

# 'I've just got to take that risk and have faith . . .': The challenge of gaining and maintaining trust in patients undergoing knee surgery with a regional anaesthetic

**Luke Ewart**

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## Abstract

Traditionally, the focus of the operating theatre has been on conducting safe, efficient surgery with unconscious patients. However, the care of awake patients is now a prominent feature of modern perioperative practice as the volume of surgery performed under regional anaesthesia increases. The aim of this novel study was to understand the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment. Data were gathered through observation and ethnographic interview and analysis followed a constant comparative grounded theory approach. The concepts of Trust and Faith are identified as recurrent themes highlighted in the data. This article identifies the need to understand patients' expectations regarding the clinical encounter and how subsequent treatment will develop, so that, reasons for any deviation can be discussed openly and an explanation provided. Each clinical encounter takes place within a relationship based upon an uneven distribution of power, enacted through the interaction itself, with the health care professional in a dominant role. It is the responsibility of health care staff to recognise and negate this power imbalance and reinforce trusting relationships so information and treatment options are not presented as a 'fait accompli' but negotiated through jargon free easy to understand language.

## Keywords

Trust / Faith / Regional anaesthesia / Ethnography / Knee surgery / Power

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## Introduction

The operating theatre is a unique environment, which is both highly specialised and technological. There is a need for perioperative staff within the operating theatre to combine patient care with technological ability while retaining the centrality of the patient to this work (Bull & Fitzgerald 2006). For the patient, the operating theatre is an alien environment, as although their surgical procedure will have been explained to them, the nature of the activities that make up this work remains unknown. In contrast, practitioners are well versed in the technologically driven perioperative routines of care that make up this work. This may focus attention away from patients, resulting in a degree of dehumanisation, stress, fear and ambivalence (Barnard & Sandelowski 2001, Kleinman 1988, Missel et al 2022).

During the perioperative period, patients have distinct requirements that need specialised care. Scheduled surgery is essentially a planned trauma that affects the whole person, during which time the individual depends entirely upon others. Issues of identity and agency are

significant when considering patients' surgical experiences. Since agency is a human capacity and process to act and make choices (Hardin 2001), it has the tendency to shift along a continuum during illness. When individuals do not, or cannot fully enact agency during the course of illness, the way they define and understand themselves shifts. Perioperative staff caring for the patient during surgery ordinarily adopt a medical or scientific perspective towards the patient's body, whereas patients view this experience from a lived perspective. For staff, the extraordinariness of medical technology becomes ordinary and familiar in ways that may deter practitioners from recognising that

Canterbury Christ Church University, Canterbury, UK

### Corresponding author:

Luke Ewart, Canterbury Christ Church University, Rowan Williams Court, 30 Pembroke Court, Chatham Maritime, Kent, ME4 4UF, Canterbury, UK.

Email: luke.ewart@canterbury.ac.uk

patients are undergoing an unfamiliar, traumatic and life-altering event (Lapum et al 2010).

Much of the population faces a surgical experience at some point in their life, and as all Western countries are experiencing growth in the number and proportion of older persons in their populations (ONS 2018), this is likely to have a direct impact on the future of anaesthesia and surgical care. The type of anaesthetic used for many surgical procedures now involves a local or regional rather than general anaesthetic. This anaesthetic technique is advocated as a part of the enhanced recovery after surgery (ERAS) programme and has been associated with early mobility (McDonald et al 2016) and early discharge (Frassanito et al 2020). The relative safety of regional anaesthesia means that many orthopaedic patients who would previously have been denied an operation, because of the dangers associated with a general anaesthetic in the presence of comorbidities, are now able to have surgery. A meta-analysis of randomised controlled trials suggested that regional anaesthesia is associated with both a reduced initial mortality rate and lower incidence of deep vein thrombosis in comparison with general anaesthesia in hip fracture patients (Urwin et al 2000). However, this represents only one part of a complex perioperative experience and to assess patient outcomes fully, it is necessary to look beyond the traditional outcome measures of morbidity and mortality and to recognise that measures of patient experience are equally important indicators of outcome quality.

As orthopaedic surgery is increasingly being conducted with a regional anaesthetic (Neal-Smith et al 2021), there is a need to understand the context of the lived experience of orthopaedic patients remaining conscious in the operating theatre. In addition, an understanding of this experience may identify the skills, attitudes and behaviours that staff need to ensure the patient's perioperative experience is a positive one. In short, more knowledge and a clearer understanding of how people experience orthopaedic surgery while conscious with a regional anaesthetic may therefore lead to being able to offer improved perioperative care to these patients.

## Methods

### Design

This research project was conducted in an acute UK hospital, which provides a range of emergency and elective services and is one of several sites that make up one of the largest National Health Service (NHS) Trusts, serving a population of around 750,000 people. The study employed an 'ethnographic mosaic' design (Ewart & Blackman 2022, Palmer 1928), where ethnographic interviews and participant observation were carried out to gather data consisting of 22 interviews and 122 pages of transcribed field notes.

Ethnography often involves a combination of data collection techniques to assess the validity of inferences between indicators and concepts by examining data relating to the same concept from numerous sources, such as interviewing, participant observation and/or documents (Hammersley & Atkinson 2007). Thus, what was learnt through participant observation helped not only to understand data collected through staff interviews and preoperative and postoperative patient interviews, but also to highlight questions for those methods to enhance understanding of the phenomenon being studied. The advantage of this study design was to allow the phenomenon under investigation to be examined within the social and cultural context in which it exists.

### Positionality and reflexivity

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

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

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

The character of social research (and ethnographic research in particular) is such that exploration and engagement involves co-constructing the social world in collaboration with the actors we engage with through observation or discourse (Atkinson 2017). For example, my professional background is based firmly within the operating theatre and although I have not been in regular clinical practice for several years, I have maintained my registration as an Operating Department Practitioner with the Health and Care Professions Council. Thus my positionality will be influenced not

only by my experiences and role in the operating theatre, but also by the experience of the politics that have played out in the development of my profession in relation to nursing and medical colleagues.

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

. . . reflects the position that the researcher has chosen to adopt within a given research study (Savin-Baden & Howell-Major 2013: p71).

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

### *Recruitment/sample*

Sample size is not of primary importance in qualitative research design. The important factor relates to whether the participants encompass the range and diversity present in the target population to ensure coverage of defining characteristics that are relevant to the research question (Lincoln & Guba 1985). A variety of factors can influence the amount of data qualitative researchers gather, and this is not only restricted to numbers of interviews, but also by the presence of participant observation. This study employed a combination of two non-probability sampling strategies: convenience sampling for patient participants and purposive sampling for staff participants. Two adult

patients scheduled for joint arthroscopy with local anaesthetic (local infiltration into the knee capsule) and five adult patients scheduled for knee arthroplasty under spinal anaesthesia (as part of an enhanced recovery programme) were recruited to the study and interviewed both before and after surgery. Although it is normal for this patient population to receive sedation as a part of the anaesthetic, this is not administered until after the local or regional anaesthetic and is classed as minimal or moderate sedation, meaning that patient responsiveness remained 'normal' or 'purposeful' throughout (ASA 2019). The number of participants engaged within this study offers the advantage of penetrating beyond a small number of people without generating an unmanageable amount of data and is considered an appropriate number, particularly as the 22 interviews undertaken were supplemented with participant observation amounting to 122 pages of transcribed field diary. The data from interviews and observation provided an opportunity for participants' interpretations to be expanded upon and what was observed could be clarified.

### *Data analysis*

Field notes were made during participant observation to keep an accurate record of relevant points and were produced day by day to describe or recount the events, experiences and interactions of the ethnographer in the field at that moment. In addition, participants undergoing scheduled surgery for knee arthroscopy, or knee arthroplasty under regional anaesthesia, each took part in individual audio-recorded interviews prior to their operation. These interviews followed an ethnographic interview approach, which differs from a traditional interview in that there is no structured interview guide. Instead, the interview attempts to build a rapport with participants to encourage an opening up which enables participants to express themselves in their own way. The goal of these interviews was therefore to gather rich, detailed data directly from the participants, in their own words and in the social milieu under investigation (Heyl 2013).

Data analysis took place through a constant comparative approach that followed the six steps of grounded theory methodology (Glaser & Strauss 1967). Data from the transcripts of interviews and contemporaneous field notes from participant observation were classified, sorted and arranged using the software programme NVivo 12. Analysis was carried out within case (ie: looking for themes within each transcript) and across case (ie: between the different transcripts) and began with reading, re-reading and annotating the transcripts to identify themes, concepts and categories within and across the transcripts and field notes. This was an inductive process that involved learning from the data rather than starting with preconceived notions about the subject matter (Tie et al

2019). Codes were then organised around concepts, from which patterns or themes developed and a sense of possible connections between the information was gained.

### Ethical considerations

The study was approved by the NHS Health Research Authority (16/SC0153) and Trust Research and Development department. All participants were treated in compliance with the ethical principles on human research. Written consent was obtained from each participant before entering the study. The participants were informed of the purpose of the study, and anonymity and confidentiality of the data were assured. The participants were also informed about their right to withdraw from the study at any time without needing to state a reason. The participants were assured their care would not be affected in any way if they declined to take part in the study. All participants were informed some of their words might be quoted, but it should be noted that pseudonyms have been used throughout and other modifications made at the time of transcription to ensure anonymity has been maintained. In addition, other characteristics, such as job title or ethnicity, have also been changed to conceal identities and maintain the confidentiality of the data provided by participants.

### Results/discussion

Trust was identified as a key theme since it was most prominent across the data set. In other words, this key theme was repeatedly articulated by different interview participants and was frequently observed during participant observation. Denzin (1997) suggests ethnographic researchers enter the same terrain as 'storytellers' when writing about social, cultural and medical situations. By presenting the theme identified through the data analysis in this way, the intention is to provide a feasible account or 'story' of the experience of being a conscious patient during regional anaesthesia and knee surgery in the perioperative environment.

The concept of trust is a human universal, which can be found in all societies throughout history (Pilgrim et al 2011). Definitions of trust vary (eg: it can be both a noun and a verb), but it can be regarded as 'a characteristic belief that the good will, sincerity, or truthfulness of others can generally be relied upon' (Rotter 1967: p651).

Trust at its most positive is a comforting experience, which rewards the placing of trust in friends and relatives in ongoing predictable relationships with a sense of wellbeing and belonging (Pilgrim et al 2011). Han et al (2022) have suggested that establishing trust may be as important as providing timely information and following up on the patient's understanding.

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

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

*Astrid:* Yes. I want them to take control. They know what they're doing.

*Interviewer:* So how much do you know about these people that you're giving over control to?

*Astrid:* Absolutely nothing.

*Interviewer:* So how are you comfortable giving over control to someone you don't know?

*Astrid:* Well I've just got to take that risk and have faith. These people, they are all people out there who've got a



*job where they want to help people. They've only got the, that interest, you know and if anything went wrong it would be just fate, an accident.*

Here, Astrid acknowledges that she has no knowledge of the individual practitioners, but has faith in them as they represent the professions, which in turn make up the health service. In other words, Astrid has faith in the institution and the individual elements that make up that institution. Calnan and Rowe (2006: p16) refer to this as an embodied trust, which involves the patient basing their judgement on the reputation of the organisation or individual. This is supported by the reference to 'fate', which implies that individual practitioners are exempt from blame should anything go wrong during Astrid's treatment.

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

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

Once again, the patient is placing trust in an organisation rather than an individual who is known to them. Whereas this type of trust in an individual who is not known personally would normally be a form of thin interpersonal trust, the knowledge of the organisation as having a trusted position in society, means that a thick interpersonal trust is replaced by faith in the organisation as a whole.

These data extracts demonstrate how patients use faith as a strategy to have confidence in the 'they' which is the health care team, despite knowing nothing about these individuals and not having met them previously. This fits with both Uslaner's (2008: p104) notion of 'moralistic trust' where trust is viewed as having a moral dimension that requires people to be treated as if they were trustworthy and Calnan and Rowe's (2006: p16) view that embodied trust implies clinicians altruism is unquestioned and well intentioned. Overall, there is an expectation of the NHS as being worthy of a common faith and holding a position of trustworthiness in the community. However, the extent to which trust in individual medical staff is simply blind faith (Skirbekk et al 2011) bestowed upon individuals as representatives of a wider group, or a kind of conditional trust (Calnan & Sanford 2004) situated somewhere between acceptance and critical trust (Poortinga & Pidgeon 2003) depends upon the specific relationship and the particular circumstances.

The need for trust to develop through an interpersonal relationship over a period of time as in relational

continuity (Haggerty et al 2011) was recognised by surgeons as being important. John [an orthopaedic surgeon] explained it as:

*you get a couple of bites at the cherry to get to know them [the patient] and I think that is really important as a surgeon. When you're going to do such a massive operation on someone and you get a doctor/patient relationship reasonably well established – because things don't always go to plan and if you've just turned up on the day to do something on someone and then you're like a technician and your patient is like, on a conveyor belt, you haven't got that level of trust. They don't really know you . . .*

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

Calnan and Rowe (2006: p16) suggest that patients may rely on an 'informed trust', which is associated with the use of information to calculate whether trust is warranted in a given clinical exchange. In this type of trust relationship, the patient typically weighs up the information given with a greater suspicion and scepticism about others' intentions. The data gathered during the course of the fieldwork indicate when a patient feels their treatment is following a standardised protocol or policy rather than being based on their individual circumstances, a conflict can arise, which undermines trust. This is reflected in the following extract from a preoperative interview with Tina (an arthroscopy day patient):

*Tina: Yes, so you have to start off with a GP appointment, who then says you need an X-ray. I know an X-ray would show nothing. I said 'no I need an MRI' but 'no we can't do that because it's part of the protocol'. So you go for an X-ray, you wait weeks for that result and*

then you wait weeks to go back to the GP to get that result and then he says 'oh you need an MRI' and I said 'yes. I did say that'

**Interviewer:** What was his reaction when you said that to him?

**Tina:** Well I wasn't very happy at that point actually. I wasn't very happy because the initial consultation wasn't great with my GP. So then you wait weeks for an MRI. And then you wait weeks to get the result and then you wait weeks to go back to the doctor.

**Interviewer:** Did you have to chase those results up as well or did they?

**Tina:** I did yes. No I had to chase the results. And then you wait weeks to see an orthopaedic person.

This extract demonstrates how the trust relationship was undermined because the doctor followed a standardised protocol that Tina felt inappropriate for her, rather than one constructed through an interpersonal relationship. This resulted in real and tangible consequences for Tina, as she needed to wait longer before being referred for surgery. Despite the delay being due to a protocol that was dictated by the system, Tina explained this in terms of a poor consultation with the general practitioner (GP) rather than as a fault with the protocol or system. Trust has previously been found to build iteratively through experience, which has been used to explain the greater trust in long-term rather than short-term medical relationships (Kao et al 1998). Long-term relationships have been found to imply a sense of affiliation between the patient and health care professional as in 'my doctor' or 'my patient', which may be referred to in terms of an implicit contract of loyalty by the patient and clinical responsibility by the health care professional (Haggerty et al 2003).

Although patients are often unable to articulate how they make decisions of trust, Mechanic and Meyer (2000) found one strategy was for patients to test their knowledge or expectations against the actions of the doctor. As medical knowledge has become more widely available via the internet, patients are now presenting with some background information and expectations. The role of the medical professional is often to clarify and explain the information the patient already has as well as placing this in the context of the information the doctor is imparting to the patient. Where the patient's expectations and the actions of the doctor do not align, there is an impact on the trust relationship. For Tina, trust in her GP was undermined because she had some knowledge as a nurse, which led her to feel her individual experience was not being understood at the personal level. In other words, her expectations and the actions of her doctor did not align, which resulted in a lack of partnership building in this exchange.

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

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

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

## Conclusions

Trust is a complex and multifaceted phenomenon that is relational in orientation and depends upon a mixture of both past experience and social culture. Trust can either be thick and embodied (Calnan & Rowe 2006), as in the trusting relationship between family or close

friends, or thin and generalised or moralistic (Uslaner 2008), such as the trust in a profession or organisation. Both doctors and patients employ strategies to enable the development of a trusting relationship and the 'bridging' (Mechanic & Meyer 2000) of the knowledge gap present within the power dynamic of the medical encounter.

In deciding whether to trust the surgeon and place themselves in a position of vulnerability during surgery, patients evaluate the information available to them. First, the patient evaluates their personal need for surgery, taking into account the degree of pain and disability. A patient who is in constant severe pain is more likely to accept the vulnerabilities associated with surgery, even when there is a thin cognitive trust relationship, than one who is not. Second, knowledge of the institution providing health care is evaluated. An institution seen as non-exploitative, with a good societal reputation, such as the NHS, can supplant the need for a thick interpersonal level of trust with a moralistic trust (Uslaner 2008). Finally, the use of a shared decision-making model serves to reassure the patient their individual needs and circumstances have been taken in to account as part of the consultation. This communication increasingly involves the explanation of information the patient already has from other sources, which may be contested by the patient. Where the information deviates from the expected diagnosis and course of treatment, without sufficient explanation, the development of deep emotional and affective trust can be undermined.

### Future research

Trust is a universal phenomenon in health care interactions and there are aspects of the experience of this patient group, which are likely to be transferable to other surgical populations. However, there are also likely to be some differences which are worth exploring further. In particular, the tacit skills health care professionals display when developing shared decision-making with patients undergoing surgery is not known and is an area worthy of further research.

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