In recent years, I have developed a successful operating room (or) briefing technique that promotes and prompts good rapport and efficient communication among all of the team for a given procedure. Our success with this process has prompted questions about why and how we do it. Certainly, our model is just one of many, but I’m pleased to share. Depending on your personal communication style, initiating OR briefings may seem very basic or very unnatural. The constant is that you need a plan for what you want from the pre-op briefing, and some specific techniques to accomplish your goals.

Generally, I wait until the patient is intubated to begin the briefing. That way, we can get everyone’s full attention because everyone is usually in the room, and there is a relative lull in the intensity of the work. We literally gather around the patient, so the patient is in the center. I ask everyone in turn to say his/her first and last name and what his/her role in the case is, e.g., Jo Shapiro, attending surgeon; Sue Smith, attending anesthesiologist; so-and-so, student; etc. Many of us know each other already, but not 100 percent of the people know each other 100 percent of the time. Students come and go, residents change, nurses change, surgeons change, etc. By knowing everybody’s name and role, we begin to build (or reinforce) a sense of teamwork.

We start with the standard time out or “safety pause” in which we confirm the patient’s name and what procedure we will be performing, including laterality. This lets us establish a shared mental model so that we all know what we are going to do in the case. It sounds basic, but because surgery is complicated, there might be a variation in the technique, the briefing helps make sure everybody is on the same page. That, in turn, will help the nurses and the physicians know what instruments might be needed so that people can do less of the scurrying around ad-hoc work that they end up doing if you don’t brief them. Because the nurses, of course, want to be competent, they want to know what’s coming; the surgeon’s entire plan, the instruments he or she will need, etc. Without that, nurses are running in and out of rooms just to find things. With everyone on the same page and knowing in advance what might be needed, the nurses’ process is more efficient and engenders fewer risks.

We discuss anything that may be different about this procedure from the usual, as well as any concerns any team member has regarding the particular patient. For example, the resident may remind us that the patient is wearing a magnet for pacing, and we need to avoid monopolar cautery.

I then ask that we all use the OR equivalent of read backs; when somebody asks for something, he or she should verbally repeat the request: “4-o chromic please. “4-o chromic.” That prevents errors or delays due to requests being misinterpreted or just not heard. So for example, if we ask for a particular instrument, the circulating nurse may say, “Muscle biopsy clamp. I need to go to another room to get that,” rather than just disappearing, leaving the surgeon to wonder whether the request was even heard in the first place.

**Anybody Any Time**

Next, I say, “This is a team effort and everybody’s input is valuable. If there is anything that you do not understand or that you think is of concern, I want you to call it out. We need to hear from anybody at any time if you have concerns.”

Unless prompted and encouraged, some team members may hold on to information, or not give it to the right person, because of the hierarchical cultural barriers to speaking out. And in our hospitals, if you don’t explicitly welcome input, you probably won’t get it. And, if the team leader doesn’t mean it—if he or she really doesn’t want input from other people and is saying she does pro forma—that quickly becomes known and renders the words ineffective. Or, if you say it and then when someone does give input you don’t act on it, or you ignore it, or you belittle it, then the sense of inclusion and trust is over, it’s absolutely over.

Much of this communication process can be uncomfortable or unfamiliar. For example, not all anesthesiologists are used to telling you what’s going on when the patient is having problems. We are not acculturated to have them tell us, “We’re having a problem with the blood pressure right now.” I didn’t train to say, “Listen, we’ve lost more blood here than I thought we would. I just want to let you know.” Even though everybody would say that’s good medicine, it is not habitual. Since I started these briefings, it has become more of a habit for our teams—I have noticed more clinicians routinely briefing each other during the case, more routinely updating each other as to how the patient is doing, and that’s really helpful.

**Flattening the Hierarchy...Temporarily**

While the briefing process does not ask anyone to perform clinical tasks they are not trained for, we are challenging some established behaviors and (bad) habits. The pushback I get from physicians is that they are afraid that what we are advocating is no hierarchy at all, any time. What I hear is, “I’m not comfortable with anyone just telling me what to do or disrespecting my orders. I cannot have people constantly questioning me because I don’t have the time to sit and explain it.”

*Continued on next page*
**Triggers**  (cont’d)

_Better Outcomes:_ BIDMC looked at the risk of full-code patients dying outside of an ICU—what the literature generally calls “unexpected mortality” or “non-ICU, non-DNR mortality.” Since beginning the triggers program in 2005, unexpected mortality at the BIDMC has fallen by more than 50 percent, even after adjustment for age, case mix, and comorbidities.

A **New Verb in Clinical Language:** The Triggers Rapid Response process has helped to enhance collaborative communication by standardizing the expectations for response when a patient becomes unstable. The criteria and the naming of the program with the “trigger” phrase provides rule-based communication that eliminates ambiguity in the expected response. Over the past two years, the triggers program has become a part of the day-to-day work in the care of BIDMC’s non-ICU patients. In interdisciplinary rounds, it is now common to hear “Mr. S triggered at 1300 for a low blood pressure.” BIDMC now has a new verb!

We are particularly proud of the decision to use the existing primary care team to respond to the bedside; the patient is best served by an initial response by the physician who knows him or her. This level of response also fits with BIDMC’s teaching mission. And finally (and not insignificantly), this level of response did not require the addition of staff resources.

So if we think back to that long ago night shift on our medical surgical unit…

We no longer rely on the nurse to decide if a call is necessary, knowing that there are other factors that might influence the decision to call for help. We no longer rely on the intern or resident to decide whether the attending should be called, since there are other factors that might influence the decision to notify the attending physician of a change in the patient’s status. We have standardized the rules and, in doing so, we have developed a new collaborative process for communication.

**References**

1. Institute for Healthcare Improvement. 100,000 Lives Campaign. March 20, 2005; www.ihi.org/Programs/Campaigns/CampaignV.htm.


**OR Collaboration**  (cont’d)

That fear—that we’re slowing things down with indiscriminate interruptions—can prevent some physicians from seeing that we are not talking about equal responsibilities. The attending surgeon still makes the decisions even if the team disagrees, but we have to improve information transfer. Especially during periods of extreme stress or emergency, we need to flatten the hierarchy—temporarily—and then be able to immediately reconstitute it.

I also do a debriefing, essentially as a teaching tool, as we are closing. I say, “What do you think went well? What would anyone do differently?” When I first began talking about this to a national audience, somebody said “Well, I’d hope you wouldn’t be disclosing any adverse event in front of the team.” But that misses the point. Who am I trying to keep it secret from? They were all there and know what happened; what better time to talk about it and learn from it? Of course there are times when it is more appropriate to say “This might have been upsetting, it was upsetting to me, and if any of you feel that you want to talk about it afterwards, we should.” But, generally, I want to take advantage of the learning opportunity while it’s fresh in everyone’s minds.

I am very lucky in that my division at BWH (Otolaryngology) has a mutually respectful relationship with our nurses, who are all talented and dedicated. But, like virtually every health care setting, we may at times work with people who are not usually involved with our particular procedures; there are sometimes staffing and training issues that may leave nurses not knowing exactly what they are supposed to be doing. That is, obviously, unfair to the patient as well as the nurses and physicians. But that is a systems problem, not an “incompetent nurse” problem (nor an incompetent anybody problem). A system that puts someone in a position of having to do something he or she isn’t trained to do is a system that needs fixing. It’s a huge issue that we all have to deal with—including those who are most vocal in complaining about it.

A second concern that, perhaps, gets less attention is when anyone fails to maintain respectful relationships with physician trainees. When I do see unprofessional behavior, often what I see are individuals looking for fault in other individuals—rather than trying to help each other or improve a failed system. Finger pointing is rarely helpful, and we need to address it.

The nature of health care is changing dramatically. Roles and responsibilities are shifting, modeling and mentoring are less emphasized, and we could all use a healthy dose of training around professionalism within the whole health care team.