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Research

Association Between Patient Satisfaction and Preoperative Task-shifting From Anesthesiologists to Perianesthesia Nurses: A Questionnaire Survey Study

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A B S T R A C T

Keywords:

task-shifting
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Purpose: We examined whether patients' satisfaction improved when patients' preoperative consultations were conducted with perianesthesia nurses (PANs) in collaboration with anesthesiologists, as compared with preoperative consultations conducted by anesthesiologists only.

Design: We conducted a study using questionnaires regarding outpatient satisfaction among patients who visited the perioperative management department of Yokohama City University Medical Center between July and December 2018.

Methods: There were 1,595 outpatients during the survey period. After exclusion criteria were applied, we analyzed 590 valid responses.

Findings: Regarding the level of understanding, 96.9% of the patients in the nurse-and-anesthesiologist group and 95.6% of the patients in the anesthesiologist-only group answered, "easy to understand," indicating no significant difference. A reduction in concerns, worries, and anxiety was reported by 86.3% of the patients in the nurse-and-anesthesiologist group and 70.4% in the anesthesiologist-only group, indicating a significant difference. Furthermore, 94.1% of the patients in the nurse-and-anesthesiologist group and 87.9% in the anesthesiologist-only group indicated patients' satisfaction with the overall evaluation, indicating another significant difference. A multiple logistic regression analysis was conducted to analyze the anxiety reduction and overall evaluation. We uncovered significant differences in PANs' examinations regarding anxiety reduction and overall evaluation.

Conclusions: Collaboration between anesthesiologists and PANs might be associated with satisfaction and reduced anxiety in preoperative patients without adversely affecting patients' comprehension of anesthesia. Further research is necessary to verify the impacts of PANs' involvement in anesthesia patient care on intra and postoperative patient outcomes and on the cost and efficiency of anesthetic care.

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In recent years, overcoming the global lack of anesthesiologists and improving the overall quality and safety regarding anesthesia have become serious issues.¹ Japan is no exception; indeed, the lack of anesthesiologists in Japan may be more severe than in other developed countries.² Throughout history, nurses have been widely

engaged in anesthesia care, as many studies worldwide have reported.^{3–6}

However, only anesthesiologists and surgeons provide anesthesia in Japan. According to a report compiled in 1995, Japan is the only developed country to have no nurse anesthetists.⁷ Since 2004 in Japan, the team care approach, along with skills transfer, has been adopted to provide efficient, safe, and high-quality health care in response to the lack of doctors and a heightened awareness of patient safety. In 2012, nurse anesthetists, called perianesthesia nurses (PANs) in Japan, who specialize in anesthesia care were introduced in Japan for the first time.⁸ A PAN trains in anesthesia nursing for 2 years, in addition to their career as an acute care nurse. They can provide anesthesia under the supervision of anesthesiologists. Eight years after the introduction of PANs, Japan is still struggling to use these

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nurses in hospitals. Task-shifting in Japanese anesthesia care is still in its infancy.

In 2008, the World Health Professions Alliance issued a joint statement on task-shifting that provided guidance regarding proper task-shifting.⁹ Their guideline emphasizes the need to continuously analyze the effects of task-shifting. However, due to its short history in Japan, PANs' effectiveness regarding the safety and quality of anesthesia care has not yet been evaluated.

Therefore, we investigated the effect of PANs' involvement in the anesthesia examination of preoperative patients. We examined whether preoperative consultation conducted collaboratively between PANs and anesthesiologists improved patient satisfaction as compared with preoperative consultation conducted only by an anesthesiologist. Our hypothesis proposes that patient satisfaction would be positively affected by the inclusion of PANs in preoperative consultations.

Methods

We conducted a questionnaire survey regarding outpatient satisfaction among patients who visited the perioperative management center of Yokohama City University Medical Center between July and December 2018. This study was approved by the Institutional Review Board, the Ethics Committee of the Yokohama City University Medical Center (B190300052). Participants were given a prospective opportunity to opt out. The study was conducted in accordance with the principles of the Declaration of Helsinki.

The Yokohama City University Medical Center is a tertiary care academic hospital with 726 beds, 16 operating rooms, and one hybrid operating room. The preanesthetic evaluations of most elective surgical patients are performed at the perioperative management center. The annual number of such patients averages 4,700. Each day, one PAN and two anesthesiologists were assigned to this center from the department of anesthesiology. The perioperative management center examines approximately 20 patients per day for an average of approximately 30 minutes each.

Table 1 demonstrates the allocation of work performed by PANs and anesthesiologists. PANs performed interviews, physical examinations, and patient risk assessments; checked test results; determined the need for additional tests on behalf of an anesthesiologist; supported decision making; educated patients; and explained the anesthesia process. Anesthesiologists performed complementary examinations after the PANs' examinations. If another patient showed up while a PAN was still seeing a patient, an available anesthesiologist would perform the preanesthetic evaluation without the help of a PAN. Patients were allocated according to our routine medical care system during this survey. The patients who were seen by a PAN followed by an anesthesiologist and those who were seen only by an anesthesiologist were categorized as the nurse-anesthesiologist

group and the anesthesiologist-only group, respectively. The comparison of these two groups of patients was the main purpose of this study.

We evaluated patient satisfaction using the Hospital Outpatient Satisfaction Scale developed by Hasegawa et al¹⁰ (Appendix). As the items in this questionnaire were non-invasive, this study was not registered in a study registry before its inception. Patients who visited the perioperative center during the study period were eligible to participate if they were low-risk and available for outpatient visits. Patients were excluded if a surrogate decision-maker was not available and if the PAN or the anesthesiologist determined that a patient had decision-making ability problems. Immediately after their medical examinations, patients were asked if they would like to participate in the survey which ensured an anonymous response. Information was obtained only from the questionnaire, which was checked by the supervising staff member; however, there was no match between the questionnaire and the medical records. The primary outcome was the patients' satisfaction with the overall evaluation, which was evaluated as either "satisfied" or "dissatisfied." The secondary outcome included subjective levels of understanding of the explanation of anesthesia (easy or difficult to understand) and "concerns, worries, and anxiety" (reduced or not). Regarding explanatory variables, we also obtained delays in preanesthetic evaluation from the time of appointment on that day (lengthy or not) and the three aspects of attitude of the medical staff (anesthesiologists' attitude in the anesthesiologist-only group or PANs' attitude in the nurse-anesthesiologist group) toward the patient (ie, kindness, privacy consideration, and listening attentively). The questionnaire items were evaluated using a five-point Likert scale, then dichotomized for analysis by treating "neither" as a negative response if the items were not normally distributed. Sex and age were also recorded.

Age was compared using Student's *t* test. Dichotomized data were analyzed using Pearson's χ^2 test. The significance level was set at 0.05. Additionally, to identify factors associated with outcomes, we performed multiple logistic regression analyses using the following factors: age, sex, presence, or absence of a PAN during examinations, delays, and anesthesiologists' or PANs' attitudes. The two-tailed significance level was set to 0.05. The impact of the different types of professionals involved in patient care on patient satisfaction was unknown, and this study was exploratory in nature. Thus, no sample size calculations were made. The statistical software we used was IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp.

Results

There were 1,595 outpatients during the survey period. After excluding 734, in which the only medical interview was provided by PANs, we received 861 responses. For the nurse-and-anesthesiologist

Table 1
The Scope of Pre and Postoperative Anaesthesia Practice and Task-shifting From Anaesthesiologists to Perianesthesia Nurses (PANs).

Phase	No.	Duties Performed by Staff in Anaesthesiology	Perianesthesia Nurses	Anaesthesiologists
Preoperative	1	Medical interview	Yes	Only if necessary
	2	Physical assessment	Yes	Only if necessary
	3	Decision making support	Yes	Only if necessary
	4	Explanation of anaesthesia care plan	Yes	Only if necessary
	5	Explanation of complications caused by anaesthesia	Yes	Only if necessary
	6	Obtaining informed consent	No	Yes
	7	Educational guidance for preoperative daily life (eg, instruction for smoking cessation)	Yes	Only if necessary
	8	Confirmation of inspection results	Yes	Only if necessary
	9	Order for additional inspections	Only as surrogate	Approving
	10	Preparing consent forms	Yes (as surrogate)	Only if necessary
Postoperative	11	Medical examination	Yes	Only if necessary
	12	Pain control as necessary	Only as surrogate	Yes

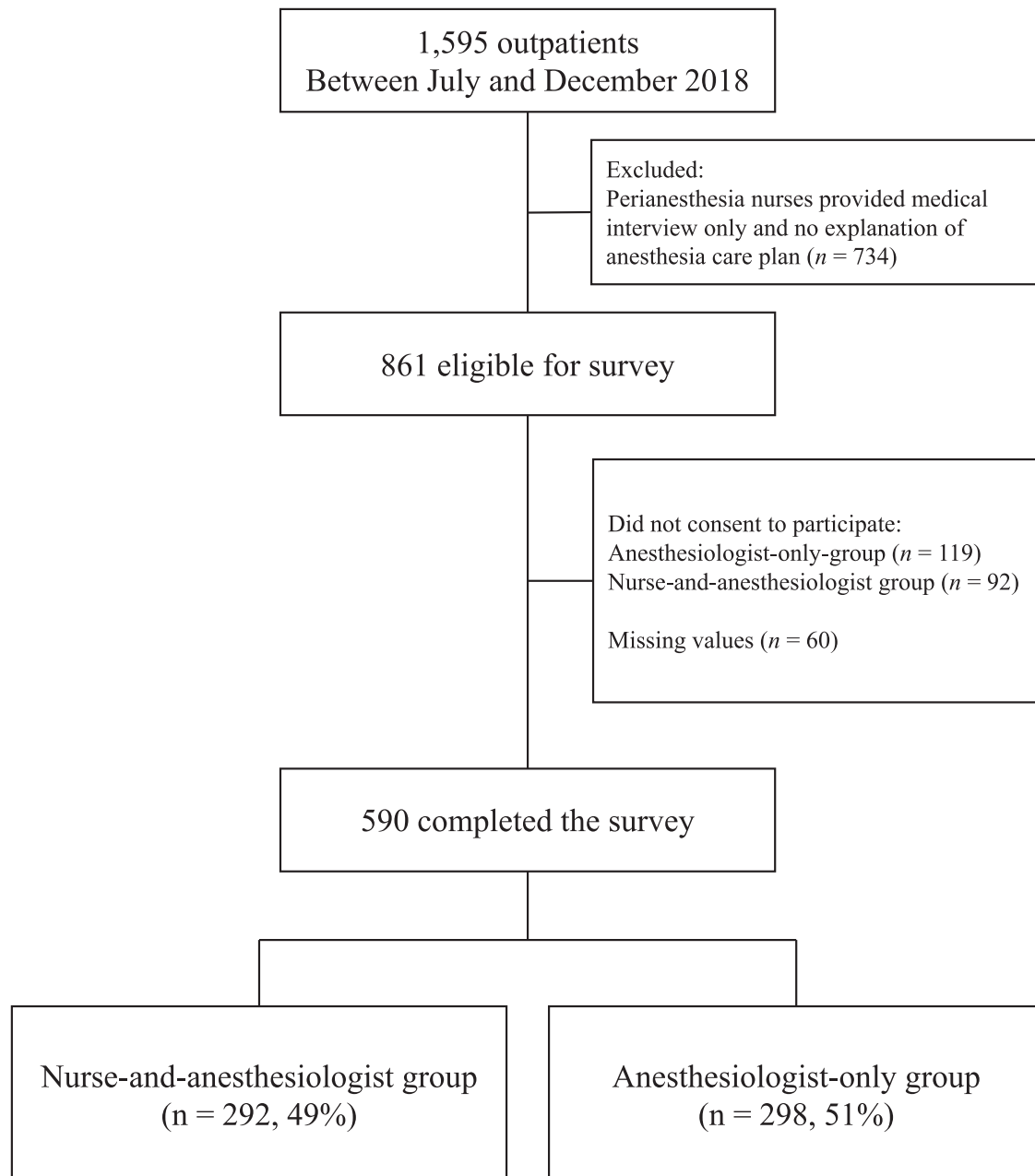


Figure 1. Flow diagram of study participants in the perianesthesia nurse and anesthesiologist and the anesthesiologist-only groups.

group, our pool consisted of 384 participants (valid responses: 292; response rate: 76%), 417 participants for the anesthesiologist-only group (298; 71%), and 60 responses with missing values (Figure 1). There were no significant differences in the patients' ages between the two groups. However, the ratio of men was significantly higher in the nurse-and-anesthesiologist group (Table 2). Regarding levels of understanding, 96.9% of the patients in the nurse-and-anesthesiologist group and 95.6% of the patients in the anesthesiologist-only group answered "easy to understand"; therefore, there was no significant difference. Patients who reported a reduction of concerns, worries, and anxiety made up 86.3% of the nurse-and-anesthesiologist group and 70.4% of the anesthesiologist-only group, thus indicating a significant difference. Furthermore, results relating to patients' satisfaction with the overall evaluation were 94.1% in the nurse-and-anesthesiologist group and 87.9% in the anesthesiologist-only group, also indicating a significant difference (Table 2).

A multiple logistic regression analysis was conducted to analyze the reduction of concerns, worries and anxiety, as well as the overall evaluation. The involvement of a PAN was found to be a significant contributor to the reduction of concerns, worries and anxiety, and satisfaction with the overall evaluation. In addition, privacy consciousness and listening attitude by PANs contributed to the overall evaluation score (Table 3).

Discussion

This study investigated the associations between the care provided by PANs and patient satisfaction. The nurse-and-anesthesiologist group reduced patients' anxiety significantly more than the anesthesiologist-only group. Not only that, but the group that received care from both a PAN and an anesthesiologist was more satisfied than their anesthesiologist-only counterparts during the preoperative anesthesia consultation.

Table 2
Patient Characteristics During Examinations by Anaesthesiologists Only or With Perianesthesia Nurses.

		Anaesthesiologists Only n = 298		Perianesthesia Nurses and Anaesthesiologists n = 292		P-Value	
		Frequency (%) / Mean (SD)		Frequency (%) / Mean (SD)			
Gender	Women	198	(66%)	162	(55%)	.023	
	Men	98	(33%)	128	(44%)		
	Unknown	2	(1%)	2	(1%)		
Age		48.47	(19.21)	46.98	(19.32)	.350	
Delays in preanesthetic evaluation	(Lengthy)	50	(17%)	60	(21%)	.239	
	Strongly agree	10	(3%)	14	(5%)	.092	
	Agree	40	(13%)	46	(16%)		
	Neither	72	(24%)	87	(30%)		
	Disagree	114	(38%)	106	(36%)		
	Strongly disagree	62	(21%)	39	(13%)		
Kindness of staff	(Yes)	281	(94%)	270	(92%)	.371	
	Strongly agree	159	(53%)	146	(50%)	.331	
	Agree	122	(41%)	124	(43%)		
	Neither	12	(4%)	20	(7%)		
	Disagree	2	(1%)	0	(0%)		
	Strongly disagree	3	(1%)	2	(1%)		
Privacy consideration	(Yes)	259	(87%)	258	(88%)	.595	
	Strongly agree	114	(38%)	126	(43%)	.653	
	Agree	145	(49%)	132	(45%)		
	Neither	37	(12%)	32	(11%)		
	Disagree	0	(0%)	0	(0%)		
	Strongly disagree	2	(1%)	2	(1%)		
Listening attentively	(Yes)	286	(96%)	267	(91%)	.023	
	Strongly agree	141	(47%)	143	(49%)	.065	
	Agree	145	(49%)	124	(43%)		
	Neither	10	(3%)	23	(8%)		
	Disagree	0	(0%)	0	(0%)		
	Strongly disagree	2	(1%)	2	(1%)		
Outcomes							
	Level of understanding (Easiness)	(Yes)	285	(95.6%)	283	(96.9%)	.411
	Strongly agree	156	(52%)	160	(55%)	.915	
	Agree	129	(43%)	123	(42%)		
	Neither	9	(3%)	6	(2%)		
	Disagree	2	(1%)	1	(0%)		
Reduced concerns, worries, and anxiety	(Yes)	210	(70.4%)	252	(86.3%)	< .001	
	Strongly agree	97	(33%)	116	(40%)	< .001	
	Agree	113	(38%)	136	(47%)		
	Neither	80	(27%)	32	(11%)		
	Disagree	5	(2%)	5	(2%)		
	Strongly disagree	3	(1%)	3	(1%)		
Overall evaluation	(Satisfied)	262	(87.9%)	275	(94.1%)	.007	
	Extremely satisfied	169	(57%)	196	(67%)	.004	
	Satisfied	93	(31%)	79	(27%)		
	Neither	36	(12%)	16	(6%)		
	Dissatisfied	0	(0%)	1	(0%)		
	Extremely Dissatisfied	0	(0%)	0	(0%)		

Table 3
Factors Associated With Outcomes.

	Reduction of Concerns, Worries, and Anxiety		Overall Evaluation	
	Odds Ratio	95% CI	Odds Ratio	95% CI
Gender (Women)	0.97	(0.63-1.50)	1.23	(0.64-2.36)
Age	1.00	(0.99-1.01)	0.99	(0.97-1.00)
Examination by nurses	2.74	(1.77-4.26)	2.31	(1.19-4.45)
Delays in preanesthetic evaluation	1.42	(0.80-2.52)	0.58	(0.28-1.18)
Kindness of staff	0.82	(0.26-2.58)	0.40	(0.10-1.64)
Privacy consideration	1.73	(0.83-3.62)	4.16	(1.71-10.15)
Listening attentively	3.10	(0.99-9.67)	4.07	(1.04-15.90)
Hosmer-Lemeshow goodness of fit test	5.06	(P = .751)	1.66	(P = .990)

CI, confidence interval.

Multivariate analysis showed that examination by a PAN was associated with anxiety reduction and overall patient satisfaction, and that overall patient satisfaction was also influenced by attitudes that allowed for attentive listening and privacy consciousness by PANs.

As women have higher preoperative anxiety than men,¹¹⁻¹⁴ some may argue that the disproportionately smaller fraction of women in the nurse-and-anesthesiologist group than in the anesthesiologists-only group may have led to a reduction of anxiety in the former

group. However, our multivariate analysis did not identify gender as a significant contributor to reduced anxiety.

On the other hand, the involvement of a PAN was associated with both anxiety reduction and increased overall patient satisfaction. Nurses have several strengths relative to doctors that may have contributed to these results. For example, nurses exhibit higher levels of empathy than doctors, such as anesthesiologists and pathologists.¹⁵ Thus, nurses tend to reduce patients' anxiety.¹⁶ Information, communication, and emotional relationships are fundamental to patient satisfaction in anesthesia care.¹⁷ Communication is emphasized as a basic nursing skill. Some PANs even study psychological counselling theory during their master's programs. Therefore, PANs may create atmospheres for patients that evoke important anxiety-reducing conversations more easily than anesthesiologists do.

Our results revealed that patients' comprehension remained unaffected regardless of whether anesthesiologists or PANs educated them on anesthesia. This result suggests that PANs, when collaborating with anesthesiologists, can provide adequate knowledge and information regarding anesthesia to patients. The primary educational goals of Japanese PANs include not only intraoperative anesthetic management but also competence in preoperative consultation. To this end, their curriculum emphasizes the acquisition of medical knowledge necessary for preoperative patient risk assessment, physical assessment, and communication skills (explaining the anesthesia process, supporting decision-making, and life guidance).

This study's clinical significance pertains to the involvement of PANs in preoperative patient care toward improving overall patient satisfaction. The concept of a perioperative management team was developed several years ago in Japan; and now there is a movement to efficiently evaluate preoperative patients through various occupations including nurses, pharmacists, dental hygienists, and more. However, nurses' roles and tasks regarding perioperative management remained unclear, including what kind of patient outcomes they could improve.¹⁸ Nonetheless, this study revealed that PANs improve the quality of preoperative consultation for preoperative patients through cooperation with anesthesiologists. Our study provides the basis for a model case of perioperative management team care in Japan.

Limitations

There are several limitations to our study. First, the assignment of patients to one of two groups, the anesthesiologist-only group, or the nurse-anesthesiologist group, was not randomized but was dependent on patient inflow. In addition, because this study was conducted under normal practice contexts, only approximately 53% of all outpatients during this study period met our eligibility criteria. The participants in the study might not be representative of all our patients. There is thus a possibility of selection bias. Second, since the study was cross-sectional, we are unable to discuss causal relationships. Third, this was a single-center study and targeted a limited number of PANs' examinations. Therefore, the generalizability of our results remains unknown. Fourth, the patients' "level of understanding" regarding anesthesia was only subjectively measured. A more objective evaluation would have required questions regarding real anesthetic considerations. Fifth, the surveyed patients' background information was limited to gender and age. We did not obtain information on other factors that might have affected patient anxiety or satisfaction, such as the invasiveness of their surgery, their previous experiences with healthcare services, and their own occupational backgrounds, which might impact the subjective perception of anesthesia. Additionally, we did not obtain information pertaining to the length of time during the evaluation per patient in this study. The time spent per patient is likely to be longer with a combination of nurse and anesthesiologist than with an anesthesiologist alone, and

longer consultations might influence patient satisfaction. Sixth, the five-point rating obtained from the questionnaire responses was divided into a binary scale, which could have influenced the interpretation of the results. Seventh, we could not have two independent professionals, PAN and anesthesiologists, interacting with the patient and responding differently. This is because nurses alone are not allowed to perform medical examinations or explain anesthesia without the supervision of a doctor in Japan. Thus, even if a nurse oversees a patient examination, an additional examination by an anesthesiologist is always necessary. This might also limit the generalizability of our study findings. Finally, the study lacked information regarding characteristics of healthcare professionals, such as information on the length of professional experience. This might affect the validity of our study findings.

Conclusion

In conclusion, our study revealed that the collaboration between anesthesiologists and PANs might be associated with enhanced patient satisfaction and reduced anxiety in preoperative patients without adversely affecting patient's comprehension of anesthesia. Further research is necessary to verify the impacts of the involvement of PANs in anesthesia patient care on intra and postoperative patient outcomes. It will also be important to study the effect that PANs have on the cost and the efficiency of anesthetic care.

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Supplementary materials

Supplementary material associated with this article can be found in the online version at [doi:10.1016/j.jopan.2022.06.010](https://doi.org/10.1016/j.jopan.2022.06.010).

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Appendix. - Questionnaire items used in the study (English version)

Please choose one option in response to each question.

1. The waiting time for consultations is long.
 - 1) Strongly agree
 - 2) Agree
 - 3) Neither
 - 4) Disagree
 - 5) Strongly disagree
2. The anesthesiologist or nurse has a kind attitude.
 - 1) Strongly agree
 - 2) Agree
 - 3) Neither
 - 4) Disagree
 - 5) Strongly disagree
3. The anesthesiologist or nurse respects my privacy.
 - 1) Strongly agree
4. The anesthesiologist or nurse listens carefully to what I want to say.
 - 1) Strongly agree
 - 2) Agree
 - 3) Neither
 - 4) Disagree
 - 5) Strongly disagree
5. The anesthesiologist's or nurse's explanations are easy to understand.
 - 1) Strongly agree
 - 2) Agree
 - 3) Neither
 - 4) Disagree
 - 5) Strongly disagree
6. The explanation reduced my worries, concerns, and anxiety about anesthesia.
 - 1) Strongly agree
 - 2) Agree
 - 3) Neither
 - 4) Disagree
 - 5) Strongly disagree
7. Are you satisfied with your anesthetic consultation?
 - 1) Extremely satisfied
 - 2) Satisfied
 - 3) Neither
 - 4) Dissatisfied
 - 5) Extremely dissatisfied