

Quality vs. Quantity of Patient Contact

By J. Antonio Aldrete, M.D., M.S.

Jorge Antonio Aldrete, M.D., M.S., has, during his long and distinguished career, displayed an insight and keen interest in the noble and healing aspects of the physician-patient relationship in anesthesiology and pain management. Most of us may recognize his name from our recovery rooms' use the Aldrete score to assess the condition of patients for discharge. His many other achievements include his being the anesthesiologist for Dr. Thomas Starzl's pioneering liver transplant team, studies that led to airlines having to maintain cabin oxygen concentrations at a minimum of 18 percent, designing the first one-piece needle for combined spinal-epidural anesthesia, founding of the Arachnoiditis Institute, his publications documenting the contributions of Latin Americans in anesthesiology, and his serving as professor of anesthesiology at, among other academic institutions, the Universities of Colorado, Pittsburgh and Alabama. However, of greatest relevance to the following essay was his 1980 publication with Frank Guerra of "The Hidden Dimension: Emotional Responses and Psychological Responses to Anesthesia and Surgery." A series of related essays about the human factor in our specialty were published as a compilation in a book, *The Human Factor in Anesthesia, Surgery and Intensive Care* in 2004, of which the following two essays were part.

—Stephen Jackson, M.D., Editor

While interviewing numerous medical students contemplating anesthesiology as their future specialty, one definite concern frequently surfaces. In their abstract idealism they expressed, in one way or another, a genuine pre-occupation for the amount of patient contact afforded by anesthesiologists in their daily practice. Though the acute care and prompt problem solving of our specialty attracted them, what they have seen and/or heard in their experience at medical school regarding anesthesiologists being in contact only with sleeping patients caused them alarm. That image hangs on us, justifiably or not, but it does and must be changed.

In reality, our contact with patients, though perhaps shorter in duration when compared to other specialties, occurs at a time crucial for our patients, at a moment when major events in their lives are about to happen.

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When we first see them in the preanesthetic interview, they are concerned about a number of unknowns. Do they have cancer? Are they going to be able to walk? Is their sexual activity going to change? Are they going to be left without a breast, a leg, a hand, et cetera? How much longer are they going to live? Will they survive the operation? [This is] only to mention a few of the more

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frequent worries that surgical patients may have the day before their operation. Our visit must provide assurance and confidence and not produce more worries. This is indeed a precious time when we may alleviate some of the patient's concerns about their operative and anesthetic experiences. What better time to explain our role in watching over their vital functions, to explain the careful administration of potent medications used during anesthesia, to warn over possible complications, to emphasize how our technique may ameliorate immediate postoperative pain, et cetera?

It may be a short contact, but if properly conducted, that interview may play not only a valuable support of the patient's emotional status but also an informational activity of what we do and how we do it, at a moment when the patient's attention is all ours. This can be extended during our encounter with them in the operating room; there, we have from five to 30 minutes, depending on the preparation for the operative procedure. While performing our functions we can literally "chat" with them, explaining what we do and why we do it and then they will be more willing to accept the pain of a needle stick, the removal of a gown, the discomfort of lying on a hard operation table. In addition, we can inquire about their sleep during the last night, their supper and other niceties to which the patient has shown interest or attraction; there again, their attention is ours, and is ours to cultivate.

Finally, let's make the post-anesthetic visit more than a "hi" meeting; let's make it a real visit. While inquiring about problems related to their surgery and anesthesia, we can add some personal touches to the conversation so as to make the patient feel that we truly know each other.

So, there is my answer to the inquiring potential resident candidates; the contact with our patients may be brief (as measured by units of time), but it is in crucial moments of the patient's life, dealing with life and death matters; thus, we can make it one for them to remember and appreciate, if we just take the time.

The preanesthetic interview, the O.R. encounter and the postanesthetic visit(s) are what we make of them, as short or as lengthy as we wish; as important or as irrelevant as we want to think they are.

Improving Communication with Our Patients

By J. Antonio Aldrete, M.D., M.S.

Though evidence that malpractice lawsuits, lack of personal recognition and lower collection of bills may be, in part, due to the inadequate communication between anesthesiologists and their patients, few residency training programs

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have incorporated into their lecture programs courses on interpersonal relations or on the humanistic approach to our specialty.

Communication may be defined as the art of transmitting a message to others, whether we use the spoken word, the written letter or the body's postures. When we interview our patients, medical competence is assumed by most [patients]. Therefore, we will be judged to a greater extent on what we say and what we do while we talk to our prospective clients.¹ To gain their confidence, we can attempt to cultivate the following:

- a. Our apparent or real interest in them, their illness, their operation and their well-being. Here, vagueness and confusion can spoil trust.
- b. Attention to detail would manifest thoroughness and careful approach, and it would demonstrate reliability. Being that anesthesiologists are considered compulsive individuals, we can easily manifest this same obsession for detail in gathering information and providing explanations.
- c. Demonstration of personal warmth can be done by learning some personal background about the patients, their name, family, likes and dislikes, profession, et cetera. Similarly, patients will appreciate and always remember a genuine understanding and show of compassion.
- d. If at all possible, exercise an utmost degree of clarity when explaining what needs to be done and why.

All these points can be verbally communicated; in doing this, words may have to be chosen, the intonation of the voice modulated, and we may emphasize some crucial points by increasing the volume of the voice or touching the patient's arm or shoulder. Let's not hide behind our professional jargon, and let's make sure the patient understands what we mean.

Failure to communicate properly prevents our patients from understanding what we wish to tell them. Therefore, it should be done in a manner understandable to the patients.

The message needs to be "both ways"; for communication to be effective, it implies that we listen, and that means listening to everything they say, not only selecting certain pieces of the conversation.² Frequently, patients communicate indirectly or by insinuation. Our clinical-human ear should be attuned to those subtle messages. It is as important to ascertain what is not spoken as well as what has been said. Then we will develop an understanding; then we are communicating.

References

1. Bulger, RJ. *Hippocrates Revised: A Search for Meaning*. New York. Medcom. 1973.
2. Henderson G. *Physician-Patient Communication*. Springfield. C.C. Thomas. 1981.