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VOICE OVER:

This is Residents in a room, an official podcast of the American Society of Anesthesiologists, where we go behind the scenes to explore the world from the point of view of anesthesiology residents.

I kind of heard about quality improvement or quality initiatives peripherally, but never really understood what it was as a medical student.

Right. And I think that's a gap in medical education because it's these things that are affecting how we practice.

I think it's intrinsic in our nature as anesthesiologists to always be looking for a solution to a problem.

No, I haven't been involved in any quality initiatives thus far in my training, But yeah, it's definitely something I'm interested in as well as a lot of my residents.

DR. ERIC REILLY:

Welcome back. I'm Dr. Eric Reilly, CA3 resident at Beaumont Hospital, your host for another episode of Residents in a Room, the podcast for residents by residents. In last month's episode we discussed clinical decision making. And today I'm back with my fellow residents to tackle patient safety and quality initiatives. As a reminder, here with me today are...

DR. JESSICA ZHANG:

Hi, I'm Jessica Zhang, one of the CA2s at Beaumont.

DR. SHERIDAN MARKATOS:

I'm Sheridan Markatos. I'm one of the CA3s at Beaumont as well.

DR. ERICA BOLZ:

And I'm Erica Bolz. I'm one of the CA1s at Beaumont.

DR. REILLY:

And thank you all for being here once again. I know it's difficult to get out of the ORs. Jes just got here about 5 minutes ago.

DR. ZHANG:

Lucky me.

DR. REILLY:

So let's start. Big picture, what are your biggest considerations for perioperative patient safety. And Jes, you're freshly out of the OR? So let's start with you.

DR. ZHANG:

I think the biggest thing starts pre operatively. When we go into assess the patient, we take a full history and physical exam. We really look at the patient and try to make sure whether they are optimized enough to go into surgery, first of all. Whether their vital signs are stable. Have they been inpatient? Why are they here? Is an emergent or urgent or elective surgery? Does this patient's co-morbidities allow them to proceed with surgery? Say we have an older patient that has coronary artery disease, is on several medications, blood thinners ... we want to make sure that we go through all of their history in the chart, as well as talking to the patient or their caregiver to fully optimize this person for surgery, as well as ordering any additional labs or imaging to help us make a decision whether we should proceed with surgery or not.

DR. REILLY:

I think that's the board answer. I think we're all done here. Sharidan anything to add?

DR. MARKATOS:

Yeah, I was just going to say I don't know what else there is to add. But one thing I guess I like to check when I first am pre wrapping a patient is whether they've had an anesthetic before and if we have it in our record, what does their record look like? Was it a pretty smooth one? Did some complications arise during the case? And why? Is that

attending who took care of them last time here today and I can talk to them about what happened? But I think it's always nice to see do they have that anesthetic record on file that we can kind of get an idea for how things are going to go today?

DR. REILLY:

All that 100%. Something we touched on in the last episode was patient autonomy. I think it was you talking about it Sharidan. And I think that's one of my biggest concern because a patient who understands what's going on is a safe patient in their own eyes. And so just making sure that they're aware of the potential risks, complications, things that can happen in a surgery, you may need a breathing tube, you may need a line in your neck, you may need a line in your wrist. And explaining why that helps keep the patient safe, I think is huge from the get go. Are there any patient safety concerns which scare you the most? Erica, you're a CA1. So I'm sure there's a lot of scary things out there.

DR. BOLZ:

This early on in my training everything kind of scares me. But I think that a lot of it is appropriate and good. It's kind of scary in a good way in that I know the risks associated with the anesthesia and I'm able to communicate them to a patient. This early on there's a lot that scares me. Things that could potentially go wrong or even forgetting certain things in my mental checklist after intubating and and inducing a patient, I definitely think that there are.

DR. MARKATOS:

My quick answer is pulmonary hypertension. That always scares me. That's probably the thing that alerts me the most to pay extra attention to the patient's history and kind of what's going on with them. I don't know if anyone else has something like that, but that's mine. Pulmonary hypertension.

DR. REILLY:

I agree. The first thing of mine was acute, right? Heart failure. Yeah. Jess, anything to add?

DR. ZHANG:

For me personally, I think just the higher the number and age just scares me more because they're usually a lot sicker or there's a lot of older patients that haven't seen a doctor for several years. So just not knowing... the unknown scares me.

DR. MARKATOS:

Yeah, Yeah, that's a great point. Jess. What? Scares me as the patients who are healthy, but they're healthy because they've never seen a doctor.

DR. REILLY:

Right. Which we see a lot of. We have a lot of patients who come and say, I've never been to a doctor, I'm great, and they are not great. I think one thing and this isn't unique to Beaumont, but across all health care that is scary as an anesthesiologist, is the emergent case, unstable patient coming in in the middle of the night? You know, during the day, there's tons of staff around. You have a lot of elective cases, a lot of ORs going. There's people who are free to help out. But oftentimes at night, you know, a lot of that staff goes home and they just have the, quote unquote, essential staff who are around. And sometimes we've all needed extra hands. And at night or in underserved areas, those hands can be scarce. And so I think that's one of the scariest things is, I think, to becoming an attending is what happens when that emergent case, that unstable patient, comes in in the middle of the night and I need help and help might be 2 minutes, 3 minutes, 5 minutes away, which might be 2 minutes, 3 minutes, 5 minutes of perfusion to the brain. You know, those are those are the things I think about.

And then kind of digging into hospital resources and patient care and best patient interests. You know, you can kind of dig into quality, quality initiatives. So you hear about QI, quality initiatives, all the time. But what does that mean to you? Jess, we'll start with you. What does quality mean to you? Quality initiatives?

DR. ZHANG:

I think to me, quality initiatives means that we're acutely aware of improvements that we can make in the OR, preoperatively and postoperatively, making sure that we're really honing in on the important things that assure patient safety. And so having these quality initiatives and metrics to allow us to kind of gauge and have data behind everything allows us to kind of see a bigger picture of how well we're doing, as well as ways we can make changes in the future to improve on our patient safety.

DR. MARKATOS:

I think patient safety is a big part of quality improvement. The other thing I think of is just the patient experience. One of the easy things to talk about or think of is postoperative nausea and vomiting. It really makes the patients experience better or worse, whether they experience it or not. Thankfully, our electronic medical record notifies us when there are patients who have three risk factors for postoperative nausea and vomiting. And so then are we as the providers and the care team, implementing the things we need to do? For instance, giving three medications from three different drug classes to help prevent that? Are we following up with that and doing that? And I find that whenever I do those things that the patients, they don't experience post-op nausea, vomiting, and I see them in recovery and they're so happy. They're like, oh my gosh, last time I was so sick. What did you do this time? And I just tell them I gave you three medications from three different drug classes. And typically that that thankfully tackles it.

DR. BOLZ:

And just kind of going off that. I think it's also really important to make sure that everyone in the perioperative team understands why we're doing these quality initiatives. So not just the anesthesia team, but the surgery team, the nursing staff, both preoperatively, intraoperative and post operatively. So I think that's also a really important part of quality initiatives.

DR. REILLY:

And I think that we try and have our monthly meetings where Dr. Price will go over quality stuff. And Dr. Colten will talk about ... Aspire and the quality metrics moving forward. Have any of those meetings or any of those quality initiatives that our hospital has adopted, has that kind of changed what you think about or how you manage stuff in the OR? Has anything changed throughout your years? Sheridan?

DR. MARKATOS:

One of the things like mpog has been focusing on is using less nitrous just because of its environmental effects. And it increases the incidence of, like we mentioned earlier, post-op nausea, vomiting. That's a easy thing to tackle. From Dr. Colton herself I've learned that a nice way to wake a patient up quickly and comfortably is to get the gas off. And instead of using nitrous, just giving small clots of Propofol as the surgeon is superficially closing the skin, they don't need too much anesthesia for that. And so you can work on getting your gas off while doing that. And I've noticed that patients wake up very smoothly that way as well. So that's just a small example of how my practice has changed by attending these quality improvement meetings.

DR. REILLY:

Yeah. And you touched on nitrous not only kind of have adverse effects for patients, but obviously it has environmental adverse effects like a wild greenhouse gas that takes forever to break down. And I think that's a cool part of quality that it's it's rooted in patient safety, it's rooted in conservation of resources, it's rooted in environmental consciousness. And yeah, I think Beaumont does a pretty great job of trying to reduce fresh gas flows, reduce our use of nitrous and desflurine, make sure we're following up with our perioperative glucose guidelines, multimodal analgesia and multimodal nausea prevention and treatment, kind of shared and was talking about. Quality is already affecting our practice, whether we know it or not. And I think it's super helpful to kind of help treat and help monitor the things that might be really tough to see otherwise, you know, like, are we using folies for one hour surgeries or only are we only using them for surgeries that are 2 hours or longer? Are we using multimodal pain regimens? Are we using regional techniques? Are we trying to get patients up and walking after surgery quickly? You know, all the stuff that's rooted in quality that is really improving patients overall stays in the hospital. I think our department does a pretty good job of it, and I think it's giving us good skills and we're seeing a lot of good stuff to take into our practices elsewhere. Do you guys feel like you've been encouraged or have you gone, you know, to certain lengths to try and do any quality projects or anything?

DR. MARKATOS:

I feel like we're definitely encouraged here at Beaumont. And whether it's an official project or not, our leadership and our attendings are always listening to our ideas. We talked about COVID in the last episode and how that impacted us, and we talked about how we were just interns at the time, and I was on the pulmonology service when it all started. And so they were really anyone who came to the E.R. We didn't even have COVID tests at the time. Anyone who came to the E.R. was suspected COVID. They got a pulmonology consult. So our team was really looked at as as what to do. And one of the things I noticed was that in the medical ICU where a lot of these patients were going and were getting intubated, they needed lines and there was just so many patients who needed central lines and arterial lines, and they were waiting hours for it. And we had our elective surgeries canceled. And so that freed up a lot of anesthesia residents. And so I emailed Dr. Soto, and even though I hadn't worked with him much as an intern, and I said, Hey, Dr. Soto, I noticed that these patients are waiting a long time for lines. And I'm sure we have a lot of anesthesia seniors who are very skilled at this and can quickly help them the NICU out while we're kind of not doing as much with elective surgeries canceled. And so thus was created the line team. That was one way we were able to both help other residents, other teams, and improve patient quality by getting them those those needed lines and monitors quicker.

DR. REILLY:

I remember that that. It was wild because you have these COVID patients recently intubated, getting wheeled back into the ICU team and the anesthesia seniors would just be following the bed. And as soon as the patient is in the room, it's like the lines are going in, they're in in like 5 minutes. It was amazing to see as an intern. It's like, oh my gosh, is that going to be me one day?

Kind of get back to quality, I mean, you're so right. That just improves the speed of which health care can be delivered to those patients. In residency. We kind of had quality thrown at us from Beaumont itself, from larger institutions like the MSA and the ASA. There's always quality metrics and things we're following. I never really heard about quality as a medical student. But I think we're all seeing it's pretty important in health care. I mean, Erica, did you ever hear about quality in med school? Was it ever focused on?

DR. BOLZ:

Honestly, no, not really. I remember a couple questions on quality improvement projects during my board exams and kind of being confused because it's not something we really touched upon during our M1 one through M4 years.

DR. REILLY:

Yeah. And Jess.

DR. ZHANG:

I kind of heard about quality improvement or quality initiatives peripherally, but never really understood what it was as a medical student.

DR. REILLY:

Right. And I think that's a gap in medical education because it's these things that are affecting how we practice, right? And it's affecting the medications patients get and how we're delivering these medications and why we're delivering these medications. So, I mean, it helps form these blueprints of care. Yet, you know, I never heard about them in med school. I didn't get any quality improvement education. It seems like it's an area that could definitely use some revamping. And we're all from different medical schools. So it's not like it was one institution, you know. And Sheridan you kind of talked

about the real life example making the positive difference, you know, with the line team and everything. Do you ever think that quality just gets pushed to the backburner, that it's a waste of time or that people just ignore it? You guys ever, ever feel that way?

DR. MARKATOS:

Not here. I could see if a quality improvement project would increase cost. How that could be difficult because kind of like how we touched on it, you know, it's about improving patient safety, it's about improving the patient's experience. And most of the time it's also to help decrease costs or conserve resources. And so I think sometimes in medicine, maybe a lot of the time in medicine, doing the right thing and doing the safe thing is going to cost more. And so I imagine that can be difficult. I haven't personally witnessed it yet, but I bet it's got to be a big problem sometimes.

DR. REILLY:

I think even just in our training, when we came in in residency, we use rocuronium a ton here at our hospital. And how often were we pushing sugammadex when we first started out?

DR. MARKATOS:

Yeah, you had to get attending approval and pharmacy approval.

DR. REILLY:

It was it was tough. Yeah. You had to get it personally delivered like it wasn't even in the Pixies most of the time. And Erica, how often are you using sugammadex now?

DR. BOLZ:

I'd say, 80 to 90% of the time?

DR. REILLY:

All the time, Right? And that's just an example of I think there is initial hesitation because of the cost. So it was a little more expensive than traditional reversal with neostigmine and Geico, but now a lot more data is out and I think a lot of places are seeing it's a safer option in a lot of scenarios and it's kind of the go to and when there is concern for residual blockade and is being used a lot more now. And we're fortunate to be at an institution that has the resources to maybe take on some of that increased

costs. But, you know, at more rural, underserved areas where they may not have those resources, I think it's clear to see that maybe while the quality could be a good idea, the initiative, they might not have the resources to implement it. There might be financial setbacks. Do you guys ever think of that when you are considering where you may want to work one day?

DR. MARKATOS:

For me, it's going to be important to work somewhere that's receptive of my ideas. Well, like I said, whether it's a formal quality improvement project or not, or me saying, Hey, I noticed this, can we do this? I think it's important that you work somewhere that wants to make those changes to make things better for patients.

DR. REILLY:

Kind of circling back, we, in residency, we have to be involved in quality improvement in some regard. Sheridan and I kind of had this Kaizen initiative where during our intern year, CA1 year, we worked through this Kaizen Workshop to try and implement a project. Mine was with ultrasounds. Since COVID and a lot of staff layoffs and stuff, I think the person who is running that kind of let go. So Jess or Erica, have you guys yet been involved in any quality initiatives or do you anticipate a way where you may get involved before residency is over?

DR. BOLZ:

No, I haven't been involved in any quality initiatives thus far in my training, but I anticipate that we will, given that I still have a couple of years left of residency. And yeah, it's definitely something I'm interested in as well as a lot of my coresidents.

DR. REILLY:

Right. I mean, I think it just shows that it can be tough when you need to have someone with initiative like Dr. Soto is, but he's not omnipresent so he can't, you know, be giving projects to all of us at all times. And you need a department that supports it, you know, And luckily at Beaumont, I think we kind of have that. But going back, do you think it'd be tougher like do you have friends at other residences who have been involved in quality or whoever mentioned it to you?

DR. ZHANG:

Not particularly.

DR. REILLY:

Yeah. I mean, I think that sometimes quality, even in residency, even though it's something that we complete or are involved in, quality improvement, I think that it's still maybe relatively undervalued, under-resourced, even for anesthesia residents. We kind of touched on, in medical school, we learn nothing about it. And then in residency, we're kind of a part of it and we get involved in a couple of projects and those with a ton of initiative might do more. But it's one of those things where, you know, it kind of I feel like it sometimes just goes to the wayside and people might not be worried about taking it to their practice. You know, when you graduate residency, you're worried about managing the blood pressure and the heart rate and and making sure the patient's alive and you get the right lines in on time. But, you know, I don't think in your every day you're thinking, how do I start a quality improvement project. You know, I don't think it's in everyone's immediate consideration. But maybe it should be because it is dictating the things that we're doing every day. You know, it's dictating how often we're checking glucose while you're in the OR. You know, it's dictating when and how much insulin we're getting, dictating what pain meds we're giving or not giving, dictating when we are and aren't starting Lidocaine infusion for ERAS protocols all of us are part of have done ERAS cases. And I mean, that's all rooted in quality improvement projects. That said, we need to get these colorectal patients out of the hospital quicker and walking and and pain free quicker. And so I think that it's important to be involved, but maybe it's just not harped upon enough.

DR. ZHANG:

I agree. And I think as a CA2 I still have some time to get involved, if not during residency, but potentially fellowship and beyond. I think we as anesthesiologists are the protector of the patient, whether we decide whether this patient is potentially not okay to proceed with surgery. So just everyday decisions that we see with our patients. I definitely want to get involved in some sort of project down the road. And I think patient safety is always changing. There's always new things that we're learning and implementing.

DR. REILLY:

And a lot of quality and following up is based on when adverse events happen, when someone's in too much pain or someone has urinary retention, you know, how have you guys seen these events being talked about or logged here at Beaumont? How is that followed?

DR. ZHANG:

I know at least on our OB service, we have a log of wet taps or spinal headaches occur after an epidural placement. And so there is this new protocol that we have that's helping us to make sure that we keep track of these wet taps that occur after the epidural is placed. And then we're continuously monitoring the patient. If they have for sure a spinal headache, we get them in immediately for an epidural blood patch and there is follow up afterwards to make sure whether this patient has improved and their symptoms. So I think that's one thing that's recently changed some of our practice and helped us to keep better track of our OB patients.

DR. REILLY:

Sheridan and Erica, Have you ever seen people recording adverse events like you can submit like a QSR? That's yeah.

DR. MARKATOS:

Yeah. I've done that a couple of times for patients. I think most of the time in the ICU. I think it's underutilized here at our hospital. And I imagine everywhere else, just because it takes a while, you know, it's something when you're busy you don't necessarily have time for. But I think it's definitely important to keep track of so that change can be made and it doesn't happen again. Thankfully, I think most of the time that I've had to submit a QSR report, it was like a near-miss event and no patient harm occurred. But you never want to get to the point where you're submitting one because patient harm did occur. And so it's stopping it in its tracks.

DR. REILLY:

You can go through all the steps. You can notice these things, you can submit the complaint, propose a solution, and sometimes it works out, sometimes it doesn't. It comes back to the resources available. And if it makes sense in the cost benefit analysis and there's a lot of things that go into these decisions.

Are there any times that you think that something that was done in the name of quality or patient safety maybe stopped you from doing your job? It maybe made it more unsafe for a patient?

I'll start. So, for example, I think it's JCO, or maybe it was the greater pharmacy ruling, but ultimately they don't want any fluids spiked longer than right before they're going to be given to the patient. And sometimes in our profession, anesthesia that isn't entirely

practical. If you have a big huge heart case or vascular case coming in, sometimes you need these drips ready to use in a moment's notice. And if you wait to spike everything or drop everything exactly when you're going to use it, it's going to delay patient care. It's going to make an unsafe situation for the patient. And so I think there was like a two week period where the pharmacy wasn't supplying us with compounded mixes of our basal pressers quick enough. And it was kind of delaying the start times on some cardiac cases. And so that got fixed real quick. We're like, we need more time. We need to be able to set this stuff up. And it got changed back. And so now we can have our drips in a timely fashion, make sure they get to the patient when they need them without delay.

Have you guys noticed anything, any instances where following protocol which is supposed to protect patients, has maybe made it more unsafe for patients because quality is not perfect, protocols aren't perfect?

DR. BOLZ:

Yeah so I think, thinking back to my intern year when I spent a lot of time in the ICUs, I spent a lot of time in the surgical ICU, medical ICU and pediatric ICU. There are different quality control measures put in place, for example, in placing lines. In the medical ICU here when you place a central line in order to verify if you're in the vein rather than artery, even though we do it under ultrasound guidance, the nurses will take a sample and run it through an AV machine to see if it is arterial or venous blood. There have been times where a patient needed a line urgently and sometimes the machine isn't working correctly. Sometimes there's a line to use it. There might only be one a avax machine on the unit. It might be currently being used. So there were a couple of times where I was placing lines in the medical ICU during a COVID wave where we were placing lines quite frequently, where even though it might only be five, ten, 15 minutes, it definitely did delay patient care because we weren't able to place the line until we met that quality metric.

DR. REILLY:

It's a great example of redundancy in the name of patient safety. You've already visualized your needle and you visualized your wire and you have dark red return. You are almost certain you are in a vein. But then they want you to follow up with another test to confirm. And that redundancy sometimes can delay patient care.

Sometimes I feel like we'll get emergent cases that are coming back and not everyone on the team realizes the urgency of the situation. And we have a lot of checks in place to make sure patients are safe. Like a big, huge pre-op screening and sometimes our

nursing staff, to their credit, do an amazing job and they want to get through all of their questions in pre-op. And sometimes they don't understand the severity of the case. And hey, we need to go back now. And sometimes that pre-op screening process can delay patient care a little bit once again in the name of safety. And everyone's doing their job appropriately. But it may be delaying the patient from getting what they need at the appropriate time.

DR. MARKATOS:

The classic question we joke about is the pre-op nurse is asking, Do you feel safe at home? And it's like, well, you know, it's very important to ask a patient who has time for that kind of question. But when we don't have time for that question, like we've got to go. We don't care if the patient feels safe at home. Unfortunately, we just need to get them to their surgery and then we can check if they feel safe at home.

DR. REILLY:

Right. Yeah. And then it goes back to the redundancy thing. You know, like we always ask patients about what medications they're on and what they're taking, and so do the nurses, and then so do the surgeons sometimes and so do the attending anesthesiologists. And, you know, sometimes that redundancy thing again, kind of delays care. So an instance where, you know, quality and patient safety may actually not be providing patient safety all the time. And so in the name of patient safety, are there tools which you use to try and follow up and make sure we're doing things according to protocol?

DR. MARKATOS:

I like to utilize the ASA website and see if there's any guidelines. For instance, I believe it was either 2017 or 2018, the ASA came out with a new statement on perioperative steroid use, stress dose steroid, and which patients require that. And I reference it frequently. And I as a CA1, I showed it to my attending who is very well read and she was shocked. She was like, what, 2017? I haven't seen this yet. And I'm always sharing it with other residents as a resource that you can use. It's got a nice little table and if they're this then they need this. Or, you know, if it's less than five milligrams of prednisone daily, you don't need stress dose steroids. And also like, what's the pathology, what's causing them to be steroids that might change your management as well. So I like to look up anything on the ASA website to see if there's guidelines for that.

DR. REILLY:

I think that's an awesome resource and going forward, something we'll use as attendings. When you are an attending, be sooner rather than later for some of us, do you think that you will be implementing quality improvement in your practice? Do you think that if you're at an academic institution, will you encourage residents to be involved in it, or is it just not super important to you? I mean, there's no wrong answer.

DR. ZHANG:

I think I'm definitely going to try to the best of my abilities to participate in quality improvement projects as well as helping residents out. If I'm at an academic institution to help residents get involved as well. I think that our practice really involves making sure that we watch out for the patient. There's always new ways that surgeries are performed and with that potentially things that could happen for the patients' perspective that we need to watch out for. So I think with our practice ever changing, I think it's important to get involved in patient safety too.

DR. MARKATOS:

To be honest, at the start of residency, quality improvement was kind of just like a checkbox of something I needed to get done. But as I've moved throughout residency, I've seen how important it is. And I may never be the QI go to person or the head of QI at my hospital, but I think it's intrinsic in our nature as anesthesiologists to always be looking for a solution to a problem. And I think that we see it all the time in anesthesia of something. Not working. Try something else. And so it's important to use that in every aspect of the perioperative period. And like I said, I may not ever be the formal QI person, but I think I'll always be looking for ways to improve. And like I said earlier, just communicating with staff, with co residents, with co faculty members, with the hospital board, whoever it may be that, hey, I've noticed this, can we make this change and see if there's something that can be done?

DR. BOLZ:

Yeah. And I think even conversations like this are really helpful, even if it's not a formal discussion on what quality improvement projects do we want to initiate now or today. But just hearing from other residents or other faculty member on quality improvement projects that they've seen, or even just conversations that they've had near misses, things like that I think is important just to kind of get keep the conversation going and kind of be thinking about this daily.

DR. REILLY:

Circling back, quality is rooted in patient safety, as we've kind of mentioned, as do you go forward, do you have any specific advice, tactics, habits, which you're going to carry with you or that you want to share which put patients at the center of being safe?

DR. MARKATOS:

Another phrase we say in anesthesia a lot is trust but verify. And I think it's important to always verify, especially anything that involves a procedure with a patient. I had an example recently where the patient marked their incorrect leg for surgery. The surgeon came in and then because that was the leg that was marked marked it, but I came in to do the block and I said I thought we were doing the right side, not the left side, and verified. And the patient was like, Oh my gosh, yes, we are doing the other side. So that very well could have been bad. They could have not only been blocked on the wrong side, but had surgery on the wrong side. And so it never, ever hurts to just always have a checklist. So every time I'm going to do a regional block, I say to the patient, Is this the correct leg or limb or whatever it is? I look at their consent sheet and make sure it says that side, and then I mark it myself and make sure the patient has marked it as well.

DR. REILLY:

Yes. So thorough communication with the patient, agreeing with everyone. Jess you have a one liner on what you think, what an anesthesiologist can do to make sure that a patient is safe.

DR. ZHENG:

I think it's probably hard for all of us to actually do, but I think speaking up is the most important thing that we can try to do advocate for our patients and really communicating with everyone involved.

DR. REILLY:

Absolutely. And Erica, what do you think for the best way to anesthesiologist can keep patients safe?

DR. BOLZ:

Not being afraid to speak up. Kind of at the beginning of residency, it's hard to speak up. But then when you really think, this is for the greater good of the patient and this is for the patient safety, it's important. Twice this month, actually, I've had to speak up and say, Hey, we haven't done a time out yet. And the surgeon and the surgery team

circulator have all been thankful both times. So I think it's scary at first. But then realizing that you're doing it for patient safety and realizing that you're the advocate for the patient in that scenario, it makes you feel a lot better with with your decisions.

DR. REILLY:

Absolutely. You know, that's that's the name of the game.

DR. MARKATOS:

To add one more thing, I've one attending told me that you are the patient's last line of defense. And so I think it's important to remember that and to just, like everyone said, communicate well, trust but verify. Make sure those timeouts and checklists are done. Take your job seriously, that you are that patient's last line of defense before they go to the O.R. and before anything happens to them.

DR. REILLY:

Inherent to the specialty of anesthesiology is quality and safety. Patient safeties are forefront. And so maybe a formal approach to quality sometimes gets overlooked. I think that in medical school and residency and into attending hood, there's definitely room for improvement moving forward. An approach of quality to quality. Like I said, inherent to anesthesiology I think is patient safety, and I think you all do an awesome job of that. I think this has been a great conversation. So thank you all for joining me and getting out of your ORs. And thank you to our listeners for once again, joining residents in a room, the podcast for residents by residents.

(SOUNDBITE OF MUSIC)

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