ORIGINAL ARTICLE

Appropriate practice of anesthesia: A plea for better training

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ABSTRACT

Background: The role of the anesthesiologist is often unknown among patients. But, the situation where the anesthesiologist is uncertain of his/her function gives more cause for concern. **Methods:** A questionnaire survey on the appraisal of anesthetic practices was carried out over 5 months using the style of clinical practice. **Results:** One-third of the anesthesiologists who responded to the survey attached little importance to the work they did by not communicating the same to their patients while 45.2% did not discuss the intraoperative findings with the surgeons. Although 57 (59.4%) of the respondents usually visit their patients on the ward preoperatively, only 16 (21.6%) discussed the proposed anesthetic procedure with the patients. Thirty-nine (40.2%) respondents claimed that they do not wear ward coats to the ward at the preoperative visit. Less than 20% consistently conducted a postoperative visit. The majority of the respondents would treat all patients as important, irrespective of social status, while 74.5% of them considered obtaining informed consent for anesthesia from patients as significantly important. **Conclusion:** The current practice of anesthesia has been found wanting in several aspects. Knowledgeable discussion by anesthesiologists with surgeons as well as enlightenment of patients and their relatives about their work will improve the quality of anesthesia care remarkably. Changes in the anesthesia training curriculum to reflect these deficiencies would be helpful.

Key words: *Anesthesia, informed consent, professionalism, training*

INTRODUCTION

The anesthesiologist's role is often unknown among patients.[1] Uncertainty of his/her function gives cause for concern. Studies have evaluated patients' perception of the perioperative environment and how it affects the anesthesia care quality in developed countries, especially the non-technical aspects.[2] Literature rating anesthesiologists' non-technical skills is sparse. This article attempts to expose some nonprofessional attitudes and lapses in anesthesiologists' practice, highlighting the need for emphasis on professionalism within the residency program.

METHODS

Questionnaires (Appendix A) were distributed from December 2007 to April 2008 to physician anesthesiologists in five tertiary health institutions within four regions of Nigeria. Questionnaires filled anonymously had consent implied by filling them based on the institutional ethics guidelines. Style of clinical practice and professionalism were examined. Results were analyzed using SPSS statistical package.

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RESULTS

Of 99 anesthesiologists, 35 (35.4%) were female and 64 were male (64.6%). The mean age was 35.7 ± 14.2 years. They included 39 registrars (39.4%), four medical officers (4%), 41 senior registrars (41%) and 15 consultants (15.2%), all married except 30 (30.3%) who were single; two did not specify their marital status. The mean number of years spent in specialty was 4.1 ± 2.0 years.

Although 57 (59.4%) visited their patients preoperatively, 16 (21.6%) discussed the proposed anesthetic procedure with their patients. Thirty-nine (40.2%) did not wear ward coats at such visits. Less than 20% consistently conducted a postoperative visit.

The majority had knowledge of practice of obtaining informed anesthesia consent and its content; 95% and 74.5% considered informed consent very important or important, respectively. Majority would treat all patients

as important irrespective of social status and would resist pressure to anesthetize poor-risk patients before achieving optimal clinical conditions. While some respondents did not know what a preoperative huddle was, 68.7% found it useful.

DISCUSSION

In developing countries, an acute shortage of physician anesthesiologists exists, with non-physician anesthesiologists being used instead. Yet, where physician anesthesiologists are found, medical professionalism is often wanting. Our study established the suboptimal levels of professional interaction between anesthesiologists, surgeons, patients and patients' relatives regarding conducting preoperative visits, discussing proposed anesthetic technique, obtaining informed consent, briefing and debriefing in the theater and postoperative visits. This finding has far-reaching implications for patients, the specialty and the healthcare system as physicians with unprofessional behavior tend to have problems with clinical practice.[3]

Fifty-seven respondents carried out preoperative visits. Patients prefer their anesthesiologist visit them before the proposed procedures.[4] Surgery is a source of acute psychological distress and fear. Preoperative anxiety occurs in 11–80% of the adult patients,[4] and uncertainty of anesthesia compounds it. Besides advantages of aiding planning of patient care, reducing day-of-surgery delay and length of hospital stay and reduction in rates of surgical complications,[5] preoperative visits reduce anxiety,[6] guaranteeing patient satisfaction. Studies show that patients choose to receive information about anesthesia by means of the preoperative visit over other means like pamphlets or multimedia.[7] Therefore, good communication skills should be a component of the anesthesiology residency training.

Just 30 respondents had knowledge of practice of obtaining anesthesia-only informed consent and the content of informed consent, and majority considered informed consent very important. One-third of the participants did not communicate the proposed anesthetic procedure (including pain relief) to their patients. Patients want anesthesiologists in complete control of their anesthesia.[8] Patients' reception of information about intended surgical and anesthetic procedure, besides possible outcome, results in uncomplicated postoperative recovery and care.[5] With informed consent, fears about brain damage, pain, death and incapacitation are dispelled.[7,4]

Name tags are a source of identification but ward coats, commonly associated with doctors in hospital wards, better reflects the identity and status of the individual, especially among patients with little or no formal education. Thirty-nine respondents did not wear ward coats at the preoperative visit. Nonverbal communication occurs on a daily basis between the physicians and the patients.[9] Besides manners and habits, ward coats give a smart appearance, embody professionalism, encourages trust between patient and physician and improve the image of the anesthesiologists' and the profession.

Most respondents did not undertake intraoperative progress discussion concerning anesthetic management of their patients with the patients' relatives. The perioperative period is a tension-filled period for family members, with anxiety transmitted from the family members to the patient.[10] Anesthesiologists must realize their professional responsibilities as physicians who are not just concerned about putting patients to sleep but are also knowledgeable in other areas of patient care.

Nearly half the respondents admitted to not discussing intraoperative surgical findings and prognosis with surgeons. A significant cause of morbidity and mortality are errors occurring during health service delivery, of which communication failure is prime.[11] Briefing (or preoperative hurdle, extended surgical time-out) and debriefing ensure teamwork between the surgeon, anesthesiologist and others to promote patient safety. Preoperative hurdles create awareness of the surgical case. The surgeon leads the team, outlining plans and ensuring comprehension by all. Debriefing, involving discussion of the periprocedural events that emphasize safety, communication and efficiency, is real-time reporting that helps identify and address recurring issues relating to the procedure.[11] For anesthesiologists, it results in reflective learning while ensuring patient safety.

Eighty-two point three percent rarely conducted a postoperative round to ensure appropriate recovery and outcome from surgery. The anesthesiologist's responsibility does not end with removal of the face mask or withdrawal of the needle from the patient's vein.[12] He looks out for anesthetic complications like nausea, atelectasis and pain and can consolidate on rapport established with the patient prior to the surgery and ease the patient's mind about future anesthetics. Surgeons have confidence in anesthesiologists with this routine. Medicolegally, it is difficult to prove negligence in anesthesiologists with this practice, even in cases of *Res Ipsa Loquitur*.[12]

CONCLUSION

Deficiencies in anesthesiologists' proficiency, lapses in duties and possible deficiencies in anesthesiologists' training program are exposed by this study. As effective

physician–patient communication (verbal and nonverbal) influences variables like patient satisfaction, patient compliance and medical outcome,[13] assessments of communication skills should be an integral part of the residency training program, like in North America and Britain. A qualitative analysis of the experiences, knowledge and real-time observations of anesthesiologists at work (Lancaster approach)[2] is also recommended. Furthermore, the WHO Safe Surgery checklist[14] should be routinely implemented by all anesthesiologists to reduce the common and avoidable mistakes in their practice.

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