



Special Article

The effects of preoperative, video-assisted anesthesia education in Spanish on Spanish-speaking patients' anxiety, knowledge, and satisfaction: a pilot study^{☆,☆☆}



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Received 21 October 2012; revised 16 December 2013; accepted 26 December 2013

Keywords:

General anesthesia;
Limited English
proficiency (LEP);
Patient anxiety,
preoperative;
Preoperative interview;
Spanish-speaking patients;
Video instruction

Abstract We studied the effect of an instructional video in Spanish on self-reported anxiety, knowledge about general anesthesia procedures, and satisfaction with the preoperative anesthesia process in patients requiring a Spanish interpreter. This prospective, randomized, nonblinded pilot study took place at Massachusetts General Hospital (MGH), a university-affiliated tertiary-care hospital. Twenty adult, ASA physical status 1, 2, and 3 patients, scheduled for elective surgery (gynecological, orthopedic, and intrabdominal surgery) during general anesthesia were studied. Anxiety, knowledge, and patient satisfaction were assessed using a visual analog scale (VAS). There was a significant reduction in anxiety score in patients who viewed the video compared with those who did not (median reduction 2 vs 0; $P = 0.020$). There was an increase in satisfaction score in the video group (median increase 2 vs 0; $P = 0.046$). There was no difference in reported knowledge-improvement scores between the two groups (3.5 vs 4; $P = 0.908$). In Spanish-speaking patients, the addition of an instructional video in Spanish to a preanesthesia interview decreased anxiety and increased patient satisfaction.

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1. Introduction

The time preceding surgery is marked by uncertainty and angst, which can be difficult to mitigate when communication barriers exist between patient and health care professional [1]. Such language barriers may lead to miscommunication, mistrust, avoidance of medical care, and heightened anxiety about the unknown [2]. Where medical interpreter services are scarce, patients who opt to use family members as interpreters may not receive the

[☆] The study took place at Massachusetts General Hospital, Boston, MA, USA.

^{☆☆} Supported by a David E. Satcher, MD, PhD fellowship, Student National Medical Association, Washington, DC 20011; and a summer internship at the Department of Anesthesia, Critical Care, and Pain Medicine, Massachusetts General Hospital, Boston, MA.

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precise message intended by the medical team [3]. As that portion of the United States' population with limited English proficiency (LEP) continues to expand, physicians are faced with the challenge of communicating and obtaining informed consent in a language that they neither speak nor understand (Fig. 1).

Technological advances make it possible to bridge the language gap, at least partially, with video modality. Video instruction has proven to be effective in many aspects of health care [4]. In studies in which a language barrier did not exist, the addition of video instruction to a preanesthesia interview increased patient knowledge about procedures and lowered preoperative anxiety [5,6]. Perioperative anxiety may adversely influence the immune system and recovery time [7,8].

We hypothesized that Spanish-speaking patients randomized to viewing a Spanish instructional video shown just before the preanesthesia interview on the day of surgery would have reduced anxiety, increased knowledge of general anesthesia procedures, and improved patient satisfaction as compared with Spanish-speaking patients who did not view the video.

2. Materials and methods

The prospective, randomized, nonblinded pilot study was conducted from July 2010 to June 2011. With Massachusetts General Hospital Institutional Review Board approval, written, informed consent was obtained on the day of surgery from 20 consecutive Spanish-speaking patients who were scheduled for surgical procedures requiring general anesthesia. Seventy percent of the study subjects had previously received information pertaining to their anesthesia during a visit to our Pre-Admission Testing Area (PATA); 30% received this information on the day of surgery. Informed consent for anesthesia was obtained with the assistance of a trained medical interpreter. Only those patients who neither spoke nor understood English and who thus required an interpreter to obtain informed anesthesia consent during the PATA assessment or preanesthesia interview, were eligible for participation.

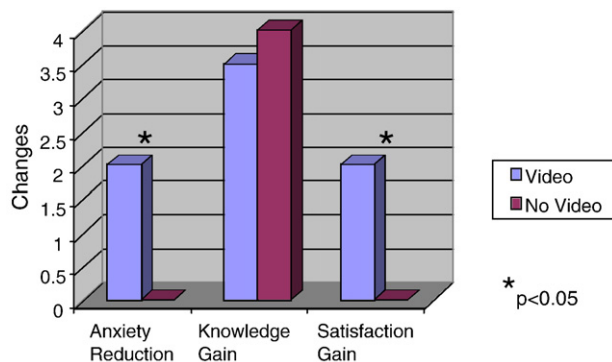


Fig. 1 Bar graph showing the changes on the visual analog scale (VAS) in anxiety, knowledge, and satisfaction, recorded from patients in both the Video and No Video groups. *statistically significant values.

Patients were excluded from the study if they were unable to provide consent (ie, were younger than 18 yrs of age), had significant cognitive impairment, significant impairment of eyesight or hearing, or an existing psychiatric disorder, or if the time between their arrival at the operating room (OR) area and the start of their surgery was less than 30 minutes.

At our institution, patients are referred to PATA by the surgical team prior to their scheduled surgery if they are either ASA physical status 3 or higher, are undergoing highly invasive procedures and/or have LEP necessitating that their anesthesia evaluation and consent be obtained with the assistance of a trained medical interpreter. For the patient who is unable to attend his PATA appointment, the anesthesia consent is obtained during the preanesthesia interview. The PATA interview is conducted by a nurse practitioner, anesthesia resident, or board-certified anesthesiologist. The standard interview format consists of confirmation of the patient's name, surgical procedure, medical and previous surgical and anesthesia histories, in addition to a review of the patient's allergies, medications, and a focused physical examination. The patient then receives an explanation of anesthesia methods and patient-specific risks/benefits. A question and answer period concludes the interview and, once the patient has expressed understanding, the informed consent form is signed by the patient and either a resident, certified registered nurse-anesthetist (CRNA), or board-certified anesthesiologist.

On the day of surgery, once the patient is put "on-call" by the OR team, he /she arrives at an induction room, a small area adjacent to the OR. There the anesthesia team (resident or CRNA and attending anesthesiologist) conducts the preanesthesia interview, consisting of a review of the anesthesia assessment, fasting status, surgical procedure, and confirmation of the site of surgery (if applicable). If not previously documented, anesthesia consent is obtained at this point with the assistance of a medically trained interpreter. When anesthesia informed consent has been previously obtained, the patient with LEP is given the choice of using a medically trained or ad-hoc (eg, family member) interpreter for the preanesthesia interview. Any questions the patient has are addressed at this time. Eligible patients were recruited for participation in our study just after verification of signed anesthesia consent. As a patient's need for interpreter services is documented at the time of booking, potential study subjects were identified from the OR schedule by two investigators who were fluent in Spanish.

On confirmation of patient's participation, an assessment of anxiety, knowledge, and satisfaction was obtained using a visual analog scale (VAS). The VAS was based on a 10-inch (25.4 cm) line drawn on paper. The extreme left side indicated no anxiety, no knowledge, or dissatisfaction; the extreme right denoted maximal anxiety, knowledge, or satisfaction. Each of the three items tested was depicted on a separate sheet of paper. The patient was asked to point to the spot on the line that most closely described his/her answer. This tool was chosen for its ease of administration and

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