VOICE OVER:

Welcome to ASA’s Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome back. I’m Dr. Adam Striker, editor and host, and this is Central Line. In today’s Inside the Monitor episode, we’re discussing Incident Command Systems, the featured topic in April’s ASA Monitor. To shed light on this complex topic, we welcome Dr. Stacey Watt, guest editor for the issue and Clinical Professor of Anesthesiology at the University of Buffalo. Dr. Watt, welcome to the show…

DR. STACEY WATT:

Well thank you very much for having me, Dr. Striker. It’s my absolute honor to be here with you.

DR. STRIKER:

Great. We’re thrilled to have you. And why don’t you start by telling us and our listeners a little bit about yourself, what your background is, and what led you to your interest in Incident Command systems?

DR. WATT:

Of course, love to. I practice anesthesia. I’m a pediatric anesthesiology specialist at the John R. Oishei Children’s Hospital in Buffalo. I got interested in Incident Command due to an event that happened to me while I was learning to be an anesthesiologist, actually in my residency program. So while I was in the residency program, checking into the VA system, all excited, so ready to go, charged up, going to be an anesthesiologist. And wouldn’t you know, as I walked into the VA emergency department, the overhead call was for an active shooter.
I learned very quickly that I not only felt powerless, felt unprepared, was panicked, that everyone else around me felt the same. And where I had thought, in being in a hospital, especially a VA and a Veterans Administration hospital, I really thought that they would be the ones absolutely at the forefront, ready to handle it. And I quickly learned that feeling of fear and powerlessness was all around me. And all I could think of is, this isn't right. I have to do something about it. I am supposed to be a leader. I am learning to be this anesthesiologist in charge of things. I should know what to do.

And in that moment, it really struck me how important it is to be a part of the solution. And I hate not knowing things. So again, that was a huge impetus for me to learn more about Incident Command, how to be prepared, how to take charge, and really how to best represent our specialty in these type of events that we are faced with.

DR. STRIKER:

I'm sure there was certainly a pretty large vacuum of knowledge and expertise, at least coming from our field with something like that, back when you started.

DR. WATT:

Yeah, and I was absolutely fortunate because one of the individuals that I ended up working with even early on in my career was Terry Burns, who was actually an ex firefighter for the Buffalo Firefighters. And I can tell you that his insight really drew me into Incident Command in his background and knowing a little bit about the system. So as I talked more to him about mass casualty, active shooter Incident Command systems, I learned what I didn't know. And I thought, this is an opportunity. Whenever you have something that you don't know about, it's an opportunity to go forth and learn it. So that's exactly what I did. I went out and looked into FEMA, got Incident Command training, learned a little bit more about it, and really tried to connect and fill that hole of things I didn't know.

DR. STRIKER:

Before we get into all the details, it's a great example of really how to tackle a problem, approach a gap in knowledge, if you will, actively look for a solution or research it yourself. And oftentimes I found over the years that you think everybody else knows or you think someone else knows. And in reality, when you do the legwork, you find out you're the one that's kind of paving the way and leading the charge on gaining new knowledge.
**DR. WATT:**

Oh, absolutely. Because a lot of us always think with anesthesiologists, they're like, well, I'm in the operating room, I'm my safe area, I control the O.R., but that's where my scope ends. And it's so wrong because we're so outside of our zone and we can be so much more in leading and being prepared and being part of the solutions that really face our hospital systems in grand scales. And that's what I found by learning a lot about this Incident Command system.

**DR. STRIKER:**

As we delve into the details, I think you hit the nail on the head. I mean, anesthesiologists are well positioned to be experts on mass casualties and experts on handling emergencies because of our training and our wide breadth of knowledge to handle different situations in different locations. And so let's use that as a segue way to start talking about Incident Command systems specifically. I don't know if people really understand what they are. Do you mind giving us a little bit of an overview, definition and then we'll touch on why anesthesiologists specifically should care about them?

**DR. WATT:**

Absolutely love to.

So most of us hear Incident Command and are actually more familiar with something called HICS, H.I.C.S, it's Hospital Incident Command Systems, which is actually just Incident Command systems brought into the hospital system. Now, for the listeners out there, Incident Command is more of a model. It's like a tool of command, control and coordination. And it meant to respond and provide a means to coordinate the efforts of all the agencies and individuals and all different systems so that they sort of mesh together or interlock in a way that they can all work together.

Because Incident Command, believe it or not, was developed in the 1970s and it was in response to an actual major wildfire in Southern California. And at the time, municipal, state, country, federal, all authorities collaborated in this form, in this firefighting resources in California. And they went back after all of the trauma and after all the damage, and they did sort of a debrief. And what they really learned from all this was the recurring problems that they had, that caused the most damage. was they really didn't have standard terminology. They didn't talk the same language. They didn't have the ability to expand or contract as the incident required. And again, that communication was so key and it wasn't consolidated, they really just weren't able to talk to one another and that caused chaos. So that's how Incident Command sort of came to us.
DR. STRIKER:

Were you surprised to find out that it was actually in the seventies where an Incident Command system was first developed? I would have thought it would have been something that might have been developed a lot earlier.

DR. WATT:

I would have thought the same thing, and especially when I delved into it, I thought, Man, we should have thought of this so much sooner. I mean, it should have been almost second nature to us, especially, I hate to say it, the anesthesiology community who deal with those issues where we're watching the O.R. and everything's all wonderful and stable and all of a sudden everything breaks loose and you're really sitting there and you're struggling and trying to incorporate all this data. You're trying to communicate with the ICU that suddenly barged in the room. You're trying to get your surgery team to calm down and finish a surgery. And you're handling like an instant command system. So why was this waiting till the 1970s to sort of take root and take effect? But you know what? Better late than never.

So I'm just happy that we have something sort of this sturdy framework that we can use to adapt to answer the calls that were necessary. Because, remember, Incident Command isn't just a simple thing for, everyone thinks Incident Command, absolute terrible catastrophes of worldwide incidents. It's not necessarily always the case. It is meant to expand and contract to fit what you face. And that's the wonderful thing about Incident Command is you can basically scale it up and down as you need it.

DR. STRIKER:

A great reminder and specifically, why do you think anesthesiologists should care? What necessitates this kind of a focus for our specialty right now? And this is the topic of the Monitor. And why do you think it's so important for anesthesiologists to know about these?

DR. WATT:

Well, for us, it is so important because I think it really calls to our specialty. It really hits all the points that we're known for, that managing trauma, managing issues and concerns.
But also, remember, it's a part of the accreditation process. Hospitals, they have to make sure that they have an Incident Command system when they're receiving accreditation and they're asked to produce it.

So not only that, we are responsible for the education of our residents. This is something we should be teaching. We should be at the forefront. We should be leading this charge because we are so well adapted. Remember in the Vegas shooting events, an anesthesiologist and trauma surgeon at that time were in the forefront together and only through their combined efforts did they really get through because the anesthesiologist, being the most versatile person on the floor, they were able to serve as ICU. They could transport patients where no one else could. They could enter the operating room, they could leave the OR. They could enter the emergency department. They could serve as triage. They were invaluable to answer to the call of an emergency system. We are the answer often. We are the plug that actually can go across all systems and fill in where other specialties, other physicians cannot. We can. And it's something that we have to remember that when push comes to shove, we can be called into service. And our service in that moment could save countless lives. And we have to recognize that and embrace that role, because it is an absolutely remarkable thing that our specialty provides.

DR. STRIKER:

It's fair to say, I mean, a lot of us, as a specialty, do this anyway. It may not be in the form of a mass casualty. It may not be formalized like a command system. But I mean, how many of us, or groups of us, run to emergencies, run when there's a crisis, organize the operating room, when there's multiple traumas. We're already doing a lot of this work. It does seem like a natural next step.

DR. WATT:

It's a natural transition because again, who was called on when actually COVID hit? We were. We were called on to go and not only manage the airways, but transport care for patients. We extended out of the operating rooms, into the units, onto the floors. We did. And we do it so naturally. You're absolutely right. We do it so naturally because we're doing it every day and we don't realize it. We just have to embrace and learn more about it so we can become even more versatile and actually expand that role to actually take on the leadership roles within it, because that's where we belong.

DR. STRIKER:
I'm glad you brought up COVID and how anesthesiologists stepped up, but more specifically, what this topic explain a little bit more how Incident Command systems can be applied to longer term problems or crises, if you will, like COVID, and not just like a mass shooting or a large accident or something like that.

DR. WATT:

Of course, that's a great question because I get that a lot too, is everyone's like, Well, I'll only have to to know this when a mass shooting or a mass casualty or something traumatic absolutely enters and there's thousands of people entering the emergency department. And I have to run the operating rooms, not necessarily when you're dealing with things such as COVID or even wartime situations. I mean, think of what's happening right now abroad. They're faced with a prolonged mass casualty event or a prolonged Incident Command event that is actually something that they have to respond to on a prolonged scale. Well, Incident Command is meant to do that as well. The frame is there and it is sturdy enough to actually extend for a prolonged time. So that means of communication can continue. So Incident Command is not only adaptable by scale. So anywhere from having ten patients to 100 to 1000, it can actually scale in distance as well. It could be the frame that holds up a hospital system as long as necessary and can communicate to get resources to ask for help or maybe even provide help to other hospitals. This is the frame that allows this to happen. And again, it speaks to the adaptability of Incident Command, but it also speaks to the adaptability of the specialty, really the ability to fit in wherever things are necessary to help and to again answer the call when we're asked to come forward, like in COVID, like in any wartime situation. So not only when that bomb hits or something else, we can respond in a greater scale.

DR. STRIKER:

Let's talk a little bit about specific roles, if you think that, well, I'm not the commander, if you will, that okay it's not necessarily my deal or I don't need to play a role in this organized or formal way of handling the crisis. What would you say to that?

DR. WATT:

I would say you do it every day. You just don't realize it. You command the operating room, you command the anesthesia area, and you're commanding the patient care at that moment. It is a very small extension, believe it or not, from running the anesthetic to actually taking command of maybe not just one OR, maybe two ORs, maybe in an Incident Command situation, you would be called to run your operating room and then actually report up through the Incident Command system to the next level. So again, Incident Command is more of a reporting up system. So you might be asked to not only
run your OR and do it well and take on patients as quickly as possible, but expand that role. Now you're running 4 ORs and you're reporting up to one of the anesthesiologists in your group or perhaps even a military person to tell what resources you need. And hey, this is what I have available. I have an operating room coming up in 10 minutes. What else you got. It's exactly that as far as everyone thinks. They can't do it until they have to. And again, anesthesiologists have an incredible already built in ability to do this and to do it incredibly well.

DR. STRIKER:

Let's say listeners out there thinking this is a great idea. My organization, as far as I know, doesn't have something formalized. You know, I'd like to actually go about and set this up. Where do I start? What would be the best place for a listener, someone out there to.

DR. WATT:

To learn more?

Yeah, absolutely. So we have a lot of, believe it or not, resources at the ready that are already built for us that we just have to utilize to learn more. Again, the Federal Emergency Management Agency or FEMA actually have courses available and they have a wonderful website. So if you actually go on FEMA and go into the Emergency Management Institute, you can actually go on courses and there's an ICS 100 course, very introductory course that you can go on and learn more. And then we even have something through the American Society of Anesthesiologists. They have some wonderful checklists and operating room procedures in for mass casualty that you could learn more about how it is to respond, what you should be doing. So there is resources aplenty out there. You just have to actually go out and find them and access them.

DR. STRIKER:

Well, you mentioned earlier about regulatory requirement, Joint Commission audits hospitals, obviously for compliance and a number of arenas. Talk a little bit about that and how the anesthesiologists can play a role in helping the organization with compliance.

DR. WATT:

Absolutely. Now, personally, I sit on our mass casualty or Incident Command systems within the hospital itself. I assist by offering my specialty training in the extension again
of the anesthesiologist role in helping them prepare. So we do drills. We look at points of how we can handle mock codes and mock drills and mock arenas. Every year we go on and we actually do these things to help not only demonstrate our preparedness for a hospital system and meet those standards of our accreditation and JCO or DNV, depending on which, again, accreditation organization you look to. But all of these things are important for the health system. So you can, as an anesthesiologist, get on those committees. And your insight is incredibly appreciative because I can tell you when I sit across the table and a lot of the individuals that have, again, military training, they’re firefighters, they’re police officers, their trauma surgeons, I can tell you that they often look to the anesthesiologist. What do you think? Can we move things across? Because they don't live in all the worlds that we do and they don't have the insight and. Also the viewpoint that we do. So our point of view and our background that we offer them in the conversation is really helpful and valuable to how they plan things in a hospital system. But also being on that committee not only is helpful to yourself, but your hospital. So again, I encourage all the listeners out there, find out more, join that Incident Command team or HICS program within your hospital or even the mass casualty group. I'm certain every hospital has one.

DR. STRIKER:

It's a great way to demonstrate value to your organization. I mean, we've been harping recently as a society to our membership on communicating with our administrators so that they not only know who their anesthesiologists are, but what it is they bring to the table and the value they bring to their organization. I think a lot of it is stressed on what you can tell the administrators, but what a great example of something you can do to demonstrate the value to your administrators. That is maybe a little bit outside the box, not necessarily just running the operating room, if you will.

DR. WATT:

I agree. Our value-added proposition, again, is not just that we get an operating room running and we can contribute to the bottom line. We can extend outside and actually impact the care that we provide to the community in such a grand scale.

DR. STRIKER:

Again, probably doing a lot of this work anyway, but it should be incumbent upon us to ensure that we’re there at the table and representing that our expertise is in use and a value to our respective organizations.

DR. WATT:
And they'll thank you for it.

DR. STRIKER:

Definitely. Let's switch gears just a little bit. Are we preparing the next generation of anesthesiologists well enough when it comes to issues like this?

DR. WATT:

I think we could do better. I say that about almost everything I talk about. So no one take offense to that. My comments. I always say that we could do more, we could teach more, we can engage our students more. And I'm talking students from fellows to residents to medical students. The future starts now for all of them, because if we don't train them the correct ways in how to embrace their specialty and expand their view and really take on these things, we're doing our specialty a disservice. We're doing our community a disservice.

We are a fantastic specialty that really extends so far, and we really do have to prepare them. And by doing this, I love that our specialty actually is celebrating this even through this Monitor. It's been great to see the expansion and everyone pitching in to say, Listen, I have something too, because whether you're in Buffalo and dealing with a snowstorm, you're in California with wildfires, you're in Louisiana with a hurricane, or you're in the Midwest and you have a drought. You don't know what you're going to deal with. And it's all applies. We're all in this together.

And if we can train our next generation of anesthesiologists by using especially our ASA that have developed these great resources and bringing them into our classrooms, the times now it is a great time to bring in these resources and show them what they can do, bring them into the drills, teach them how to take the lead, because you never know when a mass casualty event. How about if something happened to you and all that was left was your residents and your fellows and they had to answer the call. Would they be ready? I want to say yes. I want my residents and fellows to be able to stand up and step up when emergency calls. And they have to really take a charge role. If we don't teach them now, they're never going to be able to do it when it really counts.

DR. STRIKER:

Certainly, well-stated, and it sounds like this is one facet of probably revision overall of anesthesia education across the board that probably needs to always be on the constant watch, if you will, or updating, if you will, of resident curriculum. I think there's
just so many new avenues that we need to explore when it comes to resident education. And I think this just emphasizes there are a lot of blind spots that were just not seeing because we're so used to the same old, same old anesthesia education.

DR. WATT:

Right.

Oh, we've done great work. And we should take it from our past. Look at what we've done for safety in our specialty. Look at what we've done for blocks and ERAS protocols in the fantastic airway work that we've done. Now it's time to maybe put a little more emphasis on that emergency preparedness component and really taking on that Incident Command role of leadership that I think belongs to us.

DR. STRIKER:

You mentioned just a little bit ago about being the guest editor for this month's Monitor. Just tell us a little bit about that. And what would you like the readers of the ASA Monitor to take away from this issue?

DR. WATT:

I would love for them to take away that it all applies to you. So everyone always thinks it won't happen to me. I'm in a safe location and again, I hear it from all my colleagues in Buffalo. I'm going to pick on them tonight. So they all think, oh my gosh, I'm in Buffalo. I don't deal with hurricanes or wildfires. I don't have like killer bugs or snakes or alligators that are going to eat people or anything else. But you know what you do have, you have snow and you have the potential for a massive pile up on the thruway due to a snow event. You might have a blizzard that collapses a building. The risk is. Everywhere. So I'd like to tell everyone that's listening and here's my voice to say It does apply to you. You do have to be ready. And even if you think, Well, I'm just going to stand back and let others handle it, or well, you never know when you're going to be the one in the building. You don't know when it's going to hit. And I'd love for you all to be prepared to take it seriously, to learn from those wonderful authors that have joined me in this publication. Listen to their words of advice, because they've got some great ones and again, be prepared. Be part of the solution instead of being reactive, be proactive. Get out there, learn a little bit more and really be part of the solution because you can all learn more and you could all make a tremendous impact in your communities.

DR. STRIKER:
Certainly. And it's one of those things that everybody's going to learn quite a bit if it happens to them. And then unfortunately, at that point, it's late for that incident. You can be prepared for the next one. But boy, it would be great to be prepared for when that incident does happen in your community.

DR. WATT:

Oh, absolutely. Because, again, it's never too late to start and to prepare. So even if you're at the start of your career, mid-way, or at the end, jump in there, learn a little bit, learn a lot, learn as much as you can because it's interesting and it's exciting. But again, being prepared will also help you feel better about being alone in that hospital in the middle of the night when it really does happen. Because then imagine what the impact you'll have.

DR. STRIKER:

Absolutely well-stated. This has been a great topic. There's a lot of great information. Before I let you go just one more time, can you tell our listeners where they should go, at least for ASA resources when it comes to Incident Command systems?

DR. WATT:

So on the ASA resources, what I want you guys all to do is to jump on the ASA Committee for Trauma and Emergency Preparedness. It's published as an OR mass casualty checklist. But don't just look at that. There is absolutely a bunch of things in that area that will help you get your feet under you and help feel more prepared and ready to handle any situation that sort of arises in that crisis mode that you'll hit in your operating room. So an absolute fantastic resource. I encourage everyone to get online and check that out.

DR. STRIKER:

Find that on the ASA website.

DR. WATT:

Right on the ASA website.
Okay, great. Wonderful conversation, great insight. Like I said, great topic. Thank you so much for joining us, Dr. Watt. And really appreciate the time and really looking forward to this month’s Monitor.

DR. WATT:

As am I. And thank you very much for having me. And it's been an absolute joy to be a part of the Monitor, and I can't wait to see everyone out and about at the next ASA conference.

DR. STRIKER:

Absolutely. And to learn more about incident command systems, check out the ASA Monitor as asamonitor.org. To all our listeners, thanks for joining us. Please tune in next time to another episode of Central Line. And don't forget to leave us a review and follow us wherever you get your podcasts. And we'll see you next time. Take care

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