Editorial

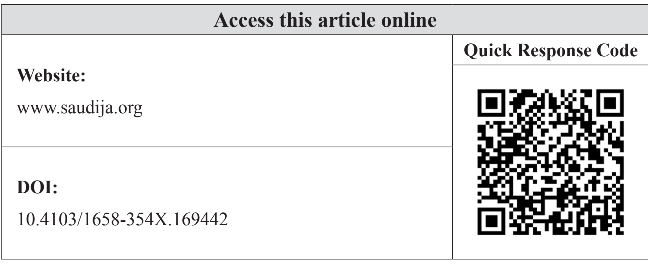
Operating room conflict resolution: Time to figure it out

The operating room remains the only place where two physicians find themselves voluntarily bound together by a mutual interest in optimal patient care yet driven by potentially divergent economic goals. Such situations may rapidly and unexpectedly devolve into interpersonal conflict and possibly adverse patient outcomes.[1] For the purpose of this editorial, we will focus on dealing with conflicts that escalate into frankly disruptive behaviors that are evident in the operating room setting such as verbal or physical confrontations. The American Medical Association defines disruptive behavior as "Personal conduct, whether verbal or physical, which negatively affects or that potentially may negatively affect patient care."[2] Although we might expect conflict among highly trained, exceptionally skilled professionals; there should be little tolerance for the evolution of the conflict into disruptive behavior. American hospital and physician practices have expressed well-documented concerns over disruptive behavior for nearly two decades including negative impacts on employee well-being and detrimental effects on safety and patient outcomes.[3,4] The American medical clearly literature reflects these concerns with the recognition of the need to prevent such occurrences and to have interventions in place should they occur. The recognition of these issues has been a gradual process over the past 20 years as most of us will clearly remember the days of the surgeon being thought of as the "captain of the ship" with tolerance to disruptive and even physically abusive behaviors toward operating room personnel. This issue of the Saudi Journal of Anesthesia recognizes the spread of legitimate concern for disruptive behavior in hospitals throughout the world and across cultural boundaries.[5] The manuscript by Attri *et al*. is thought-provoking and reminds us that measures to deal with such behaviors should be in place in operating rooms and hospitals throughout the world.[5]

Effective management of behavior begins with the development and maintenance of shared expectations. As with any process that deals with safety impact in the operating room, the most desirable and perhaps effective interventions are those that prevent problems before they occur. Therefore, the primary goal should be to institute education and interventions, which provide expectations for appropriate interactions in the operating room. Meaningful shared expectations, in turn, arise most commonly from the clear establishment of cultural norms, shared goals, and carefully aligned incentives. Medical ethics constitutes an intrinsic and foundational component of culture norms. The American medical education experience has taught us that students may be subjected to "ethical erosion" subsequent to early attempts at ethical indoctrination.[6,7] Thus, even the best educational efforts may degrade due to the mere passage of time without on-going reinforcement. To the extent that education in medical ethics is a reliable surrogate for other shared expectations, specifically behavior, we should expect that the maintenance of a culture of professional behavior requires on-going reinforcement. Reinforcement should include behavior standards in addition to the issues identified by the authors as contributing factors to operating room conflict.

As the authors note, "conflicts are inevitable." Conflicts may be as simple as disagreements regarding scheduling cases in the operating, proceeding against the standard of care for NPO times as illustrated by the authors, first case. Another common potential source of conflict as illustrated by the authors' second case is the need to cancel an elective procedure related to an acute, intercurrent illness or the need for further work-up. Other more complex and at times covert scenarios that may also lead to conflict include conflicts of interest associated with incentives from the pharmaceutical or equipment industry or uncontrolled hiring or promotion practices related to favoritism, nepotism, or discrimination.

Given the increased recognition of the potential negative impact of such problems on patient safety and personnel well-



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being, the need for effective mitigation of institutional risks has increased. In the United States, The Joint Commission requires defined institutional policies addressing disruptive behavior. As disruptive behavior is not limited to the medical staff so such policies must be global and encompass disruptive behaviors by medical staff, allied health, nursing, support staff, and administration. Policies and procedures also serve as "preconflict" guidance. The wide distribution of policies and procedures coupled with effective education and on-going re-enforcement helps to promote professional behavior and establish an institutional culture. As noted by the authors, there are several well prepared documents to aid in the development of such guidelines including those from the American Society of Anesthesiologists.

Attri *et al*. have clearly and concisely outlined some of the potential causes of conflict as well as the preliminary steps for conflict resolution.[5] While these are likely to be effective in the majority of cases, the hospital must also have in place the mechanisms to deal with physicians who are repeat offenders or those whose primary offense is of such a magnitude (physical interactions) that immediate intervention is needed. Physician executives and medical staff officers find themselves routinely confronted with the results of "escalated conflicts." Effective policies and procedures codify the shared values and expectations of the institution. Effective post conflict management requires strict compliance with widely disseminated, carefully constructed, and consensually developed policies. This limits the potential for abuse and maintains a culture built on shared values.

The time to decide how to deal with disruptive behavior by a physician or healthcare professional must start well in advance of the event itself. As noted above, this begins with a clear delineation in the hospital policy, which is approved by the Medical Staff Office delineating what is expected of those working at the hospital. We would encourage such training and education to begin during medical school and residency. It should continue beyond that as physicians and allied healthcare professionals joining hospital departments. As disruptive or unprofessional behavior may take many forms, specific definitions of what disruptive or unprofessional behavior includes must be clearly delineated in hospital policies. These disruptive behaviors go far beyond disagreements and yelling in the operating room, they may include monetary gains achieved through inappropriate means based on employment status (incentives from pharmaceutical or manufacturing companies), sexual harassment (verbal or inappropriate physical contact), drug abuse/diversion, and nepotism/favoritisim in hiring practices.

All hospitals in the United States have a specific policy, which outlines the steps required when dealing with such physicians. The nicely written manuscript in this issue of the Saudi Journal of Anesthesia is a welcome addition to the literature and should serve as the basis for the development of such policies in hospitals outside of the United States. These policies are meant not only to guide one through dealing with such behaviors in an attempt to help the person involved rectify and correct behaviors, but also serve to protect the hospital in the event of litigation such that employee be dismissed. As the physicians are required to sign that they have read and understand the policies, it is clear to third parties that they were informed of what the expected behaviors are, what constitutes disruptive behavior, and what the consequences of such behavior would be.

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References

1. Rosenstein AH, O'Daniel M. Impact and implications of disruptive behavior in the perioperative arena. J Am Coll Surg 2006; 203:96-105.
2. American Medical Association, Opinion 9.045 — Physicians with Disruptive Behavior. Available from: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9045.page. [Last accessed on 2015 Jan 04].
3. Rosenstein AH, O'Daniel M. Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians: Nurses, physicians, and administrators say that clinicians' disruptive behavior has negative effects on clinical outcomes. Am J Nurs 2005;105:54-64.
4. Saxton R, Hines T, Enriquez M. The negative impact of nurse-physician disruptive behavior on patient safety: A review of the literature. J Patient Saf 2009;5:180-3.
5. Attri JP, Sandhu GK, Mohan B, Bala N, Sandhu KS, Bansal L. Conflicts in operating room: Focus on causes and resolution. Saudi J Anaesth 2015;9:457-63.
6. Roff S, Preece P. Helping medical students to find their moral compasses: Ethics teaching for second and third year undergraduates. J Med Ethics 2004;30:487-9.
7. Feudtner C, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. Acad Med 1994;69:670-9.