The preoperative interview is the beginning of the anesthetist-patient relationship. The goal of the interview is to obtain important medical, surgical and anesthetic histories, to discuss the anesthetic choices, and to obtain an informed consent. Communication during this interview is usually dominated by closed-ended questioning. The author describes communication techniques which can be utilized to aid in the interview process, as well as throughout the course of the anesthetist-patient relationship.

The preoperative interview marks the beginning of anesthesia care for the surgical patient. The interview, made the evening before or the morning of surgery, is the only time the patient has to discuss fears of anesthesia and surgery with an anesthesia staff member. The anesthesia staff member frequently has a number of patients to interview for the following day's surgical schedule, and because of a tight schedule, this individual determines the length of the interview.

Surgical, medical, and anesthesia histories are obtained using closed-ended questioning. Closed-ended questions direct the patient response by obtaining information by a "yes" or "no" response. Closed-ended questioning does not usually allow the patient to verbalize about his or her feelings, and frequently interviewing techniques do not encourage communication.

It is important during the preoperative interview to obtain an informed consent from the patient. Also during the interview, an anesthesia care plan can be developed after a careful investigation of medical, surgical, and anesthesia histories. Moreover, during the interview, the patient can be educated about anesthesia, his or her choices of anesthesia can be reviewed and the risk factors involved discussed.

Given increasing litigation involving anesthesia, informed consent should be an important goal of the interview. Establishment of rapport with the patient will facilitate this goal and may avoid a costly lawsuit due to poor communication. We as nurse anesthetists should be aware that "specialization has nevertheless resulted in minimization of physician-patient contact."¹ We must strive to avoid this result of specialization.

Studies have revealed the benefits of a good preoperative interview. "The establishment of rapport with the patient involves creation of trust in the doctor and the nurse by not withholding information that the patient may wish to know. An explanation will do more to assuage the patient fears than the narcotic pre-medication, and will reduce the dosage required."²

The establishment of rapport requires a thorough understanding of communication techniques which allows the anesthetist to obtain information, and encourages the patient to communi-
cate. The time of the interview is frequently just after admission to the hospital. This environment is foreign to the patient with restrictions and authority dictating his or her every move. The patient has been bombarded with personal questions from several people during the admissions process. The anesthetist should be empathetic, that is, place himself in the patient's position and see the hospitalization from the patient's point of view. "It does not save time to disrupt the patient's opening statement nor stop him from talking, for it may prevent his real problems from coming to the surface." 8

**Basic communication**

Communication begins with an interaction between two people. There are three phases of interaction: 4 (1) the introductory phase, (2) the working phase, and (3) the terminations phase.

*The introductory phase* begins the relationship between the patient and anesthetist. Goals are set for the relationship during this phase. Trust is established and the anesthetist should be able to develop a mutual trust with the patient if he or she is genuine with the patient. This phase focuses on the patient, attempting to meet his or her needs, and provides information so the patient may make an informed consent for the anesthetic procedure.

*The working phase* is the period in which the purpose of the interaction is accomplished. This phase would consist of the administration of the anesthetic as jointly planned by the surgical care team with the cooperation of the patient.

*The termination phase* is the ending of the relationship. This occurs through the postoperative visit, when the patient and anesthetist reflect upon the goals established in the introductory phase. This phase is an ever important one and communication here may help avert potential litigation.

To effectively communicate, and successfully complete the three phases of interaction, one needs an arsenal of verbal and nonverbal communication techniques.

**The interview**

Research has shown that verbal communication accounts for a mere 7% of the impact of the communication process. 5 As discussed, the anesthetist must obtain medical, surgical and anesthetic histories to formulate a plan of care. This information is obtained using closed-ended questioning: "Are you allergic to any medications?" "Do you smoke?" Though these closed-ended questions are important, when used as the sole communication technique, they often leave the patient dissatisfied. 6 The patient does not have any method of obtaining feedback from the questioner, and is not given the opportunity to explain the answer.

The interview should be conducted with a balance of closed and open-ended questioning. Open-ended questions aid in conveying a feeling of caring, clarification of perception, interpretation of meaning, and the validation of observations.

By way of example, the interview begins with verbal introductions:

Anesthetist: "Hi, Mrs. Jones, I am Mr. A. of the Anesthesia Department. I would like to talk with you about your anesthetic for tomorrow's surgery. I have a few questions I need to ask before we discuss your particular anesthetic."

The interview continues with closed-ended questioning to elicit important information. Along with closed-ended questioning, a battery of verbal communication techniques are utilized which allow elaboration beyond the "yes" or "no" response. These techniques are referred to as *facilitating response*. Seeking clarification, validating, restating, the ability to elicit description, and interpretation of meaning all aid in conveying a feeling of caring and provide additional information during the interview. Here is an example:

Anesthetist: "Have you had anesthesia or surgery in the past?"

Patient: "Yes."

Anesthetist: "What type of surgery did you have?"


Anesthetist: "Did you have any problems with your anesthetic?"

Patient: "I remember I became real sick."

Anesthetist: "You became sick to your stomach?"

Patient: "Yes, vomiting, and I had a tube through my nose into my stomach."

Anesthetist: "You had an anesthetic, and then nausea and vomiting afterwards? You also had a stomach tube?"

Patient: "Yes, when I had gallbladder surgery. I guess I had a blockage and turned yellow."

In the above interview, closed-ended questions are used to elicit information. The patient's "yes" or "no" response to having had anesthesia or surgery was predictable. The interviewer then proceeds to obtain information regarding the surgery and anesthesia by asking open-ended questions. This results in additional information. When the anesthetist restates the patient's response ("You became sick to your stomach?"), still more infor-
mation is obtained. When the anesthetist restates the information obtained from the patient ("You had an anesthetic, and then nausea and vomiting afterwards? You also had a stomach tube?"); he validates the patient's earlier points. This results in a clearer view of the patient's problem of "being sick.

The communication techniques just described obtained essential patient information, and provided an environment for the patient to communicate. Here is another example:

Anesthetist: "Do you smoke?"
Patient: "Yes, I smoke."
Anesthetist: "How much do you smoke daily?"
Patient: "About two packs per day. I have been trying to quit, but it's difficult. Will my smoking affect me in any way during my surgery?"

The above patient was concerned about smoking. This concern would have been overlooked had the interviewer not asked for additional information ("How much do you smoke daily?"). In the patient's response, his feelings emerged regarding his concerns about smoking and the possible problems with surgery. These feelings would have not been expressed if the anesthetist, after receiving a "yes" or "no" answer to the question "Do you smoke?", stopped there and proceeded to pursue another line of questioning.

Communication can be discouraged with the use of blocking responses. These responses do not encourage the communication process and leave the patient feeling unsatisfied, potentially leading to a lack of trust. Blocking responses convey to the patient that his worries are not realistic and his feelings are not important as in this example:

Patient: "I am afraid of a headache after my spinal anesthetic."
Anesthetist: "Don't worry about that! You will be all right. I haven't had a patient in two months who has had a headache."

Obviously the patient is worried about the potential of a headache or the question would not have arisen. The example cited demonstrates the use of false reassurances. The anesthetist's response should have been as follows:

Patient: "I am afraid of a headache after my spinal anesthesia."
Anesthetist: "You are afraid of a headache?"
Patient: "Yes, I remember my grandmother had a spinal years ago. My mother said she had a headache for several weeks."
Anesthetist: "We have found that headaches . . ." (The anesthetist then explains incidence, causation, etc.).

In this example, the patient is encouraged to talk about his fear, and then is given additional information about the complications of a headache.

Another example of blocking response occurs when defending other health care providers:

Patient: "After my last anesthetic, I was held down in the bed in the recovery room, and I had trouble breathing. They wouldn't help me!"
Anesthetist: "I understand why they held you in bed. They knew you were afraid, and probably were protecting you from falling out of bed."

The anesthetist has completely missed the point. The patient stated she had difficulty breathing in the recovery room. Perhaps the validating techniques may have found that the patient could not breathe and this was the cause of her anxiety. As the anesthetist's response was not empathetic toward the patient, the result was probably one of mistrust on the patient's part toward the anesthetist.

The interview should have continued:

Anesthetist: "I understand you had trouble breathing in the recovery room?"
Patient: "Yes, I was awake and unable to breathe. I had a tube in my throat. I felt like I couldn't catch my wind. I was very scared!"
Anesthetist: "I am very sorry this happened to you. I will review your anesthetic record and see if we can avoid the problem tomorrow."

The anesthetist has restated the patient's communication in the above example. This provided the patient with an opportunity to further validate the anesthetist's interpretation, as well as to provide more information.

Non-verbal communication

Non-verbal communication is also very important in the interview and, as research has shown, accounts for 93% of the impact of the communication process. Thus non-verbal behaviors have a high degree of credibility.

There are four primary forms of non-verbal communication which are utilized during the preoperative interview: (1) facial expressions including eye contact, (2) paralanguage, (3) bodily actions, including touching, and (4) use of space.

More than 100 years ago, Charles Darwin wrote The Expression's of Emotions in Man and Animals in which he theorized that facial expressions are instinctive and not learned. The facial structures respond to natural conditions and are not governed by cultural conditioning.

There are six basic facial expressions: disgust, surprise, happiness, anger, sadness, and fear. Several of these expressions can be exhibited simul-
taneously. The problem of interpretation is compounded when the verbal message conflicts with the facial expression, as in this example:

Anesthetist: "We have discussed the anesthetic plan. Do you have any questions?"

Patient: "No, I do not have any questions." (Facial frowning-exhibiting disgust).

The patient gave the anesthetist two messages. However, the non-verbal message communicates that the patient did not understand what had been explained. Consequently, the anesthetist should continue to pursue the interview:

Anesthetist: "I see you are unsure of our discussion."

Patient: "Yes, there are a few things I am not clear on."

Anesthetist: "Are you not clear on our choice of anesthesia?"

Patient: "No, I would like to have a local anesthetic, however, I am not clear why I need a shot before surgery."

Being aware of non-verbal behaviors allowed this anesthetist to discover that the anesthetic care plan was not totally agreed upon by the patient. Further questioning elicited the problem on the patient's part and was resolved as follows:

Anesthetist: "I am sorry I was not clear about the preoperative medication. I would like to give this to you so you are relaxed when you arrive in the operating room. This will help sedate you for your surgery."

Patient: "I see. This will help me relax. That's fine. I thought that people having general anesthesia were the only ones to get a shot before surgery."

Eye contact is another important form of non-verbal behavior. A look is more than just seeing. Meaning is constantly conveyed in numerous visual ways, from the loving look of a patient's spouse to the stern look of a nursing supervisor. Eye contact also tells us about the particular relationships we have with another person. We tend to look at things that please us, and look away from things we dislike. Eye contact during the interview is important to communicate a feeling of caring and to aid in the promotion of a genuine trust relationship. During the interview the anesthetist should utilize eye contact to show concern for the patient and interest in his discussion, instead of looking away to the chart to write down the information.

Paralanguage concerns the delivery of a message during the interview. It is not what you say that counts, but how you say it. "The inflections in the voice, the pauses, and the rate of speech can convey happiness, anger, interest, boredom, hate, or frustration." For example, telephone conversations do not allow us to see facial expressions, thus the conversations depend upon paralanguage.

During communication we depend upon paralanguage for determination of the genuineness of a message. Myer's and Myer's cite the following examples of paralanguage:9

Verbal: "I'll be happy to do it."

Paralanguage: "I'll do it, but it will be the last time."

Verbal: "Don't worry, I'll take care of it."

Paralanguage: "Your so dumb, I better take care of it."

Obviously, it would be difficult to assume these interpretations without hearing the phrases spoken. However, one should be aware that paralanguage is an important part of communication during the interview.

Some everyday verbal expressions point to the importance of the touch or touching. We often hear people say: "Keep in touch," or "that was touching." In patient care, touching is an important as eye contact in communicating. This is very personalized, and something we should be aware of for the interview but more importantly during the working phase of our relationship with our patients. Touching is very powerful and communicates caring and respect to the patient.

Bodily actions are an extension of touching in that they convey important cues, cues that communicate positive and negative attitudes. Mehrabian believes that movement of the head and limbs indicates one's attitude toward a specific set of circumstances, and also expresses positive and negative interests. Body movement can also indicate how comfortable one is in social situations.10 The patient can send messages by viewing the television with the body turned away from the interviewer, suggesting his disinterest. In either case, most individuals send messages constantly through bodily actions.

Along with touching and bodily actions, the use of space is also communicative. A.G. White reports on an experiment conducted in the physician's office. He found that a desk may significantly alter a patient's at-ease state. In the situation where a desk separated the patient and physician, only 10% of the patients surveyed felt at ease, whereas 55% felt at ease when the desk was removed.11 Thus during the interview, it is important for the anesthetist to place himself directly in front of the patient and not "hide" behind the bed or bedside table.

According to Hall,9 there are three major interpersonal distances that govern relationships: (1)
an intimate distance from 3 to 20 inches, (2) a
social distance from 20 inches to 5 feet, and (3) a
public distance from 5 feet to 100 feet. During the
preoperative interview, the social distance is util-
ized. If however, a physical examination is indi-
cated, the intimate distance will be invaded. The
patient must be comfortable with you at this dis-
tance. Also this distance is most acceptable for ini-
tiating the trustful relationship that is necessary
later in the working relationship when the inti-
mate distance is further invaded.

The working phase

The working phase begins the morning of surgery. During this phase of the relationship, the
goals set forth during the introductory phase will
be carried out. The common goal during the work-
ing phase is the successful administration and re-
cover from the anesthetic.

Verbal communication reintroduces the an-
esthetist to the patient in the operating room. The
patient may not recognize the anesthetist due to
the traditional "scrub" clothing worn. Validating
and restating can be utilized to refresh the pa-
tient's memory of the previous visit (since the pa-
tient has probably been premedicated) and the
goals that were mutually agreed upon the night
before. By way of example:

Anesthetist: "Mrs. Jones, I will begin to make
you sleepy now (a soft touch on the arm). Your
eye lids will now begin to get heavy, and my voice
will be fading. We will be right here with you
throughout your surgery, and will take good care
of you."

The working phase is completed when the
patient successfully recovers from the anesthetic
in the recovery room and is delivered to her hos-
pital room. Due to the anesthetic drugs admin-
istered (narcotics and sedatives) the patient may
not remember the recovery room, but she still
needs to be treated empathetically. Administering
pain medication and the like are physical tasks
that must be done. Verbal communication will us-
ually dominate because the patient's sensorium and
visual acuities may be dulled. Thus non-verbal
behaviors may be difficult for the patient to eval-
uate.

The exception to this, however, is if the pa-
tient has had a regional anesthetic administered,
then his sensorium may be quite clear, and he
may be able to fully interpret non-verbal be-
aviors. Touch may aid in reorienting the patient,
providing reassurances in the recovery room. Not
only should this non-verbal behavior be utilized by
the anesthetist, but it should be utilized by the
recovery room personnel and any others who are
responsible for the recovery of anesthetized pa-
tients. Following the successful recovery from the
anesthesia process, the relationship enters its final
phase, the termination phase.

The termination phase

On the day following surgery, the anesthetist
should visit the patient. This visit is usually short
since the patient is frequently convalescing and
may still be under the influence of narcotics and
tranquilizers. At this time, the anesthetist should
briefly review the anesthetic course with the pa-
tient so as to identify any particular problems:

Anesthetist: "Mrs. Jones, good morning, I am
Mr. A. with the Anesthesia Department. I stopped
by to see how you are doing today."

Patient: "I am doing quite well, thanks to
you!"

Anesthetist: "Were there any problems with
your anesthetic?"

Patient: "I was very comfortable in the re-
cover room. The nurses gave me a shot through
the IV, and I felt much better after that. Today I
am quite sore but doing okay."

During this communication, the anesthetist
may take the patient's hand to convey an empa-
thetic environment and to show the patient that
there is indeed care for her as an individual. Other
non-verbal behaviors such as eye contact and facial
expressions are as necessary at this time as they
were during the interview process. Your mutual
goal of a successful anesthetic and recovery are
verified. The addressing of any problems here plays
a major role in concluding a successful relation-
ship. At this point, it is also important to block
communication by defending other health care
providers' actions (as was discussed in the intro-
ductive phase). The dialogue may be concluded as
follows:

Anesthetist: "I am glad your recovery went
well. You were very stable and things went
smoothly."

Patient: "Yes, I was very relieved to know
everything went well."

Anesthetist: "If any problems arise, please
have the nurses contact me. I am sure your re-
cover will continue on a smooth course."

Patient: "Thank you very much for your con-
cern."

Finally, the anesthetist should acknowledge
the end of the relationship with caring non-verbal
behavior, by taking the patient's hand. The pa-
tient then acknowledges this and the care provided
by the anesthetist.
Conclusion

The preoperative interview marks the beginning of anesthesia care for the surgical patient. This interview provides the basis of the anesthetic care plan. A balance of closed-ended and open-ended questions must be utilized to obtain information, and allow the patient to address fears of anesthesia and surgery. In addition to verbal communication techniques, non-verbal behaviors such as touching, eye contact, paralanguage, bodily actions, and use of space must be utilized effectively since it has been documented that non-verbal behaviors account for 93% of the total communication impact.5

When beginning the interview it is important for the anesthetist to verbally introduce himself or herself, and initiate non-verbal behavior with a handshake or a touch on the shoulder. This sets the stage for the introductory phase of the anesthetist-patient relationship. Goals are set for the relationship and mutually agreed upon by the patient and anesthetist. This phase is conducted within the social distance of 20 inches to 5 feet.

The second phase, the working phase, constitutes the anesthetic administration. Intimate space is violated during this phase. A combination of verbal and non-verbal communication is important. However, remembering that sensorium will be distorted due to drug administration, the verbal clues are especially important. The patient should be treated empathetically in the recovery room, with his or her immediate needs taken care of. Communication is again a combination of verbal and non-verbal techniques. Non-verbal behaviors such as patient touch is reassuring to the patient who has disturbed sensorium due to residual anesthetics.

The termination phase, usually occurs the day following surgery. The anesthetist reviews the anesthetic course with the patient to identify any problems that may confront the patient. Again techniques discussed during the introductory phase are applicable. The relationship can be terminated with a handshake or an empathetic touch of the hand. This shows the patient that he or she is cared for as an individual.

The anesthetist should strive to initiate a successful relationship with his or her patients. In this day of litigation, it would behoove the anesthetist to establish good patient relationships to help avoid costly suits. Let us remember that communication is as necessary to human relationships as the bloodstream is to an individual.

REFERENCES


(9) Myers G, Myers M. Dynamics of Human Communication, p. 171.


AUTHOR

John Aker, CRNA, BS, is a 1980 diploma graduate of Stormont-Vail School of Nursing, in Topeka, Kansas and a 1993 graduate of the Southwest Missouri School of Nurse Anesthesia, in Springfield, Missouri. He received a BS in Biology from Washburn University of Topeka, Kansas in 1984. He is currently employed by Anesthesia Associates, P.A. of Topeka, Kansas.