Chapter 11
Professionalism in the Operating Room

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Abstract Acting on behalf of their patients, surgeons and anesthesiologists can be considered the moral and fiduciary agents of them. Surgeons and anesthesiologists optimize the care of their patients by exhibiting professionalism in their shared work environment. Professionalism in the operating room demands not only competence in a physician's discipline but also a strict work ethic, adherence to the ethical principles of the profession, diligence, and effective communications skills. The prevention of potential conflicts and the resolution of existing conflicts are necessary to optimize the care and safety of patients in the operating room.

Keywords Professionalism • Operating Room • Surgeon-Anesthesiologist Relationship • Ethics • Conflict Resolution

Case Presentation

A 76-year-old female with colon cancer was admitted for an elective laparoscopic colon resection the day prior to her scheduled surgery date. The patient has diabetes mellitus, a body mass index of 36, and a vague history of coronary artery disease. The surgeon's plan was to have the patient complete her bowel preparation as well as a preoperative evaluation/workup on the admission day. The day before her surgery, an attending anesthesiologist and a senior anesthesia resident evaluated the patient, assigned the patient's American Society of Anesthesiologists Physical Status as III, stated there was no need at that time to arrange a postoperative admission to the intensive care unit, and advised the surgeon that the patient was "cleared and ready for surgery." The patient then began her bowel preparation. The next morning, the patient was brought to the operating room in the preoperative ward and

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met the anesthesiologist assigned to care for her. The anesthesiologist evaluated the patient and determined that the patient was not medically optimized for the surgical procedure given the patient's medical history and vague cardiac history. The anesthesiologist requested a cardiac evaluation of the patient and discussed with the surgeon the need to reschedule the surgery. After acknowledging the situation, the surgeon became particularly annoyed and enraged since the surgeon believed that he had taken all the steps necessary in order to prevent the surgery being cancelled. The surgeon then started complaining and shouting, the situation escalated, and disruptive behavior was displayed towards the anesthesiologist. The surgeon's behavior was witnessed not only by the patient but also by the operating room staff.

The people's good is the highest law (Cicero, 106–43 BC, De Legibus)

Introduction

In 2001, the Institute of Medicine published a landmark report that redefined patient care as the "provision of care that is safe, effective, efficient, timely and patient centered for all those who are in need" [1]. This concept of healthcare delivery placed the patient's safety and welfare at center stage. For surgeons and anesthesiologists this concept of care expands care from one that simply consists of a "flawless technique during the performance of an operation" to care that also includes all of the needs of the patient and his or her family. The application of this concept of patient-centered care requires the further consideration of enhanced communication skills and the practice of ethical principles in the care of patients [2]. Patient-centered healthcare delivery emphasizes both the surgeon and the anesthesiologist as fiduciary agents who act on behalf of their patients. Thus, in addition to strong clinical and technical skills, an anesthesiologist and surgeon should have a thorough knowledge of bioethics and the practice of humanism to provide the best care for their patients. Ethics, therefore, lies at the center of professionalism.

Surgeons and anesthesiologists work together in the same environment, the operating room. The operating room is the hospital unit where surgical procedures are performed and each operating room is designed and equipped to provide surgical care to patients with specific conditions. In an efficient, optimal operating room, there should be the guarantee of the highest quality of surgical care and patient safety; the ease of scheduling patients for procedures; an atmosphere of trust and a respectful working environment; the maximization of operating room efficiency and efficacy with a decrease in delays and cancellations of surgical procedures; and satisfaction among patients, personnel and physicians. If these issues of the operating room are considered ahead of time, on the day of surgery, the teams delivering

care can focus on the patient without distractions that could lead to conflicts and compromise patient safety. Therefore, the operating room environment requires teamwork to delivery high quality care.

In order to provide this high quality care, there is a team consisting of physicians of different specialties, nurses, technicians, and support personnel. This team approach is essential for patient care. Unusual to other areas of the hospital, though, the operating room involves two physicians (the surgeon and the anesthesiologist) sharing concurrently the management and responsibility of a single patient. This responsibility underscores important decisions, usually involving life and death. Other factors that can impact this provision of care include fatigue, sleep deprivation, and pressure on production and on outcomes [3].

Acting on behalf of their patients, surgeons and anesthesiologists can be considered the moral and fiduciary agents of their patients. Surgeons and anesthesiologists optimize the care of their patients by exhibiting professionalism in their shared work environment. Professionalism in the operating room demands not only competence in a physician's discipline but also a strict work ethic, adherence to the ethical principles of the profession, diligence, effective communications skills, and working as a member of a team. In the operating room, the prevention of potential conflicts and the resolution of existing conflicts are necessary to optimize the care and safety of patients.

In this chapter, we will review principles that promote professionalism in the operating room, provide elements that can identify the roots of potential conflicts, and introduce strategies for the prevention and resolution of such conflicts.

Professionalism and Ethical Principles

Teamwork is paramount for patient care in the operating room. Surgical and anesthesia teams work hand in hand in many procedures, be it elective or emergent, low complexity or high complexity. Mutual respect among all healthcare providers in the operating room should be the rule and excellent communication among all team members improves patient safety and promotes good patient outcomes.

Competence, diligence, legal issues and concerns, ethics, and concern for patient safety in the operating room are important considerations for all members of the perioperative team. These are concepts embodied in professionalism. In fact, professionalism comprises a "set of values reflected in the philosophy and behavior of individuals whose calling is first and foremost to serve individuals and populations whose care is entrusted to them, prioritizing the interests of those they serve above their own" [4].

John Gregory (1724–1774), a Scottish physician and moralist, must be credited as the one who allowed the transformation of medicine from a trade to a profession. A profession is a group of individuals who are bound by a common ethic or code of conduct. Gregory, in fact, introduced the foundation of medical ethics and defined medicine as "the art of preserving health, of prolonging life, of curing diseases and

of making death easy" [5]. He also introduced the concept of the physician as a fiduciary agent to the patient by being "the person having duty, created by his or her understanding to act primarily for another's benefit in matters connected with such undertaking" [5].

The concept of the surgeon and anesthesiologist as the patient's moral fiduciary agent can be captured in several reflections. For instance, the surgeon/anesthesiologist should have the patient's interest as the primary consideration in the physician–patient relationship, as well as in surgical research and education. Similarly, this commitment divests self-interest and makes it a secondary consideration. Self-interest is thus blunted and makes the fiduciary's role morally demanding.

Ethics Remains at the Center of Professionalism in Both Surgery and Anesthesiology

Presidents of the American College of Surgeons have addressed widely the issue of professionalism in surgery. Dr. Copeland mentioned the importance of a surgical way of life and defined it as "the art and practice of surgery staying in your conscious thought continually" [6]. McGinnis quoted H. Debas stating that "Professional status is not an inherent right, but one granted by society and this obligates surgeons to put their patients' interests above their own. It must not be forgotten that ethical codes are the major characteristic that differentiate professions from occupations" [7].

Ralph M Waters (1883–1979) is considered a great contributor to the development of professionalism in anesthesiology. He considered it critical to establish a systematic body of scientific knowledge, scientific organizations, and a continuous improvement in clinical practice, represented by high quality anesthesia training programs [8]. In addition, Henry Beecher (1904–1976) was also a significant contributor to professionalism and medical ethics. His role was pivotal in medical research and innovation [9].

Professionalism is the basis of the contract between medicine and society and is guided by three fundamental principles [10]: (1) **The supremacy of patient welfare**, which is the dedication of physicians to serving patients' interests. Physicians are considered the moral and fiduciary agents of their patients; (2) **Patient autonomy**: surgeons and anesthesiologist should empower patients to make informed decisions about their treatment. Nonetheless, there are clinical situations which leave room for paternalism, such as trauma patients presenting for emergency surgery who do not have decision-making capacity and do not have a known surrogate decision maker; (3) **Social justice**: Aristotle first conceptualized justice as "the rendering to each individual of what is due to him or her" -justice is interpreted as the fair, equitable, and appropriate distribution of what is due or owed to persons. More recent works on social justice originate from John Rawls' "A Theory of Justice", in which he argues that a social arrangement forming a political state is a communal effort to advance the good of all individuals [11].

Other elements that define a profession include the possession of specialized knowledge and skills that are continually honed, ethics, and the evidence of competence (including licensing and certification). Professionalism describes certain attitudes, values, and behaviors that are expected from physicians. The essential characteristics of professionalism include: accountability (the physician is responsible and liable for his or her practice of medicine); competence and diligence; humanism integrated with integrity, compassion, sympathy; effective and proper communication; and respect of and practice of ethical principles. Furthermore, terms often significantly associated with professionalism include altruism, honor, compassion, integrity, dedication, empathy, responsiveness, prudence, and an ethos of self-regulation. The set of professional responsibilities include professional competence; scientific knowledge, honesty; respect for patient confidentiality; appropriate relationships with patients; the improvement of quality of care; easy and universal access to health care; maintaining trust by managing conflicts of interest; and fair distribution of limited resources.

The Four Principles of Bioethics

The principles of biomedical ethics as stated by Beauchamp and Childress are utilized when addressing bioethical issues and analyzing clinical ethical situations [12]. The four principles of biomedical ethics are autonomy, beneficence, nonmaleficence, and justice [12]. In addition to the four principles of bioethics, truthfulness, fairness, integrity, dignity, respect of an individual's rights, and honesty are all virtues of ethical behavior physicians should also uphold. The following are the four principles of bioethics as applied to professionalism in the operating room.

Autonomy

Autonomy derives from the Greek roots *autos* (self) and *nomos* (rule, governance, law) and makes reference to the original self-determination of city-states in Greece. A patient's autonomy is respected in regard to decisions related to medical care. The autonomy of the surgeon and anesthesiologist, in addition to the patient's autonomy, should be respected (for example, circumstances involving conscientious objection) as long as their professional responsibilities are fulfilled and patient care is not compromised.

Beneficence

Beneficence involves actions for the best interest of others.

Nonmaleficence

Nonmaleficence is derived from the *Primun non nocere* dictum and includes not only the duty not to inflict harm but also the duty not to impose a risk of harm. In cases where the patient has been put at risk, both law and morality set a standard that determines if the agent causally responsible for the risk is legally or morally liable. Conversely, negligence involves an act or omission of an act that is a departure from the professional standards of medical practice. The term negligence covers two situations: (1) an act intentionally imposing unreasonable risks of harm (advertent negligence or recklessness) and (2) the omission of an act imposing risks of harm (inadvertent negligence). Cases of negligence involve a behavior that falls below a standard of care established by the law to protect patients from the careless imposition of risks. Essential elements of negligence include the following: the physician (surgeon or anesthesiologist) must have a duty to the affected party; the physician must breach the duty; the affected party (the patient) must experience harm; and the harm must be caused by the breach of duty. "Professional malpractice" is negligence that involves departing from professional standards of care. The line between due care and inadequate care (which falls below what is due) may sometimes be difficult to draw.

Justice

Justice refers to the fair allocation of resources.

Sir David Ross (1877–1971) was the first to develop the *prima facie* ethical duties. Originally in the number of 5, these duties were fidelity, reparation, gratitude, promotion of a maximum of aggregate good, and nonmaleficence [13]. Not all of these duties bear the same importance. In his argumentation, Ross stated that the duty of nonmaleficence is the initial step prior to the duty to promote a maximum of aggregate good. Also, Ross stated that the duties of fidelity, reparation, and gratitude were more preeminent than the duty to promote good. Furthermore, Ross considered that four elements are basically good: virtue, knowledge, pleasure (all considered states of mind), and justice, which represents the relationship between the first three. Following the Kantian "*moral imperative*", Ross illustrates how moral decision-making sometimes requires us to think about the past and act according to a sense of duty rather than focus on the projected outcome. Ross' duties-based (deontological) ethics served as a foundation for the work of Beauchamp and Childress.

Therefore, the principles of Ross and Beauchamp and Childress are a foundation for the ethical duties of the surgeon and the anesthesiologist. Furthermore, the ethical duties of physicians include an implicit social and moral contract within the members of the medical profession, which includes the physician's responsibility to society and their specialty; self-regulation of their profession; the professional

obligation to utilize scientific knowledge for the service of others; earning public trust in the practice of medicine; and optimizing the healthcare delivery system to uphold these moral and ethical responsibilities.

The Surgeon-Anesthesiologist Relationship

Traditionally, the degree of a surgeon's responsibility in the operating room has been compared to that of the captain of a ship and this was the ruling doctrine to judge a surgeon's behavior and liability in the operating room, considering him or her responsible for those assistants under his or her supervision. The legal doctrine, a variation of the "borrowed servant doctrine" considered that during any surgical procedure the surgeon was liable for all actions performed in the course of the operation and by anyone in that operating room. In fact, in early times, the anesthesiologist was considered one of the surgeon's dependents and the surgeon was considered the owner of the patient [14].

The doctrine of "*the captain of a ship*" was coined in McConnel v. Williams, 361 Pa. 355, 65 A.2d 243, 246 (1949), in which the Supreme Court of Pennsylvania ruled that "It can readily be understood that in the course of an operation in the operating room of a hospital, and until the surgeon leaves that room at the conclusion of the operation… he is in the same complete charge of those who are present and assisting him as in the captain of a ship over all on board, and that such supreme control is indeed essential in view of the high degree of protection to which an anesthetized, unconscious patient is entitled…" [15]. This doctrine was popular for a long time and assimilated in other judicial systems, yet its sustainability has diminished. In "Truhitte v. French Hospital," (1982 128 Cal. App. 3d 332, 348) the court explained "the captain of the ship doctrine arose from the need to assure plaintiffs a source of recovery for malpractice at a time when many hospitals enjoyed charitable immunity, which is no longer the case" [16]. But most important, the court also stated that "the theory that the surgeon controls all activities of whatever nature in the operating room is unrealistic in present-day medical care where today's hospitals hire, fire, train and supervise their nurse employees, implement surgery protocols and can absorb the risks of noncompliance" [16].

To perform his or her duties the surgeon requires the collaboration from other hospital employees and staff who do not report to or are not employed by the surgeon. Among this staff is the anesthesiologist who also has his or her own professional and scientific autonomy. Not only do anesthesiologists provide the benefits of unconsciousness, sedation, analgesia, and relaxation, but also resuscitate patients and provide life-sustaining measures to facilitate the surgeon's ability to care for the patient. The surgeon and anesthesiologist must work as a team, working jointly during the perioperative phases of care to achieve the best quality of care, the highest patient safety level, and the best outcome for the patient. This shared responsibility demands a clear definition of roles and a mutual respect of competencies.

Anesthesia is a unique medical specialty as it has a limited direct patient relationship. The anesthesiologist provides care to a patient who is referred primarily by a surgeon. Furthermore, the time-limited care provided by the anesthesiologist occurs during the perioperative period. After the immediate postoperative recovery of the patient, this relationship ceases and the surgeon most often resumes the sole care of the patient. Therefore, the patient's outcome in the immediate postoperative period depends, in addition to other factors, on how well the surgeon, anesthesiologist, and healthcare team work together as a team and communicate with each other. Sound ethical practices in the operating room are imperative and must be recognized by all providers involved in the patient's care.

Conflicts in the Operating Room

The healthcare environment is particularly prone to conflicts. It has been estimated that conflicts occur during the management of 50–78% of patients, and that 38–48% involve interpersonal conflicts among health care staff [17, 18].

The potential for interpersonal conflicts is heightened in the operating room where a broad range of healthcare professionals perform their tasks with overlapping and sometimes poorly defined areas of responsibility. Furthermore, the operating room is the only area of the hospital where two physicians of different specialties – each with its own professional autonomy – concurrently share direct responsibility for the same patient. Moreover, the roles of these physicians are such that one cannot perform his or her task without the other. In these situations, a conflict may arise. A conflict may be considered as "a state of disagreement or disharmony between persons or ideas" [19]. The conflict usually causes an emotional stir among those individuals involved. The conflict may arise between the anesthesiologist and surgeon, but also between these specialists and other operating room personnel such as nurses and technicians. Conflicts may also progress to harassment and disruptive behavior. Operating room and hospital leadership should establish and communicate the appropriate code of conduct in the operating room and be uncompromising in its corrective decisions and actions. The implementation and enforcement of operating room policies and regulations require the cooperation of all those involved in patient care. As conflicts in the operating room can compromise surgical and anesthetic care, successful conflict resolution will promote better patient care and safety, improved quality of care, and better patient outcomes.

The leading causes of conflict between surgeon and anesthesiologist include personal and cultural factors. Among the personal factors are poor communication skills; different personality traits; different personal values and beliefs; lack of appreciation by the other profession; and different models of salary and/or reimbursement for procedures. Furthermore, caring for sicker patients undergoing more complex surgical procedures may bring potential conflicts involving futility, appropriate versus inappropriate indications for procedures, do not resuscitate orders in the perioperative period, advance directives [20], as well as the care of Jehovah's Witness patients.

Operating room delays and cancellations are the most frequently felt source of conflict. The incidence of cancellations is around 2–14% of cases, but it can reach 21.8% in a tertiary care center [21]. Some of the common causes for delays and cancellations are the need for additional tests and consultations, shortage of blood supply, food intake by the patient prior to surgery, lack of availability of beds in adequately monitored postoperative care units, absence of essential equipment, and poorly controlled systemic diseases.

There are various measures to improve the relationship between surgeons and anesthesiologists and to prevent potential conflicts in the operating room. For instance, there should be agreement regarding the risk stratification and optimization of patients for surgery. When there is a disagreement regarding whether a patient is optimized for surgery, physicians should focus on the care of a patient and not on personal issues. Furthermore, a second opinion from a peer can be sought. In addition, an effort should be made to start the cases on time, with both surgeons and anesthesiologists being monitored and disciplined when late. Furthermore, there should be truthfulness regarding the scheduling of cases and honesty with respect to the duration of a procedure. However, at times and appropriately so, the duration of a procedure may be increased by an intraoperative complication and by the nature of practicing in an academic setting involving the education of resident physicians. Frequent communication of the surgeon with the anesthesiologist and the operating room staff with updates during a procedure may provide the team with a more objective estimate of the duration of the operation. Another measure to improve the relationship between surgeons and anesthesiologists is to include anesthesiologists on important decisions, such as introducing a new technology or a surgical innovation [22].

The performance of surgical procedures in an accredited setting mandates an environment in which all participants (patients, staff, nurses, colleagues, residents, students, and other personnel) are treated with respect. Discrimination on any level (race, age, gender, sexual preference, disability, or religion), bullying behavior, and harassment must be banned in every day activities and reported to ensure the employment of corrective measures.

Conclusion

In summary, conflicts in the operating room can arise because of the complexity of the environment and the interactions of a diverse set of individuals involved in patient care. Acting on behalf of their patients, surgeons and anesthesiologists can be considered the moral and fiduciary agents of their patients. Surgeons and anesthesiologists optimize the care of their patients by exhibiting professionalism in their shared work environment. Professionalism in the operating room demands not only competence in a physician's discipline but also a strict work ethic, adherence to the ethical principles of the profession, diligence, and effective communications skills. The prevention of potential conflicts and the resolution of existing conflicts

are necessary to optimize the care and safety of patients in the operating room. The following elements can improve professionalism in the operating room and be utilized for conflict prevention and resolution:

- Awareness of the organizational culture of the institution. Once this is understood, change and improvement can be implemented.
- Respectful attitude. For example, be helpful, nice, courteous, and polite. Be cordial and easy to work with. Do more than what is expected from you.
- Culture of safety. Try to prevent errors and be gentle with those of others.
- Communication. Keep clear and precise communication, verbal and written. Be prompt in replying to others.
- Reliability.
- Flexibility. Do not complain for every detail.
- Promotion of education at all levels.
- Being able to receive constructive criticism.
- Fulfilling responsibilities.
- Promoting ethical behavior.

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