

# Let's Start With My Name: Improving Communication in the OR

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## Introduction

Studies of medical mistakes have estimated that errors, often related to miscommunication, may account for as many as 251,000 deaths annually in the United States.<sup>1</sup> Such numbers make medical errors the third-leading cause of death after cancers and cardiovascular disease. These rates are significantly higher in the United States than in other developed countries, such as Canada, Australia, New Zealand, Germany and the United Kingdom.

However, for many reasons, less than 10% of medical errors are reported. This lack of communication results in critical incidents and subjects these errors to root cause analysis.

Improving patient safety would seem to require more than voluntary reporting. Organizational changes need to be implemented and institutionalized. Communication breakdowns among clinicians, patients and family members can lead to medical errors, and effective communication may prevent such mistakes.<sup>2</sup>

In another study, insufficient communication was found to be a factor in causing errors in 60% of incidents.<sup>3</sup> A more global review, comprising a so-called scoping review method (i.e., a review in which there is a broad overview or “scope” of a research question, with more general inclusion criteria) and a comprehensive literature search of PubMed and the Cumulative Index to Nursing and Allied Health Literature, included a total of 25 studies conducted in 27 countries across six continents.<sup>4</sup> Overall, a median of 10% of patients were affected by at least one adverse event (AE; range, 2.9%-21.9%), with a median of 7.3% (range, 0.6%-30%) of all AEs being fatal. Between 34.3% and 83% of AEs were considered preventable (median, 51.2%).

The three most common types of AEs reported were those related to surgery, medications/fluids (either overloaded or undermanaged, with clinicians ordering the wrong fluid or too often), and health care-associated infections (for instance from extended cases where repeat dosing is indicated). Poor communication drives the latter two types of AEs.

### Anonymity in the OR

How can we as anesthesiologists be involved in ways to improve communication and hence patient safety in the OR? Over the years, many, if not most of us, have become numb or immune to the appellation of “anesthesia.” For example, how often do we hear, “Vital signs—OK, anesthesia?” or “Anesthesia, I must have more relaxation”? What about the questions thrown out seemingly to a third party as though we were not there: “Is anesthesia ready yet?” “Has anesthesia given the antibiotics?”

Why do we tolerate such indifference? While many have initially tried to balk at the gaseous name, many have also just succumbed after a few tries and tolerated it. A few have challenged the indignity. But, how does this make us, the nameless, feel? In some ways subservient? Less important? Just a fixture in the OR? Can we do our best job when we do not even have a name? Do we become distracted or feel a comeback is indicated? Can patient safety be affected?

A recent discussion on the American Society of Anesthesiologists (ASA) Open Forum Discussion group (April 2021) asked, “Does anesthesiology suffer from a ‘respect gap?’” The general consensus was that indeed we do, partly because we have allowed it.

We might question why this situation came about. Perhaps we have made our job so easy that we are becoming unimportant, or there are so many handoffs and changing faces that others in the OR do not want to take the time to learn all the people involved. Maybe some of us just don’t care and put up with it or do nothing to change the situation. Then again, perhaps surgeons do not realize that failing to acknowledge our partnership is hurtful.

### Safety Is the Issue

In a newsletter, the Anesthesia Patient Safety Foundation noted that effective teamwork in perioperative

teams is a prerequisite for patient safety. Yet, what is rarely discussed openly is the importance of dyads in teams.<sup>5,6</sup> While there is generally good communication between surgeons and their residents and between surgeons and nurses, communication between anesthetic care providers and surgeons can be sadly lacking, with only 29% of anesthesiologists having any meaningful communication with the surgeon.<sup>7,8</sup>

On the other hand, when one is working with a respected colleague who is familiar and the feeling is mutual, the team is much more likely to have a happy day and the patient is more likely to have a better outcome.

The types of negative stereotyping from a surgical and anesthetic point of view are shown in Table 1.

Surgeons may have a point.<sup>9</sup> They look up and see an unfamiliar face. They may ask what is happening only to be told that everything is fine, and they may see social media on a computer screen or hear a beep from a text message. After all, while the anesthetic model is often a team approach and usually works on a shift system, surgeons tend to work alone or with one resident and stay with the case throughout.

**Table 1. Some Examples Of Stereotyping by Surgeons And Anesthesiologists**

Anesthesia Provider	Surgeon
They always underestimate blood loss.	They just want to go home early; they don't care about my patient.
They rush me to do more cases so they can make more money.	They are always ready to cancel my case.
They don't care about medical issues.	They are always playing on the computer or reading something; they seem distracted.
They are never honest about how much time they will need.	They never say when they are giving vasopressors.
Our drugs do not increase bleeding; open blood vessels do that.	All inhaled agents increase bleeding.
Vasopressors increase blood pressure. NSAIDs decrease the need for opioids.	Vasopressors increase bleeding and so do NSAIDs.
Drug interactions must be considered.	My patient takes what the internist says, so it's fine.

**NSAIDs**, nonsteroidal anti-inflammatory drugs

Adapted from reference 5.

Then again, there are fundamental differences in vision. Table 2 outlines some of these differences.

One of the early formal attempts to increase communication and hence patient safety was suggested about 20 years ago. A universal protocol, known more commonly as a “time-out,” which the Joint Commission defines as “an immediate pause by the entire surgical team to confirm the correct patient, procedure, and site,” was introduced in 2003, when the Joint Commission’s Board of Commissioners approved the original protocol for “Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery” for all accredited hospitals, ambulatory care centers and office-based surgery facilities.<sup>10,11</sup>

Initially viewed as a safety measure to prevent harm as a result of operating on the wrong patient or the wrong site, time-outs quickly evolved to promote enhanced performance of the OR team.

The protocol is divided into three steps: pre-procedure, surgical site marking before incision and a final debriefing. Elements to be verified include the plan for the procedure and team member assignments, and most importantly defining the best means to communicate among team members during the procedure. Indeed, before skin incision, and initiated by a designated team member, introduction and identification of all team members is required, including names. (Hint for all: “My name is not anesthesia.”)

However, catastrophic events still occur, with serious consequences for the patient’s health and the physician’s career, as well as severe financial implications for the health care system. While time-outs can be effective, compliance remains a major impediment to implementation, and gaps in its daily use still occur.<sup>12,13</sup>

### Strategies to Improve Communication

What can we do to fix or at least decrease bad outcomes? Talking comes first. Some surgeons may see time-outs as a means to delay their work. Involvement is

probably more easily achieved by asking other surgeons to try to persuade them rather than issuing mandates. For our part, starting with the procedure, we could ask what the surgeon is going to do. Standing up and showing interest is helpful as well as sharing any new procedure we might be using if that is possible. As Mark Twain said, “I can live for two months on a good compliment.”

If time permits, engaging in pre- and postoperative surgical rounds goes a long way to better understanding. Anesthesiologists might suggest giving a talk during surgical residency or weekly rounds—for the benefit of the residents, of course—on anesthetic advances. Participate in hospital committees, especially OR committees and infection control, where working as a team can be emphasized.

Inviting surgeons to social events and even giving a luncheon for a new surgeon can be most effective in improving relations. Surgeons often are unaware of the training that goes into anesthesia, just as we may be uncertain as to exactly how much education and practice have been required of the surgeons to get where they are today. Dialogue along these lines is helpful for better understanding. Training together in simulations, especially in crisis situations, is also worthwhile.

Difficult situations arise. Personal electronic devices and loud music are major distractions. Arguments have been made that they help maintain focus and avoid boredom.<sup>14</sup> However, a closed claims study by the ASA showed a significant number of claims were related to distraction. Distraction-related claims were found to be a result of substandard care 91% of the time compared with 50% of other claims. Settlements were made in greater than 80% of these cases, with median payments of \$725,937.<sup>15</sup>

Agreement in the OR must be reached, as loud noise often results in loss of important information and delay in appropriate care. Other examples of difficult situations might include a case of severe epiglottitis, for which the difficult airway algorithm could be accelerated and a trained surgeon could secure a surgical airway rather than wait for multiple failed attempts at intubation. Or perhaps a surgeon wants to do a bilateral robotic or even laparoscopic inguinal hernia repair on a morbidly obese patient who has several comorbidities. Would it be safer to do an open repair under a regional block?

Perhaps these difficult situations create a less-than-perfect outcome, generating a critical incident and root cause analysis. Rather than finger-pointing, an appreciative inquiry with input from everyone might provide more information and a better outcome.

### Conclusion

It is important to remember that the majority of surgeons are working for the good of their patients and should be given the benefit of the doubt. Many anesthesiologists enjoy excellent working relationships with the OR team, but moments do arise when situations can turn on a dime. It is essential to demonstrate patience and establish communication from the beginning.

**Table 2. Surgeons and Anesthetic Care Providers Approach Procedures Differently**

Anesthesiology View	Surgical View
Pharmacology	Pathology
Physiology	Incise/cut
Data collection	Dissect
Rapid changes/minute-to-minute changes	Ligate
Constant calculations	Suture
Independent practice	Dependent on nurses, anesthesiologists

Decades ago, I was interviewing a modestly dressed middle-aged woman as part of a preanesthetic visit. I started by saying, "Good morning, Ms. Dugan." With a determination that belied her small stature, she looked

straight at me and replied, "That will be Sister Mary Louise."

As she said, let's start with my name.

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