

We're Being Watched: A True Tale of Life in Today's OR

By Karen Sibert, M.D., Associate Editor

My operating room has turned into a “hostile work environment,” and I am “uncomfortable.” Those key words, if uttered by a nurse, are enough to freeze everyone into immobility and send any “offending” physician straight to the hospital’s “Well-Being Committee.” But because I’m a doctor blaspheming about the “Accrediting Group Which Must Be Obeyed,” my comments are ignored or, at best, humored. The Accrediting Group’s “standards” are accepted as “sacred,” and nothing about them can be challenged, even though they often fail to keep pace with the best current clinical information. The “standards” may be meant to promote safety, but this morning they are directly interfering with the delivery of care to my patient.

I’m here on Sunday morning, on call, looking after a woman who has developed a bleeding ulcer after gastric bypass. As I connect her monitors, I am acutely conscious of the fact that I’m being watched. I’m neither joking nor paranoid. There is a “tracer” nurse standing in our OR with a clipboard. Her job is to watch for violations of the “standards” and report back to the administrative powers that be. The fact that she’s here is a significant distraction. What’s worse is the insulting implication: that no one in this room, doctor or nurse, has this patient’s best interests at heart, and that we all require constant surveillance.

What am I doing differently with the knowledge that I’m being watched? You can bet that I’m paying close attention to the trash—specifically, to the five different types of trash for which I, as a board-certified physician, am personally responsible. No kidding. There is a small bucket into which I am supposed to throw all empty medication vials. There is a large blue-and-white receptacle into which I am supposed to throw all wasted drugs and empty IV bags. There is a sharps container. There is a red bucket at the foot of the OR table for anything bloody, including the empty bags from blood transfusions. And finally, there is a trash bag for your basic trash. It’s lucky I have had all those years of school, or this trash sorting could get confusing. I imagine that my patient would be very comforted to know that this is a major concern during her anesthetic.

I have some anxiety when I intubate the patient, but not because the airway is difficult. I am wearing gloves, and I have touched the patient. Before I touch any other equipment, I am supposed to remove the gloves and sanitize my hands. Can I squeeze the bag first? Listen to the lungs? Turn on the ventilator? These distracting questions remain unanswered, and I muddle through as best

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I can. No doubt I am in violation of something, but the “tracer” nurse is watching the circulating nurse insert the Foley catheter, so I am safe for the moment.

Next on my list is the Accrediting Group's fascination with anesthesia syringes. Obsessive-compulsiveness is a good trait in an anesthesiologist, and my medication syringes have always been meticulously labeled and arranged in a set order to reduce the likelihood of error. But this is no longer enough. Despite the fact that I am the only anesthesiologist here—there is no nurse anesthetist, resident, or colleague—I must remember to put my initials on each syringe lest I commit a serious violation. Worse yet, if I should put a label on a syringe before, rather than after, I draw up the drug, then I am guilty of using a “pre-labeled syringe” for which, I think, I can be shot or at least fined. And if I have used up all the drug in a syringe, and set the empty syringe down on my cart for a moment instead of putting it directly into the right kind of trash receptacle, at once it becomes magically transformed into a “pre-labeled syringe,” and again I am guilty.

But I am coping. I have my special pen for labeling syringes. Many of the drug labels are coated with a waxy substance, which makes it hard for some pens to write on them. With my special pen, usually I can get the label marked with the date, drug concentration, time, and my initials in two or three tries. Because I will use dozens of syringes in the course of the day, it's lucky that I have my special pen or I would have time for little else. I understand that accurate labeling is important. But I am the only anesthesiologist here, drawing up medications right now solely for this patient. No one will touch these syringes but me. I would like to see the “evidence base” that proves that writing the date and time and my initials over and over again is worth more of my attention than, perhaps, monitoring the surgical field or the EKG.

Doing this case isn't much fun, although I quite like giving anesthesia as a rule. My patient's heart rate is hovering in the 40s, dipping occasionally into the 30s, and glycopyrrolate so far hasn't made much impact. Some well-meaning person has given my patient her morning dose of atenolol before she came to the OR. No doubt this person wasn't taking into account the fact that my patient was having surgery for a bleeding ulcer, or that laparoscopy is often associated with vagal stimulation and bradycardia. So now this is my problem, not theirs. The Accrediting Group has decreed that anyone who takes a beta-blocker must receive it during the perioperative period, and as they have decreed, so has it been done. Perhaps this “standard” will be revised some day in light of the POISE study,¹ but that won't help my patient this morning.

I look over at the OR nurses, an experienced team who are just as unhappy as I am. Every move they make is being watched, and they are in a state of acute self-consciousness not conducive to the smooth performance of their tasks.

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Everyone who works in an OR knows that the work goes best when people are at ease doing what they know how to do, in a pattern that they have done well a thousand times before. When you are feeling awkward and harassed, you are not at your best.

None of this is the “tracer” nurse’s fault. She is a small, pleasant middle-aged woman, who seems happy to be in the OR and interested in everything we do. She asks about the purpose of the “blue thing” stuck to the patient’s leg, which we explain to her is called a “bovie pad.” We want to be cooperative and don’t mind answering her questions, but as she continues to make check marks on her clipboard, we can only wonder what they mean.

At the end of the case, the “tracer” nurse confides to me that I am the best anesthesiologist she has observed yet. For a moment I am suffused with pride, but then I become wary. I ask her why she thinks so. She replies—and I wish I were making this up—that it is because I didn’t turn on any music until after the “time out.”

I don’t know where all this will end. Until hospital leaders—administrators, physicians, and nurses—declare a halt, outside agencies will continue to create more and more rules to keep themselves in business. Medical personnel will be harassed with petty rules and endless documentation until they become hopelessly apathetic, terminally surly, or leave medicine entirely. Some of the recent “evidence-based” clinical standards have already done real damage—I recommend to anyone who thinks otherwise Dr. Mark Zornow’s excellent commentary entitled “Do No Harm” in the January *Anesthesia and Analgesia*. Dr. Zornow concludes, “The ‘Law of Unintended Consequences’ tells us that the hubristic attempts to regulate and control processes often have negative outcomes.”²

Unless these intrusive edicts affecting our practice are controlled, I fear what manner of physician will be available to take care of me when I am in my eighties. No one with sense would volunteer to serve a life sentence practicing medicine in this environment. We as anesthesiologists should be the ones setting the standards for our work, not outside reviewers with little comprehension of what we do or the negative effect they are having on our ability to focus our full attention on the safe practice of anesthesiology.

Selected References

1. The POISE Study Group. Effects of extended-release metoprolol succinate in patients undergoing non-cardiac surgery (POISE trial): a randomized controlled trial. *Lancet* 2008 May 31; 371(9627):1839-47.
2. Zornow MH. Do No Harm. *Anesth Analg* 2009; 108:374-5.