Should patients routinely be visited by the anaesthetist once they have left the recovery area?

An anaesthetic preoperative assessment for all patients is the standard of care in UK hospitals, but guidance from the Royal College of Anaesthetists (Curran and Rowbotham, 2009) states that a postoperative visit by an anaesthetist is only recommended in certain circumstances, such as those patients graded American Society of Anesthesiologists (ASA) physical status 3, 4 or 5, or patients discharged from recovery with invasive monitoring in situ. There are a number of potential advantages of a routine postoperative visit by the anaesthetist, so why is this not performed? This article examines the arguments for and against a routine postoperative visit by an anaesthetist.

For

For his/her own education, there is clear value to the anaesthetist seeing patients postoperatively. The ability to assess the efficacy of interventions will allow the doctor to assess what does and does not work for specific patient groups. In addition, the efficacy of regional blocks may be assessed, and evidence of delayed complications sought. This may encourage evolution of practice. The postoperative visit may also provide a platform for data collection for audit.

From the patient's perspective, the anaesthetist will be a familiar face; someone who was present throughout the procedure and may be able to explain perioperative events. In addition, having established a rapport, the anaesthetist may be able to address postoperative symptoms such as pain and nausea more effectively than surgical or nursing colleagues.

There are also a number of potentially significant safety benefits. The anaesthetist's role as perioperative physician, along with his/her unique knowledge of physiology in both stressed and non-stressed states, may allow significant input into postoperative fluid balance and organ support.

Dr Dominik Krzanicki *is Speciality Registrar, and* **Dr Ed Burdett** *is Clinical Fellow in the Department of Anaesthesia, UCL Hospital, London NW1 2BU*

Correspondence to: Dr D Krzanicki

Against

Is an additional postoperative visit by an anaesthetist simply an unnecessary duplication? It is perhaps disingenuous to suggest that the anaesthetist appearing for a snapshot is more able to manage the patient's physiology than the surgical team who will provide real continuity and deal with such patients on a daily basis, with the help of the acute pain team. Other systems such as intensive care outreach are often available to provide additional care for the patient who deteriorates postoperatively.

A study by Lee et al (1998) concluded that major postoperative complications occurring within 48 hours of leaving recovery were rare, and predominantly occurred in ASA 4+ patients and those who had an operation out of hours. These patients would normally be referred to an intensive care unit or to an intensive care unit outreach team postoperatively, rendering the possibility of the anaesthetist discovering an otherwise undiagnosed severe complication in ASA 1–3 patients having elective surgery very unlikely.

Ward turnover of patients is very high; the logistics of the visit are potentially problematic. Simple tasks such as finding patients postoperatively make the process time consuming. Inevitably, the 48-hour week imposed on trainee doctors by the European Working Time Directive (Morris-Stiff et al, 2005) will mean that such visits will either force the trainee anaesthetist to voluntarily breach the hours limit or require some clinical time to be ring-fenced to allow visits. Time spent at the hospital is at a premium for many trainees and following up patients may, even if practical, not be the best use of training time. From a service delivery perspective, there would have to be a reallocation of anaesthetic resources to allow time for routine follow up, which would inevitably lead to a reduction in theatre throughput.

From the patient's perspective, there is no evidence that increased postoperative contact with the anaesthetist improves satisfaction (Zvara et al, 1996). There is also a chance that the anaesthetist could pass mixed messages to the patient on the exact outcome of the procedure. A smooth and uneventful anaesthetic may not make up for the bad news of a poor surgical outcome.

Finally, could such a visit actually potentially cause harm to the patient? The possibility of the anaesthetist acting as a vector for transmission of infectious disease is small but nevertheless real. The spectre of hospital-acquired infections may be an incentive to limit unnecessary contact.

Conclusions

Ideally anaesthetists would visit all patients postoperatively, for the patient's reassurance and for the doctor's education. This is seldom practical, and is not the best use of time. Robust systems should be in place to ensure that patients are followed up by appropriately trained staff after they leave the recovery area. If, however, the anaesthetist considers that a particular patient would benefit from the extra specialist care that he/she can provide, or that seeing the patient might help to improve future practice, then a postoperative visit would most likely be welcome. BJHM

Curran J, Rowbotham D (2009) Postoperative care. In: *Guidelines for the Provision of Anaesthetic Services.* Royal College of Anaesthetists, London (www.rcoa.ac.uk/index.asp?pageID=477 accessed 2 August 2009

Lee A, Lum ME, O'Regan WJ, Hillman KM (1998) Early postoperative emergencies requiring an intensive care team intervention. *Anaesthesia* **53**: 529–35

Morris-Stiff GJ, Sarasin S, Edwards P, Lewis WG, Lewis MH (2005) The European Working Time Directive: One for all and all for one? *Surgery* **137**(3): 293–7

Zvara DA, Nelson JM, Brooker RF et al (1996) The importance of the postoperative anesthetic visit: do repeated visits improve patient satisfaction or physician recognition? *Anesth Analg* **83**: 793–7

Anaesthetic and critical care dilemmas are coordinated by Dr Pervez Sultan and Dr Kate Adams, Specialist Registrars in Anaesthetics, University College Hospital London

Ideas for future dilemmas can be sent to Rebecca Linssen bjhm@markallengroup.com