

Conflicts in the operating theatre

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Purpose of review

Quality and safety of healthcare depend on team performance. Conflicts decrease team performance. A number of studied factors involved in the development and solution of conflicts are discussed.

Recent findings

An operating team consists of individuals, with specific roles requiring specific expertise and skills, performing interdependent tasks with patient treatment as a common goal. Teams are prone to conflicts: a dispute, disagreement or difference of opinion related to patient management, requiring some decision or action. Many factors determine the character of the conflicts, and these vary between different countries, hospitals and teams. Factors include culture, professional social status, personality of members, etc. Conflicts can induce innovation, but can also result in job dissatisfaction. They even can affect the functioning of the hospital. On average, four conflicts can be observed per operation, which are mostly solved immediately.

Communication in an open atmosphere is a major issue in dealing with conflicts. If conflicts are unresolved they grow into relationship conflicts, which are difficult to handle.

Understanding the factors that contribute to the conflict is important for mediators. Most conflicts arise about theatre management, case acceptance, unexpected changes in the team or incapability of one of its members.

Summary

There are many possible inductors of conflicts. Conflicts should be immediately resolved by open communication and respectful discussion.

Keywords

conflicts, multidisciplinary team work, workplace culture

Introduction

Nowadays, healthcare has become more and more a matter of teamwork. This is especially the case in the supportive medical specialities (i.e. anaesthesia, pathology, microbiology, radiology, etc.), which do not cure patients themselves, but by providing care contribute to the treatment given by the treating specialities (i.e. internal medicine, surgery, obstetrics, gynaecology, neurology, etc.). Supportive medical specialists thus mainly act in a team. A team in this context consists of two or more individuals, who have specific roles that require specific expertise and skills, performing interdependent tasks with a common goal.

The members of the team have to work together in an efficient and effective manner which requires a special attitude. Thus, not only knowledge and skills, but also attitudes are the basis of teamwork in healthcare [1*]. Such an attitude is not always present in persons that are essentially trained to behave as individualists – as is the case in initial medical education. Conflicts are a problem in the whole of modern healthcare. Here, we will limit ourselves to conflicts faced by the anaesthetist as a member of a team providing anaesthesia for diagnostic and therapeutic activities of other specialists, mainly surgeons.

Factors involved in the production of conflicts

The fact that people have to work in a team dealing with difficult cases, and that the team consists of people with a strong personality working in a limited space, creates a special atmosphere in the operating theatre. Both the surgical specialists and the supporting anaesthetists have their own expertise and their own professional responsibilities. This means that they have their own opinions about how to deal with a case and how to solve an existing problem. There are differences in training methodology, the social esteem amongst the specialists is different and there also are differences in personality amongst the people involved. In addition, ethical and legal aspects play an important role in the development of differences in opinion. All these factors make the occurrence of conflicts in the operating room likely. In general, in most situations, there exists a fruitful collaboration and the individual cases finish without any serious dispute or controversy. In some situations, however, a serious conflict may arise, causing turmoil in the hospital and it may even result in court cases.

In this medical context a conflict is a dispute, disagreement or difference of opinion related to the management

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of a patient, involving more than one individual and requiring some decision or action. It has been demonstrated that such conflicts arise on average four times per routine surgical case, but are resolved right away by communication and understanding each other's position. They most frequently involve surgeons and nurses, and less frequently surgeons and anaesthetists. Such conflicting situations frequently start with discussions on topics that can essentially be brought back to the following issues: Who is responsible for a particular treatment?, Who decides what to do (what type of anaesthetic, what postoperative treatment, etc.)?, Who has the last word on the decision to operate or not to operate?, Who decides whether a new case is started?, Who decides what the order of the cases is to be? Very seldom they concern the ability and expertise of an individual team member. These conflicts are so-called task conflicts (Who, What, When and Why). As mentioned above, diversity in training, experience and perspective causes differences of opinion between physicians of different specialities, and is the main reason for a conflict. Sometimes in such discussions the patients are directly involved; on other occasions it is purely a dispute concerning 'might and power' or the esteem of the profession. When task conflicts are not resolved they may become chronic and disruptive or may become personal and then involve the relationship between two individuals. Some such conflicts can extend into disagreements between the professions involved (surgery vs. anaesthesia, physicians vs. nurses). Then it is not only that particular team that may be affected, but the whole operating room or even the whole hospital.

The fact that there are differences amongst personnel (physicians vs. nurses) in perception about what is right or wrong, good or bad and high or low quality is not always realized. Also, the physician members of the team frequently forget that others (nurses, technicians, etc.) are also members of the team and should play their own role in decision making.

The conflicts vary by type and topic from country to country, from hospital to hospital and even from operating room team to operating room team. They not only depend heavily on legal rules and customs grown in the professions, but also on culture, gender, generational biases, role perception and personality. Sometimes the patients are not directly involved; in other cases the patients start to become part of the dispute. Some cases come to court, be it the professional councils or the public courts.

Is a coherent team important?

Job satisfaction depends on the working climate. For surgeons and anaesthetists this is mainly determined by the efficacy and atmosphere in the team. Task-related stressors and social stressors at work are considered

important predictors of strain [2]. This was also confirmed for anaesthetists in a study by Kinzl *et al.* [3]. The reasons for dissatisfaction are related to hospital politics (anaesthesia is an expense rather than an asset), long hours and their appreciation by surgeons (professional image). Only 45% of anaesthetists in a Canadian study felt highly appreciated by surgeons and only 49% of surgeons thank the anaesthetists at the end of a case [4]. Burnout is not uncommon amongst anaesthetists. Thus, a good relationship with surgeons is desirable for the anaesthetists. It has been well demonstrated in the past that coherence and quality of a team are highly important factors for patient safety and outcome. Multidisciplinary teams must work in a coordinated, cooperative manner, and adhere to preset rules and roles in order to be effective. This requires an atmosphere of open and clear communication. Communication must also be structured and leadership must be visible. Structured communication uses SBAR (gives a description of the *situation*, the *background* of the problem, the *assessment* and the *recommendations* for dealing with it). Physicians, in general, are used to communicating along these short lines, whereas other healthcare workers are used to giving an extensive history on all the aspects involved in the case. If there is something wrong in the communication, errors and even disasters may happen, and the patient's safety may be in danger. Thus, the atmosphere or culture in the operating room is an important factor in the quality of the teamwork and determines job satisfaction. If conflicts lead to job dissatisfaction of one of the members, they disturb and endanger the team performance – as all relationship conflicts do [5]. One of the problems in the resolution of such conflicts is that not many people consider problem solving their responsibility. In one study it was demonstrated that participants denied their profession having responsibility for creating or solving tension in the operating room, but instead accused the other participants groups ('it is not me, but them. . .') [6].

Disruptions in the atmosphere of the operating room

The atmosphere in an operating room can be easily disturbed, not only temporarily but likely also more permanently. It largely depends on human behaviour and interrelation, and the way team members communicate. Model-roles and behaviour drivers of culture are important factors. Thus, leaders should behave correctly as an example of good manners. Disruptive behaviours affect team dynamics and patient outcome. They are more likely to occur in areas of high intensity such as the operating room and intensive care unit than in other places in the hospital. Rosenstein and O'Daniel [7] undertook a survey to study disruptive behaviour peri-operatively. Eighty-six percent of the participants had observed disruptive behaviour in the hospital. It is not unique for physicians, but also involves nurses.

Fifty-seven percent found it more common in males. In another study [8**] they found that employees recognised daily disruptive behaviour by surgeons 15% of the time and weekly 22% of the time, by anaesthetists 7% daily and 12% weekly, and by nurses 7% daily and 22% weekly. The most frequent was yelling and shouting (in 79% of cases), disrespectful interaction (72%), abusive language (62%), berating in front of peers (61%), condescension (55%), insults (52%), abusive anger (36%), berating in front of patients (34%), berating in private (27%), and physical abuse (5%). They concluded that disruptive behaviour caused adverse events (67%), medical errors (67%), compromised patient safety (58%), and impaired quality (68%) and patient mortality (28%). Elsewhere it is concluded from studies that surgeons are more in conflict than other physicians. Frequently, these are task conflicts with operating room nurses and anaesthetists.

Surgeons frequently do not call it a conflict, but consider it part of the game where they have to stand for the interest of the patient in a dispute, disagreement or difference in opinion related to the management of the patient. Another point is that many surgeons, as a professional group, regard themselves as 'better' or 'higher-valued' professionals than the other groups [9**].

Conflicts in the operating room demand immediate resolution of the problem because of the importance of the work taking place. This prohibits 'periods of cooling off' and 'let the case come to rest' – as is frequently practised in other areas of healthcare. In addition, if task conflicts are not resolved and return time after time, they may turn into relationship conflicts or interpersonal conflicts that disturb the performance of the team [10]. Poorly managed conflict is a major source of stress for the individuals, and can manifest as distraction, decreased commitment, emotional exhaustion and physical illness.

Although the prevailing myth exists of an autocratic militaristic communication in most operating rooms, one study [11] did find a wide range of subtle communications among members of the operating room team. In many commands there was *asking* rather than *ordering*. In another study [12] it was noticed by the same investigators that team members frequently tend to simplify and distort others' roles and motivations. Such behaviour reflects professional rivalries in the operating room team. In some institutions, however, surgeons are still trained with a method of intimidation and harassment. Such training is distasteful and wrong – it results in the impression that such behaviour is normal for surgeons and remains frequently observed later in daily practice [13].

Acceptation of surgical cases

In some countries anaesthetists depend on surgeons for their employment and thus their income. This can result,

and in the past has resulted, in a situation where the anaesthetist is easily intimidated by the surgeon. In many countries around the world I have seen anaesthetists struggle with such decisions regarding acceptance of cases. These anaesthesiologists believe that the indication for surgery, and thus for anaesthesia, is made solely by the surgeon and that the anaesthesiologists has no say in it, or even is not responsible for it. Such a view is, of course, not right. Anaesthetists, like all other team members, also have their own professional and ethical responsibility. This requires that, based on the autonomy of the patient, the anaesthetist must legally and ethically obtain informed consent of the patient for the activities employed in such treatment whenever this is possible. It should, however, be noted that written informed consent for anaesthesia is not an official legal requirement in most Western jurisdictions. Anaesthesia is associated with its own both predictable and unexpected hazards; it is a constant and complex exercise in professional judgement. Thus, surgeons must be regarded as being incapable of informing patients sufficiently about anaesthesia and its risks [14]. This informed consent for anaesthesia must be obtained by the anaesthetist; thus, the anaesthetist is also confronted with all the aspects of competence and incompetence, and the duty to inform the patients about possible risks and alternatives for the treatment. The anaesthetist is liable when administering an anaesthetic to a patient without consent. For example, when the anaesthetist has obtained consent for an epidural anaesthesia and the surgeon, for their own reasons, requests a general anaesthetic, can cause a discussion and conflict. A conflict can also rise when an anaesthetist is requested to administer an anaesthetic in a nonemergency case, without obtaining informed consent, e.g. an extra case at the end of the list. Modern well-trained surgeons do not depend on an attitude of arrogance and self-opinion. Modern well-trained anaesthesiologists no longer take a dependent attitude. Communication within the team is the solution.

In most situations there is no discussion whatsoever about whether a patient should be operated on or not. The disorders of the patients and sensible treatment procedures are clear. In some cases, however, this is less clear to the members of the team. In addition to technical assessments, ethical and evaluative considerations are other factors that are part of the final decisions made in the treatment of patients. Such factors are, amongst others, communication and cooperation. It is apparent that physicians not only have to deal with patients and their relatives, but also with colleagues. Therefore, it is customary to seek consensus between members of a healthcare team. When this is based on evidence and expertise there is no objection. Sometimes, however, it is a personal opinion not based on sensible reasons that a case is demanded by an unwise surgeon. If in such cases

interpersonal dynamics produce consensus through exhaustion with debate, lack of time, dominance of a certain personality and thus lead to a conclusion without connection with the need of the patient, problems will arise later on when similar cases are presented. Conflicts can also arise immediately if participants maintain their own 'value positions' and a dominant person pushes one opinion ahead, leading to a decision which is not supported by other members of the team. Such situations should be avoided. Recognising values of reaching consensus without pressurising is part of leadership. Effective leaders flatten the hierarchy, create familiarity, and make it feel safe to speak up and participate. Authoritarian leaders reinforce large authority gradients, creating unnecessary risk [15].

Management of the operating theatre

With the changing roles in the operating theatre, where anaesthetists are more and more becoming the managing directors, the chance for conflict is in my opinion increasing. Surgeons are the first contractors with the patients and other contracts only follow these; in other words, patients come to the hospital for surgery and not for anaesthesia. This introduces a possible conflict with the anaesthetists who may have their own demands and opinions. Therefore, not only anaesthetists but also representatives of the surgeons must be involved in the management of the operating rooms.

The operating room is also the battlefield of biopolitics where conventional hierarchical structures and newer concepts of cooperation and teamwork meet each other. In this way biopolitics and bioethics cannot be separated. Surgeons should realize that in this modern era they have to move from a culture of heroic individualism to one of collaborative teamwork [16[•]]. This is a difficult goal to reach, not least because medical education is individual-centred, aiming at acquisition of skills and knowledge of the individual physician (autonomy in profession), whereas team building is completely ignored. Practitioners still maintain traditional boundaries between professions by stereotyping the 'other' professionals in the team. This frustrates interprofessional activities necessary to improve patient outcome. Undre *et al.* [17^{••}] found that both anaesthetists and surgeons have the perception that in the operating room not one team is active, but that multiple highly specialized independent teams are at work on the same patient. Seventy-five percent of the participants wanted the collaboration between these separate teams to improve.

Surgery by a not originally assigned surgeon

Another source of conflict is when surgeons operate upon patients that expect to be operated by another surgeon. Can the anaesthetists go by without objecting to such a situation? In my opinion not! I strongly believe that this

is an infringement on the autonomy of the patient and the anaesthesia department head should discuss such habits with the surgical department head. The same is the case when there is fraudulent misrepresentation of a second actor's identity, i.e. a student or a trainee is represented as a young specialist. This does not imply that trainees cannot be involved in the treatment of the patient; however, they should be properly supervised and the patient must be informed.

Incapable team members

Members of the team should take action when they observe that one of the members of the team is incapable of performing to an adequate level. Such incapability can be the result of many things such as lack of knowledge or experience, tiredness from long working hours, and illness, but also from the effect of intoxication with drugs or alcohol.

Conflict prevention and resolution are usually completely absent from both clinical training and medical ethics curricula. Interpersonal skills such as interviewing are taught, but the focus is usually on obtaining and providing information, not negotiation of conflict prevention.

Conclusion

There are many possible inductors of conflicts in the operating theatre. Such conflicts should be immediately resolved by open communication and respectful discussion amongst team members.

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- of special interest
- of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 160).

- 1 Baker DP, Day R, Salas E. Teamwork as an essential component of high-reliability organizations. *Health Serv Res* 2006; 41:1576–1598.
 - 2 Dormann C, Zapf D. Job satisfaction: a meta-analysis of stabilities. *J Organ Behav* 2001; 22:483–504.
 - 3 Kinzl JF, Knotzer H, Yraweger C, *et al.* Influence of working conditions on job satisfaction in anaesthetists. *Br J Anaesth* 2005; 94:211–215.
 - 4 Jenkins K, Wing D. A survey of professional satisfaction among Canadian anesthesiologists. *Can J Anesth* 2001; 48:637–645.
 - 5 De Dreu CKW, Weingart LR. Task versus relationship conflict, team performance and team member satisfaction: a meta-analysis. *J Appl Psychol* 2003; 88:741–749.
 - 6 Lingard L, Regehr G, Espin S, *et al.* Perceptions of operating room tension across professions: building generalizable evidence and educational resources. *Acad Med* 2005; 80 (10 Suppl):s75–s79.
 - 7 Rosenstein AH, O'Daniel M. Disruptive behaviour and clinical outcomes: perceptions of nurses and physicians. *Am J Nurs* 2005; 105:54–64.
 - 8 Rosenstein AH, O'Daniel M. Impact and implications of disruptive behavior in the perioperative arena. *J Am Coll Surg* 2006; 203:96–105.
 - 9 Rogers DA, Lingard L. Surgeons managing conflict: a framework for understanding the challenge. *J Am Coll Surg* 2006; 203:568–574.
- An overview is given of how to deal with conflicts and the consequences of not resolving the inducing problems.

- 10 De Dreu CK, Weingart LR. Task versus relationship conflict, team performance and team member satisfaction: a meta-analysis. *J Appl Psychol* 2003; 88:741–749.
- 11 Lingard L, Reznick R, Espin S, *et al.* Team communications in the operating room: talk patterns, sites of tension, and implications of novices. *Acad Med* 2002; 77:232–237.
- 12 Lingard L, Reznick R, DeVito I, Espin S. Forming professional identities on the healthcare team: discursive constructions of the 'other' in the operating room. *Med Educ* 2002; 36:728–734.
- 13 Muselman LJ, MacRae HM, Reznick RK, Lingard LA. 'You learn better under the gun': intimidation and harassment in surgical education. *Med Educ* 2005; 39:926–934.
- 14 Mulcahy D, Cunningham K, McCormack D, *et al.* Informed consent from whom? *J R Coll Surg Edinb* 1997; 42:161–164.
- 15 Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Qual Saf Health Care* 2004; 13 (Suppl 1):i85–i90.
- 16 Bleakley A. A common body of care: the ethics and politics of teamwork in the operating theater are inseparable. *J Med Philos* 2006; 31:305–322. In a philosophical manner, this article describes collaboration in the operating theatre and the various theories about cooperation.
- 17 Undre S, Sevdalis N, Healey AN, *et al.* Teamwork in the operating theatre: cohesion or confusion? *J. Eval Clin Pract* 2006; 12:182–189. The authors studied the cohesion of teams in the operating room, and describe the importance of team structure, team roles and team communication.