Health-Promoting Collaboration in Anesthesia Nursing: A Qualitative Study of Nurse Anesthetists in Norway

Gertrud Averlid, RNA, MPH
Susanna Bihari Axelsson, PhD

Perceived stress of nurse anesthetists and their work environment has been the focus of several previous studies. This article presents a study of different factors that may contribute positively or negatively to the work environment of nurse anesthetists in Norway. It focuses on factors that nurse anesthetists perceive as health promoting at work and indicates how a healthy work environment can be created.

A qualitative method was used, which included interviews with a strategic sample of 14 nurse anesthetists working in anesthesia departments. The data were collected in 2008. A grounded theory approach was used as the method of analysis. From the data analysis emerged 1 core category, Collaboration for better or worse—the fate of nurse anesthetists at the workplace. There were also 3 categories, Management as organizer of conditions, Well-being in an operating theater, and Clarity of role, and a number of subcategories.

Collaboration through teamwork emerged as a crucial factor in the work environment of nurse anesthetists, while management was considered an important factor for creating a healthy work environment. Production pressure and communication difficulties were perceived as negative for the work environment. Management should therefore be actively involved and oriented toward creating favorable conditions for collaboration.

Keywords: Health promotion, leadership, management, nurse anesthetists, workplace.

The workplace of a nurse anesthetist is very restricted, since most work tasks are performed inside the operating room. Continuous observation and bedside presence requires professional and efficient management of the entire patient situation. The profession is characterized by high workload, both dependent and independent work, and unpredictable situations.

In Norway there are 2 different anesthesia care providers, nurse anesthetists and anesthesiologists, which can include anesthesiology fellows. A nurse anesthetist has a bachelor's degree in nursing and 18 months of training in nurse anesthesia. A nurse anesthetist is subordinate to the anesthesiologist and works with direction from the latter, but also functions as a nurse with all the responsibilities that belong to the nursing profession.

In accordance with the Norwegian Standard of Anesthesia, a nurse anesthetist has the competence to provide and maintain general anesthesia of functionally healthy patients and to collaborate in a team with an anesthesiologist if the patient has more complex diseases. The nurse anesthetist can also independently observe patients undergoing regional anesthesia and/or sedation.

Nurse anesthetists and anesthesiologists have many overlapping skills, and therefore the allocation of work tasks can be a source of conflict. A good team climate can, however, promote high efficiency and a sense of well-being among the team members. Managers of anesthesia care teams have a particular responsibility for creating arenas where the team members can communicate with each other, and as a result patient safety and outcome can become optimal.

Because every workplace is an important arena for health promotion, it is important that managers have enough understanding and knowledge about factors that promote the health and well-being of their employees. This requires a holistic view of leadership, which may contribute to the satisfaction of subordinates in work situations, while a 1-sided focus on production may have negative effects on both psychological and physiological aspects of health. Feedback from managers may be an “energy releaser,” which is experienced as health promoting by the subordinates.

Learning is another positive factor that improves the motivation of the employees and makes their work more challenging, manageable, and meaningful. Both feedback and learning are important for collaboration between professionals, and collaboration may also contribute to their work satisfaction.

Against this background, the aims of this study were to examine different work factors that nurse anesthetists perceived as health promoting in their workplace and to make them visible for the management of anesthesia workplaces. An additional aim was to indicate how a healthy work environment can be created in an anesthe-
The following research questions were formulated: What do nurse anesthetists perceive as health promoting in their work environment? How can management contribute to promote a healthy work environment from the point of view of the nurse anesthetist?

Conceptual Framework

The main concepts used in this study belong to 2 different fields of research: health promotion and health management. In regard to health promotion, this study is based on Antonovsky’s salutogenic model of health called sense of coherence. This model describes life experiences in terms of comprehensiveness, manageability, and meaningfulness. To describe the development of sense of coherence, Antonovsky used the concept “generalized resistance resources,” which can help a person to avoid or combat a wide variety of stress factors. A person with a strong sense of coherence has the ability to mobilize generalized resistance resources that can contribute to better health, whereas a person with a weak sense of coherence does not have this ability.

The work environment is an important factor for health promotion in the workplace. It includes physical and psychological as well as social aspects. The psychosocial work environment is often described using the “demand/control/support” model of Karasek and Theorell. The model consists of 3 dimensions: job demands, decision latitude, and social support from managers, professionals, or both. These dimensions may be combined in different ways to produce different work environments.

In regard to health management, this study is based on theories of management and leadership. According to Yukl, there are 4 broad categories in which the activities of managers can be described: (1) build and maintain relationships, (2) make decisions, (3) collect and give information, and (4) influence people. The efficiency of these activities depends on the organizational environment as well as the competence and motivation of the subordinates.

Another important aspect of health management is collaboration across disciplinary, professional, or organizational boundaries. This study deals mainly with transprofessional collaboration, which according to Lauvås and Lauvås is the ultimate model of teamwork and is most relevant in an anesthesia setting, where a holistic view of the patient is expected to dominate. Their model includes a common understanding of methods and knowledge, which depends on communication between the individuals involved.

Previous Research

In a study by Perry concerning the Certified Registered Nurse Anesthetist (CRNA), several negative environmental work factors were found, including heavy workload, production pressure, staffing issues, and work schedule. The experience of heavy workload was explained partly by high production pressure. Staff shortages and limited opportunity for breaks and time off were perceived as strain. The most important negative factors were problems of interdisciplinary relationships, the behavior of the anesthesiologist, work policies, and coworkers’ neglect of their duties. Gevers and colleagues also found that acute strain inhibits effective teamwork behavior between doctors and nurses in medical emergencies.

In another study, Alves found a significant connection between employment arrangements, educational levels, and scope of practice (SOP) of nurse anesthetists. The relationship between SOP and work-related stress was associated with role expectations and responsibility. The group with high SOP scores experienced higher work-related stress than the group with lower SOP scores. These results indicate that improved competence goes together with more stress because of higher role expectations and more responsibility. On the other hand, responsibility was also accompanied by a feeling of confidence and self-esteem in the work situation. In any case, coping resources and social support were needed and used by everybody, regardless of SOP, in the handling of work-related stress.

In another study of nurse anesthetists, by Jones and Fitzpatrick, role conflicts, unclear expectations, and limited SOP was shown to result in more work-related stress and less work satisfaction. A healthy collaboration between CRNAs and physicians, in which both partners strive for mutual adaptation, was recommended as the ultimate team constellation for quality of care as well as patient safety.

In a study of healthy workplaces by Arwerson and colleagues, several factors of importance were found. The most important factor was leadership. Other important factors were communication between the employees and the manager, the importance of feeling needed, working in an organization with a good reputation, opportunities for development and learning, and the ability to cope with new demands. These factors were not related to anesthesiology. However, the question is, in what way could leadership in an anesthesia workplace contribute to a better health-promoting work environment?

Materials and Methods

• Design and Sample. To answer the research questions, we chose grounded theory as a relevant analytical approach. This theory was first described by Glaser and Strauss as a comparative method for analysis of qualitative data. It is a method for studying individuals’ perceptions, main concerns, or problems and for generating concepts explaining basic social processes. Grounded theory emphasizes the participant’s voice (via interview), while theory is being constructed in an interactive process between the researcher and the data generated. In the analysis phase the researcher strives for saturation,
which is reached when no new information is generated by new data.25,26

The study sample consisted of 14 nurse anesthetists (8 women and 6 men, aged 28-61 years, with 1-31 years of practice), who worked in 6 different hospital anesthesia departments in the southeast region of Norway. The size of the departments ranged from 20 to 90 employees. This sample was chosen in a strategic way to reflect the composition of the nurse anesthetist workforce in Norway in terms of age, gender, and experience (Norwegian Association of Nurse Anesthetists [ALNSF], unpublished written communication, 2008). The size of the sample was based on experience from grounded theory of how many participants are required to reach saturation.26

Oral and written inquiries for participants were made, and were delivered in person by the first author (GA) to the anesthesia nursing managers of 3 different departments. They had the responsibility to forward the inquiry by internal mail to their subordinate nurse anesthetists. Unfortunately, only 4 participants responded. A new inquiry was then sent out, which resulted in 1 more participant. After this reminder, 3 more departments were contacted. These contacts resulted in 7 more participants: 3 of them from a large department, 2 from a medium sized, and 2 from a small department. This brought the total to 12 participants (6 female and 6 male nurse anesthetists). Two of them had their training and practice from other Nordic countries. Finally, 2 female participants with less experience (1 and 8 years, respectively) were recruited, making for a total sample of 14 participants.

**Data Collection and Analysis.** Data were collected from May to November 2008. An interview guide was used, which included questions divided into 3 themes that were all concerned with workplace health (experience of health related to work situation, collaboration, and management). Some of the questions are reproduced in the Table. All interviews were conducted in person by the first author (GA). The interviews lasted between 50 and 90 minutes.

During the interviews, the participants were also given the opportunity to raise questions of relevance to them. The researcher was aware of the importance to listen and to try to avoid biases. The researcher also tried to establish dialogic validity by asking follow-up questions to strengthen the intersubjectivity between the interviewer and the participant. Throughout the process, the researcher tried to be as open and honest as possible, and every step was carefully considered and assessed in accordance with guidelines for qualitative interviews.27,28

The interviews were audiotaped and then transcribed verbatim by the first author soon after the interviews. Because of logistical and practical reasons, however, some of the interviews had to be conducted immediately after each other, which precluded a consecutive transcription and analysis of the interviews. The interviews or recoding of previously analyzed data. A core category was finally identified, which described a psychological process. This core category was central to the data and could be related to all categories and subcategories.

According to Norwegian regulations, the study plan was submitted to the Regional Research Ethical Committee for approval, but the committee concluded that it was not necessary for ethical approval. The Data Inspectorate approved the procedure of collecting data, and the data were deleted 2 years after approval in accordance with the regulations. Consent from the participants was obtained by voluntary participation in the interview. Oral information was given before each interview. Confidentiality was promised, as was safety from views were analyzed according to Malterud’s29 norms for a complete data analysis. The categorization was accomplished according to the principles of Strauss and Corbin.27 The analytical techniques included open, axial, and selective coding.

*Open coding* means that the substance of data was captured and segmented into substantive codes, which were concretely labeled. The process of open coding resulted in clusters of codes with similar content, which were gathered into categories with more abstract labels. In *axial coding*, each category was further developed, and subcategories were identified. Comparisons and relationships among the categories were sought, and data were put together into new entities. Some categories had both positive and negative features. In *selective coding*, the categories were saturated (until no new information was generated by new data) with either new transcribed interviews or recoding of previously analyzed data. A core category was finally identified, which described a psychological process. This core category was central to the data and could be related to all categories and subcategories.

**Table.** Excerpts From the Interview Guide

<table>
<thead>
<tr>
<th>Question</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you describe what health at the workplace means for you?</td>
<td>Experience of health in relation to work situation</td>
</tr>
<tr>
<td>Do you perceive that workload and quality of work tasks are related to</td>
<td></td>
</tr>
<tr>
<td>each other?</td>
<td></td>
</tr>
<tr>
<td>Are there physiological or psychological strains in your job?</td>
<td></td>
</tr>
<tr>
<td>If any, do you experience that they have an effect on your health?</td>
<td></td>
</tr>
<tr>
<td>How do you perceive collaboration in teamwork?</td>
<td>Experience of health in relation to collaboration</td>
</tr>
<tr>
<td>Have you perceived situations with deficiency of collaboration, which</td>
<td></td>
</tr>
<tr>
<td>have influenced patient quality?</td>
<td></td>
</tr>
<tr>
<td>Do you think the management has influence on how collaboration functions?</td>
<td></td>
</tr>
<tr>
<td>Do you think that your manager’s view of health has an influence on your</td>
<td>Experience of health in relation to management</td>
</tr>
<tr>
<td>opinion of health?</td>
<td></td>
</tr>
<tr>
<td>Do you think that the style of leadership influences the view of health</td>
<td></td>
</tr>
<tr>
<td>in your department?</td>
<td></td>
</tr>
<tr>
<td>Do you have the possibility to participate in decisions that may</td>
<td></td>
</tr>
<tr>
<td>influence your health?</td>
<td></td>
</tr>
</tbody>
</table>

Opening question
Can you describe what health at the workplace means for you?

Experience of health in relation to work situation
- Do you perceive that workload and quality of work tasks are related to each other?
- Are there physiological and psychological strain in your job?
- If any, do you experience that they have an effect on your health?

Experience of health in relation to collaboration
- How do you perceive collaboration in teamwork?
- Have you perceived situations with deficiency of collaboration, which have influenced patient quality?
- Do you think the management has influence on how collaboration functions?

Experience of health in relation to management
- Do you think that your manager’s view of health has an influence on your opinion of health?
- Do you think that the style of leadership influences the view of health in your department?
- Do you have the possibility to participate in decisions that may influence your health?
individual consequences of participating (by ensuring that there would be no identifying or recognizable quotations or information used).

Results
The analysis of the interviews yielded 1 core category, 3 categories, and a number of subcategories. The core category was formulated as Collaboration for better or worse—the fate of the nurse anesthetist in the workplace. It describes on one hand the dependent role of the nurse anesthetist due to his or her subordinate position and on the other hand the good feeling of collaborating in a team to improve patient care.

The first of the 3 categories, Management as organizer of conditions, indicates the opportunity for managers to create a healthy and supportive work environment, from both a collaborative and a health-promoting view. The second category, Well-being in an operating theater, includes all the factors that facilitate collaboration but also those that are barriers to collaboration. The third category, Clarity of role, describes the possibilities and restrictions in the nurse anesthetist role, and their influence on collaboration. These categories are related to 8 subcategories shown in the Figure.

• Collaboration for Better or Worse. The core category, Collaboration for better or worse—the fate of the nurse anesthetist in the workplace, describes the nurse anesthetist profession as a complex and important function in the operating room, highlights the vulnerability of the profession as well as the role that the nurse anesthetist has in relation to other professions, and describes the most important part of the work environment.

Collaboration was described as both good and bad. Good collaboration was the most common situation, and it made the work pleasant and challenging. Bad collaboration was when the nurse anesthetists believed that they were not respected, when they were not able to use their competence, or when they felt a lack of trust. The participants reported that collaboration was mostly dependent on the personality of the individuals involved. They described their work situation as independent but also lonely, a demanding setting in which they had to cope with the demanding work situation.

Collaboration in teams and support from their own profession were important factors of well-being and satisfaction for the nurse anesthetists. In addition, collaboration was regarded as a condition to achieve good-quality patient care. In a collaborative context, it was important to have feedback concerning work performance as well as opportunities to discuss professional problems. The opportunities for discussions, however, depended on the time schedule and the physical environment.

• Management as Organizer of Conditions. First among the categories is Management as organizer of conditions. In the interviews, management was described mostly in connection with managers of anesthesia care teams. Despite the fact that in Norway these managers—the chief nurse anesthetist and the chief anesthesiologist—are not present in the operating room, the nurse anesthetists perceived that the managers determined the working conditions. Different aspects of this category are described in 3 subcategories: View of health, Physiological and psychological needs, and Workplace adaptation.

• View of Health. The nurse anesthetist profession was described as demanding and with a health-promoting perspective as a necessary condition for practice. However, participants experienced that managers showed little interest in initiating health-promoting activities, neither physical activity nor any other health-promoting activities. The nurse anesthetists believed that the managers regarded health as a personal responsibility. Several participants mentioned that it was crucial to keep themselves in good physical condition to be able to cope with the demanding work situation.

• Physiological and Psychological Needs. The nurse anesthetists experienced that the equipment they had to work with (operating room tables, anesthesia machines) was heavy and sometimes badly adapted to small or narrow operating rooms. Since members of different professions were collaborating around the patient, all of them did not have the same focus on using equipment for transferring and turning the patient. The participants also expressed the view that there was little time for reflecting over their work-related task performance.

One participant said, “It is quite important with time and opportunities that there is a manager who can be there or some other person that you can take aside and say something there and then. So you don’t serve it up at the dinner table.”

• Workplace Adaptation. The participants thought that their managers really wished to take care of them and to adapt the workplace and the working conditions to their needs and desires, but their experience was that the managers often lacked both the ability and the time to do so.
Instead, it seemed that only the senior coworkers and the employees with reduced work capacity or special needs could get the attention of the managers.

- **Well-being in an Operating Theater.** The second category is called Well-being in an operating theater. The work environment was regarded as a crucial factor for the well-being of nurse anesthetists. It was described mainly in terms of collaboration among colleagues and with other professions, but also as opportunities for personal and professional learning and development. Different aspects of this category are described in the following 3 subcategories: Variations and unpredictability, Teamwork, and Appreciation.

- **Variations and Unpredictability.** The work situation was described as demanding, but there were variations in intensity, which allowed some downtime. The variations from full control to unpredictable emergency situations were important for their choice of profession. These variations were experienced as challenging and exciting, especially for the younger nurse anesthetists, which contributed to their work satisfaction.

“Variation in the work is for me health promoting; it is a challenge for the brain; it is a lot of things.”

There were also negative views related to not knowing what the day would bring or where to work the next day. With this unpredictability, the nurse anesthetists wanted to have more time to take care of the patient, especially at the induction and the end of the anesthesia.

- **Teamwork.** Teamwork was recognized as a development of collaboration, although it sometimes led to frustrations. Working in teams was perceived as working without management, since the managers had no influence in the operating room. There the team members created the conditions for patient care and decided in which way to provide the care. Participants emphasized that the team was dependent on the combination of individuals, but the work was often adapted to the anesthesiologist in charge. Sometimes the anesthesiologists were appreciated and accepted as good enough to take off the anesthesia. Competencies were given more responsibility and believed that the anesthesiologist trusted them. Their competencies were perceived as careful and respectful to the nurse anesthetists. Teamwork contributed to a sense of well-being at work.

“Well-being is with the patient in the center, and all of those I work together with around the patient; that is my well-being at work.”

Communication was perceived as a crucial factor of team collaboration, contributing both to a clear task allocation and to avoiding misunderstandings that would endanger patient safety. Simple phrases such as “good morning” and “I’m glad we are working together today” were perceived as contributions to a good atmosphere and a sense of coherence in the workplace.

- **Appreciation.** The participants perceived that their managers seldom expressed appreciation for their work. Even when the nurse anesthetists could feel that they were doing a good job, they did not hear it expressed. In their opinion, the managers had extensive tasks and a lack of time and ability to appreciate the work of their subordinates. The nurse anesthetists, on the other hand, were very self-critical, and it was important for them to get feedback. Appreciation gave self-confidence and motivation for further tasks. It also contributed to a good atmosphere in the operating room. Good patient outcomes were positive for the whole team and strengthened collaboration.

“If I am able to administer anesthesia professionally [which means that the patient falls asleep and wakes up in an adequate way, is stable during the anesthesia maintenance, and] the patient feels well … at recovery—these are the things that tell me if I have managed to do a good job.”

Some participants expressed that they perceived feedback from the anesthesiologist as a good appreciation. According to them, the anesthesiologist could best evaluate how they were working. Support from colleagues was perceived as positive and worked as a special form of appreciation. It was also common to use a colleague as a mentor to ask for and get advice.

- **Clarity of Role.** The third category is called Clarity of role, which was described with great discrepancy in the interviews depending on the work experience of the participants. Experience was described as a feeling of security and the ability to cope with the different situations that may arise. There were, however, different views on the role to be subordinate and take orders. The different aspects of this category are described in 2 subcategories: Scope of practice and Direction.

- **Scope of Practice.** The participants who were employed in small units and had a long practical experience felt a special relationship with the anesthesiologist. They were given more responsibility and believed that the anesthesiologist trusted them. Their competencies were appreciated and accepted as good enough to take care of the patients. It was expressed that to know each other was the basis for mutual trust. If the nurse anesthetists were less known to the anesthesiologist, trust was reduced dramatically. This was also the case when a new and insecure anesthesiologist tried to supervise without adequate knowledge and experience.

Participants with more than 10 years’ experience described a special feeling of authority and self-confidence. Some of them described this feeling as creating an aura of trustfulness in relation to the anesthesiologists and in relation to the nurses in the operating room.

“I think I dare because of my age; I have been practicing my profession for such a long time…. I just cannot stand there and let the patient suffer if I think I can do something.”

Participants with less than 5 years’ experience described the opposite situation, in which they found it demanding to cope with their own and others’ expectations, and they perceived the situation as stressful. With less experience, they had more needs for assistance and support.
Discriminability. At smaller units the nurse anesthetists worked more independently, and they could wake up the functionally healthy patient themselves after receiving instruction by telephone from the anesthesiologist in charge. This independence was perceived as positive and gave the nurse anesthetists a feeling of trust and professionalism. In other units, often the largest ones, the nurse anesthetists were not allowed to wake up the patients without an anesthesiologist present; sometimes they believed that they were not trusted.

“We have the same tasks; we work in a similar way, so there is a competition between the nurse anesthetist and the anesthesiologist. Therefore, I guess it is necessary for them sometimes to demonstrate that they are in charge.”

In the most cases, however, there was a relaxed relationship between the nurse anesthetists and the anesthesiologist. The nurse anesthetists accepted working on orders from the anesthesiologist, and the problems experienced were classified as dependent on personalities.

Discussion
The recruitment of participants was difficult, and therefore the sampling procedure had to be extended. Voluntary participation was used, and the researcher was contacted either directly by the participants or indirectly by their managers. It cannot be excluded that the sample procedure influenced the results. Presumably, the participants took part in the study based on their interest in the topic. Maybe the knowledge and experiences expressed could have somehow differed with participants who were not as interested in the topic. The heterogeneity of the sample was given priority, and strategic sampling was therefore used.

The core category describes the dilemma of the nurse anesthetist of on the one hand being professional and independent, and on the other hand being dependent on the competencies, skills, and willingness of other professionals to cooperate in providing good anesthesia care. The formulation “for better or worse” in the core category is connected with the subordinate role of the nurse anesthetist and the collaboration with the anesthesiologists as positive but also challenging. Regarding not being allowed to use one’s own skills and knowledge without supervision, frustrations can arise. This may be accompanied by diminishing self-esteem, which can contribute to a lower sense of coherence, especially in relation to meaningfulness.

“for better or worse” illustrates the collaboration not only as a possible source of conflict but also as something that is part of the situation and must be accepted. Despite this, teamwork was perceived as an important factor for work satisfaction. The optimal collaboration in the anesthesia care teams seemed to be transprofessional or cross-professional, where the boundaries were eliminated and empowerment was reached for both the experienced and the inexperienced nurse anesthetists. The participants could experience, as previously described by Lauvås and Lauvås, that when different professionals participated and contributed in the search for knowledge and made solutions together, complementary competencies were reached and individuality became less visible.

Role expectation in anesthesia nursing can also be seen in light of the core category, “the fate of the nurse anesthetist.” This means that while the anesthesiologist takes responsibility for the technical and medical treatment, the nurse anesthetist is responsible for the patient’s general safety. According to the Norwegian Law of Health Professions, there is no demand for optimality in the distribution of tasks and responsibilities, which means that many tasks can be fulfilled by nurse anesthetists despite the higher qualifications of the anesthesiologists. This situation can create a competition for tasks when both professions have sufficient competence. This dilemma can be even worse if a nurse anesthetist has more informal competence for a certain task than an anesthesiologist. This competitive dilemma may threaten the nurse anesthetist’s identity and autonomy, which has been described by Jameson as an intractable conflict.

The managers of the anesthesia care teams have to make plans and accomplish tasks according to the decisions of the top management of the department or the hospital. Yukl has described how strategies and priorities are decided at the top level of an organization. Managers at lower levels have a crucial role as organizers and facilitators of working conditions. The core category illuminates this balance between production and health. An imbalance may lead to feelings of inability and a low sense of coherence. From a patient perspective it is also crucial that the nurse anesthetists are not forced to overlook important control and checking routines, as described by Perry, who found that production pressure was a negative factor that affected patient safety.

Variation and a reasonable amount of unpredictability in work was perceived as positive. Task performance contributed to self-esteem, and, in accordance with Alves findings, greater expectations and responsibility provided positive stress. Less experienced nurse anesthetists perceived excitement and challenges as stressful, but at the same time they experienced them as positive for their well-being. These findings are contrary to those of Jones and Fitzpatrick, who found that a low score of SOP (indicating less scope) gave more stress and was a negative factor toward well-being. Appreciation and support from colleagues seemed to compensate for a lack of leadership in the operating room and for a lack of feedback from the patient. It was experienced as a major factor of well-being.

Responsibility of anesthesia maintenance was especially important for the experienced nurse anesthetist, and if it was questioned, it was perceived as a lack of trust. Such situations could be avoided when the profession-
In particular, communication between close collaborators and managers of anesthesia units, who may add better members and creating favorable conditions for their colleagues of nurse anesthetists. Nevertheless, it is hoped that work satisfaction and the well-being of nurse anesthetists, as emphasized the importance of establishing common goals for the reason that communication problems are often a consequence of relationship problems, and with improving relations the possibility for mutual communication will also be improved, which earlier also was emphasized by Øvretevit.19

Briefing reports have been suggested by other researchers as a good method in this context.4,6-8 Briefings could, for example, bridge the perceived gap between the experienced nurse anesthetist and the theoretically skillful but less experienced anesthesiologist, and in that way create mutual trust and more pleasure in the work situation.

This study has revealed that nurse anesthetists perceive that the main health-promoting factors are the behaviors of close collaborators, especially their personality and collaborative skills. As mentioned in the introduction, good team collaboration is extremely important for patient safety.4,6-9 In addition, it has implications for work satisfaction and the well-being of nurse anesthetists, as the current study has shown.

This research is based on the experiences of a small group of nurse anesthetists. Nevertheless, it is hoped that the results can provide managers with added knowledge, so they can be more actively involved in motivating team members and creating favorable conditions for their collaboration.

Future research should include the anesthesiologists and managers of anesthesia units, who may add better knowledge and insight into the challenges of collaboration between anesthesia providers in the operating room setting. In particular, communication between close collaborators in anesthesia care teams seems to be a topic of interest.

REFERENCES

10. Ljusenius T, Rydqvist LG. Healthy Leadership: Leadership from a Health Perspective [in Swedish]. Stockholm, Sweden: Arbetskyddsnamn-
den; 1999.