wenger, 1991). Exploring these inter connections provides a way to engage in the practice – theory project that insists on participation in the lived in world as a unit of analysis in a theory of social practice. If the person is both a member of a community and an agent of activity, the concept of the person closely links meaning and action in the world.

This view follows that of a situated learning activity which explains how apprentices learn their trade and progress to full participants. However, patients do not follow this progression. Although the social world in which patients move and are centred is within this community of practice for a short while, there is no opportunity to progress through the stages to become full members. Instead, patients remain as outsiders and are never granted full member status or afforded the privileges associated with full membership. Instead, the patient remains a stranger who is both involved and disconnected as Simmel (1950) explains:

> *"He is not radically committed to the unique ingredients and peculiar tendencies of the group, and therefore approaches them with the specific attitude of 'objectivity'. But objectivity does not simply involve passivity and detachment; it is a particular structure composed of distance and nearness, indifference and involvement"* (Simmel, 1950 p.404).

More recently, there has been an accumulation of research associating biomedical practices and epistemological bases with stances of depersonalisation and objectification of the patient. This tendency towards objectification centres medical forms of attention on the body as a material entity (Gross, 2012). As the clinical gaze expands through new medical and scientific technologies, the body is becoming increasingly observable and knowable as it is exposed to scrutiny and manipulation as a biomedical machine (see chapter six 'The clinical gaze'). Defined as such, the clinical gaze will give this bodily body precedence over embodied subjective experience, the latter remaining almost beyond biomedical epistemological reach. These interactions are typically portrayed in the literature as double sided tensions: the voice of medicine and the voice of the life world. The term 'life world' was first used by Husserl (1970) in his phenomenological description of human society and subsequently modified by Habermas (1984) to describe the skills, competencies and knowledge that ordinary members of society use in order to negotiate their way through everyday life, to interact with other people and ultimately to create and maintain social relationships (Pearce et al, 2009). The voice of medicine refers to the body in abstract decontextualizing terms, whereas the voice of the life world conveys a view of the patient as grounded in the world as it is experienced subjectively (Shilling, 2012). However, ethnography can provide an holistic examination of the patient and their complex subjective personal aspects of human existence in the context in which it happens, rather than the reductionist and materialistic view of a biomedical epistemology (see chapter two 'Methodology').

Much of the social science literature relates to the way practitioners objectify their patients, reducing them to a pathology or mechanical body that can be repaired by opening up, rerouting or replacing individual pieces (Prentice, 2013). However, this reductionist view of patients separates them from the social and historical circumstances that contextualize the whole person and has led to suggestions that this approach is dehumanizing (Young, 1997). Unlike general anaesthesia where the patient is rendered unconscious, with regional anaesthesia the patient continues to experience their physical being during the surgical process, albeit in a markedly different way. As the regional anaesthetic takes effect, a distinct area of the patients' body begins to lose sensory information. The sensation of temperature is the first to be lost, followed by touch, pain, the ability to move and then finally pressure. However, this temporary adjustment to the patients' physical state also influences the way in which they view themselves and the world around them. While the patient undergoing a general anaesthetic gives up all agency until consciousness is regained, the patient undergoing a regional anaesthetic retains consciousness and correspondingly, agency. However, this must be mitigated against the altered sensations associated with the anaesthetic techniques which temporarily dissociate the anaesthetised area with the personhood that retains agency. The medical staff may 'borrow' an arm while blood is taken, thus alienating the arm from the personhood and creating a psychological distance between the patient and the actions taken on the arm, on the understanding that the arm will be returned to the patient to become a part of the person again. The request to borrow the patients arm invites the patient to exercise a different kind of agency. Rather than agency to control the arm, the patient exercises their agency in lending the arm to the medical staff.

In order for this interaction to be able to take place within the constraints of normal social boundaries, personhood is set aside during the treatment of the clinical body. This removes opinions and emotions, so that the body can be examined and treated objectively and scientifically (Fox, 1957). Objectivity in this sense equates to emotional detachment and is consistent with the scientific values of objectivity and containment of emotion (Prentice, 2013). Patients may also use an objectification of their own body to distance themselves from painful procedures or poor outcomes. A patient who states 'I am in pain' is expressing their discomfort in terms of how the pain is impacting upon their personhood, whereas a patient who says 'my foot hurts' is using a linguistic form of objectification to distance themselves from their troublesome foot. This phenomenon has been recognised in fertility clinic consultations by Thompson (2005) when patients have objectified their fertility problem as belonging to their hormones or ovaries as in statements such as 'my ovaries are not working properly' which is opposed to the statement 'I am pregnant' which is much more closely associated with personhood.

During a medical consultation, a person moves from the realm of the ordinary, in which they retain personhood and are able to act as a social being, into the realm of medicine, in which the body is little more than 'organs in a sack of flesh' (Young, 1997) and open to scrutiny. The move from the social realm to the medical realm creates a disarticulation that fragments the self into a collection of parts so that the person becomes a biological object and moves from being a person to becoming a patient. The individual in the social realm is supported with props such as clothing, jewellery and other signifiers that relay information about the person's capital in the social arena; whether financial, educational or symbolic. In the medical realm, these are removed and replaced with a standardised hospital gown and patient identification bracelet. It should be noted however, that the shift from one realm to the other may not necessarily be a single definitive act, but an intermittent, periodic partial process which is an aspect of the medical examination.

Concealments of the body behind evidential boundaries such as clothing, facial expression, gaze direction, posture and gesture are introduced during a medical examination, while others may be removed. The body, which is the locus of self, becomes reframed during this period to exclude some of its symbolic properties, especially those of a sexual nature, suggesting that these symbolic properties do not reside within the body, but are attributed to it by people and situations.

In Western society, medical consultations generally follow an established pattern. Firstly, the person is greeted by the medical professional, which serves to represent a social discourse in a medical arena. This is then followed by history taking, where information is elicited about the sick body. This represents a kind of storytelling, which Goffman (1974) refers to as a 'social construction of the self' in which:

> *"what the individual presents is not himself, but a story containing a protagonist who may also happen to be himself"* (p.541).

In other words, the performer in the realm of medicine constructs a self in the realm of narrative. Young (1997) suggests this narrative embodiment of the self, moves against the person's progressive embodiment over the course of the examination. For Young, the process of history taking is the first step in dislodging the self from the body. A process which serves to set aside the social person from the physical body; a process which continues through the medical examination. An alternative interpretation is that this process allows the person to assume the character of the patient and therefore, the self to become an active participant in examining and discussing the body. During the history narrative, the person refers to the troublesome part of them and fragments the body down to isolate that particular part of the body from their true self. Through this process, medicine, and surgery in particular, reconfigures a social person as a medical object. The individual is transposed from the realm of the ordinary into the realm of medicine. The corporeal self becomes a medical body and medical discourse becomes represented bodily. Natanson (1970) suggests there is no way to section the body off from itself or the embodied self from its circumstancing world. However, regional anaesthesia acts as a medium through which parts of the body are isolated and so the bodily experience of the world is radically altered or reduced to those aspects of the body which are not anaesthetised. Further discussion of the patients bodily experience in relation to this study can be found in chapter five.

The process of objectification can be clearly seen during surgery, when the patient's body is covered with sterile drapes which isolate the surgical area from the rest of the body. The process of draping creates a sterile field but also visually reduces the body to focus the surgical team's attention on the operative site (Prentice, 2013). Typically, during this draping process, the patient's head is isolated with a surgical screen outside of the sterile area which prevents the patient from being able to see the surgery as it takes place. This creates a distinction between the body as object and the person who owns the body, enabling what Goffman (1961) describes as the server/client relationship to pass through the repair cycle. In this analogy, the body is regarded as a possession that needs attention but cannot be left under the care of the server while the client goes about their other business. One solution to this is general anaesthesia. Another is to create an ontological duality that distinguishes the person as a social individual from the physical parts that belong to that person in the form of their body. Thus a social interaction can take place on one level, while the mechanical assessment or repair can simultaneously take place on another level. This allows the surgeon and patient to have a relatively innocuous conversation about the weather, while an intimate physical examination is simultaneously carried out. In this way, a civil social interaction can take place while the physical interaction is conducted as if the person were not there as a social being, but only as a possession someone had left behind.

By isolating the face from the rest of the body within the surgical field, the unique contribution of the face to the individual's sense of personhood is acknowledged. The face embodies the individual's sense of identity and represents the place where he or she recognises him or herself. Through the face an individual can be named, judged, assigned a sex, an age, a skin colour, an emotion or can remain anonymous in an undifferentiated crowd. The face belongs to an individual and represents sufficient diversity to signify without ambiguity the difference between one person and another. The face is the territory of the body where individual singularity is inscribed (Le Breton, 2015) and can be regarded as the place where personhood resides more than anywhere else. This separation of the body from the face during surgery has significance as it allows the patient's body to be free during surgery to act in ways that are not attributable to the individual. The agency of the body is temporarily passed by the patient to the medical team. The patient is then able to retain a sense of self without feeling accountable for the actions of their body, over which they have no control. Le Breton (2015) suggests that by erasing the face through artifice, the individual is liberated from the constraints of identity. The surgical screen acts in a similar fashion to a mask which guarantees the patient a degree of anonymity that lifts prohibitions, since the individual no longer has to fear being unable to look themself in the face and answer for their acts, as the face is hidden from their own attention and that of others. The individual is literally unable to 'lose face'. For the surgical team, the surgical screen promotes the 'non-person' solution (Goffman, 1961) which allows surgery to be conducted as though the patient were present only physically and not as a social person.

For De Certeau (1997), gaining knowledge of the whole person is tantamount to a voyeuristic guilt of self-pleasure which leads to nothing other than merely ‘looking on’. De Certeau uses the analogy of a striptease to examine the notion that by stripping away the ordinariness, an undeniable truth will be found, when in reality, it is the mundane and ordinary which gives the everyday its richness. When a stripper bares all, the spectator is similarly dispossessed of the one thing that gives meaning to the moment – the clothes. The stripper’s clothes represent all of that which is ignored – the mundane, ordinary, repetitive and dull words and gestures of similarly ordinary folk going about the boring business of their everyday lives (Buchanan, 2000). The stripper’s clothes not only cloak the nudity, but also contradict it in such a way as to give it meaning. Similarly, the absence of the social aspect of the patient, both contradicts and gives meaning to the patient as a bodily object. This objectification of the body can be regarded as a device to protect the individual sensibilities of the person. In this view, the medical professional is only able to treat the patient to the extent that they ignore the person and even then must guard against thinking about the patient as a whole: as something greater than the sum of the parts (wounds and ailments) as to do so would be to lose all objectivity and to cloud judgement.

Merleau-Ponty (2001) suggests that if we refuse to acknowledge the inherent diversity of perspectives that intersubjectivity entails, then we cannot help but be ‘God Like’. This view is similar to looking at the city of New York from the top of the world trade centre (De Certeau, 1984). The difficulty being that:

> *“one cannot grasp the unity of the object without the mediation of bodily experience”* (Merleau-Ponty, 2001 p.203).

The experience of viewing the city from above, with the streets and alleyways laid out like a map is not the same as experiencing the everyday hustle and bustle of city life which leads to a distinction between what De Certeau (1984) refers to as ‘a geometric space’ and an ‘anthropological space’.

1.6 Summary

This literature review has identified a gap in the literature examining the patient’s experience of being conscious in the operating theatre environment during regional anaesthesia and surgery. In order to gain a better understanding of this experience, literature providing an explanation of the theoretical background of key concepts utilised within the study has been examined. Bourdieu's theory of practice and in particular his concepts of habitus, field and capital have been discussed in relation to how subjective human agency and objective social structures exist in a dynamic, interdependent relationship (Bourdieu, 1977 and 1990). As contemporary practice within the operating theatre is surrounded by forms of knowledge that are peculiar to this environment, these practices and the forms of knowledge that surround them mean that medical and other health professionals have an implicit power over the people in their care. Foucault's understanding of power as something that is not possessed, but as something that is exercised within social relationships, is discussed further in relation to the microlevel of the operating theatre in chapter six. Foucault's concept of the clinical gaze' (1976), is also drawn upon in relation to techniques of power which act in combination on the body to produce the individual as an object.

Key ethnographies that have been conducted within a medical setting and in particular a perioperative environment have been discussed in order to contextualise the current study and provide some background and tradition to which the current study belongs. Goffman's description of the repair cycle (1961) and theatrical metaphors (1959) have been drawn upon to add another layer of understanding to the social reality of the operating theatre and the relationships between actors in this environment. This literature review suggests studies that have been conducted in the operating theatre previously have tended to reside within a positivistic paradigm and those that do not, have tended to focus on the role of the medical or health professionals rather than the patient. This present study argues for a repositioning of the patient as the focus of the operating theatre and suggests positivist research examining the embodied conduct of practices and skills exhibited during operating theatre work should be balanced by interpretivist studies.

CHAPTER TWO: METHODOLOGY

2.0 Introduction

The aim of this thesis is to understand the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. Through such an understanding the nature of the relationship between the conscious patient and the rest of the perioperative team can be established and the most important factors that influence the perioperative experience of this patient group clarified. As there will exist multiple perspectives of the interaction between the patient and the rest of the perioperative team during local or regional anaesthesia and surgery, it is in understanding these diverse perspectives and the interplay between them that enables a holistic understanding of the patient experience. The ethnographic account produced as a result of this study is concerned with the surgical experience of patients within the social context in which it occurs in the environment of the operating theatre. That is from the anaesthetic room, where the regional anaesthesia is applied, through the operating theatre. The scope of this study ends with the patients experience within the recovery room which is considered a separate environment.

This methodology chapter provides an overview of the study design. The term ‘methodology’ is used to refer to the principles and ideas on which researchers base their procedures and strategies (Holloway and Galvin 2017). The background and use of ethnography will be discussed in terms of the foundation of the research methods and the personal nature of the qualitative research methodology. Vidich and Lyman (1994) note that:

> *“lurking behind each method of research is the personal equation supplied to the setting by the individual observer”* (p.24).

The significance of this approach is implicated in the choice of methodology and forms the basis of an important criterion against which the research is evaluated. The chapter begins by examining paradigms of knowledge in order to situate the interpretivist methodology of the study. This is followed by a discussion of my role as an ODP, programme director, senior lecturer and ethnographer and how these impact on my position in the field. Finally, the methods, including the setting, participants, recruitment and selection, data collection, analysis and ethical considerations will then be described. Thus, whilst the research methods are discussed, this chapter first addresses the philosophical foundations of the methods and their relevance to the present study which have enabled the research questions to be answered.

2.1 Research questions

1. How do patients undergoing knee surgery with regional anaesthesia make sense of their place in the perioperative environment?
2. What strategies do patients utilise to influence their experience of having surgery with regional anaesthesia?
3. What strategies do perioperative staff utilise to influence the patients experience of having surgery with regional anaesthesia?
4. To what extent can ethnography aid an understanding of the diverse experience of a patient undergoing regional anaesthesia and surgery in a perioperative setting?

I adopted an ethnographic approach to enable a comprehension of the relationship between the conscious patient in an operating theatre and the rest of the perioperative team. This has in turn helped to clarify what the most important factors influencing the perioperative experience for this patient group are, which may inform the future delivery of appropriate person-centred care. The study has generated an authentic ethnographic account of the experience of patients undergoing surgery that could contribute to future ways of interacting with and caring for surgical patients in the perioperative environment. This has been achieved through a preoperative, perioperative and postoperative approach to data collection:

1. In depth preoperative interviews were conducted with patients.
2. Perioperative participant observations were conducted during the patients' surgical experience.
3. In depth postoperative interviews were conducted with patients.
4. In depth postoperative interviews were conducted with staff.

This approach allowed for repeated observations, conversations, and in depth interviews to elicit the views of patients and perioperative staff to produce concrete description and theoretically supported interpretation of the behaviour and relationships that are enacted in the context of everyday life in an operating theatre setting.

2.2 Methodology

The term methodology refers to the branch of knowledge concerned with the philosophical assumptions underlying different methods. In this context, methodology includes both the theoretical underpinnings and the overall framework and research strategy within which the specific methods are to be used (Punch, 2016). The methodology not only guides the strategy for the study but also the methods of inquiry and the tools and techniques employed. Methods of inquiry are necessarily based on assumptions about what constitutes knowledge of the reality being studied, what constitutes knowledge of this reality and what are appropriate methods for building knowledge of this reality (ibid). Together these assumptions constitute what is meant by the term 'paradigm'. Kuhn (1970) proposed that a mature science operates within a paradigm of theoretical and methodological ideas embodied in major discoveries that act as exemplars of the field concerned.

2.2.1 Paradigms

A paradigm can be regarded as a comprehensive model of understanding that provides viewpoints and rules of how to look at particular problems and how to solve them. Kuhn (1970) stated:

> *"Paradigms gain their status because they are more successful than their competitors in solving a few problems that the group of practitioners has come to recognize as acute"* (p.23).

Paradigms can be regarded as overarching philosophical systems, or:

> *"a basic set of beliefs that guide action"* (Denzin and Lincoln, 2003 p.245).

Guba and Lincoln (1994) suggest the primary question guiding paradigms is ontological:

> "*what is the form and nature of reality and the nature of being in the world?"* (p.108).

Ontology is the study of the nature of being, becoming, existence or reality, as well as basic categories of being and their relations. This can more simply be explained as being concerned with the nature of reality. Since the late 19th century the dominant ontological position in the natural sciences, has been logical positivism. A positivist ontology believes that the world is external (Carson, 2001) with a single objective reality to any research phenomenon or situation regardless of the researcher's perspective or belief (Hudson and Ozanne, 1988). Since the Mid 20th century, positivist conceptions of the scientific method and knowledge have stressed objectivity, generality, replication of research and falsification of competing hypothesis or theories. Positivist methodologies tend towards a quantitative approach and assume an unbiased and passive observer who collects facts without participating in the creation of them. This separation of facts from values, suggests there is an external world separate from scientific observers and their methods that allows for the accumulation of generalizable knowledge about the world. Researchers who adopt the positivist paradigm aim to discover causal explanations and to make predictions about an external knowable world.

The operating theatre is a highly medical environment, which traditionally follows a positivist biomedical model of care. This approach assumes a mechanistic view of illness and the body it occurs in, regarding illness in terms of causation and remediation. The illness experienced by the patient is effectively regarded as a fault in the machine that needs to be fixed. Although compounding factors such as the mind, the family and the environment may be acknowledged; these are generally seen as secondary to the pathology. This approach follows:

> *"a scientific process involving observation, description and differentiation, which moves from recognizing and treating symptoms to identifying disease aetiologies and developing specific treatments*" (Clare, 1980 p.375).

The biomedical model is generally regarded as well suited to subjects such as surgery where diagnosis and treatment are extremely circumscribed and structural. However, this belief in a scientific logic, a unitary method, objectivity and truth, has legitimised reducing qualities of human experience to quantifiable variables. The position this study assumes is that all knowledge is subject to some interpretation or categorisation, which itself is socially constructed. As Crotty (1998) notes, even the way a molecule or virus is categorised or grouped is determined by human interpretation and manipulation.

While knowledge gleaned from a positivist stance has a role to play in a science based perioperative care, this methodology cannot provide a rich understanding of patient experience in the way other methodologies which have a closer association with the applied environment are able to (Engel, 1977). Greenhalgh (1999) suggests the experience of applying research findings to the clinical encounter often results in a dissonance, which occurs when a narrative interpretive approach is disregarded in favour of positivistic evidence alone. Within surgery, there are often situations that raise questions for research that do not fit within the positivist paradigm of testing *a priori* hypothesis with the use of quantitative methods such as randomised controlled trials or cohort studies. Sometimes relationships are not known, poorly understood or illogical when taken out of context. These questions do not propose in advance the relationships to be tested, they are not capable of being answered with the use of study designs that isolate and define variables and test them in controlled experiments (Farre and Rapley, 2017). The research questions in this study can best be explored by research methods that are able to uncover issues of meaning and context, complex relationships and the processes of decision making. Answers to such questions are best obtained in natural settings and by asking individuals or groups for their own perspectives.

The research questions, values, beliefs and assumptions in this study are aligned to a constructivist paradigm. This paradigm has a relativist ontology which regards there as being numerous realities and ways of accessing them (Gray, 2014). Constructivism developed in response to criticisms that emerged regarding positivist approaches to science and learning. Rejecting the idea that there is one knowable truth, constructivists believe:

> *"knowledge is a process of actively interpreting and constructing individual knowledge representations"* (Jonassen, 1991 p.5).

Reality is therefore not something that is revealed, but is instead reached through a process of construction, through an active, subjective, engaged, and (inter)personal process of ongoing inquiry. This perspective challenges the idea that knowledge exists freely in the world and can be obtained through objective measures. Instead, all information is regarded as subject to interpretation by the researcher or learner and because knowledge is based on theory, a separation of researcher and subject is not possible. Therefore the aim is for all researchers to recognise and come to terms with a situated subjectivity rather than aspire to an impossible objectivity so that subjectivity can be recognised as a resource for deeper understanding (Crang and Cook, 2007).

2.2.2 Epistemology

Epistemology is concerned with the nature of human knowledge, where it comes from and how it is limited. Both ontology and epistemology are central philosophical arguments in the pursuit and understanding of truth. The stance taken in relation to these philosophical arguments has given rise to different schools of thought, each of which has contributed to human knowledge and the ways in which it is understood. The result is that different paradigms have each provided a unique lens or perspective through which the complex nature of the world can be understood (Lincoln and Guba, 1985).

In this thesis I have employed a constructivist epistemology to examine the theory of knowledge by concentrating on how knowledge is acquired. The observer creates reality, by giving meaning to what is observed (Jonassen, 1991), so that reality is constructed through a person's active experience of it. Furthermore, a constructivist perspective regards any one person's interpretation or construction as being just as 'true' as any other person's interpretation or construction, providing it works within a particular context (Doan, 1997). This implies that all constructions or interpretations that 'work' are equally valid and that no single 'truth' or interpretation exists (Dickerson and Zimmerman, 1996). Constructivists therefore reject the positivist idea of one knowable truth and regard knowledge as something that is constructed through experiences rather than discovered in an external world. Starting with the assumption that social reality is multiple, processual and constructed, the constructivist approach takes into account the researchers position with its corresponding privileges, perspective and interactions as an inherent part of the research reality (Denzin and Lincoln, 1994). The constructivist acknowledges that research occurs under specific conditions, which the researcher may or may not be aware of and may not be generated through choice (Guba and Lincoln, 1994).

Table 1. *Contrasting positions of positivism and constructivism (adapted from Dudovskiy, 2016)*

Paradigm	**Ontology**	**Epistemology**	**Methodology**	**Axiology**
Positivism	Objectivist - External objective and independent of social actors.	Only observable phenomena can provide credible data – facts. Focus on causality and law like generalisations, reducing phenomena to simplest elements.	Deductive. Hypothesis testing.	Research is undertaken in a value free way. The researcher is independent from the data and maintains an objective stance.
Constructivism	Relativist – socially constructed, subjective, may change, multiple.	Subjective meanings and social phenomena. Focus on details of situation, a reality behind these details, subjective meanings motivating actions.	Inductive. Positions researcher within the study.	Research is value bound, the researcher is part of what is being researched, cannot be separated and so will be subjective.

From an epistemological perspective, interpretivism is closely linked with constructivism, and looks for

> *"culturally derived and historically situated interpretations of the social life-world"* (Crotty, 1998 p.67).

Interpretivism regards natural reality and social reality as different: the natural sciences are regarded as nomothetic and look for consistencies in the data in order to deduce laws, whereas social sciences are ideographic and deal with the actions of the individual (Gray, 2014). Therefore, the methods used to investigate them are different.

2.2.3 Symbolic interactionism

This study has been influenced by symbolic interactionism although does not form a part of the symbolic interactionist tradition. This theoretical perspective explores the inherited meaning system of culture and views human actions as constructing self, situation and society (Charmaz, 2014). Central to symbolic interactionist thought is the idea that individuals use language and significant symbols in their communication with others. Symbolic interactionists are less concerned with objective structure than with subjective meaning; that is how repeated, meaningful interactions among individuals come to define the makeup of 'society' (Carter and Fuller, 2015).

Because the self is a social object, it is constantly changing for the actor because it continues to be defined and redefined in any given social interaction. This view of the self is radical in that the self is:

> *"no longer a solid given entity that moves from one situation to another. It is a process continuously created and recreated in every social situation"* (Berger, 1963 p.106).

The social nature of the self means that it can be regarded as a process rather than a stable entity. The way we act and react in any given situation depends upon the circumstances of that situation and would be markedly different in another situation or social interaction.

Within this study an assumption has been made that some understanding of the meaning participants ascribe to incidents is necessary to explain the interactions between staff as well as the interactions between staff and patients during the perioperative experience. This study has been influenced by a symbolic interactionist approach to the nature of social reality, which explains social life as characterised by a multiplicity of viewpoints and denies the existence of a single social reality (Blumer, 1969). The term 'Symbolic Interactionism' was devised by Herbert Blumer (1969) and draws on the work of George Mead. As both were at the University of Chicago, this technique is often referred to as the Chicago School of Symbolic Interactionism. This approach argues that people's behaviour is based on the meaning those behaviours have for them. Those meanings are based on and derived from the interactions an individual has with others. Symbolic interactionism regards individuals as active beings engaged in practical activities in their worlds and emphasises how people accomplish these activities. A symbolic interactionist perspective produces a dynamic understanding of actions and events, the implication of which is that the situation must be seen as the actor sees it. The meanings of objects and acts must be determined in terms of the actor's meanings and the organisation of a course of action must be understood as the actor organises it. Thus the observer must adopt the perspective of the actor in order to see the social world from that perspective (Gabe et al, 2004). However, it should be noted these meanings are subject to change based on an individual's interpretation. Communication in the operating theatre is sometimes underpinned by hidden meaning and an analysis of these exchanges will demonstrate that understanding what patients and perioperative staff say and do frequently requires the use of methods which afford participants the opportunity to explain both what was said or done, and what was not said or done. Hence the theoretical perspective (the philosophical stance underlying the methodology) utilised here is influenced by that of symbolic interactionism.

A symbolic interactionist perspective addresses the interpretation of subjective viewpoints and how individuals make sense of their world from their unique perspective rather than how common social institutions define and impact individuals (Carter and Fuller, 2015). Charles Cooley was one of the earliest proponents of symbolic interactionism with his concept of the 'looking-glass self'. Cooley (1902) suggested that self-determination, or how one regards oneself, is not an isolated phenomenon but includes others:

> *"As we see our face, figure and dress in the glass and are interested in them because they are ours, and pleased or otherwise with them according as they do or do not answer to what we should like them to be; so in imagination we perceive in another's mind some thought of our appearance, manners, aims, deeds, character, friends and so on, and are variously affected by it. An idea of self of this sort seems to have three principle elements: The imagination of our appearance to the other person; The imagination of their judgement of that appearance; some sort of self feeling, such as pride or mortification"* (p.184).

Cooley regarded the second element in this process as essential, as it is the sentiment of the imagined effect of our reflection on another that leads us to pride or shame (Rousseau, 2002). For example, we are ashamed to appear lazy to someone who is hardworking, or proud to someone who is modest.

George Herbert Mead was a contemporary of Cooley, who contributed to the emergence of symbolic interactionism through the development of his theories about the relationship between self and society. Mead (1934) subscribed to the idea that individuals use language and significant symbols in their communication with others and distinguished between the ‘I’ and the ‘Me’. The ‘I’ is that which thinks, sees and names, but it can never be directly scrutinised because it would then cease to be an ‘I’ and become a ‘Me’ instead. The ‘I’ evades inspection and therefore direct personal and social control (Rock, 2001). In contrast, the ‘Me’ is the self made visible, audible and objective and there are as many ‘Me’s’ as there are situations in which it can be displayed. One is not quite the same when with an employer, children, parents or strangers. Individuals interpret the situation they are in and each one summons up a different version of ‘me’ who acts and performs in a manner deemed appropriate to that situation. Furthermore, if a situation can shape a self then a self can also shape a situation and within that process, there is sufficient variability and ambiguity to enable a degree of improvisation and invention (Turner, 1962). This perspective establishes the social nature of the self, thought and community as a product of human meaning and interaction. Each person becomes human through interaction with others and institutional patterns are learned in communities dependent on shared language and symbols (Deegan, 2001).

2.2.3 Dramaturgy

Within this study, a dramaturgical approach to symbolic interactionism will be drawn upon, which uses an analogy between social life and the theatre to examine how human beings accomplish meaning in their lives. Dramaturgy takes non-verbal behaviour into account in the social scene and how this is expressed when scrutinising features of an individual’s or group’s action to offer explanations of this action. This interpretive approach tries to link action to its sense rather than behaviour to its determinants (Geertz, 1983) and views the definition of the situation as arising from how actors perform the observed action. Burke (1945) first suggested that analysis should begin with theories of action rather than theories of knowledge and proposed five key terms of dramatism:

> "*We shall use five terms as generating principle of our investigation.*
> *They are: Act, Scene, Agent, Agency, Purpose. In a rounded statement about motives, you must have some word that names the act (names what took place, in thought or deed), and another that names the scene (the background of the act, the situation in which it occurred); also, you must indicate what person or kind of person (agent) performed the act, what means or instruments he used (agency), and the purpose"* (p.XV).

None of these terms is independent of the others, as all are necessary in accounting for the piece of conduct. In addition, any individual piece of conduct is situationally specific and meaningful only by virtue of the context of its occurrence (Reynolds and Herman-Kinney, 2003).

Goffman advanced the dramaturgical approach through the identification and addition of a spatial aspect to the way in which actors behave. Goffman (1959) distinguishes between social spaces in which aspects of a particular performance are in progress. The 'front' region is the area where the activity occurs in the presence of other people: an 'audience'. Here some aspects of the activity are emphasised while others, that may discredit the fostered impression of the activity, are suppressed. A backstage area is a region in which the illusions and impressions of a performance are produced and constructed, but also where the impression fostered by the performance is actively contradicted as a matter of course. Examples of this include restaurants, where the kitchen is physically separated from the seating area and the customer is not party to the process of preparing the meal; and backstage in a theatre, where the special effects are manufactured and actors are routinely out of character.

> "*One of the most interesting times to observe impression management is the moment when a performer leaves the back region and enters the place where the audience is to be found, or when he returns therefrom, for at these moments we can detect a wonderful putting on and taking off of character"* (Goffman, 1959 p.74).

Although the majority of backstage areas are spatial and physically separated from the front region, the backstage area can also be temporal, such as when the audience has yet to arrive and the stage is used for rehearsal. Goffman's distinction for the temporal change in stages generally rests upon the physical presence or absence of the audience:

> *"To see this we need only glance into a restaurant , or store, or home, a few minutes before these establishments are opened to us for the day. In general, then, we must keep in mind that when we speak of front and back regions we speak from the reference point of a particular performance, and we speak of the function that the place happens to serve at that time for the given performance"* (Goffman, 1959 p.77).

However, in the operating theatre it is often not the patient's physical presence that determines when the stages change, as the patient is present throughout, but the consciousness of the patient (Hindmarsh and Pilnick, 2002). When the patient is awake the region is 'frontstage', but when the patient loses consciousness through a general anaesthetic, this area then becomes 'backstage'. If the patient remains conscious throughout the surgery, as in local or regional anaesthesia, the boundaries are less clear and staff must find other ways to create a backstage area. When the patient is sedated and the distinction between wakefulness and unconsciousness is ambiguous, staff must determine when the area is frontstage and when it is backstage and act accordingly.

For Goffman, two characteristics of social interaction are equally important: drama and ritual. These two characteristics complement each other and both are implicated in the collaborative manufacture of selves (Charon, 1998). Operating theatre settings abound with strategic use of space, time, props and performance rituals that reveal hierarchies, divide roles, enforce rules and prepare the scene for task performance. Operating theatre personnel may take these arrangements for granted as being the way in which they complete their tasks, but working within these arrangements gives workers meaning and in turn influences how they continue to reproduce their roles to carry out their work.

For constructivism there are multiple realities and in order to gain a deeper understanding, the researcher must get close to the study's participants. This raises a question of axiology; what is the nature of the enquirer's values and value judgements of knowledge of the world? By minimizing the distance or 'objective separateness' (Guba and Lincoln, 1985) between researcher and participant, the researcher must make explicit the values, assumptions and bias that they bring to the study together with the ‘value-laden’ nature of the information gathered. This ensures the study is trustworthy and credible. The language employed within the constructivist paradigm is personal, literary and based on definitions which evolve during the study. While the language employed within the constructivist paradigm is personal, literary and based on definitions which evolved during the study, the research process within the constructivist paradigm incorporates empiricism, where knowledge is gained from experience:

> *“inductive, emerging and shaped by the researcher’s experience in collecting and analysing the data”* (Creswell, 2007 p.19).

This ethnography provides an opportunity to investigate the processes of identity formation and production of power relations within the operating theatre, along with how these processes are negotiated by those involved in this environment. Foucault (1982 p.781) has argued that power and knowledge are inseparable. Power is manifested in established structures, cultural belief systems, practices and sources of knowledge. This goes beyond the capacity of individuals into social structures and institutions. Foucault (1984 p.66) further argues that reality is socially constructed through multiple dominant discourses informed by science, laws, policy, practices, codes of behaviour and education. In the operating theatre, the dominant discourses of technology, medicine, skill and competency are communicated and sustained through its culture. Capital in this field comes in the form of competence and expertise and the value of a member’s contribution to the team is measured by the amount of knowledge and competence they possess. However, as Greenhalgh et al (2015 p.1) note, patients do not inhabit the evidence based world of randomized controlled trials, they live in the idiosyncratic and unpredictable world of an individual person in a family context or the context of social isolation. The knowledge and competence the patient possesses is in the context of living with and managing their disease on a day to day basis rather than epidemiologically based and generalizable ‘truths’. This contributes to a power imbalance as the skill and competence of managing an illness on a day to day basis is valued less than the skill and expertise of the surgical team in treating the disease. If perioperative care is to be tailored to a particular patient’s priorities and circumstances, I believe there is a need for data that is personally significant in the here and now.

2.2.4 Grounded theory

Grounded theory is a qualitative research methodology concerned with the generation of theory, 'grounded' in data that has been systematically collected and analysed. The founders of grounded theory, Glaser and Strauss (1967) originally worked together in a study examining the experience of terminally ill patients who had differing knowledge of their health status. Some of these patients suspected they were dying and tried to confirm or refute their suspicions. Others tried to understand their situation by interpreting the treatment received from care providers and family members. Glaser and Strauss examined how the patients dealt with the knowledge they were dying and the reactions of healthcare staff caring for these patients. Throughout this collaboration, Glaser and Strauss questioned the appropriateness of using a scientific method of verification for this study. During this investigation, they developed the constant comparative method, a key element of grounded theory, while generating a theory of dying first described in ‘Awareness of Dying’ (1965).

Glaser and Strauss subsequently went on to write ‘The Discovery of Grounded Theory: Strategies for Qualitative Research’ (1967). This described the practice of generating theory from research which is ‘grounded’ in data and was presented as an alternative to dominant positivist methodologies utilised in scientific inquiry with their reliance on hypothesis testing, verification techniques and quantitative forms of analysis. The dominance of these positivist quantitative approaches often led to qualitative research being disregarded as *“impressionistic, anecdotal, unsystematic, and biased”* (Charmaz 2014, p6). However, grounded theory proposed a new, structured, robust and credible research design with which to explore qualitative, open-ended research questions about human experiences and social processes (Charmaz and Bryant 2016; Stern 2013) in an aim to close *“the embarrassing gap between theory and empirical research”* (Glaser and Strauss, 1967, p.vii).

The development of grounded theory combined the depth and richness of Strauss’ qualitative research background and Glaser’s training in quantitative survey research (Walker and Myrick, 2006). Together Glaser and Strauss developed a systematic, iterative research method for collecting and analysing data, leading to the generation of theory which aims to explain a social process, rather than test or verify existing theory (Lingard, Albert and Levinson, 2008). Grounded theory research has subsequently gained popularity beyond its origins within sociology and is now widely established across a range of different disciplines including healthcare (Foley and Timonen 2015; Holloway and Galvin 2017; Nishikawa et al 2021), business (Gligor, Esmark and Gölgeci 2016; Holton and Walsh 2017; Neghabi and Anoosheh 2021) and information systems (Birks et al., 2013; Urquhart 2013; Ma et al 2021). The broad appeal and application to different disciplines, has meant grounded theory research has developed, adapted and transformed. This evolution away from the original, classic grounded theory has created debate as to whether the approach has been "*eroded or evolved*" (Bluff, 2005, p.165). After publishing 'The Discovery of Grounded Theory', Strauss and Glaser went on to write independently, expressing divergent viewpoints in the application of grounded theory methods. Glaser wrote 'Theoretical Sensitivity' (1978), and Strauss went on to publish 'Qualitative Analysis for Social Scientists' (1987). However, it was Strauss and Corbin's publication 'Basics of Qualitative Research: Grounded Theory Procedures and Techniques' which resulted in a rebuttal by Glaser over their application of grounded theory methods.

The original version of grounded theory is now commonly referred to as the 'Glaserian' or 'classic' grounded theory and is located within the post-positivist paradigm with claims for the 'discovery' or 'emergence' of data. The underlying principle of classic grounded theory is that by following the methodological procedures systematically, the researcher will reveal the objective theory that is situated in the data, and the same theory will be revealed irrespective of the person undertaking the analysis (Glaser and Holton, 2007). Glaser has maintained a strong connection to the original classic version of grounded theory and continues to advocate for the researcher as a neutral, impartial observer gathering data to 'discover' theory as an external reality (Glaser 1978, 1992, 2007, 2009, 2011). Although it has been argued the classic version of grounded theory is both contradictive and incompatible with the principles of qualitative research (Bryant and Charmaz, 2007), Glaser (2002) asserts classic grounded theory forms a unique methodological paradigm which does not to belong to either quantitative or qualitative research methods.

One of the most contentious issues in the classic version of grounded theory is in the use of literature, with Glaser and Strauss' (1967) directive to examine literature after data gathering. Classic grounded theory rejects a prior reading of the literature, giving reasons related to the distorting effects this may have on analysis. Glaser advocates *"as discovery and emergence are at the heart of the grounded theory method, relevant literature cannot be known at* *this stage"* (Heath, 2006, p.520). The argument is therefore for a researcher to have 'theoretical sensitivity' through a *"theoretical insight into his* [sic] *area of research, combined with an ability to make something of his* [sic] *insights"* (p.67). This insight should not be confused with preconceived theories or ideas regarding the research area, but researchers should *"remain sensitive to the data by being able to record events and detect happenings without first having them filtered through and squared with pre-existing hypotheses and biases"* (Glaser, 1978 p.3). This was a position from which Strauss later distanced himself, in a move that contributed to the rift between the two researchers. The split between Glaser and Strauss subsequently led to the development of different forms of grounded theory, so that currently three main 'schools' can be discerned: the classic (Glaserian) school, the Strauss and Corbin (Straussian) school and more recently, the Constructivist (Charmaz) school.

Strauss and Corbin attempted to develop grounded theory with a more prescribed set of coding categories (open, axial and selective) and protocols by which to guide the researcher through the method (Heath and Cowley, 2004). Although Strauss and Corbin's (1990) approach to grounded theory adhered to the same basic research processes as classic grounded theory, i.e. the gathering, coding, sampling, and categorizing of data (Walker and Myrick, 2006), nuanced differences in the utilization of such processes reflected different methodological assumptions. In the first instance, Straussian grounded theory advocated an alternative coding process to Glaser and Strauss' (1967) original method. Glaser and Strauss' (1967) classic version of grounded theory was very much focused on emergence. Emergence being the generation of codes and categories directly from data. In classic grounded theory, codes and categories were thus *"not selected prior to data analysis...and often labelled from words found in the data themselves"* (Kendall, 1999, p.744). Like classic grounded theory, Strauss and Corbin's (1990) adapted method also saw coding as an important part of the method. However, Strauss and Corbin (1990) advocated for using a coding framework as part of the coding process. This approach has been criticised for being largely prescriptive and therefore distanced from the original inductive principle of grounded theory, potentially transforming it into an inflexible, rigid and deductive procedure (Willig, 2013). Glaser repudiated this changed approach, accusing Strauss and Corbin of *"forcing data into preconceived categories"* (Ritzer and Ryan, 2010, p.272) and of undermining classic grounded theory tenets. A further and significant divergence was that of verification. Glaser asserted that grounded theory was nonverifiable as theory could only be verified after its development, whereas Strauss and Corbin contended that verification should be a continuous process via examination of the data throughout (Bulawa, 2014).

The third and final version of grounded theory discussed here is known as 'constructivist' grounded theory and was developed by Charmaz (2000) as a response to the above models. Constructivist grounded theory reflects the basic beliefs of constructivism as a paradigm of inquiry. Guba and Lincoln (2005) describe constructivism as ontologically relativist, epistemologically transactional and methodologically dialectical (Guba and Lincoln, 2005). This means that a constructivist grounded theory assumes an active, rather than neutral observer, whose decisions shape both process and product throughout the research (Charmaz, 2009). Therefore, it can be argued that at the core of this model is the acceptance of subjectivity and the acknowledgment of the active involvement of the researcher in the construction and interpretation of data through dialectic processes with the participants and the data (Charmaz, 2014). Realities are therefore assumed to be multiple and layered, not unitary and self-evident (Pidgeon and Henwood, 2003). In other words, the researcher is not seen as an independent and objective observer, but rather an intrinsic part of the constructed reality of the research process (Clarke, 2012).

Constructivist grounded theory additionally views the process of categorization, generating themes, as dialectical and active (Charmaz, 2019). This version of grounded theory challenges the belief that there is an objective truth that can be measured or captured through research enquiry (Crotty, 1998). Constructivist grounded theory also brought new concerns to the fore, such as reflexivity and representation of research participants. Previously, *"grounded theorists like many qualitative researchers, had not examined their assumptions about data collection, themselves as observers and writers, and the situated nature of their studies"* (Charmaz, 2015, p.404). Charmaz's (2015) constructivist version of grounded theory regards grounded theory strategies as tools for researchers to use and adapt to fit their empirical problems. As such, Charmaz's approach to the method is less prescriptive than either classic or Straussian versions. Such methodological considerations are important, and impact upon the way grounded theory has been used within this thesis.

The grounded theory utilised in this PhD study has drawn upon the constructivist approach which views actors as having the means to control their destiny through actions and reactions to conditions. This method seeks to uncover conditions, how actors respond to conditions and the consequences of their actions, to explain:

> *"... how social circumstances could account for the interactions, behaviours and experiences of the people being studied"* (Benoliel, 1996 p.413).

The intention of this study was to investigate the interplay between staff and between staff and patients in a perioperative environment during a surgical procedure conducted with local or regional anaesthesia. Data collected for the study takes the form of preoperative and postoperative interviews with patients, field notes taken during participant observation and interviews with operating theatre staff.

Lofland (2007) has argued that methods associated with grounded theory are not new because ethnographers have conducted inductive research, made comparisons, checked hunches and offered conceptual analyses for many years before grounded theory. However, the traditions of learning to conduct ethnography have remained uncodified (Charmaz, 2014). A grounded theory explicitly provides the means for achieving the rigour and efficiency that earlier ethnographies have been accused of lacking. While the Chicago School of Ethnographers combined both research training and supervisory mentoring followed by immersion in the field (Palmer, 1928, Blackman, 2010). Specifically, the development of grounded theory set out a more systematic, rigorous and explicit analysis of qualitative data about the world (Charmaz, 2019). A grounded theory emphasis on the constant comparative method leads ethnographers to compare data with data from the beginning of the research rather than after all the data has been collected. This enables concepts to be developed through coding and analysing the data concurrently in order to demonstrate relations between concepts and categories (Taylor and Bogdan, 1998). Grounded theory methods move ethnographic research toward theoretical development by raising description to abstract categories and theoretical interpretation (Corbin and Strauss, 2015). But at the same time research participants' experiences were placed at the heart of the research process.

In this sense, grounded theory dispels the positivist notion of passive observers who merely absorb their surrounding scenes (Charmaz and Mitchell, 2001). In generating this grounded theory, each conceptual category identified in the research process was considered provisional until it earned its way into the theory by being repeatedly present (or conspicuously absent) in the data collected through interview, or observation. If the concept did not stand up to continued scrutiny, through its repeated demonstrable relevance to the phenomenon under investigation it was discarded (Corbin and Strauss, 1990).

In this PhD a grounded theory influenced by the constructivist approach has been used to provide an opportunity for determining the 'real' nature of patient experience. As the research questions are open-ended and do not involve hypothesis testing, they are well suited to exploration using this form of grounded theory. Most grounded theory studies begin with broad open questions (Corbin and Strauss, 2015), the primary aim of which is to shed light on an unexplored social process or phenomenon where coherent praxis does not yet exist, thus influencing practice in the future (Birks and Mills, 2011). With emphasis placed strongly on the actor's point of view, situational and contextual variables, with an attempt to interpret and explain the reasons for underlying behaviour, this grounded theory approach provides a valuable perspective from which to study the complexities of patient participation within the context of the operating theatre setting. According to Charmaz and Mitchell (2001), grounded theory and ethnography share common criteria, ontological and epistemological assumptions, as well as some similarities in data collection and analysis. Both grounded theory and ethnography are used to investigate phenomenona in a naturalistic setting, with researchers selecting their sample as data emerges through data analysis (Pettigrew, 2000).

For this PhD study I decided to follow a single model of grounded theory instead of selectively using elements of various models. This aimed to strengthen the coherence of the study and contribute to its epistemological and methodological robustness. I chose a constructivist approach to grounded theory as like Charmaz (1990) I believe that meaning does not lie dormant within objects waiting to be discovered, but is created as researchers interact with and interpret their participants experiences, stories, views and opinions. The constructivist approach to grounded theory in this PhD study acknowledges the researcher and the participant as co-

constructors of knowledge and also supports the understanding and exploring of perceptions and constructions of phenomenon.

2.2.5 Ethnography

Ethnography is both a process (an ethnography is conducted), and a product (the outcome of this process is an ethnography) that utilises a combination of research methods including participant observation, ethnographic interviewing, field notes and reflective journaling to create an authentic account of a cultural behaviour (Delaine, 1997). The aim of an ethnographic enquiry is to examine events and details of experience to generate an interpretation which provides an in depth, holistic and contextualised account that provides insight into the cultural constructions of the phenomenon under consideration (Leininger, 1985):

> *"Ethnography is the study of people in naturally occurring settings or 'fields' by methods of data collection which capture their social meaning and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally"* (Brewer, 2000 p.6).

Ethnographies have been used to study a diverse range of settings and social phenomena, with each as individual as the subject matter on which it focuses (Mills and Morton, 2013). However, there remain some common characteristics evident in most, if not all, ethnographies (Hammersley, 1998). Initially, behaviour is studied within an everyday context, rather than a controlled or experimental situation and is normally focused on a single setting or single group of people. Data collection is relatively unstructured in that it does not involve following through a detailed plan set out in advance. The data that is gathered usually comes from a range of sources, such as participant observation and informal interviews or conversations without pre-determining categories for interpreting what people say and do. Finally, analysis of the data involves interpretation of the meanings and functions of human interaction and mainly takes the form of verbal descriptions and explanations with any quantification playing a subordinate role at most (ibid).

The term 'Ethnography' was taken from social anthropology and refers to the situated, empirical description of peoples and races (Rock, 2001). The early social anthropologist approach was largely based on second-hand data gathered from missionaries and travellers, with the result that their data was often inaccurate or misleading and the analysis was speculative or evaluative (Blackman, 2007). By the early 20th century it was increasingly recognised that in order to overcome the methodological deficiencies of earlier accounts, it was necessary to collect data in a more rigorous and systematic way. The need to experience first-hand the lives of the people being studied, learn their language and live among them is largely attributed to Malinowski (1922). Malinowski suggested the aims for scientific fieldwork are to describe customs, traditions, institutions, and structure, to give 'the skeleton' of the tribe (what people say they do). This is then fleshed out through description of how daily life is actually carried out, what Malinowski (1922, p.20) refers to as the '*imponderabilia'* of actual life (how they do it). Finally, the typical ways of thinking and feeling that are associated with the institutions and culture under investigation are recorded (O'Reilly, 2005).

The use of ethnography within modern sociology has largely been attributed to what has become known as the 'Chicago School of Ethnography' (Bulmer, 1984). This group of ethnographies studied face to face interactions in specific locations and for the first time began to portray social worlds experienced in everyday life within a modern, often urban context (Deegan, 2001). Blackman (2010) has suggested the approach taken by the Chicago School constituted an ethnographic mosaic that experimented with empathetic strategies which would go on to become the defining characteristics of urban ethnographic practice. The Chicago School approach resonates with the approach that has been undertaken in this study through the integration of symbolic interactionism and a mixture of ethnographic data collection methods. The goal of the fieldwork conducted during this study was to collect a thick description (Geertz, 1973) through learning the relations, practices, positions and rituals that take place when a patient is having a local or regional anaesthesia and surgery in the operating theatre. An ethnographic approach determined the type of questions asked, the way the research was conducted, the type of data collected and the nature of the findings. The cultural and interpretive nature of the study has addressed the relationship between the patient and perioperative staff within the culture of the operating theatre and the use of participant observation is one tool that has been used in an ethnographic mosaic approach (Palmer, 1928; Blackman, 2010).

Many ethnographies have been conducted within medical settings although most of these have focussed on medical decision making, training, patient behaviour or interprofessional relationships. Early medical ethnographies such as Becker et al's (1961) 'Boys in White' or Goffman's (1961) 'Asylums' shared a theoretical background in symbolic interactionism with the Chicago School of Ethnographers which viewed social organisations as sites of interactions rather than structures. Bloor (2001) has identified four themes identifiable in medical ethnographies:

1. Symbolic interactions in medical institutions
2. Socially constructed character of professional medical categories
3. Experience of illness and the sociology of the body
4. Contemporary challenges facing medical ethnography

The approach taken in this PhD study draws upon a symbolic interactionist ethnography, which is committed to reconstructing an actor's view faithful to the everyday experience of the subject. The influence of symbolic interactionism within this thesis provides a view of human action as always taking place in a situation that confronts the actor and that the actor always acts on the basis of defining the situation that confronts him (Holloway, 1997 p.4). The basis of this study is a belief in the view that selves and gestures are understood based on previous experiences, where patterns of outcomes or responses in a given social world are learnt and ideas about the world are formulated and reformulated through acting upon it. Furthermore, institutional patterns are learned in communities dependent on shared language and symbols. Individuals learn about the world they are in through interaction; ideas are reformulated and new questions formed which in turn can lead to new ways of acting and new ideas. At each step, not only does the world appear to change, but also those that question it as they learn more about their environment and their identity, potential and capabilities within it. Each person becomes human through interaction with others and people cannot fully know themselves or others *"as they really are"* (Rock, 2001 p.29).

2.3 Positionality and Reflexivity

Positionality refers to an individual's world view and the position that has been adopted in relation to a specific research task (Savin-Baden and Howell, 2013). Put simply, this is 'where the researcher is coming from' and concerns ontological assumptions (the nature of social reality), epistemological assumptions (the nature of knowledge) and assumptions about human nature and agency. This is shaped by values and beliefs that we, as individuals, all hold and includes aspects such as: political allegiance, religious faith, gender, sexuality, historical and geographical location, race, social class and status and (dis)abilities (Wellington and Bathmaker et al, 2005). Some of these aspects of positionality are culturally ascribed or fixed, for example, I am without disability, white, male, heterosexual and English. Other aspects such as personal life history and experiences are more subjective and contextual.

Reflexivity can be understood as the researchers examination of their own beliefs, judgments and practices during the research process and how these may have influenced the research. If positionality refers to what the researcher knows or believes, then reflexivity can be regarded as what the researcher does with this knowledge. Reflexivity is defined by Robson (2002) as:

> *"an awareness of the ways in which the researcher as an individual with a particular social identity and background can have an impact on the research process"* (p.22).

The character of social research (and ethnographic research in particular), is such that exploration and engagement involves co-constructing the social world in collaboration with the actors we engage with through observation or discourse (Atkinson, 2017). For example, my professional background is based firmly within the operating theatre and although I have not been in clinical practice for several years, I have maintained my registration as an ODP with the Health and Care Professions Council. The role of the ODP is less well known than many other healthcare professions but is similar to that of theatre nurses and the two professions overlap in many areas. Essentially, the ODP is:

> *"Concerned with the maintenance and restoration of the physical and psychological status of the surgical patient at all levels of dependency, through assessment, planning and delivery of individualised care"* (CODP, 2009 p.3).

ODPs are involved in caring for surgical patients throughout their perioperative experience. This is normally explained in relation to the three phases of care within the operating theatre. During the first, the anaesthetic phase of care, the ODP assists and supports the anaesthetist in caring for the patient throughout all forms of anaesthetic interventions, whether general anaesthetic, local anaesthetic or regional anaesthetic. The second is the surgical phase, where the ODP supports and assists the surgeon in the role of the scrubbed practitioner and is responsible for the surgical instruments, swabs, sutures and other equipment. The third phase of care is in the post anaesthetic care (recovery) unit. Here the ODP supports and monitors the patient's physiological parameters and provides appropriate treatment until the patient has recovered from the effects of the anaesthesia and/or surgery and is transferred to the ward. Thus, being from a professional background similar to, but different from, a theatre nurse will have a likely impact upon my position in the field. As a member of this relatively new profession (ODPs did not gain statutory registration until 2004 and came under the remit of the Chief Allied Health Professions Officer for England in 2017), my positionality will be influenced not only by my experiences and role in the operating theatre, but also by the experience of the politics that have played out in the development of my profession in relation to nursing and medical colleagues.

As well as my personal history as a professional who has worked in the department where the fieldwork was undertaken, I am also a university lecturer and I have trained several members of staff who work within the department. This means that the types of relationships that I have with study participants fall into three categories:

1. I am a researcher known only in that capacity.
2. I am a former member of staff with known competence and experience.
3. I am a teacher who has passed judgement on the ability of others.

Although these categories may overlap, for example, I may be known as both a former member of staff and a teacher, each of these positions has an impact on the relationships that I have within the theatre department. Some positions are more privileged than others and in some cases I am afforded more access and involvement than in others. Judging the identity that I have been afforded by the other members of staff and negotiating my way through these identities in differing circumstances has proved challenging at times. Recognising the influence that each of these roles has on the research process is equally challenging.

In general, an emphasis on positionality endeavours to challenge the notion of universal, omniscient and value-free knowledge and to verify that a researcher's personal and political position mediates his/her research questions, interpretations, analyses and writing (Choi, 2006). Positionality:

> *"...reflects the position that the researcher has chosen to adopt within a given research study"* (Savin-Baden and Howell-Major, 2013 p.71).

This is normally identified by locating the researcher in relation to three areas: the subject, the participants and the research context and process (Greene, 2014). Reflexivity characterised by the on-going analysis of personal involvement, openness and transparency of potential influence, is seen as critical to the credibility of the study (Mantzoukas, 2005). My triple role or triple identity as an ODP, university lecturer and researcher, has reinforced the recognition of a need to interrogate my own feelings and beliefs. This has led to me reflecting in my field diary upon the influence my prior clinical experience, professional relationships and role as university lecturer has had on my relationships in the field. I am also aware my disability free, whiteness, heterosexuality, Englishness and maleness, correspond with characteristics aligned with a traditional position of power. Consequently, throughout the data collection process, I was aware that I must maintain a reflexive standpoint when observing (and interviewing) participants in order to avoid introducing leading behaviours or projecting my own views and feelings onto the situation. Reflexivity is therefore seen as essential in limiting bias to allow the emergence of a thorough understanding of the experience of this patient group in the operating theatre.

2.4 Insider/outsider perspectives

The terms insider and outsider (Merton, 1972) are labels used to denote the relationship a researcher has when undertaking research within a particular culture (Bruskin, 2018). An insider is considered to be either part of the culture being researched (Gioia and Chittipeddi, 1991), or have natural access to, or be an active participant in the culture (Alvesson, 2009). There are both advantages and disadvantages with being an insider in the culture being studied. As an insider, it can be easier to understand perspectives of the participants, especially if the language of the specific culture is already known. This can make it easier to understand events from the perspective of participants to produce emic rather than etic interpretations (Geertz, 1973; Schieffelin and Ochs, 1986). However, insider status can lead to a familiarity which makes it difficult to distinguish events, while it is also possible to give an over sympathetic account (Hammersley and Atkinson, 2007) with shared biases (Hornberger, 1994).

My analysis of the culture of the operating theatre is clearly influenced by my status as an insider, which could mean I am too native to analyse the culture the way an outsider would. However, this view of the insider/outsider positionality as a dichotomy ignores the grey zone; the blurred lines between being an insider and an outsider and the negotiations and renegotiations that are ongoing during fieldwork. These discussions are much broader than a matter of an employee contract or affiliation with an organisation or culture (Bruskin, 2018). During my time spent in the field, I was both insider and outsider depending upon the perspective the natives in the field took towards me. As a registered ODP and university lecturer teaching in this area, I was seen as an insider. When I was not known in this capacity but regarded purely as a researcher, I was treated predominantly as an outsider. Despite this variation, I would regard myself as much more of an insider than an outsider in this environment. Therefore, when transcribing my field notes I attempted to make the familiar unfamiliar, as Wagoner (2008) suggests:

> *"new meanings can be produced through messages coming from outside a group (e.g. other cultures, experts and active minorities), but can also be created by creatively using social tools one already possesses by belonging to a society. The two pathways of creativity are related and opposing processes: the former 'makes the unfamiliar familiar', whereas the latter 'makes the familiar unfamiliar'"* (p.467).

This approach was deliberately taken in order to address the tension between an emic and an etic interpretation of data. A purely emic approach is difficult to achieve since most research is informed, to some degree, by the researcher's *a priori* knowledge and background as well as from previous studies. Similarly, an entirely etic stance risks ignoring emerging themes and concepts which may prove new and innovative. The challenge was therefore to combine participation and observation so as to become capable of understanding the setting as an insider while describing it to and for outsiders.

2.5 Research methods

The production of text through observation and ethnographic interview and its concomitant interpretation have been the central tenets of this study. This section provides an overview of their use and the way in which the research was carried out. The setting is discussed along with participants, recruitment and selection, data collection, analysis and finally ethical considerations.

2.5.1 The setting

The study was conducted in an acute hospital in the south of England, which provides a range of emergency and elective services and is one of five sites that make up one of the largest NHS Trusts in the country, serving a population of around 759,000 people. The Trust provides comprehensive maternity, trauma, orthopaedic, paediatric and neonatal intensive care for a diverse population with a broad age range. Participant observation took place in four locations in the hospital which together reflect the areas visited by patient participants during their surgical journey.

Setting 1 – Joint school

The first setting was in an outpatients area during the session known as ‘joint school’. The joint school is run within the Trust as a feature of the ‘Enhanced Recovery Programme’ which focuses on educating patients and carers about the process of hip or knee replacement surgery preoperatively, and how to become actively involved in the recovery process. Here, patients attend a presentation explaining each stage of their care so there is an understanding of what to expect. The presentation lasts for about an hour and is followed by an individual interview with a member of the occupational therapy team, who checks the patient’s home situation to ensure all essential equipment and support is in place prior to admission for surgery.

Setting 2 – Main theatre

The second setting for the participant observation was in the main theatre department. Within this department are eight operating theatres, four each side of a long corridor, which cover a range of specialities including ear, nose and throat surgery, head and neck surgery, trauma and orthopaedics, general surgery, gynaecology and obstetrics. Each theatre has a similar geographical layout and comprises an anaesthetic room, operating theatre, scrub area and laying up room (see figure 1 below).

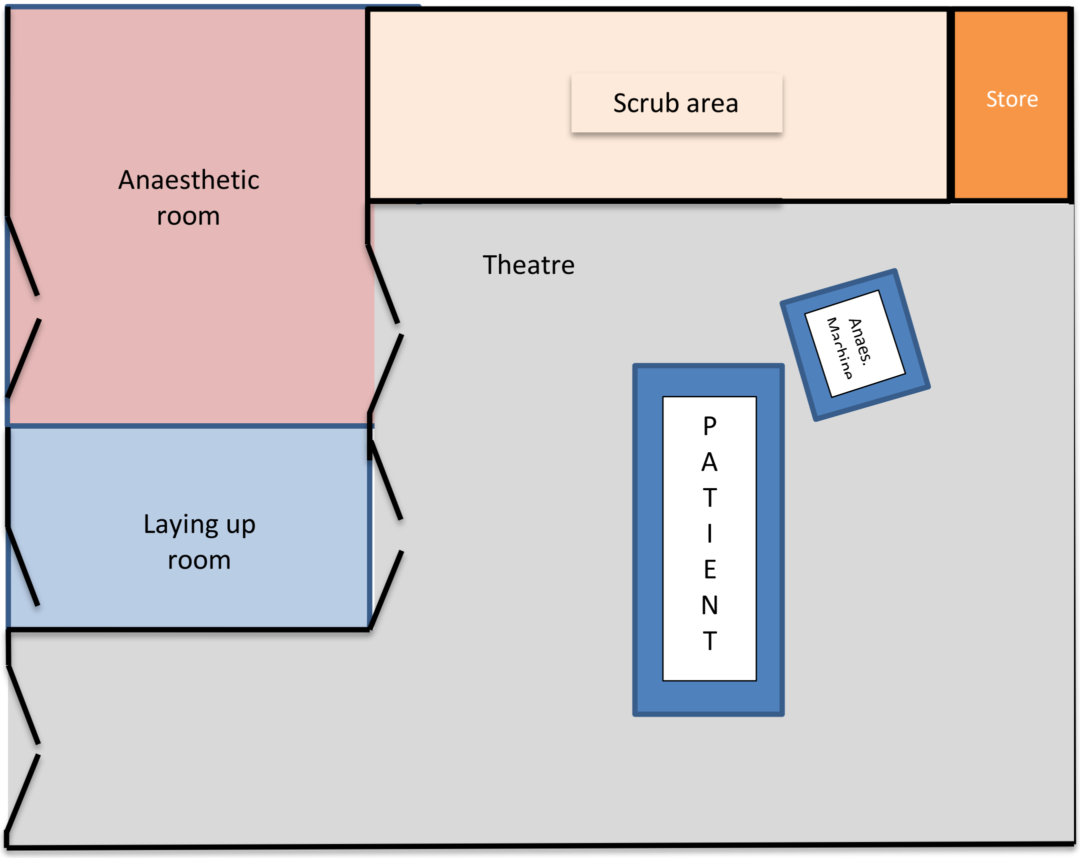
Setting 3 – Day surgery unit

The third setting for participant observation was in a day surgery unit. This is in the same building but a separate unit to the main theatre department although some staff and equipment are shared between the two. This department consists of three operating theatres which specialise in a range of operative procedures which do not require the patient to remain in the hospital overnight. The layout of each theatre in the day surgery unit is similar to that of the main theatre and consists of a comparable arrangement of anaesthetic room, operating theatre, scrub area and laying up room.

Setting 4 – Outpatients clinic

The fourth setting for participant observation was in the outpatients clinic where patients attend an appointment with a surgeon and their progress is reviewed. These appointments are often following referral from a General Practitioner (GP) and each clinic consists of a mixture of preoperative and postoperative patients.

Figure 1. *Operating theatre layout*



2.5.2 Gaining access

Gaining access to the field required several days of preparation and some reliance on previous relationships with key gatekeepers, as well as the forming of new relationships with others. The need to demonstrate consistency and integrity to gatekeepers, especially given the ethnographic nature of this research study, proved to be a key aspect of negotiating access during this time. Despite being granted official approval by the Trust to undertake the study (see appendix 1), entry to the field was initially negotiated through informal emails and phone calls to familiar people within the department. This was followed up through discussions with senior staff including managers, consultant anaesthetists and surgeons. Informal visits were made to the department in order to publicise the study, introduce myself to the relevant gatekeepers and to identify the most suitable time to gain the relevant information. Høyland et al (2015) have emphasised the importance of identifying local managers or gatekeepers who have the experience and expertise to both recognise a research proposal's value and suggest the appropriate route by which to seek access. Within this study, once initial contact was made, these gatekeepers often led to formal and informal introductions within the department. This strategy was further supported by previous nursing and ODP contacts, to lead to the establishing of a rapport and personal access which in turn contributed greatly to gaining relevant information for the study. For example, contacts I already had in the operating department introduced me to members of the surgical team which in turn led to an interview with a consultant surgeon. Pope (2005) notes that alliances with particularly powerful gatekeepers in an organisation can positively influence how research is perceived especially as some people may be suspicious of a researcher's presence and intentions. I found that being introduced by a recognised member of the theatre department acted in a way similar to a reference and that acceptance and access was often much smoother when presented this way.

2.6 Sampling strategy and sample size

This study employed a combination of two non-probability sampling strategies: convenience sampling for patient participants and purposive sampling for staff participants. Although non-probability sampling may be limited due to the subjective nature of choosing a sample which is not representative of the population, this strategy can be useful in studies such as this one, where the research does not aim to generalise results to the entire population. Convenience sampling involves recruiting members of the target population that meet certain practical criteria, such as easy accessibility, geographical proximity, availability at a given time, or the willingness to participate (Given, 2008). In this instance the convenience sample were patients scheduled for knee arthroplasty or knee arthroscopy with a regional anaesthetic at the hospital which was the study site and who were willing to take part in the study.

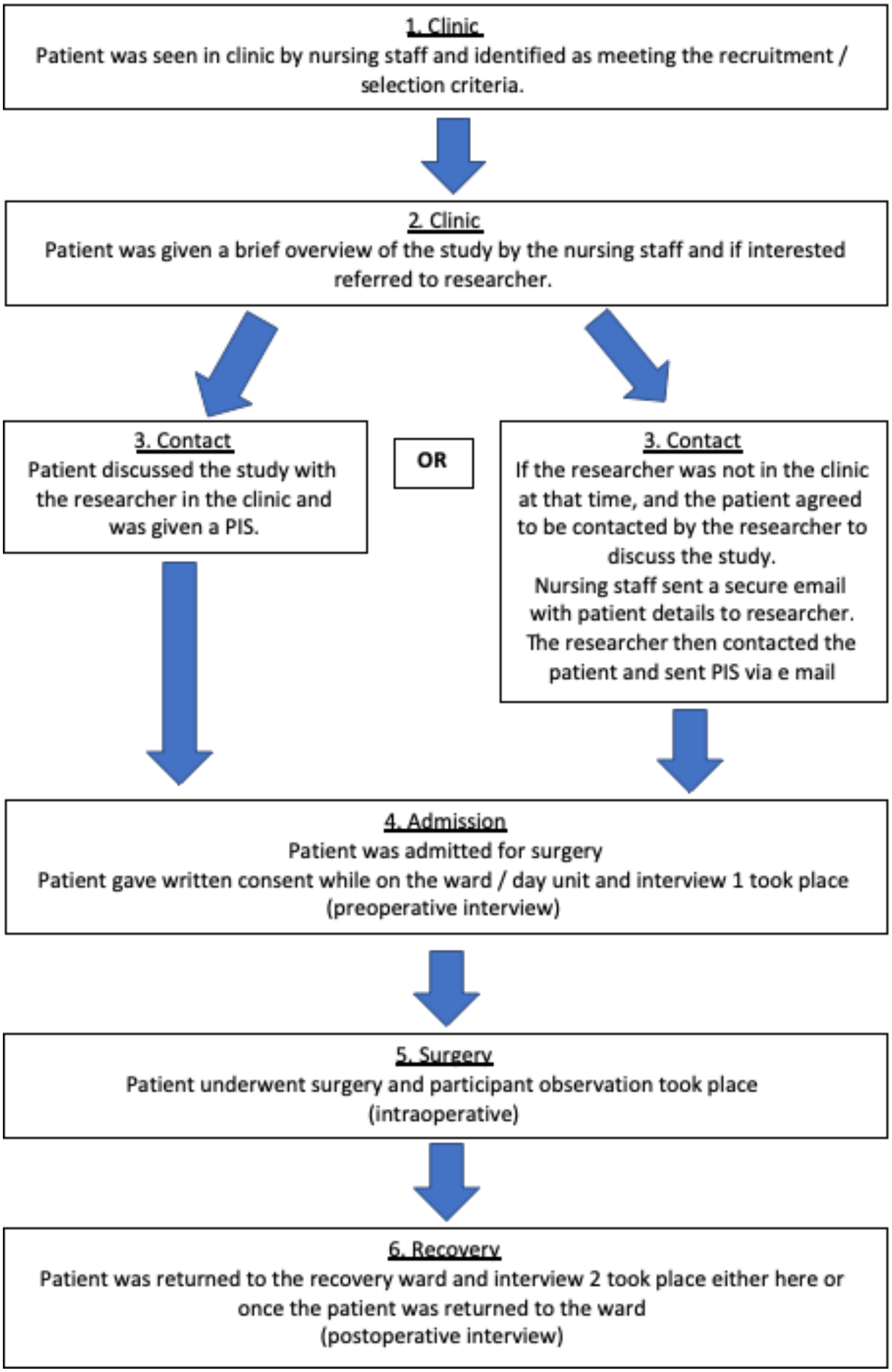
Purposive sampling relies on the researcher's own judgement to obtain a sample of the population to participate in the study. Lincoln and Guba (1985) state that in order to provide robust explanations from which wider inferences can be drawn and to generate conceptual frameworks applicable to the broader population, it is essential that qualitative samples be selected purposively to encompass the range and diversity present in the target population. Purposive sampling of this nature is widely used in qualitative research for the identification and selection of appropriate cases related to the phenomenon of interest (Palinkas et al, 2015). This serves two purposes; to ensure the key areas of relevance to the subject matter are included, and to ensure that within each of the key criteria, some diversity is included so that the impact of the characteristic concerned can be explored. In order to gain a thorough understanding of the views staff hold relating to the interactions that take place within the operating theatre, a purposive sample was necessary to select an appropriate range of staff grades, experience and background. As my starting point was that the viewpoint of the surgeon was likely to be different from that of the anaesthetist, scrub nurse, ODP or anaesthetic nurse it was necessary to purposively recruit participants from each of these professional groups. By gathering information from a range of these perspectives, a more rounded view of the culture of the operating theatre could be ascertained.

Sample size is not felt to be of primary importance in qualitative research design. Rather the important factor relates to whether the participants encompass the range and diversity present in the target population to ensure coverage of defining characteristics that are relevant to the research question (Lincoln and Guba, 1985). A variety of factors can influence the amount of data qualitative researchers gather, and this is not only restricted to numbers of interviews, but also by the presence of participant observation. The number of participants engaged within this study offers the advantage of penetrating beyond a small number of people without generating an unmanageable amount of data and is considered an appropriate number, particularly as the 22 interviews undertaken were supplemented with participant observation amounting to 122 pages of transcribed field diary. The data from interviews and observation provided an opportunity for participants' interpretations to be expanded upon and what was observed could be clarified.

2.6.1 Recruitment and selection of patients

The process of recruiting patients was carried out through the clinical team, a process with which I did not foresee any difficulties. I attended the pre-assessment clinic when suitable patients were being seen by the clinical team, which usually happened several days prior to admission for surgery. The pre-assessment nurse then made the initial approach to see if the patient was interested in finding out more about the study and if so, I discussed the study, answered any questions and provided a participation information sheet with further details (see appendix 2). Following the initial approach, if I was not in the clinic but the patient was interested in taking part in the study, the nurse sent me the patients details via a secure email (see appendix 3) and I contacted the patient to discuss the study. If the patient agreed to take part in the study, I then met with them on the ward once they were admitted prior to surgery and answered any further questions before obtaining written consent (see appendix 4) and commencing the initial preoperative interview. This meant the patient had sufficient time to read the information provided and was in a position to make an informed decision about whether to take part in the study. Although there was some variation in the exact timing of this process, patients always had at least 24 hours between deciding whether or not to take part and signing the consent form. Figure 2 below provides an overview of the patient recruitment process.

Figure 2. *Flow diagram of process for recruiting patients*



1. Clinic
Patient was seen in clinic by nursing staff and identified as meeting the recruitment / selection criteria.

2. Clinic
Patient was given a brief overview of the study by the nursing staff and if interested referred to researcher.

3. Contact
Patient discussed the study with the researcher in the clinic and was given a PIS.

OR

3. Contact
If the researcher was not in the clinic at that time, and the patient agreed to be contacted by the researcher to discuss the study.
Nursing staff sent a secure email with patient details to researcher.
The researcher then contacted the patient and sent PIS via e mail

4. Admission
Patient was admitted for surgery
Patient gave written consent while on the ward / day unit and interview 1 took place (preoperative interview)

5. Surgery
Patient underwent surgery and participant observation took place (intraoperative)

6. Recovery
Patient was returned to the recovery ward and interview 2 took place either here or once the patient was returned to the ward
(postoperative interview)

Unfortunately, this process did not always prove to be as straightforward as anticipated. As Ewing et al (2004 p.452) note:

> *"gatekeeping responsibilities represent considerable challenges for researchers*".

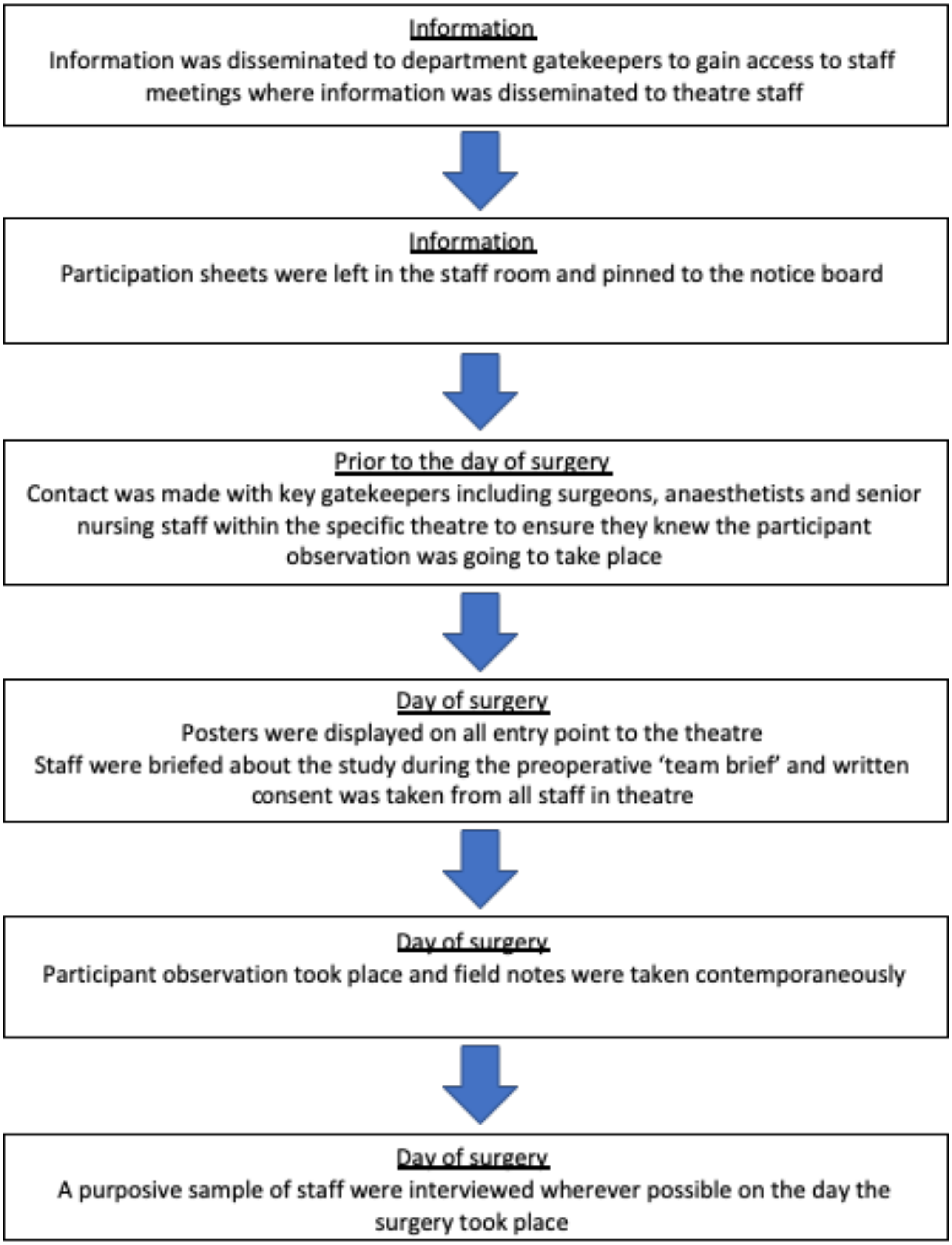
In order to recruit patients to the study, I first needed to know when suitable patients were attending for pre-assessment. Firstly I explained the inclusion criteria (patients scheduled for knee arthroplasty with a regional anaesthetic) to the pre-assessment nurses, and was subsequently given assurances I would be contacted if there was a potential participant booked into any particular clinic. However, in reality, the pre-assessment nurses were often unaware of which patients were attending for pre-assessment until the morning of the clinic and so I was not contacted at any point during the 21 months of participant recruitment and field work. However, I was able to recruit some patients through this route, albeit purely by chance, by attending the pre-assessment clinics on random days and 'getting lucky' that there happened to be suitable patients being pre-assessed. On some of these visits there were no suitable patients scheduled for pre-assessment and it served purely to remind the pre-assessment staff that the study was ongoing and still recruiting participants. However, on other days I was fortunate and there were patients being pre-assessed who met the inclusion criteria of the study. On each occasion I visited, the pre-assessment nurses were happy for me to be there, to discuss the study with any potential participants and introduce me. On one occasion I was allocated a separate office and when suitable patients had been pre-assessed, the nurse discussed the study and routinely referred these patients to see me.

More problematic was the recruitment of patients scheduled for an arthroscopy. As these procedures are carried out as day cases, the pre-assessment process is conducted within the day unit itself. Once again, it was difficult to predict when these patients were being seen prior to surgery. As not all patients scheduled for an arthroscopy will have this surgery with a local anaesthetic, it quickly became apparent that the only way to identify potential participants was to contact the administrators who book patients on to the operating session. Once I knew when these patients were scheduled for surgery, I could identify an appropriate time to attend the pre-assessment clinic. However, the operating list is organised through a separate waiting list office, which cannot easily be accessed and so I needed to be introduced through a recognised insider with admission to this area. Fortunately, I was able to discuss this with one of the senior pre-assessment nurses, who kindly took me to the waiting list office, knew the code for the door, and introduced me to the waiting list office team. It was only following this introduction that I was able to gain sufficient information to finally be in a position to then be introduced to potential participants who might agree to take part in the study.

2.6.2 Recruitment and selection of staff

The study was discussed with staff prior to commencement of the research project and participant information sheets distributed (see appendix 5). Staff participants were identified on the day of the surgery, according to the operating theatre list allocation and consent gained following the theatre team brief prior to the commencement of surgery (see appendix 6). The research design was overt in that I endeavoured to ensure participants were made aware of my presence and that research was being conducted. In order to enhance this, posters were placed at key points within and around the operating theatre so that staff were aware that observational research was being conducted (see appendix 7). It quickly became clear that contacting senior staff (especially the surgeon and anaesthetist) a few days beforehand to discuss the study and answer any queries made the process simpler on the day. Høyland et al (2015) found that access to an operating theatre demands a continuous negotiation throughout the fieldwork in order to gain the approval of the particular surgeon in charge of the operation. In my study, it was not just the surgeon, but also the anaesthetist who effectively became a gatekeeper of the operating theatre. This inevitably increased the total number of gatekeepers for the study considerably and when I was not able to contact senior staff in advance (because they were unavailable or on annual leave for example), explanations needed to be provided on the day of the observation. On one such occasion the anaesthetist did not read the participation sheet or sign the consent form until after the patient's operation was finished and so I did not feel it was appropriate to record any field notes during that session as informed consent had not been explicitly obtained. Figure 3 below outlines the process undertaken in the recruiting of staff participants.

Figure 3. *Flow diagram of process for recruiting staff*



Information

Information was disseminated to department gatekeepers to gain access to staff meetings where information was disseminated to theatre staff

Information

Participation sheets were left in the staff room and pinned to the notice board

Prior to the day of surgery

Contact was made with key gatekeepers including surgeons, anaesthetists and senior nursing staff within the specific theatre to ensure they knew the participant observation was going to take place

Day of surgery

Posters were displayed on all entry point to the theatre

Staff were briefed about the study during the preoperative 'team brief' and written consent was taken from all staff in theatre

Day of surgery

Participant observation took place and field notes were taken contemporaneously

Day of surgery

A purposive sample of staff were interviewed wherever possible on the day the surgery took place

Staff members who were identified to be interviewed were approached following surgery to organise a mutually convenient time and place to conduct the interview. On the whole, staff interviews took place shortly after surgery in a private area within the department. The exception to this was one member of nursing staff, one anaesthetist and one surgeon, where arrangements were made to return to conduct the interview at a more convenient time the following week.

2.6.3 Participants

Two adult patients scheduled for joint arthroscopy and five adult patients scheduled for knee arthroplasty under regional anaesthesia were recruited to the study and interviewed both before and after surgery. One further patient scheduled for joint arthroscopy was recruited and interviewed prior to surgery, but had been discharged following surgery before I was able to conduct a follow up interview. These patient groups were chosen to enable an exploration and understanding of the experience of having surgery with local or regional anaesthesia. Although it is normal for this patient population to receive sedation as a part of the anaesthetic, this is not administered until after the regional anaesthetic and is classed as minimal or moderate sedation meaning that patient responsiveness remained ‘normal’ or ‘purposeful’ throughout (ASA, 2004). In addition to the patients, three surgeons, one anaesthetist, one anaesthetic assistant, one scrub nurse and a recovery nurse were also interviewed, making a total of 22 interviews as well as numerous other incidental conversations that took place during the course of the fieldwork and were noted in the field diary.

2.6.4 Data Collection

Ethnography often involves a combination of data collection techniques to assess the validity of inferences between indicators and concepts by examining data relating to the same concept from numerous sources such as interviewing, participant observation and/or documents (Hammersley and Atkinson, 2007). This research project employed an ethnographic study design, where ethnographic interviews and participant observation were carried out to gather data consisting of 22 interviews (see table 2 below) and 122 pages of transcribed field notes (see table 3 below). The advantage of this study design was to allow the phenomenon under investigation to be examined within the social and cultural context in which it exists. This was an empathetic approach concerned with interactive communication that enabled research participants to be active in the study. A further benefit of utilizing an ethnographic study design was the inclusion of participant observation to gather data in the environment in which it occurred. The term ‘participant observation’ has been used, as I was actively present in the field, although not directly involved in the process of giving care.

Table 2. *Interviews*

Interview		**Number (n=)**	**Gender**
Pre-operative (patient)		8	
	Arthroscopy	3	3 female
	Arthroplasty	5	4 female, 1 male
Post-operative (patient)		7	
	Arthroscopy	2	2 female
	Arthroplasty	5	4 female, 1 male
Staff		7	3 female, 4 male
	Surgeon	3	
	Scrub Practitioner	1	
	Anaesthetist	1	
	Anaesthetic Assistant	1	
	Recovery Practitioner	1	

Table 3. *Participant observation*

Setting	**Number of observation periods (n=)**	**Participants (n=)**	**Gender (patients)**
Joint School	2	7 consultations	4 female, 3 male
Fracture Clinic	2	7 consultations	4 female, 3 male
Day Surgery	2	3 surgeries	3 female
Main Theatre	4	4 surgeries	3 female, 1 male

Participant observation is the data collection technique most closely associated with ethnography (Brewer, 2000) from its origins in British anthropology and the Chicago School of Ethnography (Bulmer, 1984). As such, participant observation is a central feature of ethnography which mitigates against one limitation of relying on interview data alone: i.e. what people do and what people say they do are not always the same. This can serve as a check against participants' subjective reporting as well as gaining an understanding of the social and cultural contexts in which these experiences took place. Atkinson (2017) states:

> *"The value of close participant observation lies in our capacity to observe knowledge in action. It can also give us the opportunity to acquire – possibly at an elementary level – some elements of knowledge and skill. Further, because much knowledge is tacit and only partially, if ever, explicated, it is not recovered through interviewing alone. In fact, there is little or no substitute for direct participation and observation"* (p.123).

Thus, observation in this study allowed an immersion in the field which enabled an understanding of the culture surrounding patient care and the features of usual practice and processes.

Participant observation was carried out during surgery to observe first hand the interactions and context of patient experiences. The advantage of participant observation is that it offers the opportunity to examine the breadth and complexity of the human experience. This method is useful to examine the phenomena of human interaction: with other people, places and with states of being such as age and health status. Through participant observation, factors important for a thorough understanding of the research problem that were not part of the original research design could also be uncovered. This is a stated advantage of the method:

> *"because although we may get truthful answers to the research questions we ask, we may not always ask the right questions"* (Ang, 2014 p.153).

Thus, what was learnt through participant observation helped not only to understand data collected through staff interviews and preoperative and postoperative patient interviews, but also to highlight questions for those methods in order to enhance understanding of the phenomenon being studied.

Field notes were made during participant observation to keep an accurate record of relevant points. During my field work I chose to adopt the position of 'blatant scribe' (Emerson et al, 2001 p.356) and openly recorded field notes on observed talk and action throughout periods of participant observation. This served to establish me in the role of 'note taker' (Emerson et al, 2001 p.356) from the beginning and was a position widely recognised in the field as being a necessary part of my researcher role. Field notes represent a distinct form of ethnographic writing which are composed contemporaneously either in, or in close proximity to, the field. These writings are produced day by day and describe or recount the events, experiences and interactions of the ethnographer in the field at that moment. Therefore, as field notes represent the ethnographers deepening knowledge, emerging sensitivities and evolving insights they evolve during the time spent in the field, often taking on new and unpredictable directions.

In addition to the data collected through contemporaneous field notes taken during participant observation, participants undergoing scheduled surgery for knee arthroscopy, or knee arthroplasty under regional anaesthesia each took part in individual audio-recorded interviews prior to their operation. These interviews followed an ethnographic interview approach, which differs from a traditional interview in that there is no structured interview guide. Instead, the interview attempts to build a rapport with participants to encourage an opening up which enables participants to express themselves in their own way (see appendix 8). I sought to gather rich, detailed data directly from the participants in the social milieu under investigation (Heyl, 2013). The goal of these interviews was therefore to learn more about the operating theatre setting from those whom experienced it themselves, in their own words and in a natural setting.

Preoperative patient interviews lasted approximately 30 minutes each (the shortest was 22 minutes and the longest was 43 minutes) and helped enable an understanding of the preconceptions and expectations these individuals had before undergoing their surgery. All five arthroplasty patients were accompanied by a family member or partner during the preoperative interviews. Before commencing the interviews I made a point of checking if the participant would prefer to be interviewed alone, but all chose to be interviewed in the presence of the family member or partner. Although these were not joint interviews, where family members were interviewed simultaneously (Voltelen et al, 2018), at times the family member or partner did contribute to the conversation to clarify or elucidate upon points. This proved helpful and at times enabled me to gain further information which contextualised the responses provided during the interview. For example Helen [a patient scheduled for a knee replacement] was accompanied in her preoperative interview by her daughter Louise. During the interview, Louise responded to questions to explain or contextualise her mother's answers:

> *Helen: It was him that said that he would put me on the waiting list.*
> *Luke: OK. How long ago was that?*
> *Helen: Ooh 6-8 weeks ago.*
> *Louise: What, when they originally put you on the list it was about 18 months, about a year ago wasn't it?*
> *Helen: No when they came in to see this time. I think it was about 6-8 weeks ago, I can't remember now.*
> *Louise: It's been a long process.*
> *Helen: Mr Henry was on holiday. So Sam was doing the clinic that day.*
> *Louise: But ultimately it was as a result of you losing weight wasn't it. Because all the time you were overweight and they wouldn't do surgery you so you waited a long time to get to this point. Three and a half stone lighter and they agreed to do it.*

Patients took part in a second interview once they were returned to the ward environment and were comfortable and fully recovered. This postoperative environment varied between the recovery ward, the day case discharge area and the post-operative wards. These interviews were also audio-recorded, and lasted between 13 and 35 minutes. The day case surgery patients tended to have shorter post-operative interviews than the in-patients. However, all took place in a private environment where the patient agreed to talk. Although interviews can be seen to take place in a socio – political context of potentially unequal power relations, the intention was for no ones perspective to be privileged. By speaking directly to the patients and utilizing strategies such as incorporating and restating key terms and phrases used by the respondent, the intention was for the respondents' voice to be ranked equal to the professionals' voice so the risk that professional language would override and distort respondent meanings was reduced.

As well as the patients, three surgeons, one anaesthetist, one anaesthetic assistant, one scrub nurse and a recovery nurse also took part in individual audio-recorded interviews. These interviews took place in a mutually agreed private location within the hospital as soon as was feasible after the operation and lasted between 12 minutes and 33 minutes. The purpose of these interviews was to gain knowledge and understanding of factors influencing the patient experience from the staff perspective and to clarify and elucidate upon points identified in field notes through participant observation (see appendix 9). Thus data was collected through preoperative interviews, perioperative participant observation and postoperative interviews of both patients and staff though what Blackman (2007 p.205) describes as an ethnographic mosaic. This approach to data collection is derived from the Chicago School where a combination of different qualitative methods may be used within the context of naturalistic settings. This is particularly important, because one source on its own is not always reliable (Flick, 2007). Within this study, the ethnographic mosaic approach has involved the comparison of data relating to the same phenomenon but deriving from different sources or accounts of the different participants located within the setting.

All participants gave permission for the interviews to be recorded on a digital audio recorder and each interview was then transcribed *verbatim* prior to analysis. Notes made in the field diary during participant observations were transcribed as soon as possible after data collection in order to produce fresher, more detailed information about the day's events. Emerson et al (2011 p.49) suggests those who put off writing up fieldnotes find with the passage of time, the immediacy of lived experience fades and so the process becomes a burdensome, even dreaded, experience. Transcription therefore acted as an essential part of the process which served to correct the limitations of intuition and recollection (Heritage, 1984, p.238).

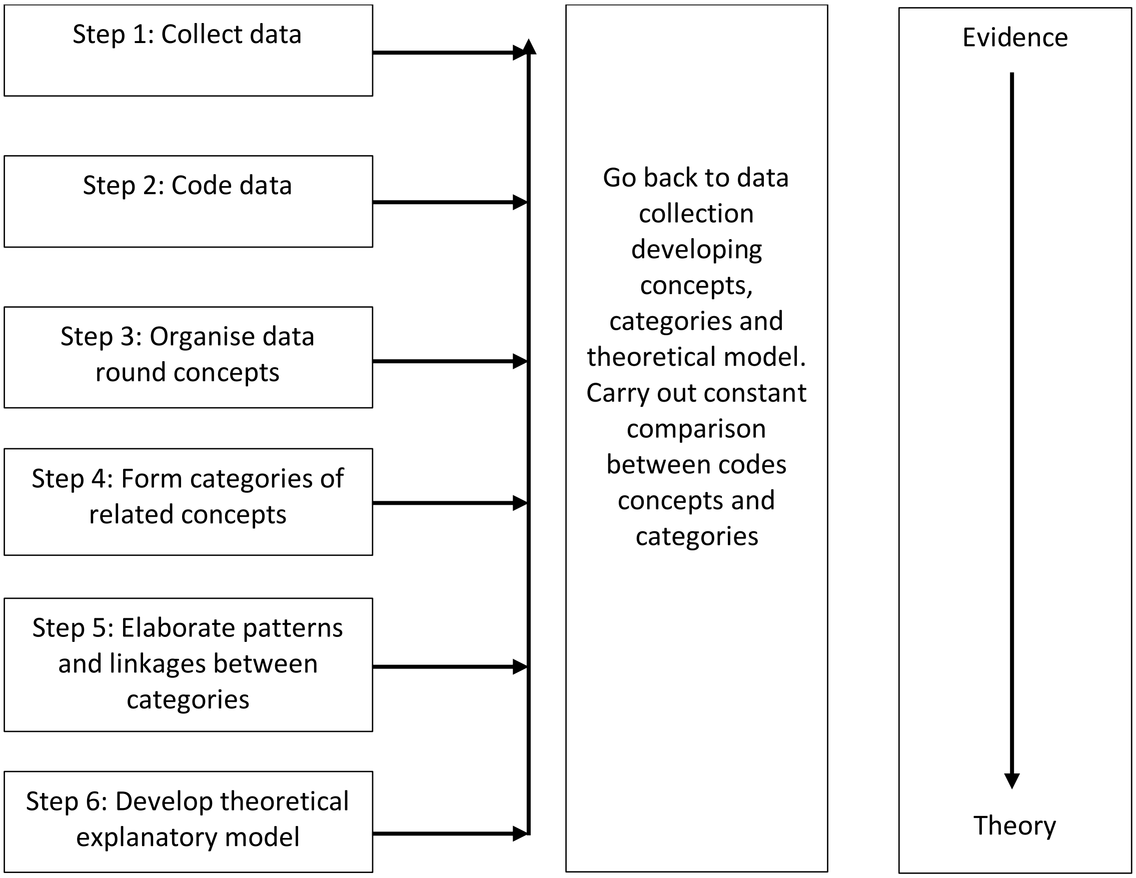
In conducting this ethnography I have relied on multiple sources of evidence which has helped to elucidate which inferences from the data seem more likely to be valid (Hammersley and Atkinson, 2007) and is an approach that has not, as far as I am able to tell, been conducted previously in studies examining the experience of patients undergoing regional anaesthesia and surgery. This method therefore generates new data that will help clarify the most important factors influencing the perioperative experience for this patient group.

2.6.5 Analysis

Qualitative analysis focuses on establishing meaning and interpretation. In order to arrive at explanations of the social situations and processes experienced in the operating theatre, it was first necessary to systematically reduce the complexity of the information generated in the data collection phase (Gläser and Laudel, 2013). Data from the transcripts of interviews and my contemporaneous field notes from participant observation were classified, sorted and arranged using the software programme NVivo 12 as a data management tool. The use of the NVivo 12 software allowed the individual extracts of data to be coded into a number of different but overlapping themes. The advantage of this was not only to save time but also to systematically build the data into a manageable database which could be revisited when necessary.

The six interactive, concurrent steps of grounded theory methodology (see figure 4 below) were conducted following a constant comparative analysis approach (Glaser and Strauss, 1967).

Figure 4. *Steps of grounded theory (Glaser, 1978)*



Fereday and Muir-Cochrane (2006) describe the analysis of themes as a form of pattern recognition within the data, where emerging themes become the categories for analysis. Once distinct patterns were identified, the remaining data were linked to, and integrated with, these broader themes (Gläser and Laudel, 2013). The first stage of the analysis was to become fully immersed in the data (Silverman, 2010) and began with data collection. As the researcher I was thoroughly familiar with the resultant data as the ethnography progressed. I transcribed two of the interviews myself and checked all of the remaining transcripts for accuracy. I also transcribed all of my field notes from the field diary into a word document noting down initial ideas in the form of memos which I highlighted in red text. For example, the following memo on X-rays was made at the time of transcribing:

> *X-rays are invasive views of the patient, but because it is not possible to recognise an individual from the shape of their bones they are anonymous – unless the person is introduced by way of history or background. X-rays are not bones. They are a representation of the bones. Doctors use X-rays when discussing with patients what they perceive to be the problem. The patient's symptoms need to be explained by the doctor in terms of the X-ray. Where there is a discrepancy, the X-ray is used as evidence to support the medical view. This is regarded as definitive, regardless of what the patient is experiencing. This disenfranchises the patient, because the 'medical gaze' is given priority over the patient experience.*

This comment demonstrates an early identification of the role the medical gaze plays in the consultation process, although not fully formed as a theme at this point. Memos such as this were kept to record theoretical notes that occurred during the coding process. These helped identify concepts, emerging ideas or other thinking that encouraged further exploration to begin the process of making cohesive sense from the data. Memos also helped keep track of assumptions, biases and opinions during the research process (Roper and Shapira, 2000).

The next stage involved generating preliminary codes across the data set. Coding is essential to the development of a grounded theory as Charmaz (2006) explains:

> *"coding is the pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you define what is happening in the data and begin to grapple with what it means"* (p.46).

Analysis was carried out within case (i.e. looking for themes within each transcript) and across case (i.e. between the different transcripts) and began with reading, re-reading and annotating the transcripts to identify themes, concepts and categories within and across the transcripts and field notes. This was an inductive process that involved learning from the data rather than starting with preconceived notions about the subject matter (Tie et al, 2019). Data analysis commenced concurrently with data collection in order to allow additional themes to be identified and subsequently followed up. Numerous initial themes were necessary at this stage because it was not possible to predict what might emerge as relevant or important while the analysis progressed. As the data collected in this study was in the form of written words from the field diary and transcripts of interviews, it was necessary to group those words into meaningful categories or descriptive labels so they could be organised to compare, contrast and identify patterns (Munhall, 2012). This iterative form of open coding was conducted without any restrictions or purpose other than to discover meaning in the transcripts in an open way that allowed for the discovery of the unexpected without encouraging final closure. Codes were then organised around concepts, from which patterns or themes developed and a sense of possible connections between the information was gained. For example, one passage from the field diary states:

> *Leena* [the anaesthetic practitioner] *stands nearby but waits before engaging in conversation. "Are you warm enough?" she asks.*
> *"It's beautiful – lovely" Nigel replies. He is referring to the forced air warmer that is blowing warm air at him.*

This was coded as body\physical sensation\comfort which later became part of the overarching concept of embodiment. During the analysis a constant comparison method was used (Glaser and Strauss, 1967), which constantly compares each piece of data with codes and notes that have already been identified. However, it should be noted that not all data became codes or fitted into concepts. Outliers, or cases, situations or events that did not fit with the rest of the data were also identified and further explored to identify any patterns or connected findings related to developed theories grounded in the data. The comment by Helen [an arthroplasty patient] in her postoperative interview:

> *“ I will do the exercises because I am determined I am not going to be in that wheelchair for the rest of my life”*

was initially coded as perspectives\long term perspective\optimism, but this was not developed further as there was limited data to support the evidence of this as a separate concept across cases.

Using a grounded theory approach (Glaser and Strauss, 1967), analysis of the observation data informed which healthcare professionals were approached for a formal interview, and interviews helped to guide the focus of further observations. Matters that appeared to be of particular importance or relevance to the study were followed up and interviews also helped explain and put into context data gathered through observations. For example, it became clear that to understand the context of the day case arthroscopy patient’s experience, as well as observing and interviewing patients, I would need to spend some time interviewing the surgeon that carried out the surgery.

Following the steps of grounded theory identified by Glaser (1978) (see figure 4), data analysis led to an affirmation and understanding of existing concepts that were then applied in new and novel ways to this setting to generate new theory. Consequently it was possible to consider comments from the research participants and through the interpretation of data that certain ideas and points could be applied to offer increased understanding of the actions within the setting. Thus the extract from the field diary:

> *“You have a nice pink leg now” she says (the leg is painted in a pink solution that stains so that it is clear which areas have been covered and which areas have been missed). Nigel clearly remembers this part of the process from when he has visited operating theatres in his working life “Not the brown stuff? The iodine?” he asks. Jane explains that we do not use iodine for preparing skin for surgery anymore.*

Was coded as capital\cultural capital\patient capital where patient capital could be described as arising from elements of a language of description, which formed from a crucial and interactive approach to the data.

Four key themes were identified during the analysis of the data which then formed the basis for the empirical chapters: trust (chapter 3), capital (chapter 4), embodiment (chapter 5) and the clinical gaze (chapter 6). The key themes were identified since they were the most prominent across the data set. In other words, these key themes were repeatedly articulated by different interview participants and were frequently observed during participant observation. Each of these themes is discussed in more detail in the separate empirical chapters.

2.7 Ethical considerations

Ethical approval was granted on 7th April 2016 (Rec reference: 16/SC/0153, see appendix 10). This section will consider the ethical principles underpinning the research and consists of four sub-sections which address informed consent, participant's anonymity and confidentiality, data protection and the care and protection of the participant.

Murphy and Dingwall (2001) note that like all researchers, ethnographers have a responsibility to not only protect research participants from harm, but also to have regard to their rights. Beauchamp et al (1982) gives a set of principles to be followed in order to protect research participants from harm. These include the principle of *non-maleficence* that researchers should avoid harming participants, *beneficence*; that research on human subjects should produce some positive and identifiable benefit rather than simply be carried out for its own sake, and *autonomy or self determination*; that the values and decisions of research participants should be respected. Although this project has been approved by the NHS Research Ethics Committee and the Trust's Research and Development office (see appendix 1), these responsibilities do not stop once ethical approval has been granted and the study commences. Geertz (1973) explained ethnography in terms of a fundamentally interpretive enterprise which cannot be disentangled from either values or ethics. Although the risk of harm is not the same for an ethnography as it would be for a biomedical randomised controlled trial involving a new drug or surgical procedure (Murphy and Dingwall, 2007), there remains a risk of harm which needs to be considered and attended to as the field work unfolds (these issues are discussed further in section 2.7.4 Care and protection of the participant). As Parker (2007) notes, ethnographic research has implications for the communities it studies and consequently, has an increasing perception of having a duty to represent or ensure a voice to marginalised or vulnerable groups. It was therefore necessary to maintain a mindful consideration of the well-being of the individuals being studied throughout the field work while simultaneously attempting to understand the voices and the silences observed.

2.7.1 Informed consent

Within the biomedical paradigm, informed consent has tended to be interpreted in anticipatory terms. This raises concerns for ethnographers as it is based on the notion that the methodology, research questions and the implications of these can be anticipated, discussed and agreed to before the research has begun (Parker, 2007). Strathern (2000) has suggested this places the relationship between the ethnographer and participants on an unequal footing, with the ethnographer as 'initiator' in the 'point of production' (p.295). In this ethnography, consent needed to acknowledge the research undertaken was based upon the tentative development of research questions and analysis in the context of emergent themes not entirely compatible with the concept of anticipatory informed consent.

In order to gain informed consent, a healthcare professional who had been briefed on the study first approached the patient to see if they were interested in taking part. All participants (patients and healthcare professionals) who were approached to take part were provided with written information in the form of participant information sheets (see appendices 2 and 5 respectively) supplemented by verbal explanation where required and asked if they would like to take part. Participants were informed that the study involved observation of the interaction during the surgical experience and that interviews would involve questions around these experiences for clarification. The aims and objectives of the study were explained and posters (see appendix 7) displayed throughout the observation periods to explain this work was in progress and during this time, informal interviews or casual conversations that occurred may play a role in the fieldwork.

Written consent was obtained from all those agreeing to take part prior to interviews or participant observation. It was explained to both patients and healthcare professionals that their participation was entirely voluntary, they were free to withdraw from the study at any time, and that confidentiality would be maintained. Patients were reassured that the standard of their care would not be affected in any way by the research; and healthcare professionals were reassured that it was not the purpose of the research to question their competence.

2.7.2 Participant’s anonymity

Anonymity and confidentiality of participants are central to ethical research practice. Throughout the study, I strove to reassure participants that I would make every effort to ensure the data they provided could not be traced back to them either in this thesis or in any reports, presentations or other forms of dissemination that may arise from it. Before giving consent to take part, all participants were informed that some of their words might be quoted. However, it was also explained that pseudonyms would be used and other modifications made at the time of transcription, to ensure anonymity was maintained. In addition, I have also changed other characteristics of participants such as job title or ethnicity to conceal identities and thereby maintain the confidentiality of the data provided by participants.

2.7.3 Data protection

The interviews were audio-recorded and the recordings, transcriptions and observation notes were kept in a locked drawer to which only I had access. An anonymisation log of all replacements, aggregations or removals made to the original transcripts was recorded and stored separately from the anonymised data files. Audio recording equipment used to record interviews and data from field notes was kept in a locked filing cabinet when not in use and data uploaded to a secure password protected server or desktop computer with all recordings removed from the portable device as soon as possible. All data and personal information was stored securely within university premises in accordance with the General Data Protection Regulation (2018) and the University’s own data protection requirements. Data could only be accessed by myself and my supervisors and all data was made anonymous (i.e. all personal information associated with the data was removed).

2.7.4 Care and protection of the participant

Despite the risks for research participants taking part in this study being minimised as much as possible, there will always remain a chance that subject matter will include topics that are emotionally difficult for participants to recall or discuss. Examples of this could include the discussion of adverse events or critical incidents which involve theatre staff or the discussion of the perioperative experience of patients. In reality, this type of discussion did not arise in a problematic way during the study. However, in the course of the patient interviews, some unanticipated topics of conversation arose at the initiation of the patient. One such unexpected turn in the discussion involved the mental health of Janet [the patient]'s husband:

> *"He was watching porn – now he has never… ever… And it was only um he hadn't turned the channel over and when I came down in the morning I put it on. Well its only mild porn during the day yeah and and he just denies it you know. And then eventually because he was looking so unkept [sic] and everything it came out that he had this drinks problem. He had been dropping off at Tesco and buying bottles of wine and everything. It it it's worrying in so much as..."*

In this instance, before continuing, I queried with Janet whether she was happy to continue with the interview being recorded and reassured her of the anonymous and confidential nature of the interview. Janet expressed her wish to continue, which we did. However, after the interview had concluded, I reiterated the support that was available from the Trust's patient experience team and patient liaison service. Although this was not an area I was asking about directly, in order to gain an understanding of the factors that patients regard as being the most important in influencing their surgical experience, it should be recognised that unexpected issues need to be allowed to come into ethnographic conversations and be elaborated on where relevant (Crang and Cook, 2007).

The discussion of personal issues such as this was mitigated in part as interviews were only conducted with the knowledge and approval of the participant. I also have experience, knowledge and understanding of the perioperative environment as an ODP registered with the Health and Care Professions Council, which enabled me to adopt an empathetic approach towards research participants, especially those recalling emotionally difficult experiences. The option for patients who became anxious or distressed to be referred to the Trusts Patient Experience Team (PET) or Patient Advice and Liaison Service (PALS) was made clear in advance and reiterated during the interview where appropriate. It was also made clear that interviews may be paused or suspended where necessary, although during the data collection period this only occurred in response to patients needing some medical intervention (for example the nurse checking blood pressure and other routine observations) or clinical staff being temporarily called away during the interview to respond to other commitments.

2.8 Summary

The methodology discussed in this chapter has been guided by my values, beliefs and assumptions and the methodological outlook is from an interpretivist theoretical perspective (influenced by symbolic interactionism), underpinned by a social constructionist epistemology. Key symbolic interactionist influences such as Cooley (1902), Mead (1934) and Goffman (1959) are cited in relation to the approach to the fieldwork and data collected from the perioperative environment. The tradition of the Chicago School has been highlighted as an ethnographic approach that has been used to gather data from preoperative and postoperative patient interviews, participant observation and staff interviews, although other incidental data from the field such as casual or informal conversations have also contributed to the information gathered. The problems associated with participant recruitment have been considered alongside how the use of non-probability sampling was shown to be effective in establishing a relevant sample with which to perform participant observation and ethnographic interviewing processes. The importance of gatekeepers and the complexities of adopting an insider/outsider research position have been examined in relation to the multiplicity of research positions assumed within the fieldwork. Further to this, a reflexive approach towards participant observation and ethnographic interviewing is discussed as an effective way to gain research data appropriate to biographical research, particularly within the context of the fieldwork location. The use of grounded theory methods have been reviewed within the context of medical ethnographies as these methods have been used to analyse the data, with the intention that although the findings of the study are not the ‘truth’ they are ‘truthful’ and reflect the genuine negotiations between the researcher and the participants.

CHAPTER THREE: TRUST

3.0 Introduction

This chapter is the first of four empirical chapters presented within this PhD thesis, each of which corresponds to one of the four main themes identified during the data analysis. Denzin (1997) suggests ethnographic researchers enter the same terrain as 'storytellers' when writing about social, cultural and medical situations. By presenting each of the four themes identified through the data analysis in this way, the intention is to provide a feasible account or 'story' of the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. The theme presented within this first empirical chapter is 'trust'.

The concept of trust is a human universal which can be found in all societies throughout history (Pilgrim et al, 2011). Definitions of trust vary (for example it can be both a noun and a verb), but it can be regarded as:

> *"a characteristic belief that the good will, sincerity, or truthfulness of others can generally be relied upon"* (Rotter, 1967 p.651).

Trust at its most positive is a comforting experience which rewards the placing of trust in friends and relatives in ongoing predictable relationships with a sense of well-being and belonging (Pilgrim et al, 2011). However, a generalised or societal trust which is not based on knowledge of the individual to be trusted has been described as 'thin' interpersonal trust, and this differs from the 'thick' interpersonal trust people have in close friends and family (Dawson, 2019). Generalised or societal trust relationships are typically found where there are conditions of risk and uncertainty; circumstances which are almost always present in surgery. Expectations are such that members of the surgical team must possess not only the necessary technical skills to perform the surgery, but also the ability to foster trust with the patient. Due to the nature of the discipline, members of the surgical team must establish a bond of trust with their patients, based upon clear, effective, and caring communication, the quality of which is often judged not only by what is said but also how it is said (Rodriguez and Pellegrini, 2019). The surgical patient grants a discretionary, temporary power to the surgeon in order to achieve something desirable; improved health or even preservation of life (Axelrod and Goold, 2003). As a consequence, the trusting patient is placed, reluctantly, in a position of susceptibility in relation to the surgical team. Therefore, an ability to trust can be seen as a fundamental element of the surgical process because of the necessity for the patient to give up agency to the surgical team in a relationship that depends upon trust. Trust in this context involves an amount of vulnerability and patients typically proceed with caution because there is a significant possibility of harm. This trust relationship extends beyond the patient's need to trust, as spouses, parents and others who have an interest in the care for their loved one must also place their trust in the surgical team.

Erikson (1963) described the capacity to trust others as an essential element in the development of a healthy personality and successful social adjustment. Trust versus mistrust is the first stage outlined in Erikson's theory of psychosocial development (1963) which begins at birth and continues to approximately 18 months of age. During this stage, the infant is uncertain about the world in which they live and looks towards their primary caregiver for stability and consistency of care. If the care received is consistent, predictable and reliable, then a sense of trust develops which is subsequently carried into other relationships. However, if care is inconsistent, unpredictable and unreliable, the infant does not have confidence in the world around them or in their abilities to influence events, which leads to a sense of mistrust, suspicion, and anxiety. Erikson's (1963) theory of psychosocial development can be regarded as relational in its orientation because it encompasses an individual meaning-making constructed by the self in relation to others (Josselson, 1987). Dawson (2019) has argued that a propensity to trust is not based solely upon an individual's personal experiences but is also influenced by strong cultural roots. This view suggests the concept of the trustworthy professional is sustained as much through social culture as it is by individual experience.

3.1 Trust and Faith

The concept of trust is predominantly associated with situations of uncertainty and risk, where predictions are made about expected future behaviour based on known previous outcomes. Conversely, faith involves placing trust in people or groups of people who are not known personally and therefore is not based upon outcomes from previous experiences. If trust can be regarded as a strategic response to trustworthy behaviour by others, faith is a variant of trust in that it is a more moralistic trust. Moralistic trust relies on the moral directive that people should always be treated as if they are trustworthy (Uslaner, 2008). The term 'faith' clearly has religious connotations as it is more commonly used in a spiritual context. While trust is grounded in experience, faith is considered an allegiance, duty or loyalty to something and can be regarded as having belief even in the absence of tangible proof.

The trust in medical staff was described in terms of 'faith' by several patients in this study. Expressions of faith in the hospital or healthcare provider may be an expression of a common faith in the NHS, which itself is reflective of the communal trustworthiness the NHS has in UK society. Trust between the patient and their healthcare provider has been shown to be influenced by the funding arrangements of the healthcare system (Gilson, 2003). The non-exploitative ethos of the NHS, which remains free at the point of contact, removes overt financial incentives affecting provider behaviour. In turn, this increases the perceived trustworthiness of the providers working within it (Whitehead, 1993). Conversely, Mechanic (1996) has suggested some healthcare initiatives in the USA have generated distrust because they were believed by patients to create financial incentives for the doctor to act against the patient's interest (e.g. by reducing the amount of time spent with patients or by discouraging certain forms of treatment), even though this was not supported by the empirical evidence (Mechanic, 2001). Furthermore, transparent mechanisms for funding and resource allocation may reflect a perceived fairness that promotes trust in the healthcare system, with positive trust associations for the providers themselves (Levi, 1998; Offe, 1999). However, every trust relationship sets up a potential power imbalance which may expose one party in the relationship to unethical behaviour. This is especially evident in situations where one party controls access to resources the other party wants and benefits personally through this relationship (Warren, 2002).

Trust based on the prediction of the behaviour of an unknown third party, may be a 'blind faith' in as far as the patient does not know the numerous individuals involved in the caring process. Although the individual does have some knowledge or experience of the trustworthiness of the NHS as a whole, blind faith without caution may enable the abuse of power in the form of exploitation or domination, especially given the vulnerability of surgical patients. In the following extract taken from an interview with Astrid [a patient scheduled for a knee arthroscopy] just before her operation, Astrid explains how she has faith in the treatment she will receive:

> *Astrid: Yes. I want them to take control. They know what they're doing.*
> *Luke: So how much do you know about these people that you're giving over control to?*

> *Astrid: Absolutely nothing.*
>
> *Luke: So how are you comfortable giving over control to someone you don't know?*
>
> *Astrid: Well I've just got to take that risk and faith. These people, they are all people out there who've got a job where they want to help people. They've only got the, that interest, you know and if anything went wrong it would be just fate, an accident. It's not, you know.*

Here Astrid acknowledges that she has no knowledge of the individual practitioners, but has faith in them as they represent the professions which in turn make up the health service. In other words, Astrid has faith in the institution and the individual elements that make up that institution. Calnan and Rowe (2006) refer to this as an embodied trust (p.16) which involves the patient basing their judgement on the reputation of the organisation or individual. This is supported by the reference to 'fate', which implies that individual practitioners are exempt from blame should anything go wrong during Astrid's treatment. One patient (Nigel, a patient scheduled for a knee replacement) chose to research the reputation of the surgeon prior to the operation in order to help make an assessment of whether to trust the surgeon to operate. As he explained when I interviewed him before his surgery:

> *Luke: OK. How do you feel about Mr Kapel? Have you ever met him before?*
>
> *Nigel: Yes, well I've met him when I first was referred to the hospital in the summer. And then I met him about half an hour ago.*
>
> *Luke: And how do you feel about him doing the operation?*
>
> *Nigel: Oh very confident yes because obviously having spoken to him it was good to know that he wanted to do what I wanted him to do in terms of the procedure. And then of course I did the usual checks on the internet to see how many he's done, what his success rate is and so on.*
>
> *Luke: You checked him out rather than checking the operation out?*
>
> *Nigel: No I checked him out. Oh yes.*
>
> *Luke: Do you do that for everybody?*
>
> *Nigel: Oh yes.*
>
> *Luke: And what was it on there that made you think yes he's ok, or no he's not OK?*

> *Nigel: Things like infection rate which was very satisfactory whether it was compared with the national average or in terms of a figure on its own. His experience of doing the operation... These are the main things yeah.*

Doreen [a patient scheduled for knee replacement surgery] was more willing to put her faith in the surgeons as she explained in her preoperative interview:

> *"I'm quite happy. The doctors know what they are doing. It's a routine job for them. they've done it many times. I've every faith in what they are doing so I'm not worried about that side of it".*

Once again, the patient is placing trust in an organisation rather than an individual who is known to them. Whereas this type of trust in an individual who is not known personally would normally be a form of thin interpersonal trust, the knowledge of the organisation as having a trusted position in society, means that a thick interpersonal trust is replaced by faith in the organisation as a whole. These data extracts demonstrate how patients use faith as a strategy to have confidence in the 'they' which is the healthcare team, despite knowing nothing about these individuals and not having met them previously. This fits with both Uslaner's (2008) notion of 'moralistic trust' (p.104) where trust is viewed as having a moral dimension which requires people to be treated as if they were trustworthy and Calnan and Rowe's (2006) view that embodied trust implies clinicians altruism is unquestioned and well intentioned (p.16). Overall, there is an expectation of the NHS as being worthy of a common faith and holding a position of trustworthiness in the community. However, the extent to which trust in individual medical staff is simply blind faith (Skirbekk et al, 2011) bestowed upon individuals as representatives of a wider group, or a kind of conditional trust (Calnan and Sanford, 2004) situated somewhere between acceptance and critical trust (Poortinga and Pidgeon, 2003) depends upon the specific relationship and the particular circumstances.

Violet [a patient scheduled for knee replacement surgery] did not use the word 'faith' when she was interviewed before surgery, but she did express a similar sentiment when discussing her attitude towards her operation:

> *Violet: Look, this is my attitude. I've done my job all my life. Somebody else can do theirs. That's their job. I'm removed from it. I'm just the bit in the middle that they're concentrating on.*
>
> *Luke: OK. So you're quite happy to just sort of hand over control to…*
>
> *Violet: Yes they know their job. I'm not going to interfere.*
>
> *Luke: So you've met the surgeon?*
>
> *Violet: Yes, He's sweet*
>
> *Luke: And you've met the anaesthetist?*
>
> *Violet: Yes*
>
> *Luke: OK. So how did you decide that you're quite happy to give over control to those people?*
>
> *Violet: How did I decide? That's their job. They know what they're doing presumably. I don't. They can do what they do.*

In this extract, Violet initially appears to be demonstrating her faith in the doctors, whom she does not know, to perform her surgery. However, she has met both the surgeon and anaesthetist briefly and based on this meeting has decided the surgeon in particular is *"sweet"*. Because Violet is not in a position to be able to judge the practical competence of the surgeon before her surgery, she uses the only tools at her disposal: the ability of the surgeon in social situations. Violet draws the conclusion that if the surgeon is socially adept, he is also surgically adept. Mechanic (1998) suggests that while the authority of physicians to reinforce expectations of treatment has its advantages, this is increasingly less likely to come from patients' belief in the supremacy of physicians, but may arise from the ability of clinicians to develop relationships of mutual trust (p283). These relationships are characterized by demonstrations of empathy, support, guidance and care which help patients cope constructively with the uncertainties of illness and gaps in medical knowledge. In situations where these interpersonal skills are not adequately demonstrated, trust may not be forthcoming. When asked, Violet went on to explain how she refused the opportunity to have her surgery performed sooner at a different site, purely because she did not feel happy with the surgeon there:

> *Violet: Well I did have a phone call to say would I be prepared to go to this other hospital? and I said you know if they had a vacancy and could get me in quicker. And I said "yes*

> *anything to get it done quicker." Well, I went to see and I'm afraid I didn't like the surgeon there. I felt he was doing his damnedest to put me off having it, having the operation. I just didn't like him at all. So when I came back here for the pre-assessment I told them I don't want to go there.*
>
> *Luke: What was it about him, I don't know, was it attitude or..?*
>
> *Violet: His attitude, his... He made me feel as if I, you know it's put on to put me off as if I didn't really need it. Now how did he know what pain I was in? how far I could walk? how much it was? how debilitating it is not being able to get around? But he's a surgeon. Presumably he does know. He has other patients but I just, no, I didn't want him doing it.*

Violet felt let down by the surgeon's lack of willingness to engage in understanding her individual experience and by a failing to demonstrate characteristics of honesty and respect. Green (2004) has proposed the shift towards shared decision-making in doctor-patient relationships, through a provision of information and greater patient involvement in care, can produce greater interdependence between patients and clinicians. Shared decision making can be regarded as a process whereby patients are involved as equal and active partners with the medical and healthcare professionals in clarifying acceptable medical options in order to choose the preferred course of care that is appropriate to the individual (National Voices, 2014). These elements of doctor's behaviour have previously been identified as influencing the trust experiences of patients and have been highlighted as fundamental aspects of the patient doctor relationship which are more noticeable by their absence than their presence (Thom and Campbell, 1997). Although these characteristics do not relate to the technical ability of the surgeon to carry out the surgery competently, without a fundamental level of trust Violet felt unwilling to allow this surgeon to operate on her. Instead preferring to endure her symptoms until an opportunity to have her operation with a different surgeon arose.

3.2 Institutional trust

Trust relies on the belief that another person or body of people will act in your interest in a future enterprise. Both interpersonal trust (between a patient and doctor or other healthcare professional) and institutional trust (between a patient and hospital or healthcare system) are critical for the functioning of healthcare, including patient engagement with providers and adherence to recommendations (Christmas and Millward, 2011). At the heart of healthcare provision is the patient/provider interaction so the effective delivery of healthcare requires not only the supply of care but also the acceptance and use of services by the patient (Gilson, 2003). However, while institutional trust operates on a macro level, interpersonal trust operates on a micro level and the relationship between the two is complex. Calnan and Sanford (2004) have demonstrated that levels of trust in the overall system are less important for patients than the levels of clinical competence demonstrated in addressing patients' personal needs and interests. Patients are able to trust individual medical practitioners to be proficient despite not trusting the system to function effectively, although this trusting relationship can be undermined where patients feel they are not being listened to or treated as an individual. The strategies patients use to make trust determinations and test trustworthiness reveal important dynamics of the trust relationship. Calnan and Rowe, (2006) suggest patients may rely on an 'informed trust' (p16) which is associated with the use of information to calculate whether trust is warranted in a given clinical exchange. In this type of trust relationship, the patient typically weighs up the information given with a greater suspicion and scepticism about others' intentions. The data gathered during the course of the fieldwork indicates when a patient feels their treatment is following a standardised protocol or policy rather than being based on their individual circumstances, a conflict can arise which undermines trust. This is reflected in the following extract from a preoperative interview with Tina [an arthroscopy day patient]:

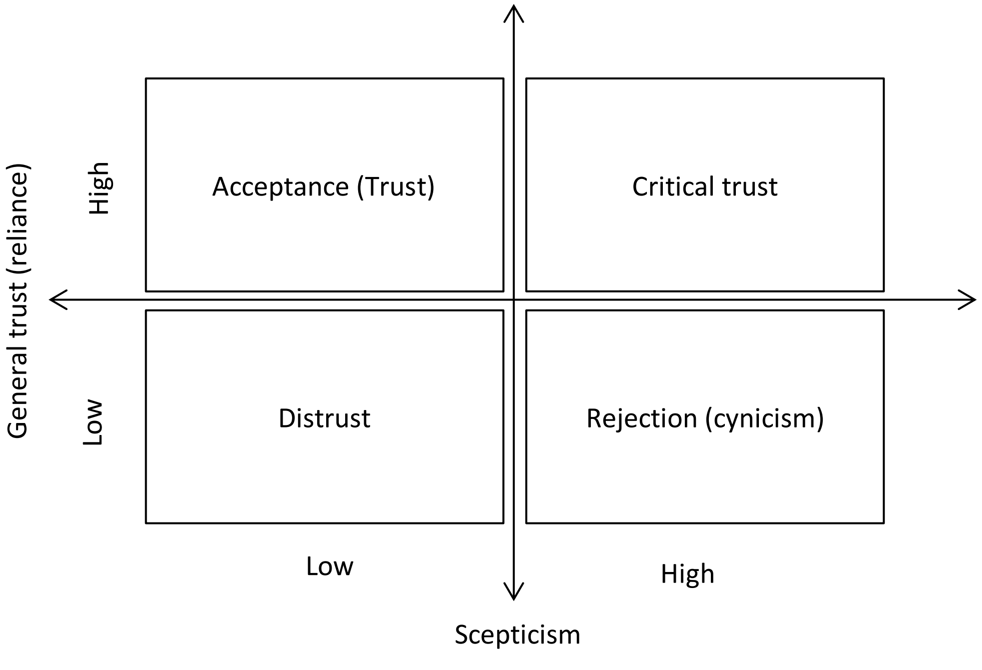
> *Tina: Yes, so you have to start off with a GP appointment, who then says you need an X-ray. I know an X-ray would show nothing. I said "no I need an MRI" but "no we can't do that because it's part of the protocol" So you go for an X-ray, you wait weeks for that result and then you wait weeks to go back to the GP to get that result and then he says "oh you need an MRI" and I said "yes. I did say that"*
> *Luke: What was his reaction when you said that to him?*
> *Tina: Well I wasn't very happy at that point actually. I wasn't very happy because the initial consultation wasn't great with my GP. So then you wait weeks for an MRI. And then you wait weeks to get the result and then you wait weeks to go back to the doctor.*
> *Luke: Did you have to chase those results up as well or did they?*
> *Tina: I did yes. No I had to chase the results. And then you wait weeks to see an orthopaedic person. The whole thing has been going on probably since about last September.*

This extract demonstrates how the trust relationship was undermined because the Doctor followed a standardised protocol which Tina felt was not appropriate for her. This resulted in real and tangible consequences for Tina, as she needed to wait longer before being referred for surgery. Despite the delay being due to a protocol which was dictated by the system, Tina explained this in terms of a poor consultation with the GP rather than as a fault with the protocol or system. Trust has previously been found to build iteratively through experience, which has been used to explain the greater trust in long-term rather than short-term medical relationships (Kao et al, 1998). Long term relationships have been found to imply a sense of affiliation between the patient and healthcare professional as in 'my doctor' or 'my patient', which may be referred to in terms of an implicit contract of loyalty by the patient and clinical responsibility by the healthcare professional (Haggerty et al, 2003). This affiliation may be referred to as longitudinality, relational, or personal continuity, and it fosters improved communication, trust, and a sustained sense of responsibility (Freeman and Hjortdahl, 1997).

Although patients are often unable to articulate how they make decisions of trust, Mechanic and Meyer (2000) found that one strategy was for patients to test their knowledge or expectations against the actions of the doctor. As medical knowledge has become more widely available via the internet, patients are now presenting with some background information and expectations. The role of the medical professional is often to clarify and explain the information the patient already has as well as placing this in the context of the information the doctor is imparting to the patient. Where the patient's expectations and the actions of the doctor do not align, there is an impact on the trust relationship. For Tina, trust in her GP was undermined because she had some knowledge as a nurse which led her to feel her individual experience was not being understood at the personal level. In other words, her expectations and the actions of her doctor did not align which resulted in a lack of partnership building in this exchange. Sharing power and working in partnership with the patient have previously been found to help ensure patient's preferences are considered and needs met (Thom and Campbell, 1997). Patients are able to provide a unique first-hand perspective of the care and services received, to provide feedback on whether their needs and preferences were met or not (Pomey et al, 2015). However, trust should be understood as a dynamic phenomenon, where patients and doctors view and change the conditions and content of their trust relationship depending upon the specific circumstances (Skirbekk et al, 2011).

Data from the study suggests where there is a high general or societal trust and a lack of scepticism in an organisation, there is a trusting relationship. Within this type of relationship, decisions and communications are likely to be accepted with what Walls et al (2003) term *'uncritical emotional intelligence'* (p.134). Poortinga and Pidgeon (2003 p.971) have proposed a typology of trust ranging from full trust to deep distrust (see figure 5 below). Where a high degree of general trust exists in parallel with a high degree of scepticism, this forms a relationship Poortinga and Pidgeon (2003) describe as *"critical trust"* (p.971). In this type of relationship, information may be accepted, questioned or treated with a certain amount of scepticism. According to O'Neill, (2003), the importance of full trust tends to be exaggerated as the public has enough knowledge and competence to have an effective distrust. In this instance, distrust is not destructive, but an essential component of accountability in an attempt to optimize relationships with health professionals and the care that is received.

Figure 5. *Typology of trust (Poortinga and Pidgeon, 2003)*



In situations where general trust is low and scepticism is also low, a relationship of distrust is generated. Distrust becomes deeper in circumstances where general trust is low but scepticism is high, resulting in cynicism, evidenced by a lack of trust in an organisation combined with a scepticism towards the intentions of the organisation. This can be seen in the following fieldwork example. Janet [a patient attending for a knee replacement] provides an illustration of low general trust and low scepticism. Some of the reasons for her low general trust were revealed when I spoke with her before her operation.

> *Luke: Is there anything else that you are thinking about in the back of your mind about having the operation?*
> *Janet: Only about what if it goes wrong? I have asked not to have a blood transfusion. Not that I am a Jehova's Witness it's just that I don't like the idea. If I absolutely need one then obviously then I would have one but I would really prefer not to.*
> *Luke: Why is that? What's worrying about that?*
> *Husband: You have a phobia*
> *Janet: I have OCD. I suffer from germ, I see germs everywhere*
> *Luke: and you associate the blood with that?*
> *Janet: I don't like… I… yeah. A postman bled all over the envelope and I had a hepatitis one and it found out I had Hepatitis A. I had never known I had it. But we tend to think that I had a bile duct stone before I could have my gall stones removed and I was so ill after that so… I was in hospital for about a fortnight*
> *Husband: it might have been when you*
> *Janet: I don't know if I picked it up then I don't know, I hadn't been abroad, I hadn't been anywhere.*

In this section, Janet seems to be mixing up several stories into one less cohesive narrative. The idea that she does not want a blood transfusion is mixed with a story about the postman bleeding on an envelope, neither of which is fully explained as Janet then goes on to say that she had previously contracted Hepatitis A. For her, blood equals virus or disease and she does not want a blood transfusion as she feels she may contract further diseases. However, Janet also recognizes that there may come a point at which a blood transfusion is necessary to sustain life. Blood is therefore both life giving and disease bearing – a contradiction that is itself difficult to come to terms with. The stigma associated with a blood borne infection is one that Janet seems to feel strongly, as she frames her explanation in a way that tries to explain why contracting this disease is not her fault. This type of stigma can be seen as both *"an abomination of the body*" and *"a blemish of individual character"* (Goffman, 1963 p.13). A justification is offered that she contracted the disease during previous surgery, which is seen as a socially accepted set of circumstances recognized as being outside the patient's control. Nevertheless, the awareness of this stigma contributes to Janet's feeling of insecurity. By being aware of the stigma, Janet's trust in the organisation has been undermined because she feels she may have contracted Hepatitis A when she last underwent surgery. This has therefore challenged her generalised trust in the organisation, as her previous experience with the organisation is one where she has been let down.

Calnan et al (2013) describe the patient provider relationship within healthcare as a prime example of a trust relationship where trust is used as a means of "*bridging between both parties to the encounter*"(p.682), in what is otherwise an asymmetric power dynamic. A situation where the patient begins from a position of distrust, can lead to a breakdown in the communication upon which interpersonal trust is built. A lack of trust in the organisation can therefore impact upon partnership building in the clinical encounters which follow. In the following interview extract Janet [a patient attending for a knee replacement] is reluctant to discuss aspects of her care with the anaesthetist:

> *Luke: "So you have spoken to Dr Chisolm and you have agreed that you are going to have the injection in the back and you are also going to go to sleep'*
> *Janet: Yes*
> *Luke: How did you decide that? What made you decide that?*
> *Janet: I am always really sick under anaesthetic, so I am hoping that I won't be with the sleeping one. I didn't mention it to her. Perhaps I should have done.*
> *Luke: OK. So you have had anaesthetics before have you?*
> *Janet: Yes I had keyhole on my knee. I have had numerous ops yeah.*
> *Luke: How long ago was that?*
> *Janet: What the keyhole?*
> *Luke: Yes*
> *Janet: Last year*
> *Luke: Right and that was for the same thing was it?*
> *Janet: Yes and I was given tablets so that I wasn't sick. Perhaps I ought to mention it to her.*

Even though Janet realizes that there are aspects of her treatment that she knows she should discuss with the anaesthetist, she does not. For example, she mentions to me the reason she has decided on this choice of anaesthetic technique is because she has a history of being sick after anaesthetics. However, she has not discussed this with the anaesthetist who has responsibility for this aspect of her care. When asked why she did not discuss this with the anaesthetist she replied:

> *" You're a bit of a … aren't you? You just take it they know what they are doing don't you?"*

Here, Janet seems to be acknowledging the asymmetry in the doctor–patient relationship and the need for her to trust the doctor. Typically, doctors have knowledge that the patient lacks, and the power to order investigations and treatments. However, Janet has not recognised there is asymmetry in the other direction too; patients have knowledge about their symptoms, and their family and social history (Fritz and Holton, 2019) which the doctor does not have knowledge of. This has resulted in a power imbalance which may be in part because Janet's initial distrust of the organisation has prevented effective partnership building, shared decision making and appropriate bridging through trust at an interpersonal level.

3.3 Trust in the Profession

Professionalisation is a historically situated process (Larsson, 2014) which has been regarded as a functional, public spirited and civilizing initiative. This interpretation is supported by how, in the eighteenth century, the professional guilds allowed a knowledge base to develop alongside ethical, altruistic values with standards upheld in relation to public services such as law and medicine (Carr-Saunders and Wilson, 1933; Parsons, 1954). An alternative understanding is to connect the development of the professions to the exercise of power and pursuit of self-interest by elite groups seeking to create a monopoly for their services through restricting numbers in a profession to maintain fee levels and social standing (Johnson, 1972; Larson, 1977). Both of these views suggest professionalisation was a process which developed independently from direct state intervention (Faulconbridge and Muzio, 2012). However, the state is directly involved in the institutionalisation, reorganisation and regulation of professional expertise and is often the main end-user of professional and technical services in a number of contexts (Freidson, 1994). Professional expertise is also often certified by the state; which provides a 'professions' mandate'

(Hughes, 1971 p374) that gives professions the authority to recommend how others (the public) ought to act in relation to the professional providing the service. In particular, the client must trust the professional's judgment and skill and all secrets which relate to the affairs in hand must be revealed (Hughes, 1963).

Professionalism has traditionally been regarded by society as a desirable quality evident in individual practitioners. However, within a relationship-based profession such as medicine, this needs to be manifest through a combination of values, knowledge, skill, integrity and good judgement. Although an initial willingness to trust varies, most people begin with the assumption their health care professional is competent and appropriately motivated (Mechanic and Mayer, 2000). The willingness of patients to accept this situation and maintain the status quo depends in part upon the cultural capital (Bourdieu, 1984) bestowed upon doctors as a profession, which subsequently leads to a perception of the individual doctor as having the necessary competence, honesty and integrity to warrant the trust bestowed upon them. This is reflective of the professions' mandate (Hughes, 1971) whereby members of a profession must be trusted, but also protected from the consequences of any professional actions. Older definitions of professionalism positioned the doctor within an exclusive group, defined through specialist knowledge and expertise. Friedson (1970) has framed professionalism as less of an exercise in shared values, than a concealed power play where the control of decision making and professional control over medical choices is associated with the control of information. Constructivists have questioned medical claims to knowledge on more radical grounds (for example Friedson, 1970, Dreyfus and Rabinow, 1982), arguing that what is referred to as 'truth' or 'knowledge' are in fact constructs of the operation of power (Christmas and Millward, 2011). This view regards the concept of medical professionalism not as a quality of individuals, but as a kind of rhetorical strategy to perpetuate power. Constructivism therefore encourages a closer look at the dynamics of power in medicine, and the way ideas like 'trust', 'knowledge' and 'evidence' can serve those dynamics. In many situations, doctors do not need to persuade their patients as there is a reliance on a control of access to desired services (certificates, medicines, operations) and on a tacit appeal to the patient's trust in the doctor's knowledge and competence (Friedson, 1970).

More recently, medical professionalism has broadened to include the ability to communicate specialist knowledge, diagnosis and treatment options in an easy-to-understand way, rather than seeking to use specialist knowledge as a means to create distance from, and a dependency of, the public. Cumberledge, (2005) explains:

> *"Deference is dead. In the modern world, patients want a more equal relationship with their doctor. The Internet supplies a wealth of information, not always accurate; science provides new technologies, sometimes potentially dangerous; management monitors and expects results in productivity, on occasions engendering unavoidable conflict"* (p.109).

The Royal College of Physicians (RCP) (2005), has defined the nature and role of medical professionalism in a modern society as

> *"A set of values, behaviours, and relationships that underpins the trust the public has in doctors"* (p.15).

This suggests a certain reliance on the public trusting doctors because of their status as professionals, rather than their competence as individuals. These relationships are therefore not the same as those based on high-quality, personalized recommendations which form a key feature in many trust relationships. Instead, the patient is asked to trust the institution and the institutionalised form of cultural capital (Bourdieu, 1984) held by doctors in the form of academic qualifications (this is discussed in more detail in chapter 4). These qualifications confer a conventionally constant, legally guaranteed value upon the holder and:

> *"by conferring institutional recognition on the cultural capital possessed by any given individual, the academic qualification also makes it possible to compare qualification holders and even to exchange them (by substituting one for another in succession)"* (Bourdieu, 1984 p.51).

However, trust is a multifaceted concept which is related to the numerous interpersonal relationships patients have with family and friends, medical and other health professionals as well as the system underpinning their health journey. From the patient perspective, interactions limited to the thin interpersonal relationships based on institutional reputation are less satisfactory than the thick interpersonal trust that is built up through numerous encounters with an individual in a relationship of relational continuity (Haggerty et al, 2011).

3.4 Trust in the Doctor

The need for trust to develop through an interpersonal relationship over a period of time as in relational continuity (ibid) was recognised by surgeons as being important. John [an orthopaedic surgeon] explained it as

> *"you get a couple of bites at the cherry to get to know them and I think that is really important as a surgeon. When you're going to do such a massive operation on someone and you get a doctor/patient relationship reasonably well established because things don't always go to plan and if you've just turned up on the day to do something on someone and then you're like a technician and your patient is like, on a conveyor belt, you haven't got that level of trust. They don't really know you… I refuse to operate unless absolutely necessary on big cases that have been added to my list by somebody else. So only my registrar and myself would be able to add cases to my own waiting list and everyone that goes on that list I've vetted so I know who they are and what's going on".*

McAllister (1995) categorized trust on the basis of two dimensions; an evaluation of performance (cognitive trust) and an emotional response (affective trust). Each of these dimensions should be treated as separate constructs, as each affects relationships in different ways (Johnson and Grayson, 2005). For example, a satisfactory evaluation of a surgeon's reputation may lead to cognitive trust, which in turn affects a willingness to invest further in the relationship. Evidence of affective trust, however, may be seen as a deeper trust which is demonstrated if both parties feel an emotional bond has developed which enables a sense of security to be facilitated. In the extract above, John highlights the importance of getting to know his patients in advance of their surgery, suggesting a need to establish a relationship which develops an emotional, affective trust. In contrast, operating on the day without having previously met the patient would be limited to a relationship of cognitive trust, attributed to the institution or surgical role, rather than to an individual.

Similarly, Jay [an orthopaedic surgeon] explained when interviewed, the importance of building a relationship with the patient over a period of time and the potential consequences if the trust relationship was not adequate.

> *"You've seen them right from the beginning so they think that I am their surgeon so usually I don't come across that situation. Only I come across it when somebody else has seen the patient and they have put them on the list and then they come on my list, then there may be a problem. I'm always, I'm honest with them and I tell them "look, your surgeon was so and so and I think you'll come onto my list today. During the years I've done a few thousand surgical joint replacements so that at the end of the day it's your decision because I'm meeting you for the first time so if you think that you would like to have* [your operation] *by the same surgeon who saw you in the clinic because you've got confidence in them I won't feel bad. By all means I can make arrangements for you to come back and see the same surgeon to have it operated". And the majority of them they say "no, no, we've heard about you. We are quite happy for you to do the surgery" But there are one or two funny ones, who tell me, I haven't come across, touch wood, if they come like that I would send them away".*

The use of the phrase *"I am their surgeon"* suggests a level of affective trust built up between Jay and the patient through a relational continuity. However, Jay feels there is a minimum requirement for the patient to have at least cognitive trust in his abilities as a surgeon and if this is not present, he would be unwilling to operate. Understanding the basis of trust that operates within the surgeon – patient relationship may suggest practical implications for the management of the interaction. For example, affective trust is unlikely to develop if there are frequent breaches of cognitive trust (Takala, 2010).

Fritz and Holton (2019) proposed one strategy used in building trust in medical encounters is the increased use of medical investigations and treatment. This view is supported by Henscher et al (2017) who suggest strategies used by health professionals to address uncertainty, include behaviours for avoiding potential regret. Therefore, in situations where clinical judgement is not trusted, there is a tendency to order further investigations or treatments *"to be on the safe side"* (Fritz and Holton, 2019 p.31). In some circumstances then, overuse and overtreatment may appear to be a 'rational' choice in clinical decision-making, even when associated with a risk of harm. In the following extract from the field diary, Barbara [the patient] attends the orthopaedic clinic complaining of pain in her left knee, especially when going down stairs. The X-ray confirms that Barbara has osteoarthritis. Although the 'gold standard' treatment for osteoarthritis of the knee is knee replacement surgery, knee prosthesis' have a limited life span and Jay [the orthopaedic surgeon] is confident this pain can be managed initially through an injection of steroids into the knee.

> *Jay says that he would not recommend a knee replacement unless Barbara's quality of life is affected. If she is not in too much pain, he "would not recommend to have it just yet". This should not be seen as "a quick fix as it can take six months to see an improvement, although most have significant improvement after six weeks". He then examines Barbara's knee, who rolls up her trouser leg. Jay examines the knee and asks Barbara to bend her knee as much as possible. Once he has done this he offers her an injection into her knee which should help with the pain and inflammation. Barbara is quite clear that she would rather "go for a knee replacement". Jay runs through the complication rates, to make sure that these are understood. One in 8000 get an infection, there is a risk of clots forming which then move to the lung, some people still experience pain and stiffness in their knee after surgery and the knee replacement does not last forever (although 95% last for twenty years, some last for less than ten years). Jay asks "So I will put you on the list OK?"*

This question acts as a proxy for 'are these risks acceptable to you and do you want to go ahead with the surgery?' Jay is faced with a choice during this consultation. He can reassure the patient that, in his clinical judgment, a steroid injection will address the pain she is experiencing, or he can agree to perform surgery which will treat the osteoarthritis of the knee, but which may not be permanent and increases the risk of infection and clots forming on the lung. In making her decision, the patient evaluates the information relayed to her by the surgeon and compares how it aligns with her expectations. At this stage trust is initially at a cognitive level. However, by involving the patient in a shared decision making process, the surgeon is able to demonstrate a certain amount of trustworthiness, so the relationship develops to one of affective trust. Shared decision making stresses the importance of patient preferences and rigorous discussion of therapeutic risks/benefits based on these preferences. However, empirical studies have highlighted discrepancies between shared decision making and realities of surgical decision making (Clapp et al, 2019). By involving Barbara in the decision making, Jay has demonstrated his trustworthiness as was recorded in the field diary as the consultation progressed.

> *Once it has been agreed that Barbara will have surgery, she then asks about the injection and how long it lasts. Jay replies that he cannot be sure as it varies from person to person. Barbara's son asks how it works and Jay explains that the injection is an anti inflammatory – although no further explanation is given around what this means. Barbara reiterates that she will go for the knee replacement because she had an injection in her shoulder which didn't work very well, as it only worked for about three weeks.*

By explaining how she arrived at her decision, Barbara mitigates against why she has decided to reject the steroid injection and embark upon a course of action different to that which has been suggested by the healthcare professional. This makes clear that Jay's trustworthiness is not in question, but Barbara is basing her decision on her previous experiences of both a knee replacement and steroid injections. By drawing upon these previous experiences, Barbara demonstrates knowledge of her body and how she has responded in the past to similar treatments. This is in contrast to Jay saying that he cannot be sure how long the injection lasts as it varies from person to person. Barbara does not need to worry about the experience of other people as she is only concerned with how long this injection will last for her. Based on how long similar treatments have lasted for her previously (albeit in a different area) Barbara has personal knowledge which she uses to form a judgement about how long it is likely to last on this occasion. Jay may have expert knowledge of the injection, but Barbara has expert knowledge of her own body and she uses this expertise to make her decision of whether or not to have the injection. In making her decision, Barbara also draws on the experience of her previous knee replacement surgery which had a positive outcome.

3.5 Trust in the patient

Trust is regarded as a central tenet of the relationship between patient and doctor or other healthcare professional. A degree of trust is necessary to create an environment in which honest communication can thrive, so that patients feel able to disclose sensitive or potentially stigmatising problems with confidence and without fear of being disbelieved or disparaged

(Rogers, 2002). For the patient, trust involves an attitude of optimism about the possible responses and competence of the person trusted (Jones, 1996). However, there is also a requirement for the doctor or healthcare professional to trust the patient. Pilgrim et al (2011) highlight how it is not uncommon in medical practice to have frustrations with patient behaviour. Patients may avoid seeking help in a timely fashion and therefore do not always act in a way that promotes their own health. Alternatively, the patient may act inappropriately in the sick role (Parsons, 1951). Therefore, there are numerous ways in which a patient cannot be trusted to act in their own interests about their health (Pilgrim et al, 2011). Shilling (2002) notes roles assumed by doctors and patients are based on a "*universalism"* (p.631) with respect to the criteria through which they interact. This acts to prevent doctors basing judgments on personal bias or favouritism, but also prevents patients from seeking to *"assimilate the physician to the nexus of personal relationships"* (Parsons, 1951 p.456).

If illness is regarded as a breakdown in the general *"capacity for the effective performance of valued tasks"* (Parsons, 1964 p.262), then losing this capacity will have an impact on social commitments in specific contexts such as the family and the workplace. Illness is not a disregard of social norms, but instead an inability to conform to them. This is an important distinction as it is the difference between illness and immorality or crime (Parsons, 1964 p.270). Illness is described as *"one of the most important withdrawal behaviours in our society"* which creates a *"disturbance of the total person"* (Parsons, 1951 p.31) affecting all of the individual's particular role performances. However, an exemption from social commitments is only sanctioned when a diagnosis has been made and a disease has been acknowledged. Where someone is thought to be adopting the sick role without good cause, trust in that person is limited. The mitigations that are made relate to the specific disease and only grant exemption from certain social commitments which can be excused as a direct consequence of that particular illness. In circumstances where the individual seeks exemptions from social commitments that are not regarded as directly related to the officially diagnosed disease, trust in the individual to act appropriately in the sick role may be questioned.

The majority of research relating to trust in the medical encounter has focused on patients trust in the physician rather than the physician's trust in the patient (Anderson and Dedrick, 1990; Safran et al, 1998; Kao et al, 1998; Thom, Bloch, and Segal, 1999; Thom et al, 2011) and research that has been conducted on patient-doctor trust has mainly relied on survey methods that use standardized instruments (Dawson, 2019). Many of these studies have utilised a single survey question which has produced conflicting and inconsistent results (Miller and Mitamura, 2003). Consequently, little is known about the doctor's view of trust in their relationships with patients. The following field diary extracts highlight the case of Doreen [a patient who has been admitted for knee replacement surgery]. In the first extract, Dr Trant [the anaesthetist] outlines her experience of meeting Doreen during her preoperative visit to the ward.

> *Dr Trant explains that Doreen experiences a lot of pain from a bad back and elsewhere. When asked about this, Doreen said she can experience up to five different headaches all at the same time. Dr Trant said that she didn't want to get into this with her, so moved the conversation on quickly.*

The suggestion here is that Doreen is either grossly exaggerating her pain or that her pain is not relevant to the anaesthetic. Either way, Dr Trant does not deem it worthy of further discussion during her preoperative visit. This view was not dissimilar to what I perceived to be the attitude of the staff when I visited the ward to see Doreen prior to her operation.

> *When I arrive at the pre-assessment lounge, I see a woman with dark glasses asking the nurses if she can have a larger gown as this one is 'strangling' her. The nurses ask if they can help me. I explain my position as a researcher and that I am there to speak with Doreen Valley. As I mention Doreen's name there is something of an intake of breath and rolling of the eyes.*

There is clearly hidden meaning in this action. The implication is that Doreen is a difficult or hard work patient. An implication that fits with the view (although not explicitly stated) of Dr Trant [the anaesthetist]. This attitude may be in part because Doreen is not seen as conforming appropriately to the sick role (Parsons, 1951). Doreen has a diagnosis relating to her arthritis and is therefore legitimately attending for knee replacement surgery. However, she is still expected to meet her other social commitments and to behave in a manner appropriate for a patient attending for knee replacement surgery. The diagnosis does not exempt her from the need to accept the treatment she receives once she has been admitted to the ward. Such treatment includes the need to wear a standard hospital gown and forms part of the ‘Universalism’ (Shilling, 2002) of the relationship between medical staff and patients. Rogers (2002) notes a lack of trust may be due in part to “*a natural human tendency to distrust accounts which one wishes to disbelieve”* (p.79). This kind of distrust is especially prevalent where the medical view is supported by evidence from the medical realm (or conversely, where the patients view is not supported by this type of positivist scientific evidence). Doreen has no diagnosis and the only evidence she can provide related to her headaches is experiential. This leads the medical staff to conclude that Doreen’s account of her headaches cannot be trusted. This is seen as a failure of Doreen to act appropriately in the sick role which in turn amounts to total personal failure, since the loss of *“approvals”* (for specific role performances) adds up to a loss of *“esteem”* (for the person as a whole) (Parsons, 1964 p.266).

The assumption by medical staff is that patients are doing their best to tell the truth until experience suggests otherwise. When a patient is trusted, their experiences are validated and competence is recognised. Consequently this leads to an enriched view of beneficence which incorporates the patient's own expertise into the conception of what is in their best interests (Rogers, 1999).

3.6 Shared decision making and the asymmetry of knowledge

The biomedical model, which traditionally forms the basis of the doctor – patient interaction, strives for objectivity (Rhynas, 2005). The purpose of history taking and physical examination is to transform the signs and symptoms of the patient’s subjective experience into a pathophysiological disease state which can be objectively categorised and understood. This creates a need to standardise patients’ signs and symptoms and to examine them through a medical lens. Only symptoms which fit the acknowledged disease pattern are accepted; complaints described by the patient which do not fit this pattern are side-lined, rejected or disbelieved. In this way, observable, measurable physical signs and clinical investigations are seen as objective and are consequently privileged over subjective patient accounts of symptoms. More recently, shared decision making has been advocated in a move away from a paternalistic approach towards a more equitable clinical interaction in order to elicit patients’ values and goals (Clapp et al, 2019).

Questioning is an essential aspect of the relationship between the patient and healthcare professional which allows for the simple transfer of information, from both patient to doctor or other healthcare professional and vice versa. Although patients are increasingly demonstrating a degree of health literacy; defined by the Nutbeam (1999) as:

> *"the cognitive and social skills that determine the motivation and ability of individuals to gain access to understand and use information in ways that promote and maintain good health"* (p.64).

This information often needs to be clarified and explained in a way the patient can understand and relate to. Asking questions and receiving answers diminishes the clinical information imbalance between doctor or healthcare professional and patient which enables the establishing of a relationship both sides are happy with; the amount of information that is wanted, the ways in which it is to be imparted, the degree to which discretion is to be transferred and over which topics (Fritz and Holton, 2019). Consequently, this interaction may enable a cognitive trust relationship to develop into one of affective trust. Solomon and Flores (2001 p.8) suggest trust allows a:

> "*freedom to think for oneself and speak up with one's ideas. It includes as its consequence (not its cost) the freedom to be questioned and criticized – and the right to be recognized and (if deserving) rewarded".*

However, Fritz and Holton (2019) highlight the very practices of questioning needed to establish whether trust is well founded may also work to undermine it. The uncertain information doctors or other healthcare professionals are able to provide may not be sufficient to satisfy patients, especially when this information is coming from someone not yet trusted. Thus knowledge is offered as a form of power to patients (Pilgrim et al, 2011) albeit an incomplete knowledge leading to limited power.

Shared decision making aims to facilitate informed consent through a discussion where patients are presented with an overview of potential therapeutic benefits and harms in relation to their personal preferences (Clapp et al, 2019). However, the ability of informed consent to act as a mechanism for enhancing patient involvement in preoperative decision making has been questioned (Dixon-Woods et al, 2006). The legal requirement for informed consent has been suggested as being at the heart of the asymmetry of doctor – patient relations (Silverman, 1987). Wiener et al (1980 p.32) clarify the requirement as:

> *"in proposing a therapy or diagnostic procedure, the physician must disclose all relevant information that a reasonable person would need to make an intelligent decision about his* [sic] *proposal".*

This principle begins with the assumption of an asymmetry of knowledge. The patient needs to be informed, because they know less. The patient gives consent to the doctor's proposal because the doctor has the knowledge to make such proposals (ibid). This asymmetry persists because:

> "*even with the best patient education there still remains in the physician patient relationship an unequal distribution of knowledge"* (Wiener et al, 1980 p.36).

Instead of acting to facilitate discussions in a process of shared decision making, informed consent can be presented as an institutional ritual which does little to facilitate the patient's ability to exercise autonomy. This is especially the case where the patient's primary language is not English or in those patients with lower levels of education (Ankuda et al, 2014).

Until recently, the main criterion for deciding what risks should be communicated to the patient for any chosen treatment (as well as assessing reasonable care in negligence cases) was based on the Bolam principle of 'what a reasonable body of doctors would do'. This indirectly led to a paternalistic approach towards patient consent. However, the Supreme Court ruling in the case of Montgomery vs Lanarkshire Health Board (2015) was clear in that:

> *"doctors must take reasonable steps to ensure that patients are aware of any risks that are material to them, and they should inform their patients of alternative treatments".*

This has led to a requirement for health care professionals to tailor information to the patient's individual needs. This reflects a move away from the traditional paternalistic model of consent, towards a more patient centred shared decision making approach. However, in addition to providing the patient with the information they need to be able to make a decision about the treatment or procedure they want (if any), there is now an additional requirement for the doctor to determine what information is important for that particular patient in those particular circumstances (RCS, 2016). Although the intention is clearly to empower patients in a shared decision making model, it should be noted that a power imbalance persists, in that it is the doctor that retains control of both the information needed for the patient to be able to make a decision about their treatment and also the doctor that determines what information is deemed important to that particular patient. The doctor assesses the patient's capacity to understand and retain information and in specific circumstances, is able to withhold information from the patient on the basis:

> *"the doctor deems that this might cause the patient psychological harm to a degree which outweighs the benefits of informing them"* (RCOS, 2016, p.13).

Improving these dimensions of shared decision making may therefore improve surgical patients' experiences through engaging patients in their own healthcare decisions more fully to achieve truly shared decisions about their surgery (Ankuda et al, 2014).

In order for a patient to give informed consent for any treatment or intervention, the patient first needs to trust they have been provided with all the relevant information needed to make an informed decision. Rita [a patient admitted for knee arthroscopy] explained to me before her operation:

> *As far as I'm aware I'm having the keyhole surgery. I've been told I've got, on the X-rays, a slightly torn meniscus. And then the gentleman that has just seen me, because I had to sign the form and they might have to do another procedure, because they won't exactly know until they get in there. But it could mean, I don't know if it's his words…but scraping and anything they find that may need doing, I've had to give consent to. The only query I had was on the form it said you could get some bleeding, was the fact that I've got to have an injection to thin my blood but he's answered that. When I said to him "it just seems if*

> *I'm going to bleed you'll give me an injection to thin my blood" But the gentleman answered that question and I'm quite happy with that.*

In this extract, Rita is happy to acknowledge an element of uncertainty surrounding the procedure she is having but describes the relationship as one where she 'had to give consent'. Rita is therefore placing her trust in the surgeon to act appropriately, even though she has not previously met the surgeon and refers to him in a formal context as *"the gentleman".* In this context, consent is informed in so far as a decision has been made on the trustworthiness of the surgeon conducting the operation. In the absence of a relationship of relational continuity where thick interpersonal trust develops over time in an ongoing relationship, the trustworthiness of the doctor primarily depends on two factors; firstly, the presence and image of intermediaries that can be relied on for information about the doctor (Coleman, 1990; Levi, 1998). That is, if someone known to be trustworthy recommends a particular healthcare professional, the patient is more likely to trust that individual. Secondly, the trustworthiness of the institution that backs up the healthcare professional (Hardin, 1996). Trust in individuals can also be reinforced by an institutional trust (Khodyakov, 2007). In order for a patient to consent to the operation, there has to be some level of trust in the surgeon. However, patients have rarely had experience of the surgeon's skill previously, so trust and consent are often based on the hospital's reputation.

3.7 Beds and tables

In order to understand and make a judgement about what the patient deems to be important

> *"The discussion has to be tailored to the individual patient. This requires time to get to know the patient well enough to understand their views and values"* (RCS, 2016, p.4).

This requirement highlights the need for patients and doctors to know one another well enough to have developed a relationship of mutual affective trust. However, this presents a difficulty in that it highlights the two often opposing views of the same phenomenon. A simple example of the different views in the context of this study can be seen in the way the operating table is referred to by staff and patients as can be seen in the following extract taken from the field diary:

> *Dr Chisolm* [the anaesthetist] *says 'the table is going to go up… are we switched on?' pushing some buttons as she says this. Sandhya* [the anaesthetic practitioner] *adds 'you are not going to fall off, this is a very sophisticated table'.*

Despite attempts to make the operating table look like a bed: with the addition of a blanket, sheet and pillow, both Dr Chisolm and Sandhya refer to the 'table'. This contrasts to the patient view. Violet [following her knee replacement] referred to:

> *"sort of going on the bed and going in sort of drowsy and such like".*

Similarly, Doreen [following her knee replacement] said:

> "*it was almost as if the bed was moving".*

The difference between these two perspectives is that the physician's view is from the medical world, whereas the patients view is from the life world. Mishler (1984) applied Habermas's theory of Communicative Action to medical encounters, to demonstrate the tensions created between the voice of medicine and the voice of the lifeworld in the complex arena of health interactions. The voice of the lifeworld refers to the patient's contextually-grounded experiences of events and problems in life. These are reports and descriptions of the world of everyday life expressed from the perspective of a 'natural attitude' (Barry et al, 2001). People sitting or lying on a table is normal for the environment of the operating theatre, but in the lifeworld of patients, this is not normal and highlights a difference in environments and what is normal to those groups of people within this environment. In the life world, the bed is to lie on. In the medical world, the bed becomes the table, upon which, things are inspected. This change in terminology and use of language creates a realm shift which serves to reframe the space, from a bedroom, where people routinely go to sleep, into an anaesthetic room, where people also routinely go to sleep, but within a clinical space where the body is available for inspection. The presentation of significant events are therefore dependent on the patient's biographical situation and position in the social world. This contrasts with the voice of medicine, which reflects a technical interest and expresses a 'scientific attitude' to provide a meaning of events through abstract rules that serve to decontextualize and remove events from personal and social contexts (Mishler, 1984, p.104). However, in order to be able to take into account the individual patient's views and values to build trust and promote shared decision making, the doctor is now expected to acknowledge influences from the patient's lifeworld which may impact upon that decision making process.

3.8 Summary

Trust is a complex and multifaceted phenomenon which is relational in orientation and depends upon a mixture of both past experience and social culture. Trust can either be thick and embodied (Calnan and Rowe, 2006), as in the trusting relationship between family or close friends, or thin and generalised or moralistic (Uslaner, 2008), such as the trust in a profession or organisation. Both doctors and patients employ strategies to enable the development of a trusting relationship and the 'bridging' (Mechanic and Meyer, 2000) of the knowledge gap present within the power dynamic of the medical encounter.

In deciding whether to trust the surgeon and place themselves in a position of vulnerability during surgery, patients evaluate the information available to them. Firstly, the patient evaluates their personal need for surgery, taking into account the degree of pain and disability. A patient who is in constant severe pain is more likely to accept the vulnerabilities associated with surgery, even when there is a thin cognitive trust relationship, than one who is not. Secondly, knowledge of the institution providing healthcare is evaluated. An institution seen as non-exploitative, with a good societal reputation, such as the NHS, can supplant the need for a thick interpersonal level of trust with a moralistic trust (Uslaner, 2008). In addition, where the reputation of the surgeon is known through personal recommendations from close, trusted social connections, this can act as a surrogate for thick interpersonal trust. Finally, the use of a shared decision making model serves to reassure the patient their individual needs and circumstances have been taken in to account as part of the consultation. This communication increasingly involves the explanation of information the patient already has from other sources, which may be contested by the patient. Cognitive trust and the obligations of the doctor in the medical encounter must be evident before the relationship can move to a more relational/affective level. Where the doctor is seen to deviate from the expected diagnosis and course of treatment, without sufficient explanation, the development of deep emotional and affective trust can be undermined.

There is a moral imperative that doctors trust patients. Although deceptive patients do exist, a reaction of mistrust may be due to a natural human tendency to mistrust accounts which one wishes to disbelieve. Adopting the sick role (Parsons, 1951) and accepting the need to behave in socially accepted ways that adhere to the universalism of their position (Shilling, 2002) as a surgical patient is difficult for many people and requires a degree of trust. Beginning any medical encounter from a default position of trust encourages an appraisal of reasons for not trusting, which can highlight prejudice or stereotyping. In demonstrating trust, doctors reaffirm the moral agency of patients and encourage patients to retain autonomy in a process of shared decision making. In contrast, a lack of trust creates an additional burden to the existing problems of ill health, which contributes to hostility and inhibition of good clinical care.

CHAPTER FOUR: DISTRIBUTION AND CURRENCY OF CAPITAL IN THE OPERATING THEATRE

4.0 Introduction

Within the operating theatre, the dominant discourses of technology, medicine, skill and competency are communicated and sustained through a culture originating in a positivist paradigm. Capital is distributed and primacy given to specialist knowledge based upon an experimental cause and effect model with according demonstration of competence. Those with this knowledge are recognised by others as leaders whose opinions and actions are highly regarded in terms of their role performance (Gillespie et al, 2004). Members of the team who do not possess corresponding specialist knowledge have lesser capital in this field and are regarded as being of lower status, whereas the ability to manage stressful situations linked to knowledge and experience is beneficial and rewarded by moving up the hierarchical ladder. This is in contrast to knowledge of the individual patient which is widely accessible through patient notes and access to the patient. Knowledge of (and access to) the patient body can be regarded as an example of the objectified state of cultural capital. For Bourdieu (1986) the product of accumulated labour in the objectified state:

> *"depends for its real efficacy on the form of the distribution of the means of appropriating the accumulated and objectively available, and hence the profits they produce, is mediated by the relationship of (objective and/or subjective) competition between himself and the other possessors of capital competing for the same goods, in which scarcity and through it social value is generated"* (p.245).

Thus as access to and knowledge about the patient is widely available, the capital afforded to this is diminished because it is widely distributed among all those that have access to the patient. In the same way a luxury car affords objectified cultural capital to the owner, this is reduced when the luxury car is a pool car that is accessible to all members of a group. Similarly, routines are accessible to all practitioners and facilitate action by relieving the need to continuously deliberate on the correctness of every action (Berg, 1992). Thus, routines make practice more efficient by directing the practitioner along a previously validated path of safe practice. However, knowledge of such routines does little in the way of accumulating capital. Rather, they make the work 'invisible' (Goodwin, 2013) as the work 'just gets done' so that it has no voice, is unidentifiable and forgettable. The culture of the operating theatre is therefore anchored to the core features of specialist knowledge, experience and demonstrated competence and it is this capital that is most highly valued.

4.1 Patient capital

Patients do not exclusively inhabit the medical world but enter it from the complex background of their ‘social-world’. For patients, meaning making is through information seeking, lay consultations and particularities, rather than through a positivistic medical model based on mean values and generalizable truths (Greenhalgh et al, 2015). Patients are social beings, who bring their own capital in its various forms with them into the social field of the hospital. The degree to which this capital is recognised and valued, varies in as many ways here as it does in any other field. However, patients value the capital they bring with them to this situation and may choose to demonstrate their capital in order to distinguish themselves from the homologised patient group. In the following extract from the field diary, Nigel [a patient scheduled for knee replacement surgery] is within the operating department about to have the spinal anaesthetic administered when he demonstrates capital in the form of knowledge from his previous employment:

> *Dr Basu [the anaesthetist]: starts to give an antibiotic into the cannula in Nigel’s hand.*
> *Nigel: “what one is it?”*
> *Dr Basu: “ Tycoplanin its very strong, that’s why I give it slowly”*
> *Nigel: “What type is that?”*
> *Dr Basu: shows him the vial and says “This one”*
> *Nigel: replies that it is a new one on him. He mentions selling drugs in his role as a pharmaceutical company representative, “when Augmentin was new. It’s a gram-negative decarboxylase inhibitor. I’ve forgotten most of what I knew - 99% anyway”.*

This knowledge is not directly relevant to the situation because the drug Nigel mentions is different to the one that is being used here. However, by demonstrating this pharmaceutical knowledge, Nigel is also indicating he has some appropriate cultural capital which should be valued. This is in contrast with the next example from the field diary, where the patient (Noor) has his cultural capital (as a chef) unexpectedly recognised in the outpatients clinic by the surgeon who wants to organise a leaving party for a member of staff.

> *Mr Kapel [the surgeon] sits down again and turns to his computer for a second, before turning back to Noor and mentioning that there is a member of staff who is leaving the department. He says that he will send Noor for an X-ray which he will look at and may do an injection to help with the pain. Mr Kapel then returns to the topic of Kate's leaving do and says to Noor "it's for 40 to 50 people. Can you do that?" Noor is clearly confused as he seems to unable to see the connection between this and his shoulder pain. Mr Kapel laughs and explains what he means more clearly "No, no 40 to 50 people coming to your restaurant! I will send you to see Wendy afterwards".*

The introduction of the patient's social world to the medical world is unexpected and confuses the patient. Mr Kapel, who is aware of the patient's background as a restauranteur assumes that the patient can see the connection between the comment about a member of staff leaving and the fact that he owns a restaurant. However, the fractured way in which this has been integrated in to the earlier conversation, leads to confusion that needs to be clarified. At this point, the patient has moved into the medical world and as a consequence, has left behind the capital related to his social world that he feels is not relevant in this environment. For Mr Kapel, this conversation follows a natural development, the member of staff is leaving and so the staff want to organise a leaving meal for her. Noor has a restaurant, so while he is seeing him for his painful shoulder it makes sense to organise the meal to take place in his restaurant. However, as can be seen in the extract, Noor is surprised to be appropriated into the network that forms the basis of the surgeon's social capital. Through this act, the surgeon's network is widened and his social capital increased. However, this can only be achieved if the capital of the patient is equally recognised, at least culturally through his skill as a chef, and possibly economically as the owner of the restaurant. This is returned to later in the consultation:

> *He injects this solution into Noor's shoulder, who winces visibly as the injection goes in. Mr Kapel [the surgeon] says "I am doing this injection so he can cook!" to which the nurse adds*
> *"oh, for all of us? – Oh from xxxxx restaurant"*

The nurse’s comments suggest that she recognises both the cultural capital of Noor as the chef, but also of the surgeon who ‘knows’ the chef and whose social capital is demonstrated through association with the cultural capital of the chef.

In order for capital to be accepted, there must be some recognition of the value of the capital by a third party. The first example above (Nigel) took place within the operating theatre which is bounded by forms of knowledge that are unique and include various standards of practice. This knowledge is almost exclusive to staff who routinely work in this environment. A patient in the operating theatre has limited opportunities to demonstrate any form of capital that is relevant and valued by those for whom this forms a normal field of practice. However, Nigel was able to demonstrate some understanding of the work of the operating theatre and displayed this to the anaesthetist in an attempt to show cultural capital related to this field of practice. As the simplest sociological view of the individual or self, is that he is to himself what his place in an organisation defines him to be (Goffman, 1961), the operating theatre clearly limits the possibilities for the patient to develop a fully formed view of self during this time. As Goffman notes, the self may not yet be formed or may exist in conflicting dedications (1963, p18). Because the patient is a transient member of the operating theatre personnel, there are limited opportunities to determine an appropriate place within the organisation. This leads to adopting the generic position of ‘patient’. A patient is a position (or role) which is open to the professional vision of the natives of the field of practice (Lave and Wenger, 1991). Professional vision is the socially organised way of seeing and understanding events that are answerable to the distinctive interests of a particular group. It refers to the process through which practitioners learn to see the objects with which they work (Goodwin, 1994 p606). Thus in the operating theatre people are viewed with professional vision to become patients.

As capital needs to be accepted or rejected by a third party, there are instances where patients demonstrate capital in the form of knowledge which is incorrect, but is acknowledged by the staff as ‘close enough’ to be accepted. For example from the field diary:

> *Dr Basu [the anaesthetist] adds “you will be awake so you will hear everything” (It is not clear if she says this as a reminder to the patient or as a reminder to the surgeons). But*

> *Nigel [a patient scheduled for knee replacement surgery] adds "And smell everything too – when the reamer gets going".*

The reamer is an instrument that is similar to a drill but is used to wear away the bone of the hip socket. This is not applicable in this operation as Nigel is having a knee replacement, which does not necessitate the use of a reamer. Although Nigel is mistaken, no one corrects him as the point is made that there will be smells in the operating theatre which he will be aware of during the operation. Nigel is only able to make this point because he has capital in the form of knowledge acquired through experiences from his working life observing hip replacement operations.

Knowledge is a form of cultural capital all medical staff are expected to possess. Cahill (2012) found that information or knowledge exchange was perceived by patients to be a core requirement for any level of participation. Furthermore, patients expressed the view that information giving was a normative expectation and that being receptive to information was critical to the establishment of a healthcare relationship where a patient's contribution was to be recognised and promoted. However, emphasis on the value of the information varies according to how the information giver is viewed. Although it might be expected that information given by the medical staff would be given primacy, this is not necessarily the case. The capital demonstrated by the medical staff is cultural capital in the form of qualifications that informs and validates the information imparted. However, the capital demonstrated by friends and family is in the form of social capital with according connections that often overlap with those of the patient. Value is often afforded to the knowledge and opinions gathered from these connections to influence patients decisions. During the course of my fieldwork, I came across several instances where patients had relied upon friends or relatives experiences to inform their final decisions. This is apparent in the following excerpt from a preoperative interview with Helen [a patient scheduled for a knee replacement] when she was deciding whether to have a spinal anaesthetic or to opt for a general anaesthetic:

> *Helen: Yes. Right up to this morning I was still dubious but I had decided I would have it because everybody kept saying about it. They said it would be better for my heart and my lungs, including my daughter because she'd had the epidural. As I say this morning I said*

> *to, I can't think of the anaesthetist's name, I said "what do you think? Do I go for the full?" "No" she said "that one all the time" She was like "I recommend that all the time".*

Although the information given to the patient emphasises the advantages of a spinal anaesthetic, Helen needs reassurance from her social world that this is the correct choice for her. An important point to note here is that Helen was not having an epidural injection. The anaesthetic is a spinal anaesthetic, which is similar to an epidural in that it is an injection in the back, but the two procedures are different and it is the spinal anaesthetic that is discussed by the anaesthetist, the joint school and at pre-assessment. The notion of an epidural anaesthetic has therefore been introduced from outside the hospital context through connections within the social world. Before the information conveyed by medical staff is accepted as being appropriate for the individual patient, it is subject to checking and validating for the patient through their social connections. In doing so, information is passed through several stages of capital before being fully accepted. Information from the cultural capital of the medical staff is accepted as correct, but needs to be verified through the social capital shared with friends and family before being fully accepted for this patient in this set of circumstances.

The following extracts are from a preoperative interview with Tina, [who was waiting for her knee arthroscopy to take place]. Tina, who is also a nurse, was able to utilise her capital to her advantage leading up to her admission for surgery. In the first extract, it is clear that Tina was able to ensure she was referred appropriately and booked for surgery through utilising her cultural capital.

> *Tina: So I had my referral, I had that on the 18th of January when I saw the Registrar. And then I didn't hear anything for about 3 or 4 weeks so I rang and then I got a pre-assessment within a week. And then… so… a pre-assessment, and again I didn't hear anything so I rang and I got a date. So by ringing each time.*
> *Luke: you were speeding things up a little bit really.*
> *Tina: Yes it's a bit worrying really if you don't ring I think.*
> *Luke: How did you know who to phone?*
> *Tina: I just knew to phone the um, initially the consultant's secretary would be my point of contact.*

> *Luke: Did they give you that number when you came to the clinic?*
>
> *Tina: No.*
>
> *Luke: How did you find that out?*
>
> *Tina: Just did a bit of detective work. I'm a nurse don't forget.*
>
> *Luke: Oh right. Are you a nurse here?*
>
> *Tina: No.*
>
> *Luke: Right, but you know how the system works?*
>
> *Tina: Yes, or doesn't work!*

Rather than relying on social capital to validate the information she is given, Tina utilises her own cultural capital to verify her progress as a patient. However, as she moves closer to the operating theatre and surgery, Tina moves further away from an environment where her capital holds currency and so both capital and influence are diminished. This continues to the point that Tina feels she has lost her identity as an individual and has joined the homologous group of patients.

> *Tina: I don't mind. I don't like being in a gown. I think that's disenfranchising almost. Do you know? Does that explain that?*
>
> *Luke: What is it about the gown that you don't like?*
>
> *Tina: It alters your perspective. You know if I was a nurse then I would be more in control than being a patient. It's quite interesting to see it on the other side even though this isn't the area that I would work in. But especially when nurses stand up and they… And I'm always doing that.*
>
> *Luke: Are you still working as a nurse?*
>
> *Tina: Yes.*
>
> *Luke: So has that made you feel that maybe you will act slightly differently towards your patients?*
>
> *Tina: I would hope I would but you don't get time. We have these ideals but in fact, you know.*
>
> *Luke: So is there something about wearing the gown and being seated, whereas the nurses are wearing uniforms and standing up that changes things?*
>
> *Tina: Yes maybe. It's not being seated so much. It is that the lack of identity isn't it. I've got this silly thing on [pulling at her hospital gown]*

> *Luke: And of course it's got your, this is your identity on here isn't it? your wrist band.*
> *Tina: yes that's right but I don't have my personal clothes so I don't have control. I'm now 'a patient'.*

Although Tina is a nurse, the capital associated with this identity has limited value for her in this situation. She is in a department other than the one in which she normally works and although her nursing qualifications hold some value as formalised cultural capital, she is not known and has no connections demonstrating social capital in this field. For Tina, the wearing of a gown and removal of personal artefacts such as clothes and jewellery denotes the removal of capital and forms a part of the diminishment of her agency. Goffman (1961) views this as a process of 'disculturation' or 'role stripping' which renders the individual 'reduced from a person with many roles to a cipher with one: the inmate role' (Allot and Rob, 1998 p104). This difference is further emphasised through the uniforms the staff wear and with which Tina herself would ordinarily associate within a clinical situation such as this. Uniforms mediate interactions between individuals and groups; they offer observers visual clues that lead to expectations of the wearer's behaviour and social status (Becker et al, 1961). The effect of removing personal artefacts and replacing these with a uniform has is a homologising one which reduces each individual to an identity which is easily recognisable as either staff or patient. Although Tina is normally staff, in this context she reluctantly acknowledges the need to adopt a role of 'patient' and the disenfranchising effect this has on her. For Tina, the embodiment of this difference is in the way the staff stand and the patients sit. As the interview continues, Tina rationalises the need to adopt the identity of a patient as a choice:

> *Tina: And even though I could get up and go out I don't want to obviously because I need to be here.*
> *Luke: So what can you do as a patient to try and regain some of that identity as a person?*
> *Tina: I just rationalise it and think well that's rather silly really Tina because the gown is necessary, there are other people here in a gown and I won't be in it for long and then I can get my own clothes on and get home.*
> *Luke: So it's an identity that you adopt to go through the process to then become you again when you go out.*

> *Tina: Absolutely, that's true. Yes it's almost like sublimation. You have to submit to the process… and you do.*
>
> *Luke: So is that how you feel though, that you're submitting to the process rather than being an active participant?*
>
> *Tina: No, both of those things. Yes there is an element of submission, i.e. wearing a gown, having wrist bands on you, waiting. But also being an active participant, especially having it under local because I've elected to do it, well not elected, I wasn't given a choice. But if they'd given me a choice I would have gone for local anyway.*

For Foucault (1975) individuals are knowingly and wittingly enlisted into their own self fashioning as agents consciously monitoring their overall conduct and who appreciate the rules governing the wider context of conduct. Here Tina accepts her role and although she acknowledges the option of getting up and going out is open to her, she stays within the rules of the situation and waits 'patiently'.

Cultural capital accrues through an engagement in cultural practices, which includes the repeated enactment of healthcare exchanges, such as gaining biomedical knowledge, calculating approaches to decision-making and engaging in self-surveillance or risk reduction behaviours (Shim, 2010). While some patients, such as Tina, may be quite adept at engaging in these practices and deploying the accumulated cultural capital they have in healthcare interactions, many others respond in ways that have been formed through a less empowered habitus. An example of this can be seen in two interviews with Janet [a patient attending for knee replacement surgery]. In her preoperative interview, Janet acknowledges there are aspects of her treatment she knows she should discuss with the anaesthetist, but she does not. For example, she mentions to me the reason she has decided on this choice of anaesthetic technique is because she has a history of being sick after anaesthetics. However, she did not feel able to discuss this with the anaesthetist who has responsibility for ensuring she is not sick after the operation.

> *Janet: I am always really sick under anaesthetic, so I am hoping that I am hoping that I won't be with the sleeping one. I didn't mention it to her. Perhaps I should have done.*
>
> *Luke: OK. So you have had anaesthetics before have you?*
>
> *Janet: Yes I had keyhole on my knee. I have had numerous ops yeah.*

> *Luke: How long ago was that*
>
> *Janet: What, the keyhole?*
>
> *Luke: Yes*
>
> *Janet: Last year*
>
> *Luke: Right and that was for the same thing was it?*
>
> *Janet: Yes and I was given tablets so that I wasn't sick. Perhaps I ought to mention it to her.*

Janet's husband suffers from an early form of dementia and Janet has concerns about his ability to cope without her being at home. However, this also means that Janet has limited social capital to draw upon to inform her discussions with the anaesthetist and validate that her concerns about post-operative nausea and vomiting are relevant and should be raised. The last comment "*Perhaps I ought to mention it to her"* was addressed to me and may have been seeking validation from me that this is an appropriate point to discuss with the medical staff. Even the decision to have surgery seems for Janet to have been decided by a higher authority and turns her from active decision maker to passive recipient of treatment:

> *Janet: …I mean you are in the lap of the gods with your op aren't you? I mean you either have it or you can't walk. Or it's painful walking so…*

By describing surgery in this way, Janet seems to be resigned to a lack of capital in this field and consequently to have given up her agency to a higher authority for this period of time. The higher authority is in fact the perioperative team (Surgeon, anaesthetist and theatre staff) rather than Gods, but still reflects the amount of influence Janet feels she is able to exert is limited. (For further discussion on the role of faith and trust in the patients' perioperative experience see chapter 3 'Trust'). Janet's habitus has been formed through her past experiences, schemes of thought and perception, long-lasting ways of organising action, and general sensibilities about an understanding of how the world works. This has led to Janet relating to healthcare exchanges as being enacted by a higher authority and also links to the earlier statement where she did not mention being sick to the anaesthetist, who for her represents the higher authority.

By way of demonstration that habitus is more deeply ingrained than a world view that is formed by a single medical experience, Janet's view after the operation was not radically different to how it was viewed beforehand. In the postoperative interview, conducted once Janet had been discharged from the theatre recovery room and returned to the ward, I asked whether she would be happy to have the same anaesthetic if she needed an operation on her other knee.

> *Janet: Um I would have to think long and hard about it. You know I was impressed, it wasn't as painful in my back as I thought it would be. I think the bit where you are sitting there having it done um I think not to be put to sleep, but it would have been nice to have some relaxant, but perhaps they can't do that.*
> *Luke: OK that's quite interesting so even though you have had one done you think you would still be just as worried next time around? So having gone through the experience once already has that reassured you at all? Or hasn't it made any difference?*
> *Janet: Um I mean I know what to expect but I did feel when I was waiting there – sitting up waiting for them, my it would be nice if you could you have just taken something that made you feel like I'm alright because up to the moment, I knew I was alright but I… I was aware of it and I don't think I could ever have not had the sleeping one.*

Even though Janet feels reassured that everyone involved was competent, she would prefer to be less aware of what is going on around her. Bourdieu (1977) emphasises the systematic inequalities in the ability to both accrue and take advantage of cultural capital. Cultural capital can be regarded as deeply relational and refers to the ability of dominant social groups to shape institutional arrangements, but also to define the types of activities, resources, and behaviours that carry value in those contexts (Serre and Wagner, 2015). The distribution, transmission, movement, and exchange of cultural capital thus carries with it what Shim (2010) refers to as *"the indelible imprint of hierarchical domination"* (p4). This relationality can be emphasised by underscoring the critical role of healthcare professionals as agents who can solicit, evaluate, shape, and foster the patients ability to exercise cultural capital within the context of healthcare. The option of being asleep offers Janet the opportunity to pass her agency to the anaesthetist for the duration of the operation, so that rather than relying on her own capital, she is able to rely on the more powerful capital of the anaesthetist to act as her advocate.

In the earlier example, Tina was feeling disenfranchised as she waited to be brought to the operating theatre for her surgery. During the theatre 'team brief' before the start of the operating session, her cultural capital was mentioned to the team as potentially relevant information as I recorded in the field diary:

> *Rachael [a junior orthopaedic surgeon] continues: "The second patient Tina, she is a nurse. She has injured the medial meniscus of her right knee so we will need the three and a half millimetre shavers."*

This had minimal impact at the time as the discussion moved very quickly on to the equipment that may or not be required, but was recognised by the surgeon Mr Khan when he met Tina in the anaesthetic room before surgery started.

> *Mr Khan [the orthopaedic surgeon] enters the anaesthetic room from theatre as Dr Basu [the anaesthetist] leaves with the patient notes. He looks at Tina and says: "Oh, you are a nurse aren't you?*
> *Tina: "Yes, a chemo nurse."*
> *Mr Khan: "Oh that's alright then, I will explain it all. We are going to give you two injections into the knee then before we make any incisions."*

And once Tina has been moved into the operating theatre Mr Khan reiterates:

> *"we will be using that screen. I will be using the same screen so I will be able to explain everything."*

Healthcare professionals do not simply respond to the capital that patients mobilize but are able to contribute to their capacity to do so. During the clinical encounter, healthcare professionals can signal to patients the kinds of actors they would like them to be within the clinical situation. Cahill (2012) found the calibre of the connection between patient and nurse was critical to the extent to which patients established a readiness for a participatory role in their healthcare during both the preoperative and postoperative periods. I suggest this can be further extended to include the relationship between patient and staff during the perioperative period. Through the information that providers communicate to patients, and the ways in which they do so, providers can actively cultivate the patient's demonstration of capital. Danielle [the scrub nurse for Tina's surgery] noted when interviewed, the need to adjust the amount of detail relayed to individual patients during their surgery:

> *Luke: So the second lady had experiences of being a nurse. Now, when they were doing the operation they seemed to explain quite a lot to her compared to the first one.*
> *Danielle: Yes. Maybe that's because Mr Khan knew her background so felt that he could maybe give more information. But I think listening to what he was telling the first patient, it was probably at the right level for her.*
> *Luke: Ok so they do change it according to…*
> *Danielle: Well I haven't looked after many medical. And some patients say they don't want any information. They will just lie there and let us get on with it. They don't want to be told what's happening. Each patient's different I think.*

Danielle mitigates the need to explain and involve the patient in discussions about their surgery with the patient's choice to be a passive recipient of care. In her view, patients have a right to make an active choice to be in a position where they leave their agency behind for the duration of the operation. This is a position recognised within the operating theatre as it is similar to that associated with the administration of a general anaesthetic. However, Mr Khan clearly acknowledged Tina's background as a nurse and with it recognised her cultural capital. This enabled him to discuss the surgery in more detail than with the previous patient who had no such background and led to a re-empowerment of Tina as she said afterwards in her postoperative interview:

> *Tina: And the fact that he talked everything through is great, yeah.*
> *Luke: So you were watching it all on the TV screen?*
> *Tina: Yes.*
> *Luke: Did it help to be able to see, this is the bit here? The fluffy bits and the sticky out-y bits and all of that?*
> *Tina: Yes I think so yeah.*

> *Luke: Has it reassured you about what's gone on in your knee and what caused everything?*
>
> *Tina: Oh totally because I could see what he did, yeah.*
>
> *Luke: So to what extent do you think having your nursing background helped to understand?*
>
> *Tina: Not with the anatomy and physiology bit of the knee etc. etc., because that's not what I do. But certainly I think psychologically and knowing what to expect in hospital and that environment. You know the theatre based stuff and also having had something done before. And you know, the hierarchy as well.*

When capital is demonstrated by patients this is not through consciously and deliberately calculating individuals strategically pursuing planned goals, but as actors possessing habitus, or general styles, habits, and dispositions that influence the direction, manner and shape of their actions. Interactions within the operating theatre are in many ways unique, less flexible and more authoritative than those of the everyday world (Maynard, 1991). However, despite this power imbalance, interactions cannot be viewed simply from the relative structural positions of staff and patients; instead, social power and inequality are realized, or made real, through the interaction itself. The disparity in social status and interactional dynamics in the operating theatre, needs to be mitigated against through a fostering of relationships with patients that empowers a demonstration of cultural capital.

Through involving patients in care decisions, staff can enable patients to demonstrate cultural capital. However, this appears to be a tacit skill that during the fieldwork staff found difficult to elucidate: as the extract from the interview with Danielle [the scrub nurse] highlights.

> *Danielle: But that's…It just happens. I can't explain. I don't consciously think "this patient is this". It just, I look and think "oh right" and if they don't want to talk then that's fine. And I just adapt as it happens. That's a really difficult question actually.*
>
> *…But it's just like, it makes you think. And sometimes actually if you're, once you've done the name band check and you go back into the lay-up room and do the, you know, laying up your [instrument] sets, especially with G.A.s you don't, that's it, that is your total sum of interaction with a patient. And you don't actually and even if it's a local and they don't*

> *want to talk, then that again you're not interacting with them. I don't know. I've never consciously made a decision when to include and not to include a patient. I think you just gauge a situation at that time. I don't know.*

Similarly, for the anaesthetist, there is a recognition of the importance the patient is involved and that an assessment of the individual patient is necessary to determine how much agency is appropriate to apportion to the patient during this time. However, the process for how this decision is made is a tacit one that is acquired over time and through experience rather than as a skill that is actively taught or consciously learnt. Dr Michaels [the anaesthetist] explains:

> *Dr Michaels: No I engage by whom is in front of you and how they respond to your questions. How open they answer their questions or closed, whether you have to probe more, whether they talk more. Yeah, I guess there is a skill you acquire over time.*

Within the operating theatre, the patient is discussed in a biomedical context rather than as a social being. This is in contrast to the context of a person who has a subjective experience of their disease, which is seen as having limited relevance in the surgical milieu. Mauleon et al (2007) have suggested the relationship between carers and patients during surgery with regional anaesthesia, is unequal as carers have both knowledge of, and power over, the patient's body as an object for treatment. This unequal relationship is enhanced during discussions about the patient in their absence, which treat the patient as a biological entity rather than as a social being. Data indicated in the interview with Dr Michaels [the anaesthetist] any information outside this sphere was seen as not relevant and a waste of time:

> *Luke: Then during the team brief how much information do you pass around about individual patients and how do you decide what you need to tell everybody?*
> *Dr Michaels: Again I think that's something you learn through experience. It needs to be concise but relevant. So we usually just try and stick to the clinical facts. So the surgeon will stick to what operation they're having, what equipment they need and I will stick to what anaesthetic I plan to give and any relevant medical problems, like them being diabetic or having a heart condition or bad COPD. And we might mention if a patient is particularly anxious. But generally in the team brief it's quite factual.*

> *Luke: Is there a reason for not including anything about the patient's background? So you don't say "this is…."*
>
> *Dr Michaels: Time. Not relevant. If it is relevant we'll include it, but the purpose of the team brief is to make sure everyone knows what we're doing, on whom, with what equipment and what the plan is. I suppose at that moment in time it's less relevant whether or not the patient had a shower that morning or you know.*

However, staff are in a position to encourage patients to demonstrate their cultural capital throughout their perioperative journey. One way to achieve this is through acknowledging patients' understanding of their own personal medical history. Although this information is readily available in the medical record within the patients notes, recognition that this information belongs to and resides with the patient, enables the patient to retain some agency in an otherwise medically dominated field. For example, in the following extract from the field diary, the anaesthetist asks Doreen [a patient scheduled for knee replacement surgery]:

> *"You have a red wrist band because you have some allergies. Do you remember them all?"*

This question empowers Doreen to take ownership of her body through her allergies, even though much of the agency related to her physical self is about to be passed to the medical staff.

While patients may be objectified by hospital practices, there remains an opportunity to exercise agency, despite appearing compliant. Van der Geest and Finckler (2004) found expectant mothers willingly complied with their obstetricians' instructions, even when these led to significant sacrifices or suffering, because these women were oriented towards the fulfilment of their goals. Similarly, these surgical patients were oriented towards the goal of a positive surgical outcome and the resolution of ongoing pain and immobility. However, in order for patients to be happy to comply with the requirements of surgery, this needs to be rationalised. The ways in which this can be achieved are varied but include: patients demonstrating their capital so they feel included and valued as a member of the process, receiving sedation to the extent that consciousness is lost and all agency is handed over to the anaesthetic team, or rationalising the need to comply with instructions to achieve a desired outcome.

The degree to which staff are confident in enabling patients to be active participants in their perioperative journey varies widely. Staff who had a ward based background saw themselves as having the requisite skills and ability to communicate most effectively with patients. One such example which was recorded in the field diary:

> *As the team tidy up the theatre, I ask Jane [a scrub nurse] what she thinks of having an awake patient in the operating theatre. Jane says it is about "making sure they are aware that we are aware. We are used to it from obstetrics where they are always awake with no sedation. As an old ward nurse, I am used to talking to patients more than some others who forget. I stand at this end so I know what they can hear".*

Other staff saw this as secondary to their main purpose. Brian [an anaesthetic practitioner] explained when interviewed:

> *Brian: The patient will ask questions, obviously we've still got things to do, so we can't sit with patients chatting to them because you would have things to do. They'll ask questions or the anaesthetist will interact with them. My job is to get ready for the next one, preparing, make sure everything is ready for the anaesthetist so there is no interruption with the turn around of the list… my priority*
> *Luke: But a knee replacement is going to take what? 45 minutes to an hour something like that?*
> *Brian: I'm a bit obsessive. Soon as I get them on the table I want to be ready for the next one in case there's something wrong. I don't know something in my brain, OCD, whatever you like to think. I like to be ready.*

One explanation of this difference is through Goffman's occupational relationship between server and served. Goffman (1961) divided specialised occupational tasks into two distinct categories. In the first, the practitioner 'meets the public' as a result of the work, whereas in the second the practitioner performs the occupational tasks only for the established members of the work organisation. The contrasting positions cited above may be reflective of the differing views these staff have for their role within the operating theatre. The attitude of Jane, the 'old ward nurse' is more closely aligned to that of a public facing occupation, with an understanding that this forms a fundamental part of her role. Conversely, Brian was focused on the technical aspect of his role and avoided patient interaction other than when undertaking clinical interventions that necessitated communication with the patient. Menzies (1970) made explicit how healthcare professionals cling on to routine tasks as a social defence mechanism against high levels of anxiety and stress. Within this study it can be seen that some staff found patient participation more difficult than others, because this required the formation of a closer relationship with the patient and challenged routine practices and professional boundaries.

Although patients are encouraged to be active participants in their care and care decisions, the process of transforming from the 'lying down patients of the past' to the 'standing up consumers of the future' (Cayton, 2003) involves both a demonstration and recognition of capital. Opportunities for patients to demonstrate cultural capital within the operating theatre are limited to biomedical knowledge, experience of the patient role, or knowledge of personal medical history. This is despite Goffman's (1961) point that *"medical men still claim to rely on the patient for reporting symptoms; the client is still a participant to be respected in the service relationship"* (p297). Interactions between practitioners and patients then, have the capacity to encourage patients to become active participants in their own care, while the effects of organisational conditions on these interactions may reproduce existing inequalities in the distribution of capital in the operating theatre.

4.2 Ethnographers capital

Junker (1960) suggests that shifts in role can occur over the course of fieldwork and that the ability to move between roles allows one to discount their effects on the data.

> *"Different roles within a setting can be exploited then in order to get access to different kinds of data, as well as to acquire some sense of the various kinds of bias characteristic of each"* (p.36).

This model identifies a range of roles the researcher undertakes during fieldwork, moving from complete participant, through participant as observer, observer as participant and complete observer. However, what this model fails to acknowledge is that the movement between these states is influenced by more than just the researcher. During my field work I moved between these states, but this was not always through choice. The position I was afforded by informants within the field often depended upon whether the capital I possess was recognised and accepted by them. In some instances, I was regarded as possessing sufficient cultural capital so as to be able to move freely from complete observer to complete participant unimpeded. In fact, this change in status was not always through choice. On occasions I was asked, or even expected, to participate in certain aspects of patient care. This is highlighted in this entry from the field diary:

> *I assist in transferring the patient from the anaesthetic room, and hold the limb being operated on for the surgeon while he cleans the area with antiseptic solution. In addition to this, as one operation is coming to an end, Dr Basu [the anaesthetist] asks if I will stay with the patient while she sees the next patient in the anaesthetic room. I agree and am left to monitor the anaesthetised patient in the operating theatre while Dr Basu begins some of the preparatory work in the anaesthetic room: such as checking the patient details and inserting a cannula in the patient's arm.*

Conversely, there were also times where I had taken for granted that this would be the case, when in reality, my cultural capital was not recognised and I was treated as an outsider. In the following extract from the field diary my presence was being questioned not to me directly, but to a senior member of the operating theatre staff.

> *Dr Michaels [the anaesthetist]: Has he asked permission?*
> *Yvonne [senior theatre staff]: (Seeing me) Oh Luke, I know Luke*
> *Dr Michaels: Have you signed in? because you are a visitor.*
> *Luke: No, not yet, I suppose I should…*
> *Yvonne: Yes because you are not written down anywhere otherwise, and if there's a fire we won't be looking for you.*
> *Luke: Ok I will go and do that*
> *Dr Michaels: What's your plan for the day? Are you just going to join us?*
> *Luke: Yeah I will just hang around and try not to get in the way, if that's Ok.*
> *Yvonne: I have known Luke for ever*

> *Dr Michaels: because the other patients haven't consented for your involvement have they? Your observation?*
>
> *Luke: No that’s true, I do have an honorary contract here anyway though and...*
>
> *Yvonne: Yeah, I didn't know it was Luke, Luke's fine. Luke is one of the tutors at college and it’s part of their role to …*
>
> *Dr Michaels: Yeah. Ok. Well if you are happy then.*

(It should be noted that although I was intending to join the theatre team for the duration of the operating session, I would not have been formally acting as an ‘observer’ or making field notes during this time). In this exchange, Dr Michaels was questioning whether my cultural capital had currency. The limited resources afforded by my social network meant I was not known to her directly and my social capital was not sufficient to be accepted unquestionably. However, the involvement of Yvonne, introduced a common element, where our two social networks overlapped, meaning that my social capital could be validated and accepted. However, I was not afforded full insider status on this basis. I was still expected to sign-in to the department as a visitor, which I had not done previously because I felt like an insider and this was something that only outsiders did.

4.3 Summary

Within the operating theatre, capital is distributed and primacy given to specialist knowledge sustained through a culture originating in a positivist paradigm. Capital demonstrated by medical and other health professionals in this arena is cultural capital which takes the form of qualifications often based upon biomedical knowledge. However, patients place value on the knowledge and opinions gathered from social capital connections to inform their understanding and contribute to healthcare decisions. Patients may also demonstrate cultural capital that is applicable to the operating theatre. However, the ability to both accrue and take advantage of cultural capital in this context is dependent upon medical and other health professionals acknowledging the types of activities, resources, and behaviours demonstrated by patients as having value. Through a fostering of relationships with patients that empowers a demonstration of cultural capital, medical and other healthcare professionals are able to contribute to the capital that patients are able to draw upon and their capacity to do so. Although there is a need to explain and involve the patient in discussions during their surgical experience, this appears to be a tacit skill that some staff found more difficult than others and it should also be recognised that patients have the right to choose to be a passive recipient of care.

CHAPTER FIVE: EMBODIMENT AND DISEMBODIMENT IN THE OPERATING THEATRE

5.0 Introduction

The body exists within both a physical and social world simultaneously, with the traits exhibited within these spheres often presented as oppositional. The physical world is presented as representing the stable and unchanging nature or biology of the body, while the social world represents the environment and history of the body which is subject to constant change (Young, 1997). The continual exchange of meanings between the two kinds of bodily experience is one where each reinforces the other to the point where the body cannot be considered without simultaneously involving a social dimension (Douglas, 1996). As Shilling (2012) notes, "*acting people are acting bodies" (p8)* so it is not possible to develop a theory of human agency without acknowledging the role the body plays as an integral part of human agency. Embodiment, in contrast, is contextual and bound within the specifics of time, place, physiology and culture that together comprise enactment (Hayles, 1993). Embodiment can be regarded as how individuals experience themselves, with the body as the locus of the self, indistinguishable from and incorporated within the body. Surgery disrupts this experience by creating a situation where the embodied self is exposed to a violation, albeit one with which the self is complicit.

This chapter will examine how patients make sense of their embodiment with a partially anaesthetised body during what Goffman (1961) refers to as the 'repair cycle'. The concept of 'dystance' is introduced to enable an understanding of the meaning patients attribute to the temporarily altered sensation of their anaesthetized body. By focusing on the patient's subjective experience of reality during their surgery, an understanding of how divergence from experiences in the present creates a view of the body as dystanced will be proposed. How a dystanced body leads to the surgical team assuming agency for the anaesthetised part of the patient's body will be discussed along with how patients use this to understand and come to terms with their perioperative bodily experience. The meaning patients attribute to the anticipated noises of the operation will be compared to the reality of their experience along with strategies used to make sense of this difference. Finally, the need for staff to maintain a backstage area (Goffman, 1961) in the perioperative environment and the effect seeing behind the scenes can have on the patient perspective will be considered.

5.1 Cartesian Dualism

The fieldwork conducted within this study brought to the fore a recognition of the problems mind/body relations raise for patients experiencing regional anaesthesia. Cartesian mind and body dualism represents the metaphysical stance that mind and body are two distinct substances, each with an essentially different nature. Descartes described the mind as an un-extended, immaterial but thinking substance, whereas the body was seen as an extended, material but unthinking substance. Ryle (1949), explains that:

> *"a person… lives through two collateral histories, one comprising of what happens in and to the body, the other consisting of what happens in and to his mind… The events in the first history are events in the physical world, those in the second are events in the mental world"* (p.11-12).

A Cartesian approach has led both medicine and sociology to follow a mind/body dichotomy which focusses on the mind as defining individuals as social beings, while relegating the body to little more than a vessel in which the mind resides. The widespread acceptance of this world view has contributed to the dominance of the positivist paradigm within medicine and for empirical observation and measurement to be regarded as the only legitimate domain of enquiry (Mehta, 2011). Accordingly, during the perioperative period, patients have commonly been treated as biomechanical organisms which can be understood by examining the constituent parts using the principles of anatomy, physiology, biochemistry and physics. However, this approach has been accused of depriving patients of their humanity during the surgical experience because a clinical practice shaped by the notion of the body as a machine devoid of self, creates an impersonal, technical attitude which disempowers patients (Kriel, 2003). Sullivan, (1986) suggests that a Cartesian endeavour to know another person must involve seeing through that person's attempts to conceal their real thoughts and feelings, so that it is not possible to truly know someone else without knowing the person inside the body.

5.2 Dasein

More recently, a patient centred approach has been advocated to foster inclusion and self-determination. This approach is more closely aligned to Heidegger's (1927/2011) concept of 'Dasein' which equates to 'there-being' or 'being in the world' and emphasises the linkage between self and world (Allen-Collinson and Owton, 2015). According to Heidegger (1927/2011), Dasein is not static, nor can it be measured objectively. Instead, there is always meaning, although the meaning of being is subject to the context of that being. Heidegger claims that

> *"The essence of Dasein lies in existence"* (1927 p.42).

The focus is therefore not *what* is human, but what it is *to be* human (Fealy, 2008). Dasein has a corporeal aspect which was recognised by Merleau-Ponty (2001), who examined 'being in the world' in terms of 'flesh in the world'; because forms of corporeal knowledge are deeply connected to sensory experience. Patients undergoing surgery with a local or regional anaesthetic, experience an altered bodily state which temporarily alters their being in the world. However, the world of Dasein is one always shared with others and therefore inherently social (Heidegger, 1927/2011).

5.3 Solicitude

Heidegger refers to the interactions of Dasein with others as 'Solicitude' (1927/2011 p.121) and identifies three forms this may take. The first is the negative mode. In this mode Dasein may remain indifferent to or disregard others in the same way that everyday objects or equipment are taken for granted and largely ignored. This was evident in the actions of theatre staff in and around the patient and was observed on several occasions. In the following example from the field diary, Mr Kapel [the surgeon] acts and talks over (and about) Janet [the patient] as though she were not present, even though she is awake and able to answer for herself.

> *Mr Kapel enters the anaesthetic room and removes the blanket covering Janet. Turning to Dr Chisolm he says: "she was going to have a catheter wasn't she?"*
> *Dr Chisolm: "No she doesn't want it".*

For Heidegger (1927/2011) it is these deficient and indifferent modes of solicitude

> *"...that characterise everyday, average being-with-one-another"* (p.121).

The second and third modes of solicitude are both positive but take two different forms. In the second mode of solicitude one ‘leaps in’ and takes over for the other (Heidegger, 1927/2011). In this form of solicitude the other is dominated and becomes dependent. This is demonstrated in the following extract from the field diary:

> *Santokh* [the anaesthetic practitioner] *takes the left hand of Rita* [the patient] *and with a quick word of warning inserts a pink cannula. He covers this with a clear plastic dressing before attaching the plasmalyte infusion. Rita is a little unclear of the purpose of the drip and asks “why am I having a drip? I am not having sedation”. Santokh replies “this is just to give you a bit of fluid because you have not eaten or drunk anything – we don’t want you to faint because you are dehydrated”.*

Although Rita is not sure of the purpose of this drip, it is seen as a necessary part of the procedure and through this action Santokh is ‘leaping in’ to represent her interests, albeit through acting for, rather than with her. Fealy (2008), suggests with this form of solicitude, care is taken away from the other. In contrast to this, the third mode of solicitude does not leap in, but instead ‘leaps ahead’ of the other (Heidegger,1927/2011). In this way care is returned to the other. The following example from the field diary illustrates this:

> *Once Helen* [the patient] *has entered the anaesthetic room, Dr Michaels* [the anaesthetist] *explains the position that she needs Helen to be in. As she does this Dr Michaels sits on the operating table with her legs over one side, facing the cupboards on the left to demonstrate what she means. Helen stands from her wheelchair and gives Lucy* [the anaesthetic practitioner] *her dressing gown, who puts it in a plastic bag. Helen shuffles to the footstool and unsteadily steps up and sits on the operating table the way Dr Michaels has shown her.*

Here the patient retains her autonomy and rather than being positioned, she is encouraged to position herself. This kind of solicitude is described as authentic, in that it acknowledges the existence of the other, rather than treating the other as a ‘what’ with which they are concerned. Heidegger explains

> *"Everyday being-with-one-another maintains itself between the two extremes of positive solicitude – that which leaps in and dominates, and that which leaps forth and liberates"* (Heidegger, 1927/2011 p.122).

While a patient centred approach has been adopted for surgical patients within the preoperative and postoperative periods, the perioperative stage of the patients' journey has been slower to adapt and literature relating to patient centred care within the operating theatre is more limited (Arakelian et al, 2017). In order to achieve a truly patient centred approach in this setting, a balance needs to be struck between the indifference of everyday being-with-one-another, leaping in to act for the other and leaping ahead to enable the other to act for their self.

5.4 Embodiment

Embodiment is the way in which people experience and inhabit their bodies and the way in which these bodies incorporate and express social information (Cassel, 1997). Although bodies are biological, their meanings are social, and endowed with meanings that are non-verbal, which Bourdieu, (1977) refers to as 'Learned by body'. Much of the social science literature relates to the way practitioners objectify their patients, reducing them to a pathology or mechanical body that can be repaired by opening up, rerouting or replacing individual pieces (Prentice, 2013). But this reductionist view separates embodied patients from the social and historical circumstances that contextualize the whole person, which has led to suggestions of this as a dehumanizing approach (Young, 1997). This reductionist approach has become dominant in modern medicine and has become accepted as being almost inevitable within the patient's surgical experience. Nigel, [a patient scheduled for knee replacement surgery] explained during his preoperative interview:

> *"To me it's like. With anything, it's a bit like taking a car into the garage. Something's not working properly and you want a replacement part if you can't fix what's there already. That's all it is… Spare part surgery is applicable to all parts of the body these days pretty well isn't it? So I think yeah we are like cars".*

This creates a distinction between the body as an object and the person who owns the body, along the lines of Cartesian dualism. However, the benefit of this distinction is to enable what Goffman

(1961) describes as the ‘server/client relationship’ to pass through the repair cycle. In this analogy, the body is regarded as a possession that needs attention but cannot be left under the care of the surgeon while the person goes about their other business. Clearly, an individual cannot leave their knee behind to be repaired, so a resolution must be found. One solution to this problem is general anaesthesia. This creates a situation where the patient is physically present, but through a lack of consciousness is also absent. Another solution is to create an ‘ontological duality’ that distinguishes the person as a social individual from the physical parts that belong to that person in the form of their body. In the following field diary extract, Doreen [the patient] chats to Leena [the anaesthetic practitioner] during Doreen’s knee arthroplasty operation:

> *“Do you know anything about tortoises? Would you like to know?” Doreen asks before explaining about Holly her tortoise and describing how tortoises hatch.*

At the same time as Doreen and Leena have a conversation about Holly the tortoise, the surgeons (Mr Kapel and Mr Grosse) continue with the operation as noted in the field diary:

> *Mr Kapel applies the cement, saying “long osteotome” in a loud voice. “Andy”,* [the scrub nurse] *“you can tidy up later. Concentrate here.” Mr Grosse scrapes away the excess cement as Mr Kapel holds Doreen’s foot in a fixed position and adjusts the tibial prosthesis, hammering it in place.*

Thus a social interaction takes place on one level, while the mechanical assessment or repair simultaneously takes place on another level. This is not dissimilar to the situation where an intimate physical examination is carried out while the medical practitioner and the patient have a relatively innocuous conversation about the weather. In this example, a social exchange takes place with Leena, the anaesthetic practitioner, while the physical contact is simultaneously conducted by the surgeons as if Doreen were not there as a social being, but only as a possession someone had left behind. Unlike general anaesthesia where the patient is rendered unconscious, with regional anaesthesia the patient continues to experience their physical being during the surgical process, albeit in a markedly different way. As Doreen explained to me shortly after her knee replacement had taken place:

> *"Well I couldn't feel it by then but I was able to see that they'd lifted my leg and they started painting all that antiseptic orange-y stuff on it. And that was only because I'd raised my head and I could actually see what they were doing".*

As the regional anaesthetic takes effect, a distinct area of the patients' body begins to lose sensory information and gradually becomes distant from the person as a social individual. The sensation of temperature is the first to be lost, followed by touch, pain, the ability to move and then finally pressure. However, this temporary adjustment to the physical state also influences the way in which patients view themselves and the world around them. Patterson, (2018) has suggested that the interface between a positivist medical paradigm and a sociological one is temporally and spatially located in the separation of the body of the patient from their individual and cultural identity. While the patient undergoing a general anaesthetic loses these aspects of identity along with consciousness and agency, the patient undergoing a regional anaesthetic retains consciousness and correspondingly, both agency and individual and cultural identity. However, this must be mitigated against the altered sensations associated with the anaesthetic techniques which temporarily dissociate the anaesthetised area with the personhood that retains agency. As the local anaesthetic takes effect and sensation is lost, agency is passed from the patient to the healthcare professional. In this situation, the patient becomes what Turner (1992) describes as

> *"a thinking and choosing agent, not a feeling and being agent"* (p.87).

The following field dairy extracts, which took place in the anaesthetic room, follow this process with Doreen as her spinal anaesthetic takes effect:

> *Dr Trant "OK can we get you to do the leaning thing? Slump your shoulders and push back towards me – no not that way, the other way..." she attaches a large sticky drape to Doreen's shoulders so that it hangs down like a curtain with a hole in the middle and injects a small amount of local anaesthetic in to the centre of Doreen's back. As she does this she says: "you might feel a bit bruised", before changing the needle and injecting some more. The area bulges a little, like a bee sting in the centre of Doreen's back. "A bit of pushing now" she says as she inserts a long orange needle into the area where the local anaesthetic was injected. "Can you feel anything in your legs or bottom?" Dr Trant asks as*

> *she withdraws the introducer in the centre of the needle and some clear fluid flows into the end of the needle. "I am just giving you the injection now so stay nice and still…" She attaches a syringe to the end of the orange needle and injects the contents.*

Until the point where the anaesthetic is administered, Doreen retains her agency and remains an active participant in the process, thinking and choosing as well as feeling and being (Turner, 1992). She is able to arch her back and move into the right position to help the anaesthetist find the correct place to administer the anaesthetic injection. Once the solution has been injected and begins to take effect, Doreen gradually becomes more and more 'distanced' from her legs. To begin with, Doreen's legs are 'close' and she retains agency of them the same as she does for any other part of her body. However, as her legs become anaesthetised, they become psychologically distanced (Trope and Liberman, 2003) as sensation is lost and she is unable to feel or control them. This loss of control is tested by asking Doreen to move her legs and to assess whether there is any sensation associated with them. As was recorded in the field diary:

> *Dr Trant: "Try lifting your legs…" (there is little movement) "ok, that's good."*

The effect of this assessment is two fold. As well as assessing whether the anaesthetic has taken effect, it also assesses to what extent the agency of Doreen's legs should be assumed by the surgical team. Once the anaesthetic has taken full effect, the psychological distance (Trope and Liberman, 2003) between Doreen and her legs is great. The anaesthetic creates a cognitive separation (Baltatescu, 2014) so that Doreen no longer experiences her legs in the present. Instead, Doreen's experience of her legs is replaced with a memory of this experience. As a consequence, Doreen temporarily passes this aspect of her agency to the healthcare professionals. Prentice (2013) described a similar exchange where medical staff may 'borrow' an arm while blood is taken. This objectifies the arm and alienates it from the personhood to create a psychological distance (Trope and Liberman, 2003) between the patient and the actions taken on the arm. The request to borrow the patients arm invites the patient to exercise a different kind of agency. Rather than agency to control the arm, the patient exercises agency in lending the arm to the medical staff on the understanding that the arm will be returned to become a part of the person again.

Once the anaesthetic has taken full effect, the preparations continue as noted in the field diary:

> *Leena* [the anaesthetic practitioner] *leaves and calls the surgeons to place Doreen's leg in the correct position for the surgery. Mr Grosse* [the surgical registrar] *enters first and starts by applying a tourniquet cuff around the top of Doreen's thigh. As he lifts Doreen's leg, Dr Trant* [the anaesthetist] *points to it and Doreen notices her leg is in the air "ooh – I didn't know it had moved!" and then she adds "helloo!" in a slightly drunk tone. I look at the drug tray and remember that Dr Trant has given Doreen a small amount of sedation (1mg midazolam). Mr Kapel* [the senior surgeon] *arrives and helps to prepare Doreen's leg for surgery.*

The surgeons do not introduce themselves to Doreen in this instance, nor do they ask her permission to move her leg. An assumption has been made that because the sensation in her leg has been lost, agency has been passed to the surgical team. Doreen is now psychologically distanced (Trope and Liberman, 2003) from her own leg, to the extent she no longer has control or knowledge of where her leg is.

The result of distancing Doreen from her leg, is that of distancing the embodied person as an individual social being from the patient as a mechanical object to be fixed. While the person retains agency for the non-anaesthetised area, the process of separating the person from the patient is further facilitated through an isolation of the surgical area from the rest of the body. The following observation taken from a field diary entry in the operating theatre illustrates how this is carried out:

> *Mr Kapel and Dr Patil* [the surgeons] *enter the operating theatre from the scrub room. They are both dressed identically in surgical gown and gloves, with a type of surgical hood which resembles the helmet of a space suit. The hood covers the surgeons head completely in the same blue paper material as the scrub gown and drapes, with a Perspex screen at the front and a headlight which shines a strong light wherever they direct their gaze. These helmets make it difficult to hear what they are saying, as their voices are muffled. Eric, the scrub practitioner also enters, but from a different direction. Eric has been preparing the instruments that will be used for the case in the 'laying-up' room and now enters from a*

> *separate anteroom with several trolleys of surgical instruments. He is not wearing the same surgical hood as the surgeons, although he is wearing a facemask with a large Perspex screen attached. Tony the circulating practitioner is wearing the standard blue scrub suit. He holds Janet's leg aloft from the heel as the two surgeons stand one on each side of the operating table and apply a pink antiseptic solution to clean the area that will be operated on. Another blue drape is then spread underneath Janet's leg as Tony holds it in the air. A sterile stocking is placed over Janet's foot and the surgeon takes over from Tony in holding it aloft. Janet's leg is now deemed to be sterile and therefore moves from outside to inside the sterile field. Janet's leg is finally wrapped in a bandage from her foot to just below her knee, leaving the knee and about 7" either side exposed. This exposed area is then covered in a light brown plastic film which sticks to the skin.*

This process serves to completely cover every part of Janet and removes any trace of the person associated with the body part. Hirschauer (1991) suggests this surgical preparation serves to narrow the body's visual shape as it is *"parcelled out into regions"* (p.289) to create a disappearance of everyday bodies, which correspondingly implies anonymity.

The uniform that is being worn by each of these actors identifies their role in the action. Prior to the surgery, all of these members of the team were dressed identically in blue scrub suits. However, once the operation commences, the two surgeons are the most elaborately dressed as they are closest to the surgery. The addition of the scrub gown, gloves and hood serves to protect both the patient and the surgeons, as this acts as a barrier to infection being transferred in either direction. This barrier is also a psychological one as the surgeons are barely recognizable as individuals while they are dressed this way, which is reinforced by the muffling of their voices. Neither Janet nor the surgeons are recognizable as individuals during this time, which acts to dehumanize both. The process continues as was recorded in the field diary:

> *A large blue drape is spread over Janet's top half, from the waist up. The furthermost end of this drape is lifted up and each corner is attached to a drip stand – one on each side of the operating table.*

There is a distinction being made here between the two halves of Janet, an ontological dualism which separates the knee and the person. For Goffman, (1963) the body is the material property of the individual. Individuals normally have the ability to control and monitor their bodily performance and the body is associated with the exercise of human agency. Janet’s lower half represents the troublesome knee and is no longer under her control. The agency of this lower part has been passed to the surgeon and becomes the surgical half, whereas the upper half or ‘head end’ is where Janet resides. This goes beyond the notion of Cartesian dualism, which divides the person into mind and body, because although the upper half of the body remains under Janet’s control and consequently remains a part of Janet’s personhood, this is distanced from the biomechanics of the knee which is now under the control of the surgical team.

5.5 The blood/brain barrier

The process of covering the patient in blue surgical drapes serves to create a sterile field but also visually reduces the body to focus the surgical team’s attention on the operative site (Prentice, 2013). This serves to isolate the two areas; the head or patient end from the knee or surgical end and thus continues to reinforce the ontological duality of body and self. Typically, during this draping process, the patient’s head is isolated with a surgical screen outside the sterile area. This serves to prevent the patient from being able to see the surgery as it takes place (and also prevents the surgeons from seeing the patients face during surgery). One surgeon (John Henry) referred to this screen as “the blood brain barrier”; the barrier that separates the blood which symbolises the operation, and the brain which symbolises the person. By isolating the face from the rest of the body within the surgical field, the unique contribution of the face to the individual’s sense of personhood is acknowledged. The face embodies the individual’s sense of identity and represents the place where he or she recognizes him/her self. Through the face an individual can be named, judged, assigned a sex, an age, a skin colour, an emotion or can remain anonymous in an undifferentiated crowd. The face belongs to an individual and represents sufficient diversity to signify without ambiguity the difference between one person and another. The face is the territory of the body where individual singularity is inscribed (Le Breton, 2015) and can be regarded as the place where personhood resides more than anywhere else.

This separation of the body from the face during surgery has significance as it allows the patient’s body to be free during surgery to act in ways that are not attributable to the individual. The agency of the body is temporarily passed by the patient to the medical team. The patient is then able to retain a sense of self without feeling accountable for the actions of their body, over which they have no control. Le Breton (2015) suggests that by "*erasing the face through artifice"* (p.6), the individual is liberated from the constraints of identity. The surgical screen acts in a similar fashion to a mask which guarantees the patient a degree of anonymity that lifts prohibitions, since the individual no longer has to fear being unable to look themself in the face and answer for their acts, as the face is hidden from their own attention and that of others. The individual is literally unable to 'lose face'. For the surgical team, the surgical screen promotes the 'non-person' solution (Goffman, 1961) which allows surgery to be conducted as though the patient were present only physically and not as a social person. During this time, the patient loses sight of their body as the surgical screen serves to prevent the patient's gaze going beyond this point.

5.6 Giving up agency

Karlsson et al (2012b) have suggested the lack of sensation from the anaesthetised area breaks contact with those parts of the body, so the body must be entrusted to the responsibility of carers. Hirschauer (1991) presents this as a distancing of the person from their body, so the body becomes partially or completely distanced from the person and the free disposal of themself, so that autonomy is lost. However, the distancing of the person from their body can be seen in the context of Goffman's (1961) repair cycle, as a method of dealing with the difficulties of having one's body treated and having to overlook the fact that it cannot be used in the usual fashion while it is being repaired.

> "*Since the client must reside in the workshop during the active treatment phase of the repair cycle, he is well situated to see the difficulties of assimilating everything that occurs around and to him to the service model"* (Goffman, 1961 p.302).

Autonomy is not therefore lost, but temporarily suspended as the patient is distanced from part of their body and agency is passed to the server for the duration of the repair cycle. As Janet [a patient who had undergone a knee replacement] explained in her postoperative interview:

> *Janet: It wasn't as painful as I thought it would be. I thought the needle would be…really kind of hurt. It did but not as much as I thought it was going to hurt no.*

> *Luke: So better than you expected?*
> *Janet: Yeah and I, it was only when he picked up my leg over his shoulder that I thought it must be numb.*

Here Janet is referring to the surgeon who came in to the anaesthetic room and prepared her for surgery. Although the surgeon did not explain what he was doing, the significant event is not that a strange man is manipulating her leg, but that the leg was completely numb. By this point, Janet has already given up agency of this part of her body to the control and responsibility of others.

> *Luke: because you were a bit worried about that before weren't you? You were worried about how you were going to know if it was numb*
> *Janet: How I would know it would really really be numb yes.*
> *Luke: So were you really happy about that before or was it only when he lifted your leg right up into the air that you felt oh ok this is…*
> *Janet: only when he lifted, because it was a funny feeling. It felt like I could feel my knees. I obviously couldn't but it felt like… like I could still feel my knees.*
> *Luke: when you say you could feel your knees how did it feel?*
> *Janet: it did feel like I could have gone like that (moves leg) with my knees but yeah*
> *Luke: So when you tried to move your legs, what was that like?*
> *Janet: That's a really odd sensation it just is so…you just can't. It's like its glued to the bed isn't it? What your brain wants to do it just doesn't… doesn't do it.*

The dissociation between self and body is highlighted here. As the known boundaries of the body are altered it raises questions of where is the 'self' and who is the 'I'. This process is normally accepted with a certain amount of resignation on the part of the patient. This was highlighted by Violet, when interviewed on the ward shortly after her knee replacement surgery:

> *"It's got to be done. It's like I was saying to my daughter beforehand, it's inevitable. You get to that stage when it's just inevitable, there is nothing you can do to stop it. Just go with it".*

Similarly, Astrid explained when she was interviewed on the ward before her arthroscopy:

> *Astrid: I feel like, no I don't feel in charge. I feel like, I'm quite happy to be guided and everyone doing everything for me. I feel like I'm just following the instructions and whatever.*
>
> *Luke: Are you happy with that?*
>
> *Astrid: I'm happy with that, yes. I want them to take control. They know what they're doing.*
>
> *Luke: So how much do you know about these people that you're giving over control to?*
>
> *Astrid: Absolutely nothing.*
>
> *Luke: So how do you then be comfortable with giving over control to someone you don't know?*
>
> *Astrid: Well I've just got to take that risk and have faith. These people, they are all people out there who've got a job where they want to help people. They've only got the, that interest, you know and if anything went wrong it would be just fate, an accident. It's not, you know...*

This resignation may indicate a transition to the next stage in the process for the patient. The person becomes the patient when they attend the clinical environment. The patient becomes a case when they are unable to move for themselves and bodily control is handed over to a third party. Once the knee has been cut open and the underlying structures have been exposed the case becomes a disease, which is then treated by removal of the affected area and replacement with an artificial joint.

5.7 Comfortably numb

The body in this process is neither a 'disappeared body' in the sense of a recessive body which is largely absent from thought in everyday lives, nor is it a 'dys-appeared body' which is brought to the fore through acute pain, disease or pleasure (Leder, 1990). Instead, this is a body that is conspicuous by its absence. The body has been taken away to be repaired, and in doing so the patient's personhood becomes 'dislodged' from his or her body (Hirschauer, 1991 p.287). It is 'distanced' and in its place is an absence which is perceived in terms of comfort. This is in contrast to the presence of the patient's body which is experienced in terms of the discomfort or pain that has led to the need for surgery. Nigel [a patient who had undergone a knee replacement] explained in his postoperative interview how he experienced his body during this time:

> *Luke: So what about lying still on the operating table?*
> *Nigel: Oh no problem, lovely.*
> *Luke: That was OK?*
> *Nigel: Lovely, because normally when you try and lie in one position you can't. You turn over and all the rest. But because from here downwards was, didn't exist, there was no problem at all.*
> *Luke: What is it like having that sort of sensation where, like you say that bit doesn't exist?*
> *Nigel: Lovely. Lovely.*
> *Luke: Why was it lovely?*
> *Nigel: It was so restful and relaxing and warm. That's why. Nothing unpleasant about it at all.*

Similarly, Doreen said in her postoperative interview:

> *"It's weird because you can hear the noises and feel the vibrations all the way up to your shoulders and the bed is moving, but it's confusing the brain because you can't feel anything even though you know it's happening. It's like it's not there. It's numb. Comfortable, but it's like it doesn't exist. The top half is all warm and cosy but the other half isn't there".*

5.7.1 Heat

Heat was a bodily sensation that was often associated with comfort during the surgical experience. Potter (2008) describes how heat can be regarded as a specialised form of touch. While touch is a proximal sense which requires physical contact between the body and an external object, heat is trans-boundary in that it is perceived both within the human body and at the boundaries where the body touches or merges with the external world (Allen-Collinson et al, 2018). What commences as a tactile experience; the touch of an external heat source on skin (such as the heated air of the warming blanket), contributes to the generation of feelings of inner core heat, which merges the concepts of 'external' and 'internal' heat (Allen-Collinson and Owton, 2015). Heat in this sense is perceived as comfortable in that it acts as a surrogate for touch, which has a well recognised comforting effect on patients (Hankela and Kiikkala, 1996; Mitchell, 2008; Bergman et al, 2012). As Doreen [a patient scheduled for a knee replacement] explained when interviewed after her operation:

> *"The thing that was totally different to anything I've had before was that heated blanket over me. Now that was lovely. I really really liked that. Yeah it was comforting. It was nice. I mean I wasn't cold even before going in but just having that extra little bit of warmth coming over you. I'm not sure whether it was psychological or whatever, I'm sure it helped me relax. I'm sure it did. Yeah, yeah".*

Experiences of physical warmth (or coldness) have been shown elsewhere to increase feelings of interpersonal warmth (or coldness), without the person's awareness of this influence (Williams and Bargh, 2008). In support of this, magnetic resonance image (MRI) studies of the brain have demonstrated an involvement of the insula region of the cerebral cortex in processing both physical temperature and interpersonal warmth (trust) information (Sung et al, 2007). Although active warming of patients during surgery has been shown to reduce incidences of surgical site infection, overall length of hospital stay and transfusion requirements (Riley and Andrzejowski, 2018), the association of warmth with comfort and relaxation has not previously been implicated in helping patients to feel more at ease with their surroundings during the perioperative experience.

5.7.2 The sounds of surgery

Heat is not the only sensation with a trans-boundary capacity which is experienced by the patient. Sounds are similarly trans-boundary in that they are emitted at the intersection of an action and a body (Kane, 2014). Objects have an inherent capacity to make sound, whether this be through the interaction of a plectrum and a string, air forced through a vocal tract or a bat on a ball. Thompson (2012) describes the transcending power of sound as emerging from its relationship to the body. It:

> *"addresses me as matter, rendering the body porous. I can feel it in my lungs, my stomach, my throat"* (Thompson, 2012 p.211)

so that the:

> *"bordered body is taken to its outer thresholds, its margins"* (Thompson, 2012 p.213).

The sounds of surgery are created through the physical interaction with the patient's body during an operation, which reduces the person to a noise making object, but also as an entity capable of experiencing and interpreting sound.

The noises associated with the operation were well recognised by participants in this study as forming a part of the surgical experience. For some patients this was simply a matter of fact. The following exchange was recorded in the field diary during a period of observation in the pre-assessment clinic known as the 'joint school'. Before the session begins, the participants chat among themselves:

> *The conversation between participants continues – one man mentions being awake during the surgery; "wide awake, while they are chopping things up. I might think I am in a workshop somewhere". He then describes how he and his wife have just moved and have put a workshop up 'out the back'.*

Here the male participant is not expressing concern, but rather relating this unusual situation to his own circumstances to normalise it. In this exchange the operating theatre is regarded as a practical space (similar to a workshop) where the work of surgery is carried out. However, not everyone is so matter of fact. During this same observation in the joint school, one man needed to leave the session early. When I queried this afterwards with the occupational therapist running the clinic, I was told:

> *"he was a relative who felt faint because of the talk about drilling and sawing and had to leave".*

This fear of the sounds associated with surgery is not simply a case of misphobia – a fear or hatred of certain sounds. Nor is it an example of phonophobia – a fear of loud noises. These are sounds that have not been heard as they have not yet happened, so it is not the sound itself, but the association of these sounds with their origin that some patients are fearful of. This phenomenon is recognised by staff, as Leena, [an anaesthetic practitioner] explained when interviewed:

> *Leena: sometimes they are scared if they hear the banging and all the, you know, all the saw noises. So it's better not to maybe. And most of them, they prefer actually to go to sleep.*
> *Luke: Is that something they've told you?*
> *Leena: Yeah yeah. They said "oh when are you going to put me to sleep? I don't want to hear noise. I don't want to hear the saw" yeah, yeah yeah.*

This is more akin to the phenomenon of acousmatic sound – where a sound is heard without seeing what caused it. Just as acousmatic sound can take on the signification of a strange and supernatural event – a creepy effect without a cause – that can invoke a feeling of terror, dread, or a state of awe (Kane, 2014), the imagined sounds of surgery are dissociated from their cause as separate parts of a single physical event. The case of imagined sounds presents a challenge, as the source or cause which is not seen is imagined. This is highlighted in an interview with Violet shortly before her knee replacement operation:

> *"Just you hear the noises, all the hammering and banging and drilling. I don't want to see them do that to me".*

Here Violet conflates hearing the noises and seeing the surgery. It is not the sound itself which causes anxiety in the patient, but what the sound represents. The sound of a drill coming from a workshop does not create anxiety in the same way as the sound of a drill coming from a dentist's surgery. Kane, (2014) notes that sound is often treated symbolically as a metaphor for some other form of experience. In the case of these patients, sound acts as a metaphor for the physical and mechanical part of the surgery. However, the sounds of surgery become real once surgery starts and so have the capacity to alter the course of events. The following field diary extract, taken during Janet's knee replacement operation, serves as an example of how the noises of surgery can have real implications for the patient and anaesthetic during the surgery:

> *Dr Patil* [the trainee surgeon] *drills some smaller holes and these are used to hold the bracket in place. She then uses a power saw to cut through the bone to the desired shape. The noise of the saw is much louder than the drill. As Dr Patil uses the saw, Dr Chisolm* [the anaesthetist] *looks at Janet closely, her gaze passing from the anaesthetic monitor to Janet's face and back again.*
>
> *'She doesn't want to hear…I give a bit of Propofol at the noisy bits. She is at 1ug – she drinks a bit of sherry!' As the noise rises, Janet's respirations as shown on the anaesthetic machine rise from 14 to 17. Dr Chisolm explains how she remembers one patient who opened their eyes at this point and became quite annoyed – saying 'someone answer the door!'*

This anecdote represents how patients are not aware of their immediate situation but assimilate the experience into what is normal in their everyday life-world. It is more likely that the knocking is coming from the front door than from someone knocking surgical instruments into their knee. For Dr Chisolm, the noise levels are represented in the physiological response of the patient. The noise is cancelled out by increasing the amount of sedation (Propofol) so the patient no longer shows a physiological response. Similarly, Doreen related the noises of her operation to a more commonplace occurrence she has experience of, as she explained when interviewed on the ward after her operation:

> *Doreen: Amazingly good. Yes. More noise than I thought there might be. More sounds of drilling than I thought there might be.*
> *Luke: How did you feel about that?*
> *Doreen: It was like listening to my neighbour doing his DIY next door. When I say neighbour you know they are very very close. So the noise level is comparable with him doing his DIY. Just to sort of put it into perspective.*
> *Luke: Did you associate that noise with what was happening to you?*
> *Doreen: I was aware of it but because I couldn't feel anything then it didn't bother me as they were doing it to my leg. I suppose subconsciously I did but not consciously for it to matter. The thing that I found the strangest was the hammer. The sound didn't bother me. I was intrigued with it. But there was some quite hefty blows. And it was funny because as*

> *they were hitting of course the vibration travelled up my leg. And that I found really weird because I could hear it and I could feel the sort of the vibrations coming up and I couldn't feel anything down on my leg or my knee or anything. So my brain got a bit confused because it's you know, it's happening down there but nothing was happening down there.*
> *Luke: So how did you rationalise that?*
> *Doreen: Isn't this good.*
> *Luke: So you were quite happy about it?*
> *Doreen: Oh yeah, yeah. Especially when at one point they were giving some really loud hard bangs and I was thinking "oooh" because it was almost as if the bed was moving and since I've lost weight, my bottom has gone really squashy and it was quite funny because it was almost like being on a soft cushion because I felt as though my bottom was going backwards and forwards. And then it sort of vibrated up. Right up to my shoulders. And it was a really strange feeling, pleasant feeling.*
> *Luke: Pleasant?*
> *Doreen: Yes. It was a pleasant feeling but it was really strange because you know it was like at one point it was almost like they're trying to knock through a wall. And then I thought "don't be silly, they are working on your leg"*

Although Doreen is aware of what was happening to her, she rationalises this in two ways. Firstly, she associates the sounds with those from her life world. Her experience is telling her the most likely cause of these sounds is Dave doing his DIY next door (the small amount of sedation helps with this). However, the movement that goes along with the physical nature of the surgery; the physical interaction that is creating the sound is one that involves her body. This is revealed when the interaction crosses from just sound to include movement as well. Fortuna (2017) notes that body movement has a role in processing, sharing and giving meaning to sounds. Although the senses are often considered as being separately activated by specific physical stimuli, making sense of an environment is not a static and objective process. Instead, sense making arises from an integration of the different senses. The interview continues:

> *Luke: So you had to remind yourself what they were doing?*
> *Doreen: That I was in hospital and they're actually working on my leg. But because I couldn't feel anything at all, it, you know, it was a really strange situation. And then of*

> *course when they got the drills out, or the saws or whatever they were using and at one point that got really really loud. And my mind instantly switched to "oh Dave's out in the garden again" Because we've got a covered in part. And my mind straight away switched to "ooh I wonder what Dave's doing today with his DIY"*
> *Luke: Was it a case of your brain trying to put it into some sense for you?*
> *Doreen: yes it wasn't switching off because of "oh I don't like this" It straightaway was associating the sounds with what I knew. And that first sound instantly made me think of Dave doing his DIY.*

For Merleau-Ponty (2001), learning is relative to the body's interaction with the world. Cognitive, physical, emotional, and spiritual meanings of motion, and changes in surroundings, are created through an active corporeal experience. These experiences are manufactured through an integration of the senses. This contributes to the second approach Doreen uses to rationalise what is happening to her. By associating the lack of feeling with a lack of action, Doreen is able to deny the surgery is taking place. Because the surgery takes places beyond the screen in the area designated as 'down there' Doreen can neither see nor feel it, so rationalises that 'nothing was happening down there'. The movement which is created by the surgeons in the process of performing the knee replacement forces Doreen to associate the sounds and the movement together to the operation she is having. However, this is difficult to rationalise, given the absence of seeing or feeling what is happening to her body and it is this that causes Doreen to be confused.

5.8 Backstage in the theatre

In order to further the illusion of the patient's absence, surgery takes place in what Goffman (1959) refers to as a backstage area. Goffman (1959) suggests that back regions are commonly cut off from the area of the performance by physical partitions, so that members of the "audience" cannot intrude. These physical partitions vary in that they can block out lines of sight, sounds or both. The surgical screen in this instance acts as a demarcation between these front and backstage areas (Goffman, 1959). Behind the screen, the surgeons and scrub practitioners are able to discuss the details of the surgical procedure as this is where the mechanical part of the server client relationship (Goffman, 1961) takes place. Conversely, the social person to person interaction with the patient takes place on the other side of the screen. This separation is reinforced through the need to maintain the sterile field which encompasses the operation site, the drapes that cover the patient, the fronts and arms of the surgical gowns, the instruments and the associated trolleys. All members of staff are aware of the sterile field and understand the need to protect this area. However, this separation of the social frontstage area and the mechanical backstage area (Goffman, 1959) is not without its problems. Some staff are more willing or able to talk with patients on an interpersonal level during surgery than others and are therefore more comfortable interacting in the frontstage area (Goffman, 1959). Jane, [a scrub nurse] explained this shortly after the patient had left theatre for the recovery ward:

> *"it is about making sure they are aware that we are aware. We are used to it from obstetrics where they are always awake with no sedation. As an old ward nurse, I am used to talking to patients more than some others who forget. I stand at this end so I know what they can hear".*

This was also highlighted during an interview with the scrub nurse Danielle:

> *" I mean I think I've heard several nurses in my time, theatre nurses, say they're in theatre so they don't have to interact with patients because they're asleep. So I do think it makes a difference. And I think culturally as well, we're quite diverse and we've got some members of staff who don't actually want to speak. You've met my little friend Odo. She has a lot of difficulty saying some English words so she probably doesn't want to talk to the patient because they won't understand her".*

The need for the healthcare professional to remain close to the patient during this time is well documented (Mauleon et al, 2007; Karlsson et al, 2012a). It is acknowledged that a lack of identified support can leave the patient feeling no longer in control, at risk of feeling insecure, alone and not able to participate in the intraoperative situation (Bager et al, 2015). By remaining close to and in view of the patient, the healthcare professional acts as a surrogate body through which the patient is able to reach out. Although the use of monitoring equipment may enable perioperative staff to observe the patient's physical status from a distance, this only monitors the patient's organs rather than the patient as a person. Mol and Law (2004) describe the difference as being between an objective, public and scientific way of knowing the body from the outside and a subjective, private, personal way of knowing the body from the inside. However, monitoring the patient's physical status in this situation is regarded as normal and can act to reassure both the staff and patient that everything is progressing as expected. Sound in this context, can provide a reassuring presence, as was noted in the field diary shortly after Rita [a patient scheduled for a knee arthroscopy] had a local anaesthetic injection in her knee:

> *The anaesthetic monitor beeps in the background. The SaO2 reads 97% and the heart rate is 79. Rita moves the wires, as these are pressing against her neck. The machine stops bleeping and Rita looks up at the screen.*

Although the noise made by the monitor is in the background and as such is unobtrusive, the absence of the regular bleep is noticeable by its absence, more than by its presence. The halting of the familiar regular sound causes a passive shift of attention, so that the reaction, even for the patient, is to look towards the monitor for reassurance that all is well.

Similarly, patients also look to the interactions between staff for reassurance that all is well. This is not always done overtly, because patients often feel as though they are not a part of the action. Instead this can be done covertly through listening, as Violet [a patient scheduled for knee replacement surgery] highlighted after her surgery:

> *"I was more or less hidden from them wasn't I? They'd got the screen up. They were talking to one another - but I was listening".*

This suggests that Violet was still present and retaining agency albeit in a slightly subversive way. By listening to what was happening behind the screen, Violet was eavesdropping on the backstage area (Goffman, 1959). Violet was not the only patient to describe listening to the behind the scenes talk. Even though Astrid [a patient scheduled for a knee arthroscopy] was looking at the television screen during her surgery, and was given a commentary of the operation as it happened, she too felt the need to listen to conversations in the backstage area:

> *Astrid: I was only aware of what I could see in front of me. My head was down like this (she tilts her head down) so I couldn't see very much at all. I was aware there was people*

> *behind me and so on. So a lot of it I, just literally because I was, couldn't see what was going on but I was listening to it as much as I could to people.*
> *Luke: Oh, you were listening were you? Did you pick anything up?*
> *Astrid: Yeah, there was somebody saying something "is it worth doing that now?" or something. That was about all. I don't know if he did or didn't.*

What Astrid is referring to here is an interaction between Mr Khan [the consultant surgeon] and Otis [a trainee surgeon]. This interaction was recorded in the field diary:

> *He* [Mr Khan] *moves the scope to the inner side of Astrid's knee again. "That's where you get the pain, there" he says showing us an area which is slightly more pink and not covered with the same smooth white cartilage as the rest of the knee. "there is no meniscus there. There is a bit there, but it is all fluffy. You can see the difference in colour. You can see there is bone on bone arthritis which gives you the pain." Otis asks whether there is any benefit in doing anything to the meniscus in a situation like this. "If there is an unstable tear, then yes, but yes you are right".*

This answer is implicit, because Otis has not suggested that Mr Khan does not do anything, he has simply asked the question. However, Mr Khan has picked up on the implied statement that there is no point in doing anything to the meniscus because there is no way to regrow the cartilage; Astrid will eventually need a knee replacement.

While the explanation that Mr Khan gives Astrid concerning the inner workings of her knee is a frontstage action (Goffman, 1959), the question Otis poses does not include the patient and is not directed towards her. This is an action that would normally be conducted backstage (Goffman, 1959), as it is:

> *"related to the performance but inconsistent with the appearance fostered by the performance"* (Goffman, 1959 p.135).

Within the operating theatre, backstage areas (Goffman, 1959) are often temporal in nature, created when the patient is rendered unconscious through general anaesthetic. In this example, Otis is not used to a situation where the patient remains awake and so gives an unintentional glimpse of backstage action (Goffman, 1959) which would normally be conducted in an area away from the patient. Although Astrid does not understand the meaning of this overheard conversation, the purpose of this covert listening is to gain an insight into the routine of surgery. Astrid wants to be reassured that everything is running smoothly according to the routine. In the same way an aeroplane passenger might watch a flight crew to reassure themselves that all is well, the patient watches the theatre staff to be reassured everything is running smoothly.

Occasionally, the patient will be intentionally allowed a glimpse of the backstage area (Goffman, 1959). However, this is a rare occurrence as the ontological duality of the patient is maintained throughout; the knee and the person are kept separate. Despite this reductionist approach, sometimes the patient wants to know how their surgery is progressing. On these occasions, the surgeon may speak to the patient from beyond the screen, but the screen does not come down. Mr Henry, [a senior orthopaedic surgeon] explained during an interview:

> *"If they're fully awake and they're engaged and they want to know then I keep them updated if they want to know or "how's it going?" sometimes you hear over the blood brain barrier - that blue sheet. Sometimes they say "can I have a look at …whatever" and sometimes trying to keep sterility going as much as possible you can walk round and just show them want we've done. Femoral head and worn out hip. But most of the time in recent months patients have been quite heavily sedated. I think we showed somebody their femoral head last week. Oh no, last week we showed someone the metal plate we'd taken out of their ankle. She was awake throughout the whole procedure, just numbed from the waist down. She had a wound breakdown and she was really keen to see what was causing the wound not to heal. And it was this big clumpy metal plate that someone had put in. The skin just wouldn't heal over the top of it. So she was so relieved to see it. And whenever we do take metal work out a patient, or a loose body like a bit of bone floating in the knee, psychologically it's good for them to see it because it prepares them mentally saying "the op's been a success" It's good for their wellbeing I think to see that it's worked. We've done what we said we're going to do. Here it is in the tin. You can see it with your own eyes in a little glass bottle. Can't take it home but you can see it. And I think from a psychological point of view that is really reassuring."*

In this scenario, the patient is not permitted into the backstage area directly (Goffman, 1959), rather the medical staff determine how much or how little to show the patient. This is framed in terms of maintaining sterility, as the sterile field is a closely guarded space in the operating theatre. However, a look alone does not compromise sterility. Instead it exposes the inner workings of the surgery which may instead compromise the social basis of the repair cycle (Goffman, 1961).

5.9 The repair cycle

Goffman (1961) explains the repair cycle in terms of three phases of social interaction; a technical part that contains the relevant repair information, a contractual part that contains the terms under which the repair task is carried out and a social part that contains the civilities, courtesies and signs of deference. On the whole, patients are happy to go along with this arrangement. However, if the patient wants more information related to the technical part of the interaction, then this necessitates access to the technical arena where the repair task is conducted. Where this is granted, it is on the contractual terms set by those undertaking the repair. Nigel explained after his knee replacement surgery, during his interview in the recovery ward:

> *"I didn't talk to Mr Kapel because I don't know how happy he is to talk you through the procedure as he's doing it. I don't know to what "leave me alone. I'm concentrating" and so on. It's a bit like if you're in a driving test actually talking to the guy next to you and telling him what you're seeing and what you're doing, I would personally find that interesting. "right I'm going to do this next. I'm going to do something else next" But because I don't know Mr Kapel I thought "leave him alone. Leave him to get on with it"*

In order for this social interaction to be successful, both the healthcare professional and the patient must adopt the roles attributed to them during this exchange. Goffman explains that:

> *"in performing a role the individual must see to it that the impressions of him that are conveyed in the situation are compatible with the role appropriate personal qualities effectively imputed to him. The sober judge, cool pilot, accurate and neat book keeper all provide a basis of self-image"* (Goffman, 1959 p50).

Surgeons during this time are expected to be dexterous, inspirational and resilient (Royal College of Surgeons, 2018), whereas the patient is expected to have little involvement in this process other than as a docile body (Hirschauer, 1991) or receiver of treatment. In either case:

> *"A self awaits the individual awaiting the position, he need only conform to the pressures on him"* (Goffman, 1959, p.51).

These roles last for the limited duration of the surgical intervention which Goffman (1959) describes as an example of a situated activity system, a:

> *"somewhat closed, self compensating, self terminating circuit of interdependent actions"* (p.51).

In accepting the role of surgical patient for this limited period of time, the individual is seen as meeting their obligation to the sick role (Parsons, 1951) by seeking and submitting to appropriate medical care. The patient's role in this interaction is to act and be treated as though they are separated from their knee, which has been taken away to be repaired.

Leder (1990) describes the body in terms of being a 'tool' which can best be understood as an 'incorporated' structure which withdraws from consciousness in so far as it remains within the tacit body. However, at moments of breakdown, Leder (1990 p.83) explains:

> *"I experience* to *my body not just* from *it. My body requires a direct and focal thematization"* (p.83, emphasis in original).

This is in contrast to the disappearances that characterise ordinary function and everyday experiences, where the body recedes into the background and is not in conscious thought. The concept of Dysappearance describes a mode through which the body is brought into explicit awareness. It is because the normal healthy body disappears that direct experience of the body is skewed towards times of dysfunction. Leder (1990) calls this the principle of *dys*-appearance; where the body appears in focus but in a *dys* state, usually in times of pain or physical discomfort. Similarly, I am introducing the term *Dystance* to explain the abnormal feeling experienced by patients; described as the anaesthetised part of their body having ‘gone’ and needing to have their legs ‘returned’. The prefix ‘dys’ comes from the Greek, meaning ‘abnormal’ or ‘bad’ and is found in English words such as dysfunctional. However, dys also reflects the Latin root ‘dis’ which signifies ‘away’, ‘apart’ or ‘asunder’. I employ the spelling ‘dys’ both for its Greek connotations and to allow for a visual distinction between dystance and distance, but with the connection to the Latin significance also intended. Furthermore, this is combined with ‘stance’ which is described as both ‘a way of thinking about something’ and ‘a deliberately adopted bodily pose’ (OED, 2019). Therefore, *dystance* is used to reflect how the feeling of an abnormal apartness from the body is experienced and considered by the patient. This separation continues beyond the surgical procedure and the return of the patient to the ward, until the effects of the anaesthetic have completely worn off. For the patient, the surgical experience is not over until the feeling in their legs is regained and the dystance between the self and the body is returned to normal. Only then can the person begin to shed the role of patient.

This return of sensation was described by patients in terms of their legs being returned. As Janet [a patient scheduled for knee replacement surgery] said on the ward after her operation:

> *“Apparently it is about 4 hours before you get your legs back. Again, she* [Dr Chisholm, the anaesthetist] *just said don’t worry about it. There’s nothing you can do about it you see.”*

Similarly, Doreen [a patient scheduled for knee replacement surgery] explained after her operation:

> *“Yeah. Because at the moment we don’t really know how quickly I’m going to get mobile. And until I get my legs back…”*

Both of these participants describe the absence of their legs in terms of waiting to get their legs back in a similar way to how one might wait for a car to be returned from the garage. Although the distance between the patient and their knee has not physically changed, there is a dystance that means the knee could easily be in a separate room somewhere else while the repair takes place. Rather than overtly demonstrating subservience to the power of the surgical team, this solution allows the patient to exist as a social person while simultaneously existing as a body part which is passed through the repair cycle (Goffman, 1961). As Tina [the patient] explained after her arthroscopy:

> *"My leg became theirs"*

which suggests it is not until the sensation returns that the patient is reunited with their legs to become whole once again and the repair cycle is complete.

5.10 Summary

Several aspects of embodiment have been identified within the data collected through the field work. The idea that a part of the body becomes dystanced as sensation is lost, fits with Hirschauer's (1991) notion that the patient is 'dislodged' as a person from their body (or part of their body) as the anaesthetic takes effect. This dystance leads to responsibility for the anaesthetised part of the body being taken over by the medical staff. Participants described this as an expected element of surgery with few qualms about giving up agency for part of the self to another person for the duration of the operation. Although the physical distance between the person and their knee during surgery is no greater than at any other time, the knee is outside the present experience of reality, so that a dystance is created and increased through the use of standardised surgical routines. These actions serve to limit the amount of sensory information being received by patients about their body. Anaesthesia prevents any feeling from the area being operated on, while sterile drapes and a screen prevent the patient from being able to see their lower half. The dystance created serves to enable the patient's knee to be taken into the repair cycle (Goffman, 1961) where it can be fixed as a purely mechanical object, with the knee being returned only after surgery has been completed and the ability to feel has resumed.

Noise was identified as potentially problematic for patients and an element that was both unwanted and frightening. The sounds of the operation were reified by patients as representing the physical part of surgery. However, the reality was that the sounds were not found to be as frightening as was anticipated. Hearing is one sense that cannot easily be isolated and so it was the meaning making that went along with the noises that was adapted to provide an understanding of where these sounds were originating from.

The techniques employed by staff to create a backstage area (Goffman, 1959) for their work, while remaining in the same locale as their audience, (the patient) are complex. Although the patient may be drowsy and have restricted peripheral vision at different moments, the presence of a physical partition does not guarantee the maintenance of a backstage area in which to coordinate perioperative work. Patients are still able to exercise a degree of agency by listening to discussions taking place behind the screen. Although these discussions may not be fully understood, hearing routine discussions about the work of the department can have a reassuring effect on the patient (or otherwise). Staff in this situation need to be aware that if a backstage area is needed for collaboration between medical staff, it is not enough to rely solely on a physical barrier acting as a boundary between the frontstage and backstage areas (Goffman, 1959). This may need to be supported through other more subtle non-verbal methods of communication, such as glances between people and things.

CHAPTER SIX: THE CLINICAL GAZE

6.0 Introduction

This chapter examines Foucault's concept of the clinical gaze (1976) and the implications of this for current surgical practice. The introduction of the clinical gaze, which Foucault (1976) attributes to the 'birth of the clinic' is discussed in relation to the move away from an emphasis on the patient's account of their disease experience, to one which could be seen, heard, felt and subsequently classified by doctors. The development of the view of patients as 'objects of knowledge' will be reviewed in relation to the evolution of the medical record along with the effect this has on the objectivity and subjectivity of the patient during the perioperative journey. Application of the clinical gaze though the use of modern technologies is considered in relation to patient consultations and the surgical experience of participants in this study. The multiplicity of clinical gazes within contemporary clinical practice and the strategies for combining these into one cohesive view is discussed with reference to how patients are able to contribute to this. Instances where there is a divergence between the medical perspective and the patient's perspective and strategies used in the management of this conflict will be examined. How patients come to terms with viewing themselves in a biomedical setting and the approaches employed by both patients and medical or other healthcare staff during this time in the distribution and maintenance of patient agency during the surgical experience will be considered.

6.1 The beginning of clinical gaze

Foucault (1976) introduced the concept of 'the clinical gaze' to describe the primacy given to medically gathered sensory data in the diagnosis and treatment of disease. This approach originated following the age of enlightenment and the French revolution. Prior to this point medicine was largely speculative, with the emphasis placed on the patient's own account of their experience of their illness. Doctors were expected to interpret the patients' complaints with the limited knowledge and instruments available. During this time of humoral medicine, it was necessary for physicians to engage with their patients in an attempt to understand their complaints and make a viable diagnosis. The narratives of patients' symptoms were therefore seen as a central part of the transaction between patient and doctor (Furst, 2001) and a mutual relationship existed between domestic healers and professional physicians. Domestic medical manuals were common at this time and often published by physicians in a user-friendly way that used lay language, avoided Latin or technical terms, and focused on practical and simple ideas (Resier, 1978; Starr, 1982). In one such manual Buchan (1789), states:

> *"everything valuable in the practical part of medicine is within reach of common sense"* (cited in Starr, 1982 p.33).

For Foucault, the reforms of the medical profession and especially medical education, combined with the transformation of the hospital into a site of study which together led to a situation where patients could be positioned and held in the focus of the gaze (Berg and Harterink, 2004). With the development of the clinical gaze and the sight, touch and hearing trinity (Foucault, 1976), the body became the focus of investigation. For the first time diseases became regarded as conditions of the body rather than as separate entities which inhabited the body. Instead of examining the disease according to its position in a nosological table, the disease became classified according to the changes it affected upon the body (Mol and Law, 2004). These changes could only be recognised through a comparison to a set of standardised texts which recorded what was considered 'normal' and which enabled the clinician to look through the confusion of subjective disease signs and symptoms to:

> *"unravel the principle and cause of an illness through the confusion and obscurity of the symptoms to know its nature, its forms, its complications, to distinguish at first glance all its characteristics and differences, and by means of a prompt and delicate analysis separate it from all that is foreign to it: foresee what beneficial or detrimental effects might occur in the course of its duration; use the favourable moments that nature provides to effect a solution, calculate the forces of life and the activity of the organs, augment or diminish their energy as required and decide when to act and when to wait"* (Foucault, 1976 p.88).

The emergence of investigative techniques able to probe the indirectly accessible 'inner depths' of the body was not a consequence of this epistemological change but a constitutive element of it (Berg and Harterink, 2004). For example, the stethoscope was invented in 1816 and for the first time allowed diagnoses to be made using scientifically classified, characteristic sounds of different diseases. The stethoscope required the physician to *"isolate himself in a world of sounds, inaudible* *to the patient"* (Starr, 1982 p136), which initiated a move towards a new mode of medicine rooted in *"pragmatically established facts"* (Furst, 2001 p.21). This in turn encouraged physicians to interact less with the patient and *"more with the sounds from the body"* (ibid) even though patients can neither hear these sounds nor interpret them. This subsequently led to an alteration in the clinician - patient relationship which privileged the interpretation of the doctor over that of the patient. This approach regards the body as the space of origin and distribution of disease:

> *"The space whose lines, volumes, surfaces and routes are laid down in accordance with the familiar geometry of an anatomical text"* (Foucault, 1975 p.8).

Knowledge in this view does not depend upon the particular standpoint an observer has upon an object, but the observer in remaining distant from the object of observation, takes a voyeuristic view of the person as a body which:

> *"Inflicts on practice a much more fundamental and pernicious alteration which, being a constituent condition of the cognitive operation, is bound to pass unnoticed: in taking up a point of view on the action, withdrawing from it in order to observe it from above and from a distance, he constitutes practical activity as an object of observation and analysis, a representation"* (Bourdieu, 1977 p.2).

In seeking explanations for the nature of diseases that are beneath the surface of the body, the clinical gaze led to the development of anatomical pathology in order to explain the relationship between death and post mortem phenomena:

> *"It is when death became the concrete a priori of medical experience that death could detach itself from counter-nature and become embodied in the living bodies of individuals"* (Foucault, 1976 p.196).

This has led to criticisms of the clinical gaze being more concerned with knowing death than learning about life (Buchanan, 2000). Whereas death had previously been regarded as a single moment, this view became altered to reflect the pathological changes seen to develop inside the body over a period of time. However, what the clinical gaze ignores most is the patient's subjectivity. The personality, culture, beliefs and individual's perception of illness and treatment are ignored as the emphasis is placed on the results of pathology tests or the patient's malfunctioning or diseased organ or limb, to the detriment of the whole person (Peerson, 1995).

6.2 The patient/person dichotomy

To maintain the purity of the gaze, a distinction is drawn between the patient and the person. The clinician guards against thinking of the patient as a whole, for fear of losing objectivity and clouding judgement:

> *"The observing gaze refrains from intervening: it is silent and gesture-less. Observation leaves things as they are: there is nothing hidden to it in what is given. The purity of the gaze is bound up with a certain silence that enables him to listen. The gaze will be fulfilled in its own truth and will have access to the truth of things if it rests on them in silence, if everything keeps silent around what it sees"* (Foucault, 1976 p.107).

Instead, an ontological position of the person as an object of positive knowledge is adopted, where the patient's body is something to be known, understood and explained:

> *"in relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into account only to place him in parentheses"* (Foucault, 1976 p.7).

This has been described as a vertical process, where the doctor imposes a label on a patient as a means of asserting control over the illness management process (Sanders and Roberts, 2018). Gillis (2006) has identified the process of taking a patient's medical history as potentially externalising the patient from the record of their own experience. This view regards the patient record as a product of a medical construct based on information coming from the patient, but one that is governed by the perceptions, categories and language of medicine. However, Foucault (1976) also notes:

> "*The gaze is no longer reductive, it is, rather, that which establishes the individual in his irreducible quality. And thus it becomes possible to organize a rational language around*

> *it. The object of discourse may equally well be a subject, without the figures of objectivity being in any way altered"* (p.XV).

The suggestion Foucault makes here is that the clinical gaze can view the patient as both subject and object simultaneously. The patient as subject, is viewed merely as a vessel containing the disease or disorder which is the true object of enquiry and focus of the clinical gaze (Jenkins, 2018). The clinical gaze is therefore not directed at the individual in this engagement, but at the disease, so that the individual's personhood is temporarily ignored during this exchange. Mol and Law (2004) explain how this results in an object-body which is exposed and publicly displayed through measurement, touch, comparison and description while the subject-body remains private. In other words, we *have* a public object-body and *are* a private subject-body.

This creation of an object-body through the introduction of the clinical gaze resulted in the perceptions of the clinician being given primacy over the views of the patient and subsequently created a power imbalance. The idea that the gaze gathers evidence which should be respected as a guide to the truth and as a neutral arbiter among competing views (Tonelli, 2009) became established. If evidence could be seen as residing within the object-body then it was external to the subject-body and could be manipulated through experimentation. As Foucault notes:

> *"It is natural that observation should lead to experiment, provided that experiment should question only in the vocabulary and within the language proposed to it by the things observed; its questions can be well founded only if they are answers to an answer itself without question, an absolute answer that implies no prior language because strictly speaking it is the first word"* (Foucault, 1976 p.108).

As evidence began to be tested through experimentation, propositions could be verified and accepted or falsified and rejected. Such a deductive approach is rooted in a positivist epistemology and the sight, touch, sound trinity that is the foundation of the clinical gaze forms what Hacking (1983) describes as one of the six positivist instincts, pro-observation:

> *"What can be seen, felt, or touched provides the best content or foundation for all the rest of our non-mathematical knowledge"* (Hacking, 1983 p.41).

However, as Greenhalgh et al (2015) note, patients do not inhabit the positivistic evidence based world of randomized controlled trials, they live in the idiosyncratic and unpredictable world of an individual person in a family context or the context of social isolation. The knowledge and competence the patient possesses is in the context of living with and managing their disease on a day to day basis rather than epidemiologically based and generalizable 'truths' which can be seen by the clinical gaze. This contributes to a power imbalance as the skill and competence of managing an illness on a day to day basis is valued less than the skill and expertise of the surgical team in treating the disease. Bleakley and Bligh (2009) have suggested this imbalance strays into the 'anti-humane' and inhibits true patient-centred medicine. Although the illusion of objectivity:

> *"could only be accomplished with the complicity of the patients themselves"* (Foucault, 2006 p.509),

patients want to have their human agency recognised (Jenkins, 2018). If perioperative care is to be tailored to a particular patient's priorities and circumstances, there is a need to avoid an objectifying, reductive medical gaze to allow the subjective patient to have co-ownership of their diagnosis and treatment.

6.3 The contemporary gaze

A further difficulty with Foucault's analysis is that it does not account for contemporary, complex developments of the clinical gaze. As the gaze is distributed across practitioners through the increasing use of complex, representational diagnostic tools, different types of gazes establish different patients, diagnoses, treatments and outcomes. The patient established in humoral medicine is different to that established in contemporary western medicine, just as the patient established in the X-ray department differs from that in the operating theatre. Each medical gaze foregrounds its own patient through observing the specific norms associated with that speciality. Consequently, each gaze constructs its' patients in unique ways, with a unique medical perspective and a specific lens through which to observe. Therefore each gaze constructs a different patient body with its own limitations, each of which has its own implications for the human agency of the patient within that medical context (Jenkins, 2018). Mol (2002) suggests that:

> *"objects come into being – and disappear – with the practices in which they are manipulated. Since the object of manipulation tends to differ from one practice to another, reality multiplies"* (p.5).

However, the increasingly multifocal, conflicting gazes of differing health professions, must in turn either "hang together" (Mol, 2002) or risk fragmenting with a resultant decreased care co-ordination and medicalisation of health, with less patient centred care.

The team brief prior to the start of the surgical operating list serves to act as a mechanism through which the differing views can be brought together to provide an inclusive single reality made up of the multiplicity of realities generated through the multiplicity of medical gazes. This point was highlighted during interviews with staff members. For example, Leena [the anaesthetic practitioner] said:

> *Leena: We have the team brief in the morning. So first the surgical side, so the surgeon talks about their side and then we go to the, on this side it's more about equipment what they want from the technical point of view. And then we've got anaesthetic side which is more medical history about the patient you know. And anaesthetic as well side, what they want, is there going to be a general anaesthetic, is he going to have a regional anaesthetic, and complications.*
> *Luke: So what sort of things would they tell you about the patient at that meeting?*
> *Leena: Past medical history. If he's, I don't know, diabetic, has he got heart problems, has he had any surgery in the past, about the mobility, if he's able to walk, if not. If they're nervous, if not because this is another aspect very important as well.*

Similarly, Dr Michaels [an anaesthetist] explains:

> *"It needs to be concise but relevant. So we usually just try and stick to the clinical facts. So the surgeon will stick to what operation they're having, what equipment they need and I will stick to what anaesthetic I plan to give and any relevant medical problems, like them*

> *being diabetic or having a heart condition or bad COPD. And we might mention if a patient is particularly anxious. But generally in the team brief it's quite factual."*

Both of these interviewees are highlighting the differences between what Leena calls "sides"; a term which is suggestive of an opposition. The gaze of the surgical side concentrates on the technicalities of the surgery and the equipment and processes that involves. In contrast, the anaesthetic side casts its gaze on the anaesthetic technique and the comorbidities that may influence those processes. The bringing together of these sides in the team brief can only happen because there is a partition or cleavage, where one perspective differs from another (Mol, 2002). Therefore, the team brief serves to construct an embodied patient, where a patient with a body is produced through the interrelation of the patient with numerous healthcare professionals, investigations and a medical record which records and amalgamates these interrelations (Berg and Harterink, 2004).

This process can also include the patient, as Danielle [the scrub nurse] explains:

> *"I mean I think part of the, now with the WHO check list you're always including them whereas before we were waiting until they were asleep before we did any name band checks and stuff. Now we are including them right from the beginning and again I think it comes down to the actual assessing the patient whether they want to be included in everything, as in giving information and stuff like that. So I don't know. It's not something that I've actually thought about."*

Rather than maintaining dominance over the patient through the multiplicities of the clinical gaze, clinical medicine is now able to make use of available technologies to include the patient in discussions about their health or illness. This encourages a more horizontal dynamic where the authority of the clinical diagnosis can be questioned, challenged, and negotiated to enable the patient to retain some ownership and therefore control over the illness (Sanders and Roberts, 2018). The following extract from the field diary is typical of the way the observed consultations took place; beginning with a discussion about symptoms, followed by the surgeon giving an explanation using images brought up on the computer screen to highlight relevant points:

> *Mr Kapel* [the surgeon] *turns to the patient's notes and shows Amanda* [the patient] *some photographs of the inside of her knee taken at the time of surgery. As he does this he explains the anatomy of the knee and where the cartilage was worn and a tear was identified. Amanda checks that it was the cartilage that was the problem and not the ligament. Mr Kapel responds "yes, the ligament is great, I have shaved off the cartilage. The ligament is wide and fine, it was the cartilage. This outer one is smooth and OK…"*

This type of discussion necessitates some understanding of the biology of the body on the part of the patient. Where this understanding is limited, the surgeon acts as a conduit through which the information obtained via the clinical gaze is channelled. The effect this has is to invite the patient to gaze along with the doctor. However, the interpretation of the information being relayed is still through the medium of the medical professional, so the dominant discourse is negotiated between the surgeon's medical knowledge of 'knees' and the patient's subjective experience of 'my knee'. The sharing of the image can therefore be regarded as more than just a didactic device (Gross, 2011). It can be interpreted as an example of what Bourdieu calls 'symbolic power':

> *"The power of constituting the given through the utterances of making people see and believe, of confirming or transforming the vision of the world"* (Bourdieu, 1991 p.170).

As the consultation continues, Amanda returns to her subjective experience and it falls upon the surgeon to form a connection between the information provided by the medical gaze in the form of photographs of the inside of Amanda's knee and the subjective experience Amanda has of her body:

> *Amanda explains that since she had surgery, the pain in her knee is "in a different place", it is now at the front of her knee rather than at the side. She explains that she runs quite a lot and running is causing her pain because she feels she is over compensating without realising it. With this, Amanda looks at Mr Kapel with some concern and asks "should I give up running? Because I love it, but if it's causing the pain because I am over compensating…"*

To begin with, Amanda is drawn into a surgical reductionist view of her knee, and away from her subjective corporeal experience. This process serves to invite the patient to become a part of the clinical gaze and to see what the surgeon sees. Viewing their knee through the same sociocultural lens as the surgeon can be beneficial for patients to gain an understanding of what is happening inside their body from a medical perspective. For Foucault, the gaze reveals the 'truth' to both the doctor and the patient who adopt the roles of master and pupil:

> *"The genesis of the manifestation of truth is also the genesis of the knowledge of truth. There is, therefore, no difference in nature between the clinic as science and the clinic as teaching. A group is thus formed consisting of the master and his pupils, in which the act of recognition and the effort to know find fulfilment in a single movement. In its structure and in its two aspects as manifestation and acquisition, medical experience now has a collective subject; it is no longer divided between those who know and those who do not; it is made up, as one entity, of those who unmask and those before whom one unmasks. The statement is the same; the disease speaks the same language to both"* (Foucault, 1976 p.110).

In revealing the 'truth', the surgeon is in a position of authority as it is through his language that the 'truth' is described. The following field diary extract demonstrates:

> *Noor Fayad* [The patient] *is an Asian man in his forties who is accompanied by his wife, who is smaller and wears a head scarf. Noor speaks limited English, but explains he is suffering with pain in his right shoulder and elbow. Mr Kapel* [the surgeon] *feels his right elbow and shoulder, then does the same on the left side. There seems to be some confusion, as Noor believes the problem is with his elbow, whereas Mr Kapel thinks it is the shoulder causing the problem. Mr Kapel stands in front of him and holds both hands in his hands and asks Noor to push against him, moving his hands outwards. Noor does not understand the instruction and moves in the opposite direction, thus complying with the force exerted by Mr Kapel, rather than to his instructions. Mr Kapel explains again what he wants Noor to do. At this point, Noor's wife also explains – in what I presume to be Noor's first language. Mr Kapel also speaks in this language and this time Noor*

> *complies with the instructions. He says that he will send Noor for an X-ray which he will look at and may do an injection to help with the pain.*

When Noor and his wife return following the X-ray, the consultation resumes as was noted in the field diary:

> *Noor has had his X-ray and Mr Kapel types some details into the computer to bring the picture on to the screen. He looks at it for a few seconds saying "yes, you have impingement, no fracture".*
> *Mrs Fayad asks "What does impingement mean?"*
> *Mr Kapel explains by pointing at the X-ray. "You see this part here? It's like the beak of a crow, it should be flat. When he lifts his arm up it is impinging here". On the X-ray it is clear to see that the bone is curved over the end of the shoulder joint. And this means that the gap between the bones of the joint is limited. Mrs Fayad asks "Can you do the injection today?" and then translates for her husband, who looks confused and not entirely sure that he wants the injection. Mrs Fayad answers for her husband "Yes, we will go for the injection", then says something to her husband again and reiterates "Yes we will go for the injection".*
> *Mr Kapel says "let him decide, it's his body!" before speaking to Noor in his first language. Noor responds by lifting his arm and wincing, saying that it is "painful". At this, his wife laughs and says "he is worried, that's why!"*
> *Mr Kapel discusses the possibility of doing some "keyhole surgery" to shave the shoulder. As he explains this, Noor moves to sit on the examination couch, reluctantly removing his tee shirt.*

Here the discussion is held in English, even though there is another language that would clearly make communication easier. Whatever the reasons for Mr Kapel to speak English to this patient, the result is the privilege associated with his status as a medical professional is maintained (in a similar way to 19th century medics speaking latin). The explanation given to describe the term 'impingement' is through a comparison of the shoulder joint to a crow's beak. This explanation remains common in orthopaedic anatomy texts. For example, Hoppenfield et al (2017) describe the coracoid process of the shoulder joint as a hook shaped palpable bony protruberance:

> *"resembling a crow's beak, as is implied by its name, Corax"* (p.23).

The comparison to a crow's beak is dated from the early 18th century, but may stem from as early as the 2nd century (OED, 2019. The tradition of comparing objects with each other, is typical of the 18th and 19th centuries and was conducted to:

> *"obtain a clear conception of their identity, and are thus enabled to give to each of them their appropriate appellation and the relation in which they stand to each other, we are better prepared for acquiring a knowledge of their intimate nature and properties"* (Brewster, 1830 p.697).

However, this is not a description that is likely to resonate in the 21st century and may be more reflective of an outdated description learnt during medical education rather than an inclusive attempt to describe the individual anatomy of Noor's shoulder.

6.4 From spiders to bumblebees

Despite the dualism between knowing bodies objectively from the outside or subjectively from the inside (Mol, 2004), the surgeon must relate the clinical information gathered through the numerous gazes to the subjective experience of the patient. Even though every gaze, from whatever perspective, is refracted through a sociocultural lens and the interpretation of what is seen is shaped by these refractions (Malterud et al, 2004) there is a need for the diagnosis and proposed treatment to fit with the information that has been gathered. The ontology (that is, the very existence) of symptoms invisible to the surgeon's clinical gaze will thus tend to be questioned.

The following extract from the field diary was recorded in the out patient's clinic and serves as an example of a patient feeling one thing which is not supported by the clinical view:

> *Mr Henry* [the surgeon] *explains a brief medical history of the next patient - Mrs Brown. She has had a road traffic accident that has damaged her knee. Her knee was repaired with a metal plate and some wires, but that was later replaced with a total knee*

> *replacement. Mr Henry mentions an insurance claim but does not elaborate on this before going to the waiting room and returning with the patient. A woman of about 70 enters. She is wearing a long brown overcoat and is using two crutches to walk. Accompanying her is another woman, I later learn is her daughter Mary. Mrs Brown sits on the chair nearest the desk and Mary sits in the chair next to her. The conversation begins with Mrs Brown asking Mr Henry about his holiday – it seems that Mr Henry was away for a while which meant that Mrs Brown's appointment was delayed by a couple of weeks. As this was something that had a direct on Mrs Browns appointment, it is seen as a relevant line of enquiry, rather than prying into the Doctor's personal life. Mr Henry replies that he went to Florida, to which Mrs Brown answers "Oh you are always jetting off".*

This brief exchange in the personal or social arena acts as a prelude before the consultation moves into the medical arena. Once these social 'niceties' have been seen to, the patient is transformed from a person who can interact with the doctor on a human/social level into a patient. With this change, the relationship between the two protagonists alters so that the power balance moves from one in which the patient is light heartedly chastising the doctor for causing a change to the schedule of appointments, to one in which the doctor takes charge of proceedings and the patient becomes a much more passive participant. The consultation continues as was recorded in the field diary:

> *Once Mrs Brown has sat down, Mr Henry introduces me, explaining my position as a researcher ('doing some research with the NHS') and checks that Mrs Brown is happy for me to sit in on the consultation. She looks at her daughter, who does not respond, then she looks at me, smiles and says: "yes that's fine". Mrs Brown then removes a dressing that is covering her right knee. This dressing appears to be something that is home-made rather than something that has been provided by the hospital. When Mr Henry asks about this, Mrs Brown says she "can't stand anything touching it". And it feels as though she has spiders crawling under her skin. This clearly means something to Mr Henry as he checks*
> *"it feels like you have bumblebees under the skin?"*
> *"Yes"*
> *"Where about? Just in the lower end of the scar or all over?"*
> *"Just in the bottom part"*

> *"No shooting pain?"*
> *"No just the bumblebees"*

This is an interesting exchange, because the doctor has changed the description of pain that the patient is experiencing – from spiders to bumblebees. This is a minor change, but because it is a change in the descriptive term being used, suggests the doctor is able to describe the sensation better than the patient – even though he cannot actually feel the sensation first hand. This may be an example of what Frank (1992) describes as 'narrative surrender' where a patient's story is recast by medicine and redefined through a biomedical lens which marginalises the patient's voice. Thus Mr Henry moves from the realms of the objective observer, into that of the subjective patient experience. He is able to do this only because this description is accepted as having been validated through a standardised medical text describing this sensation. This change is then acknowledged by the patient as being correct, thus undermining her position as the expert at feeling this sensation. The appointment proceeds, as was noted in the field diary:

> *Mr Henry explains that this is known as "hypersensitivity". He then goes back through the history of the surgery that has been conducted on Mrs Brown's knee, starting with the surgery that was carried out by his colleague shortly after the initial trauma and proceeding to the knee replacement. As he does this, he brings up a series of X-rays on the computer screen, which demonstrate each stage of the surgical journey Mrs Brown has been on. After this, Mr Henry looks at Mrs Browns knee (rather than the diagrammatic representation of her knee which has been examined on the screen up to this point). This is almost like regarding Mrs Brown's knee as being physically here in the present but also available in the past by means of medical images. Referring to the amount of movement Mrs Brown currently has in her knee, Mr Henry says "You are a very determined woman, so with a bit more work we will get you to 90 degrees".*
> *Mrs Brown replies that her knee has been giving way occasionally. Mr Henry explains the way that the knee replacement is made is such that it is not be able to give way because of a post that stabilises the prosthesis. As he does this he brings up an X-ray of Mrs Brown's knee and points out the post that runs from the upper part of the knee to the lower part. This seems to reassure Mrs Brown.*

Although Mrs Brown is experiencing symptoms that suggest her knee is giving way, this is contradicted by the medical view. By validating the medical view with evidence in the form of X-rays, the patient has limited options open to her as she is not able to provide positivist ‘evidence’ to support her claim. She could insist that her knee is giving way and ask for an alternative explanation for why it feels like this, or she can accept the medical view that this is not happening. The continuing discussion was recorded in the field diary:

> *At this point, Mary* [Mrs Brown’s daughter] *interjects that her mother has not had any “hydro-physio”. Mr Henry seems surprised as this is something he expects that the insurance company would have paid for as a part of the claim, but Mary explains “The insurance company are not going to pay - we settled the claim because of Mum’s age”.*

This interjection serves to provide an alternative explanation for the sensation of the knee giving way – the knee is not as stable as it should be because Mrs Brown has not had the hydro-physio she needs. This results in an explanation that has successfully negotiated the path between the subjective patient experience and information provided by the objective medical gaze. The discussion continues as recorded in the field diary:

> *The hydro-physio will not be provided by the NHS without a referral letter from Mr Henry, and he agrees to make the referral as “we must try and get the knee to 90 degrees”.*

The use of language here suggests they are working together as in “we” but at the same time, it is “the knee” rather than “your knee” which denies the patient’s ownership of her knee but implies an equal interest in improving the function of Mrs Brown’s knee.

6.5 Body tourism

One interpretation of the inclusion of patients in the clinical gaze is to create an imbalance in the power dynamic which exerts pressure on the patient to view themselves from the biomedical perspective of the clinical gaze. For Foucault:

> *“Power exercised on the body is conceived not as property, but as a strategy . . . [it] is exercised rather than possessed; it is not the ‘privilege’, acquired or preserved, of the*

> *dominant class, but the overall effect of its strategic positions an effect that is manifested and sometimes extended by the position of those who are dominated .. . this power is not exercised simply as an obligation or a prohibition on those who 'do not have it', it invests them and is transmitted by them and through them; it exerts pressure upon them just as they themselves in their struggle against it resist the grip it has on them"* (Foucault, 1975 pp.26-27).

However, although the surgeon can be regarded as exercising power over the patient during this time through control of the direction of the gaze, this also restricts the actions available to the surgeon because of the availability of information provided by the gaze. The surgeon's actions are limited to those which are both consistent with the clinical picture and that which is seen through the clinical gaze to rectify the problem. This demonstrates an association between the patient's subjective experience and the clinical gaze which does not just empower the medical professional, but enables patients to convey their needs as well as enabling medical professionals to interpret them.

In the following field diary extract, Mr Khan (the surgeon) performs an arthroscopy on Tina (the patient) and shows her the damage inside her knee:

> *He [Mr Khan] inserts the scope through the incision he has just made and the screen shows a picture of white with a few red spots. He explains to Tina what is on the screen: "The structure at the top is your kneecap. This white fluffy bit on your kneecap? That shouldn't be there, but it's not too bad". He moves the scope around "see that? That is damage". I look up at the screen and it is clear that there is a flap of white material that seems out of place when compared to the rest of the area. A silver hook with a blunt end is inserted through another incision and can be seen on the screen. The hook is used to show patients which bit is which and terms such as 'femur' and 'tibia' and 'meniscus' are used to explain the anatomy. The hook is used to show where the 'fluffy bits' are. Rachael [the junior surgeon] also helps to explain where these are. A comparison is made between the normal smooth areas at the back and outside compared to the front and inner side. Five pictures have been taken as the scope has moved around the knee and these are in a neat line on a smaller screen. Another instrument is inserted in place of the hook. This is described as*

> *a shaver, which trims the fluffy loose areas of cartilage to make it appear smooth. As Mr Khan uses this instrument, Tina says "I can feel it vibrating!" After a few minutes of 'shaving' the cartilage, this is replaced by another instrument. This, Mr Khan explains, uses radio frequency to make it smoother.*

Here Tina is invited to become a part of the clinical gaze and like a body tourist, is given a guided tour of her knee. This represents an ontological duality for the patient where viewing on the screen provides an inclusive opportunity to understand the medical view of her knee which is outside her subjective embodied experience. To use Goffman's dramaturgical explanation, the view on the screen becomes the 'frontstage' area, where the patient is invited to view the inner workings of her knee. The patient's knee is itself hidden beneath blue drapes behind a screen and remains 'backstage'. The patient is invited to watch the surgeon's performance on the screen but is excluded from the backstage workings of the surgical team such as preparing instruments, making incisions and counting swabs. However, this view is only possible to the extent that the patient is able to isolate her 'self' from her knee. Looking at the surgical instruments inside the knee on the television screen is acceptable, whereas looking at the knee with the surgical instruments protruding is not. As Tina explains in her postoperative interview:

> *Luke: And then they, during the operation they were showing you everything that was going on on the screen. Was that useful?*
> *Tina: It was useful. Because I didn't know what I would see. I didn't want to see, I didn't want to look down at the working end bit because I didn't want to see the movement. I knew what they were doing but I didn't want to see them physically doing that.*
> *Luke: What moving your leg?*
> *Tina: no moving the instrument about to visualise. I didn't want to see that but I didn't mind seeing the instruments inside me on the television screen.*
> *Luke: Why did you get that difference?*
> *Tina: Because when I was a student nurse I nearly passed out when I saw a Denham pin through somebody's ankle. Have you ever seen them? And weights off the end of the bed?*
> *Luke: Yes and traction.*
> *Tina: And it really, I didn't like it at all. Maybe it was that, you know, pins in your body. And I know that they're quite, not um, they are quite enthusiastic about moving things*

> *about aren't they? That's a good word isn't it. And the fact that he talked everything through is great, yeah.*
>
> *Luke: So you were watching it all on the TV screen?*
>
> *Tina: Yes.*
>
> *Luke: Did it help to be able to see, this is the bit here? The fluffy bits and the sticky out-y bits and all of that?*
>
> *Tina: Yes I think so yeah.*
>
> *Luke: Has it reassured you about what's gone on in your knee and what caused everything?*
>
> *Tina: Oh totally because I could see what he did, yeah.*

As visualizations of the body have increasingly built upon the distanced and mediated viewing of electronic images, gaze and body have become further detached from one another (Bauer and Olsen, 2009). This dissociation allows the patient to become comfortable looking at the inside of their own body, but not at the instruments entering and leaving through the surface of the knee.

It is an acceptable and even enjoyable experience to look at the digital image of the knee on the screen, but macabre to look at the knee itself. Mulvey, (1975) notes there are circumstances in which looking itself is a source of pleasure, just as conversely there is pleasure in being looked at. Freud (1949) called this 'scopophilia' and gives by way of example the voyeuristic actions of children who have a desire to see and make sure of the private and forbidden. Thus the curiosity of the patient in seeing the inside of her knee sates a desire to see into the hidden and exclusive world of the surgeon.

Similarly, Nigel [a patient scheduled for a knee replacement] also raises this point in his postoperative interview:

> *Nigel: My preference would have been, because I discussed with Mr Kapel, my preference would have been to be able to watch it on a TV screen. Not to be able to sit up and watch it because I know if I actually see my own blood I flake out. But to see it on a screen I'm watching like a TV programme so it doesn't relate to me. "Oh yeah that's what you do. Yeah go ahead. Do that. That's fine". I would have liked to been able to have done that.*

> *Luke: It's quite an interesting point of view isn't it?*
>
> *Nigel: Evidently at Hospital XXX they have those screens. Because I'm fascinated by the whole procedure.*
>
> *Luke: But your own blood makes you feel, what faint? or sick? or?*
>
> *Nigel: It's funny, It's not conscious. I can look at other people's blood. Absolutely no problem at all but if the dentist waves my two teeth in front of me that they've just extracted - out I go. It's weird isn't it.*
>
> *Luke: But you think if you watched it on a TV screen…*
>
> *Nigel: I'm divorced from it because I can't feel anything. I could just be watching it "oh right, so that's what they're doing is it" As though they are doing the operation on somebody else.*

The following field diary extract demonstrates how the patient (Rita) is able to retain agency within the context of her knee arthroscopy:

> *Mr Khan* [the surgeon]*, who has scrubbed now and is dressed in a surgical mask, gown and gloves similar to Santokh* [the scrub nurse] *points to the television screen on top of a tall trolley and says to Rita "OK Mrs Bird, we are going to use that screen there. Just keep an eye on that screen and I will explain everything. Don't look here – you won't see very much, look there". He picks up a 10ml syringe of fluid with a green needle attached and explains that he needs to do a further two injections. These are to numb the skin because the injections she has already had "have numbed the inside of the knee".*
>
> *"You can call me Rita" she replies.*
>
> *Mr Khan does not acknowledge this but instead says "OK time out please". The team then run through a series of questions where different members of the team answer in turn. Questions such as:*
>
> > *"Was this patient discussed at the team brief?" – "Yes"*
> >
> > *"Has the knee been marked?" – "Yes"*
> >
> > *"Are there any problems with equipment?" – "No"*
> >
> > *"Has the consent been signed?" – "Yes"*
>
> *Obi* [the anaesthetic practitioner] *enters the theatre while this is going on and says to Darna* [the anaesthetist] *"We can't do anything there – a kiddy is coming for next door".*

> *Mr Khan injects Rita's knee and she flinches slightly. Obi and Darna discuss needing to wait for the child to be anaesthetised for theatre 9 before they are able to use the anaesthetic room. Obi suggests using the recovery room as an alternative but Darna rejects this idea on the basis that there are not enough staff. Rita clearly hears this conversation and jokes "yes, you have to make sure I am alright!"*

Rita is a passive actor within this context as the action revolves around her. Firstly, Mr Khan does not acknowledge that she has a first name that she would prefer to be called, and secondly Darna and Obi discuss the inner workings of the operating theatre along with the need to concentrate on preparing for the next patient. This is a conversation that is intended to be 'backstage' (Goffman, 1959) and not one that would normally be overheard by a patient in the operating theatre. However, Rita makes it clear that she has overheard what Darna and Obi were discussing and also that she has a vested interest in these decisions. Rita wants to ensure that if Darna and Obi are concentrating on the next patient, she is not disadvantaged or forgotten. The procedure continues as was noted in the field diary:

> *Mr Khan "you should feel a bit of pressure but it shouldn't be sharp. If you are looking at the screen you won't see anything just yet. It's not in HD – if you want HD you have to pay!"*
>
> *The scope is inserted into Rita's knee and the picture is clearly visible on the screen. "look there, that's beautiful no? that bit at the top is your kneecap. There is a bit worn out in the middle of the white bit. That's the inner side of the knee. Bend the knee a bit now. Is it hurting? Let it go loose – let it hang (over the side of the trolley)". The two medical students that were present at the team brief arrive dressed in theatre scrub suits. They move so that they are out of the way but can see the screen. The machine that is pumping fluid into the knee whirrs noisily in the background.*
>
> *"Is that the meniscus?" asks Rita.*
>
> *"No, that's the femur. I will show you in a minute." The screen is now more white than pink. "That's the inside of your knee and that's the meniscus there. Let me just put another instrument. Can you see that?" He inserts an instrument and on the screen there is a blunt metal hook visible. He manipulates this so that the hook is behind part of the cartilage "that's your meniscus there" he says. "Don't tighten your muscles. See, that's better, see*

> *there" as he moves the hook inside Rita's knee it is clear there is one area that does not have any soft white tissue covering it (exposed bone). "I haven't seen anything completely normal to show you!" he laughs. Another instrument is inserted. This is a 'shaver' and appears like a rod with a 'Z' shape on the end. "What is that doing Doctor?" asks Rita. Mr Khan shows her the teeth moving on the end of the shaver and how it trims away loose sections of cartilage.*

Although the position of power is held by the surgeon as the one who is directing the clinical gaze, Rita is still able to influence this process. By asking Rita to "bend the knee a bit now", Mr Khan recognises that there are some parts of this process that are controlled by the patient. By using "the knee" as opposed to "your knee" he is inviting Rita to regard her knee from the objective rather than subjective viewpoint. This continues with "is it hurting?" which continues a medical reductionist view of the patient, asking her to focus on "it" rather than "are you in pain?" This contrasts with the more subjective response to Rita's question "is that the meniscus?" which is answered with "that's your meniscus there", which foregrounds the anatomy in the person in the present. Similarly, "Let it go loose – let it hang (over the side of the trolley)" refers to the knee as an isolated external object which they are both observing, whereas "Don't tighten your muscles…" is much more personal to Rita as an individual, with agency enough to influence the surgical process. By adding "see, that's better…" Mr Khan includes Rita in ownership of the surgical field as it is seen via the medical gaze on the screen. The surgery continues, as was noted in the field diary:

> *"See those bundles coming down? That's the cruciate ligament". Mr Khan moves the scope around the other side of Rita's knee and as he bends her leg, Rita winces. "It's not my knee, it's my hip" she says.*
>
> *"Ok, remind me when you see me in clinic to look at your hip ok? This side is much more normal". He shows her the damaged side and compares it to the smooth shiny cartilage on the healthy side. It is easy to see the difference between what appears healthy and what does not. Two photographs are taken with the scope and these appear on the second screen as still images. The inner side of Rita's knee is the damaged side. This is the side she said in the anaesthetic room was the most painful. Mr Khan shows Rita how much he has trimmed from her cartilage to make it smooth again. "Can I have a wand please" he asks.*

> *(The idea of using a wand conjures up images of a magician performing magic. Perhaps this is an image that surgeons like to foster.) After a short while, Joanna returns with an instrument. It was not in the immediately adjacent laying up room, which meant she had to go further to find it. "I am going to use a radiofrequency probe. It may be painful, but let me know ok?"*
>
> *"The arthritis is the knobbly bits is it?" asks Rita.*
>
> *Mr khan shows Rita the end of the probe on the screen and it is easy to see how it burns the white 'fluff' to make the white areas smooth again. Rita's saturation is 94% and the machine bleeps once. Mr Khan does not look up but says "another 30 seconds I promise and we will be done" as he says this, Rita jumps. "Sorry, we are done anyway" and he gives Rita a quick guided tour of the finished product. "It looks better, definitely" she says. As the fluid is pumped through the knee to wash out any debris, the scope is left outside the knee and there is a distorted view of the room on the screen.*

Foucault's concept of the "discursive regime," (1975) maintains that discourse or a codified body of meaning about a topic is intimately related to power:

> *"the individual and the knowledge that may be gained of him belong to this production"* (Foucault, 1975 p.194).

As knowledge and meaning here are shared using images and communication with an inclusive language, power becomes distributed as both the surgeon and patient gaze together. It has been noted elsewhere (Mauleon et al, 2007; Karlson et al, 2012) that patients' feelings of control are connected to the notion of having influence. As Rita is included throughout the surgical process, she is able to feel as though she has been involved in (rather than a passive recipient of) her surgery. By gazing together, Rita is able to use the criteria of the medical gaze to literally 'see' an improvement in her objective knee, even before she has had the opportunity to experience an improvement in her subjective knee.

6.6 Summary

Foucault's concept of the clinical gaze was originally intended to explain the marginalisation of patients through an imbalance in the power dynamic played out between patients and medical professionals. This view regarded patients and their history as being created by medical professionals through discourse, knowledge and power, rather than through the patient's own illness narrative. However, the introduction of new technologies has led to the development of numerous different gazes, each appropriate to the individual specialism. While this may result in the patient becoming the subject of the gaze, the disease remains the object of the gaze. Data from the study suggest this separation enables the patient to be invited to look objectively along with the medical professional to see what they see and to understand the disease from the medical perspective. This 'shared understanding' is often equated with a 'shared biomedical understanding' and impressions of the patient's ability to display biomedical ways of thinking about their health condition may influence the healthcare professional's perception of the patient. While this may help the patient to make sense of their illness experience and lead to a more satisfying patient-centred care, the objective medical view can also contradict the patients subjective view. In these instances, the power of the medical voice often presides and the clinical gaze is given primacy over the patient experience with evidence provided in the form of medical artefacts to support this view.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

This PhD study set out to understand the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. To achieve this aim, a preoperative, perioperative and postoperative approach has been utilised in the production of data through observation and ethnographic interview. The ethnographic account presented in this thesis is concerned with the surgical experience of patients within the social milieu of the operating theatre. A constructivist grounded theory approach has been used to provide an opportunity for determining the 'real' nature of the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment and for this experience to be explored.

7.1 Methodology

The thesis has drawn upon the work of three key theorists in an attempt to provide an understanding of the experience of patients undergoing knee surgery with a local or regional anaesthetic. Bourdieu's theory of practice and in particular his concepts of habitus, field and capital have been discussed in relation to how subjective human agency and objective social structures exist in a dynamic, interdependent relationship (Bourdieu, 1977 and 1990). The argument has been made that within the operating theatre, capital is distributed and primacy given to specialist knowledge sustained through a culture originating in a positivist paradigm. I have put forward the view that this situation creates a systematic inequality, where healthcare professionals solicit, evaluate, shape, and foster the patients' ability to exercise cultural capital within the context of their perioperative experience. This has led to an examination of Foucault's theory of power; which regards power as something that is exercised within social relationships. Power relationships have been examined in the context of the operating theatre in order to understand ways in which these patients accept their potential for action is constrained within the limits placed upon them by social forces.

Foucault's concept of the clinical gaze (1976), is also discussed in relation to techniques of power which act in combination on the body to produce the individual as an object. Although originally intended to explain the marginalisation of patients through an imbalance in the power dynamic played out between patients and medical professionals, I have argued the introduction of new technologies has led to the development of numerous different gazes, each appropriate to the individual specialism. This has led to a ‘shared biomedical understanding’ where the patient has become the subject of the gaze, with the disease as the object of the gaze. This separation enables the patient to be invited to look objectively along with the medical professional to see what they see and to understand the disease from the medical perspective.

Goffman is the third key theorist that has been drawn upon within the thesis. Goffman’s concept of the total institution (1961) has been utilised to explain the process an individual goes through in the transition to becoming a patient. By ‘leaving off’ individual social signifiers and ‘taking on’ the identifiers provided by the hospital, the patient enters a social space that is both structured and dominated by the institution. This limits the ability of the patient to demonstrate their true self-identity or convey additional social information about themselves, but is undertaken in the belief it is a necessary process in their best interests. Once this process has been gone through, the individual presents in the role of a patient, in a ‘social construction of the self’ which is enacted through a kind of storytelling where the protagonist also happens to be the self. The procedures that are enacted to distinguish the person as a social individual from the physical parts that belong to that person in the form of their body, have been discussed in relation to Goffman’s description of the repair cycle (1961). This sociological theory has been expanded upon to explain the distinction drawn in the operating theatre between a person on a social level and on a physical level, so a social interaction can take place on one level, while the mechanical assessment or repair can simultaneously take place on another level. Together, the work of these three theorists has been drawn upon to add another layer of understanding to the social reality of the operating theatre and the relationships between actors in this environment.

The Operating theatre is a complex medical environment, which traditionally follows a positivist biomedical model of care. This model is widely accepted as appropriate for subjects such as surgery where diagnosis and treatment are extremely circumscribed and structural. Research conducted within the operating theatre has therefore tended to follow a positivistic approach and those studies that do not, have tended to focus on the role of the medical or healthcare professionals rather than the patient. However, in order to understand the embodied conduct of practices and skills exhibited during operating theatre work, an exploratory methodology was necessary to examine the patient experience within the operating theatre itself. The ethnography conducted for this thesis interpretative research in which behaviour is studied within an everyday context and allows for a comparison to be made between what people say and what they do. This approach strives to avoid reducing qualities of human experience to quantifiable variables and repositions the patient at the centre of the work of the operating theatre.

The fieldwork, methodology and position I adopted in undertaking this study was integral to the success of the research in locating and immersing myself into the culture and practices of the hospital clinics and operating theatres I visited. Whereas I was initially cautious about the merits of undertaking research from the position of observer, I was able to become reflexive and flexible in my approach to the research setting and research participants by implementing aspects of my autobiographical background (Measham and Moore, 2006). Within this context, my identity as both an insider and outsider, depending upon the situation and other actors within the field, were significant characteristics which influenced the data collection aspects of the research and thesis. As discussed in chapter two 'Methodology', I found my role and the level of participation expected of me varied widely depending upon which aspects of my biography were known or acknowledged by the natives in the field. These characteristics and the associated social and cultural capital (Bourdieu, 1977) also influenced the degree of difficulty I had in accessing various groups within the operating department. Where I was known as an ODP with clinical experience in the operating theatre I was able to access areas and perioperative staff relatively unimpeded. However, the disadvantage of this identity was that at times there were expectations I would participate to a varying degree in the work of the operating theatre. My identity as a university lecturer also enabled relatively free access, although the disadvantage of this identity was one of perceived power relations. At times, I was given the impression staff felt I was assessing their practice or that my purpose was to report to the department or hospital management. The third identity was that of pure researcher. As a novice ethnographer, this was a role I was least familiar with and found the most difficult to negotiate. Access afforded in this role tended to be more formally arranged than in either of the other identities and tended to be based upon a form of professional courtesy rather than on an interpersonal basis. However, access was eased by having an extended period of time in the fieldwork locations and utilising gatekeepers to introduce and vouch for me. It should be noted however, that each of these roles were attributed to me by the natives of the field, rather than being positions that I was able to prescribe for myself. This meant that fieldwork involved a constant negotiation and renegotiation of my position. Negotiations which were open to confusion or potential conflict where I was unclear which role I was being afforded during any particular interaction.

Findings of the study specifically related to the methodology were two fold. Firstly, the issue of informed consent in an ethnographic study of this nature is complex. Consent within a biomedical environment such as the operating theatre tends to be based on the notion that the methodology, research questions and the implications of these can be anticipated, discussed and agreed to before the research has begun (Parker, 2007). This is similar to the consent patients give prior to surgery, where risks, outcomes and complications are quantified in advance. Within this ethnographic study, consent needed to acknowledge that the research process was ongoing and the research would continue to evolve following data analysis throughout the fieldwork and data collection period.

The second finding related to the methodology is that ethnography can be seen as a way of accessing practices and interactions in the context in which they occur. This can subsequently aid an understanding of the behaviours surrounding the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. Through the ethnographic method I was able to develop a ‘thick description’ (Geertz, 1973 p.6) in order to provide a nuanced understanding of the diverse experience of a patient undergoing regional anaesthesia and surgery in a perioperative setting. As a detailed way of witnessing human events in the context in which they occur, ethnography can help healthcare professionals to understand elements of the patient experience beyond the reach of many positivist research approaches. This is especially true of the perspectives patients and clinicians have of their worlds and the differences between them. It is therefore a particularly valuable methodology as patients’ views on the experience of illness or delivery of service are becoming increasingly valued as central to a modernised NHS.

7.2 The bodily experience

The customary view of the operating theatre is one focused on conducting safe, efficient surgery with unconscious patients. However, this focus has begun to shift as the volume of surgery performed under local or regional anaesthesia has increased. Care of awake patients in the operating theatre is now a routine element of modern perioperative practise and support for the conscious patient has become a key concern for perioperative staff. Accounts of the patients experience of conscious surgery with a regional anaesthetic are sparse in the literature and those that exist have not adequately addressed the complex nature of this phenomenon. Issues of identity and agency are significant when considering patients' experiences of the operating theatre. For patients, making sense of their place in the perioperative environment is a complex process which involves information seeking, lay consultations and understanding medical information related to their disease and surgery.

Chapter five 'Embodiment and disembodiment in the operating theatre' has suggested several solutions that go some way to allowing the patient to exist as a social person while simultaneously existing as a body part which is passed through the repair cycle (Goffman, 1961). The separation of the face from the rest of the body through the use of a surgical screen during the operation acts to separate the parts of the body which are in the sterile field from those which are outside. In addition, the screen creates an ontological duality which isolates the areas of the body which are in the repair shop from the rest of the body which remains part of the social being of the patient. Rather than feeling overtly subservient to the power of the surgical team, this solution enables the patient to retain agency as a social person who is both present and absent during the repair cycle. However, the screen is largely symbolic in this respect. Although the patient may not be able to see beyond the screen, it is still possible to hear what is happening outside the direct field of vision. In this way, patients may be covertly listening to the interactions around them.

By focusing on the patient's subjective experience of their surgery, an understanding of how patients comprehend their anaesthetised body has been proposed. Leder's (1990) explanation of the principle of *dys*-appearance, whereby the body is drawn into explicit awareness is discussed in contrast to the normal healthy body which is largely withdrawn or disappears from everyday consciousness. Data presented in the thesis has been drawn upon to introduce the term *dystance* to explain the abnormal feelings and consequent relationship with the body experienced by patients during regional anaesthesia. This is commonly described by patients as the anaesthetised part of their body having 'gone' and needing to be 'returned'. The concept of dystance has been used to interpret how the patient makes sense of this feeling of an abnormal apartness from their body in the perioperative environment.

7.3 Patient strategies

In order to make sense of their position in the operating theatre and influence their experience, patients utilize several strategies available to them. These strategies include: demonstrating capital to become included and valued as a member of the process, receiving sedation to the extent that consciousness is lost and all agency is handed over to the anaesthetic team, or rationalising the need to adopt a passive role to comply with instructions to achieve a desired outcome (chapter four 'Distribution and currency of capital in the operating theatre'). Each of these strategies depends to some degree on a relationship of trust which enables the patient to place themselves in a position of vulnerability to the healthcare professionals (chapter three 'Trust'). To build trust, patients draw upon resources available to them. This may be in the form of personal recommendations from close, trusted social connections, or personal knowledge of the institution as non-exploitative, with a good societal reputation. Patients also increasingly present with some knowledge and understanding of their disease or surgical procedure which is used to form expectations of the clinical encounter. Where the diagnosis and treatment deviates from that which is expected, patients expect a sufficient explanation. If such an explanation is not forthcoming, the development of deep emotional and affective trust can be undermined and the relationship compromised.

Patients are social individuals, who bring their social and cultural capital in its various forms with them into the environment of the operating theatre. The degree to which patient capital is recognised and valued can be understood as an everyday form of power, deployed in a social context, which varies in as many ways here as it does in any other field. For the patient, the operating theatre represents a social field within which they must negotiate to maintain or alter the distribution of different forms of capital. However, patients begin from a position of disadvantage, because signifiers of social capital have already been removed prior to entering the operating department as part of the process of being admitted into the total institution (Goffman, 1961). The degree to which the patient is able to demonstrate knowledge and understanding is reflected in the cultural capital apparent in this situation. The amount of cultural capital evident varies from healthcare professionals having surgery, with concomitant professional knowledge, through a personal understanding of the disease experience, to a lay understanding learned from friends, family or the internet. Staff in this environment demonstrate cultural capital in the form of knowledge and patients perceive the exchange of this knowledge to be a core requirement for any level of participation. However, patients also value the capital they bring with them into this field and may choose to demonstrate their capital in an attempt to distinguish themselves as a unique individual. Alternatively, patients can choose to give up agency to the perioperative team partially or entirely, by either accepting a passive role or through the use of sedation which removes the person as a social entity from the interaction.

7.4 Staff strategies

Strategies employed by perioperative staff to influence the patients experience of having surgery with regional anaesthesia identified in the course of this study are nuanced. Through a fostering of relationships with patients that empowers a demonstration of cultural capital, medical and other healthcare professionals are able to contribute to the capital that patients draw upon and their capacity to do so. Although the social field of the operating theatre may be organised in such a way as to reproduce existing inequalities in the distribution of capital, staff are able to empower patients to become active participants in their own care. An example of this is the acknowledgement of the patients' understanding of their own personal medical history. A recognition this information belongs to and resides with the patient, rather than in the medical record, can encourage the patient to retain some agency in an otherwise medically dominated field.

The use of a shared decision making model serves to reassure the patient their individual needs and circumstances have been taken into account as part of the interaction. Shared decision making increasingly involves the explanation of information the patient already has from other sources, which may be queried by the patient. While there is a need to explain and involve the patient in discussions from pre-assessment through the surgical experience, this appears to be a tacit skill that some staff found more difficult than others. Staff recognise the importance of involving the patient in discussions and the necessity of assessing each individual patient to determine how much agency is appropriate to apportion during this time. However, the process for how this decision is made is a tacit one that is acquired over time and through experience rather than as a skill that is actively taught or consciously learnt. It should also be recognised that patients may not want to retain agency during this time, instead opting to be a passive recipient of care.

One strategy utilised by staff was to include patients in the clinical gaze. By opening up specialist knowledge to the patient through visual representations of their body in the form of scans, X-rays and endoscopic visualisations, the patient can be shown the biomedical perspective of their illness experience. Patients are then able to utilise this knowledge to align what is seen and what is felt to bridge the gap between the medical world and the life world. Direct interpersonal communication during this process serves to reassure the patient they are being treated as an individual and their needs are being met. Where it is not possible to include the patient in the clinical gaze during the operation, having a member of staff interact on an individual basis reassures the awake patient they are not a forgotten element of the perioperative process and helps negate the reductionist approach towards the patient as ‘a knee’. Further support throughout this process is often through strategies which make the patient more comfortable. This may be in the form of the regional anaesthetic which, as well as allowing the surgery to take place pain free, removes the background pain these patients experience on a daily basis. This pain free period is interpreted by patients in terms of feeling comfortable and having their needs met.

The operating theatre is a highly technological environment which for staff is taken for granted as an ordinary part of the work setting. For patients, these technologies can have an alienating effect in so far as they are unfamiliar and represent the extraordinary nature of their situation and location. Perioperative staff must balance the need to demonstrate technological ability (which reinforces their cultural capital in this field) and ensuring the patient remains the focus of the work of the operating theatre. If the focus of attention is drawn away from the patient and towards the technology, the patient may only remain central physically and from a medical or scientific perspective rather than from the lived perspective of a social person. However, technology does not have to act as a barrier to staff patient interactions. Technology can also be comforting for patients. Physical comfort may be enhanced through the use of technology such as the forced air warming device which was perceived by patients as a comforting element of their perioperative care and one which may act as a surrogate for the comforting aspect of human touch.

7.5 Implications for practice

7.5.1 Developing a therapeutic alliance

Each clinical encounter commences from a position of trust but takes place within a relationship based upon an uneven distribution of power. This power imbalance is enacted through the interaction itself with the medical or healthcare professional in a dominant role which potentially exposes the patient to unethical behaviour. Therefore it is the responsibility of the medical and other healthcare staff to recognise and act in ways that negate this power imbalance. The use of a shared decision making model helps move the interaction to a more even basis and serves to reassure the patient their individual needs and circumstances have been taken into account as part of the interaction. Wherever possible, relationships with patients should be built over a period of time in an ongoing relationship of relational continuity. Repeated interactions with the same medical or healthcare professional can help develop the trusting relationship from one of cognitive trust, based upon an evaluation of performance, into one based upon a more interpersonal affective trust.

Shared decision making should begin by gaining an understanding of individual patient expectations and preferences with the commensurate risks stressed according to these. The need for clear interpersonal communication is not new, but that patients are increasingly presenting with information gained from the internet or other sources which subsequently needs to be explained is a relatively new phenomenon. The medical or other healthcare professional needs to understand the expectations the patient has about the way the clinical encounter and subsequent treatment will develop, so that reasons for any deviation from this can be discussed openly and a clear explanation provided. Information and treatment options should not be presented to the patient as a *'fait accompli'* but negotiated through a jargon free easy to understand language.

7.5.2 Cultivating the patient's capital

Within the operating theatre, staff have specialist knowledge, experience and demonstrated competence which is highly valued and represents their cultural capital in this field. Conversely, patients in this environment are limited to following routines laid out for them by the institution along a previously validated path of safe practice. Patients as individuals can then easily become one aspect of the invisible work of the operating theatre that has no voice, remains unidentified and is forgettable. To mitigate against this, patients are able to draw upon social capital preoperatively and postoperatively to check information with friends and family and to interpret the information received on a personal level. Within the operating theatre these opportunities are clearly far more limited. During the perioperative period family members are not present, so a good interpersonal connection between the patient and staff is crucial in encouraging and cultivating patient capital in the operating theatre.

The staff – patient relationship is also critical in establishing the extent to which patients want to adopt a participatory role during their perioperative experience. A recognition needs to be made that the amount of agency patients want to retain and degree to which patients want to be actively involved during their operation varies significantly between individuals. For staff, the basis upon which judgements are made to determine how much to involve each patient during their operation is difficult to explain. This type of tacit knowledge is not easily recognized or acknowledged, but it can be a key factor in making decisions about how much agency to apportion the patient. Not all patients want to be an active participant during their surgery, but equally, this position may change as the surgery progresses and the patient has a better understanding of the surgical experience. Discussions around this aspect of patient care need to be made open and explicit, as better decisions are likely to occur when tacit knowledge is employed overtly.

7.5.3 Acknowledging the embodied experience

For patients, surgery is an embodied experience which involves giving control of part or all of their body to someone else to achieve a positive bodily outcome. While this may be perceived as a frightening experience, several aspects of the experience of undergoing surgery with a local or regional anaesthetic were regarded by patients as being comfortable. This patient group normally experiences a constant level of background pain associated with their osteoarthritis and the administration of the spinal anaesthetic removes this background pain to enable the patient to be pain free and comfortable during this period. This is an aspect of the regional anaesthetic that was not discussed with patients in either the joint school or consultation with the surgeon or anaesthetist in advance of surgery, but may be an influencing factor for the patient in determining whether to undergo a general or regional anaesthetic.

The use of technology is routine in the operating theatre and whereas for the staff this forms an everyday part of the practices of the operating theatre, for patients this can be both reassuring and isolating. Where staff attend to the monitoring or technological version of the patient rather than the person, this can become an obstacle to interpersonal communication, leaving the patient feeling isolated. However, in other instances, technology can be used to supplement the reassurances provided by staff. The heat provided by the forced air warming blanket serves to do more than maintain the patients body temperature. The warmth was perceived as comforting in a manner similar to that provided by human touch. This should be remembered and taken into account when making the decision whether to apply this equipment to the patient.

The use of a surgical screen to separate the face of the patient from the surgical area is an elegant solution to the problem of allowing the person into the repair shop. The screen is accepted by patients as a necessary part of the process, especially where the reasons for this are explained in terms of maintaining the sterile field and accompanied by instructions to keep hands and arms placed across the chest and away from the sterile surgical area. Staff on the other hand may become too reliant on this screen to provide a convenient backstage area (Goffman, 1959) where discussions about the inner workings of the operating theatre can take place. Although there is a need to have such a backstage area, it must be remembered that the awake patient is still able to hear and therefore follow some of the discussions and backstage work that is being conducted on the other side of the surgical screen. This type of covert monitoring of the backstage work may not be fully understood, but the patient is acutely aware where it relates to them at this vulnerable time and so look to the actions and demeanour of the staff for reassurances. Staff need to be aware their actions, interactions and discussions may be seen and heard by the patient and interpreted in unintended ways.

That patients value having a member of staff nearby to be able to interact with during their operation is already understood. Interacting with patients on this human interpersonal level during the operation is something that some perioperative staff were more willing to engage in than others. For some staff, the technical side of the work of the operating theatre took priority and patient interactions were primarily undertaken as a consequence of carrying out this work. The result of this was that at other times patients could become marginalised while more technical work was undertaken. Other staff clearly saw interacting with patients on a human level as a fundamental part of their role. The difference between these perspectives represents the interpretation of the role of the perioperative practitioner as being either technical or public facing. While the operating theatre was once a place where the public facing aspect of healthcare was minimised through the use of general anaesthesia, the increase in the number of patients having surgery with a regional anaesthetic means that staff may need to reframe their understanding of their role away from a focus on occupational tasks, to one where patient participation is valued and encouraged.

7.5.4 Accessing the clinical gaze

The development of diagnostic and therapeutic technology has meant the clinical gaze (Foucault, 1976) has now evolved beyond how it was first interpreted. The multiplicity of gazes from different medical and other healthcare perspectives are no longer the sole preserve of professionals, as they can now be made accessible to the patient. Access can be given to these clinical views in an attempt to empower the patient through co-ownership of the diagnosis and to enable an informed understanding of the treatment options. Although the patient’s body remains the focus of the gaze and the focus of investigation, access to and interpretation of the gaze can avoid reducing the patient to an individual body part or disease, as the patient can be enabled both as a physical and social being. Including the patient in the clinical gaze in this way serves to empower an active participant in a relationship where power is distributed more evenly between the individual actors. However, a power imbalance still remains, in that it is the surgeon who directs the gaze in this context and also interprets the meaning of what is seen. Therefore, care needs to be taken to ensure the gaze is used in a way that explains the patient’s subjective experience rather than to reinforce the objective view of the surgeon.

Enabling patients to watch their surgery as it occurred was seen as a beneficial aspect of arthroscopy patients’ surgical experience within this study. This is an aspect that could be expanded further than just arthroscopy surgery as patients undergoing a knee replacement also expressed a desire to see what was being done to them. However, patients did not want to watch their surgery in the flesh, but via a television screen. Thus patients wanted to be simultaneously both present and distant during their surgery. As many operating theatres have cameras built into the operating lights, it would be technologically possible to show knee replacement patients their surgery on a screen in real time and this may be an option worth exploring in the future. For many patients, being able to see the internal aspect of their knee that was causing pain or immobility and the improvement afforded as surgery progresses, has a reassuring effect.

A further aspect of the clinical gaze that needs to be considered is the need to gather together the multitude of differing clinical gazes, each of which brings its own perspective to bear on the surgical patient. Within the operating theatre, the team brief that occurs prior to the start of any operating session serves as a way to align the different views of the patient, whether surgical, anaesthetic, radiographic, haematologic, nursing or others to form a single coherent entity. This provides an opportunity for the viewpoint from each gaze to be discussed to generate an holistic view of the patient as a whole rather than treating the patient as a collection of individual but separate constituent perspectives. It is therefore imperative that the team brief goes ahead with all participants involved with the patient's perioperative care being given the opportunity to contribute within an even power distribution. This should be recorded in the patient's medical record in such a way as to reflect each perspective and give an accurate account of the factors influencing the patient's treatment.

7.6 Further research

In further research I would like to continue to examine the patient experience of remaining awake in the operating theatre during surgery with a regional anaesthetic as this remains an area of interest. One aspect of this experience that I feel warrants further investigation is the use of the clinical gaze to involve the patient in understanding their body and illness experience from a medical perspective. As technology improves and continues to be an integral part of perioperative practice, the opportunities for opening the clinical gaze up to the patient are likely to increase. Although this does not currently form a routine part of surgical or anaesthetic care, several of the participants in this study expressed a desire to be able to watch their surgery on screen as it was happening. As this is a relatively new phenomenon, there has been little research examining how the concept of the clinical gaze has developed with the addition of new technologies for the 21st century.

Although I believe there are aspects of the experience of undergoing knee surgery while awake with regional anaesthesia which are transferable to other surgical populations, I believe there are also likely to be some differences which are worth exploring further. Caesarean section patients are one example of a surgical population which is routinely undergoing surgery with regional anaesthesia while remaining awake. While the caesarean section patient is routinely accompanied by a partner into the operating theatre, the surgery is usually conducted without sedation or the involvement of the patient in the clinical gaze. To what extent this patient group is able to retain agency during this life changing event, and the degree to which this experience is influenced by an understanding of the surgery as the mother’s birth experience rather than a surgical experience is not known and would be worth exploring further.

PERSONAL REFLECTION ON THE PhD.

In undertaking this PhD I wanted to understand what it was like for patients to be awake in the operating theatre while their knee surgery was conducted with a regional anaesthetic. I feel the thesis provides a deeper understanding of this experience than was previously known and identifies some strategies that can be utilised to further the person-centred care delivered in the operating theatre. Throughout the writing of this thesis I have felt the burden of responsibility to reproduce the patient experiences as honestly and accurately as possible and hope the reader has been drawn into the accounts I have provided. I particularly enjoyed my time in the field with the concomitant development of thick description and the process of making the familiar unfamiliar, even though much of this material did not make it into the final thesis. The process has been one of reflexivity and self-development which has enabled me to become more confident in the use of ethnography as a methodology. However, I must acknowledge the process of participant observation proved far more complex than I had foreseen and involved negotiating my place in the operating department on a daily basis. It became apparent to me that my position as an insider or outsider was dependent far more on the natives of the field than it was on my own perspective. Eventually, I recognised my triple identity as an ODP, lecturer and ethnographer and became more adept at assuming the identity most appropriate for the circumstances in which I found myself. The experience of withdrawing from the field work has left me wondering what happened to the patients I interviewed after they had been discharged home. I wonder whether Nigel made the race meeting he wanted to marshall. Did Doreen continue to lose weight? Was Janet able to care for her husband after she returned home? Although I do not feel my exit from the field was detrimental to the participants in any way as they had already begun the process of recovery, there remains an element of the process that, for me, has not achieved full closure. However, overall the experience of conducting this study has been a positive one which has enabled me to become more critically aware of my own clinical practices and my outlook has become more person-centred as a result.

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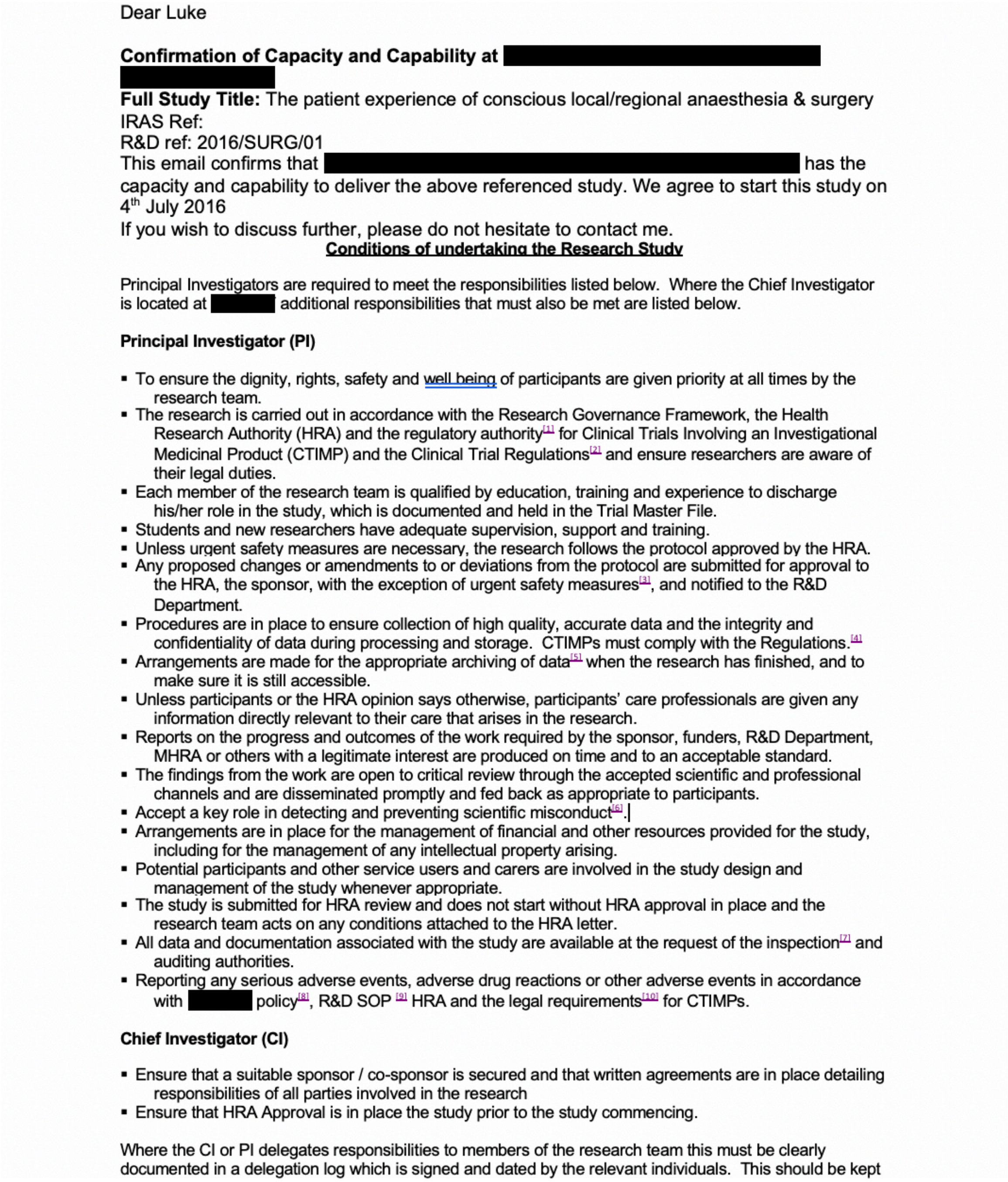
APPENDICES

Appendix 1 – Research and Development approval



Dear Luke

Confirmation of Capacity and Capability at [redacted]

Full Study Title: The patient experience of conscious local/regional anaesthesia & surgery
IRAS Ref:
R&D ref: 2016/SURG/01
This email confirms that [redacted] has the capacity and capability to deliver the above referenced study. We agree to start this study on 4th July 2016
If you wish to discuss further, please do not hesitate to contact me.

Conditions of undertaking the Research Study

Principal Investigators are required to meet the responsibilities listed below. Where the Chief Investigator is located at [redacted] additional responsibilities that must also be met are listed below.

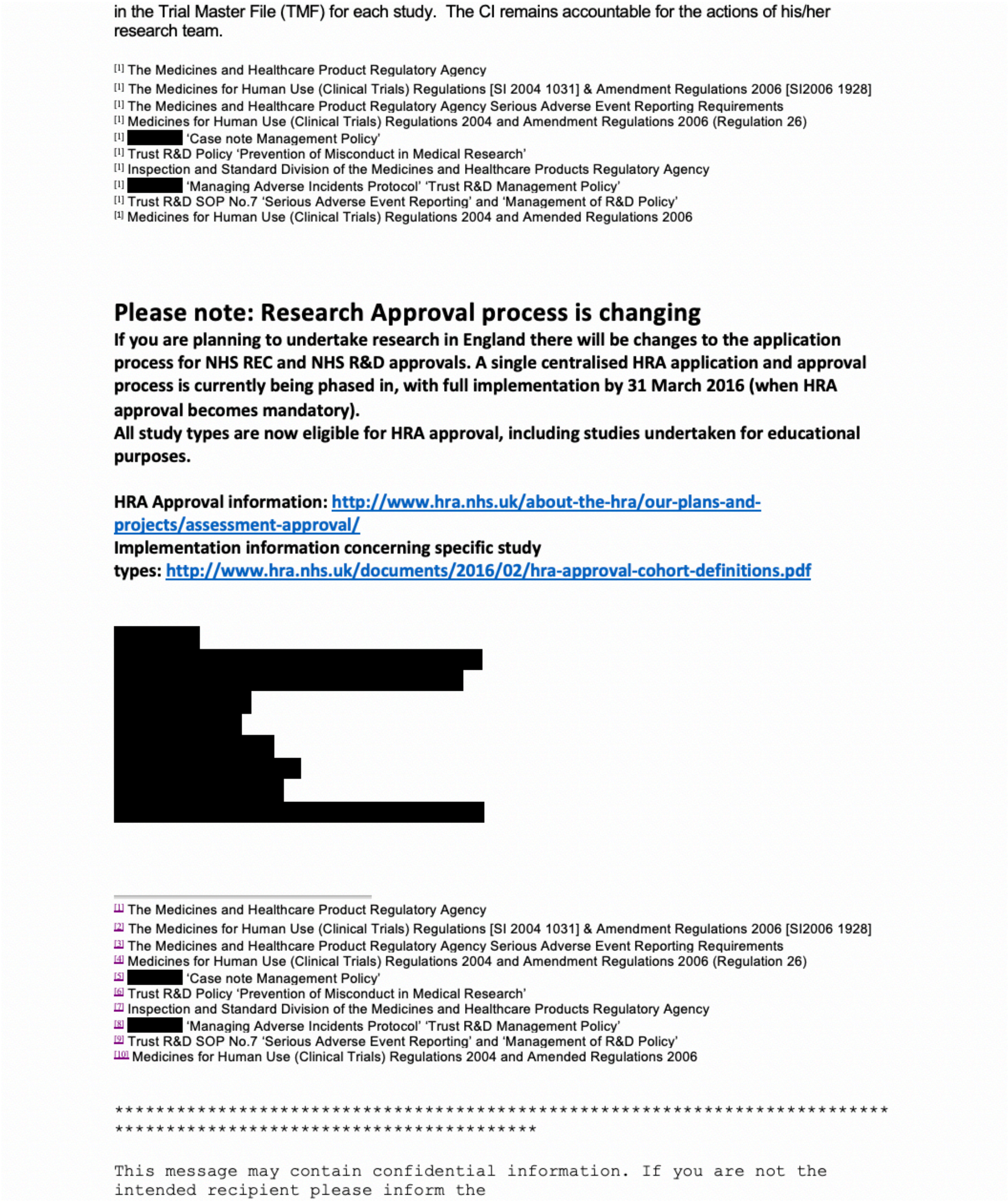
Principal Investigator (PI)

- To ensure the dignity, rights, safety and well being of participants are given priority at all times by the research team.
- The research is carried out in accordance with the Research Governance Framework, the Health Research Authority (HRA) and the regulatory authority[1] for Clinical Trials Involving an Investigational Medicinal Product (CTIMP) and the Clinical Trial Regulations[2] and ensure researchers are aware of their legal duties.
- Each member of the research team is qualified by education, training and experience to discharge his/her role in the study, which is documented and held in the Trial Master File.
- Students and new researchers have adequate supervision, support and training.
- Unless urgent safety measures are necessary, the research follows the protocol approved by the HRA.
- Any proposed changes or amendments to or deviations from the protocol are submitted for approval to the HRA, the sponsor, with the exception of urgent safety measures[3], and notified to the R&D Department.
- Procedures are in place to ensure collection of high quality, accurate data and the integrity and confidentiality of data during processing and storage. CTIMPs must comply with the Regulations.[4]
- Arrangements are made for the appropriate archiving of data[5] when the research has finished, and to make sure it is still accessible.
- Unless participants or the HRA opinion says otherwise, participants' care professionals are given any information directly relevant to their care that arises in the research.
- Reports on the progress and outcomes of the work required by the sponsor, funders, R&D Department, MHRA or others with a legitimate interest are produced on time and to an acceptable standard.
- The findings from the work are open to critical review through the accepted scientific and professional channels and are disseminated promptly and fed back as appropriate to participants.
- Accept a key role in detecting and preventing scientific misconduct[6].
- Arrangements are in place for the management of financial and other resources provided for the study, including for the management of any intellectual property arising.
- Potential participants and other service users and carers are involved in the study design and management of the study whenever appropriate.
- The study is submitted for HRA review and does not start without HRA approval in place and the research team acts on any conditions attached to the HRA letter.
- All data and documentation associated with the study are available at the request of the inspection[7] and auditing authorities.
- Reporting any serious adverse events, adverse drug reactions or other adverse events in accordance with [redacted] policy[8], R&D SOP [9] HRA and the legal requirements[10] for CTIMPs.

Chief Investigator (CI)

- Ensure that a suitable sponsor / co-sponsor is secured and that written agreements are in place detailing responsibilities of all parties involved in the research
- Ensure that HRA Approval is in place the study prior to the study commencing.

Where the CI or PI delegates responsibilities to members of the research team this must be clearly documented in a delegation log which is signed and dated by the relevant individuals. This should be kept



in the Trial Master File (TMF) for each study. The CI remains accountable for the actions of his/her research team.

[1] The Medicines and Healthcare Product Regulatory Agency
[1] The Medicines for Human Use (Clinical Trials) Regulations [SI 2004 1031] & Amendment Regulations 2006 [SI2006 1928]
[1] The Medicines and Healthcare Product Regulatory Agency Serious Adverse Event Reporting Requirements
[1] Medicines for Human Use (Clinical Trials) Regulations 2004 and Amendment Regulations 2006 (Regulation 26)
[1] [redacted] 'Case note Management Policy'
[1] Trust R&D Policy 'Prevention of Misconduct in Medical Research'
[1] Inspection and Standard Division of the Medicines and Healthcare Products Regulatory Agency
[1] [redacted] 'Managing Adverse Incidents Protocol' 'Trust R&D Management Policy'
[1] Trust R&D SOP No.7 'Serious Adverse Event Reporting' and 'Management of R&D Policy'
[1] Medicines for Human Use (Clinical Trials) Regulations 2004 and Amended Regulations 2006

Please note: Research Approval process is changing

If you are planning to undertake research in England there will be changes to the application process for NHS REC and NHS R&D approvals. A single centralised HRA application and approval process is currently being phased in, with full implementation by 31 March 2016 (when HRA approval becomes mandatory).

All study types are now eligible for HRA approval, including studies undertaken for educational purposes.

HRA Approval information: http://www.hra.nhs.uk/about-the-hra/our-plans-and-projects/assessment-approval/

Implementation information concerning specific study types: http://www.hra.nhs.uk/documents/2016/02/hra-approval-cohort-definitions.pdf

[redacted]

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[1] The Medicines and Healthcare Product Regulatory Agency
[2] The Medicines for Human Use (Clinical Trials) Regulations [SI 2004 1031] & Amendment Regulations 2006 [SI2006 1928]
[3] The Medicines and Healthcare Product Regulatory Agency Serious Adverse Event Reporting Requirements
[4] Medicines for Human Use (Clinical Trials) Regulations 2004 and Amendment Regulations 2006 (Regulation 26)
[5] [redacted] 'Case note Management Policy'
[6] Trust R&D Policy 'Prevention of Misconduct in Medical Research'
[7] Inspection and Standard Division of the Medicines and Healthcare Products Regulatory Agency
[8] [redacted] 'Managing Adverse Incidents Protocol' 'Trust R&D Management Policy'
[9] Trust R&D SOP No.7 'Serious Adverse Event Reporting' and 'Management of R&D Policy'
[10] Medicines for Human Use (Clinical Trials) Regulations 2004 and Amended Regulations 2006

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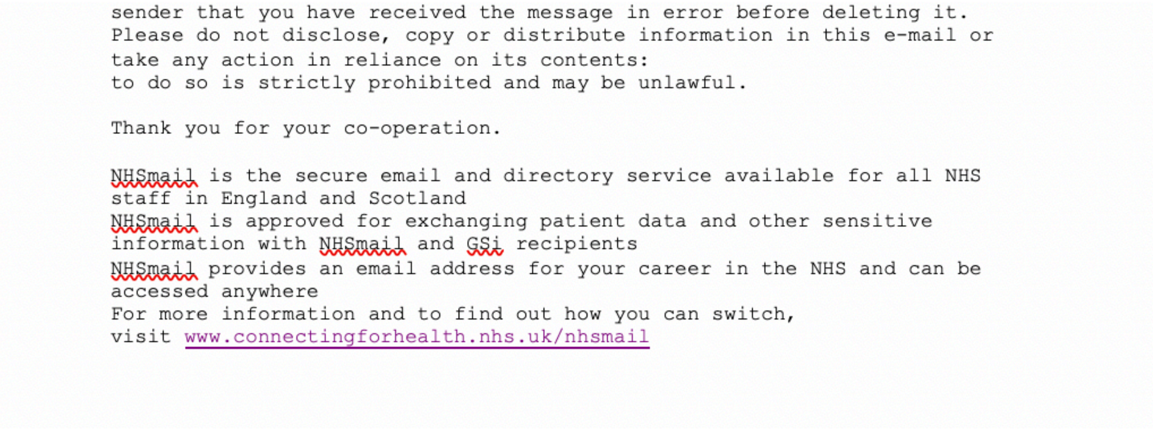


sender that you have received the message in error before deleting it.
Please do not disclose, copy or distribute information in this e-mail or
take any action in reliance on its contents:
to do so is strictly prohibited and may be unlawful.

Thank you for your co-operation.

NHSmail is the secure email and directory service available for all NHS
staff in England and Scotland
NHSmail is approved for exchanging patient data and other sensitive
information with NHSmail and GSi recipients
NHSmail provides an email address for your career in the NHS and can be
accessed anywhere
For more information and to find out how you can switch,
visit www.connectingforhealth.nhs.uk/nhsmail

Appendix 2 - Participant information sheet – Patient

PARTICIPANT INFORMATION SHEET (PATIENT)

THE PATIENT EXPERIENCE OF BEING CONSCIOUS DURING LOCAL/REGIONAL ANAESTHESIA AND SURGERY.

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Part 1 tells you about the purpose of the study and what will happen if you choose to take part. Part 2 gives you more detailed information about the conduct of the study. Please ask me if there is anything that is not clear or if you would like more information. Once you have done this please take time to decide whether or not you wish to take part. You do not have to take part in this study. Your standard of care will not be affected whether or not you choose to participate.

PART 1

What is the purpose of the study?

This study is a research project that aims to understand what it is like from the patient's point of view to have surgery under local/regional anaesthesia while remaining conscious. An understanding of what patients experience is important to developing compassionate patient centred care and we hope this knowledge will help us to provide improved care for patients having surgery with this type of anaesthetic.

The study will interview between 20 and 25 patients in total.

Why have I been chosen?

You have been chosen because you are scheduled to have surgery with a local/regional anaesthetic. The study needs a variety of participants undergoing a range of surgical procedures. Being chosen to take part in the study does not imply anything about you or your particular circumstances.

What will happen to me if I take part?

There will be no changes to your treatment if you choose to take part. We would like to gain some additional information from you. You will be asked to take part in two individual face to face interviews with the researcher, each lasting about 30 minutes, which will be audio recorded. The first interview will be after your admission but before your surgery and will ask questions about your expectations of having surgery under local/regional anaesthesia. The second interview will be after you have had your operation, have returned to the ward and are comfortable. This interview will ask questions about your experience of having your operation under local/regional anaesthesia. The researcher interviewing you (Luke Ewart), is an Operating Department Practitioner registered with the Health and Care Professions Council with over 27 years experience of working within the operating theatre. He will also be present as an observer during your operation. A summary of the final results of the study will be made available to you if you wish.

Do I have to take part?

Participation is entirely voluntary. It is up to you to decide whether or not to take part in the study. The study will be described to you and you will then be given this information sheet. If you agree to take part your consultant will be informed as a matter of courtesy. You will be asked to sign a consent form for the study at the time of your first interview. You will be free to withdraw from the study at any time without giving a reason. This would not affect the standard of care you receive.

What is the study trying to find out?

The aim of the study is to understand what it is like from the patient's point of view to have surgery under local /regional anaesthesia while remaining conscious. An understanding of this experience is important to inform the delivery of appropriate patient centred care.

What are the possible disadvantages or risks of taking part?

There should be no disadvantages or risks in taking part. Some inconvenience may arise from being enrolled in the study and taking part in interviews. However, participation is entirely voluntary and interviews will be carried out within the hospital setting when convenient for you.

What are the possible advantages of taking part?

Some people may find it beneficial to discuss their expectations and experiences of surgery. The information gained from the study may also help develop the care received by people having surgery
with local/regional anaesthesia in the future.

Will my taking part in the study be kept confidential?

Yes. All information about you will be kept confidential and your anonymity will be maintained. However, in the unlikely circumstances where disclosures are either in the public interest or required by law, the researcher has a professional responsibility to disclose information. In accordance with the HCPC Standards of proficiency (2012) disclosures will be made "where necessary to prevent a serious crime or actual or potential harm to the patient or others" (p13).

If you are considering taking part please read the additional information in part 2 before making your decision.

PART 2

What will happen if I don't want to continue with the study?

You can withdraw from the study at any time without giving a reason. If you withdraw from the study you will be asked if the information you have given up to that point can still be used in the study. If you do not want any of your information used, then this will be destroyed.

What if I have a question?

If you have any questions about any aspect of this study, you should contact me (the researcher).

Researcher: Luke Ewart 01634-894439

E-mail: Luke.Ewart@canterbury.ac.uk

Will my taking part in this study be confidential?

There are very strict rules about collecting research information. All data and personal information will be stored securely within Canterbury Christ Church University premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by the researcher (Luke Ewart) and his supervisors. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

What will happen to the results of the study?

The results of the study will form the basis for an M.Phil /Ph.D thesis and may also be published in academic journals or presented at academic conferences. Although some of your words might be quoted, pseudonyms will be used and other contextual modifications made to ensure your anonymity is maintained. At no time will you be identified in person. A summary of the results will be made available for you to view if you choose.

Who has reviewed this study?

All research in the NHS is approved by an independent Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. The study has also been reviewed by my research supervisors at Canterbury Christ Church University.

What happens now?

If you would like to take part in the study, you can either contact me yourself:

Researcher: Luke Ewart 01634-894439

E-mail: Luke.Ewart@canterbury.ac.uk

or complete the slip below and return it to the healthcare professional who gave you this information sheet. I will then contact you to answer any questions you might have.

If you do not wish to take part, there is nothing you need do.

Thank you for considering taking part in this study.

I am interested in taking part in the research study:

"The patient experience of being conscious during local/ regional anaesthesia and surgery".

Please arrange for the researcher to contact me.

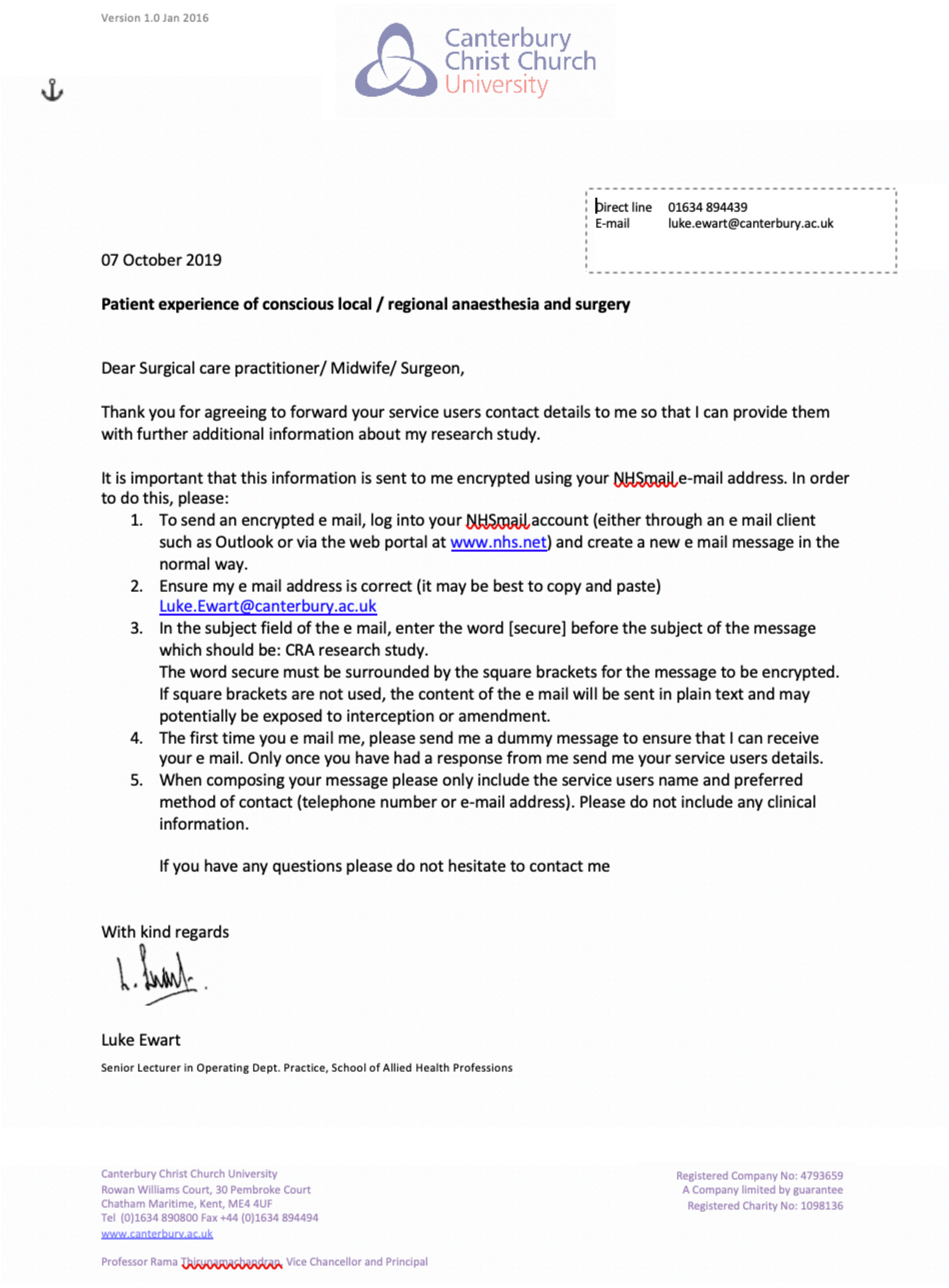
Name ____

Telephone: ____

E-mail: ____

Preferred method of contact ____

Appendix 3 – Letter regarding secure forwarding of patient details



Version 1.0 Jan 2016

Canterbury
Christ Church
University

Direct line 01634 894439
E-mail luke.ewart@canterbury.ac.uk

07 October 2019

Patient experience of conscious local / regional anaesthesia and surgery

Dear Surgical care practitioner/ Midwife/ Surgeon,

Thank you for agreeing to forward your service users contact details to me so that I can provide them with further additional information about my research study.

It is important that this information is sent to me encrypted using your NHSmail e-mail address. In order to do this, please:

1. To send an encrypted e mail, log into your NHSmail account (either through an e mail client such as Outlook or via the web portal at www.nhs.net) and create a new e mail message in the normal way.
2. Ensure my e mail address is correct (it may be best to copy and paste) Luke.Ewart@canterbury.ac.uk
3. In the subject field of the e mail, enter the word [secure] before the subject of the message which should be: CRA research study.
   The word secure must be surrounded by the square brackets for the message to be encrypted. If square brackets are not used, the content of the e mail will be sent in plain text and may potentially be exposed to interception or amendment.
4. The first time you e mail me, please send me a dummy message to ensure that I can receive your e mail. Only once you have had a response from me send me your service users details.
5. When composing your message please only include the service users name and preferred method of contact (telephone number or e-mail address). Please do not include any clinical information.

If you have any questions please do not hesitate to contact me

With kind regards

Luke Ewart

Senior Lecturer in Operating Dept. Practice, School of Allied Health Professions

Canterbury Christ Church University
Rowan Williams Court, 30 Pembroke Court
Chatham Maritime, Kent, ME4 4UF
Tel (0)1634 890800 Fax +44 (0)1634 894494
www.canterbury.ac.uk

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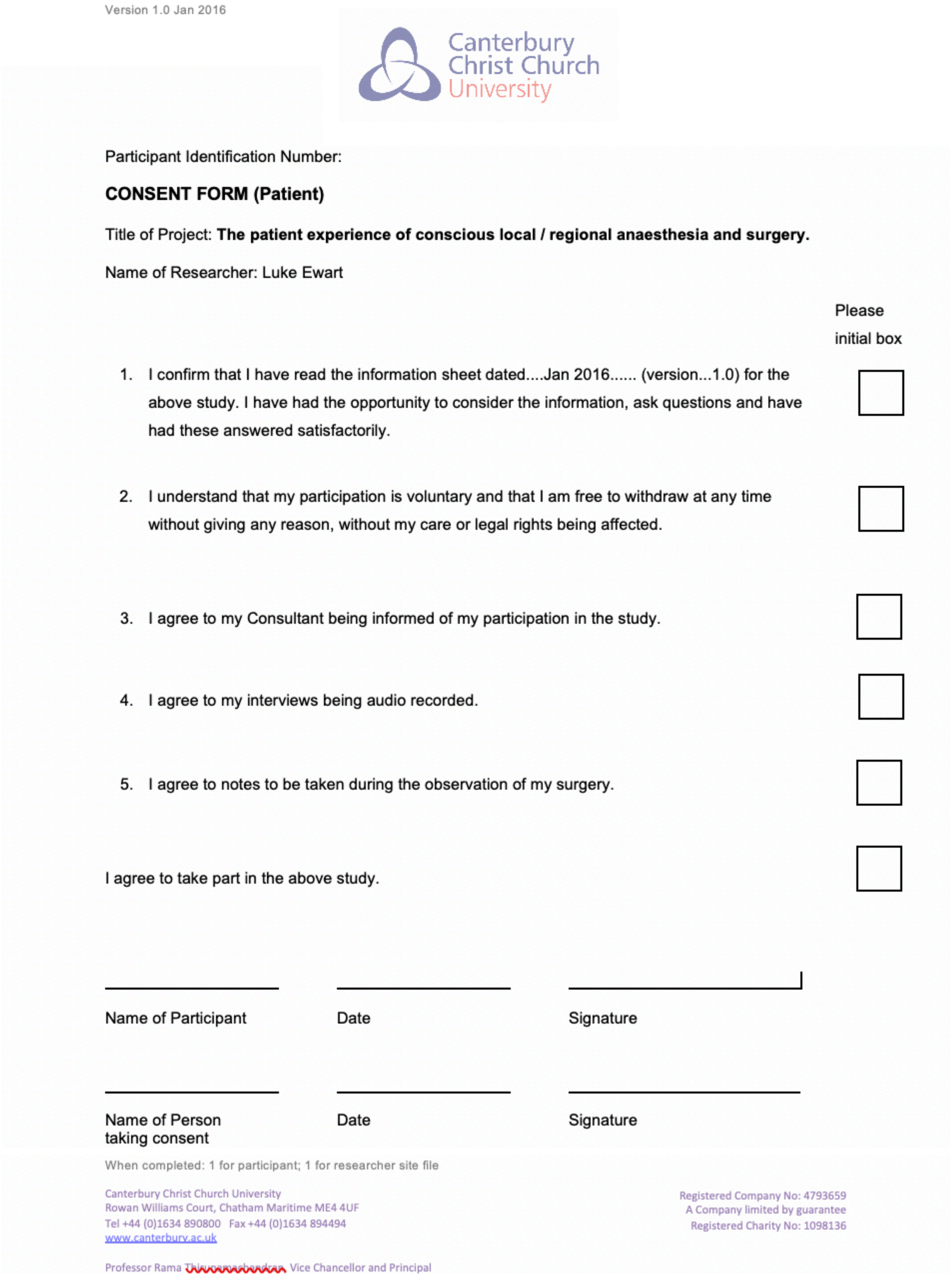
Registered Charity No: 1098136

Professor Rama Thirunamachandran, Vice Chancellor and Principal

Appendix 4 – Consent form – Patient



Version 1.0 Jan 2016

Canterbury
Christ Church
University

Participant Identification Number:

CONSENT FORM (Patient)

Title of Project: **The patient experience of conscious local / regional anaesthesia and surgery.**

Name of Researcher: Luke Ewart

Please initial box

1. I confirm that I have read the information sheet dated....Jan 2016...... (version...1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my care or legal rights being affected. ☐
3. I agree to my Consultant being informed of my participation in the study. ☐
4. I agree to my interviews being audio recorded. ☐
5. I agree to notes to be taken during the observation of my surgery. ☐

I agree to take part in the above study. ☐

________________	________________	____________________
Name of Participant	Date	Signature
________________	________________	____________________
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file

Canterbury Christ Church University
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Professor Rama Thirunamachandran, Vice Chancellor and Principal

Appendix 5 - Participant information sheet – Staff

PARTICIPANT INFORMATION SHEET (STAFF)

THE PATIENT EXPERIENCE OF BEING CONSCIOUS DURING LOCAL/ REGIONAL ANAESTHESIA AND SURGERY.

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Part 1 tells you about the purpose of the study and what will happen if you choose to take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask me if there is anything that is not clear or if you would like more information. Once you have done this please take time to decide whether or not you wish to take part.

PART 1

What is the purpose of the study?

The need to care for an increasing number of conscious patients having surgery under local/regional rather than general anaesthesia is leading to a change in the nature of patient care in the operating theatre. Although anaesthetists assume full responsibility for patients during anaesthesia, the increase in the use of local and regional anaesthesia means that support for the conscious patient is becoming a major responsibility for other perioperative staff such as nurses and operating department practitioners. As theatre staff care for patients throughout the perioperative period, an understanding of what patients experience is important to providing compassionate patient centred care. More knowledge and a clearer understanding of how patients experience surgery under local/regional anaesthesia while conscious may therefore lead to being able to offer improved perioperative care to these patients.

This study is a research project that is trying to understand what it is like from the patient's point of view to have surgery under local/regional anaesthesia while remaining conscious. For this reason, I want to observe how staff in the operating theatre interact with patients and each other during the perioperative period. The information I get from this study will help to put the patient's perioperative experience into context and provide a clearer understanding which may lead to improved perioperative care for patients having this type of anaesthetic in the future.

Why have I been chosen?

You have been chosen because you are part of the perioperative team caring for a patient having surgery under local/regional anaesthesia. Participants with a variety of roles within the perioperative team will be included. Which members of the perioperative team are interviewed will depend upon their role and the interactions that have taken place during the observation. Being chosen to take part in the study does not imply anything about you personally.

What will happen if I take part?

As someone involved in caring for a patient having surgery under local/regional anaesthesia, I am asking your permission to observe you as a member of the team providing care to the patient during their perioperative experience. I am a registered Operating Department Practitioner with over 27 years experience of perioperative care. During this period of observation, I will make notes relating to the actions and interactions of the staff and patient. I will not intervene in the patient's care or ask you to do anything (beyond allowing the observation). You do not have to agree to the observation. If you decide you do not agree to the observation, but other members of the team have agreed, then the observation may go ahead although any actions or interactions involving you will not be recorded or reported in any way.

In addition to the observation, you might be asked to participate in an audio recorded interview. The study will interview between 20-40 participants from a variety of backgrounds within the perioperative team including:

Surgeons
Surgical Care Practitioners
Anaesthetists
Perioperative Nurses

Operating Department Practitioners
Assistant Theatre Practitioners
and Theatre Support Workers

The aim of the interview is to gain an understanding of your experience of caring for the patient that has just surgery under local/regional anaesthesia. The interview would take place in a mutually agreed private location within the hospital as soon as is feasible after the operation and last approximately 30 minutes. A summary of the final results of the study will be made available to you if you wish.

Do I have to take part?

Participation is entirely voluntary. It is up to you to decide whether or not to take part. You do not have to take part in the observation or interview and you are free to withdraw from the study at any time without giving a reason. You will receive a copy of this information sheet to keep and I will ask you to sign a consent form to show you have agreed to take part.

What is the study trying to find out?

The aim of the study is to understand what it is like from the patient's point of view to have surgery under local/regional anaesthesia while remaining conscious. An understanding of this experience is important to inform the delivery of appropriate compassionate person centred care.

What are the possible disadvantages or risks of taking part?

There should be no disadvantages or risks in taking part. Some inconvenience may arise from having an observer in the operating theatre, although I am an experienced operating department practitioner and will make every effort to be as unobtrusive as possible. Taking part in an interview may also be inconvenient. However, participation is entirely voluntary and interviews will be carried out within the hospital setting when convenient for you. Each interview will last approximately 30 minutes and you can stop the interview or withdraw from the study at any time at any time, without needing to give a reason.

What are the possible advantages of taking part?

The study will not help you personally, but the information gained from the study may help develop the care received by patients having surgery under local/regional anaesthesia in the future.

Will my taking part in the study be kept confidential?

Yes. All information will be kept in the strictest confidence and ethical and legal practice will be followed. However, in the unlikely circumstances where disclosures are either in the public interest or required by law, the researcher has a professional responsibility to disclose information. In accordance with the HCPC Standards of proficiency (2012) disclosures will be made “where necessary to prevent a serious crime or actual or potential harm to the patient or others” (p13).

If the information in part 1 has interested you and you are considering taking part please read the additional information in part 2 before making your decision.

PART 2

What will happen if I don’t want to continue with the study?

You can withdraw from the study at any time without giving a reason. If you withdraw from the study you will be asked if the information you have given up to that point can still be used in the study. If you do not want any of your information used, then this will be destroyed.

What if I have a question?

If you have any questions about any aspect of this study, you should ask to speak to me (the researcher) and I will do my best to answer your queries.

Researcher: Luke Ewart 01634-894439

E-mail: Luke.Ewart@canterbury.ac.uk

Will my taking part in this study be confidential?

All data and personal information will be stored securely within Canterbury Christ Church University premises in accordance with the Data Protection Act 1998 and the University’s own data protection requirements. Data can only be accessed by the researcher and his supervisors. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

What will happen to the results of the study?

The results of the study will form the basis for an M.Phil/Ph.D thesis and may also be published online, in suitable academic journals or presented at academic conference. Although some of your words might be quoted, pseudonyms will be used and other contextual modifications made to ensure your anonymity is maintained. At no time will you be identified in person. A summary of the results will be made available for you to view if you would like to do so.

Who has reviewed this study?

All research in the NHS is looked at by an independent Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. The study has also been reviewed by my research supervisors at Canterbury Christ Church University.

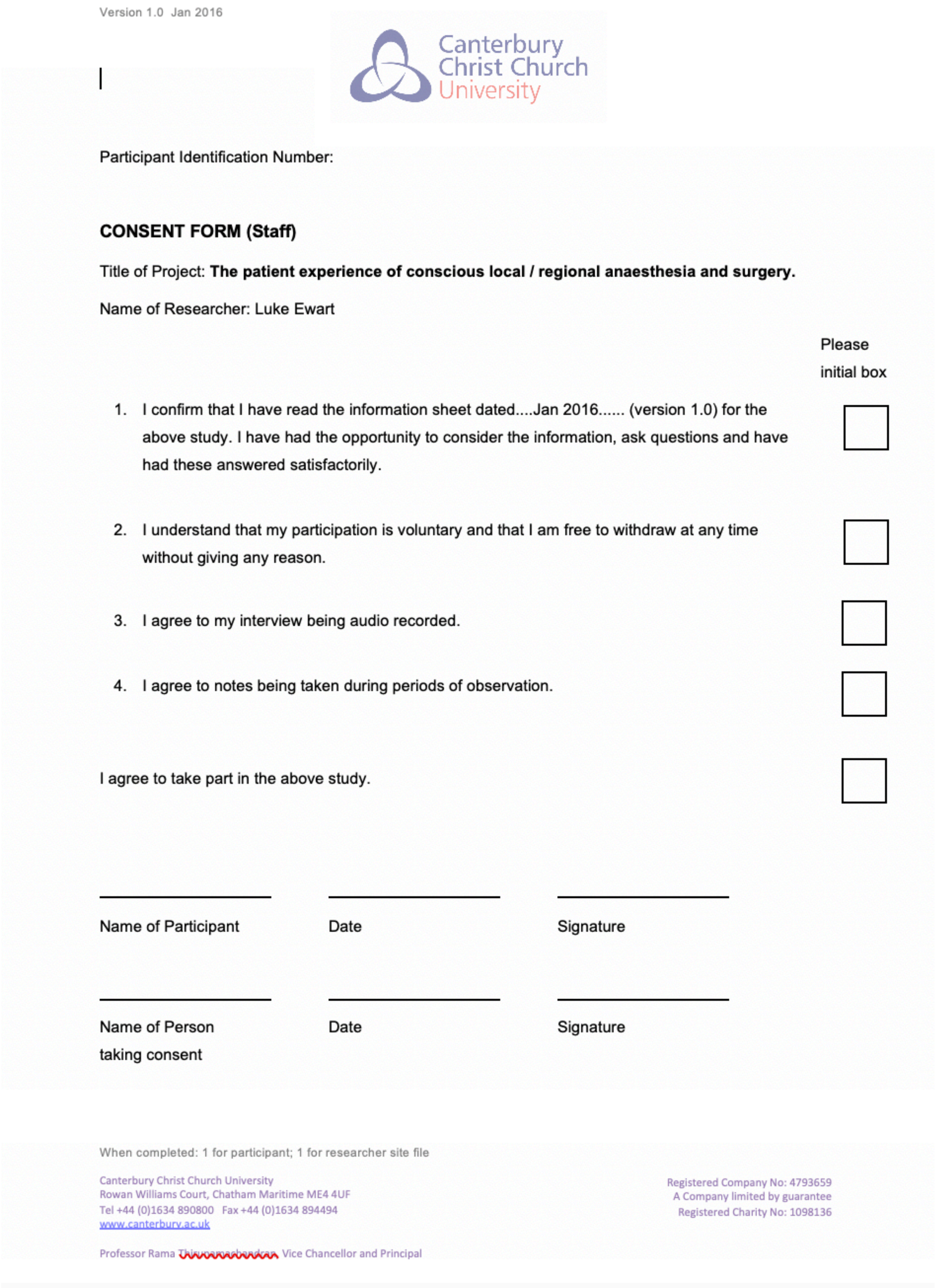
What happens now?

If you would like to take part in the study, you can contact me in advance:
Researcher: Luke Ewart 01634-894439
E-mail: Luke.Ewart@canterbury.ac.uk
Or wait until the day of surgery and I will answer any questions you might have.

If you do not wish to take part, there is nothing you need do.

Thank you for reading this information leaflet. If you have questions now or in the future please do not hesitate to contact me.

Appendix 6 – Consent form – Staff



Version 1.0 Jan 2016

Canterbury Christ Church University

Participant Identification Number:

CONSENT FORM (Staff)

Title of Project: **The patient experience of conscious local / regional anaesthesia and surgery.**

Name of Researcher: Luke Ewart

Please initial box

1. I confirm that I have read the information sheet dated....Jan 2016...... (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I agree to my interview being audio recorded. ☐
4. I agree to notes being taken during periods of observation. ☐

I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file

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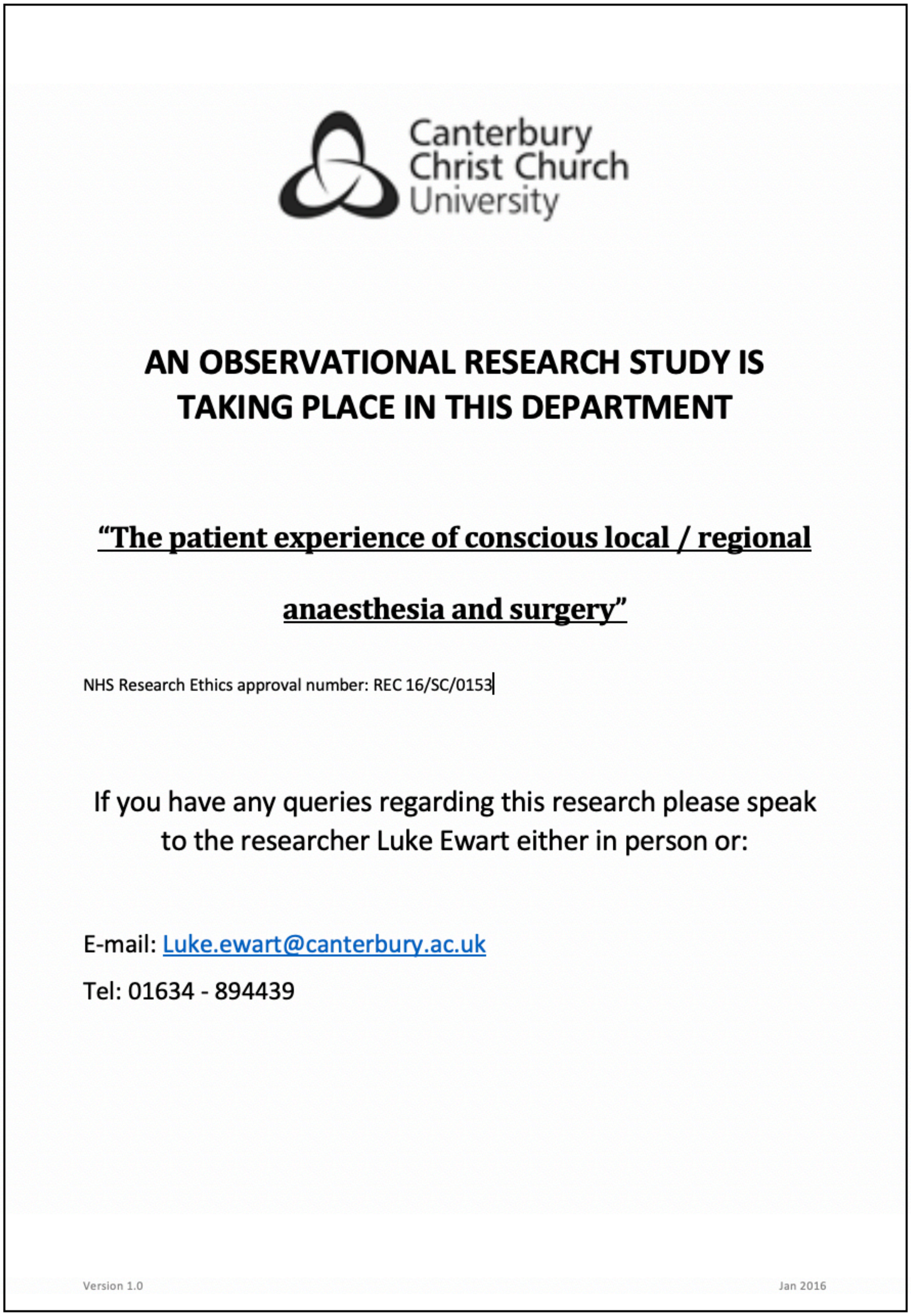
Professor Rama Thirunamachandran, Vice Chancellor and Principal

Appendix 7 – Poster



Canterbury
Christ Church
University

AN OBSERVATIONAL RESEARCH STUDY IS TAKING PLACE IN THIS DEPARTMENT

“The patient experience of conscious local / regional anaesthesia and surgery”

NHS Research Ethics approval number: REC 16/SC/0153

If you have any queries regarding this research please speak to the researcher Luke Ewart either in person or:

E-mail: Luke.ewart@canterbury.ac.uk

Tel: 01634 - 894439

Version 1.0

Jan 2016

Interview approach - Patients

An unstructured interview approach similar to that outlined by Spradley (1979) was used. There was not a structured interview guide. Instead, I attempted to build a rapport with participants, encouraging participants to open-up and express themselves in their own way. Because ethnographic interviews are intended to be semi-structured and open-ended, the exact wording of the questions changed depending on the context. Furthermore, the questions were not meant to "stand alone," but rather to elicit responses that were followed up during the interview in order to explore the participant's perspective further.

At the start of every interview there was a brief explanation about the nature of the interview and the research in which I was engaged. For example:

> *"This study is trying to understand what it is like from your point of view to have surgery under regional anaesthesia. An understanding of this experience is important to providing compassionate patient centred care and may lead to improved care for patients having this type of anaesthetic in the future".*

Next was an explanation about the way information from the interview would be incorporated into the final project. For example:

> *"This research will help me to learn about the way patients experience surgery under regional anaesthesia. I will take the information I gather and study it to discover which aspects of the experience are regarded as the most important and why".*

I also addressed technical issues that needed to be clarified from the outset with participants. For example:

> *"I'd like to write some of this down as I go to help me better recall what you have said. I would also like to audiotape this interview so that I can go over it later and not be tied to pen and paper as we talk; would that be OK?"*

It was important to emphasize to participants that I was seeking information on their own terms. Therefore I explained to participants:

> *"I am not really interested in technical language about your operation unless you already think in that way. There is no "right" answer about your experience. The best answers are your answers that sound like you and use language you would usually use. So as you talk, I'd like you to talk about your experience in the way you might to a family member or friend".*

Following these explanations, questions tended to be open-ended which allowed participants to express what they think in their own words. For example:

> *"Can you describe for me what it was like to have your surgery under regional anaesthesia?"*
>
> *"What was your relationship like with the staff looking after you while you had your surgery?"*
>
> *"Was there any part of your experience that you would describe as particularly good? Can you tell me about that? - If necessary, follow up with a question like: "So what was it that made that a good experience?"*

> *“Was there any part of your experience that you would describe as particularly bad? Can you tell me about that? Again, if necessary, follow up with a question like: “So what was it that made that a bad experience?”*

Structural questions were used to enable me to discover information about domains – the basic units in the participant’s cultural knowledge. They helped to enable me to discover how the participant has organised their knowledge. An example of such a structural question would be:

> “*What are the stages that you went through once you were admitted into the operating theatre?”*

The questions that have been outlined in this interview schedule are intended to be viewed as examples only. In the course of each interview the pattern of questions varied and clarifying questions were asked according to the kind of responses that were provided by each informant in the course of conversation.

Appendix 9 – Interview approach for staff

Interview approach - Staff

An unstructured interview approach similar to that outlined by Spradley (1979) was used. There was not a structured interview guide. Instead, I attempted to build a rapport with participants, encouraging participants to open-up and express themselves in their own way. Because ethnographic interviews are intended to be semi-structured and open-ended, the exact wording of the questions changed depending on the context. Furthermore, the questions were not meant to "stand alone," but rather to elicit responses that were followed up during the interview in order to explore the participant's perspective further.

At the start of every interview there was a brief explanation about the nature of the interview and the research in which I was engaged. For example:

> *"This study is trying to understand what it is like from your point of view to have patients undergoing surgery under regional anaesthesia. An understanding of this experience is important to providing compassionate patient centred care and may lead to improved care for patients having this type of anaesthetic in the future".*

Next was an explanation about the way information from the interview would be incorporated into the final project. For example:

> *"This research will help me to learn about the way patients experience surgery under regional anaesthesia. I will take the information I gather and study it to discover which aspects of the experience are regarded as the most important and why".*

I also addressed technical issues that needed to be clarified from the outset with participants. For example:

> *"I'd like to write some of this down as I go to help me better recall what you have said. I would also like to audiotape this interview so that I can go over it later and not be tied to pen and paper as we talk; would that be OK?"*

Following these explanations, questions tended to be open-ended which allowed participants to express what they think in their own words. For example:

> *"What information do you already know about a patient when they come to theatre?"*
>
> *"How do you go about making a patient feel at ease?"*
>
> *"From your perspective as a surgeon / anaesthetist / nurse etc. what makes it easier to interact with a patient?"*
>
> *"To what extent do you include the patient in what is going on during the operation? Again, if necessary, follow up with a question like: "What factors do you feel are the most important in contributing to this?"*

Structural questions were used to enable me to discover information about domains – the basic units in the participant's cultural knowledge. They helped to enable me to discover how the participant has organised their knowledge. An example of such a structural question would be:

> "*What occupies most of your time during the operation?"*

The questions that have been outlined in this interview schedule are intended to be viewed as examples only. In the course of each interview the pattern of questions varied and clarifying questions were asked according to the kind of responses that were provided by each informant in the course of conversation.

Appendix 10 - Research Ethics approval

Health Research Authority
South Central - Berkshire Research Ethics Committee
Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1389

07 April 2016

Mr Luke, D. A. Ewart
Senior Lecturer
Canterbury Christ Church University
Rowan Williams Court
30 Pembroke Court
Chatham Maritime
ME4 4UF

Dear Mr Ewart

Study title:	**The patient experience of conscious local / regional anaesthesia and surgery.**
REC reference:	**16/SC/0153**
Protocol number:	**N/A**
IRAS project ID:	**169896**

Thank you for your letter of 5 April 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mr Stephan Ramey, nrescommittee.southcentral-berkshire@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
GP/consultant information sheets or letters [Letter to consultant]	1.0	01 March 2016
Interview schedules or topic guides for participants [Interview approach]	1.0	01 March 2016
IRAS Checklist XML [Checklist_01032016]		01 March 2016
IRAS Checklist XML [Checklist_06042016]		06 April 2016
Other [letter re: secure e mail]	1.0	01 March 2016
Other [Poster]	1.0	24 February 2016
Other [Research activity timeline]	1.0	24 February 2016
Other [Summary CV Supervisor 2]		01 March 2016
Participant consent form [Patient]	1.0	24 February 2016
Participant consent form [Staff]	1.0	24 February 2016
Participant information sheet (PIS) [Patient]	1.0	24 February 2016
Participant information sheet (PIS) [Staff]	1.0	24 February 2016
Participant information sheet (PIS) [Patient - Tracked]	2.0	05 April 2016
Participant information sheet (PIS) [Staff - Tracked]	2.0	05 April 2016
REC Application Form [REC_Form_29022016]		29 February 2016
Referee's report or other scientific critique report [Peer review report]	1.0	15 January 2016
Research protocol or project proposal	1.0	24 February 2016
Research protocol or project proposal [Protocol - tracked]	2.0	05 April 2016
Summary CV for Chief Investigator (CI)		24 February 2016
Summary CV for supervisor (student research) [CV J. McInnes]		01 March 2016
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Patient]	1.0	01 March 2016
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Staff]	1.0	01 March 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

16/SC/0153 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

PP
David Carpenter
Chair