



American Society of
Anesthesiologists™

Central Line
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(SOUNDBITE OF MUSIC)

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:

Welcome to Central Line. I'm Dr. Adam Striker, your host and editor. Today, we're back again with a good friend of the show, Dr. Steven Shafer. Today, we're going to discuss reporting systems and specifically the potential weaponization of these reporting systems against physicians, nurses, all clinicians -- a topic covered in the September issue of the RSA Monitor. This certainly should get interesting. So, Dr. Shafer, welcome back to the show.

DR. SHAFER:

Dr. Striker, it's a pleasure to be here.

DR. STRIKER:

Well, I understand that you reached out some months ago to readers of The Monitor and asked if they felt reporting systems were weaponized against them. First off, why were you compelled to do that? And then, if you don't mind, tell us a little bit about how you move from that initial question to to this particular issue of the Monitor.

DR. SHAFER:

Yes. Yes. Well, I wasn't particularly compelled to do it. But just listening to my colleagues in the break room between cases over many years, there is a lot of discussion that goes on about "you can't believe that this happened to me." And oftentimes they involve colleagues being written up for things that they consider just ridiculous. But nonetheless, they have to go and there's a process by which these things are reviewed and the people are left really quite annoyed with how this unfolded. And after hearing this many times back in February, I thought, let me just see if what's

happening at Stanford is kind of a universal experience among anesthesiologists. And I've got to tell you, I really kicked a hornet's nest. I sent just a thing to the blog there, run by the ASA for the community comments asking people, "have you ever had an experience where you felt the system had been weaponized against you?" I also sent similar request to my colleagues at Stanford, to a number of physicians on various email lists that I have. It took about three days to get over 200 responses, and the responses were just wild. A lot of them were jaw dropping, people describing how reports of their most mundane kind of infraction or things that happened in emergencies, or things where they were doing the right thing, but it was misinterpreted by somebody else as the wrong thing. And just as an example of the latter, somebody was using quite a bit of jaw thrust during a sedation case and was written up because the nurse thought it looked painful. Well, versus not breathing. I mean, you've got to open the airway. And after seeing all these reports, I said, well, this needs to actually be an entire issue of the Monitor to look into this. So it was one of the most overwhelming responses to an email or a request for feedback that I've ever received. And it was quite astonishing.

DR. STRIKER:

Well, there's a lot I do want to cover regarding this topic, because we all, I think, have been in these situations. But let's start off with just tackling the the big item that I'm sure people are thinking of, which is physicians often feel unfairly targeted by event reporting. At least there's this perception that incident reports are used to settle scores or correct the perceived power imbalance in medicine. So if you don't mind, take us inside some of those first hand experiences you're talking about and how that looks to especially anesthesiologists from their perspective. Just give us a little bit more of a picture of what we're talking about.

DR. SHAFER:

Sure. So so here's one of the reports that I receive, which helps to set the stage for a lot of them. This is a resident who had recently given birth, and she asked the charge nurse if there's a place where she could pump between cases, as a lot of women do when the child is very young. And she had been told that there was a little vacant room next to the room where the cardiac bypass equipment was stored and nobody was using it. And could she possibly use that just to have a few minutes in private to to pump between cases? And the response was that she was written up for a safety violation for the potential infection risk she was creating. And she looked at this. And in her response to it, she said, first off, I didn't do anything, I simply asked a question. But she also said, I am being targeted here. First off, the fact that she's a woman and a lot of the reports from women, they did feel that their sex was the basis of the report, that a man would not have been targeted in the same way, and that the fact that she was a young mother.

This also reflected a lack of sensitivity to her goals of trying to breastfeed a child and be able to do that. And there was no infection risk. This is a made up risk.

You read this and you say, what on earth? How can you explain this? It's unimaginable. A reports of a young resident again, oftentimes, if you're younger, I think you get singled out a little more easily. You felt perhaps would be an easier target. A resident went in to a code and needed to start a stat arterial line. We've all been there and took a little one of the little swabs and quickly swabbed down the area over the arteries so they could start the line. They went and toss it into the trash can and the other line went right in code was I don't know how the code worked out actually, that wasn't included. But he got written up because when he tossed the little sponge stick that he used to sterilize the artery or sterilize the skin over the artery, it missed the trashcan and hit the wall. So he was accused of a written up as an unsafe disposal of a sterilizing sponge stick.

What's interesting to me is that when physicians do feel they've been targeted, they also feel compromised, defensive and damaged by the experience. If you're a younger physician, you may have to report to the head of a residency your resident, or you may have to report to a division chief. If you're now an attending physician, if you're part of a group, you may have to report to the head of the group. You may have to report to a hospital committee that looks into these things. But a common thread was they felt that, first off, that it was written by somebody who didn't understand. It was written by somebody who was, in a sense, looking to settle a score over some interaction that they felt was unpleasant. It was assumed to be true. There was no sense that, oh, this is ridiculous. Don't worry about it. Thanks for the phone call, but rather please defend your actions, which are which we assume have been correctly reported here and very often in the process, the only thing that the person that they were talking to was interested in was how to get past this, which usually are rather frequently involve the person who was written up writing a letter of apology. So what do you say? "I'm sorry. I asked if I can find a room I could pump in. I'm sorry that I missed the trash can when I throw the sponge, stick into it after starting, I've sort of started arterial line during a code?" I mean, but, but nonetheless, they had these people had to write letters of apology and it left them feeling that the system was rigged against them. So the physicians clearly felt it was unfair. Now, the incidents that I've described so far are, in a sense trivial, but they're also ones that are more consequential.

I received a handful of reports, probably six, seven or eight reports, where people had lost their jobs and what they said, the theme behind those cases was that the reporting system had been systematically weaponized by one or more people or groups that were trying to get rid of a physician, which they had an issue with. or at least in one case, a group of CRNAs resented having physicians come in because they wanted independent practice, and the CRNAs. routinely filed multiple reports against every physician in the

practice in order to create a physician only practice. Now, having said this, I have to tell you that I had no ability to validate the reports that I received, so I took them at face value and the report about the CRNAs, it's possible that that didn't happen. Maybe this particular place only hired terrible physicians. And this experience, they're always reported, maybe they totally deserved it. I can't tell you because I have no way of validating it, but it ranged from the trivial to multiple cases where the weaponized reports actually led to loss of employment.

DR. STRIKER:

Okay so the more trivial ones you mentioned at first, like the one in the pump room and the throwing the was it chloraprep or alcohol.

DR. SHAFER:

Yeah, that's just what is was.

DR. STRIKER:

You said, that they were forced to write letters of apology. That's what they said they had to do. Or do you know what? Do you know what the hospital organizations response was to those?

DR. SHAFER:

What I can tell you is, and I don't know if I reported them in my listing--I have a whole article called You Can't Make This Stuff Up. And I don't know if it's the case report in there, but the ones from Stanford, and I probably received 20 or 30 reports just from my Stanford colleagues, in that case, I know exactly what happened because it wasn't just an email, but it grew out of conversations with my Stanford colleagues over many months. And I can tell you absolutely in those cases, they had to write letters of apology regardless of what the facts supported.

DR. STRIKER:

But was that the only response? In other words, did the hospital acknowledge the validity of the report, for instance, in one that there actually was an infection risk, or number two, that there was some kind of danger to throwing the chloraprep and it hit the wall? Or was it simply the hospital saying, listen, I think the nice thing to do is just write an apology. But we're not actually admitting that there is a true risk here or anything. Do you know if that was that part of it?

DR. SHAFER:

Yes, I do. And the response is better worded. A nice thing to do would be to write a letter of apology. And you are going to do that tomorrow. I'll see it on my desk.

DR. STRIKER:

So they never did admit that, yes, there was an infection risk in there.

DR. SHAFER:

No, there's no adjudication.

DR. STRIKER:

Okay.

DR. SHAFER:

So that's another common thing. By the way, the common theme is the reports are taken at face value without any effort at adjudication.

DR. STRIKER:

Well, and I think that's probably going to be at least serve as some basis for the reasoning we're going to discuss here as to why these are occurring and how it relates to the true purpose of of the incident reporting system itself. So first off, let's just talk about why. Why are these systems in place? I mean, generally speaking, health care organizations make reporting systems available, presumably to address safety issues and and or make the workplace environment a safer, more palatable place to work, but particularly for the safe care of patients. Is that is that fair?

DR. SHAFER:

That's absolutely correct. And and such systems are absolutely necessary. And a number of people who responded to the email that I sent out wrote not with their own report, some sort of horrible thing that had happened to them, but rather to say, boy, I sure hope you don't try to say that these systems aren't necessary, because for patient safety, we have to identify when things happen that compromised patient safety. We have to categorize them to see are there systemic issues, something that happens

again and again that we can address and we can fix before there's really an injury from it. And the same with reports on being in a productive and healthy work environment for the employee's. Health care is a very high pressure environment to work in, and it's inevitable that in that kind of high pressure, lots of risk that you take every day in terms of just even if you're transporting a patient from one place to another place, bad things could happen during the transport. Every instant of your life as a health care provider has potential risk to the patients. It's a high stakes, high acuity activity that we're involved in, and people are going to get stressed and there will be difficult interactions among individuals. And so these systems are necessary.

One issue was the need to bifurcate issues that directly involve patient safety with issues that involve the workplace environment and issues involving patient safety. People didn't have any question about that except that it was interpreted as in the case of somebody looking for a place where they could pump between cases and then being reported as an infection risk. What's a really benign request that somehow made a patient safety issue? The patient safety system was used to report this woman.

So these systems are necessary. And one of the things that we try to do in this issue of the Monitor is we have a number of articles that talk about the necessity of these systems but explore ways of having the systems be effective while not having them so easily abused to settle scores.

DR. STRIKER:

I think a lot of us would say that patient safety is at the top of the top of the list of every anesthesiologist's concern and frankly, should be at the top of every clinician's concern. But I think those same people would say that safety is thrown about quite liberally in that people use it as an argument for almost anything. And I think it probably does a disservice to true patient safety, because if people become numb to the term at some point, it does potentially cause further harm by not allowing for true safety issues.

DR. SHAFER:

That's exactly right. People turn to safety because no one wants to argue against patient safety. And so we try to have systems that encourage reporting. A number of things, other things came up in the process of collating these reports and looking at the various responses. One thing is that hospitals will look at the patient safety reports and feel that if they're getting a lot of reports, that they must be doing a good job of sort of identifying the bad actors and identifying, you know, the physicians or nurses who are causing a lot of incidents. And I have to tell you, by the way, that nurses also often feel that reports are weaponized against them. The few nurses who did weigh in and reply to

me reported things not dissimilar to what physicians were replying in this request. So this is not a physician versus nurse. This can be a physician versus physician, which were some of the reports I got. It can be administrators reporting physicians, it can be administrators reporting nurses. I mean, these reports are kind of misused and it's not just a physicians are being hurt by aggrieved nurses. It cuts in all directions. But but with the same common theme.

And the other thing was an interesting observation, and I have a paper in science relative to this, which is people have certain event rates that they expect. And when what you're looking at changes, your perception of the event rate doesn't change because you alter the goalposts. So behaviors that would have been considered benign 20 years ago are suddenly reportable because the behaviors that were really considered egregious and reportable 20 years ago just don't happen anymore. So looking at like the number of safe reports at Stanford, that's what they're called as a safe report, emphasizing the patient safety aspect. The number hasn't really gone up or down. I think that people are trying to be safer. People are trying to behave better towards their colleagues and this and that. But our perception changes because people just sort of expect to see this, you know, a couple of times a month in there as their work here, maybe a couple of times a year, it's they're working. But whatever their perceived incidences of this, they will change the definition so that they perceive at that number of times. So it's very hard to know what to make of these reports and the numbers of reports that we get.

DR. STRIKER:

Well, there's certainly a lot left up to interpretation in how these are managed and what the ultimate goals are. I do want to discuss specifically the aspect of anonymous reporting. There's certainly pros and cons. What do you perceive are the pros of anonymous reporting?

DR. SHAFER:

You raise a very good question about anonymity of these reports. One of the fundamental issues here is the imbalance of power. Hospitals have a hierarchy. At the top of the list is the hospital administration. The people who occupy the C-suite are the ones who have the authority to hire and fire anesthesiologists and pretty much everybody else in the hospital. And so we are often very reluctant to complain about these people in any way, shape or form, because if they don't like what we say, they might fire us for it. But shortly below that level of the hierarchy are the physicians. And as the physicians, we are expected to exercise sound and careful judgment literally every second of our active working lives. And we are expected to be skilled and

knowledgeable and we are expected to take command of situations which are sometimes uncharted and successfully and safely navigate the patient through that. So that is our job as physicians. Nurses then represent another level and nurses in their training are taught to follow hospital policies and procedures, and they are taught to follow the orders given by physicians. They have medical judgment and they are expected to use medical judgment. But medical judgment was in a much smaller box than the medical judgment in which physicians operate. Nurses are very uncomfortable, often reporting back to physicians. If it's if a physician might know their name, because we have the ability to potentially report them up the hierarchy and influence their professional lives. So the anonymity is needed for them to report to us.

But anonymity invites abuse. And by the way, the hierarchy then keeps going down to the administrators and to the orderlies and everybody, and] for there to be any useful feedback system, it's felt, and I think correctly so, that it has to be anonymous. But anonymity intrinsically breeds abuse, and it doesn't matter if it's anonymity and reporting systems or anonymity and the peer review process when you submit a manuscript or anonymity in emails and spam and everything else, inability to know the sender separates often a demand to follow the truth. Anonymity is important, but it prevents accountability. And what I mean by that is, is that when something is anonymous, you cannot cycle back with the person who said it and ask for the evidence to support the statements that were made. If I make a statement, the burden of proof is on me to show that my statement is true. But if I file an anonymous report and nobody knows who filed the report, there's no way to ask the person to support what they've said with evidence. So the anonymity is really a difficult issue with these reports. And the people who said that they had lost their jobs represents cases where that anonymity was collectively used to make it appear that somebody was, in fact, a serial offender, a serial bad actor, where they felt it was one or two bad interactions with a specific individual that because of anonymity, were allowed to cascade into a false impression that this person is a bad actor. And you see the exact same thing playing out on social media today. People using the anonymity of the Internet to troll their political opponents or troll a celebrity who does something egregious. It's a much smaller problem at a hospital, but it is the same thing. Anonymity is kind of the curse if accountability should be a standard.

DR. STRIKER:

I certainly get the point that you take that to the extreme, in social media. People that are anonymous are more brazen to say things. But I do think in the hospital system it is an issue. But how big of an issue is it? In other words, we don't really know what percentage of incident reports or this vindictiveness or carry with it, this degree of personal conflict versus true safety reporting. I mean, I don't want to paint a picture of

the incident reporting system as being this off the rails system that's just about petty fighting. I have to think that most are legitimate issues. But do we know that?

DR. SHAFER:

Excellent question. And the answer is, I don't know it. I can tell you from the rapid and overwhelming response that a lot of physicians have had very adverse experiences with it. So this is not an uncommon event. And I think a lot of people reading the next issue of the ASA Monitor or listening to this podcast will say, Yes, that happened to me.

But to your question, I think it frequently is used the way it's supposed to be used. I can give you several examples from my own practice. I filed a staff report because my anesthesia machine wound up having a relatively exhausted CO2 absorber, and I had to put the flows up quite high and not breathe any of the gas and the circle system in order to not deliver the patient an excessive amount of carbon dioxide. So I called my anesthesia tech. The anesthesia tech was able to change the canister during the case, and that fixed the problem. But about ten, 15 minutes later, I heard a code call to the next room and I'm doing a case by myself. There was nothing I could do. I'm just looking up to my case. But at the end of the day, I talked to the person next door. I said, Oh my gosh, what happened? And the person said, You cannot believe what happened. Everything was fine. I checked everything out. I went out to get the patient. I brought the patient in. I induced anesthesia. I intubated the patient. I went to turn on the ventilator and there was no carbon dioxide canister. I thought, Oh my God, I know exactly what happened. I needed a carbon dioxide canister. They obviously took it off of your machine and they gave it to me. So I wrote up a safe report on that. You know, if you want to give somebody a new carbon dioxide canister, don't take it from the adjacent room. Now, that's a legitimate, safe report. And there's no settling scores or anything like this. And I've written up other safe reports for equipment that failed when it shouldn't have failed or for the unavailability of equipment that was urgently needed. And I suspect most safe reports are like that. I suspect most safe reports there really wasn't an incident where something was unsafe. It was observed and somebody said, we can't let this happen again. So I don't know the numbers, but I suspect I don't know what you're saying is exactly right. The vast majority of these do what they're expected to do. The issue is that once you're targeted, even once or twice by one of these reports over the period of a couple of years, it stays with you and you feel that an injustice has been done that can never be reversed. The other thing is part of it is people don't know the disposition of these. The feeling is there's a black mark somewhere on your record, and if they ever decide that they're going to terminate you or you leave and you want a job somewhere else, and you ask them to say, Was I a good citizen? They will pull up this hidden, unmarked file and this will come back to haunt you. So it's also people don't really know what happens to these reports.

DR. STRIKER:

Well, I think that gets to the the balance here, the pros and cons, anonymous reporting. I mean, there's obviously some some tangible benefit to having this as an anonymous system and there certainly, as you point out, potential for abuse. But don't you think this is really incumbent upon the institutions themselves or the individuals tasked with collating and moderating these reports and triaging them appropriately and addressing them appropriately, and also incumbent upon the institution to inform their the employees, but specifically the clinicians, whether it's nurses, physicians, technicians, advanced practice providers, whatever that here's what happens when an incident report is filed. Here's how we address it. I feel like a lot of the the consternation with this reporting system that that you're describing could really be alleviated with appropriate institutional oversight in communication with their clinicians. Do you do you agree?

DR. SHAFER:

So, yes, but you outlined exactly what is needed. First of all, the responsibility to handle this correctly rests with the institution. And the institution has to look at the reports, has to figure out how to handle these in a way that they accomplish the goals of improving patient safety and addressing workplace issues that might affect provider well-being. But at the same time do it in a way that is transparent. And in a way that is respectful of everybody involved. Both the report he and the reporter is respectful of those individuals and seeks to not have individuals harmed by the process. So by way of example, at Stanford, we have a dean. When there are issues among our faculty, particularly issues with who somebody reports to and whether or not the person leading a faculty division or a faculty group or a faculty effort is handling the job professionally or is discriminating against some of the people or creating a hostile environment. There's a dean that is that we go to, and the dean very clearly views her job as improving the system and having, at the end of the process, everybody who is involved better off for the experience. Now, now that actually takes a lot of work. And the only reason that a place like Stanford does this is because everybody involved in these cases are faculty. So we're all kind of an equal. We're all physicians, we're all at equal ranks. But the dean does an excellent job of looking into concerns. And even the person who might be the leader who feels that they're being ganged up against or whatever, typically at the end of the process says, This was useful and I feel I'm doing a better job now as a result of the process. It's it's hard to do that. To your comment, it is the institution that owns it and the institution in owning it, I think needs to view the process as not "I need a letter of apology and then the whole thing is behind us." That's not the experience of the people who write letters of apology. I think some process that that explains to the person what happens and then explains that that this doesn't go into your super secret file, where it's going to be pulled

prior to your next promotion or your next clinical evaluation, or when you want to move to another institution or doesn't get reported in the state of California. I think an explanation that allows somebody to say, okay, that was a pain in the neck, it's resolved, is useful. And what I don't know is the extent to which the institution ever goes back to the person who wrote the report and says, by the way, you know, do you really think this was a reasonable thing to write your report about? I have no information whether the whether the institution does that or not. One would hope that they do, but my guess is they don't.

DR. STRIKER:

Well, it seems that are two separate issues, but they're intertwined. I mean, I think conflict between clinicians can certainly lead to safety issues. So I don't want to entirely dissociate the two, but it does seem like there should be at least a couple of different pathways. One, if you have conflict or feel that there's a personal disagreement with another clinician, that is one pathway and appropriately addressed. And then then you have the safety issue itself. Now there is overlap, but it does feel like there's an opportunity. It seems like it would be reasonable to have at least a couple of different pathways to resolve these issues, don't you think?

DR. SHAFER:

Absolutely. Absolutely. We have. There are various surgeons who Stanford routinely sends to charm school, and that's because they're associated with not very pleasant, intraoperative or perioperative behaviors. And there's no question that interpersonal relations among health care providers affects patient safety. I've just finished a month of working with first year residents, and one of the things that I make an effort to teach the first year residents is that when dealing with surgeons in particular who are difficult, it is never appropriate to start to argue with people in the operating room because a surgeon who is so angry that the instruments are shaking is going to harm the patient. When people get angry about anything, it starts to cloud judgment. And I say Your job in the operating room, no matter what happens, is to maintain a calm and pleasant atmosphere among everybody in the OR, because that is in the best interest of patient care. So exactly as you were saying, how we the environment that we maintain professionally among our colleagues has to be calm and respectful in order to get the best outcomes for patients.

Now, I am sufficiently senior that I will occasionally ask a surgeon to speak after a case is done and. I'm kind of mellow and easygoing and I just say, you know, I think this was probably not the way to proceed. And usually I get a similarly kind and thoughtful response. Part of that's just my seniority in the system. But that that is something which

if if my junior colleagues could learn that that would be very useful. But to your point, it is a patient safety issue. When somebody is loud, aggressive, angry, inappropriate, demanding or underlying of all of this disrespectful. If there's a single word that characterizes what is triggering for these kinds of reports, it's when a person feels they've been treated with disrespect. And it doesn't matter whether you are somebody at the lower rungs who works for the hospital for minimum wage, or if you are the CEO of the hospital and you're making tens of millions of dollars a year, if people feel they're being treated disrespectfully, it is very triggering. And you're right, that response can be not just a matter of settling scores, but can be a patient care safety issue. So there has to be mechanism to report that and address it, and that's part of what makes it so complex. Again, I'm going to put a little plug in for the September issue of the ASA Monitor, because we have several papers that try to address these issues, specifically what the institution can do to try and have the benefits and the intent of patient safety reporting without the sense that the reports can be weaponized against them. So the September issue tries to address these with a number of special articles.

DR. STRIKER:

I do want to talk briefly about barriers to reporting, but let's take a short patient safety break and we'll be right back.

(SOUNDBIT OF MUSIC):

DR. SCOTT WATKINS:

Hi this is Dr. Scott Watkins with the ASA Patient Safety Editorial Board.

Medication errors remain one of the greatest threats to patient safety in the operating room. Anesthesia providers often recognize drugs by the size, color, or shape of the packaging and use standard-colored labels to designate classes of drugs. For this reason, look alike/sound alike medications are one of the leading contributors to medication errors in the operating room. Strategies to prevent errors from look-alike/sound alike drugs include: arranging drug trays so that look alike/sound alike drugs are separated, use of color coded labels with Tall man lettering, use of pre-filled medication syringes, using technology to scan bar codes and/or vials, and using generic rather brand names.

Finally, no discussion of safe medication practice would be complete without a reminder to always observe the five rights -- the right patient, the right drug, the right dose, the right time, and the right route.

VO:

For more information on Patient Safety, visit asahq.org/patientsafety22.

DR. STRIKER:

Oftentimes safety issues are identified, but then incident reports either are filed and don't get addressed or are never or never filed in the first place. And there's you know, there's this old study, old, I guess, relatively speaking, from 2006, I believe. And it was a study studying attitudes and barriers to incident reporting, like a collaborative hospital study. And I'm just going to read from this this table, the three most prevalent barriers to reporting that both doctors and nurses agreed upon appears that, number one, I never get any feedback on what action is taken. More than half of doctors and more and over 60% of nurses both agreed to that. Number two, the instant form takes too long to fill out and they don't have time. And number three, the incident was too trivial. Those were the top three if you take both doctors and nurses together. Did you get a sense of that from the reports you received?

DR. SHAFER:

Absolutely. And the top of the list is the notion of trivial. That people wrote up what they consider to be very trivial actions. They were taken against them with the sense that I would never be motivated to go to the trouble of writing an incident report. Let's just take the two examples I gave you. The woman who just said, Do you think anyone would mind if I use this empty or rarely used room between cases to pump? I mean, the that person considered this infraction to be trivial, and yet that was not perceived that way by the nurse was actually a I believe that was actually the case where the nurse was actually the or head nurse us said, oh my gosh, you represent an infection risk. The case of the Cloroprep stick that was thrown and missed the trashcan hit the wall. That's kind of the height of trivia. And yet the person who wrote it up obviously didn't perceive it that way. And I think that for physicians, myself included, the vast majority of times, that I think maybe I'll should write should write something because something didn't go quite right. I just think about it and either I say something in real time to the person to address it and then it's addressed or it's just too trivial to to write up. Whereas for others, specifically, nurses and administrators who write a physician's, their definition of what is trivial seems to be quite different. What merits reporting?

I would say for most physicians, the reason they don't write reports is they it's too trivial and it's just not worth the time invested. We] have a lot of production pressure. We have to look after the next patient and we're a little happier, I think, to let bygones be bygones and just say, yeah, you know, there's stresses we're working in a high pressure

environment like health care. One of the things I talked about was where there was an interaction between a nurse and a resident, where the resident dropped off a patient in the ICU and gave a report and left, but was checking his cell phone messages outside the door when the nurse, in the process of trying to untangle all of the lines, pulled out the IV. And so this was a nurse that was in training. And the other nurse came over and just said, oh, not a problem. Just write up an incident report and blame the resident. And this is a trainee being instructed, just write up an incident report. And so different thresholds for writing these and you ask about barriers. Even then, after this, the resident went in and said, Well, I'm standing out here. There was an I.V. when I dropped the patient off. You just pulled it out. Why are you instructing this nurse to report this? That got reported as another incident report. So the resident got two reports against him for this. Meanwhile, the resident never reported it at all. It just it was deemed too trivial. So we have different definitions of what's trivial. And to some extent we also have different in medicine, as physicians, we have different definitions of what's worth our time. And it's just seen as not being worth our time for the most part.

DR. STRIKER:

Well, and I do want to clarify. So the number one, at least on this list that both doctors and nurses agreed on was I never get any feedback when action is taken, but I was trying to put them together. But actually the top three, for doctors, the next two were incident form takes too long to fill out. They don't have time. And the incident was too trivial. To your point, that was actually not for nurses. Specifically, the incident was too trivial, was not in the top three. The next two, in addition to never getting any feedback for nurses, was when it's a near-miss, they don't see any point in reporting it, and when the ward is busy, they forget to make a report. And so perhaps indicating a difference in perceived workflow or demand issues or just a perception between two different clinical groups, if you will?

DR. SHAFER:

Well, yes. And the other thing is, I think that for most physicians. You know, we're we're in the position of giving the orders. And if we see something, we typically think, okay, we can address this by just simply giving the order and the person will learn. Whereas for nurses, if they see something, they, they, they don't have the option of giving the physician an order and assuming that the physician is going to learn from the experience. And so, that in and of itself represents a different reason for reporting.

So I'll give you an example. Again, this is just taken from the article called You Can't Make This Up, a physician rounding in the ICU saw a nurse draw up a bag to be to be attached to the arterial line. And the bag was almost entirely air. There was, for

whatever reason, the nurse was pressurizing a bag that had virtually no fluid in it. Don't know if they had a leak or what. There was no fluid in the bag and was about to hook this up to an arterial line. Well, as you well know, if you are trying to if you look up an air bag to an arterial line, you're going to give the patient a massive air embolus and you will kill the patient in short order. So seeing the nurse pressurizing this bag attached to the transducer, to the arterial line, the attending just said, what the hell? And stopped and immediately disconnected the bag turned off the valve so that it could not go to the patient and told the nurse, What are you doing? This bag does not have fluid in it. And this could potentially kill the patient. Well, needless to say, this generated an incident report by the nurse saying that the physician had been loud and aggressive. Now, the fact that the nurse was probably potentially within seconds of killing the patient, the physician felt that had been resolved by telling the person, you cannot, do understand, if you pressurize and give air under pressure through an arterial line, the valve doesn't. The air pretty much flows right through the the pressure control valve there. And it's really dangerous. And the physician kind of thought that resolved everything. There's nothing more to be said. The nurse doesn't have a chance to say that. And what they perceive is so very, very different. So the physician thought there's no need for report because this is kind of a mistake that this nurse probably is a rookie, doesn't really understand. Now, this nurse understands. The the nurse the nurse's perspective is this physician is horrible and I shouldn't have to work with this person again. So you understand the different perspectives that they have here. And as a result of this long explanation, I've utterly forgotten your question.

DR. STRIKER:

Just clarifying the differences in the the top three barriers, if you will, for each group and and what what maybe prevents people from filling out certain reports when they probably should.

DR. SHAFER:

Yeah. And so to the physician, there was the barrier was there was no need for it. The physician felt that it had already been addressed at the bedside.

DR. STRIKER:

I] think a lot of us can relate to those those barriers when we actually do see something. And or by the end of the day, it's like I've forgotten about it and now I'm on to other issues and then there's other problems that have arisen. And but to be quite honest, key one to me is the top one. The number one for both of them was I never get any feedback on what action is taken. And that goes back to where I feel that an institution

really is ultimately responsible for the management and maintenance of this system. And if you want to get good results in terms of patient safety from a system like this, the clinicians have got to see what the results of filing these reports are, if and if they're if there's never any action taken or they're not sure if there is, I don't see how it can be successful.

DR. SHAFER:

So first off, I don't disagree with what you say, but we're going to reverse the interview for a second. And I'm going to interview you because you practice anesthesia just like I did. So let me ask you a question. When was the last time you saw something transpire with a patient and one of your colleagues and you thought this probably isn't in the patient's best interest?

DR. STRIKER:

This week.

DR. SHAFER:

Right? Right. And why did you not file an incident report?

DR. STRIKER:

Oh, number one, that's the that's my biggest thing. I don't see any action taken. I mean, this is we're talking about a large institution.

DR. SHAFER:

But you're not did you not take action at the time to tell somebody, by the way, think about this and explain whatever your thought was about about what was going on?

DR. STRIKER:

Absolutely.

DR. SHAFER:

Yeah. And that's my that's the point that I'm making, is that I think for most of us, we see stuff. But as physicians, we kind of feel that we have a responsibility, not just that we're

entitled to, but we actually have a responsibility to teach, to clarify, to improve the system in real time.

DR. STRIKER:

I mean, absolutely do that. But if you perceive the time this is going to take to file and I'm not going to see any results of this particular filing, it's not worth it. Or, there's sometimes so many it's like I have to pick and choose, you know? And so, I mean, I filed plenty of incident reports, but there's oftentimes just too many things to spend that much time on. You have to pick and choose which ones you feel this is worthy of my time. It's worthy of follow up. If I don't get the follow up, I'm going to follow it myself. But a lot of things, yeah, to your point are trivial enough. I solve it in real time, but probably just not worth my time to fill out this particular report and be able to follow it up on because I don't get the feedback.

DR. SHAFER:

And so I'm, I'm the same, you know, I, what I see things is sort of like the TSA's logo. If I see something, I say something and I try to be sure that I'm just as respectful and kind and thoughtful, but if I see something, I say something. But I've never received any follow up. I've probably filed a half dozen incident reports in my career. I have never received follow up.

DR. STRIKER:

Well in my previous administrative--when I say administrative position, administrative in the Anesthesia Department position, where I saw these incident reports in my previous institution, you know, I got first hand look and accounting of what happened with these things. And so I did get to see a little bit under the hood, if you will, of what happens with some of these. And and there were, I mean, a good number of of the of the true safety ones that were addressed properly. But whether, you know, and if you don't disseminate that information to your own department, I don't know how much other individuals on the ground level are going to get that feedback, what exactly happened and what measures were taken.

DR. SHAFER:

And that's key. So one of the articles talks about what we should do as anesthesiologists, and what they mentioned is we need to get involved in the process, we need to understand it, and we need to have anesthesiologists involved in assessing critical incidents that arise in the perioperative period. Because if we don't know what's

involved, it's easy to be paranoid about the whole system. And if we know what's involved, then we understand perhaps that the institution has more equipoise than sometimes it's sometimes apparent to us by the by the incident reporting system in and of itself.

DR. STRIKER:

Well, and I'm glad you mention that, because that brings me to the last point, which is what do we specifically do as individuals or professionals to help the system that at least some individuals in each department have to be involved in this system to help disseminate that information?

DR. SHAFER:

Yeah. And so exactly. So we have several articles on this by people who are very much involved in incident reporting systems, talking about how their institution tries to make the system one that works to actually improve patient safety, address issues of behavior that compromises either safety or a respectful workplace environment, but at the same time realizes that the way these are handled is sensitive, particularly to the person who is being reported as having done something that violates either patient safety or a respectful environment, that includes being involved in the committees that are addressing these reports. It involves reporting back to the department how this is being addressed. It involves being transparent with the faculty, being involved with the whole department, not just the physicians, but everybody saying, here's what happens to these reports and here is why you should not panic if one is filed about you. And you should know that you can engage the process to, in a sense, try to provide balance into what actually is going on here.

One of the most interesting aspects of the report that I got back, this is actually from colleagues at Stanford, an anesthesiologist, a surgeon and a nurse who jointly wrote about incident reporting systems from different perspectives. But they brought to my attention the concept of DARVO, which is really fascinating And I had not heard it before. But DARVO specifically means deny, attack and reverse the victim and the oppressor. And so what DARVO is when you say, Oh, you did something and the DARVO report is to you immediately deny it, that didn't happen. You then attack the person who has brought the allegation and you then claim that you are the victim and that the person who brought the allegation is in fact the oppressor. So we see this in many aspects of our life today, but it gave me pause for the September issue about weaponized reports, because it's possible that the reports that I received where the physicians were kind of denying the seriousness of the actions, and they are basically accusing their accuser of bias and dishonesty and inappropriate reporting. And they are,

in fact, reversing the positions of a victim and oppressor. So is this all, DARVO? It's a good question. I think part of how an institution addresses this is to say there are two sides to every story. And we don't have to establish a guilt or innocence by the party who's being reported on. Nor do we have to establish a motive, good or bad, by the person who's filing the report. What we want to do is to identify true patient safety issues, and we want to create a respectful workforce environment so that we don't put anybody in the position where they deny, attack and reverse victim and oppressor. Sharing that perspective to me was really educational in trying to place the whole incident reporting system into perspective for how institution can approach it and not try to assign blame to either party or assign an ill motive to either party, but simply protect patient safety and create a respectful workplace environment.

DR. STRIKER:

Yeah, I think we all want a respectable workplace environment and I truly believe the vast, vast majority of individuals that are working in a health care facility to take care of patients want what's best for the patient and want an environment that a patient feels comfortable and safe when they get care.

DR. SHAFER:

Yes.

DR. STRIKER:

Dr. Shafer, thank you so much for joining us again and sharing your insights. It's always, always a pleasure to have you on.

DR. SHAFER:

Dr. Striker, it's always a pleasure. Absolutely. Thank you so much.

DR. STRIKER:

All right. Take care. And thanks, everyone, for listening to this episode of Central Line. Visit asamonitor.org to read all about the issues we've covered on this show. Please join us again next time. And if you like the episode, if you like the series, don't hesitate to leave a review. Tell your friends about it. Always appreciate it. So take care.

(SOUNDBITE OF MUSIC)

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