Perioperative patient advocacy
- having the patient's best interests at heart
To Göran
Perioperative patient advocacy
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Abstract


Patient advocacy implies taking action on someone else’s behalf, and has been described as a key element of nurses’ professional care. In the perioperative setting, it involves not only critical decision making, but also all the small things that the nurses do for the sake of the patients during their working day. Since previous research on the advocacy role of a registered nurse anesthetist (RNA) is sparse, and has not been conducted in a Swedish context, this thesis was intended to contribute to a greater understanding of advocacy in the perioperative context. The overall aim was therefore to explore the characteristics and consequences of perioperative patient advocacy (Study I), and to describe RNAs’ views of advocacy in anesthetic nursing through interviews (Study II), a questionnaire (Study III), and observations (Study IV).

The synthesis of the characteristics and consequences of perioperative patient advocacy was interpreted in this thesis as the RNAs having the patient’s best interests at heart, in that they (1) had control of the situation, (2) preserved human values, and finally (3) were emotionally affected, as the results from the four studies suggested this as the core of perioperative patient advocacy.

Perioperative patient advocacy is not always perceived as easy. In praxis, it is linked to the code of ethics outlined by the International Council of Nurses, which states that all registered nurses, regardless of their working context, shall respect human rights, promote health, prevent illness, and ensure that the individual receives accurate and sufficient information. This thesis elaborates on how this is done by describing how RNAs exert perioperative patient advocacy and how they interact in order to facilitate the best possible care for the patient. The results deepen the understanding of perioperative patient advocacy from the RNA’s perspective and contribute to a new insight in the RNA’s professional role.

Keywords: Perioperative, Patient advocacy, Ethics, Advanced nursing, Content analysis, Rasch analysis, Integrated review

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### Abbreviations

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<th>Description</th>
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<tr>
<td>I-CVI</td>
<td>Content Validity Index for Items</td>
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<td>ICN</td>
<td>International Council of Nurses</td>
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<tr>
<td>ICU</td>
<td>Intensive care unit</td>
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<td>OR</td>
<td>Operating room</td>
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<td>ORN</td>
<td>Operating room nurse</td>
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<td>PN</td>
<td>Nurse working in the perioperative setting in countries such as Australia, the UK, and the USA. In this thesis a PN is a registered nurse anesthetist, an operating room nurse, or a registered nurse working in the perioperative setting</td>
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<tr>
<td>PNAS</td>
<td>Protective Nursing Advocacy Scale</td>
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<td>PNAS-Swe</td>
<td>Swedish version of the Protective Nursing Advocacy Scale</td>
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<tr>
<td>RN</td>
<td>Registered nurse</td>
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<td>RNA</td>
<td>Registered nurse anesthetist</td>
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LIST OF PUBLICATIONS

This thesis is based on the following four papers, which are referred to in the text by their Roman numerals:

I. Perioperative patient advocacy: an integrative review.
   Sundqvist A-S, Holmefur M, Nilsson U, Anderzén Carlsson A.

II. Holding the patient’s life in my hands: Swedish registered nurse anaesthetists’ perspective of advocacy.
    Sundqvist A-S, Anderzén Carlsson A.

III. Protective nursing advocacy: translation and psychometric evaluation of an instrument and a descriptive study of Swedish registered nurse anesthetists’ beliefs and actions.
    Sundqvist A-S, Anderzén Carlsson A, Nilsson U, Holmefur M.

IV. Registered nurse anaesthetists practicing of perioperative patient advocacy – an observational study.
    Submitted.

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INTRODUCTION

My interest in patient advocacy first arose during my clinical training to be a registered nurse anesthetist (RNA). I remember how fragile and vulnerable I believed the anesthetized patient was completely in the hands of another human being, the RNA. This caught my interest and resulted in a literature study regarding patient advocacy during my RNA education. I began to wonder whether perioperative patient advocacy is equivalent to anesthetic nursing or whether it is something else. Perioperative patient advocacy is described as being not only about critical decision making but also visible in all the small things that the nurses do for the patients during their working day.1 The rationale for this thesis is therefore to increase the knowledge and contribute to a deepened understanding of what perioperative patient advocacy really is.

Patient advocacy has been described as a key element of nurses’ professional care,2,3 and implies taking action on behalf of another.4,5 In nursing, patient advocacy is related to patient care that focuses on the patient’s needs and wishes, including informing, protecting and speaking for the patient.1,6,7 Patient care that focuses on the patient’s needs and wishes has similarities with person-centered care, as found in an integrated review from the perioperative context. Among other things the review identified that person-centered care involves respecting the patient as a unique human being, and implies that the patient should be involved in their own care. The patients described that the presence of a perioperative nurse (PN) was calming since it prevented them feeling lonely and thereby promoted their wellbeing.8

Patient advocacy has also been described as a situation where the nurse acts in order to protect the patient against inappropriate practice.9
BACKGROUND

Nursing is a discipline and profession that includes caring, and so this thesis assumes that caring actions are required for nursing. Caring should use a holistic perspective taking in the entirety of the patient’s situation. This requires interpretation and understanding, and involves knowledge, skills, patient trust, and the ability to manage all elements simultaneously in the caring context. Excluding a patient as a person, or ignoring the patient’s experiences or values is regarded as non-caring and amoral.10 The Swedish Society of Nursing’s Foundation of Nursing Care Values states that nursing care is provided at the individual patient’s level, and is aimed at promoting health and well-being and to alleviating suffering regardless of the patient’s cultural background, age, sex, and social conditions. The core nursing values are based on a person-centered care in which the nurse is open to the patient’s perspective, and the patient’s experiences and self-determination are taken into account. Nursing values are linked to human existence and consist of respect for human vulnerability, dignity, integrity, and autonomy.11

The perioperative nursing context

Nursing has a long tradition, and working in the perioperative setting has been identified as the first area of specialization for nurses.12 Perioperative nursing can be described as all nursing activities performed during the preoperative, intraoperative, and postoperative phases of a patient’s surgical experience. For the patient the preoperative phase begins at the time the decision is made that the patient is to undergo a surgical procedure, and for the perioperative nurse when receiving information about the patient and starting to prepare for the patients surgical procedure. The preoperative phase ends when the patient is placed on the operating table. Next comes the intraoperative phase, which extends to the patient’s admission to the post-anesthesia recovery room or the intensive care unit (ICU). Finally, the postoperative phase, begins when the patient is admitted to the post-anesthesia recovery room/ICU and ends when the patient is discharged.13 Perioperative nursing involves the caring process as well as the surgical treatment techniques that serve life and health in order to alleviate suffering. It has been stated to be founded on caring and ethics.14
Surgical teams are comprised of physicians and nurses, all with well-defined roles. Working in a team, they take on responsibilities that are specific to their roles and are recognized and understood by all members of the team. In order to take care of the patient perioperatively, the PN must demonstrate knowledge of the procedure itself and any particular necessities for the individual patient. This requires nurses to be familiar with using various surgical instruments and anesthetic equipment. In the rapid pace that prevails in the perioperative setting, PNs must manage to coordinate and prioritize their daily workload due to the acuity of the patient’s condition and the individual patient’s requirements. They also need to collaborate with other members of the surgical team in pursuit of their common goal to ensure the best and safest possible outcome for the patient. The nurse practices a holistic perspective in the technical environment by combining caring aspects with the technological environment the nurse makes the medical technology acceptable to the patients.

In Sweden, nurses working in the surgical team are either operating room nurses (ORN) or RNAs. Swedish ORNs have undergone postgraduate education in perioperative care which encompasses instrument and circulating roles. The ORN’s role is based on the European Operating Room Nurses Association description of competence for perioperative nursing care, underpinned by the model of Tollerud et al. Swedish RNAs are registered nurses (RNs) who have undergone a post-graduate education in anesthetic nursing. The RNA independently induces, maintains, and carries out general anesthesia with support from an anesthesiologist.

The focus of this thesis is mainly on Swedish RNAs (Studies II-IV), but the integrated results in Study I are based on the experiences of RNAs, ORNs, and RNs working in the perioperative nursing context in Australia, Sweden, and the USA.

Anesthetic nursing

As described above, Swedish RNAs work independently when carrying out anesthetic nursing. They can, after a prescription from an anesthesiologist, perform general anesthesia during elective surgery on patients with a physical status classification of I-II according to the guidelines of the American Society of Anesthesiologists. The RNAs are not responsible for medical assessment, but in several countries they work according to standardized procedures. Anesthetic nursing involves working in a highly
technical environment and the RNA is expected to possess good medical and technical skills as well as knowledge of different anesthetic methods. RNAs must be able to interpret, assess, and cope with various difficult situations, and have good foresight, and be well prepared for administration of the anesthetic. Anesthetic nursing is performed perioperatively by the RNA on the basis of the individual patient’s needs. The RNA is constantly involved with the patient, trying to create trust, alleviate anxiety, and help the patient preserve the feeling of maintaining control over their body.

Three attributes have been identified as characterizing anesthetic nursing: keeping in touch with the patient, watching over the patient, and being one step ahead. The core element in keeping in touch with the patient is person-centered care, which includes knowing the person with all their reason, will, feelings, and needs. The RNA provides emotional and physical safety by watching over the patient during their entire surgical experience. These two attributes (keeping in touch with and watching over the patient) are the premise for the RNA to be one step ahead. Providing anesthetic nursing involves keeping vigil over the patient and doing what the patient cannot do for themself when anesthetized during surgery. It has been stated that the nurse almost becomes one with the patient, by maintaining equilibrium of all the patient’s systems in terms of breathing, stabilizing blood pressure, pulse, and temperature.

To summarize, anesthetic nursing includes providing a safe passage for the patient through the anesthesia by supporting their vital functions and giving them emotional support in a highly technical environment.

Advocacy: definition and history
Advocacy has been described as an active process of supporting someone and pleading or arguing on their behalf. The term originated in the Medieval Latin word ‘advocatia’, which in turn is derived from ‘advocare’, meaning to be called to someone’s aid. Advocacy is defined as an integral part of the nurse’s role in order to promote and safeguard the well-being and interests of their patients. It is seen as a key element of the nurse’s professional role.

Advocacy is a complex process which has been described as including not only the provision of emotional support to patients and preservation of the patient’s dignity, but also informing patients, speaking up for patients, and protecting patients from harm. In a study by Mallik, all
respondents stated that the role of a patient’s advocate was not exclusive to nursing,29 and that all healthcare providers exert patient advocacy within their own professional area, from their own professional point of view.1,30,32 This emphasizes that no healthcare professional should need to act as a watchdog over another; however, this balance might be affected if any of the professional groups see themselves as more powerful in the decision-making process regarding the patient’s best interests, and abuses that power. If this happens, there is still need for a patient advocate.33

Nursing has included advocacy throughout its history. It goes back to Florence Nightingale, who promoted equal human rights regardless of gender, social status, or religion, and thereby laid the foundation for nurse advocacy and the expectations that nurses would advocate for their patients. She believed that high-quality patient care was a basic human right, and that nurses should have the autonomy to advocate for their patients and their profession.34 Virginia Henderson described advocacy as a nurse helping an individual do what they would ordinarily do for themselves in order to maintain health, recover from illness, or die a peaceful death when they lacked the strength, will, or knowledge to care for themselves.35

As a result of the American Civil Rights Movement of the 1960s, which emerged from the social movements aiming to end racial segregation and discrimination, George Annas presented the Patient’s Bill of Rights.36 He suggested that nurses should act as Patient’s Rights Advocates, protecting and guiding the patient through the health care system.37 In 1973, the International Council of Nurses (ICN) introduced the concept of advocacy in their professional codes,38 and this has since been included in several other international codes of conduct, such as the Canadian Nurses Association’s Code of Ethics for Registered Nurses,39 the professional standards of practice and behavior for nurses and midwives in the United Kingdom,40 and the American Nurses Association’s Code of Ethics with Interpretive Statements.41

The development of theoretical advocacy models

There are several definitions of advocacy in the health care context, such as human advocacy,42 existential advocacy,43 social advocacy,44 nursing advocacy,45 and patient advocacy.2,46 An overview of a few of these theories and models is shown in Table 1 (page 18).

The first international theories and models of advocacy were developed in the 1970s, and the most frequently discussed theories/models in the
literature are those of Curtin,42 Gadow,43 and Kohnke.47 These models are based on the same core value: the belief that autonomy gives all human beings the right to choose their own actions. Since the beginning of the 21st century, the interest in patient advocacy has resulted in new theories and models, two of which have their foundation in the early theories/models of patient advocacy: the Sphere of nursing advocacy model,45 and a mid-range theory of patient advocacy.2 In these, the patient is seen as an autonomous person, and the nurse advocates for the patient when they are unable to do so themself.

Table 1: An overview of advocacy theories/theoretical models

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<tr>
<td><strong>Theory/model</strong></td>
<td>Human advocacy model</td>
<td>Existential advocacy theory</td>
<td>Functional advocacy model</td>
<td>Sphere of nursing advocacy model</td>
<td>A mid-range theory of patient advocacy</td>
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<td><strong>Central belief(s)</strong></td>
<td>All human beings have common needs and rights</td>
<td>Self-determination is a human right</td>
<td>The right to self-determination</td>
<td>The autonomous patient shall be advocated for only when in need</td>
<td>The patient is seen as a competent human being and the nurse safeguards the patients’ autonomy</td>
</tr>
<tr>
<td><strong>Nurse-patient relationship</strong></td>
<td>The nurse views the patient as a unique human being; and the patient decides what is important, not the nurse</td>
<td>The nurse is not entitled to decide what is best for the patient, and cannot determine what choices the patient should make</td>
<td>The nurse offers the patient information so that the patient can make informed choices</td>
<td>The nurse provides a semipermeable sphere between the patient and the external environment, protecting the patient while still allowing the patient to self-advocate</td>
<td>The nurse respects and promotes the patient’s self-determination and advocates for the patient only in situations when the patient is unable to do so themself</td>
</tr>
<tr>
<td><strong>Advocacy actions</strong></td>
<td>Informing, supporting, helping the patient find meaning in life and death, preserving the patient’s self-determination</td>
<td>Pleading the patient’s cause and preserving the patient’s self-determination</td>
<td>Informing, supporting, and preserving the patient’s self-determination</td>
<td>Providing a protective shield for the patient</td>
<td>Preserving, representing, and/or safeguarding the patient’s rights, interests, and values</td>
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In this thesis the concept of patient advocacy will be used. This term has previously been used by Bu and Jezewski in their mid-range theory.² They defined patient advocacy in terms of how the patients’ needs, interests, and their rights to information and self-determination in care are taken into account. This mid-range theory of patient advocacy synthesizes several theories regarding patient advocacy with the research in the field and is thereby broader than one single aspect of advocacy. It can therefore be considered anchored both theoretically and empirically,² thus appropriate to use when exploring patient advocacy inductively in the perioperative context as done in this thesis.

**Patient advocacy: a literature review**

Patient advocacy can be categorized as practice by which nurses both support and protect patients’ rights to self-determination and informed consent, and support and protect patients’ interests by intermediating for or defending these rights. Baldwin’s concept analysis of patient advocacy,⁴⁶ revealed three essential attributes connected with patient advocacy: valuing, apprising, and interceding. The nurse acts on behalf of the patient by protecting the patient’s rights to freedom and self-determination and by promoting the patient’s rights to be involved in decision-making. Baldwin also stated that patient advocacy is an essential necessary of nursing.⁴⁶

Patient vulnerability is often discussed as an important aspect of the nurse’s advocacy role. Patients with impaired ability to satisfy their own needs⁴⁶,⁴⁸-⁵³ or ensure their own right to self-determination ⁴⁸,⁵⁴-⁵⁶ are viewed by nurses as being in a vulnerable position.⁵⁷

Advocating for the patient consists of taking some kind of action on behalf of the patient,⁷⁷-⁷⁹ thereby standing up for the patient and their rights, and if necessary acting as a whistle-blower.⁵⁸,⁶⁰,⁶¹ It means protecting and defending the patients’ interests, and taking direct action.³,⁶,⁴⁹,⁵⁰,⁵⁹,⁶²,⁶³ When carried out by nurses, it can take the form of physically standing in the way to protect the patient from incompetent professional practice.⁴⁹,⁵⁸,⁶⁴,⁶⁵ The nurse represents or speaks for patients who are unable to do so for themselves, ⁵,⁵²,⁵⁷,⁵⁹,⁶⁶,⁶⁷ ensuring that patients’ dignity or privacy are protected and defending them against interventions that may cause them distress.⁵⁰ Other integral parts of patient advocacy include protecting the patient’s integrity ⁶,⁶³ and guiding the patient through the health care system.⁵²,⁶⁷
Another aspect of patient advocacy is when the nurse informs and educates the patient, sometimes in order to promote an informed consent. The nurse may also act as intermediary between patients and their families or significant others, and between patients and healthcare providers.

Factors influencing patient advocacy

There are several factors related to patient advocacy that prompt the nurse to take action on the patient's behalf. Some of these are related to the individual nurse’s characteristics and skills, other factors are organizational structures and the nurse-patient relationship.

Nurses' personal characteristics that are seen as important in relation to patient advocacy have been described as high self-confidence, the ability to be objective, and the ability to be resolute. It is the nurses’ moral compass (i.e. their inner belief) that directs them when advocating for their patients, and nurses need to take ethical principles into account when advocating for patients.

An important factor for patient advocacy is that the nurse possesses good communication skills. Hanks states that patient advocacy is an important part of nursing, and that it can reduce the risk of misunderstandings in communication, thereby contributing to increased patient safety. Bu and Wu found that nurses have positive attitudes towards patient advocacy, especially if the patients are unable to advocate for themselves. This was also prominent in a study by Davies et al. where the majority of the nurses felt that they were morally obligated to act on behalf of their patients, and this moral obligation is also stated in several other studies.

In order to advocate for the patient, the nurse needs to possess good professional training, clinical experience, and competence. The quality of the patient-nurse relationship is another factor influencing patient advocacy, and should be based on mutual understanding and trust. The better the nurse knows the patient, the greater ability the nurse has to advocate for the patient on the basis of knowing the patient's background, values, ethos, and interests. Organizational structures also influence patient advocacy. A working environment that facilitates open communication and the possibility to raise one’s voice promotes nurses’ willingness to advocate for their patients. This is important, since nurses might refrain from advocating for...
their patients if they feel unsafe. Several studies have shown that insufficient support from managers affects patient advocacy negatively. Hierarchy inhibits people from speaking up, and effective leaders might flatten the hierarchy, creating an environment in which team members feel safe and therefore willing to speak up when they have safety concerns. Good teamwork and communication are essential for safe patient care. Josse-Eklund et al. found that if nurses were supported by their colleagues, managers, and physicians, this had a positive influence on patient advocacy. A collegial relationship gives nurses and physicians greater powers to protect the patients’ best interests. This collaboration can be seen as working in partnership, with the goal of satisfying the patient’s needs while respecting the unique qualities and abilities of each professional.

Other organizational factors negatively influencing patient advocacy includes insufficient financial resources and time constraints.

Consequences of patient advocacy

The consequences of patient advocacy are those events or incidents that occur when the nurse exerts patient advocacy. Both positive and negative consequences are described in the literature.

Bu and Jezewski found that successful patient advocacy generates positive outcomes both for the patient and the nurse. Positive consequences for the patient mean that their autonomy is preserved or protected, that they are empowered, and that they get adequate and timely information so they can make their own informed decisions. It can also lead to them being offered the right treatment faster, and their autonomy being preserved. For the nurse, successful patient advocacy includes increased professional satisfaction, self-confidence, and self-esteem, as well as a preservation of their personal integrity and moral principles.

The negative consequences of patient advocacy might include not only the loss of reputation, friends, and self-esteem, but also conflicts leading to moral distress and/or moral dilemmas, where the nurse might feel powerless to do the right thing. Nurses might even lose their job as a consequence of their actions related to patient advocacy. Institutional strains may be placed on nurses practicing patient advocacy, with the result that they lose their empowerment, which evokes feelings of loneliness and vulnerability. Patient advocacy may also compromise nurses’ relationship with their colleagues, leading to anxiety and less moral
courage when it comes to standing up for the patients. When advocating for patients, nurses might be looked upon as troublemakers by their colleagues and managers, leading to conflicting loyalties for the nurses. It has been stated that patients will suffer unnecessarily if nurses do not successfully advocate for their patients, and that patients might experience discomfort if there is competition regarding the advocacy role among different health care professionals.

Critique of patient advocacy

The concept of advocacy has been disputed throughout the literature. One argument is that nurses might misuse their professional role; the skewed power position that exists between the nurse and the patient raises the question of whether there is a need for someone to protect the patients from the nurses. There is a risk of paternalism in this skewed power position, and it is the nurse’s responsibility to identify where the delicate line between advocacy and paternalism is drawn. When patients are unable to communicate, advocacy and paternalism often blend, and it is important that the nurse really knows the patient’s individual needs, desires, and wishes in order to be able to fully advocate for them.

It has been stated that nurses themselves argue that they are acting as the patients’ advocates while in their care, but also that it is nurses who adopted the term advocacy in order to professionalize nursing; advocacy, in this context, might be serving the nurses’ best interests instead of the patients'. It has also been argued that the short preoperative encounter between the PN and the patient does not provide the PN with intimate knowledge of the patient’s wishes. The PN is thus not able to create a unique relationship with the patient and is unaware of the patient’s will, and during this brief meeting may completely misunderstand the patient. The PN should safeguard the patient’s rights and safety, but doing this is not necessarily advocacy; it can instead be seen as nursing, where PNs do their best for the patient, thereby safeguarding the patient’s interests. This is also stated by Bird who considers proposing that the need of a patient advocate would suggest that the whole health care system is unsound. She argues that if all health care providers implement their responsibility, thereby acting in the patient’s best interests by providing the best possible care and avoiding harm – then patient advocacy would not be necessary.
Patient advocacy in perioperative nursing

In perioperative nursing, patient advocacy is characterized by the need to communicate for and safeguard patients who are unable to do so for themselves. This has been described as speaking for, or “giving voice” to the silent anesthetized patient, ensuring that the patient’s wishes and expressed values are met.¹

Advocating for the patient in the perioperative setting includes safeguarding the patient from harm, by maintaining their dignity and safety.¹,²,³,⁴,⁵ This implies that some type of action needs to be taken on behalf of the patient, either physically, or indirectly, such as reminding other of their duty of care.²¹

In order to provide the patient with reassurance and comfort the establishment of trust plays an important part in the patient advocacy role.¹ This is important, since patients have described the surgery situation as one in which they lose control over their bodies and their situation and need to rely on a complete stranger taking care of them;⁹⁷,⁹⁸ they are placing their lives in the hands of a stranger.⁹⁹ Trust is established in the initial meeting before surgery commences, and can be gained by both verbal and non-verbal communication. Verbally as ensuring the patient that “we are going to take care of you during the surgery” is one way for the PN to give the patient peace of mind so that the patient can trust them to take care of them.¹⁰⁰ The non-verbal communication comprises comfort and caring, described as being physically present and focusing on the patient,¹⁰¹ keeping eye contact,⁹⁹ or holding the patients’ hand.²¹

Information is seen as helping the patient to understand the procedures, which in turn leads to reassurance.¹⁰⁰

Instruments measuring advocacy

There are several different instruments for measuring different aspects of advocacy from the viewpoints of the nurse. The Attitude toward Patient Advocacy Scale (APAS) measures nurses’ attitudes toward advocacy on three dimensions: safeguarding patients’ autonomy, acting on behalf of patients, and championing social justice. The first two of these measure nurses’ attitudes on a microsocial level, and the third measures their attitudes on a macrosocial level.⁷⁴

Two instruments based on APAS have been translated and adapted to a Swedish context: the Attitudes Toward Organ Donor Advocacy Scale (ATODAS) and the Swedish version of the microsocial section of APAS.
(APAS-AMIA/SE). ATODAS, measures intensive care nurses’ attitudes towards organ donor advocacy on three dimensions: safeguarding the potential donor’s will and wishes, safeguarding the potential donor’s relatives’ will and wishes, and championing social justice.\textsuperscript{101} APAS-AMIA/SE focuses on nurses’ attitudes towards patient advocacy in community health care of older people on a microsocial level only; that is, the first two dimensions of APAS.\textsuperscript{102}

Another two instruments also exists, though neither has previously been translated and adapted to a Swedish context. The first of these, Advocacy in Procedural Pain Care (APPC), aims to clarify the meaning of advocacy and how it is implemented in pain care, from the views of both nurses and patients.\textsuperscript{103} The second is the Protective Nursing Advocacy Scale (PNAS), which measures nurses’ advocacy beliefs and actions from a protective perspective. It consists of four dimensions of advocacy: acting as advocate; work status and advocacy actions; environment and educational influences; and support and barriers to advocacy.\textsuperscript{104}
RATIONALE

International research has described patient advocacy as a key element of nurses’ professional care. In order to provide the patient with good quality care, nurses cherish their patient’s integrity and self-determination when advocating for them. International research regarding perioperative patient advocacy from the viewpoints of the perioperative nurse characterizes it as communicating for and safeguarding patients who are unable to do so themselves. Throughout the past forty years, various aspects of patient advocacy have been highlighted in the literature. However, there is still a need for additional knowledge regarding patient advocacy in order to help the nurses in their advocacy role. It is particularly important to draw attention to the patient advocacy role of the RNA, since patients undergoing surgery are unable to make their own voices heard due to sedation or general anesthesia.

There is very little previous research with an explicit focus on perioperative patient advocacy, within anesthetic nursing, and none of what does exist was conducted in a Swedish context. In order to clarify the relationship between perioperative patient advocacy and anesthetic nursing, there is a need for in-depth understanding of how it is defined, including which characteristics are the premises for perioperative patient advocacy and what consequences that might follow from perioperative patient advocacy. The ambition of this present thesis was therefore to increase the knowledge and contribute to a deepened understanding of patient advocacy in the perioperative nursing context, and contribute to a new insight into the professional role of the RNA. This knowledge, together with what is already known, might in the future create a foundation for building a tentative mid-range theory of perioperative patient advocacy. Theory building can be considered important for several reasons; for example, for helping RNAs and their students understand practice in a more complete and insightful way, or for defining the RNA profession.
AIMS

The overall aim of this thesis was to get a deeper insight into perioperative patient advocacy by exploring its characteristics and consequences. It was also aiming to describe registered nurse anesthetists’ views of advocacy in anesthetic nursing through interviews and a questionnaire, and their advocacy actions and interactions through observations.

The specific aims of Studies I-IV were:

I. To identify the characteristics of perioperative patient advocacy and the consequences that follow with perioperative patient advocacy from the perspective of the perioperative nurse.

II. To describe advocacy in anesthesia care during the perioperative phase from the perspective of the registered nurse anesthetist.

III. To translate and adapt the Protective Nursing Advocacy Scale into a Swedish version, to evaluate its psychometric properties, and to use it to describe Swedish registered nurse anesthetists’ advocacy beliefs and actions from a protective perspective.

IV. To examine the extent to which the findings from an integrative review regarding perioperative patient advocacy could be empirically supported, and to describe Swedish registered nurse anesthetists’ patient advocacy actions and interactions during the perioperative period.
METHODS

Design
Study I is an integrative review based on previously conducted empirical studies, Study II is a qualitative descriptive study, Study III is a psychometric cross-sectional study, and Study IV takes a qualitative descriptive approach. Table 2 presents an overview of all four studies.

Table 2 Overview of designs and methods

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Settings
The original scientific papers and doctoral dissertations included in Study I described work performed in the USA (n=5), Australia (n=2), and Sweden (n=2). The data collection for Study II was performed at two different county hospitals, and the data collection for Study IV was performed at one county hospital; all of these hospitals were located in Sweden. The questionnaire in Study III was sent to RNAs working in university, county, or district hospitals in Sweden.

Samples: Studies I, II, and IV
A total of seven papers and two doctoral dissertations were included in Study I. Their study populations included certified RNAs (n=33), ORNs (n=27), RNs working in the perioperative setting (n=331), and RNAs (n=31).

The general inclusion criterion in Study II was being a RNA working at least 50% of the time in nurse anesthesia care. Of the 112 RNAs’ employed
at two anesthesia departments, 105 were assessed as eligible and invited to participate. Twenty-four RNAs agreed to participate, and maximum variation was obtained by purposefully selecting 20 RNAs (10 RNAs from each hospital) with a broad range of anesthesia work experience. There were 16 female and four male participants, aged 36–61 years and with anesthesia work experience of 1–32 years.

All RNAs (n=14) employed at one general anesthesia department were invited to participate in Study IV. The general inclusion criterion was that the RNA’s main task was caring for patients in the perioperative setting, and all 14 RNAs were assessed as eligible to participate. Eight RNAs (six women and two men), agreed to participate and were included. They were aged 34–58 years, with anesthesia work experience of 2.5–30 years.

Data collection: Studies I, II, and IV

In Study I, a comprehensive database search was conducted in PubMed and CINAHL in accordance with the integrative review approach, in order to identify peer-reviewed scientific papers reporting original empirical research findings with focus on perioperative patient advocacy. English-language papers were searched for using the following keywords: patient advocacy or advocacy in combination with perioperative nursing, operating room nursing, nurse anesthetist, nurse anaesthetist, theater nurse, or operating room nurse. The search took place in January 2014, and no date restrictions were applied. The initial search produced 474 hits (PubMed n=346, CINAHL n=128), and after excluding duplicates 236 papers remained.

The relevance of each search result (n=236) was then assessed. First, the titles and abstracts were examined. Papers were excluded if they did not report any primary data collection through established research design, or if perioperative patient advocacy was discussed in terms other than from the PN’s perspective. If the titles and abstracts did not give sufficient information, the full paper was retrieved and examined prior to final decision-making about inclusion or exclusion. Five of the 236 papers, met the inclusion criteria.

A manual search for additional papers was carried out, including the reference lists of all papers and a search based on personal knowledge of the field. This produced a further seven papers as well as two doctoral dissertations, resulting in a total of 12 papers and two doctoral dissertations that were then assessed for quality. Each paper was systematically
examined using the Critical Appraisal Skills Programme for qualitative research. Five papers were excluded after the quality appraisal, leaving seven papers and two doctoral dissertations to be included in the review.

The data in Study II were collected through individual semi-structured interviews with 20 RNAs during March and April 2011. The interviews were audio-taped with the permission of the participants and lasted between 25 and 80 minutes. The interviews started with the participants being asked “What does being the patient’s advocate mean to you?”, which was followed up by “What do you think characterizes nurse anesthesia advocacy?” and “What do you think is the core of nurse anesthesia advocacy?”. The RNAs were also asked to narrate a situation in which they considered that they had advocated for a patient. The answers were probed to obtain deeper and richer data, and the interviews were concluded when no new information was forthcoming. The interviews were transcribed verbatim by a secretary with experience of transcribing interviews; this resulted in 202 single-spaced pages, which formed the basis for the analysis.

In Study IV, 16 individual, nonparticipant observations were conducted with eight RNAs. Each RNA was observed twice on two different occasions, during October–December 2015. Before commencing the observations, a detailed observation protocol was constructed and three pilot observations were carried out, one concurrently by two of the researchers. The aim of the pilot observations was to test the observation protocol and practice the observation technique. The detailed observation protocol was originally constructed as a checklist based on the actions that described perioperative patient advocacy in the categories identified in Study I: protecting, informing, value preserving, and supporting. The pilot observations were conducted at a different anesthesia department than the one where the study observations took place, and none of them were included in the study. The pilot observations led to a simplification of the observation protocol, where all details were deleted and substituted with only the names of the predetermined categories. This allowed the observer to more freely document what was observed, with the observation protocol used only as a reminder of the focus for the observations. The observer used a mobile positioning and followed the RNAs unobtrusively by shadowing them from the time they started to prepare for the anesthesia to when they passed on the responsibility for the patient to the nurse at the postoperative unit; that is, during the entirety of the perioperative care. Close attention was paid to what was happening during the observation,
for example, what actions the RNAs took, who or what initiated those actions, what was said, whom they interacted with, and the non-verbal communication that occurred. Jotted notes were made during the observations. A short (approximately 15 minutes) informal conversation interview was held with each RNA directly after each observation, in order to give the observer an opportunity to ask the RNAs to describe or clarify situations the observer did not understand. Jotted notes were taken during this conversation, and comprised an additional part of the data in the study.

The jotted notes from the observations and the informal conversation interviews were transcribed by the observer into detailed field notes as neutrally as possible immediately after leaving the anesthesia department. The transcription comprised 208 single-spaced pages which formed the basis of the analysis. The total observation time was 45 hours and 36 minutes, and the time observed per anesthesia ranged from 103 to 237 minutes per observation. One of the observations was conducted concurrently by two of the researchers to allow comparisons and an internal reliability check on the data collection.

Data analysis: Studies I, II, and IV

The process of data abstraction and synthesis in Studies I and II was conducted with an inductive qualitative content analysis following the guidelines of Graneheim and Lundman. At the first level of analysis in Study I, the results sections in the included papers and doctoral dissertations were read thoroughly several times to obtain a sense of the whole, and text that dealt with the characteristics and consequences of perioperative patient advocacy was extracted and collated into a text file. This text file was divided into meaning units, condensed, abstracted, and labeled with codes. The codes were compared based on differences and similarities, and thereafter sorted into categories that represented the manifest content. A process of reflection was used to formulate the underlying meaning of the categories (the latent content) into subthemes and a unifying main theme. Through an interactive process, the researchers discussed the codes, categories, subthemes, and main theme until consensus was reached. The process of data abstraction and synthesis in Study II also followed the guidelines of Graneheim and Lundman, and so was conducted in a similar manner as in Study I, but whereas the unit of analysis in Study I consisted of the assembled data in the text file, in Study II the unit of analysis consisted of the interviews conducted with the RNAs.
A directed qualitative content analysis was used to analyze the transcriptions in Study IV. According to Hsieh and Shannon, this is a relevant method when theory or research findings already exist but there is still a need for further description.\textsuperscript{111} The transcriptions were analyzed on the basis of the four categories identified in Study I: protecting, informing, value preserving, and supporting. A coding scheme originating from the four broad predetermined categories was constructed before commencing the analysis, and the content and borders between the categories were discussed by all four researchers until agreement was reached.\textsuperscript{108} The transcripts from the observations were read several times in their entirety to get a sense of the whole. Text that represented perioperative patient advocacy actions according to the coding scheme was then highlighted using a different color for each category. The text of each predetermined category was inductively analyzed further, and coded according to a more detailed level of content. These codes were scrutinized for differences and similarities with regard to the relevant predetermined category, and then abstracted into 11 newly identified subcategories that represented a manifest pattern. When identifying these 11 subcategories, the interactions were taken into consideration, including who initiated various actions. Figure 1 gives an overview of the analytical process.

One of the transcripts was co-assessed by all four researchers in the initial phase of analysis, and discussed until all agreed on the analysis.\textsuperscript{108} An additional five transcripts were analyzed individually by two of the researchers and then discussed until mutual agreement was reached on the identified subcategories. A co-assessment of the subcategories was then performed by all researchers until agreement was reached.\textsuperscript{108,112}
Procedure: Study III
Study III was conducted in three different phases: (1) translation of the PNAS into Swedish, (2) psychometric evaluation of the PNAS and finally (3) a description of the Swedish RNAs’ advocacy beliefs and actions from a patient protective perspective.

The original PNAS is composed of 43 items, and each item is rated on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). There are four subscales, made up of 37 of the items: acting as advocate (16 items), work status and advocacy actions (5 items), environment and educational influences (8 items), and support and barriers to advocacy (8 items). Six items are not included in the four subscales of the PNAS. An overview of the translation and psychometric evaluation process is given in Figure 2 on the next page.

Phase I: Translation of the PNAS into Swedish
Permission to translate and use the PNAS was obtained from the originator of the instrument, Dr. Robert Hanks, and from the journal owning the copyright. The back-translation method for cross-cultural research was used for translation and adaptation. The original English version of the PNAS was translated into Swedish by a native Swedish-speaking translator familiar with the health care context. The translation was reviewed by the authors, and a pretest Swedish translation was established.

Participants
Five Swedish-speaking persons with good knowledge of the English language were recruited (expert panel 1): one RNA, one anesthesiologist, and three researchers of whom two had advocacy as their main research focus.

Procedure
The original English version and the translated version of the PNAS were sent to expert panel 1. The panel was asked to read and compare the original items with the translated items and consider if the items were consistent, and if not, propose a new Swedish wording. Some linguistic modifications of the items were made according to the experts’ comments. The items were thereafter back-translated by a native English-speaking translator, blinded to the original wording. The back-translated items were sent to, and approved by, Dr. Hanks.
Figure 2 Flowchart showing the translation and psychometric evaluation process in Study III

Original PNAS
43 items

Phase I
Translation into Swedish by a bilingual translator

Modification by the authors
Expert panel 1 read and compared
Modification according to expert panel

Back-translation by a bilingual translator blinded to the original wording

Phase II
Content validity (n=43 items)

Expert panel 2 assessed each item
Content Validity Index
Removal of one item

Face validity (n=42 items)

Pretest
Led to no changes

Construct validity (n=42 items)

Rasch analysis
Removal of thirteen items

Swedish version of the PNAS (PNAS-Swe)
29 items
Phase II: Psychometric evaluation of the PNAS

The psychometric evaluation of the PNAS was undertaken in three steps: (1) content validity, (2) face validity, and (3) construct validity.

Participants

To evaluate the content validity of the 43-item Swedish version of the PNAS, a second expert panel (expert panel 2) was invited to participate. This expert panel consisted of four RNAs and two registered nurses caring for cardio-thoracic patients.

To evaluate the face validity, a pretest was carried out in a sample of 10 ORNs caring intraoperatively for patients undergoing surgery. This sample was chosen since ORNs care for patients intraoperatively, but was not the target population for the web survey.

To evaluate the construct validity, a study population was identified consisting of all RNAs with an e-mail address registered with Vårdförbundet (n=1,425), which is the Swedish trade union and professional organization of the four registered professions of nurses, midwives, biomedical scientists, and radiographers. There were 273 valid responses to the questionnaire, giving a response rate of 19%. Among the individual item responses, 20 of 8190 were missing (0.2%). Twenty-one percent of the respondents were men. The RNAs were aged from 24 to 67 years, and their work experience as an RNA varied from 0 to 42 years. Forty-eight percent of the participants worked in a university hospital, 31% worked in a county hospital, and the remaining 21% worked in a district hospital.

Data collection

In order to allow calculation the Content Validity index for each item (I-CVI), expert panel 2 were asked to assess the comprehensibility and relevance of each item in a Swedish context on a 4-point Likert scale ranging from 1 (not relevant at all) to 4 (very relevant).

The ORNs recruited to assess face validity were instructed to review the instrument for its readability, to report whether they found any of the items inappropriate, and to record how long it took them to answer the instrument.

The Swedish version of the PNAS along with questions regarding demographic data was sent as a web survey to all of the potential participants by e-mail, in order to be able to evaluate the construct validity. Two reminders were sent to all of the potential participants. The data collection was carried out during October–December 2013.
Data analysis
The content validity was determined by calculating the I-CVI; that is, the number of experts giving a rating of either 3 or 4 on the 4-point scale divided by the number of raters. An I-CVI value ≤0.5 was considered low, ≤0.67 fair, and ≥0.83 excellent.

Regarding the face validity of the instrument the ORNs found the items easy to understand and non-offensive, and it took them about 10–15 minutes to answer the instrument. No changes to the instrument were made after this pretest.

The Rasch measurement model was used to evaluate the construct validity of the 42-item Swedish version of the PNAS. This is a probabilistic item response theory model which estimates how an item relates to the underlying construct. The rating scale model was chosen because this model is recommended when the rating scale can be assumed to be the same across items. Version 3.8.1.0 of the Winsteps® Rasch measurement computer program was used for the analysis (Copyright 2014 John M. Linacre).

Construct validity was evaluated by analyzing the four subscales separately. The first step was to evaluate the rating scale functioning using the criteria of a frequency of >10 responses and an outfit mean square (MnSq) of <2 per category for each item. The category probability curves were visually inspected for the expected distinctive peak. The average category measure and thresholds were expected to increase monotonically; if not, this would indicate disordered thresholds. If thresholds are disordered, they should be collapsed in order to have a well-functioning rating scale. Item and person goodness-of-fit was evaluated using infit MnSq >1.3 together with a standardized z-value outside the range of −2.0 to +2.0 as the indicator of poor fit. Unidimensionality was evaluated by a principal component analysis (PCA) using standardized residual variance with Eigen-values greater than 2.0 as indicators of non-unidimensionality. The inter-item residual correlation was calculated to evaluate local independence, with a correlation >0.3 suggesting some local dependency and thus implying that the response to one item was dependent on the response to another item. Item and person reliability was evaluated by calculating the person and item reliability coefficients. These coefficients are bounded by 0 and 1, and values over 0.67 indicate fair reliability.
Phase III: A cross-sectional study of Swedish RNAs’ advocacy beliefs and actions

A cross-sectional study was undertaken in order to provide a description of Swedish RNAs’ advocacy beliefs and actions.

Participants and data collection
The sample and data collection were as described above in the section on construct validity in phase II.

Data analysis
The data analysis was based on the RNAs’ responses to PNAS-Swe. Descriptive statistics were used to analyze the demographic data. The raw sum scores of each PNAS-Swe subscale were transformed in the Rasch analysis from ordinal-level data to interval-level data measured in PNAS units. The PNAS unit range corresponded to the subscale raw score range for each subscale. The mean PNAS units for each subscale were calculated so that the RNAs’ protective beliefs and actions could be illustrated. An independent t-test was used to determine if there were any differences between men and women on the four subscales, and Pearson’s r was used to examine whether there was any relationship between the participants’ age or work experience and their advocacy beliefs and actions from a protective perspective. Alpha level of significance was set at <0.05. Version 22.0 of IBM SPSS Statistics for Windows was used to perform the analyses (Armonk, NY: IBM Corp.).
ETHICAL CONSIDERATIONS

All studies were conducted following the ethical principles of medical research involving humans or animals, and conformed to the principles outlined in the Helsinki Declaration of Ethical principles for medical research involving human subjects. An advisory statement that Studies II-IV were ethically acceptable to perform was given by the Regional Ethical Review Board in Uppsala, Sweden (2011/029, 2013/242, and 2015/248). Since Study I was an integrative review of published papers and dissertations no ethical approval was applied for. Nevertheless, ethical considerations were taken into account in the quality review of each paper included.

To ensure that participation was voluntary, participants in Studies II and IV were given both verbal and written information about the studies, and signed a written informed consent to participate before data collection. They were informed that participation was voluntary, that they had the right to withdraw from participation at any time without any explanation, and that it was possible to contact the author with concerns related to the study. The participants in Study III were given written information about the study, and informed that participation was voluntary and that answering the web survey implied consent to participate in the study.

An observational study could be seen as an intrusion into the lives of those observed, and so all professionals that could have been indirectly observed during any of the observations of the RNAs in Study IV were informed about the study a few months prior to observation. This included not only the RNAs but also the ORNs, assistant nurses, anesthesiologists, and surgeons. These professionals were informed about the study and assured that the main focus of the observations would be the RNAs. Since the patients would also be a part of the observation context, they were informed about the study at the ward on the morning of surgery. They were informed that the main focus of the study was the RNAs, and that the researcher would be present and taking notes during the whole surgical procedure. Each patient was asked for permission to conduct the observations during their surgical experience, and none declined. Patients due to undergo surgery can be anxious and cognitively affected, so asking them about permission to conduct observations of RNAs during their surgical experience might be regarded as unethical. Thus, special attention was given when approaching the patients. When asking for permission, each individual patient’s body language was observed, and if they had expressed or signaled unease or discomfort in anyway, the observation
would have been cancelled. Patients undergoing surgery in the genital area were excluded for ethical reasons.

All the participants in Studies II-IV were guaranteed secure data storage, and throughout the studies all data were treated with confidentiality. The unidentified data were kept in a locked cabinet. When illustrating the findings, the participants were kept anonymous. In Study II the participants themselves chose the location for the interview, which might have made the interview situation less stressful. The focus of the interviews in Study II was on different perspectives of the RNAs’ experiences of patient advocacy; this is not a particularly sensitive topic, and so the risk of harm for the participants was considered to be low.

The recruitment process in Studies II-IV was based on the aim in each respective study, and did not discriminate in terms of gender, religion, or values. All participants in each study were provided with the same information, had the same possibilities to receive additional information, and in Studies II and IV had the same opportunities to withdraw from participation at any time.

In Study II, 24 RNAs registered their interest to participate. Since the advisory statement from the Regional Ethical Review Board in Uppsala, Sweden (2011/029) was given for interviewing 20 RNAs, this was the number selected for the interviews. Exclusion of the other four RNAs might be seen as injustice, but the initial information letter had informed all potential participants that selection would take place and that they all had the same possibility to be chosen. They were further informed that there would be a purposeful selection of RNAs in order to include both male and female participants with a range of anesthesia work experience.
RESULTS

The overall aim of this thesis was to get a deeper insight into perioperative patient advocacy by exploring its characteristics and consequences. It was also aiming to describe RNAs’ views of advocacy in anesthetic nursing, including their perioperative advocacy actions and interactions.

The synthesis of the characteristics and consequences of perioperative patient advocacy were interpreted as having the patient’s best interests at heart, which covered having control of the situation, preserving human values, and being emotionally affected (Figure 3), as the results from the four studies suggested these as the core of perioperative patient advocacy.

<table>
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<th>Having the patient’s best interests at heart</th>
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<td>Characteristics (Studies I-IV)</td>
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<td>Having control of the situation</td>
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Perioperative patient advocacy is a complex process. In Study I, the core of its characteristics and consequences was interpreted as doing good for another human being – a balancing act between philanthropy and personal gratification. The findings concerning the characteristics of perioperative patient advocacy covered the actions taken by the PN on behalf of the patient in terms of protecting, informing, value preserving, and supporting. These four categories were used when conducting the directed content analysis of the observations with the RNAs in Study IV; this analysis revealed that they were all covered in praxis and thus empirically supported.

In Study II, holding the patient’s life in my hands was interpreted as the unifying main theme describing the RNAs’ perception of patient advocacy. The RNAs in Study III described protecting the patient from harm as an important characteristic of perioperative patient advocacy. They believed that nurses who are committed to providing good patient care are better patient advocates.

The consequences of perioperative patient advocacy are related to its characteristics. Satisfaction (Studies I-II) and the feeling of courage (Study II) were
both interpreted as positive consequences. However, there were also negative consequences related to perioperative patient advocacy; it made the nurses feel vulnerable and constrained (Study I), and they at times experienced moral stress when advocating for their patients (Study II). However, in Study III, the consequences of perioperative patient advocacy were not connected to the negative consequences described in Study I and II. In this study, the RNAs instead felt supported when advocating for the patient.

**The characteristics of perioperative patient advocacy**

When analyzing the results from the four studies, it became clear that the characteristics of perioperative patient advocacy could be interpreted as having control of the situation and preserving human values.

**Having control of the situation**

The nurses’ preparedness for the upcoming perioperative activities was an important factor in their having control of the situation, and thus being able to advocate for their patients. In order to have control of the situation, the nurses took care of the things the patients could not do themselves due to sedation and general anesthesia (Studies I, II and IV). This included safeguarding the patients by intervening and arguing on their behalf (Studies I, II and IV) and thus, protecting them from potential harm (Study I). In Study IV this was described as shielding the patient from harm, and included making sure that no adverse events would happen to the patient while in the RNAs’ care:

> The RNA looks from the anesthesia monitor to the respirator to the infusion pump and then back at the anesthesia monitor again. She raises her hand and says [with emphasis]: “Stop. Stop the surgery right now. Her [the patient’s] pulse is racing and her blood pressure is high. I’m increasing the depth of anesthesia, but I’m taking it slowly. I will tell you when it’s okay to carry on.”

*From observation no 13, Study IV*

The RNAs did not submit to what others thought was best for the patient; instead, they questioned others’ decisions and argued their case if they
thought this would produce the best outcome for the patient, thus shielding the patient from harm (Studies II and IV).

The RNAs were one step ahead and had control of the patient’s situation by maintaining all the patient’s systems (Study I, II and IV). In doing this they were observed gathering and evaluating the patient’s physiological status, thereby adapting their nursing actions to the need of each unique patient (Study IV). In order to optimize, maintain, and monitor the patient’s body functions, the RNAs were observed performing a number of nursing actions such as preventing tissue damage by massaging the patient’s arms, changing the position of the patient’s arms and head, and moving the saturation probe from one of the patient’s fingers to another (Study IV), or as in Study I when the PN ensured that the patient was positioned correctly on the operating table. This was also described as a part of patient advocacy in Study II, where the RNAs stated that they, for example, ensured that the patient’s fluid balance was maintained, that the patient was kept warm, and that the hygiene level was satisfactory.

Being one step ahead involved mental preparation. The RNAs had several different strategies for providing the best possible care for the patient, which was described as “having the entire care plan clear in my mind” (Study II). This was also evident in Study IV, when the RNAs were observed being continuously one step ahead and thus, prepared for the upcoming perioperative activities. They were, for example, observed interacting with the surgeons by asking what phase of the surgery they were in, so they could be prepared for the next step in their perioperative care of the patient.

In Study IV, the actions that could be described as the RNAs’ specific nursing actions for the patient were observed to be initiated almost solely by the RNAs themselves, such as when they were optimizing, monitoring, and maintaining the patient’s body functions. Although standing a little bit aside, the RNAs were seen to always have a careful eye on the patient, the operating monitor, or the anesthesia equipment. They were vigilant enough that a glance from the ORN or a small change in the surgeon’s voice could be a sufficient signal that something was not quite right, leading the RNAs to act on behalf of the patient. Although most of the actions were initiated by the RNAs themselves, they were also observed interacting with other members of the surgical team when taking action on the patient’s behalf. This could for example be when the RNAs and the ORNs together took precautionary actions to prevent any unnecessary pressure on the tissue, when they interacted with a colleague/ORN/assistant nurse.
to ensure that the patient was correctly positioned on the operating table, or when they asked the anesthesiologist about the postoperative pain regime. The RNAs were also observed interacting with the patient, for example when having a dialogue regarding the patient’s positioning on the operating table.

In Study III, the items in subscale 1 (Table 3), acting as advocate, described different protective actions that the RNAs took in order to advocate for their patients, including speaking out on the patient’s behalf, being the patient’s representative, or protecting the patient from harm. The high mean score indicates that the RNAs strongly agreed that they needed to take action on behalf of the patients in order to protect them from harm (Table 3).

<table>
<thead>
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<th>Table 3 An overview of the results from each subscale in Study III</th>
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<td><strong>Subscale</strong></td>
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<td>Acting as advocate</td>
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<td>Environmental and educational influences</td>
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</table>

a Mean score, standard deviation (SD), range and possible range are shown in PNAS units.

In order to have control of the situation, the nurses verified information in the patients’ medical record and provided the other surgical team members with information about the patient (Studies I, II and IV). The RNAs in Study IV were observed gathering information about the patient and the patient’s physical status, which involved interaction with the other team members and the patient. This included the RNAs reading the patient’s medical records and interviewing the patient preoperatively. This communication was not only initiated by the RNAs themselves; it was also observed to be initiated by the patient when they had something they wanted to inform the RNA about. The RNAs in Study IV were also observed sharing the information they had collected with other team members, as described in Studies I and II.

**Preserving human values**

Value preserving entails paying respect to the patient as another human being, by upholding the patient’s integrity and meeting their every need (Study I, II and IV). In order to be able to provide empathic and psychosocial support to
the patient, thus advocating for the patient, the RNAs strove to gain the patient’s trust via verbal or non-verbal communication (Studies I, II and IV). Verbal support consisted of the assurance that the patient was going to be taken care of and kept safe during anesthesia (Studies I, II and IV), and the promise that the RNA or a colleague would be with the patient and watch over them during the anesthesia (Studies II and IV):

The RNA looks the patient in the eyes, puts a hand on the patient’s shoulder and says: “I’m going to be here with you during the whole surgical procedure. I’m not going to leave you. Not even for a second.” The patient looks the RNA in the eyes and nods.

From observation no 14, Study IV

An example of non-verbal support is shown in Figure 4, where the RNA is looking the patient in the eyes and laying a hand on the patient’s shoulder (Studies I, II and IV). Non-verbal support was also described as holding the patient’s hand (Studies I, II and IV), indicating “I am here for you” and trying to mediate a feeling that taking care of patients and providing them with anesthesia was something the RNAs did every day (Study II). The RNAs in Study IV were observed staying very close to the patient, and paying attention to the patient while they were awake. The RNAs narrated that they treated the patients equally (Study II), and that they tried to meet their every need (Studies II and IV). The RNAs considered it important to treat the patient with respect and to preserve the patient’s integrity (Studies I, II and IV). In Study IV the RNAs were observed upholding the patients’ integrity in several different ways, such as: protecting the patient from unnecessary exposure by covering the patient with blankets regardless of whether they were awake or not, and by closing down the patient’s digital medical record on the computer when leaving a room, thereby assuring that no unauthorized staff had access to the patient’s medical record. This was also narrated by the RNAs in Study II as

Figure 4 Example of non-verbal support
an aspect of perioperative patient advocacy. An example of how the patient’s integrity was preserved by one of the RNAs in Study IV is described below:

The RNA turns around to face the patient and discovers that a member of the surgical team has removed the sterile draping and the patient is lying naked on the operating table. The RNA rushes to the patient and exclaims, while covering the patient with blankets: “But isn’t anyone going to cover the patient up? You’re just going to undress him and let him lie there naked?”

From observation no 12, Study IV

The RNAs in Study II viewed themselves as the patient’s representative and link to the surrounding world, thereby safeguarding the patient’s autonomy. This meant that the patient’s needs were met in accordance with their previously expressed wishes, and not according to the wishes of the RNA. In Study IV, the RNAs helped the patient to uphold their autonomy by giving them the opportunity to choose between two or more options when possible, for example asking how much or how little support they wanted under their neck, and how thick they wanted their blankets to be. These actions were observed taking place in close interaction between the patient and the RNAs/other team members.

The RNAs in Study IV were observed paying attention to the “whole person” and practicing a holistic perspective when physically close to the anesthetized patient, stroking the patient on the cheek and forehead or laying a hand on the patient’s shoulder or arm. The RNAs had many quite discreet ways of showing the patients respect. The small things that were observed included looking the patient in the eyes and focusing on the patient while talking to them, and confirming the use of the patient’s correct first name if there were several names written on the patient’s medical record.

Informing the patient was described as part of perioperative patient advocacy in Studies I, II and IV. The aim of this was not only to provide the patient with information, but also to enable patient participation (Study IV). In Study IV it was observed that the provision of information was often initiated by the RNAs themselves, but it could also be initiated by the patient, for example if they expressed in some way that they had not understood the information given. The RNAs in Study II narrated that
they ensured that the patient had all the information needed before commencing anesthesia, and that informing the patient sometimes also included acting as an interpreter to explain the information given by the surgeon or anesthesiologist. The role of an interpreter was also observed in Study IV, where the RNAs sometimes needed to rephrase the information given to the patient by other members of the surgical team.

The consequences of perioperative patient advocacy
Since perioperative patient advocacy is complex and not always perceived as easy, the consequence of exerting these actions is that the nurses are emotionally affected.

Being emotionally affected
There were both positive and negative consequences related to perioperative patient advocacy. The consequences of perioperative advocacy were related to the perioperative advocacy actions that the PNs (Study I) and RNAs (Studies II-III) took on behalf of the patients, and it affected them emotionally.

Being vulnerable in one’s professional role was connected to a moral stress which could be almost overwhelming, leading to a hesitation to advocate for the patient (Study I). The findings in Study II also identified moral stress due to disrespect from other members of the surgical team, and a feeling of rejection when the RNAs’ convictions about the patient’s well-being were ignored.

Protecting the patient from harm and speaking up for the patient were not perceived as easy, but the RNAs in Study II said that they did it anyway. Although they could find it difficult to advocate for the patient, the RNAs stood firm, arguing for what they were convinced was best for the patient (Study II and IV). The RNAs answers in subscale 3, environment and educational influences, in Study III agree that they did not doubt their own abilities to advocate for the patients and that high self-confidence made them better patient advocates. Table 4 on the next page presents an overview of the results of the RNAs’ answers to all items in Study III.

However, the RNAs in Study II stated that they had to summon up courage to be able to advocate for the patient. Advocacy could also make the nurses feel satisfied, since it meant that they were defending the rights
of a defenseless human being, and thereby doing the right thing (Studies I and II).

Table 4 Summary of the RNAs’ answers to the final version of the Swedish version of the Protective Nursing Advocacy Scale (PNAS-Swe)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean score (SD)a</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subscale 1: Acting as advocate</strong></td>
<td></td>
</tr>
<tr>
<td>Patients need nurses to act on the patients’ behalf</td>
<td>4.57 (0.65)</td>
</tr>
<tr>
<td>As the nurse, I keep my patient’s best interests as the main focus of nursing advocacy</td>
<td>4.69 (0.59)</td>
</tr>
<tr>
<td>Nurses who understand the benefits of patient advocacy are better patient advocates</td>
<td>4.43 (0.70)</td>
</tr>
<tr>
<td>I am acting on my patient’s behalf when I am acting as my patient’s advocate</td>
<td>4.55 (0.65)</td>
</tr>
<tr>
<td>I speak out on my patient’s behalf when I am acting as my patient’s advocate</td>
<td>4.44 (0.77)</td>
</tr>
<tr>
<td>I am acting as my patient’s voice when I am advocating for my patient</td>
<td>4.52 (0.68)</td>
</tr>
<tr>
<td>I am acting as the patient’s representative when I am acting as the patient’s advocate</td>
<td>4.42 (0.82)</td>
</tr>
<tr>
<td>I am advocating for my patient when I protect my patient’s rights in the health care environment</td>
<td>4.49 (0.73)</td>
</tr>
<tr>
<td>I am acting as a patient advocate when I am protecting vulnerable patients from harm</td>
<td>4.66 (0.64)</td>
</tr>
<tr>
<td>Nurses that act on a patient’s behalf are preserving the patient’s dignity</td>
<td>4.14 (0.76)</td>
</tr>
<tr>
<td>I am acting on my patient’s behalf when I am acting as my patient’s advocate</td>
<td>4.55 (0.65)</td>
</tr>
<tr>
<td>I speak out on my patient’s behalf when I am acting as my patient’s advocate</td>
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</tr>
<tr>
<td>I am acting as a patient advocate when I am protecting vulnerable patients from harm</td>
<td>4.66 (0.64)</td>
</tr>
<tr>
<td>Nurses that act on a patient’s behalf are preserving the patient’s dignity</td>
<td>4.14 (0.76)</td>
</tr>
<tr>
<td>I am ethically obligated to speak out for my patients when they are threatened by harm</td>
<td>4.11 (0.92)</td>
</tr>
<tr>
<td>Vulnerable patients need my protection in harmful situations</td>
<td>2.49 (1.20)</td>
</tr>
<tr>
<td><strong>Subscale 2: Work status and advocacy actions</strong></td>
<td></td>
</tr>
<tr>
<td>I may suffer risks to my employment when acting as a patient advocate</td>
<td>2.41 (1.22)</td>
</tr>
<tr>
<td>Nurses that speak out on behalf of patients may face retribution from employers</td>
<td>1.87 (1.08)</td>
</tr>
<tr>
<td>Nurses that speak out on behalf of vulnerable patients may be labeled as disruptive by employers</td>
<td>1.90 (1.02)</td>
</tr>
<tr>
<td>When nurses inform and educate patients about patients’ rights in the clinical setting, the nurses may place their employment at risk</td>
<td>1.61 (0.84)</td>
</tr>
<tr>
<td><strong>Subscale 3: Environment and educational influences</strong></td>
<td></td>
</tr>
<tr>
<td>I scrutinize circumstances that cause me to act as a patient advocate</td>
<td>3.81 (0.92)</td>
</tr>
<tr>
<td>I utilize organizational channels to act as a patient advocate</td>
<td>3.81 (1.02)</td>
</tr>
<tr>
<td>I would benefit from the advice of ethics committees to be a more effective patient advocate</td>
<td>3.38 (1.14)</td>
</tr>
<tr>
<td>I am able to be a better patient advocate because I have more self-confidence</td>
<td>4.41 (0.78)</td>
</tr>
<tr>
<td>Nurses that are committed to providing good patient care are better patient advocates</td>
<td>4.38 (0.75)</td>
</tr>
<tr>
<td>Increased dedication to nursing increases the nurse’s ability to act as a patient advocate</td>
<td>3.53 (1.07)</td>
</tr>
<tr>
<td>Increased nursing education enhances the nurse’s effectiveness in patient advocacy</td>
<td>1.67 (0.78)</td>
</tr>
<tr>
<td><strong>Subscale 4: Support and barriers to advocacy</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of time inhibits my ability to act as a patient advocate</td>
<td>4.36 (0.79)</td>
</tr>
<tr>
<td>Nurses practice patient advocacy more when they are working in a tolerant work environment</td>
<td>4.23 (0.88)</td>
</tr>
<tr>
<td>Nurses who are supported by physicians are better patient advocates</td>
<td>4.40 (0.78)</td>
</tr>
<tr>
<td>I doubt my own abilities to provide advocacy for my patients</td>
<td>1.71 (0.76)</td>
</tr>
<tr>
<td>I am less effective at speaking out for my patients when I am tired</td>
<td>2.53 (1.29)</td>
</tr>
<tr>
<td>I am not an effective advocate because I am suffering burnout</td>
<td>1.56 (1.14)</td>
</tr>
</tbody>
</table>

a The results of the RNAs’ answers on each item are presented with mean scores and standard deviations (SD) for the sake of clarity, although the answering alternatives on PNAS-Swe are on an ordinal scale level. Each item is rated on a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree).
In Studies I and II, the nurses described that they lacked support from managers, which could lead to an inability to address unsafe practice (Study I). The PNs felt constrained from taking actions on behalf of the patient, due to conflicting loyalties; they were caught between the professional expectation that they should advocate for the patient and the tradition that the surgeon/anesthesiologist has the final say (Studies I and II). When analyzing the RNAs’ responses regarding how their work status and employment might be affected when advocating for their patients (subscale 4, Table 4) they agreed that the practicing of perioperative patient advocacy increased if they worked in a tolerant work environment, and that they were better advocates for their patients when supported by physicians who facilitated them in providing protective nursing advocacy (Study III). They also reported that they did not face any retribution or risk of job loss when advocating for their patients (subscale 2, Table 4).

The time allocated to each patient was regarded as insufficient (Studies I-III). In addition, most of the RNAs in Study II perceived that the organization did not have the patient’s best interests at heart, as it was the operation schedule that dictated the pace. This could lead to the nurses being unprepared and thus unable to take care of the patient in accordance with what they believed to be appropriate care (Studies I and II):

... it’s difficult when the patient has to go to the loo... I say yes, certainly, you can go. I act as if I mean it but deep down inside I think damn, this is going to take a few minutes. It’s crazy and I’m ashamed of my thoughts. I stand there and say of course you can go to the loo, while thinking shit, more time wasted.

From interview no 12, Study II

In Study II the RNAs narrated that they had a moral and/or medical responsibility for the patients’ well-being while in their care, described as an “enormous challenge in order to do the best for each patient every time”.

ANN-SOFIE SUNDQVIST  Perioperative patient advocacy  47
The psychometric properties of the PNAS
The psychometric evaluation of the PNAS included assessment of its content, face, and construct validity.

Content validity
I-CVI ranged from 0.50 to 1.0 for the 43 items. Item 11 was excluded because it had low I-CVI and was judged to be difficult to understand by both expert panel 2 and the authors. Of the remaining 42 items from the original instrument, 25 showed excellent I-CVI (≥0.83), 15 fair (0.67), and 2 low (0.50). These items were retained to enable evaluation of their face and construct validity.

Face validity
No further changes were made to the instrument after the pretest, since the ORNs found the items easy to understand and appropriate. It took them about 10-15 minutes to answer the instrument.

Construct validity
Since six of the items did not load adequately to any factor in Hanks’ original analysis, they were removed before conducting the Rasch analysis.

The five-category rating scale of the 36-item PNAS functioned properly only for subscale 2, work status and advocacy actions. The thresholds for subscale 1, 3, and 4 were disordered, and therefore rating category 2 (neither agree or disagree) was merged with rating category 3 (moderately agree) for these three subscales. This produced well-functioning rating scales with distinctive peaks.

Table 5 on the next page provides an overview of the construct validity and reliability of the final modified version of the Swedish PNAS (PNAS-Swe). Four of the items in subscale 1 (items 2, 26, 27, and 37) and two of the items in subscale 4 (items 42 and 43) showed poor item fit according to the set criteria, and were removed. The PCA of the item residuals showed unidimensionality for all four subscales. No local independence was found between the items in any of the subscales. Item and person reliability of the 36-item PNAS was acceptable for the four subscales, as was person misfit. Item 32 was removed from subscale 2 due to low I-CVI (0.5).
Table 5 Overview of the construct validity and reliability of the final Swedish version of the Protective Nursing Advocacy Scale (PNAS-Swe)

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Misfitting items(^a) (n)</th>
<th>Eigen value(^b)</th>
<th>Local dependency(^c)</th>
<th>Person reliability coefficient</th>
<th>Item reliability coefficient</th>
<th>Person misfit %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acting as advocate</td>
<td>4</td>
<td>1.9</td>
<td>0.26</td>
<td>0.74</td>
<td>0.95</td>
<td>5.5</td>
</tr>
<tr>
<td>Work status and advocacy actions</td>
<td>0</td>
<td>1.6</td>
<td>0.00</td>
<td>0.79</td>
<td>0.99</td>
<td>4.8</td>
</tr>
<tr>
<td>Environmental and educational influences</td>
<td>0</td>
<td>1.8</td>
<td>0.26</td>
<td>0.69</td>
<td>0.98</td>
<td>5.5</td>
</tr>
<tr>
<td>Support and barriers to advocacy</td>
<td>2</td>
<td>1.9</td>
<td>0.18</td>
<td>0.64</td>
<td>1.00</td>
<td>5.5</td>
</tr>
</tbody>
</table>

\(^a\) According to item fit criteria i.e., MnSq >1.3 in combination with Zstd >2.0 or < -2.0
\(^b\) After misfitting items had been deleted
\(^c\) Largest standardized residual correlation between any two items

PNAS-Swe thus consists of four subscales and a total of 29 items (see Table 4, page 46). The optimal rating scale comprised a five-category rating scale for subscale 2 and a four-category rating scale for subscales 1, 3, and 4.
DISCUSSION

The four studies in this thesis provide a description of the complexity of perioperative patient advocacy. It sheds a light on the sometimes difficult and demanding task of advocating for the anesthetized and vulnerable patient. The core of perioperative patient advocacy is interpreted in this thesis as having the patient’s best interests at heart, covering having control of the situation, preserving human values, and being emotionally affected (see Figure 3, page 39).

The results reported in this thesis show that patient advocacy in the perioperative setting is not only about critical decision making and protecting the patient from harm, but also interwoven in all the things that the RNA do for the sake of the patient. The goal of perioperative patient advocacy is to ensure that the individual patients are safely guided throughout their whole perioperative experience; this is achieved when the nurses support the patients’ unique physical and psychological needs. Perioperative patient advocacy is in this thesis interpreted as two folded: the first part consists of all actions nurses take on behalf of their patients, and the second part consists of the nurses’ ethical obligation towards another human being. Although two folded, the two parts are interwoven, when expressed in the actions provided by the RNAs. The first part of perioperative patient advocacy can be linked to the general description of nursing, for example as, outlined by Benner. She describes the essence of nursing in seven competence domains, and argues that patients often need a nurse to defend them, which she terms “the advocacy power”. Since the patients in the perioperative context are regarded as vulnerable due to sedation or general anesthesia, they can be considered completely unable to influence their own situation. Thus, perioperative patient advocacy is linked to nursing, but can be seen as something wider. It can be interpreted as an umbrella where the nurses acts as the patients’ link and protective shield towards the surrounding world (Figure 5 on the next page), covering all nursing and all other actions that are taken on behalf of the patient. This umbrella is upheld by the nurses due to a moral, ethical and medical obligation towards a defenseless, silent, and anesthetized patient.

The second part of perioperative patient advocacy, the ethical obligation towards another human being, is closely related to the biomedical ethical values and principles which involve sympathy and compassion towards another human being. Caring ethics highlights the importance of an emotional commitment and willingness to act on behalf of another,
The surrounding world

Perioperative patient advocacy

Having control of the situation
- Arguing
- Being prepared
- Being one step ahead
- Intervening
- Preventing tissue damage
- Having an hawk eye
- Being vigilant
- Maintaining patient’s systems

Preserving human values
- Empathic and psychosocial support
- Preserving human values
- Informing
- Staying fully focused
- Having eye contact
- Non-verbal communication
- Interpreting
- Upholding the patient’s integrity

The patient-nurse relationship

Figure 5 Perioperative patient advocacy as a protective shield with examples of perioperative advocacy actions undertaken by the nurses in this thesis

where the nurse’s sensitivity to face the patients’ needs and vulnerability are integral parts of their professional morality. It places special importance on mutual interdependence and emotional receptiveness. Relationships in health care include persons that are vulnerable and dependent on professional care givers, in this thesis exemplified as a relationship between a patient that is vulnerable and dependent on the nurse. When the nurse feel for the patient and the patient’s needs are being absorbed by the nurse, a moral relationship is established between them.125

Above the core of perioperative patient advocacy, as identified in this thesis, have been described. Below perioperative patient advocacy will be discussed under the headings of Fawcett’s four concepts human beings, environment, health, and nursing.126 These concepts are used in a first attempt to form a foundation for a future tentative mid-range theory of perioperative patient advocacy.

Human beings

According to Fawcett is the concept of human beings referring to the individuals that are recognized in families, communities, and other groups that might be seen as participants in nursing. The human being was earlier
regarded as a recipient of health care but is today seen as co-actor and participant in nursing.126

The patient
The patient was in this thesis implicitly considered to be vulnerable due to sedation or general anesthesia (Study II), but nevertheless seen as an autonomous and competent human being whose views were taken into account (Study IV). The central belief in several advocacy theories and theoretical models is that the patient is autonomous and has the right to self-determination,2,42,43,45,47 and patient vulnerability has been seen as the most prominent reason for the nurse to advocate on behalf of the patient.2 The patient has the primary responsibility for their health and is able to make their own decisions, but there can be several reasons why this ability is compromised. Vulnerable are referred to as patients who are unable to represent themselves or protect their own rights, needs, benefits, and wishes,2 which in the perioperative setting is related to the silent anesthetized patient.1 Patients may have to be advocated for if they are treated unethically or incompetently by some members of the healthcare team, and sometimes the patients themselves verbally request nurses to act on their behalf.2

In this thesis the patient was seldom referred to as a co-actor in nursing,126 but on the other hand in Study IV when the patient was observed providing the RNAs with information, or when having a dialogue with the RNA regarding the positioning on the operating table or how to hold the breathing mask in front of the patient’s nose and mouth could implicitly have been one expression of the patient as a co-actor in nursing.

Environment
Environment includes the physical surroundings comprising the human beings significant others and the settings in which nursing occur, ranging from private homes to the society in general. The concept refers to local, regional, national, and international, and global conditions, as well as cultural, social, political, and economic conditions that are related to time and human beings. Environment can also be seen as contextual since it is part of an unavoidable setting where the human being consistently is one part.126 Anesthetic nursing takes place in a high-tech environment,26 unavoidable for the patient who is going to undergo surgery. This environment is usually unfamiliar to the patient and has from the patient’s view been described as stressful and frightening.97,127 Factors that affects the environment has in the studies in
this thesis (Studies I-IV) been described as hierarchical structures, lack of support from managers, and time constraints, which is in line with the results from previous studies.28,30,68,72,73,78-81,83

The RNAs in Study III agreed that they were better advocates if they were supported by physicians and if working in a tolerant environment. Leaders who create an environment that facilitates open communication, and the possibility to raise one’s voice against inappropriate treatment promotes nurses’ willingness to advocate for their patients,49,75 which in turn fosters a healthy and caring environment, both for the patients and for the healthcare professionals.128 Since hierarchical structures inhibit people from speaking up in order to prevent erroneous decisions,129,130 leaders that flatten these structures create an environment that promotes team members in speaking up and feeling safe while doing so, resulting in safer patient care.81,131

Time constraints comprises an environmental factor influencing patient advocacy both in the general,28,30,68,80 and the perioperative nursing context.73,83 The nurses in Studies I-III stated that the time allocated to each patient was regarded as insufficient, and the RNAs in Study II perceived that it was the operating schedule that dictated the pace; that the organization did not have the patient’s best interests at heart.

The results regarding speaking up on the patient’s behalf differed between Study I, and Studies II and IV. This might be due to the environmental fact that several studies included in Study I were conducted in countries other than Sweden,132,133 such as the USA4,5,16,79,134 and Australia,135,136 so the differences might be linked to the terms of employment protection in different countries. Employees in Sweden have strong protection through the Employment Protection Act (SFS 1982:80),137 which would have facilitated the patient advocacy role for the RNAs in Studies II-IV, whereas the protection for employees in countries like Australia and USA could be much weaker.138 The responses from the RNAs in Study III are in line with this, as their answers regarding how their work status and employment might be affected when advocating for their patients indicated that they did not believe that their employment was at risk. Studies from other countries, thereby other environmental conditions have shown that advocating for the patient can be risky for nurses since they might be seen as troublemakers,48,49 lose their reputation and credibility,58,78 and sometimes even lose their employment.46,58,78,86
Health

The concept health focuses according to Fawcett on a human being’s lived experience of being healthy or ill, and the sense of well-being. Health includes when the human being is healthy, but also when being ill or dying.\textsuperscript{126}

The goal with perioperative patient advocacy is to ensure that the best and safest possible care is provided to the patient, which implicitly can be interpreted as maintaining the patient’s health. Maintaining the patient’s health is multifaceted task, and to ensure this the RNAs in Study IV were observed having a close interaction with all members in the surgical team. Although everyone had their own professional role, they reminded each other of their responsibilities so that the best possible care would be provided to the patient, thereby upholding the patient’s health and advocating for the patient not only from their own professional point of view but in terms of reminding other team members of their responsibilities towards the patient. Working as a team, as shown in Study IV, has similarities with Benner’s competence domain of organizational work role competencies. If optimal care is to be given to the patient, thereby upholding the patient’s health then everyone involved in the patients’ care has the right to share their own view of what they consider is the optimal care. Working as a team is important in order to provide the patient with an effective treatment, and differences of opinion are inevitable and necessary features.\textsuperscript{124} This gives nurses and physicians greater powers to protect the patients’ best interests,\textsuperscript{18,139} thereby implicitly upholding the patient’s health.

Nursing

Fawcett describe nursing as a caring relationship since it enables a constitution of connection and concern. The concept of nursing refers not only to the actions that the nurses take on behalf of or in cooperation with other human beings, but also to the goals and outcomes of these nursing actions. Nursing is seen as a condition of a mutual process between the nurse and the other human being, which encompasses assessment, labeling, planning, intervention, and evaluation, thus how nursing actions can be achieved.\textsuperscript{126}

The core nursing characteristics identified in this thesis are the perioperative advocacy actions described in having control of the situation and preserving human values. This can be interpreted as a constitution of
connection and concern, where *having control of the situation* represents the nurse’s concern for the patient and *preserving human values* the connection between the nurse and the patient. An overview of the relationship between Benner’s competence domains\textsuperscript{124} and the core nursing characteristics identified in this thesis is presented in Table 6.

<table>
<thead>
<tr>
<th>Competence domain\textsuperscript{a}</th>
<th>Core nursing characteristics\textsuperscript{b}</th>
<th>Advocacy actions\textsuperscript{c}</th>
</tr>
</thead>
<tbody>
<tr>
<td>The helping role</td>
<td>Preserving human values</td>
<td>Building trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respecting the patient’s autonomy</td>
</tr>
<tr>
<td>The teaching-coaching function</td>
<td>Preserving human values</td>
<td>Enabling patient participation</td>
</tr>
<tr>
<td>The diagnostic and patient monitoring function</td>
<td>Having control of the situation</td>
<td>Being one step ahead</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gathering information</td>
</tr>
<tr>
<td>Effective management of rapidly changing situations</td>
<td>Having control of the situation</td>
<td>Being one step ahead</td>
</tr>
<tr>
<td>Administering and monitoring therapeutic interventions and regimens</td>
<td>Having control of the situation</td>
<td>Optimizing, maintaining, and monitoring the patient’s body functions</td>
</tr>
<tr>
<td>Monitoring and ensuring the quality of health care practices</td>
<td>Having control of the situation</td>
<td>Shielding the patient from harm</td>
</tr>
<tr>
<td></td>
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<td>Providing a secure environment</td>
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\textsuperscript{a} Competence domains as outlined by Benner\textsuperscript{124}

\textsuperscript{b} Core nursing characteristics as identified in this thesis

\textsuperscript{c} Examples of perioperative advocacy actions identified in this thesis

These core nursing characteristics covers all nursing and all specific caring practice that RNAs perform on behalf of their patients which harmonizes well with Fawcett’s\textsuperscript{126} concept of *nursing* and they might even be seen as equivalent.

The nurse
The nurse in this thesis is a PN or RNA assumed to exert perioperative patient advocacy by *having control of the situation* and *preserving human values*. The nurse is responsive to other human beings needs, and advocating for the patient is associated with emotional consequences for the nurse, thus *being emotionally affected*. This responsiveness could implicitly be seen when the RNAs used a holistic perspective when providing nursing care. The RNAs paid attention to the “whole person”, by seeing each human
being with their own unique needs behind all the medical technology (Studies I, II and IV).

The nurses’ willingness to advocate for their patients was evident in the results. In Study II this was interpreted as the RNAs holding the patient’s life in their hands, which included both a moral, ethical, and medical responsibility for the patient. Logstrup describes this as an absolute and unconditional ethical obligation. He states that we always exist together, interwoven in other people’s lives, and that this means holding a part of that other person’s life in our hands. The interpretation of the meaning of holding the patient’s life in one’s hand varies; it could be something that seems trivial from the nurses’ view, such as keeping eye contact (Studies I, II and IV), or conversely something crucial, such as preventing other members of the surgical team from making mistakes that could endanger the patient’s health (Studies I, II and IV).

When the patient was unconscious due to general anesthesia and thereby unable to advocate for themselves the nurse acts the patient’s surrogate decider. This implies that the nurse protects the patient’s well-being by assessing all risks and benefits among all options available, instead of the patient. When doing so, the RNA must take into consideration the patient’s previously expressed preferences, values, and perspectives; or perhaps, as found in Studies I and II, use themselves as a metric. In Study II, the RNAs said that when advocating for their patients they tried to imagine the patient’s situation and treated the patient as they themselves would like to be treated; this was also described as a part of perioperative patient advocacy in Study I. When using themselves as a metric the nurses have to put their personal views aside and treat all patients the same.

The RNAs in Study II stated that they followed laws and local guidelines as well as their own values and beliefs when advocating for the patient, which is in concordance with an earlier conducted study. This led to that the nurses sometimes overrode their patients’ previously expressed wishes (Studies I and II), thereby interpreted that they are using the best interests standard when advocating for their patients. The best interests standard can be seen as an aspect of paternalism, as the RNAs might override the patient’s known preferences by intentionally intervening in order to avoid harm or to benefit the patient. The relationship between the nurse’s medical responsibility and the patient’s wishes might therefore be seen as a conflict of interests. The challenge for the RNAs is that if they focus on meeting the patient’s expectations and satisfying the patient’s desires, it could result in poor medical safety jeopardizing the patient’s...
health and well-being. The use of the best interests standard is quite contrary to the principle of respect for human autonomy, which involves respecting the decision-making of autonomous persons, including each person’s right to have their own view and the right to make reasoned and informed consent. This principle also includes a fundamental obligation for all health care professionals to respect a patient’s autonomous choice.125 The reason why the RNAs sometimes override the patient’s wishes is that from a caring perspective they know what is best for the patient (Studies I and II). This might be justified by the use of the principle of beneficence, which entails taking action by helping another person including preventing harm, removing harm, and promoting good. The principle of beneficence includes all forms of action intended to benefit another person, and refers to a moral obligation to act for the benefit of others.125

Having control of the situation

Having control of the situation, which is interpreted as the nurse’s concern for the patient, was in this thesis found to entail specific nursing actions undertaken by the nurse in situations where the patient was unable to advocate for themself (Studies I, II and IV). This can be compared to earlier research into patient advocacy, showing that nurses advocate for their patients to restore the balance in the patient’s self-determination.48,53,55-57,59,68

The implicit meaning of perioperative patient advocacy in this thesis included the nurse acting as the patient’s representative, thereby upholding the patient’s rights. This involved the nurse providing nursing actions that were beneficial to the patients by assessing, labeling, planning, and intervening, but also by evaluating these actions (Studies I, II and IV), which is in concordance with Fawcett’s concept of nursing.126 The actions that were undertaken are comparable to Benner’s competence domain administering and monitoring therapeutic interventions and regimens,124 and similar results have been found in earlier studies, not only in the perioperative setting,1 but also from the general nursing context where nurses protect the interests of patients with impaired ability to satisfy their own needs.33,46,48-50,53

Having control of the situation can be described as the nurses’ being prepared for any upcoming perioperative activities by being one step ahead, thereby linked to Benner’s the diagnostic and patient monitoring function and effective management of rapidly changing situations, since it involves detecting significant changes in the patient’s condition, observing early warning signals, thinking ahead, anticipating problems, and predicting
the patient’s care needs. To intervene and argue on the patient’s behalf implies that the nurses are speaking up for their patients (Studies I-IV), which is consistent with previous descriptions of patient advocacy both from a general nursing context and from a perioperative nursing context. This has similarities with Benner’s competence domain monitoring and ensuring the quality of healthcare practices, since according to Benner it is the nurse who coordinates the multifaceted interaction between the patient and the other members of the health care team, in order to discover and thereby prevent any mistreatment of the patient.

Preserving human values
The connection between the nurse and the patient is incorporated in preserving human values, which is regarded as an important part of perioperative patient advocacy in this thesis. Preserving human values represents several actions undertaken by nurses in order to respect the patient by upholding the patient’s integrity and preserving the patient’s autonomy, which has been described as a basic assumption for patient advocacy. Preserving human values is closely related not only to Fawcett’s concept of nursing, but also to the biomedical ethical values and principles, including emotional commitment to other human beings, and willingness to act on their behalf. This was found both explicitly and implicitly in the results; explicitly when the RNAs verbally ensured the patients that they would be taken care of and that the best care possible will be provided to them (Studies I, II and IV), and implicitly in the non-verbal communication when the RNAs stayed close to the patient, kept eye contact, laid a hand on the patient’s arm, and stayed continuously focused on the patient (Studies I, II and IV) which was interpreted as the nurses tried to obtain the patient’s trust by providing empathic and psychosocial support to the patient (Studies II and IV). The feeling of trust has been highlighted as an important part of the patient’s perioperative experience in earlier studies, since it influences the patient’s emotional balance by reducing stress both before and after surgery, and might reduce postoperative pain and the need for analgesia. This relates to Benner’s competence domain the helping role, where aspects of being close to the patient, providing comfort, and communicating by touch are regarded as important, but so also are making the patient feel engaged in the care given and helping the patient to have control over the situation.
Enabling patient participation through information was implicitly found to be a part of preserving human values in Study IV, as it seemed that the RNAs were trying to make the patients involved in their own care, which has been described as a facilitator for the patient’s understanding of the procedures. Benner states in her competence domain the teaching-coaching function that it is the nurse who informs the patient about what to expect and corrects any misconceptions, in order to guide the patient through the health care system. The nurse makes the unaccustomed and worrying known to the patient and therefore less frightening.

**Being emotionally affected**

*Being emotionally affected* relates to the impact of the consequences that the nurses experienced when providing perioperative patient advocacy to their patients. Patient advocacy in the perioperative setting was not always perceived as easy by the nurses, and could lead to moral stress (Studies I and II) and vulnerability (Study I).

Moral distress and vulnerability has in previous conducted studies been related to that nurses feel an ethical and moral obligation to advocate for the patient, yet not have the authority to do so. It is the nurses conscience or self-reflection about whether someone’s acts are right or wrong, good or bad together with an internal sanction through critical reflection that could trigger this moral distress. Feelings that are connected to moral distress are sadness, guilt, remorse, and frustration, which is described as a feeling of shame by one of the RNAs in Study II (see quotation on page 47).

The results in Studies I and II showed that the nurses experienced a feeling of satisfaction when advocating for their patients, since they were doing something good for another human being (Study II). This is in line with previously results, and is indicated as leading to greater work satisfaction in general nursing settings. The results in the two latter studies show that the positive impact of patient advocacy leads to greater work satisfaction and increased self-esteem, as well as safeguarding nurses’ dignity and moral principles. This feeling of satisfaction - the feeling of doing something good for the sake of another human being - might even be the reason why the nurses persist in their patient advocacy role despite the moral stress and vulnerability it causes them.
Methodological considerations
The results in this thesis are based on data collected with several different methods: an integrated review of earlier empirical studies (Study I), qualitative data collected with interviews (Study II) and observations (Study IV), and quantitative measurements collected with a questionnaire (Study III). Lincoln and Guba suggested the concept of trustworthiness as a way of assessing rigor in qualitative research, consisting of four criteria: credibility, dependability, confirmability, and transferability. Triangulation, which refers to the combination of different methodological approaches and data collecting strategies, has broadened the perspectives in this thesis, which may have strengthened the results, but there are also possible limitations to the studies. The strengths and limitations are discussed below.

Credibility/internal validity
One of the key criteria to ensure trustworthiness in the findings is the establishment of credibility, which can be seen as equivalent to the more positivistic stand of internal validity. Purposeful selection of participants, for example in Study II where the informants were both male and female RNAs from two different hospitals in Sweden with a broad range of anesthesia work experience, might have contributed to a rich description of perioperative patient advocacy, thereby enhancing the credibility of the results. A limitation of the data collection in Studies II-IV, which might threaten the credibility, is that participation in the studies was optional. This might have resulted in non-representative samples, since it is possible that participating RNAs were more interested in or had a more positive attitude towards perioperative patient advocacy. On the other hand, informants with rich experience and willingness to share are valuable in order to achieve a rich description. In Study II, the results of the interviews might have been affected both positively and negatively by the fact that they were conducted by a researcher with the same profession as the interviewees (an RNA). The interviewed RNAs might have been more willing to share their experiences due to feeling safe with an interviewer who had the same profession and was used to the vocabulary. On the other hand some RNAs might have decided not to share their experiences because of a sense of shame or failure. This could be seen as a socially desirable responding, which is a form of response distortion in which participants want to make a good impression. However, the RNAs...
willingly shared their personal views and narrated situations in which they felt that they failed in their advocacy role, which this might decrease the risk of the results being influenced by desirable answers.

There are several other ways in which credibility may be achieved. In order to increase the credibility, an interactive process took place between all of the researchers involving discussion of the analysis until consensus was reached in Studies I, II and IV.\textsuperscript{110} The credibility of the results was further enhanced by presenting examples of the meaning units, condensation, and abstraction (Studies I and II), representative quotations (Study II), and extracts from the observations (Study IV) in order to allow the reader to judge whether the analysis was reasonable in relation to raw data.\textsuperscript{109,110}

Literature reviews have limitations associated with inconsistent search terminology and it is therefore recommended using at least two or three search strategies.\textsuperscript{105,148} Study I therefore included a comprehensive database search which was conducted in cooperation with an experienced librarian, together with a manual search; this might have increased the number of studies eligible to be included in the review.\textsuperscript{105} Each study that met the inclusion criterion was appraised in order to systematically investigate the quality of these papers.\textsuperscript{106} This quality judgement was conducted concurrently by two of the authors. Five papers did not meet the quality criteria and were therefore excluded. All these precautions increase the credibility of the results.\textsuperscript{108} The included studies had different types of research design, which according to Whittemore might increase the depth and breadth and, thereby contribute to a more complete description of the topic of interest and enhance the credibility of the overall results.\textsuperscript{148}

The interviews in Study II were transcribed by a secretary, but the transcripts were thereafter read through by one of the researchers while simultaneously listening to the recorded interviews. According to Shenton, this is another way to increase the credibility of the results.\textsuperscript{109}

The credibility of the researcher is especially important in qualitative research, as it is the person who is the major instrument of data collection and analysis.\textsuperscript{146} In Study IV, one of the observations was performed concurrently by two of the researchers, one of them experienced at conducting observational studies; comparison of their jotted notes showed good consistency, which again increases the credibility.\textsuperscript{108,109} Two of the researchers have experience of anesthetic care, having worked as RNAs for several years, another one of the researchers is a RN specializing in pediatric care, and the last researcher is a registered occupational therapist. Three of the
researchers are senior researchers; and this, together with the multidisciplinary roles, may be a strength of the studies, increasing the credibility of the results.\textsuperscript{109} During the observations in Study IV, the observer tried to be discreet and neutral in order to minimize the intrusion, and also tried to avoid interactions with the team members. This was sometimes difficult, and can be seen as a limitation of the study. Despite the risk of influencing the observations, thereby decreasing the credibility, covert data collection\textsuperscript{108} was not regarded as an alternative since it is never easier and preferable than overt data collection.\textsuperscript{107} Video recording was considered as more intrusive than the presence of a single observer since RNAs are accustomed to working closely with others and thereby being indirectly observed. During the observations the RNAs seemed to ignore the observer, and several of them later confirmed that they had forgotten that they were being observed, and so continued with their work as usual. The observer spent several days in the anesthesia department before commencing the observations in order to be a familiar face to the staff. This prolonged engagement was undertaken in order to gain an adequate understanding of the organization and to establish trust between the researcher and the RNAs.\textsuperscript{145}

Fourteen items from the original PNAS were deleted in Study III in order to ensure content validity, leaving 29 items to be included in PNAS-Swe. Six of the items were deleted since they did not contribute to the original instrument,\textsuperscript{31} two of the items due to low I-CVI, and the remaining six items due to poor item fit (see Figure 2, page 33). Of these 29 items, 10 showed fair I-CVI (0.67) while the remaining 19 showed good or excellent I-CVI.\textsuperscript{117} According to Lynn, all items with an I-CVI below 0.83 should be removed from an instrument before distributing it to potential participants.\textsuperscript{116} The decision of retaining or deleting items was based on weighing together the results from three different validity evaluations (content, face, and construct), and the items with fair I-CVI were retained since they were considered to contribute something unique to each subscale. The I-CVI calculation was not reported when the original PNAS was constructed,\textsuperscript{31} which made it impossible to compare I-CVI values between the two versions. The construct validity evaluation was performed by measuring unidimensionality, item-fit, and local dependency between any two items, and it showed good general measurement properties for the four subscales of PNAS-Swe. Concerning the rating scale functioning, three of the four subscales in PNAS-Swe showed disordered thresholds indicating a possible problem. Two of the rating categories (2 and 3) in subscale 1, 3, and 4 were therefore collapsed, leading to a
well-functioning rating scale with distinctive peaks. The rating category neither agree or disagree was more frequently responded to than the rating category moderately disagree from the original five-point Likert scale, which indicates that the rating scale could benefit from being asymmetric. Retaining the rating category neither agree or disagree and only deleting moderately disagree might be sufficient for a new wording. It is possible that this could introduce bias, since the rating scale would be asymmetrically weighted towards agreement, but changing the rating category strongly disagree to disagree might bring it back into balance. A possible new four-point Likert-scale might then range from 1 (disagree) to 4 (strongly agree), with the scale steps 2 (neither agree or disagree) and 3 (moderately agree) in between. PNAS-Swe needs to be used with these new and revised rating scales in order to confirm their validity.

**Dependability/reliability**

In the positivistic paradigm, different techniques can be used to show that similar results would be obtained if the study was repeated in the same context, with the same methods, and with the same sample. In the naturalistic paradigm, reliability has similarities with dependability, and the processes within the study should be reported in detail in order to enable a future researcher to repeat the work. Another way to increase the dependability of the results is for the researcher to be consistent when collecting and analyzing the data. An interview guide was employed in Study II to ensure dependability of the interviews, and in Study IV an observation protocol with the predeterminated categories was used to ensure dependability of the observations. The transcribed detailed field notes in Study IV were analyzed stepwise by analyzing all categories one by one, in one observation at a time, until all categories and observations had been analyzed. This was done in order to enhance the dependability of the analytical process.

In Study III, the four subscales from the original PNAS were retained in the Swedish version of the instrument in order to keep the two versions as similar as possible, thereby increasing the reliability of PNAS-Swe. Three of the subscales in PNAS-Swe (1, 2 and 3) showed satisfactory reliability coefficients while the person reliability coefficient for subscale 4 was lower than the conventional lower limit of 0.67. Despite this, the subscale was considered reliable since it only included a few items which in itself may lower the person reliability coefficient.
In Study III, Vårdförbundet\(^{114}\) distributed the instrument and the two reminders as a web survey to their RNA members who had an e-mail address registered within the organization. Since the members update their e-mail addresses themselves, it is impossible to know how many of these addresses were up to date, and hence impossible to know how many of the potential participants received the web survey. This is a weakness of the data collection. If the instrument and reminders had been distributed on paper by ordinary mail to all of the potential participants, a larger proportion of the RNAs might have received the web survey. The low response rate (19% after two reminders) from the RNAs is another limitation influencing the reliability of the results in phase III of Study III. The relatively large number of items (n=42) in the questionnaire might have been the reason for this. An increased response rate might have been possible if all of the items with low I-CVI and the items that did not load adequately to any of the subscales in the original PNAS had been removed before the instrument was distributed.\(^{150}\) When the response rate from this study is compared with the results from similar studies, for example Hanks development of the PNAS, where the response rate was 10%,\(^{31}\) and Bu and Wu’s development of APAS, where the response rate was 19%,\(^{74}\) there are indications that there might be a problem with achieving a high response rate in this type of study.

A limitation of Study IV could be that the predetermined categories used when gathering and analyzing the observations originated from the results in Study I, where the participants in the included studies were nurses with different professional roles working in the perioperative setting (ORNs, RNs, and RNAs). The reason to include studies with both ORNs and RN working in the perioperative setting instead of solely RNAs was that there was a lack of studies of perioperative patient advocacy from the viewpoints of the RNAs, and therefore impossible to conduct an integrative review from their point of view. Study I was nevertheless used for the observation and analysis process in Study IV, since the results in Study I involved nurses working in the perioperative nursing context, and not in a general nursing context. The observations in Study IV were made with only RNAs and this might have increased the dependability of the results. The content of the 11 subcategories that emerged during the analysis in Study IV was more systematically described than the content of the categories in Study I, since Study IV used empirical raw data with more contextual information than the data in Study I, where the analysis was based on the results from previously conducted studies, including the
interpretations made by the original authors. This might have increased the dependability of the results in Study IV.

**Confirmability/objectivity**
Confirmability in qualitative research is comparable to objectivity in quantitative research, meaning that the results should reflect the experiences of the informants and not the researcher’s perception.\(^{145}\) The use of a tape recorder in Study II increases the confirmability,\(^ {109}\) and the observations in Study IV were conducted in a setting where none of the observers were employed, which is in accordance with the methodological literature since it enhances confirmability.\(^ {107}\)

The observer is the instrument for data collection in observational studies.\(^ {107,109}\) Since the main observer in Study IV was a RNA, prior to entering the observational phase she reflected together with a senior researcher upon her preunderstanding of perioperative patient advocacy and her expectations of what she might find in order to increase confirmability.\(^ {109}\) This preunderstanding of the context could still be seen as a limitation since it can influence the confirmability,\(^ {146}\) but it can also be regarded as a strength, since it was the prerequisite that made it possible to capture the complex work process during the observations in Study IV. The preunderstanding of the context was used in order to deductively analyze the observations in a more constructive way. An inductive analysis might have threatened the confirmability to a higher degree.

A possible limitation of Study I is that one of the studies included in the review was performed by two of the researchers themselves. They strived to bracket their presuppositions during the analysis, and thus meet the data naively. During the analytical process they repeatedly returned to the data in order to avoid being interpretive. To increase confirmability, the two other researchers critically revised the analytical process and results.

**Transferability/external validity**
Determination of the possibility of transferability rests with the reader,\(^ {145}\) and its quantitative correlate is external validity. The results in quantitative research should be applicable to a wide population, but this is impossible in qualitative research since the findings are often specific to a small number of participants in specific contexts.\(^ {109}\) The patterns identified in qualitative research are dependent on context, which influences
transferability.\textsuperscript{109,110} Demographic data were therefore provided in Studies II and IV in order to enable the reader to draw conclusions on similarities between the study context and the context to which the results are to be transferred.\textsuperscript{110}

The studies included in Study I were conducted in three western countries (the USA, Australia, and Sweden), and thus had a western world perspective. However, the fact that they originated from three different countries, rather than just one, might strengthen the results and enable the reader to draw conclusions about the transferability of the findings, at least from a western world perspective.\textsuperscript{145} Study III was a cross-sectional study conducted in a Swedish context with a small sample, which threatens the external validity of the results. Demographic data have nevertheless been provided in order to help the reader to judge if there is a possibility of drawing any conclusions between the results and a wider population of RNAs.
Clinical implications and future studies

Perioperative patient advocacy is in praxis linked to the code of ethics outlined by the ICN, which despite having no explicit mention of advocacy still states that all RNs, regardless of their working context, shall respect human rights, promote health, prevent illness, and ensure that the individual receives accurate and sufficient information. This thesis has elaborated on how this is done, by describing the complexity of perioperative patient advocacy. The results presented here show how RNAs exert perioperative patient advocacy and how they interact in order to facilitate the best possible care for the patient. Upholding the self-determination and autonomy of the anesthetized and vulnerable patient is sometimes perceived by the RNAs as difficult and demanding, but nevertheless regarded as an important part of their patient care.

The clinical implications for perioperative patient advocacy are found not only in the ethical and medical responsibility the RNAs have for their patients, but also in the interpretation of Swedish laws and regulations. Different aspects of patient advocacy are mentioned implicitly in Swedish laws and regulations, such as speaking for the patient, protecting the patient’s rights, upholding the patient’s right to self-determination, safeguarding the patient’s right of receiving understandable information, and protecting the patient from improper medical and ethical treatment. According to the Swedish Health and Medical Services Act (SFS 2017:30) and the Swedish Patient Safety Act (SFS 2010:659), the patient shall be provided with understandable information so that the care can be given in consultation with the patient. The care should be based on respect for the patient’s autonomy and integrity, and provided with respect for human equality and for individual human dignity. This relates to the part of patient advocacy in which healthcare professionals give understandable information to the patient so that the patient can make informed decisions about their own care, but it is also involved in protecting the patient’s rights and upholding the patient’s right to self-determination. Furthermore, healthcare professionals are required to contribute to high systematic patient safety, which can be interpreted as an obligation to protect the patient from improper medical and/or ethical treatment.

The results in this thesis may, with what is already known, form a base for theory development within the perioperative nursing context in the future, and build the foundation of a tentative mid-range theory of perioperative patient advocacy. This can be seen as important, since theory development can define a profession; in this case, the RNA profession.
Moreover, a tentative mid-range theory of perioperative patient advocacy could be used in the education and practical training of RNA-students in order to help them understand practice in a more complete and insightful way.\textsuperscript{153}

Figure 7 on the next page gives an overview of a proposal for the basis of a future tentative mid-range theory of perioperative patient advocacy with the possible main theme \textit{having the patient’s best interests at heart}. The subtheme \textit{safeguarding and caring} from Study I has been replaced with the subthemes \textit{having control of the situation} and \textit{preserving human values}, which were first introduced in Study IV and then reused in the results in this thesis. As a part of developing a tentative mid-range theory, the category \textit{informing}, with its subcategories \textit{gathering information} and \textit{sharing information}, has been merged into the subcategories included in the category \textit{protecting}. This is due to the fact that the categories \textit{protecting} and \textit{informing} in Study IV were more closely related to each other — almost interwoven — than identified in Study I. The relationship between these categories became evident when it was observed that the RNAs seemed to gather and share information to be able to take precautions in order to be one step ahead, to optimize, maintain, and monitor the patient’s body functions, and to provide a secure environment, which are three of the four subcategories interlaced within the category \textit{protecting}. This needs, however, to be further empirically studied. In order to further extend the findings from the subtheme \textit{being emotionally involved} from Study I, which comprises the categories \textit{vulnerable}, \textit{constrained} and \textit{satisfied}, interviews with RNAs should be carried out and analyzed in a future study. This second subtheme and its three categories were not investigated in Study IV, since they are the consequences connected to the perioperative patient advocacy actions that the RNAs take on behalf of their patients. Since it is difficult (nearly impossible) to observe feelings, interviews have to be conducted in order to gain an in-depth knowledge.
The emerging process

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<td>Observations with RNAs</td>
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<td>Empowering patient participation</td>
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Another challenge for a future study is the large number of items in PNAS-Swe, and the issue of the items with fair I-CVI in Study III. Further modification or deletion of the items may have to be performed. Three of the four subscales showed disordered thresholds, and so two of the five rating scales for each of these three subscales were collapsed. Since no retest has yet been performed, it is not possible to know if the four subscales with their collapsed rating scales are stable over time. Further tests are therefore needed in order to confirm the validity of the revised rating scales.
CONCLUSIONS

This thesis deepens the understanding of RNAs’ perioperative patient advocacy actions and contributes to a new insight into the RNA’s professional role. Perioperative patient advocacy is a complex process, and in this thesis its core is interpreted as having the patient’s best interests at heart, embracing everything that RNAs do for the sake of their patients.

Perioperative patient advocacy has similarities to nursing care, both from a general nursing context and an anesthetic nursing context, but consists of something wider. The patients are regarded as autonomous and competent, but also vulnerable since they become unconscious due to sedation/general anesthesia, and are therefore completely unable to act on their own behalf. Hence, the RNA can be seen as the patient’s representative and link to the surrounding world; doing everything the patient cannot do for themselves, conveying the patient’s previously expressed wishes, and thereby upholding the silent patient’s autonomy and self-determination. The RNAs are the patient’s eyes, ears, lungs, and circulation. They use all their senses in order to be the patient’s vicarious autonomy, almost becoming one with the patient. It is like an umbrella, covering all the nursing care and all the actions that the RNAs take on behalf of their patients when they are unable to do so themselves. Advocating for the patient is not always perceived as easy, and being questioned and not taken into account can cause moral stress and feelings of vulnerability. Nevertheless, RNAs is found to summon up courage and stand firm in their beliefs, since perioperative patient advocacy means defending the rights of a defenseless human being.

Perioperative patient advocacy is an ethical, moral, and medical responsibility towards another human being, where the RNAs are holding another person’s life in their hands.
SAMMANFATTNING PÅ SVENSKA

Patientföreträderskap (patient advocacy) kan beskrivas som att agera på patientens otillfredsställda behov, vilket innefattar åtgärder såsom att informera och tala för patienter. Det har också beskrivits som en situation där patientens onskemål, rädsla, utsatthet eller hot mot mänskliga rättigheter gör att sjuksköterskan agerar för att skydda patienten.

Tidigare internationell forskning har visat att patienter i samband med en operation kan uppleva förlust av de grundläggande mänskliga rättigheterna integritet, självbestämmande och människovärde. Denna förlust kan vara mest påtaglig när patienten skall genomgå en operation som kräver narkos, då detta innebär att patienten inte kan påverka sin egen situation utan är beroende av att någon annan skall föra hens talan och hjälpa hen med att tillgodose sina behov. Patienten lämnar över kontrollen av sin kropp och måste förlita sig på människor som är helt främmande. Eftersom tidigare forskning gällande anestesijuksköterskans patientföreträderskap är sparsam och inte alls studerats i ett svenskt sammanhang var målet att denna avhandling skulle kunna bidra till en större förståelse för vad patientföreträderskap inom anestesiomvård innebär.

Avhandlingsarbetets övergripande syfte var därför att få en fördjupad förståelse för patientföreträderskap i det perioperativa sammanhanget genom att undersöka vad som är dess karaktäriska och vilka konsekvenser som följer med patientföreträderskap (Delstudie I). Avhandlingen sylvtade även till att beskriva anestesijuksköterskans uppfattning och erfarenhet gällande patientföreträderskap inom anestesiologisk omvårdnad genom intervjuer (Delstudie II), ett instrument/frågeformulär (Delstudie III), och observationer (Delstudie IV).

Kärnan i det perioperativa patientföreträderskapet har utifrån resultatet i avhandlings fyra delstudier tolkats som att ha patientens bästa för ögonen vilket inbegriper att ha kontroll över situationen, bevara mänskliga värden och bli känslomässigt påverkad (Figur 8).

<table>
<thead>
<tr>
<th>Att ha patientens bästa för ögonen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karaktäriska</td>
</tr>
<tr>
<td>(Delstudie I-IV)</td>
</tr>
<tr>
<td>Ha kontroll över situationen</td>
</tr>
</tbody>
</table>

Figur 8 Översikt av resultaten från de fyra delstudierna
Perioperativt patientföreträdarskap är komplex och dess karakteristika och de konsekvenser som följer med detta är i Delstudie I beskrivet som att Göra gott för en annan människa – en balansgång mellan filantropi och personlig tillfredsställelse. Resultaten avseende dess karakteristika inbegriper de åtgärder sjuksköterskorna vidtar å patientens vägnar i form av att skydda, informera, värdebevara och stödja. Dessa fyra kategorier har använts vid observationerna av anestesisjuksköterskorna i Delstudie IV, och resultatet i den studien visade att alla fanns representerade i klinisk anestesiologisk omvårdnad. Att hålla patientens liv i sin hand tolkades i Delstudie II som essensen av anestesisjuksköterskornas uppfattning av patientföreträdarskap, vilket innebar att anestesisjuksköterskorna genom att känna ett moraliskt åtagande ger patienterna en värdig och säker omvårdnad. I Delstudie III ansåg anestesisjuksköterskorna att de skyddade sina patienter genom att agera och föra deras talan, men även att de sjuksköterskor som gav en god omvårdnad var bättre patientföreträdare.

Det fanns både positiva och negativa konsekvenser kopplade till perioperativt patientföreträdarskap. Tillfredsställelse (Delstudie I-II) tillsammans med en känsla av mod (Delstudie II) tolkades som positiva konsekvenser, medan att känna sig sårbar och begränsad (Delstudie I), samt upplevelsen av moralisk stress (Delstudie II) tolkades som negativa. Konsekvenserna var i Delstudie III inte kopplade till de negativa följder som återfinns i Delstudie I och II. I denna studie ansåg anestesisjuksköterskorna istället att de kände stöd när de företrädde patienterna.


Perioperativt patientföreträdarskap är ett etiskt, moraliskt och medicinskt ansvar gentemot en annan människa, där anestesisjuksköterskan håller en annan människas liv i sina händer.
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