SURGEON CONTINUITY AND PREOPERATIVE ANXIETY: A SINGLE-CENTRE UROLOGY AUDIT

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Introduction

Growing pressure on NHS surgical services has increasingly led to **pooled operating lists**, in which patients are distributed among a department's consultant body rather than operated on by the consultant who saw them in clinic. While pooling eases scheduling and improves waiting times, its impact on perioperative patient anxiety has received little attention.[1-3]

Aims – Key Questions:

- Is anxiety lower when operated on by one's own consultant?
- Is any difference explained by procedure, consenter seniority or perceived informedness?
- What information do patients still want on the day?

Materials/Methods

Single-centre audit at Manchester Royal Infirmary. **53 urology patients** completed a questionnaire on the day of surgery, after completion of consent process. This included the validated **Amsterdam Preoperative Anxiety and Information Scale (APAIS)**, informedness rating scale before and after meeting the surgeon (1–10), and any unmet information needs. Patients were selected across urological subspecialties with exclusion of complex cancer and robotic upper tract surgery. Statistical analysis performed in JASP.

Table 1. Cohort by procedure group and operating surgeon

Procedure group	Own consultant	Other surgeon	Total
Core urology	5	13	18
Andrology	9	4	13
Stone surgery	16	6	22
Total	**30**	**23**	**53**

Outcomes and analysis

- **Primary outcome:** APAIS anxiety score – the sum of the four anxiety questions (items 1, 2, 4, 5; range 4–20). Groups compared with the **Mann-Whitney U test**.
- **Secondary outcomes:** anaesthesia anxiety (items 1, 2) and surgery anxiety (items 4, 5); Mann-Whitney U test, significance was set at $p < .025$ (Bonferroni correction).
- **Case mix:** two-way ANOVA re-tested the surgeon effect with procedure type held constant.
- **Other questions:** seniority vs anxiety (Spearman); informedness before vs after (Wilcoxon signed-rank); unmet need by surgeon (χ^2).

Results

p = .022
lower anxiety with own consultant

p = .004
anaesthesia anxiety — the main driver

51%
still wanted more information

Figure 1. Effect of own consultant on anxiety (rank-biserial r; larger = lower anxiety)



- **Adjusted for procedure type**, the effect kept its direction and size but was borderline ($F(1,49) = 3.82$, $p = .056$); procedure itself was not associated with anxiety ($p = .646$).
- **Seniority** of the consenting clinician was not associated with anxiety (rho = −0.20, $p = .144$).
- **Informedness rose** after meeting the surgeon (Wilcoxon $p < .001$): 19 patients improved, none declined, and 30 were already at the maximum of 10 (Fig. 2).
- **Unmet information need** (27/53) was equally common with own and other surgeons (χ^2 $p = .875$). Pain control and recovery were most often wanted (Fig. 3).

Figure 2. Change in self-reported informedness after meeting the surgeon (n = 53); 30 of the 34 unchanged already scored 10 out of 10

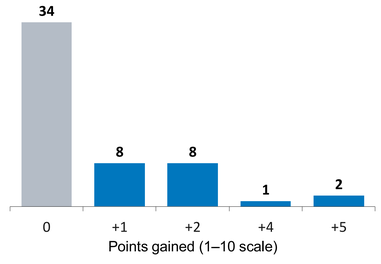
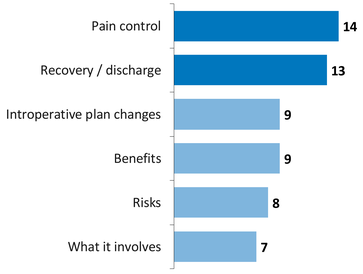


Figure 3. Information still wanted on the day (most frequent; patients could tick several inc. free text option)



Discussion

Being operated on by one's own consultant was associated with lower preoperative anxiety, interestingly concentrated in **anxiety about anaesthesia**. Procedure type, consenter seniority and information gaps did not explain this. Unmet information needs were equally common in both groups, and only 3 patients wanted more information about their anaesthetic.

This suggests the benefit reflects **trust and familiarity** rather than information. Anaesthesia-related fears centre on loss of control and on the competence of those caring for the unconscious patient, and personal rapport with clinicians has been shown to reduce preoperative anxiety.[4] Continuity of care is in turn associated with greater patient trust.[5] A known surgeon may therefore reassure most about the phase of care patients cannot oversee: while they are anaesthetised. Trust was not measured directly in this audit, so this remains a hypothesis for future work.

As pooled lists expand to meet operational demand, surgeon continuity may carry an under-recognised patient cost, which warrants consideration and further study.

Limitations

- Single-centre, observational, n = 53: associations only, modest power.
- Procedure-adjusted effect borderline; surgery-anxiety null may reflect low power.
- Ceiling effect limits the informedness analysis.

Conclusion

Surgeon continuity was associated with lower preoperative anxiety, mainly anaesthesia-related, and was not explained by case mix, staff seniority or information provision. These findings warrant adequately powered, multi-centre evaluation.

References

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