

*Age Related Concerns and Expectations of Anaesthesia Questionnaire*

**Please circle answers:**

1. Are you **male** or **female**?
2. Are you completing this questionnaire on behalf of your child? **Yes / no**
3. What type of anaesthetic did you/your child have? **GA Sedation regional/local** = (please specify e.g. spinal, arm block, eye block)
4. Are you medical personnel? **yes / no**
5. Your **age** when you/your child received your anaesthetic

Please complete

What are/were your **expectations** regarding your/your child's anaesthetic?

What were/are your **concerns** regarding your/your child's anaesthetic?

Any other **comments** regarding your anaesthetic

Please continue over page if necessary and return to Heather Nielsen.

# **Age Related Concerns and** **Expectations of** **Anaesthesia** **For Anaesthetic** **Technicians and nurses**

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# **Age Related Concerns and Expectations of Anaesthesia For Anaesthetic Technicians and Nurses**

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## **Background**

As anaesthetic technicians, we are in the position of relating to people of all ages when they are at their most vulnerable.

Almost all patients are not surprisingly, nervous to say the least when they surrender themselves into the care of the medical team assigned to them. Although many of the patients will have had previous contact with their surgeon, the majority will see their anaesthetist for a few minutes prior to their surgery and usually on the same day, especially if their case is acute.

The anaesthetic technician will usually see them immediately before their anaesthetic commences, where we promptly pierce them with an IV cannula whilst at the same time trying to appear welcoming, caring and reassuring!

I have noticed that the relationship/inter personal skills required by anaesthetic technicians will vary according to the age of the patient. We tend to rely on our own life experience and our abilities to empathise with the patient.

Although I'm sure we all relate with the best of intentions and in most cases we do an excellent job, it never hurts to highlight areas that could give us new insight into understanding and creating the optimum environment for the induction of anaesthesia for all ages.

Initially when I started this paper it was my intention to back up my hypotheses where possible by interviewing the patients concerned post surgery, thereby attaining direct and personal feedback.

I approached the patient services manager at the hospital where I'm employed and was made aware of how problematic this subject could be.

Before I could start, I needed to write an abstract, explain my Aims and Methodology, explain my belief systems and how I would achieve my results, discuss all this with the board of trustees, inform all anaesthetists and surgeons, and if all went well I could then apply to the medical ethics committee for approval. It was also suggested that I should take a course at one of the universities, the aim being to write a concise dissertation!

For this reason, I decided to take another approach. I put together a questionnaire and asked for input from family, friends, neighbours, my hairdresser and work colleagues. I've included my own experiences of working in the operating theatre together with examples from various journals and papers already written on the subject by people far more esteemed and experienced than myself.

All references used have been listed

## **Purpose of the study**

The original purpose of this article was to highlight areas of concern and expectations that patients of all ages may experience, areas where Anaesthetic Technicians can make an improvement in their practice which will in turn, impact on the patient in a positive way.

I felt my own training as an anaesthetic technician was lacking in this area, and it is not until you become a patient and end up on the receiving end of an anaesthetic or as the parent of a child about to undergo an anaesthetic, you realise that how we relate to patients while we perform our tasks can make a difference to their experience.

I asked current Anaesthetic trainees what training they received regarding the emotional requirements of the patients they come in contact with, and it seems that while the physical requirements are well covered in their training, eg positioning, very little is discussed about the emotional requirements. This may sound very touchy feely and smack of a holistic approach to anaesthesia, but patients, especially children will soon make you aware if their emotional needs are not being met!

Some of the concerns and expectations that patients may have about their anaesthetic may include:

- Awareness
- Morbidity
- Sickness – vomiting / nausea
- Pain – how much and control of
- Mobility
- Relinquishing of control
- Cost (private sector)
- Type of anaesthetic
- Previous negative experience
- Numbers of staff in theatre or anaesthetic room
- Waiting time- length of time a patient is starved etc
- Loss of bodily functions
- Needles

My aim is to explore these and hopefully highlight areas, which are applicable to certain age groups and examine how we as anaesthetic technicians can try to meet some of the patients concerns and expectations.

As anaesthetic technicians we are restricted and limited to varying degrees, but there are many areas where we can make a positive impact on the patients experience of their anaesthetic and it is these areas I hope to cover in this paper.

My objective is to write a thought provoking, tongue in cheek article for Anaesthetic Technicians and nurses.

Challenging Anaesthetic Technicians to consider their patient's emotional requirements as well as the physical.

## **Preparing children for anaesthetic**

Children respond psychologically to the prospect of surgery in a variable and age-dependent manner. It could be noted that you are in fact dealing with two people, the parent and the child.

Strategies for dealing with children and their parents could include:

Allowing a parent to be present during induction of anaesthesia

Administration of sedative premedication

Creating a supportive environment (eg) no excess noise or chatter,  
Limiting the number of people present during induction,

Deciding before hand who is the primary *actor*. This may or may not be the anaesthetist; sometimes the technician or a nurse will have a better rapport with children. This is especially important in the case of a gas induction.

Educating children and parents via verbal descriptions, tours, books, and videos.

Distraction techniques (eg) singing. *'The wheels on the bus' has the capacity to have many many verses!*

Minimising the length of time a child has to wait in the waiting room

Minimising the length of time a child is starved.

At particular risk are children who have had previous anaesthetics especially if they have experienced turbulent anaesthetic inductions.

Children tend to model their behaviour after that of the parent, if the parent is anxious that anxiety can be related to the child.

## **Guidelines for the Anaesthetic Technician**

In any social interaction, communication has two features:

One is the content or the message; the other is the process, or the manner in which the content is delivered. (1)

The tone of voice, rate of speech, inflection of words, facial expressions, head movements, hand gestures and body postures all communicate meaning (1).

For example, in an attempt to reassure a frightened parent, one might be tempted to say "don't worry" or "take it easy", phrases which might be perceived as condescending or patronizing. (1)

An alternative approach would be to acknowledge the parents stress: "I know it's tough to bring your child to the hospital for surgery; we're going to take good care of her/him.

### **When conversing with children;**

Don't talk to children in a condescending manner (*I*).

Do not convey to the child the notion that his/her feelings, concerns, or ideas are "childish"

Do not laugh at what a child says unless you are quite sure the child intends to be humorous (*I*). By the same token, don't try to always be funny or amusing to children. Children are quite aware of the difference between medical people and clowns. *Keep in mind Patch Adams could pull it off, but you may not!*

Never tease a child unless one knows him/her very well and the child knows he/she has permission to tease in return (*I*).

Initial encounters with young children are often made easier when the adults are softly spoken (*I*) (especially if the child is frightened)

Squatting or kneeling to be eye level with the child may present a less imposing image.

With children greater than three or four years of age, discuss what is about to occur in terms that they can understand (*I*), even if you decide to talk to the parent because the child is dismissive, rest assured that the child is listening intently to what is being said.

Don't lie to children, needles do hurt and propofol can sting etc. By being honest about unpleasanties, we gain trust. Again it's all in the delivery. Deliver your message with consideration to the Childs emotional state.

Lastly there is a special group of children, which deserve a mention.

These children don't need the excuse of a previous turbulent anaesthetic induction or any other excuse, indeed it will more than likely be his/her first time.

These children despite all your skills and best intentions will not under any circumstances wish to participate with anyone including their parents, they have decided to be uncooperative and that's what they'll be.

Forget emla or premedication, this child really doesn't want to be here and every one is about to realise this.

This child may have a Cherubim face framed with curls, but don't be fooled! Inside this child beats the heart of an anarchist!

This child will usually insist on dressing him/herself and will more than likely present in a Spiderman suit or fairy princess outfit complete with kicking boots.

One has to admire these children (and pity their parents) they are single minded and goal orientated; they're destined to become high achievers.

It will soon become clear that there are really only two choices with these little darlings and fortunately the choice is not yours to make.

As the technician your best practice is to plant yourself next to anaesthetic machine, preferably away from the kicking boots hand poised on the sevoflurane.

You may only get one chance!

Once the child is anaesthetised, in the best interest of maintaining good working relationships with your colleagues, you could consider warning recovery.

*In case you feel I may have been a bit callous here, I should inform you that I am the parent of one of these precious children, and I'm looking forward (very much) to the time when she produces her own little cherubs!*

Lastly consider your hospital restraints policy. Most NZ hospitals model their policies on the **UN Convention on Rights of Children**. I think it's fair to say that while Children's views must be considered in all matters & be accorded weight, dependent on the age & maturity of the individual child. Children's rights can be overridden if the procedure is deemed to be in the child's best interests (**Jeffery, 2002**). Also when a child refuses to cooperate, nurses/Anaesthetic Techs are expected to assist & this may lead to the application of some sort of restraint. (**Lamberos 2003**)

## **The Adolescent**

Like adults, adolescents are more likely to be cooperative. They respond to what they perceive to be an attentive and non-judgemental approach (1).

Adolescents are able to recognize and exhibit mature defence mechanisms.

They are experiencing a period of increased body awareness and independence. Like adults they are concerned with coping, loosing control, not waking up and dying.

I have noticed that some adolescent males are practically vulnerable, they put a lot of pressure on themselves to be brave, and in attempt to portray this may appear to others to be closed down emotionally and non-communicative. When in fact they're terrified.

Girls tend to cope a little better, probably because they don't put themselves under the same pressures, it's still alright for girls to need their mums to hold their hands, or to bring a cuddly toy with them and to even cry if they feel overwhelmed.

To both sexes, clear explanations and assurances should be provided and their need for privacy should be respected, in my view, operations of a *personal nature* (eg) circumcision or a gyne procedure can be especially gruelling emotionally for adolescents, and they become embarrassed very easily.

Adolescents should be allowed some decision-making, even if it's the simple choice of holding their own facemask for pre-oxygenation during induction (2). Like children adolescents will respond to the stresses of the pre induction environment to varying degrees, these will directly relate to the coping and defence mechanisms gained from their parents.

Positive reinforcement is important, adolescents are impressionable they respond well to suggestions of calmness, comfort and a favourable operative result.

## **Adults**

How adults respond to the peri operative experience can vary greatly depending on, the reasons for surgery, the patient's age and the patient's ability to tolerate stress (2). For instance a patient about to undergo major cancer surgery will be feeling very differently to a patient scheduled for a caesarean section or a patient about to have cataract surgery.

In my opinion, almost all adults fear losing control, or relinquishing control to others. Being part of the decision process in regard to their anaesthetic options can restore a sense of control. It gives them a sense of participation in their own care. Technicians can facilitate a sense of control for patients by listening to the patient and allowing the patient to express individual needs. Small things can make a strong impact on the surgical experience for the patient and help the person maintain a sense of control.

(eg) Your patient has mentioned he has arthritis in his knees, you know that his surgery requires that he will be positioned supine for a few hours so by discussing with him the options for positioning (eg) a narrow pillow under his knees etc is allowing him to have some control.

For patients undergoing regional anaesthesia the option of listening to *their* choice of music (3) (via head phones), or choosing to be sedated if awareness is a problem for them can help also.

As Anaesthetic Technicians its part of our job to ensure that things run smoothly. This can require a high amount of preparation. Nothing can be more disconcerting to a patient to finally make it on to the operating table only to find the staff running around looking for equipment, arm boards, head rings elbow supports, pumps and technical equipment etc. It's the patient's expectation he/she will be surrounded by competent staff who have his/her best interests at heart. Again it's the small things, having warm blankets to place on the patient once he has transferred to the operating table, shows that you are considering his/her needs.

### **Consider the seven P principal;**

***Prior Planing and Preparation Prevents Piss Poor Performance!***

## Elderly

I have noticed that elderly patients tend to be the most accepting and trusting of all the age groups. Although they expect to be treated with considerate and proficient care, they aren't too concerned with having all the information. With the elderly, less is sometimes more.

The danger here is that this can lead to a complacent attitude towards the emotional needs of the healthy elderly patient (5). It's possible to take the view that the problems or issues of the elderly are the consequence of age-related diseases.

The elderly are acutely aware of being a burden, they don't want to be any trouble, and very often don't want to bother busy medical personnel with their concerns (3). Often they are coping with major life issues, the loss of a life long partner or they are the primary care giver for an invalid partner. They very often have other health issues such as arthritis, COAD or depression.

They also have a lifetime of experiences, which shape their view of hospitals, operations and medical staff.

For some, there are concerns that saying goodbye to family members *really* could be goodbye (5). Morbidity under anaesthetic can be a very real concern. For others, loosing control of their bodily functions worries them.

The Elderly talk to their elderly friends who have either had the same operation or know of someone who has, (usually with less than desirable results).

They also watch sensationalistic medical programs on television and read about medical misadventure in the newspaper. (When good surgeons go bad! etc).

*Its surprising then that most of them seem so calm and accepting, could it be that they have had a life time to hone their skills in deception and underneath it all are just as anxious or more so than the rest of us?*

Many elderly have been raised within a religion and for some this will be a source of comfort, *I have been asked to pray with an elderly patient before they headed into theatre!*

For others, it will be family and friends who provide support.

The chances are, we've had parents or grandparents or elderly relatives who have had to undergo some sort of anaesthetic for some surgical procedure so I'm sure we've all received their comments. In researching this section on the elderly, the overwhelming technique in reducing anxiety in the elderly was human touch (4). Admittedly the majority of these results were for patients undergoing regional and ophthalmic surgery, the simple act of handholding made a significant difference to the levels of anxiety experienced by the elderly and made them feel cared for.

## Summary

Of the 150 (approx) questionnaires I sent out, I received 117 replies; these consisted of medical staff members and the general public of all ages.

An interesting aspect that came from my questionnaires to work colleagues was that when medical personnel are on the receiving end of an anaesthetic/surgery. It appeared the staff assigned to look after them assumed that *as their patients work in the medical field, they already know it all*, and therefore it appeared there was not the same degree of contact or information passed between carer and patient. *Perhaps for some of us it's possible to feel a little intimidated or uncomfortable when we are asked to care for fellow medical staff. We may feel our own practice is being judged.* **Confidentiality** was also highlighted several times by work colleagues, as was **submitting control** to others, and not **embarrassing** your self in front of people that you know and work with.

The questionnaires returned by non-medical personnel were fairly predicable. Arm blocks that failed caused a bit of distress to patients, one 60yr old gentleman felt he had to be stoic and not complain about the tourniquet pain he experienced for a Dupuytren operation when his arm block failed. The experience left a marked impression on him.

Hand holding was mentioned, and by most it was seen as comforting, however one young male remembered feeling awkward and uncomfortable when the nurse held his hand at induction.

*Maybe for young males, maintaining what they perceive as their personal space is paramount to their sense of control.*

However this seemed to disappear as men became older, with many male cataract patients mentioning how nice it was to have a hand to hold, especially when the eye block was administered. One patient went so far as to state that the fact that the nurse held his hand made him feel connected to what was going on and cared for.

Some women who had an epidural for birthing stated that they expected to have a **complete** block and were surprised and disappointed when this didn't occur.

A couple of patients mentioned that they chose to pay for private hospital treatment as they felt that they would receive a better standard of health care, eg They didn't want to wait for their surgery or they wanted the assurance that a surgeon of their choice would perform their operation. Furthermore that their anaesthetic would be administered by appropriately trained staff, not by nurses!

*This belief no doubt came about from recent media coverage on nurse anaesthetists.*

## Conclusion

As Anaesthetic Technicians we come up against many areas that can limit us in how we practice and interact with patients. I have already mentioned some of these such as our individual development of interpersonal skills and our own life experience. In addition the culture and environment of the work place, the attitudes and personalities of the anaesthetists we work with and our own skill base can all have an impact.

Add to this time restraints and poor communication between specialties (PACU, operating theatre, wards).

Sometimes it's just the sheer repetitiveness of the job.

*It's very difficult to be enthusiastic when its 4am and you are on your 5<sup>th</sup> caesarean section for the night.*

Humour can lighten the atmosphere and help put patients at ease, some of us are better at conveying this than others, but often a lighter approach is appreciated. Also there are some patients, who just want to be left alone; they want us to get on with the job so that they can put the whole experience behind them.

At times it's a patient that makes **us** feel uncomfortable or vulnerable and out of our depth, eg a prisoner or a mentally impaired patient. Hopefully your hospital will have protocols in place to manage these patients and situations, but often I've noted that while nurses may get instruction in these areas sometimes the Anaesthetic Technician is not included.

This is an area that I felt was lacking in my own training as an anaesthetic technician. It's important to remember that while we try and treat everyone with the dignity, respect and compassion they deserve, the same rules apply in return to us.

Finally it appears overwhelming that patients *expect* and are *concerned* that they should receive **competent** and **compassionate** care regardless of their age.

So I'm sure that in our day-to-day practice we all leave our own concerns and troubles at the hospital entrance, and **prepare** for, **welcome** and **relate** to all patients as if they were our own beloved family members.

Don't we?

## References

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- (5) *British Journal of Anaesthesia*, volume 87, 2001, *The challenge of anaesthesia in the elderly.*