Central Line
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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, editor and host, back again. And today I'm joined by Dr. Jannicke Mellin-Olsen, the past president of the World Federation of Societies of Anesthesiologists, which among other things, is a non-state actor in official relations with the World Health Organization. Today, we're going to talk about patient safety and the World Patient Safety Day specifically. Dr. Mellin-Olsen, welcome to the show.

DR. JANNICKE MELLIN-OLSEN:

Thank you very much. I'm honored to be with you.

DR. STRIKER:

Before we get to our topic, I'd like to learn a little bit more about you. You had a fascinating career, and I think our listeners would be interested to know how you got involved with the World Federation of Societies of Anesthesiologists and became a global leader in patient safety.

DR. MELLIN-OLSEN:

Well, I think it's interesting when you speak to people who are interested in patient safety, most of them have their own story, as do I. So when I was three and a half, I had a brother born with esophageal stenosis and other problems, and my mother knew at that time that she had to stay in the hospital with him if he would have any possibility to survive. But at that time, there were no babysitters, nobody stepped up. So I knew at that young age that I had to take care of my sister so that my mother could stay with my brother in the in the hospital. And my father had to work. So we all did what we best

could do best. Then he died because of a medical error, because the doctors wouldn't listen to our mother's input and didn't listen to her concerns. And I think all the time from that day, I knew I wanted to do something about this problem, that we should take parents seriously and also our patients and look into how we could help people. That was the reason why I became a doctor in the first place. I wanted to be a nurse because I didn't understand that there is an option to become a doctor for a lady. But I did. And and then I just want to make a difference in the world from that time on. And that's what started the story really.

DR. STRIKER:

As you've journeyed through that career, talk a little bit about your specific involvement with patient safety.

DR. MELLIN-OLSEN:

Yeah, well, I wanted to make a difference in the world, as I mentioned. So I went to other countries. I was in Lebanon in a war zone for one and a half years, the first female physician to complete military services, which is voluntary in Norway. But at that time that was not from for men.

But then when I started my anesthesiology career after that and I got involved in the Norwegian Society of Anesthesiologists, I have a very good role model in my professor at that time, Professor Sven Erick Ismail, who was a real role model and the way he approached problems and how he approached us as the junior doctors to always look at how we could improve things. He was confident in asking stupid questions. And I thought, Why on earth does he ask us all those stupid questions? He's a professor. He should know those things. And then later, I found out that the reason why he asked all those stupid questions was that we should feel competent as junior doctors to ask the same stupid questions he had. He was a pioneer when it came to discussing problems which have not yet become medical errors. So we have the problem meetings or what you could now, you would call them, mortality and morbidity. But it was not those who had caused the problems, but those who have potential to cause problems. So we had to every anesthetic we had to tick off the box if it was uneventful or if there were were anything. So then he could help us. He supported us in having a systematic approach to things that did not go exactly as planned. That was a great inspiration, of course. And then he really showed us what culture means.

And then I was involved in other organizations like the European Board of Anesthesiology. And actually what happened at that time was that I complained because I think they were just having social meetings and not doing anything. So at one

meeting in Rome, the president of the time, he said, Now there is one person in this room who thinks we are doing nothing yet. Jannicke can you come up to the stage? And then I went up to the stage and he said, Well, I hereby declare you as the leader of a task force who is going to look into European patient safety and quality. Here you have a bottle of Irish whiskey and go back to do the work. So that was actually the beginning.

I went back, I worked with the others to make the guidelines for quality and patient safety in Europe. And later it was Professor Hugo from Aachen in Germany. He suggested that we made for the Congress in Helsinki in 2010 Helsinki Declaration on Patient Safety and Anesthesiology. So I was leading that work that led to to the Helsinki Declaration on Patient Safety in Europe, which was it was a big thing when all the European countries signed that declaration. It describes what we can do, what we have to work with other stakeholders, like other clinical partners, nurses, patients, relatives, hospital owners, politicians, everything. And we all know that having a good party and signing a document is very nice, but it doesn't help if it's not followed up. And the European Society of Anesthesiology and Intensive Care have followed that and that document,The Declaration, has now been supported in so many countries in the world, and we have worked on that too to do a big change. So that was in the European way.

And then I was also involved in in the World Federation where I became a president, where also we know that two out of three people in this world do not have access to safe anesthesia and surgery. That is a huge task. It kills more than four times as many as HIV, tuberculosis, and malaria combined. And will anyone do anything about that unless we work on providing safe anesthesia to all those? And it's not only in the poorer countries, even in our high-income countries, access is not equally divided, as you know.

DR. STRIKER:

Well, I want to get to that topic in a little bit. But before that, we're talking about the involvement in the WFSA. And I know that there's World Patient Safety Day, which is September 17th every year, and it's one of the W.H.O.’s global public health days. Can you tell us just a little bit about that, the history and how that day came about?

DR. MELLIN-OLSEN:

Yeah, well, first first of all, the WFSA is a non-state actor in official relations with W.H.O., which means that we are invited to attend the World Health Assembly and other regional meetings all over the world to give our statements and to work with other stakeholders. And that you have also have the United States. Our recent President is the immediate past president of the world of the WFA, Professor Adrian Gelb, and he is

also very involved in patient safety. And we have them, in the W.H.O., we have been in contact with with the Safety Patient Safety Department and together with them, they have have a working group or a community to which every one of you listeners come. Also, you can add your interest and you can be part of that discussion group. And together this group with, with the office in the, in the World Health Organization and other stakeholders, they prepared a document which was a resolution from the World Health Assembly on global action on patient safety. And after that, then you have the same questions. It's nice to have a resolution, but many of those W.H.O. resolutions, they end up in the drawer. So somebody had to to … has to take it further. And that group, together with all the stakeholders and ministers and others all around the world, work together. What can we do to make this resolution hold? And then it was a suggestion to have a World Patient Safety Day, which is, as you said, September 17th. Every year there's a new topic every year, like it was health worker safety, it was woman and child. And this year it's on medication safety. And later, we have worked on a global patient safety action plan from 2021 to 2030 with all these stakeholders, which is the framework for all governments when they are going to work on patient safety.

DR. STRIKER:

Well, let's stay with that for just a sec. Medication safety is a huge issue. We're all aware of it. A lot of the issues we see every day in our practice, I know the Anesthesia Patient Safety Foundation has this at the highest priority on their list. From your perspective, tell us what the problems are specifically and maybe what we should be doing about it.

DR. MELLIN-OLSEN:

Well, it's it's really a huge topic. And the more you dig into it, the bigger it becomes. Actually, you have Monge in 2016. She found that one out of 20 medication administrations was with errors and one third of those led to serious events. So there is no question it's a huge problem and it's on many scales.

One thing which we are very familiar with all over the world and you in the United States as well, like I am in Norway, is the medication shortage. Because when you have to replace a medication which you are used to using with another or none at all, of course it's a risk to patients. Because you don't work with something which you are not familiar with. And also, of course, in in the whole world as a whole, you have people selling medications, which actually is not what they say that I have an example. It was in Afghanistan. Of course, it's a different setting. And so but it was with some in a Norwegian military hospital when they saw that the halo thing, which I thought they were using, it didn't work as it should be. And it was used as a pesticide or something that

could be done. How often bottles and finding it out and other places you really don't know what is in that vial, that's of course a big problem.

Then we have the storing things. If you store all the medications together, it's easier to have a take out the wrong drug. So you should have the high risk medicines stored separately, and you should have a standardization, because when we are stressed, it's normal psychology to to take the wrong thing or whatever. I mean, when you are stressed, you don't work in the way you do when you are not stressed. And we all know that at some points we are stressed and cannot concentrate on everything. So that's why we have to ensure that the packages help us. The nomenclature, we don't change. For instance, you have epinephrine in the United States. We call it adrenaline here. Just to give one example. So we have to to ensure that the that we know what we are looking for. But they have the same names and we recognize the package when they are changing the manufacturer all the time. The package is changed too. And how our drugs look like change. That's a risk. Forward things to that is the labeling that you have to look alike medications that you can have phenylephrine look like fentanyl, for instance. Very simple thing to change, but it's amazing how often you have that problem.

Then, of course, we have to label our syringes. You need to understand again the psychology of people, because if you label an empty syringe, then you might put it aside for a moment and your mind slips or whatever. So you have to make some rules. Never empty label an empty syringe. You draw the syringe first, then you label it. And the same person should label it before it leaves that person's hands.

You have color codes, but the color codes are not uniform. Why don't we agree on one type of color code so that when you change country or change hospital or whatever, you don't have to learn a whole new system of color code.

And then, of course, simple things like labeling infusion bag, labeling the lines when they go into the patient. Very simple thing, but very acceptable.

We also have a problem with hygiene, so we should add prefilled syringes. And that's also that, you know, what's in the syringe. So it's not only hygiene, but when you some people have our are savings, so they will use the same ampoule for several patients. And so infection is another additional risk for taking the wrong medication. If you don't flush the panels before you leave the O.R., when you come to the packing units, they would try to to flush it. And it will be some reminders in the remnants in the in the line. And the patient might suddenly develop tachycardia, for instance. Those are all the things.

Then you have others. I mean, I could go on and on forever. Transitional care. How do we know that, in the first place, do we know what medications the patient is on when it comes to our O.R.? Okay. We have done the pre anesthetic evaluation. I know for myself once I was a patient, I had been put on another medication which has not been put in my chart. I told the anesthesiologist and the surgeon before, please note that I have been put on an additional medication. It was just lost. And the same when we go over to other levels of care, when we go to the Pacu unit. How do we ensure that we know what medications this patient is using?

DR. STRIKER:

We could talk about this topic for hours and it's a worthy topic. But just quickly, I'd like to get your opinion. Given the choice of educating new anesthesiologists, trainees on best practices, advocacy for help with systems issues at a governmental and regulatory level, and then also help with systems issues locally at our own institutions to help with these errors. Do you think there's one area we should be focusing on more or needs more attention? I know they all do, but do you identify one as being woefully behind or something that we should be emphasizing a little more as a specialty?

DR. MELLIN-OLSEN:

Well, I think the answer we always come back to is culture, because if you have the right culture, then everything else will fall off. So if you have that learning culture that that you are not shaming and blaming, you do incident reporting and you try to learn from them. You try to facilitate that the employees are able to work in a safe environment and then they can use all these tools, which I have mentioned and I have not mentioned all of them, but we have to work on safe culture.

DR. STRIKER:

Well, speaking of the day specifically, do you mind sharing with our listeners what activities are planned for the day and how anyone can get involved if they'd like to?

DR. MELLIN-OLSEN:

Yes. For for the day specifically, then everybody can get involved. Of course, there are four target areas that have been identified by the W.H.O., and one is patients on public and the public that they are important stakeholders. The second is systems and practices of medication. I have covered some of those. The same is regarding health care professionals. I also talked about some of those, and we can try to to focus on those problem areas in our institution. And then medicines is important. And that comes

not only from us on how we view medicines, but it's also from the manufacturers and the hospitals and so on.

There are webinars and seminars that is in arranged by the W.H.O.. Then there are some hospitals that schedule them, and you could do that in your hospital too. Of course, it's a little bit late on the day for this year, but there will be years to come. National events, for instance, just to highlight the importance of patient safety initiative. Many monuments in the world are colored orange, including the pyramids in Egypt, ivory tower, the jet fountain in Geneva and other places to color things, including the hospital orange to demonstrate to everybody that we are concerned, and we are taking care of patient safety. But I think it's up to all of us. What is relevant, knowing the issues, what's relevant to our organization? What do you want to highlight? How can you make a change? And you can do that in a department level. Also, it's not I mean, every one of us can make a difference in that day.

DR. STRIKER:

Well, I want to talk a little bit more about patient safety more broadly, but we're going to do that after this short patient safety break. Stay with us.

(SOUNDBITE OF MUSIC):

DR. JONATHAN COHEN:

Hi this is Dr. Jonathan Cohen with the ASA Patient Safety Editorial Board.

One of the healthcare professional’s most crucial skills is that of communication with patients and other professionals.

Barriers include misinterpretation of context and non-verbal cues, as well as differences in language, culture and healthcare literacy. Several techniques that are simple to employ have been shown to overcome these barriers and improve communication. One of the most difficult conversations to have with a patient or involved healthcare professional is when an adverse event has occurred. Approaching these important discussions using evidence-based strategies has been shown to strengthen the relationship between the patient and healthcare professional, decrease malpractice litigation, and diminish the psychological trauma that healthcare professionals feel after being involved in an adverse event.

VO:

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

DR. STRIKER:

We usually discuss patient safety from our point of view, the point of view of caregivers, physicians, specifically. Let's shift the lens a little bit and discuss patient's view on patient safety. What do we as anesthesiologists, need to understand about how patients see the subject?

DR. MELLIN-OLSEN:

Well, I think many physicians have been patients, including me. And my experience and others, is that you see from a different perspective when you are a patient, even if you are an educated patient, you can see things are going wrong. You can see, as I told you, that I didn't know my medications. I see people coming, not washing their hands. They are many other things. Then you want them to like you because you feel that if you are a difficult patient asking too many questions, they might not give you the best care. And that's an issue. We should always remember that we are the strong partner in relation with the patient. We must respect the patient and welcome any patient from any input from the patient's other relatives. Even we know more about the patient's conditions than anything. We should always listen to their concerns and take them seriously. And that's a problem for many patients. They feel we are not listening, we are not taking them seriously, and we are not that interested in what's important to them. Some very, very small things. When we talk to patients in bed, we are standing above them and we don't meet them eye to eye. That's a very strong demonstration to those patients that we they are inferior. That influences them, that they are not telling us their concerns. So communication, we need to get the patients perspective of what matters to them. It's interesting when you talk to the patients and about even research. We do research on topics we find interesting. But is that what matters most to the patients? So there have been some initiatives like the lines. They put patients and physicians together to identify what's important. Just some examples. And we will do better jobs, give our patients better care, if we treat them more as partners.

DR. STRIKER:

These are excellent points. And anybody who's listened to this show knows that. We have certainly emphasized the idea of patient communications. In fact, the ASA is actively putting out resources for all its members to help with patient communications, not only emphasize, but also make suggestions on how to improve your communications. But yes, that we I couldn't agree more about the patient communication aspect, whether it's improving safety or letting the patient know what it is

they're going to be experiencing or engaging in a dialogue to understand what their priorities are about the anesthetic. Certainly, I encourage everyone to listen to some of our other episodes about communications. I do want to circle back to the topic that you already had mentioned, which is the global health issue in terms of lack of anesthetic care. And so do you mind just laying that framework out again for our listeners?

DR. MELLIN-OLSEN:

Yes. I mean, we know that five out of 7 billion people in this world do not have access to safe and affordable anesthesia and surgery. And many of those don't even reach the hospital. And as I mentioned, it's not only in high income, in low income countries, it's true also in remote areas in your country and in my country. So we have to have that in mind. And this is not going to change unless we take the lead, because we need to advocate with governments and with others to make them take responsibility for that. And when once our patients have reached our hospital. We must make sure that they get safe care. And we know still that too many people die in the hospital for from preventable complications. And as we know, the goal is zero preventable deaths. It should be the goal. Like, for instance, the Patient Safety Movement Foundation, to which ASA is a partner as well, are working to attain that zero goal, which is difficult, but we have to go that way. There is no alternative.

DR. STRIKER:

It's a complicated issue and it's a problem that I know is going to have a solution that is multifaceted. But in your eyes, is there something obvious we should be doing as a society to help in in that access issue?

DR. MELLIN-OLSEN:

Yes. Well, first of all, it's I mean, we have to lobby, as I know you do, with your politicians and so on, because it's very easy what some it was said by Paul Farmer that surgery is a neglected stepchild of global health. And then Craig McClellan said, and if so anesthesia is his invisible friend. So unless we make ourselves visible and what we can contribute to attain the goal, they won't see us. So that's what what can be done on that level. And we can do that locally as well. And then, of course, we have to work internally in our working settings and in our environments to try to do something about the problem and raise the issue and so on.

DR. STRIKER:

Well as anesthesiologists, leadership is a characteristic we exhibit every day in our practices. And I feel like it's one of those characteristics that oftentimes people outside of our immediate work environment don't get to see. And do you think we don't assert ourselves more broadly with that expertise when when we could have a significant impact?

DR. MELLIN-OLSEN:

Well, I certainly know we have the potential. I feel I'm not competent to speak about what is the situation in your hospitals in the United States. But I know that in many countries we are natural leaders in our our hospitals because we work with so many other specialties and we are somehow the key, the center of what's going on. We we are there in in in so many other settings. And wherever our role position is in in the organization, we can work as be role models and advocates for our patients.

DR. STRIKER:

Well, why don't you speak to what you think problems plague us the most from a patient safety standpoint?

DR. MELLIN-OLSEN:

Well, I mentioned culture, which I think really is the core of everything. But there is another big, big problem in the world and in our countries, too, and that's workforce. How do we get sufficient trained people where they are needed as anesthesiologists, like in remote areas, even if you have an. And you know that that it has been estimated that we need a bare minimum five anesthesiologist physicians per 100,000 population the population in this world. And the FSA counted all the anesthesia providers in this world and found the gap, that today to to get to that bare minimum we would need 136,000 new anesthesiologists today. And it's not going to happen soon. And it's not I mean, some countries could say, okay, let's do nurses. And I know that's a big issue in the United States, but that's not a solution either, because nurses are also in shortage. Workforce, trained workforce is a big issue.

DR. STRIKER:

Yeah. Now it's certainly on everyone's minds and it's at forefront of a lot of institutions issues, not just in anesthesia, as you pointed out. Do you think that we don't do a good enough job making our profession attractive enough? Like, do you think there's there's something we should obviously do to garner more interest in specialty of anesthesiology?

DR. MELLIN-OLSEN:

Well, it's interesting for me, because I come from another setting where anesthesiology is one is the number three most prestigious specialty next to brain surgery and cardiac surgery. We are more prestigious in my setting than general surgeons, for instance, or cardiologist. So and one of the reasons we are more are so prestigious than we have so many, many people wanted to join our specialty in my setting is that we are diverse. We are involved in in intensive care. We are involved in pain treatment and also in critical emergency medicine. We do air ambulance, which is very attractive to many. So, I mean, really, it's to to show that we are relevant and also be visible on many fronts. And I know that COVID has helped us in some way to become more visible.

DR. STRIKER:

So do you think that visibility, is it just because we're more visible? You just pointed out that it's you've got a unique perspective compared to our country, where the prestige of anesthesiology is is obviously very high. And do you think it's just visibility that people just know about the specialty and so it's on their radar when it's something they entertain as a career? Or is it because we are fundamentally involved in so many activities, whether it's ICU or pain management, that people pursuing medicine decide That's the kind of diverse career I want to have. What do you think is is more of the issue?

DR. MELLIN-OLSEN:

Yes, but I think visibility and the diversity that they are links and also to be team leaders and be visible as team leaders. So we have, like in my country, I work with nurses, but it's a totally different way than the team that is described from the United States, which is good, but also, of course, to be good when we have our students. I remember when I wanted I was going to choose the career. I thought anesthesiology was this bag you're blowing all the time. And there were some big seats in ICU, which I could never understand what was above, but I didn't understand that it's really the best specialty, because what I usually say is good for the brain, because you have to make good decisions. Very quick decision. Good for your hands because you have some practical procedures and it's good for your heart because you as anesthesiologist, we take care of the patient's best interest whenever they are at the most vulnerable and you can show your compassion and everything. And if they are able to put that forward to the students and also tell them, I mean, let them understand how much we enjoy our profession and we should talk nicely about what we are doing and so on. So I'm not complaining when the students are listening.

DR. STRIKER:

Well, one more question before I let you go. How do you see the future when it comes to patient safety? Are you optimistic or do you think it's going to be challenging?

DR. MELLIN-OLSEN:

Well, it's going to be challenging, but I am optimistic. That's the only way. I mean, what is the alternative? To work for better patient safety every day. We have to believe it's possible. I'm not saying that it's without obstacles along the road, but we have to to work on and inspire each other and trying to make the world better for patients than ourselves. We just have to to progress. And that's part of being a human being, trying to do things better every day. And I think you in the United States, the whole world is looking at you and to what you are doing. So you are really in a very good position to being leaders and showing us the way. And of course, with we are all together in this. And so but you are really in a position to inspire everybody else. And I trust that you are going to do that.

DR. STRIKER:

Well, Dr. Mellin-Olsen, you yourself are an inspiration to all of us, and I thank you for joining us. Your expertise on this matter is unparalleled. It's a pleasure to have you on and to be able to have you talk with us and share your insights on this topic. And so we truly appreciate it.

DR. MELLIN-OLSEN:

Also, thank you for giving me the voice in your podcast and to share my my visions and thoughts with all of the listeners. Thank you so much.

DR. STRIKER:

Well, thanks everyone for listening to us on this episode of Central Line. As usual, if you like what you hear, if you like the episodes, the topics, please drop us a review. Let let your colleagues know. We hope to see you next time. Take care.

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