ANAESTHETIST

STORY 3

I was involved in setting up the preadmission testing and perioperative services at my hospital. It was impressed upon me that if anaesthetists are not involved in running and setting up such a service, then it would not be done as efficiently as possible. Our preadmission clinics are run by anaesthetists as we are most affected by the condition of the patient when they are presenting for surgery. Day of surgery admissions have made preoperative assessment of patients much harder for the individual anaesthetist as, in general, we do not get to see our own patients before they arrive in hospital on the day of their surgery.

The anaesthetists in the preadmission clinics put all the patient’s health care information together and work out the risk, talk to patients – amalgamating all that information is what anaesthetics is all about. Ideally the patient presents for surgery in optimum condition; but this is sometimes not possible and we need to balance the need to optimise the patient’s condition with the problems associated with delaying their surgery (for example when this is related to treating cancer).

One of the things that has been a learning curve is how little some people seem to care about their own health. Smoking and substance abuse is common and often continue despite the onset of substance abuse related conditions such as vascular disease. I’m also perplexed that despite the patient being anxious about an upcoming procedure they will often not read the information that is given to them. Mostly they want to know about the process, what is going to happen to them and they want to be reassured by us that we know what we are doing. What is a big deal to the patients may not seem a big deal to us. Building a level of trust is really important. I always ask the patient do they have any questions and you tell them about the risks, but relatively few ask about the risks.

The pre-admission clinical takes three hours and is a big time commitment for patients. They see it as a very thorough process and are reassured by it. I take the viewpoint that if the patient wants the operation they have to take some responsibility such as ringing us to confirm their surgery date rather than us chasing them. The systems that put responsibility on the patient tend to have lower cancellation rates. A lot depends on how serious the patient thinks the condition is but we have found that asking the patient to do this results in far fewer no-shows on the day of surgery than we used to get.

Most anaesthetists are not particularly interested in doing preadmission clinics. In most clinics you will usually be seeing someone else’s patients. We try and have specialty preadmission clinics, so a clinic might see patients coming in for cardiac surgery, or breast surgery. If possible we try and get an anaesthetist whose anaesthetic practice involves this area so they understand the nuances of that type of procedure. I am lucky in that I do the specialty preadmission clinic (neurosurgery) for the area I anaesthetise in, so that I get to see many of my own patients. Even if I am not involved in a particular anaesthetic I understand the process and I know the anaesthetist and surgeon which means I can better explain to the patient what is going to happen and who is going to look after them. The specialty preadmission clinics also have nursing and surgical resident staff from the specialty so the patient sees a lot of the people who are going to be looking after them.

I enjoy seeing the patients preoperatively and then seeing their anaesthesia, surgery and admission go well. We generally have a low cancellation rate. However, no matter how well we set things up, they don’t always work. We review our cancellations to see if there are things that we could have done better. For example, if a patient has heart disease and the anaesthetist on the day cancels the operation because they felt the patient was not properly prepared, then that would be a complete disaster, a failure of the system. I like to follow through and work out what the problems are. Within the anaesthetic department such failures are discussed quite robustly and we do quite a bit of cross checking to ensure these situations happen as rarely as possible.

It is easier to do the job when the surgeons take a broad interest in the patient general medical condition and not just the surgical condition. Over half of our patients have a GP health summary when they attend our preadmission clinics (we try to get them all to bring one with them). This is another feedback mechanism to let the GP know we value their input and knowledge of the patient as well as provide us with information that the patient may forget to tell us. A well-organised surgeon will often recognise that we need an assessment from the patient’s other health care specialists (e.g. cardiologist) and will arrange this before scheduling the patient for surgery. Surgical consents are usually handled in the surgeon’s rooms. For patients whose command of the English language is not adequate we get interpreters (in person or via phone) and use family members to aid in this process. In general I don’t like seeing patients by themselves; people in these stressful environments don’t remember everything that is said. It’s harder when I have a non English speaker, interpreter and no one else. It is not such an efficient interchange, so I worry the message will get through. You say so much more to an English speaker than a non-English speaker; verbal and non-verbal cues that don’t necessarily translate so well. I prefer an English speaking family member to be present as well, even if they don’t talk. Then at least I know two people have heard the message.

Most surgeons admit the service runs well. The biggest problem on a daily basis is getting patients to theatre on time. The biggest issue is preparing people (who are often old and not very mobile) and getting consents completed on time. Whilst this should all be done prior to the day of surgery, not all clinics have surgical staff who can do consents so sometimes we have to get the consent done by the surgeon on the day of surgery or sometimes the wording on the consent is not clear and we need it clarified. This is a problem for first cases (who arrive at 6:30am when there are no surgeons around). We try not to hold up theatres up but we have iron-clad rule – you can’t get into the holding bay unless the consent is completed properly.

It would be great if anaesthetists took a broader view of their role and were more keen to be involved in the preadmission process. To do the work, you’ve got enjoy dealing with patients and have a passion for making systems work as there is lots of interaction with complex systems. I guess where our system differs from some others is having the pre admission clinic led by a specialist, rather than residents or nurses, who often do not have as much overall interest or knowledge about the general medical issues or how the process works. One of my favourite expressions is: ‘the eye does not see what the brain does not know’. So if someone is inexperienced, they’re not necessarily going to pick up all the things that ought to be investigated and resolved.

Words of wisdom to my colleagues

You need to try to take the bigger picture. If you can bring together all the information about the patient then that is of enormous value.

Questions to consider

What do you understand what the role of the anaesthetist is in the Perioperative Service?

What are the advantages of perioperative clinics?

How do you ensure informed consent has occurred and properly documented before a procedure?

How does your department discuss ways of improving the systems associated with surgery and procedures?

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