

Learning From Others: A Case Report from the Anesthesia Incident Reporting System

Case 2020-07

Called to intubate an 83-year-old septic male COVID-19 patient in pulmonary failure with acute renal failure and confusion. This would be our first COVID-19. The department chair and two colleagues produced a **written policy** for COVID-19 intubations and assembled a **backpack**. At a departmental meeting the following Monday, we were given a chance to **review the protocol, ask questions, and inspect the backpack**. The protocol specified **two anesthesia providers** for each intubation, but nobody else could be spared. The protocol specified that the backpack would not contain personal protective equipment (PPE), since it was the **responsibility of the ward/unit** to provide this, and that all intubations should be done with the **intubating provider wearing a PAPR hood**. When I arrived, they had some PPE ready. Their PAPR was being used by a nurse who could not wear an N95. I asked for an N95 mask and one of the nurses motioned to an open drawer with 3 kinds of masks, but not the one I had been fitted for. I took one that looked easy to wear, and I started to don the PPE. The patient's nurse advised me loudly that oxygen saturation had been 95 on a face mask the night before and was only 83 now, that he had just gone into atrial fibrillation and that there was no time for the rest of the PPE. **(The protocol said to never yield to this kind of pressure.)** The backpack contained rocuronium and propofol, not ideal for this patient. I requested fentanyl and ketamine. Preoxygenation was with a nonrebreather, could not get sat over 86%. Pushed 100 mcg of fentanyl, 30 mg of ketamine, and 100 mg of rocuronium. **Protocol specified a video-scope**. There was a videoscope handle and an assortment of blades in the backpack, one I had never used. I managed to assemble it and looked. Secretions and edema everywhere, no landmarks. I called a nurse into the room (everyone had left as was the protocol) to help me suction and was reminded that they are not supposed to be in the room. The sat was 70 at this point. The protocol called for **avoidance of bag-valve-mask ventilation**. I suctioned the oropharynx and introduced a regular MAC 3 from the backpack. I intubated, attached a filter and easycap, and handed the patient off to a respiratory therapist who was waiting with a bag-valve-mask. The saturation was 55 at this point and came up to 93 over two minutes on the artificial manual breathing unitambu. Time of saturation under 80% was four minutes.

Since this case was submitted in early March 2020, much about COVID-19 has changed, and more will have changed by the time we go to press. For example, early

ASA is interested in collecting vaping-specific data to formulate recommendations for anesthesiologists taking care of these types of patients. The AIRS database is now capable of receiving data for this purpose. Please enter any available information at www.aqiairs.org.

intubation was initially suggested, whereas six to eight weeks later we are leaning more toward avoiding intubation in certain patients.

The team conflict described above led to safety compromises and is the focus of our brief discussion here. Conflict refers to any time that two interests compete. We classify interpersonal conflict (just "conflict" from now on) as task-process conflict or relationship conflict. Relationship conflict focuses on people and their behavior. Relationship conflict is painful to at least one party and has been shown to negatively affect the work of individuals and teams.

There are many teachable methods to prevent conflict escalation. For many years our colleague, Dr. Susan Staudt, has offered a yearly workshop at the annual meeting of the ASA. This workshop uses the Thomas-Kilmann conflict mode scheme, which presents five strategies to deal with conflict:

- **Avoid.** This strategy usually gives the other party what they want. Avoidance is found to be the most common strategy utilized by nurses and physicians.
- **Accommodate.** We briefly discuss the issue and then we give the party what they want. This is a very cooperative strategy which takes very little time. Parties do not agree on the desirability of the result.
- **Compromise.** This strategy requires more discussion than for accommodation, so takes more time. The result is that nobody gets everything they want, and the end result satisfies (or irks) each party equally.
- **Compete.** The parties compete, but not for long because one has the authority or force of character to push through their solution. This approach can be quite fast. The parties disagree about the desirability of the result. If a patient is dying, you know what needs to be done, and the others are not listening, competing (forcing) is the best option.
- **Collaborate.** This strategy is very cooperative and takes time. It is seen as very positive. The result of collaboration is that the parties come up with a negotiated solution, like in compromise, but the parties both feel it was a win-win, and all basically agree that the solution is a good result.

In our case, let us focus first on the discussion regarding the need for the physician to hurry in. While they are discussing procedure, they are not doing it respectfully, which makes this a relationship conflict. The nurse appeared to be following a competing strategy. While it is not clear that the nurse is in a position to do so, notice that position does not always matter.

The doctor has very specific printed guidance for COVID-19 procedures, emphasized by the **bolded** statements in the case. How about his PAPR? The nurse was using it. With some collaboration, the nurse could have been excused from the ward for a short time. The PAPR could have been quickly but completely turned over while the floor staff called around for a loaner. However, the doctor avoided raising the subject. A recognizable conflict did not even start. Our reporter may have felt that an N95 is pretty much as good as a PAPR, which can be true. But he settled for a poorly fitted respirator that is far less effective.

The physician now has a conflict between the substandard protective equipment and the instruction that says he does not have to proceed without proper equipment. Unless a physician has been a military medical officer on deployment, this person probably has little experience putting oneself in physical danger to treat a patient. The instructions said to take as long as needed to don protective gear, which our reporter felt unable to follow due to the worsening clinical situation.

Our conflict scheme shows that an unpleasant but effective option was available in this scenario. Competing could have been used by the physician to reduce risk.

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that we are not ever excused from our obligation to lead and model leadership. That means forcing when needed. No strategies are good or bad. When time is short you do not have time to compromise or collaborate. When the stakes are high for abandoning your position, you cannot avoid or accommodate. Forcing is what remains. This strategy is made easier when you have written administrative backing and the traditional power gradient also supports you. In this scenario the first accommodation was agreeing to perform the procedure without a partner, which for reasons we cannot list for lack of space, would have made this situation much, much better.

The committee is very grateful that a physician reported this, and very uneasy with how it turned out. ■

Review of unusual patient care experiences is a cornerstone of medical education. Each month, the AQI-AIRS Steering Committee abstracts a patient history submitted to the Anesthesia Incident Reporting System (AIRS) and authors a discussion of the safety and human factors challenges involved. Real-life case histories often include multiple clinical decisions, only some of which can be discussed in the space available. Absence of commentary should not be construed as agreement with the clinical decisions described. Feedback regarding this article can be sent by email to airs@asahq.org. Report incidents at www.aqiairs.org.