

## Anesthesia Incident Reporting System (AIRS) Case 2022-04: Feedback is a Gift!

**A**n anesthesia incident reporter writes: “Patient arrives and was administered a slew of sedatives and anesthesia, dropping their heart rate to the point where a new device has to be placed because the original one is now broken, and now there is no way to extract it.” This reporter also said, “Lesson Learned: Don’t ever go to [name withheld] hospital.”

It seems likely that this AIRS report was submitted by a family member of the patient involved, rather than a clinician. Because AIRS allows for anonymity in reporting, we cannot tell how the individual found their way to our site, nor do we know the context of the event. We can’t tell whether the patient was presenting for an elective procedure or through the ER with acute illness. We don’t know why anesthesia was administered or even if an anesthesiologist was involved. But we can still learn from this report.

It’s obvious the patient’s experience with the health care system was not satisfying, and this should concern us. Much like the assessment of pain, quality has multiple dimensions. Care can be excellent across most of them (e.g., safe, effective, equitable, and timely) while still not meeting a patient’s desires or expectations, thus leading to a “bad experience” or dissatisfaction. A patient who experiences a rare adverse event – even one that has been disclosed in advance as a possibility – is not going to be satisfied with the care they receive. Safe and effective anesthesia that does not meet the patient’s needs should be a target for improvement, just as we would address lapses in the objective choice of procedures, techniques, and medications. It’s easy for clinicians to overlook the routine annoyances of health care that our patients experience: labyrinthine hospitals that are difficult to navigate, reams of redundant paperwork, and hours of unproductive waiting time. We know that our EDs are stressed with COVID patients and production pressure, and we know that many acute presentations are the result of longstanding contributory negligence by the patient – whether smoking or weight control or recklessness – but these factors do not change our responsibility to care for them. It’s why we went into medicine.

Patient experience is a required, and heavily weighted, outcome metric for hospitals. There is a substantial penalty to Medicare reimbursement for hospitals that fall below the mean. As partners with our facilities in delivering high-quality care, anesthesiologists should understand the importance of patient experience and do what they can to



improve it. This begins with active conversations regarding overall hospital performance, something anesthesia groups rarely seek out but are often dragged into. High-quality groups will seek to measure anesthesia-specific experience as a powerful tool to improve their own performance and contribute to the facility. The ASA Committee on Performance and Outcomes Measurement provides this resource for understanding anesthesia-specific patient experience: [asahq.org/quality-and-practice-management/patient-satisfaction-with-anesthesia-white-paper](http://asahq.org/quality-and-practice-management/patient-satisfaction-with-anesthesia-white-paper). Research has shown that clinicians with low satisfaction scores are more likely to be targeted by malpractice lawsuits and state medical board actions, so a robust system for capturing patient satisfaction data can pay for itself (*Am J Med* 2005;118:1126-33; *Ann Surg* 2019;270:84-90).

Routine collection of anesthesia-specific data provides the practice with a powerful tool for ongoing improvement. Systemic problems such as a lack of privacy in the preoperative holding area can be identified through groupwide scores. Data can motivate conversations with hospital administrators to mitigate the issue. On an individual basis, giving each clinician direct access to their benchmarked scores and patient comments (confidentially, of course), with simultaneous provision of educational materials and coaching, leads to steady improvement over time. No anesthesiologist wants to provide bad service, so feedback fuels remediation. There are several inexpensive options on the market to help groups gather and analyze patient experience data, including offerings from SurveyVitals and Provation.

Beyond the specific complaint, this case report represents another issue of concern for anesthesiologists: the prevalence of social media and the ease with which patients can put feedback into the public domain. The author of this AIRS report likely found AIRS through an online search, and it’s possible they posted similar feedback to Facebook, Google Reviews, and Yelp. Their negative experience, which included specific names of both a hospital and a physician, is now on the internet forever. How can anesthesiology practices mitigate the impact of online reviews?

First, both hospitals and anesthesia practices should make it easy for patients to provide feedback through internal channels, where it can be analyzed in context and kept confidential. Actively seeking the patient’s opinion on the quality of care is a key form of engagement and improves satisfaction in and of itself; every patient wants to be heard. It’s possible the report above would not have occurred if the patient or family member had an easy way to share their experience directly with the hospital. More tactically, soliciting feedback will identify systematic improvements to improve patient experience: everything from valet parking and better hospital signage to better Wi-Fi service in the preop unit. Ideally, requests for feedback should come under a unified

brand for the hospital, surgeon, and anesthesiologist, with specific and actionable questions for each. In practice, this unity is hard to achieve, but anesthesia groups can implement their own solutions first.

With the tools of the Information Age, it’s easy to send postoperative surveys to every patient cared for; the greater challenge is in using the results. Maximum positive impact occurs when specific patient feedback, including negative comments, is confidentially shared directly with the clinicians involved. In the short-term this will produce anger and a defensive response: “The patient didn’t understand how busy I was!” “Aren’t they happy being safe?” “I took good care of them, didn’t I?” But in the long run, it is this kind of feedback that drives positive change. Over time, clinicians will learn how to improve their interactions with patients and families, and overall satisfaction will rise.

Anesthesia groups should monitor social media for mentions of the group or individual clinicians. Some platforms (e.g., the Better Business Bureau) allow for rebuttal or correction of erroneous reports, but most (e.g., Yelp) do not. The best tactic for mitigation is preemptive collection of positive reviews to make it obvious on the site that any given negative report is an exception and not the norm. Anesthesia practices that collect patient satisfaction data report that >95% of patients are satisfied with their care; these patients should be invited to share their compliments on social media. However scary it might be to potentially enable cranky comments, experience has shown that such an approach will rapidly build a large library of positivity that provides context for the inevitable unhappy comment. Further, the compliments collected will be of value in future negotiations with hospitals and payers. Another resource that offers tips on how to respond to online reviews is Etactics ([asamonitor.pub/3rAoGmF](http://asamonitor.pub/3rAoGmF)).

Like it or not, we live in an era of rapid mass communication. The water cooler that our patients are talking around can accommodate hundreds or even thousands of listeners. As a profession, we must embrace this feedback and lean into the chance to improve holistic patient care. Denial, anger, or ignorance will not serve us as well. ■

Each month, the AQI-AIRS Steering Committee abstracts a patient history submitted to AIRS and authors a discussion of the safety and human factors challenges involved. Absence of commentary should not be construed as agreement with the clinical decisions described. Reader feedback can be sent to [airs@asahq.org](mailto:airs@asahq.org). Report incidents or download the AIRS mobile app at [www.aqiairs.org](http://www.aqiairs.org).