**Vimarsh**

**When communication fails**

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Elaine presented for surgery. As depicted by the two videos, things started going bad as soon as there was anesthesia given. There was a difficulty with the masks, and getting the airway wide enough. The case had a lot of communication and leadership concerns, that resulted indirectly in a patient's mortality.

Lead Anesthetist could be seen as being hesitant, and not being in charge. The staff in the room didn't know if the lead anesthetist was the one in charge. This can lead to having trust issues, and confusion among the staff in the room. There was a lack of awareness among the anesthetists which resulted in a lapse of time management, and staff not realizing how long it had been without proper oxygen to the patient. If taken seriously, this could have prevented irreversible brain injury to the patient. The nurses in this instance were prepared to deal with the acute crisis but never felt comfortable approaching the doctors. They were reacting fast to the situation, but at the time the anesthetists and the ENT surgeon were reacting much slower, which further caused damage to the patient, and delayed the ICU treatment. I think a lot of the concern was that the anesthetist and the assistant anesthetist weren't prepared for Plan B. They weren't prepared for a failed initial attempt, and when to move the patient to an ICU or start the tracheotomy.

All healthcare personnel should be familiar with the STEPPS program. It helps reduce preventable harm and helps the staff be ready to avert a crisis. Some of the aspects of the STEPPS program were not followed in this case. The anesthetists never really understood the status of the patient in regards to time without oxygen, along with proper communication on who the lead person is. They overlooked their environment for help from the staff and equipment. Having a proper team communication and leadership could have helped Emily.   
**References:**  
Cadogan, M., & Bassett, P. (2018, August 14). Retrieved November 5, 2019, from https://litfl.com/lessons-from-the-bromiley-case/.  
Approach, T. V. (2014, August 15). Retrieved November 5, 2019, from <https://vimeo.com/103516601>.

**Response:**

The case of Elaine depicts a pathetic scenario in the context of obligatory healthcare perspective; and asserts that like all other organizations, communication is vital in healthcare métier as well. The surgery and overall responsibilities of an operation room are incredibly fragile and therefore deemed to be tackled with a similar level of delicacy. Lack of communication among surgical staff can exacerbate the adversaries of an operation that even cause the fatalities. In due course, I agreed with the efficacy of the STEPPS program, but the device of the time-out sheet is also indispensable. The time-out session before surgery can establish better connectivity between the personnel and their implied role in the perceived setting. However, in order to utilize time-out productively, surgeons and other leading staff have to pay additional attention to all included aspects of time-out session and time-out sheet; otherwise, the absence of caution and adequate communication can suffuse detrimental consequences to the healthcare practices.

**Reference**

Berlinger, N., & Diets, E. (2016). Time-out: The Professional and Organizational Ethics of   
 Speaking Up in the OR. *AMA Journal of Ethics*, 18(9), 925–932. doi:   
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**Praveen**

**Bromiley Case**

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This case showcases the problems poor communication can lead to regardless of how experienced and clinical someone might be. Communication is a powerful tool and if properly used, situations like this case could have been prevented. The Elaine Bromiley case is an unfortunate one and the videos that were presented show a prime example of all the things that went wrong and could have been prevented. There are many different forms of communication both problems and solutions that played a role in this case. Each individual clinician in that room had their own form of mental modes. Since they all clashed, it eventually took the greatest toll on the patient. An example was the nurses that saw what was happening and although they mentioned the problems and solutions, they were pretty much turned down by the doctors. This could have been because the doctors didn’t want to acknowledge them, or maybe the nurses were afraid to be louder due to their interpretation of who has the right to say what. The husband, a pilot mentioned that if something is going wrong he wants others to say something about it. At the end of the day, he is responsible for many lives, and if someone can help by stating the problem, then solutions can be made.  With too many people in the room, there is the potential of many thought processes. Conflict management was not properly addressed since the communication was lacking. Everyone wanted to have an attempt to solve the issue of intubation, without acknowledging the elephant in the room which was the dropping O2 sat.  Any clinician knows that even a minute or two without oxygen to the brain can have detrimental effects. This went past over a half-hour.  What needs to be done is having a group leader that is both understanding and socially aware of all the people in the room, primarily the patient. Ego and experience shouldn’t be outweighed against a person’s life.  The TeamSTEPPS program shows a great outline as to how to go about patient information and communication. The status of the patient, knowing when team members are not able to perform the job appropriate (fatigue), environment, progress to the goal ( is it still appropriate?). This outline could have prevented the problems that occurred in the operating room.  This was a learning experience for the hospital and many other institutions. Communication is key in situations like this.

Approach, T. V. (2019, November 6). The Elaine Bromiley Case. Retrieved from https://vimeo.com/103516601.

Cadogan, M., & Bassett, P. (2018, August 14). Lessons from the Bromiley Case • LITFL Medical Blog. Retrieved from https://litfl.com/lessons-from-the-bromiley-case/.

TeamSTEPPS Fundamentals Course: Module 5. Situation Monitoring. (2014, March 1). Retrieved from <https://www.ahrq.gov/teamstepps/instructor/fundamentals/module5/igsitmonitor.html>

**Response**

An AHRQ operation room case portrays the similar irresponsibility of the anesthesiologist and other surgical staff during the surgery of a person who showed allergies to a certain medication. In fact, in such scenarios, operation theater personnel refer to the archetype that is widely known as “shifting the burden.” In this context, it is imperative to detect the fundamental reason for all the hullaballoo to evade the hazards in such a precarious state. All the staff should be allowed to share their concerns and suggestions right before the initiation of the surgery, and regardless of hierarchy, the sincere concerns of all included staff (even of nurses) should be considered essential. In the absence of adequate communication, the cases can yield severe outcomes, and in some cases, surgeons even operate the wrong sides. Communication is the essence of mutuality in any organization, and in the healthcare scenario, its significance increases manifold. Without discussing all the facades precisely, no medical professional can pinpoint the exact issue of the patient that can hinder the treatment processes and prescriptions to a great extent, and in some cases, the results are even life-threatening.

**Reference**

Feldman, D. L. (2008). The Inside of a Time Out. Retrieved from https://psnet.ahrq.gov/web-  
 mm/inside-time-out.