

How Anesthesiologists and Nurse Anesthetists Assess and Handle Patients' Perioperative Worries Without a Validated Instrument

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Purpose: To study how nurse anesthetists and anesthesiologists assess and handle patients' perioperative anxiety without using a validated instrument.

Design: Qualitative study.

Methods: Individual in-depth face-to-face interviews were conducted with nurse anesthetists ($n = 9$) and anesthesiologists ($n = 5$) from a university hospital in Sweden. Data were analyzed with thematic analysis according to Braun and Clark.

Findings: Two themes were identified: (1) I ask about anxiety, look for visual signs, and observe communication and (2) I handle patients' anxieties individually. In addition to subthemes describing assessment and handling of adults, it appeared that parents played an important role in children's perioperative anxiety.

Conclusions: When not using a validated instrument, assessing perioperative anxiety is commonly based on the anesthesiologist's and nurse anesthetist's experience, knowledge, views, and attitudes. The evaluator's capability of using different strategies in the assessment and handling of perioperative anxiety is important.

Keywords: perioperative, anxiety, evaluation, nurse anesthetists, anesthesiologists.

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TODAY IN SWEDEN THE CONCEPT of anxiety in connection with surgery and anesthesia is not being evaluated systematically and by means of a validated instrument. Anxiety is a subject of discussion but sometimes neither anesthesiologists nor surgical ward nurses use the word “worry” or “anxiety” when discussing these issues with the patient.¹ However, evaluating and treating symptoms of anxiety is part of medical and nursing care, particularly perioperatively, and it is important to study how nurse anesthetists or anesthesiologists assess perioperative anxiety without using a validated instrument.

Background

Patients are anxious in connection with surgery and anesthesia.¹⁻⁵ In a recent study,¹ elderly patients declared that they were anxious about losing control of their decision making and letting someone else decide about their body and life. The feeling of having no other choice but to go through surgery and anesthesia was another source of anxiety. Patients who had already experienced surgery and anesthesia felt claustrophobia in connection with using the breathing mask^{1,5} or expected pain.¹ Furthermore, the unknown environment or "frightening" vocabulary about the surgery or anesthesia was an additional cause of anxiety and many wondered what would happen if something went wrong during surgery.^{1,4}

In Sweden, patients use the word worry more often than anxiety in connection with anesthesia and surgery. However, in assessing perioperative anxiety, medical staff should closely observe what expressions patients use to describe their worries or concerns, and how these occur in each patient. According to the American Psychiatric Association⁶ worry is a milder form of anxiety. Worry may be transformed into anxiety when a person is constantly worried without having control over it.⁶

Assessing patients' anxiety is part of nursing care.⁷ In a previous study nurses reported how they look for physiological changes and observable behaviors, for example, agitation, increased blood pressure, increased heart rate, patients' verbalization of anxiety, and restlessness, to assess anxiety.⁸ Preoperative anxiety level is difficult to measure only with physiological parameters but possible measures are blood pressure, pulse, decreased heart rate variability, as well as the plasma of cortisol and urinary level of catecholamine.⁹

There are several multidimensional or monodimensional scales that may be used in assessing patients' perioperative anxiety. Multidimensional scales include the Hospital Anxiety and Depression Scale,¹⁰ the Spielberger State-Trait Anxiety Inventory,¹¹ and the Amsterdam Preoperative Anxiety and Information Scale.¹² The Visual Analog Scale¹³ and the Numeric Rating Scale¹⁴ are two commonly used monodimensional scales.

Earlier studies have suggested that patients' anxiety in connection with surgery and anesthesia have not

always been graded correctly by medical staff. In a study by Fekrat et al,¹⁵ patients' perioperative anxiety was overestimated by anesthesiologists and surgeons using the Visual Analog Scale. Moreover, in 20% of cases, the surgeons were not able to evaluate what could ease the patient's anxiety.

Without a systematic way of assessing patients' perioperative anxieties, both assessment and treatment are arbitrary. In Sweden, today, perioperative anxiety remains as a topic of discussion rather than a potential problem that is assessed by the means of an appropriate instrument. It is important to assess patients' experiences objectively and by means of validated instruments to better help patients according to the precepts of person-centered care. Although there are studies addressing the topic of assessing and addressing anxiety, few studies focus on the assessment of patients' perioperative anxieties. However, it is important to understand how anesthesiologists and nurse anesthetists assess and grade patients' worries and anxieties to further discuss the necessity of an instrument to help in assessing these feelings and also to decide what instrument could be the most appropriate one to use in grading patients' perioperative experiences.

Purpose

The purpose of this study was to examine how nurse anesthetists and anesthesiologists assess and handle patients' perioperative anxieties without using a validated instrument.

Methods

Design

The study had a qualitative design and used applicable items from the checklist of consolidated criteria for reporting qualitative studies.¹⁶

Context

The study was performed in a university hospital in Sweden with approximately 8,000 employees, where about 32,000 surgeries are performed annually. There are seven surgical departments including thoracic surgery, neurosurgery, ear, nose, and throat surgery, pediatric surgery, orthopaedic surgery, vascular surgery, urology, acute or emergency, day surgery, and gynecologic surgeries. Patients from

all parts of Sweden were cared for at the Hospital where the study was conducted.

Participants

The participants were chosen from different surgical departments. Anesthesiologists and nurse anesthetists with at least 2 years' experience in their profession were included. The participants were chosen by strategic selection to guarantee that individuals from both professions and of different ages and genders were represented. Sixteen anesthesiologists and 17 nurse anesthetists were invited to participate, of whom 5 anesthesiologists and 9 nurse anesthetists accepted. The participants were five men and nine women aged between 31 and 59 years (mean 48 years). The nurse anesthetists had between 2 and 22 years (mean 10 years) of experience in anesthesia care and between 7 and 37 years of experience in nursing care. Among the anesthesiologists, one was undergoing specialist education and had 5 years' experience in the field of anesthesiology. The other four had between 5 and 28 years (mean 18 years) of experience in anesthesia and they had been specialists for between 12 and 24 years (mean 14 years). All the anesthesiologists had a PhD degree and five of the nurse anesthetists had a Master of Science degree.

Procedure

Employee information was collected from the head managers in the hospital's Department of Anesthesia. An invitation was sent to the employee's work electronic mail address. A reminder was sent approximately 1 week after the first invitation. The participant contacted author E.A. if he or she was interested in participating in the study. An interview was then scheduled and a face-to-face interview was conducted in a room in the hospital library or a quiet room in the participant's workplace (the surgical department). An informed written consent was collected before the interview. The interviews were performed during June 2017 and April 2018. These were tape recorded and transcribed verbatim for further analysis. A test interview (the first interview) was performed and because there were no changes to the interview guide, the interview was included in the study. The interviews lasted from 22 to 55 minutes (mean 35 minutes).

The Interview Guide

The interview guide, designed specifically for this study, was based on both theoretical and clinical experience and encompassed both semistructured and open-ended questions. There were two main areas of interest, that is, how nurse anesthetists and anesthesiologists assessed and handled patients' perioperative anxiety. To deepen our understanding of the participants' descriptions, further questions were asked about participants' thoughts and about what patients were anxious. Probing questions or follow-up questions were also used during the interviews (Table 1).

Data Analysis

Thematic analysis according to Braun and Clarke¹⁷ was used. A detailed analysis of those aspects of the data relevant to the study's aim was conducted, and the themes identified relate to the specific main focus areas in the interview. In broad terms, the analysis followed the stages described by Braun and Clarke¹⁷: familiarization with data, initial coding, and then searching for and reviewing the identified themes. The interviews comprised experiences from both adults and children's care that led to presentation of separate sub-themes for assessing and handling children's anxiety. Authors E.A. and C.Ö. conducted the analysis separately and checked and confirmed the identified codes within the themes during the process. A third author, L.N., analyzed nine interviews to confirm the results.

Ethical Considerations

The study was approved by the Ethical Review Board of Uppsala University (Dnr 2017/155). Informed consent was obtained from every participant before interviews. Participation was voluntary. The study followed the regulations in the Declaration of Helsinki¹⁸ and local ethical guidelines and regulations.¹⁹

Findings

Two themes and nine subthemes were identified. Theme 1: I ask about anxiety, look for visual signs, and observe communication. Theme 2: I handle patients' anxiety individually (Table 2).

Table 1. The Interview Guide

Background questions	Age How long has the person worked as an anesthesiologist or nurse anesthetist? Academic education level
Main questions	- How do you evaluate patients' perioperative worries? - How do you handle patients' perioperative worries?
Further questions to clarify the topic	1. What is worry, in your opinion? 2. Please tell me how you assess your patient's concerns or worries in connection with anesthesia and surgery? 3. On what do you base your assessment? (Watching the body language/gestures/how the patient talks/measuring pulse or blood pressure?) 4. How do you rate anxiety/worry? When can you say that one patient is more worried than another patient? What is different between patients who are more or less worried? How can you tell? 5. Do you talk about worry in your preoperative assessment of the patient? What do you ask about and how do you ask about worry or anxiety? Please give an example of that. 6. Tell me about a situation where you asked the patient about his or her worries or anxiety. Please explain how did you do it? How did the conversation go? 7. Can you remember any patient situation when the patient has been worried and you have helped the patient to verbalize it? How did it go? Tell me more, please. What did you do? 8. How do you treat worried or anxious patients? 9. What actions do you take when the patient is worried? 10. How much of your work do you think is associated with relieving patients' perioperative worries? 11. What other measures can be taken to relieve the patient's concern?
Probing questions	What do you mean? Please tell me more. Can you explain what you mean?

Theme 1: I Ask About Anxiety, Look for Visual Signs, and Observe Communication

To assess patients' perioperative anxieties the anesthesiologists and nurse anesthetists used different strategies when talking to patients. Some of the participants emphasized that it was difficult to grade anxieties without an instrument but they also noted that years of experience made the assessment easier. As a result, the assessment was based on the views of the person who made the assessment and not according to a validated instrument. Furthermore, visual signs, such as body language, blood pressure and pulse rate, and the way patients talked or answered questions were observed to assess patients' anxieties. Anxiety was described as stress or not being able to relax and more explicitly as "a strong intrusive feeling," a "feeling resembling of discomfort," "a feeling from light to mild to severe panic and anxiety" and yet an "adequate feeling."

I have checklists for everything but I have no checklist for it (worry), as well as the psychosocial care and we do not check it out. (Participant 4)

We make different assessments, me and my assistant nurse. (Participant 3)

I think that having experience in the field may play a role (in grading worry), knowing that you have met the patient category before.... (Participant 12)

OPEN AND DIRECT QUESTIONS. Several participants used the word worry or "fear" in their conversations with the patients, because they believed that it is likely and natural that every patient is or may be anxious to some degree and why deny that by not using the word? The participants used expressions like "I can see that you are tense" (Participant 2) to start a discussion about

Table 2. Themes and Subthemes

Themes	Subthemes
1. I ask about anxiety, look for visual signs and observe communication	1.1. Open and direct questions 1.2. Asking directly is not beneficial 1.3. Body language and physical reactions 1.4. Patients' eyes and way of talking 1.5. Cooperation with parents in assessment of anxiety
2. I handle patients' anxiety individually	2.1. To acknowledge and try to understand patients' anxiety 2.2. To inform, support and calm the patient 2.3. Individual measures including giving some sense of control back 2.4. Parents helped in deciding the strategy

perioperative anxiety. They also emphasized the importance of asking further questions to drill down, questions such as "How do you feel? Are you afraid? Are you nervous?" This group indicated that if one tries to assess and "give the patient the opportunity to tell you about worry," they will talk about it (Participant 5). Prior experiences of anesthesia and surgery could also affect patients' anxiety, and it was therefore important to understand and discuss these openly. There was no systematic grading, but value words such as "more" or "less," "milder" or "severe" were used to grade patients' anxiety. Patients from other cultures who did not have Swedish as their native language were sometimes asked about anxiety through an interpreter.

... no ordinary scale (is used)... this patient is not worried, this patient is very worried/anxious, a little worried...it's more a value word... (Participant 14)

...I may ask "Have you been anaesthetized before and, if so, what happened?" Depending on the answer you receive, you will find supplementary questions from there. (Participant 10)

The participants described how it was sometimes challenging to make themselves understood.

ASKING DIRECTLY IS NOT BENEFICIAL. Some participants stated that "worry or anxiety was not his or her main focus" and "not the main part of anesthesia care" and therefore it was not asked about consistently.

I do not think it's important to me to assess whether the patient is worried because I can't do that much about it.... I don't see it as my main task to assess whether the patient is worried or not because it's nothing I add

value to, and as I said it's very hard to help them (those who are worried). (Participant 3)

Not asking direct questions about anxiety was also motivated by "*I don't want to cause worry, therefore I don't ask*" (Participant 5).

Instead, questions such as "Did you sleep tonight?" or "How well did you sleep tonight?" were asked. This group of participants suggested that "If the patient is really worried, he or she will tell us." The most important factor was to assess how big a problem the anxiety was for the patient or "how much the patient suffered because of this perioperative worry" (Participant 6). Participant 13 explained "*I do my assessment while I am doing other things (e.g. taking blood pressure)... You can do a lot through conversation and distraction... You try to calm the patient.*"

BODY LANGUAGE AND PHYSICAL REACTIONS. Almost all the study participants looked for signs of anxiety in the patients' body language. If the patient was excessively tense, had difficulties focusing, and if the patient acted almost hysterically, crying, or shouting, these were interpreted as signs of anxiety. Other visible signs were shivering, actively looking around, being restless, or having worry lines.

Patients with mental or psychiatric symptoms could be difficult to assess, as well as patients who were quiet. Some patients would look calm but did not fall asleep. Participant 11 described it as follows: "There may be people that were worried but you could not tell," as "patients could control themselves and their feelings" (Participant 5). Patients could be lost in thought, not saying

much, just lying down and staring, or conversely joking around a lot.

“It’s the body language. You notice that the person is stiff, silent, perhaps not looking at me...they may look around themselves...and when you start injecting drugs they need more to fall asleep.” (Participant 10)

Nervous physical reactions such as being sweaty, having cool or sweaty hands, high blood pressure and increased pulse rate, high muscle tension, and vessel constriction were described by the participants as signs of anxiety.

PATIENTS' EYES AND WAY OF TALKING. The participants in this study described how the patients' eyes could reveal information about anxiety, for example, glazing over, staring, or flickering. Furthermore, the tone of the patient's voice, how slowly or fast they talked, or how little or much they talked, also described something “out of the ordinary.” Patients could talk too rapidly, not answer questions, talk continuously without listening, or barely talk at all. Inappropriate or forced laughter, shouting out loud, or verbally expressing anxiety, were also interpreted as signs of anxiety. Patients who had difficulties focusing and if the patient acted almost hysterically, crying, or shouting, these were interpreted as signs of anxiety.

COOPERATION WITH PARENTS IN ASSESSMENT OF ANXIETY. Talking to children at their own level of understanding with the help of the parents, and explaining what was going to happen could facilitate the participants' effort to establish contact and make assessments. Children showed their anxiety in other ways and sometimes more openly than adults do by crying or refusing to cooperate. Older children would sometimes ask a lot of questions. Some of the children had already experienced anesthesia and were tired of being in the hospital, which they showed through their protests. If a child hides under the blanket or wants to sit in his or her mother's lap, was too quiet, or cried, these signs were evidence of anxiety.

You can't make the child do anything (cooperate). They (the children) don't want to; they only sit in the mother's lap. (Participant 9)

Theme 2: I Handle Patients' Anxieties Individually

The participants explained how they adjusted their caring actions to the patient's individual needs. Participant 4 expressed this as follows: “If the patient is *really* worried, I talk to the anesthesiologist and we try to take it easy and not stress him (*the patient*) out.” Although working with anxious patients it was important to have a plain and clear communication, be organized, and well prepared. In handling patients' anxiety, it was important to treat patients kindly and with respect.

TO ACKNOWLEDGE AND TRY TO UNDERSTAND ANXIETY. The first step in assessing perioperative anxiety was to acknowledge its existence, especially in children, as they may have trouble expressing their feelings. Furthermore, patients from other cultures and with native languages other than Swedish may also have difficulties or even have other frames of reference for expressing their anxieties. Therefore, trying to understand and always confirming the patient's feelings were important.

I tell the patient “I notice that you look scared, I understand your anxiety” Maybe I can't promise that they will survive (the surgery)...but at least I can confirm where they are now. (Participant 14)

Participant 11 pointed out that it was important for the patient to know that he or she was allowed to be worried, meaning that it was natural and there was nothing strange about that. One way of letting the patients verbalize their anxieties was to let them know that they could be a part of their care and make decisions.

TO INFORM, SUPPORT, AND CALM. Information and education were used to ease patients' anxieties. It was also important to adjust the information to each individual patient.

My task is actually to guide the patient physiologically through the surgery...the experience, but to guide them mentally too. (Participant 14)

The participants were aware that some patients might not want to know much whereas others

may want to know as much as possible about what was going to happen, every step of the way.

By informing the patient about the presence of the anaesthesiologist or the nurse anaesthetist in the operating room at all times, a calming environment could be created. (Participant 9)

Physical “support” via holding hands or placing a hand on the patient’s shoulder, thus ensuring a sense of peace and quiet, or being visible to the patient to give a sense of companionship, were strategies used. Letting the patient know that this was routine for the staff members was also a strategy used. However, opinions differed about whether to assure the patient that “it (*the surgery or anaesthesia*) is going to be OK.”

Some participants told jokes, trying to make the adult patient laugh, and used every-day small talk. Another strategy was to try to shorten patients’ suffering by working fast and letting the induction start in the shortest time possible. Short induction was frequently described in children’s cases.

...I put my hand on the patient’s shoulder and I say “You know you will be interrogated when you’re done. When we wake you up later, you must be able to recall everyone’s (the anaesthesiologist’s and nurse anaesthetist’s) name.” Then the patient usually laughs.... (Participant 9)

INDIVIDUAL MEASURES INCLUDING GIVING SOME SENSE OF CONTROL BACK. Premedication or the knowledge about the possibility of receiving premedication could ease patients’ anxieties. Other possible strategies were to listen to one’s favorite music, to take a family member with you into the operating room, or to be offered a warm operating bed.

...(I ask) do you feel like you want something calming (medication) before coming to us (on the operating day)... I explain that it makes no difference to the anaesthesia but it’s for your own comfort if you feel worried before coming to us...You can take if you want it... You don’t have to swallow it ...

You can decide there and then. (Participant 14)

PARENTS HELPED IN DECIDING THE STRATEGY. Parents’ presence with their children was an option mentioned to decide a strategy in handling children’s anxieties. “Anti-worry medication” or medication that removed the “butterflies in your stomach” was offered to children. Children who were used to being in hospital sometimes wanted to decide how they would be anesthetized. It was very important to handle children and their worries gently as this could have an impact on their future experiences if they needed further surgical interventions. An 11-year-old boy got permission to anesthetize himself. By giving control to the boy to decide when to go to sleep, he could finally relax and get on with the surgical procedure.

...he (the boy) anesthetized himself with propofol and it actually worked. We put the IV line in and he had to press the button on the infusion pump and it felt better. (Participant 8)

In children who refused to cooperate, the surgeon was consulted, and a decision was made together with the parents depending on how necessary it was to go through the surgery that very day.

Distraction was used for patients who were assessed as being affected by their anxiety. For children, looking at iPads, singing songs, soap bubble blowing, playing with toys, and telling stories, for example, about pilots (ie, the child who was about to be anesthetized) who were about to fly somewhere, were used.

...you have to divert them with toys and bubble blowing ... check stickers or watch an iPad... sing a song. But usually you get a lot of help from the parent who diverts the child’s attention so we can hold an arm to insert an IV line. And then it’s just boom, they are sleeping. It’s a really short time. (Participant 9)

Furthermore, the participants described that providing information to parents was helpful, and letting the children join the hospital’s play

therapy ward could help the children process their imaginations. For children, there was a web page and books that could be used, showing several steps in the process.

What We as Personnel Think of Patients' Anxiety

During the interviews the participants also talked about what they thought patients were anxious about perioperatively. Feeling abandoned and losing control of one's body, or being "left at the mercy of unknown people" or "feeling small" was used to describe patients' anxieties. The participants stated that patients might worry about not being able to sleep or not waking up after surgery, waking up during surgery while still intubated, dying during surgery, what could be found during surgery or about what might happen if something went wrong and complications occurred. Experiencing postoperative pain and not having faith in the medical staff were also mentioned by the participants as a source of patients' perioperative anxiety. According to the participants, younger children could have a mental image of what was going to happen, which could be different from reality. Participant 6 expressed, "*It could be difficult to grasp what the children were seeing in their mind's eye.*"

Discussion

This study highlighted the fact that anesthesiologists and nurse anesthetists used communication and looked for signs of anxiety in patients' communication, behavior, body language, or vital parameters. Perioperative anxiety was handled on an individual basis with medication and nonmedication strategies both in children and in adults. Parents of young children played an important role both in assessing anxieties and helping their children handle them.

Perhaps one of the most interesting findings in this study was how the participants addressed perioperative worries or anxieties in patients. Using and not using the word worry or anxiety was discussed by several individuals. Furthermore, a few of the participants did not regard assessment of anxiety as an important part of their duties and

thus it was not given any specific consideration. This arose from the feeling that patients could not be helped to overcome their anxieties anyway.

Not having an instrument, assessment in our study was based on the individual's experience, skills, or interest and, as one of the participants explained, "two professionals could assess the same patient's worry or anxiety differently, with lack of consensus." Thus, perioperative worry or anxiety was rather a topic of discussion based on the professional's assessment skills or on the patient's "ability" to show it, than a serious parameter that should be documented and paid attention to.

Without an instrument anxiety often is evaluated by looking for physiological changes and patients' observable behaviors.^{20,21} There are some results indicating that interventions to lower anxiety levels in preoperative and postoperative care led to a decrease in blood pressure^{22,23} and heart rate. Sunbul et al²⁴ identified that high blood pressure was correlated with anxiety and depression scores. Thus, it can be of value identifying physiological parameters and behavior of the patient known as result of physiological changes corresponding to feelings of anxiety.⁹ The interviewees described assessment of body language, physical reactions, eyes, and way of talking, and these signs could and should be assessed by means of validated instruments and including patients' own descriptions.

Information and support, holding the patient's hand, trying to calm the patient with different strategies, listening to music, and giving back a sense of control to the patients were all used by the participants in this study to ease perioperative anxieties. The aforementioned strategies listed have been studied previously and confirm the results of our study.²⁵⁻³¹ Furthermore, not every surgery is elective and the participants stated that the induction should be performed as quickly as possible to ease the patient's anxiety. Patients themselves have suggested this in an earlier study.¹ This strategy may be used both with adults and children. Another way to ease the patients' anxiety may be to ensure that the same anesthesiologist who does the preoperative assessment is

also responsible for the patient in the operating room. A third way could be for the nurse anesthetists to work according to Perioperative Dialogue,³²⁻³⁴ which means that the same nurse is responsible for the patient through all perioperative phases, that is, preoperatively, peroperatively, and postoperatively.

Interestingly, anesthesiologists and nurse anesthetists had rather a very similar picture of what the patients could worry or be anxious about, consistent with what patients explained in previous studies.^{1,4} The ability to picture the patient's anxieties could be of value when trying to explore the patient's situation, prompting relevant questions.¹ The possible differences in male and female participants' experience of anxiety were not addressed in this study, but may be interesting to address in the future because male and female medical professionals and male and female patients may have different views on and experiences of the topic.³⁵

An important point to discuss is the attitude and preferences of those who assess and address perioperative worry, that is, the anesthetists and nurse anesthesiologists. It was obvious that there are several ways to look on perioperative anxiety. Some professionals would acknowledge that it is normal for the patients to be worried preoperatively and that anxiety exists, whereas others would argue that they could cause worry by mentioning it. However, using a validated instrument, assessing anxiety would be easier and more objective. There are several instruments that are used to assess perioperative anxiety.^{8,10,13,36,37} However, no consensus has been reached among the professionals to identify the best instrument to use in perioperative settings. Even with the use of a validated instrument, this should be combined with discussion with the patient about his or her anxieties. An instrument alone does not capture the entire picture and therefore one should not rely on an instrument blindly. Maybe, as the participants stated, it is important to discuss and consider anxiety not only as a problem per se, but also to find out how significant a problem it is for the patient or how it affects the patient. In terms of choosing and using an instrument, the goal should not only be to assess and grade anxiety but

also to find person-centered solutions in cases of severe worry or anxiety.

Methodological Considerations

The study design included interviews with the same number of both anesthesiologists and nurse anesthetists. However, there were no differences in the quality of the interviews between the two professions and the interviews were rich. Data saturation was met after nine interviews. Study procedure and data analysis were described as clearly as possible to guarantee credibility and transferability, providing readers with the evidence that the research study's findings could be applicable to other contexts and populations. Confirmability was guaranteed by deepening the understanding of the phenomenon under study, as author E.A., working as a nurse anesthetist, had a preunderstanding of assessing perioperative worry. In interpreting data there should be a balance between adding a new aspect to the phenomenon under study and not adding a new meaning to the text that is not there. The influence of preunderstanding in interpreting results was minimized because authors L.N. and C.Ö., specialist nurses in intensive care and psychiatric nursing, respectively, analyzed the interviews separately to confirm the results. The final findings are a result of several in-depth discussions between the authors until consensus was reached.

Conclusions

Perioperative anxiety is a common phenomenon. When not using a validation instrument, the assessment of perioperative worry is based on the anesthesiologist's and nurse anesthetist's experience, knowledge, and views on the subject. However, although there is need for assessment of patients' experiences by means of validated instruments, it is important that the evaluator be capable of using different strategies in the assessment and handling of perioperative anxiety in patients before surgery and that this always be undertaken with a person-centered focus.

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