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PERSON-CENTERED CARE FROM THE NURSE ANESTHETISTS' PERSPECTIVE

A qualitative interview study

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Person-centered care from the nurse anesthetists' perspective, a qualitative interview study

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Abstract: Person-centered care (PCC) emphasizes seeing patients as individuals with unique needs, values, and preferences. In anesthesia care, PCC is challenged by the fact that patients are unconscious for most of the perioperative process. This study aimed to illuminate nurse anesthetists' (NA:s') perspectives on person-centred anesthesia care. A qualitative design was used, and twelve NA:s from three hospitals in southern Sweden were interviewed. Data were analysed using inductive content analysis. The analysis resulted in three main categories: *establishing a trusting relationship*, *assuming responsibility for the patient's needs* and *between production pressure and person-centered care*. Within *establishing a trusting relationship,* NA:s described the brief preoperative encounter as crucial for establishing trust and forming the basis for PCC during anesthesia. Adequate preparation and access to patient information were viewed as essential for anticipating individual needs. The category *assuming responsibility for the patient's needs* illustrated how NA:s safeguarded patients' physical, psychosocial, and relational needs, acted as patient advocates and adapted anesthesia care to individual preferences. The category *between production pressure and person-centered care* highlighted organisational and interprofessional challenges, including production pressures, time constraints, and limited discussion of PCC within teams. NA:s expressed a need for education, structured dialogue, and organisational support to strengthen PCC in anesthesia care. The findings underscore the importance of trust, preparation, and organisational commitment in enabling person-centred anesthesia practice.

Keywords: Anesthesia care, Fundamentals of Care, Patient advocacy, Person-centered care, Production pressure

INTRODUCTION

Person-centered care (PCC) is based on the perspective that patients should not be reduced to their illness or diagnosis, but should be seen as persons whose will, strengths and plans are taken into account.[1] In PCC, the patient is not a passive recipient of medical intervention but an active partner in their own care and the decision-making process. The core principles of PCC include initiating a partnership through listening to the patient narrative as well as sharing information and decision-making. Documenting the patient's narrative, including their preferences, beliefs, values, and involvement in care and treatment decisions, is also essential.[1]

PCC thus requires a healthcare approach that views the patient as a partner in the team.[2] This principle is central to the Fundamentals of Care (FoC) framework, developed in the UK in the late 2000s. The framework aims to improve basic nursing and both PCC and patient safety are emphasized.[3] It identifies *three key dimensions* for delivering holistic, person-centred fundamental care.[4,5] *The first dimension* is a positive and trusting nurse-patient relationship, the foundation on which fundamental care should be based. *The second dimension* focuses on how patients' physical, psychosocial and relational fundamental care needs are met. *The third dimension* relates to the care context, recognizing that the healthcare systems and organisations in which nurses practise play a crucial role in enabling or hindering the delivery of high-quality fundamental care.[4,5] Figure 1 illustrates the content and structure of the framework.

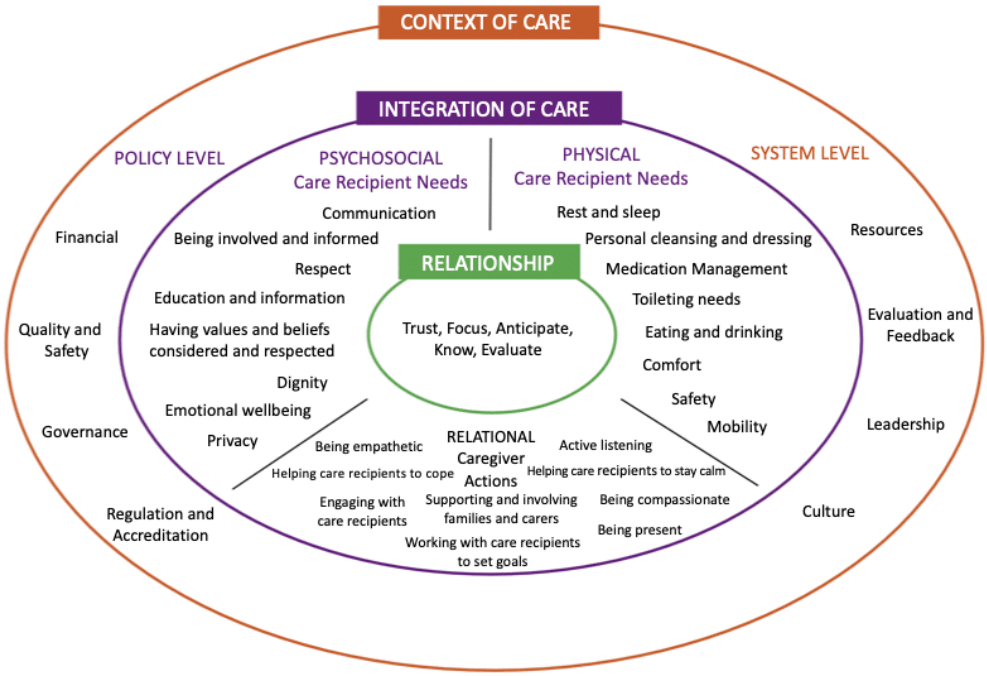

Figure 1. Fundamentals of Care framework[6] (with permission from https://ilccare.org/the-fundamentals-of-care-framework/).

Anesthesia care can benefit from the FoC framework, which although not originally developed for this purpose, can be applied across all care settings without increasing documentation burden or requiring specialized skills.[4] In an observational study, Sundquist et al.[7] found that nurse anesthetists (NA:s) work in a person-centered manner by practicing patient advocacy, and identified connections with key components of FoC, indicating the frameworks usefulness in anesthesia care. A meta-ethnography by Lekens et al.[8] reported that NA:s continuously assessed and responded to perioperative patients' needs from a holistic perspective, in line with the philosophy of PCC. The study also identified obstacles to maintaining a person-centered approach in the perioperative context. NA:s sometimes had to balance addressing patients' needs with providing efficient care, often due to production pressures. Additionally, differences in how team members and professions perceive the patient's situation could lead to conflicting interests.[8] Similar barriers were highlighted in an interview study with NA:s about their experiences in anesthesia care.[9] While this study did not explicitly inquire about PCC, the NA:s' focus on establishing a relationship with the patient and using the data collection before induction to guide care for the anesthetized patient are examples of practices aligned with both PCC and the FoC framework.[9]

When PCC in the perioperative context is described from the patient's perspective, having

enough time for the patient is essential.[10] Being recognized as a unique individual and having the time and opportunity to express one's wishes and needs is important, alongside being treated with dignity and respect.[10] The patient's perspective was also explored in a rapid review of current research on person-centeredness.[11] A recurrent theme was patient preparedness through individually adapted information to facilitate shared decision-making. Patients emphasized that the care provider should be prepared for the individual patient's needs, and that the information should be delivered empathetically and in relation to the patient's situation. A lack of communication made the patients feel unprepared for the treatment and could lead to misunderstandings and mistrust in the healthcare provided.[11]

In previous research, PCC has primarily been described from the patient's perspective, and there is limited research addressing PCC within the anesthesia context. Based on the current state of knowledge, it is evident that a person-centered perspective is present in NA:s' care. However, to the best of knowledge, no previous research has explored NA:s' perspective on PCC and how it is manifested in their clinical practice. Therefore, the present study aimed to illuminate NA:s' perspectives on person-centered anesthesia care.

METHOD

The present study was based on qualitative semi-structured interviews[12], which were analysed using inductive content analysis[13]. Both manifest and latent approaches were employed to capture explicit statements as well as underlying meanings in the data. Green and Thorogood describe the data generated in qualitative research interviews as aiming to explore participants' accounts and compare them with those of others, in order to develop a theoretical understanding of the underlying structures of beliefs.[14] The Consolidated Criteria for Reporting Qualitative Research (i.e., COREQ) checklist[15] was used to optimize the reporting of the study (Appendix 1).

Context

To work as a NA in Sweden, there is a mandatory one-year post graduate education after which license is issued through the National Board of Health and Welfare.[16] NA:s independently (elective patients ASA I and II) or in collaboration with an anesthesiologist induces, maintains, and terminates the general anesthesia.[17] Furthermore, they assess, plan,

administer, evaluate and document anesthesia measures based on the patient's needs and the specific conditions of the procedure.[17]

Participants and recruitment

The recruitment took place according to convenience sampling, a suitable option when participants need to be recruited from a particular clinical context.[12] The eligibility criteria was certified registered NA:s with a minimum of 1 year work experience in clinical anesthesia. Study participants were recruited from anesthesia departments at hospitals in southern Sweden. Heads of operations at the anesthesia departments at five hospitals were contacted to provide information and obtain approval for the study's implementation in their departments. Once approval was granted, written information about the study, along with the author's contact details, was sent by e-mail to the heads of operating wards.

In the e-mail the heads of operating wards were asked to act as gatekeepers and assist in distributing the invitation to participate to all NA:s in their units. NA:s who were interested in participating in the study were asked to contact the author to schedule an interview. Fourteen NA:s from three hospitals responded to the invitation and agreed to be interviewed. However, two of those cancelled the planned interviews due to illness and were unable to reschedule. Consequently, twelve NA:s were interviewed. The NA selected the time and location for the interview, as well as whether to be interviewed online or in person. All twelve opted for an in-person interview. The participants were between the ages 32-62, seven female and five men. They had worked as NA:s for 1-35 years (mean 11 years). Regarding previous education on person-centered care, four of the participants had attended a lecture on PCC in the workplace and one had more extensive knowledge of the subject.

Data collection

Data were collected through semi-structured interviews. This method is preferred when specific topics or areas of interest are to be explored.[12] Data were collected during August-September 2025. Based on the aim of the study, an interview guide was developed by the author and used during the interviews (Appendix 2), which according to Green and Thorogood[14] is a way to ensure that the topics of interest are covered. The interviewees' responses will also influence the course of the interview and what information emerges from it.[14]

A pilot interview was conducted to test the interview guide and revise the questions if necessary.[12] The pilot interview was also considered important as the author had not previously conducted qualitative interviews. The outcome of the pilot interview indicated that the questions were suitable as the responses addressed the studies aim. Thus, no revisions to the interview guide were needed, and the pilot interview was included in the study. The interviews took place during working hours in a separate room at the participant's workplace, a place familiar to them and at a time that would maximize participation. The location offered privacy, and disturbances were minimized.[12] The interviews lasted approximately 16-39 minutes (median 28 minutes) and, with the participants consent, were recorded on the interviewer's telephone in flight mode. The interviews were subsequently transcribed by the author before the analysis began.

Data analysis

The transcripts were analyzed according to the recommendations made by Elo and Kyngäs[13] description of qualitative content analysis. Content analysis aims to identify themes and patterns in the material and is a common approach used in qualitative research.[14] The content analysis can have either an inductive or deductive approach and be manifest or latent.[13] Inductive analysis derives from the data whereas deductive approach uses a pre-existing theory to analyze the material.[14] For the purpose of this study an inductive approach with both manifest and latent analysis was utilized.

Elo and Kyngäs[13] describe the analysis process in *three phases*: preparation, organizing and reporting. During the *preparation* phase, the transcribed interviews were read thoroughly and repeatedly by the author to gain an overall understanding and become fully immersed in the data. *Organizing* the data in inductive analysis includes open coding, creating categories and abstraction. In the open coding notes and headings were written in the text while it was being read. These notes and headings were then gathered, compared and in some cases merged with others, which resulted in the identifying of 24 codes. All aspects of the content were described in these codes, which then were collected in coding sheets. By recognizing similarities and dissimilarities the codes were clustered into nine subcategories. The next step was to form abstractions of the subcategories to describe the phenomenon, which resulted in three main categories. An example of the analysis process is provided in Table 1. The third phase, *reporting*, involved thoroughly describing the analysis process and the writing of the results. As the interviews were conducted in Swedish, the findings and citations were translated to

English at this point. Links between the results and the data, through authentic citations, were demonstrated in a clear way to ensure trustworthiness.[13] A way to enhance the validity of the analysis is to involve another researcher, to increase the likelihood that the analysis reflects the material.[14] In this study the supervisor has participated in the analysis process by reading the interviews and validating the coding and categorization of the content made by the author.

Table 1. Example of the analysis process.

Segment	Code	Subcategory	Main category
"It is really hard to be a patient in surgery. How do we create the feeling that "I am here, I will take care of you, you are safe in my hands?"	Make the patient feel safe	Brief encounter with the awake patient	Establishing a trusting relationship

Ethical considerations

The study was conducted in compliance with the ethical standards expressed in the Declaration of Helsinki.[17] No sensitive personal data was processed and thus no ethical permission was required[18] however ethical guidance was received from Malmo University´s Faculty of Health and Society advisory ethical board (dnr S2025:685).

The author gave oral and written information and obtained written informed consent from all participants before the interviews. Participation was voluntary, and the participants had the right to withdraw at any time without further explanation. Information regarding recording and storage of the data was provided both in writing and in person at the time of the interviews. To fulfill the confidentiality requirement each interview was assigned a code, only available to the author. Data were stored securely and anonymously in compliance with the Data Protection Act.[19] After each interview the data were transferred to a USB-stick and deleted from the interviewer's telephone. The signed consent forms were stored separately from the transcribed interviews, in locked cabinets accessible only to the author. The author

transcribed the interviews and except for the author, only the supervisor had access to the material. No personal data or information that can be linked to the interviewees or their workplace was transcribed. The results are presented in such way that individual participants cannot be identified, and all data will be destroyed after the project has been approved.

RESULTS

The findings describe the interviewed NA:s' perspective on person-centred anesthesia care. The analysis resulted in three main categories and nine subcategories.

Establishing a trusting relationship

The category *establishing a trusting relationship* includes three subcategories: *brief encounter with the awake patient*, *to be prepared* and *learning through experience*. NA:s described their relationship with patients as a central element of PCC, highlighting the importance of a holistic approach within the anesthesia setting. They stressed that the short period when patients were awake was critical for building trust, which forms the basis for effective PCC once patients are no longer able to communicate their needs or preferences. Establishing such a relationship required thorough preparation and access to adequate patient information, enabling NA:s to anticipate and respond to each patient's individual needs.

Brief encounter with the awake patient

NA:s described the challenge of having a very limited amount of time when patients were still awake. Within only a few minutes, they needed to form a connection and exchange essential information. Patients' previous experiences, expectations and concerns were to be considered and integrated with technical and medical aspects when planning care. Seeing the person beyond the diagnosis, a holistic view, was portrayed as fundamental for instilling a sense of security in the patient and forming an alliance.

> *"You have five minutes to get to know the person and create that feeling that I am here, I will take care of you, you are safe with me." (participant no. 9)*

Meeting the patient without a face mask and attempting to be at the same level as the patient were mentioned as strategies to gain the patient's trust. By listening to the patient, interpreting their body language and sensing their mood, the NA:s tried to identify the patient's specific

needs and strived to give the patient a feeling that they were there for them, and that they could safely entrust themselves to their care. Language barriers and cultural differences were identified as obstacles that could hinder the establishment of a trusting relationship. Further challenges emerged in cases involving patients with substance use disorders or mental health conditions, as these circumstances could complicate patient engagement.

> *"They [the patients] will not be able to express their needs to us if they do not have confidence in us…" (participant no. 7)*

Time pressure and a hectic care environment were also described as challenges. Efficiency-driven routines, such as having other team members bring the patient into the operating room, reduced the valuable minutes that were perceived as crucial for creating the relationship.

> *"They come up with 'good' solutions to save time, but in my opinion it is at the expense of the person-centered care [...] and then I don't have time to create the relationship with the patient" (participant no. 1)*

To be prepared

NA:s regarded being well-prepared as essential for developing a trusting relationship with the patient. Reviewing the patient's records and preparing medications and equipment in advance were described as basic prerequisites. They aimed to understand patients' specific needs, relating not only to medical factors but also psychosocial aspects such as anxiety, in order to tailor care. However, the quality of available information varied. The anesthesiologist's assessment was sometimes limited to standardized documentation without personal contact with the patient.

> *"The majority of our patients are assessed on paper […] no anesthesia personnel have met the patient in person[…] as a result, it has not been possible to adequately prepare." (participant no.11)*

When patients arrived in the operating ward, shortcomings in preoperative preparation or the information given to the patient occasionally limited their ability to participate in their care. These situations lead to improvised solutions such as locating an anesthesiologist to inform the patient about anesthesia options or trying to find a staff member that talked the patient's language, to help interpret, often disrupting the surgical flow. Several NA:s emphasized that preoperative dialogues, conducted either in person or by phone, helped avoid such problems.

These consultations enabled individualized information, clarification of patient questions and the collection of preferences to guide planning and necessary adjustments.

> *"They [the patients] get information about what is going to happen, and they are prepared, all the tests and everything like that is done. […] And if there is anything specific, they've [the nurses] written it down, and then I can be prepared for it." (participant no. 3)*

Learning through experience

After handing patients over to the postoperative unit, NA:s typically moved directly on to the next case, leaving little opportunity to meet patients once they had fully awakened. Several NA:s expressed a desire for structured routines that would allow postoperative encounters and provide feedback on patients' sense of safety and well-being.

> *"If you meet the patient postoperatively, you get feedback. How did I do my job? Was the patient satisfied? Did they feel safe? Did we live up to what the patient had expected us to provide?" (participant no.11)*

Although evaluating each case could be challenging, the NA:s maintained that they through experience enhanced their ability to assess individual patient needs and adapt care accordingly, to provide optimal outcomes for each patient.

Assuming responsibility for the patient's needs

The category *assuming responsibility for the patient's needs* comprises three subcategories: *patient involvement, the anesthetized patient, and adjusting anesthesia care*. NA:s described patient involvement as fundamental for PCC. Communication was central however challenging, as patients under anesthesia could not communicate verbally. Many NA:s expressed that by establishing trust beforehand, they assumed responsibility for the patient's involvement and safeguarded their interests during anesthesia.

Patient involvement

NA:s viewed patient involvement as the basis of PCC in the anesthetic context. Several believed that being flexible whenever possible made it easier for the patient to accept situations where no choices could be offered.

"There may not always be options, but if there are: Do you want to hold the mask yourself? Which arm would you like to get the iv-line in? What music would you like to listen to? Would you prefer it to be quiet?" (participant no. 7)

Some NA:s described situations in which patient involvement was overlooked, often due to inadequate preoperative information, leaving patients without the chance to make informed decisions.

Communication was repeatedly highlighted as essential for facilitating patient involvement. Tailoring information to the individual patient and having time to listen to their wishes were regarded as central components of PCC.

"It's important to take your time in the meeting, to be able to meet the patients where they are, and try to explain what's happening, all the time." (participant no.10)

Language barriers were frequently mentioned as a challenge. Accessing interpreter support was often difficult due to unpredictable operating schedules and interpreters did not accompany patients into the operating room. NA:s described using nonverbal communication, simple universal phrases, and digital translation tools to maintain some level of communication with the patient.

Children were described as a patient group for whom a person-centred approach was particularly important. Strategies mentioned to meet children's specific needs included using an iPad to provide distraction, making preparations playful, for example drawing with scented pens on the breathing mask, and allowing the child to fall asleep in their parent's arms. Several NA:s mentioned having a routine whereby the NA responsible for the patient primarily is the one who communicates with the child and the parent. Involving parents was highlighted as crucial, as they are the child's primary source of comfort and significantly shape the child's experience.

The anesthetized patient

A major challenge for PCC was that patients are anesthetized or sedated for the majority of their time in the anesthesia context. Among the NA:s, there were reflections on whether patients can be considered involved in their care at all while unconscious. However, many NA:s saw it as their responsibility to assume the patient's involvement, based on the trust

established preoperatively. Safeguarding dignity while they were anesthetized or sedated, such as preventing unnecessary exposure of the patient's body or limiting the number of students in the operating room was frequently mentioned.

> *"...that you try to maintain integrity and dignity even after they are anesthetized." (participant no. 5)*

Several NA:s expressed that they view themselves as the patient's advocate, representing them when they cannot speak for themselves. Sometimes, the NA was the only one in the operating room who had met the patient while they were awake and thus felt a responsibility to protect the patient's interests in relation to the rest of the team.

> *"I am the patient's guardian and ensure that their interests are met while they are asleep." (participant no. 12)*

Some of the NA:s also employed strategies to provide the patient with a sense of context while they were anesthetized. For example, they would ask the patient about their dreams or establish physical contact with the anesthetized patient.

> *"Try to keep your hand on the patient, maybe on their shoulder, so they feel they have support and that you're there with them." (participant no. 9)*

Adjusting anesthesia care

NA:s described anesthesia care as guided by standardized care plans that provide guidance on what is important in relation to the procedure the patient is to undergo. Making care person-centered meant identifying when these plans needed adaptation to align with the individual patient's needs. Positioning on the operating table was a frequently mentioned example, as patients' physical conditions sometimes required adjustments.

> *"It could be that they have pain in a certain area, so you try to make sure they're lying as comfortably as possible." (participant no.3)*

Other adaptations had clear medical implications but still fell within the NA:s' area of responsibility. Examples included adjusting doses of antiemetics or analgesics and using consciousness monitoring to avoid overdosing older patients. In collaboration with anesthesiologists NA:s sometimes changed anesthesia method, for instance shifting from

inhalation to intravenous anesthesia for patients with previous nausea, or from regional to general anesthesia based on patient preference.

Between production pressure and person-centered care

The category *between production pressure and person-centered care* consists of three subcategories: *team - cooperate and communicate, the anesthesia care setting* and *the focus of the organisation.* NA:s described working in a context where PCC was seldom discussed. Maintaining a person-centred approach within a team that tends to focus more on the medical and practical aspects of care, and in a setting where efficiency and production are prioritized, was considered challenging. Many NA:s expressed a desire for education and structured discussions to promote a shift in workplace culture toward more person-centred practice.

The team - cooperate and communicate

Cooperating with other professionals and carrying out anesthesia nursing in relation to their areas of focus, sometimes lead to conflicts of interest according to the NA:s. The operating room nurse sometimes prioritized standardized positioning over shielding the patient from bodily exposure and thereby protecting the patient's dignity. Surgeons occasionally lacked time to speak with patients preoperatively, and anesthesiologists often concentrated on medical assessments, leaving psychosocial aspects unaddressed. Even within the NA group, there were varying levels of interest and focus on PCC.

> *"The difficult part is reaching out to those who don't see the patient, who only see an operation schedule and a gallbladder in room 10. It's about getting through to them and making them also look at the person behind it." (participant no. 2)*

Some NA:s felt that working in smaller teams, where agreement could be reached on procedures and there was greater flexibility, would better support a person-centred approach.

> *"If we work as a team, with the same staff in the operating room all day, it becomes a WE. Then WE create a plan for the day, look at which patients we have, and discuss if there are any special challenges or things we need to keep in mind. That would be a person-centered approach." (participant no. 6)*

Team communication was repeatedly described as critical to PCC and NA:s saw room for improvement in this area. They wanted the ward staff to inform the operating department of any specific needs or challenges, such as a patient's anxiety, to enable tailored preparation.

Strong collaboration between NA:s, anesthesiologists, and operating room nurses was viewed as essential, whereas poor communication was perceived as a barrier to PCC.

Several NA:s reported that they valued continuity of care to facilitate person-centred practice, but handovers during long surgeries or shift changes were sometimes necessary. Their objective was not only to transfer the medical, psychosocial, and relational aspects of care but also to maintain the patient relationship by sharing personal details, which helps foster empathy. These handover situations could be challenging if the receiving nurse did not share the same perspective on PCC, or even the same fundamental views on nursing and patient interaction. This could lead to frustration and discomfort for the NA handing over responsibility for the patient.

> *"In the handover situation, when you see that people aren't listening to what you're saying but just go, 'Alright, alright, you can leave now.'" (participant no. 8)*

The anesthesia care setting

NA:s recognized that the care environment affected their ability to provide PCC. Patients were often admitted in busy operating ward areas, while a quiet preparation room was preferred for private conversations. For children and cognitively vulnerable patients, creating a calm space before and during induction of anesthesia was considered essential. Adjustments like dimming lights, limiting people in the operating room, using warming blankets early, and running checklists before bringing in the patient helped keep the environment comfortable.

The speciality's emphasis on technology was perceived as a potential barrier related to PCC, as attention often shifted to the monitors rather than the patient. Limited access to certain equipment could also restrict individual adjustments.

Time was consistently mentioned as a factor that either facilitated or hindered working in a person-centred way. In emergencies PCC was naturally deprioritized in favour of safe, standardized care. However, even for reasons of efficiency there was often time pressure, and this, according to NA:s, represented a major obstacle to working in a person-centred way.

> *"Time is always a factor […], I know we have limited resources, and it's difficult for a patient too when they're postponed because we don't have time. It's always a trade-off." (participant no. 2)*

The focus of the organisation

NA:s described the organisation as being strongly production-driven, sometimes leading to a standardized, factory-like workplace with significant pressure to maintain rapid turnover. Despite this, they strived to ensure patients felt cared for rather then rushed.

> *"You have to get going quickly, we need fast turnovers, and they're on us saying, 'When can we get started?' It's a lot of stress sometimes." (participant no. 3)*

The workplace language was said to emphasize production and scheduling over care. The NA:s believed that PCC could coexist with production, but that an overly production-focused management risks shift attention away from patient needs.

> *"We're expected to do the best for our patients, but then, in the next moment, a new work pattern is introduced with strictly timed start times. This doesn't take into account that patients may need different amounts of time." (participant no. 4)*

PCC was rarely discussed in the operating departments. The NA:s perceived it often fell to the individual NA to uphold PCC, sometimes encountering resistance when other members of the team had different priorities, focusing mainly on medical and practical aspects. Many expressed a wish for dedicated opportunities for team discussions, shared learning, and developing guidelines for PCC. One suggestion was to introduce PCC ambassadors to identify good practices and share them with the rest of the staff.

Several NA:s stressed the need for a shift in the workplace culture toward PCC, emphasizing management's key role in driving this change. While some colleagues were perceived as resistant to new approaches, NA:s expressed optimism that workplace culture would evolve as new staff brought different perspectives.

> *"It is easier for a workplace to stand firm in its way of working against newcomers, but it is more difficult to convert the old hands." (participant no. 2)*

DISCUSSION

The aim of this study was to illuminate NA:s perspectives on person-centered anesthesia care.

The analysis resulted in three main categories and nine subcategories. The main categories were *establishing a trusting relationship*, *assuming responsibility for the patient's needs* and *between production pressure and person-centered care*.

In the first category *establishing a trusting relationship,* the brief interaction with the awake patient was viewed as the foundation for the PCC provided while the patient was asleep. Developing trust by focusing on the patient and truly seeing the person rather than the diagnosis were key elements in the NA:s' descriptions of these short meetings, in line with the first dimension of the FoC framework, *the nurse patient relationship*.[4,5] To build this relationship and gain the patient's trust, the NA:s highlighted the need for sufficient time with the patient. This view aligns with previous research on patients' perspectives on PCC in the perioperative context, which stresses the importance of allowing providers time to listen to patients[10] and to be well-prepared.[11] In the FoC framework, this is expressed as anticipating patients' needs and knowing enough about them to adjust the care accordingly.[4,5]

According to the NA:s in the study, one way to optimize the limited time during which the patient was awake and able to participate in shared decision-making was to ensure thorough preparation before the patient arrived at the operating ward. This included ensuring that patients were well informed and had had the opportunity to discuss their preferences regarding anesthesia care in advance, in a calm and unhurried setting. The NA:s suggested that a structured preoperative dialogue was an effective way to achieve this. Those working in facilities where such conversations were already established viewed them as highly valuable, and NA:s in settings without this practice frequently expressed a desire to implement it. Given the NA:s accounts of problems associated with inadequately prepared patients, such as patients not being informed about anesthesia options or not being given the opportunity to express their preferences, the resulting need for time-consuming improvisations and disruptions to surgical flow suggests that a structured preoperative dialogue would be beneficial for both patients and the clinic. Although it requires one staff member to spend time informing the patient and clarifying their preferences, this investment may prevent delays, including uncertainty about anesthesia choices, misunderstandings due to language barriers, or unclear patient wishes. By ensuring that patients arrive well informed and prepared, preoperative dialogues support PCC while also contributing to a smoother surgical flow and reducing avoidable interruptions.

In the second category *assuming responsibility for the patients' needs* NA:s described safeguarding the patient's physical, psychosocial, and relational needs, which aligns with the second dimension of the FoC framework, *the integration of care*.[4,5] These findings are consistent with previous research[7,9], indicating that NA:s view themselves as the patient's advocate, representing the patient when they were unable to speak for themselves. The holistic perspective identified in Leken's meta-ethnography[8] was also reflected in the participants' accounts in the present study. Although standard care plans form the foundation of anesthesia care, NA:s tailor their approach to each patient's individual needs. Through continuous assessment of the patient, they adapt communication, monitoring, and psychosocial or cultural considerations to ensure flexible and responsive care. In this way, guidelines function as a supportive framework rather than a limitation, facilitating truly person-centered anesthesia care.

In the third category *between production pressure and person-centered care* NA:s expressed feelings of being caught between the organisation's efficiency demands and their wish to have more time with the patients, in order to personalize care. Previous research[7,9] shows that NA:s feel pressured not only by management but also by surgeons and operating room nurses. This dynamic was also present in the current study, where the NA:s discussed differing priorities within the interprofessional team regarding the focus of care. One explanation offered by the NA:s was that the organisation places substantial emphasis on production and the standardisation of care. NA:s state that despite discussions about PCC at higher organizational levels, little of this seems to reach everyday clinical practice. Even in operating units where managers express commitment to PCC, efforts often take the form of occasional seminars or lectures. NA:s called for dedicated forums for dialogue to better understand how PCC principles can be applied in their daily work, and to ensure that their intention to comply with patient-centered legislation is supported by the organisation.

The third dimension of the FoC framework, *the context of care,* emphasizes the organisations' role in enabling or hindering the delivery of fundamental care.[4,5] A "task and time" mentality, where nurses are rewarded for the speed with which they complete tasks, is described as the antitheses of FoC values.[4] The FoC framework advocates for a paradigm shift in which the core of nursing is recognized and valued, and where systems for documenting and evaluating nursing care are implemented. This shift aims to ensure that patient outcomes, not just productivity or task completion, are measured and prioritized.[5,6] In the anesthesia setting, a

stronger organisational focus on PCC could reinforce a shared interprofessional approach, ensuring that patient participation is valued and that psychosocial and relational needs are addressed alongside physical needs.

One suggestion from the NA:s was that the operating wards introduce PCC ambassadors. A qualitative study of an online facilitation training program (FLIP) in Swedish healthcare showed that assigning staff as PCC ambassadors was generally well received and considered relevant for improving care.[20] In anesthesia care, standard care plans primarily address the practical, technical, and medical aspects of care. The interaction between the NA and the patient, as well as interprofessional collaboration, are not explicitly addressed in workplace guidelines or official documents. Appointing a designated ambassador could serve as a starting point for fostering an attitude more consistent with the philosophy of FoC and thereby promote the development of PCC within anesthesia care.

Methodological considerations

Based on the fact that the participants needed to be recruited from a specific context (NA:s in operating wards), convenience sampling was an appropriate way to recruit.[12] Convenience sampling can be seen as an easy way to recruit as the participants come forward and identify themselves, however it might not provide the most information-rich sources. Furthermore, a potential sampling bias arises from the possibility that those who already have an interest in and are engaged in the subject might be more willing to be interviewed about it. Another risk in convenience sampling is that the informants' answers reflect experience of the setting in the workplace rather than experience of the phenomena under study.[12] In this study the participants were recruited from five different operation wards in three hospitals which could mitigate this risk.

In the recruitment process heads of operating wards were approached via e-mail and asked to be gatekeepers. Using a gatekeeper is a way to get in touch with participants and can also help legitimize the study. However, there is always a risk that the gatekeeper does not send out the request to those who are referred to, or that they in other ways affect participants' interest or opportunities to participate.[14] Five hospitals were contacted, and the departments heads of operations approved the study´s implementation in their departments. The heads of operating wards in all five hospitals confirmed that they had received the invitations to participate for further distribution to all NA:s in their units. The invitations however rendered participants

only from three of the hospitals, which could be an illustration of the risk in involving gatekeepers.

A semi-structured interview guide that was developed after reviewing previous research on PCC. Although, in hindsight, the guide could have been structured differently. Green and Thorogood[14] advise against asking participants the main research question directly, as this may lead to superficial coverage early in the interview and make subsequent probing seem repetitive. They also recommend focusing on concrete experiences rather than abstract issues[14], which was achieved in this study. Interviewers ideally are neutral and do not impact the participants answers.[12] This is however difficult to achieve, interviewer and participants interact and this can affect the responses.[12] The intention was to conduct interviews until no new information arose from the data[12] and this objective was achieved. All interviews were conducted by the author which minimizes differences in outcome related to different approach by the interviewer. However, the author had no prior experience of interviewing which might have affected the outcome of the interviews.

The interviews were transcribed verbatim by the author in close connection to the interview. The process of transcribing is considered an effective way to become immersed and familiarizing oneself with the data[12] which also is the first phase in the qualitative content analysis described by Elo and Kyngäs[13]. The reading of the data needs to be careful and the goal is to identify underlying concepts[12]. After reading the transcripts repeatedly and making notes and headings in the margins those notes and headings were transferred to a coding scheme. The approach used was coding larger segments, to grasp the idea or what was going on in the text, this can be described as holistic coding.[12] At this point the supervisor after independently having read the transcripts, validated the coding, no major discrepances in describing and interpreting the material were detected. The initial 34 codes were consolidated to 24 by merging those with similar content. The coding scheme was refined by grouping related codes into subcategories, an interpretive process according to Elo and Kyngäs.[13] The content of the subcategories guided the further grouping into three main categories.[13] The reporting of the results required the translation of findings and quotations from Swedish to English which carries a risk of distorting or loosing nuances in the participants statements. Measures taken to mitigate this risk include the use of a translation programme (Microsoft translator) to suggest or verify the translations as well as careful rereading of the English version to identify potential errors.

Lincoln & Guba[21] suggest establishing the trustworthiness of a research study by reviewing its credibility, dependability, confirmability and transferability. In this study credibility was supported by the thorough description of the analysis process and by providing quotes from the interviews to validate the findings. Dependability was achieved through describing the research process in detail and involving the supervisor to gain an external perspective and increase objectivity. An attempt to attain confirmability was through being aware of preconceptions related to the author being a NA herself and including the supervisor in analysing the data and in that way validate the findings objectively. Providing detailed descriptions of the context, participants, data collections, and data analysis facilitates the readers assessment of transferability.

In qualitative research the researcher's reflexivity is the process of critically reflecting on how prior experiences, values and biases could affect data collection and interpretation.[12] In this study, the author's background as a NA was disclosed to participants and may have shaped the interviews. Some participants appeared unsure whether they were discussing the "right" aspects and occasionally sought reassurance, suggesting that the shared professional background influenced the interaction. The interviews might have differed with an interviewer outside the profession. At the same time, shared language and experience may have strengthened rapport and allowed for deeper conversations.[14] The author has worked in several surgical wards in southern Sweden, meaning many potential participants had been colleagues. To ensure voluntariness, the current workplace was excluded from recruitment.[12] Excluding all former colleagues would have limited the sample considerably, therefore six of the twelve participants were previous colleagues. The prior relationship may have affected the participants willingness to participate and may, to some extent, have influenced their responses. Contact before the interviews was limited to scheduling.

Conclusions

The analysis resulted in three main categories and nine subcategories. The main categories were: *Establishing a trusting relationship*, *assuming responsibility for the patient's needs* and *between production pressure and person-centered care*. This study shows that NA:s consider person-centred care essential in anesthesia, despite the challenge of patients being unable to communicate while anesthetized. In the category *establishing a trusting relationship* the NA relies on the brief preoperative encounter for building trust and gathering the information

needed to tailor care during anesthesia. The category *assuming responsibility for the patient's needs* show that NA:s strive to safeguard patients' physical, psychosocial, and relational needs, adapting standard care to accommodate individual preferences and needs. In the last category, *between production pressure and person-centered care,* it is apparent that organisational pressures, time constraints, and differing team priorities limit the extent to which PCC can be fully realised. Strengthening PCC in anesthesia care requires clearer organisational support, improved interprofessional collaboration, and structured opportunities for reflection. Measures such as preoperative dialogues or appointing PCC ambassadors may help promote a more consistent person-centered approach.

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Conflict of interest

The author reported there are no competing interests to declare.

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APPENDIX 1: COREQ CHECKLIST

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the inter view or focus group?	
Duration	21	What was the duration of the inter views or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

APPENDIX 2: INTERVIEW GUIDE

Question areas:

1. Could you describe what person-centred care means to you?
2. What is your perception of person-centred care in the anesthesia context?
3. Would you like to tell me about a situation where you felt that you worked person-centred?
4. Can you provide an example of a care situation where you felt the approach was not very person-centered?
5. Are there specific ways of working that you would consider person-centered? Or any special measures that, in your opinion, can be classified as person-centred?
6. Is there anything that would make it easier to work person-centred at your workplace?
7. Are there any obstacles?
8. Are there any other thoughts on person-centered care that you feel we have not covered?

APPENDIX 3: CODES AND CATEGORIES

Codes	Subcategories	Main categories
Create a relationship	The brief encounter with the awake patient	Establishing a trusting relationship
Short meeting before anesthesia		
Making the patient feel safe		
Holistic view of the patient		
The nurse anesthetists' preparedness	To be prepared	
Preoperative dialogue		
Patient preparedness		
Postoperative evaluation	Learning through experience	
Importance of experience		
Patient involvement	Patient involvement	Assuming responsibility for the patient's needs
Communicating with the patient		
Children		
Parents/Relatives		
Anesthetized patient	The anesthetized patient	
Patient advocacy		
Protect the patient's integrity		
Adapt to the patient	Adjusting the care	
Different views within the team	The team – cooperate and communicate	Between production pressure and person-centered care
Team communication		
Surroundings and premises	The anesthesia care setting	
Time		
Focusing on production	Organisational focus	
Focusing on person-centered care		
Workplace culture		