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

Case 2021-12: Avoiding the Blame Game
This event occurred in an outpatient setting. The muscular, red-headed patient reported high anesthetic requirements and that he had woken up during every procedure he had. I told my resident to have extra propofol ready for LMA insertion. Resident pushed 200 of propofol and 100 of fentanyl; I reached for the extra propofol, only 20 mL had been drawn up. LMA was placed, and patient proceeded to sit up on the OR bed. The OR staff successfully kept him from standing up – by then I had more propofol, pushed it. Talking with resident later, she said she thought that having more in the room was what I meant. Frustrating.

From the tone of the report, it is apparent that the faculty involved felt that the resident was primarily or even solely to blame for this event by not drawing up extra syringes of propofol as intimated. Clearly, this was a preventable error, but the error was not based on an individual lack of skill or knowledge, but rather on a single failure of teamwork. By definition, a teamwork failure involves more than a single member of the team, and improvements in teamwork require understanding where each team member, not just the one who ultimately “failed,” could have been more effective. This report thus provides an opportunity to understand more deeply where and how teamwork failures arise and how to prevent them.

High-reliability organizations such as aviation and nuclear power have long acknowledged the power of teamwork and have benefited from this understanding; health care lags in that teamwork is oftentimes perceived as a luxury. Our siloed roles and responsibilities do not allow for easy cross linking – it represents a teamwork failure. By definition, a teamwork failure involves more than a single member of the team, and improvements in teamwork require understanding where each team member, not just the one who ultimately “failed,” could have been more effective. This report thus provides an opportunity to understand more deeply where and how teamwork failures arise and how to prevent them.

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