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Review Article

MThe Surgeon and the Anesthesiologist in the Operating Room: Ethical Issues and Professionalism

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Abstract

The daily practice of Surgery and Anesthesia is surrounded by a paramount moral basis; and both professionals should be considered moral and fiduciary agents on behalf of the patient. Professionalism in the OR demands a strict work ethics and adherence to the ethical principles together with competence, diligence and communication skills taking into account the fact that two physicians share the command of the patient while in the operating room. Conflict prevention and resolution is a must to enhance OR effectiveness and efficacy as well as to achieve the maximum surgical patient safety.

Keywords: Anesthesiologist; Ethics; operating room; Professionalism; Surgeon

Introduction

In its report "Crossing the quality chasm", the Institute of Medicine highlighted the quality of 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 places the patient and the patient's welfare at the core of the health care system. For surgeons as well as for anesthesiologists it expands the concept of "flawless technique during the performance of an operation" to one that encompasses the integration of all the needs of the patient and his/her immediate family. This requires the development of an additional set of skills by surgeons and anesthesiologists, including appropriate communication abilities, knowledge of ethical principles and guidelines, and the addition of those tools into the everyday practice of surgery and anesthesiology [2]. It emphasizes the moral practice of our profession and it converts both the surgeon and the anesthesiologist in moral and fiduciary agents on behalf of the patients.

The features of a modern and competent surgeon and anesthesiologist include the following traits: 1. superb clinical skills and appropriate sound judgment; 2. high technical skills, including knowledge and expertise in the surgical performance and 3. knowledge and practice of humanism, ethics, and solid moral values. Ethics, therefore, lies at the core of professionalism: a proficient surgeon or anesthesiologist needs to be not only competent to perform the art and science of surgery or anesthesiology but also ethically and morally reliable.

The operating room (OR) is the hospital unit where surgical procedures are performed and is integrated by a number of operating suites, of different complexity and infrastructure which are designed to provide surgical care to patients with specific conditions.

The aims of a successful OR are:

- The highest quality of surgical care and level of patient safety and error prevention
- An easy and quick access to the OR schedule
- An environment of trust and reliability among all of its members
- A respectful working atmosphere
- The maximization of the efficiency and the efficacy of the OR
- A decrease in the delays and cancellations

If the OR management can achieve all these goals, the day an operation takes place, all the team will just focus on the patient. Otherwise, conflicts will arise and patient safety will be compromised. The OR environment is one of the hospital areas where

effective and real teamwork needs to be maximize for its adequate activity. The final product of this unit is the performance of surgical procedures at the highest quality of delivery care.

The OR is packed with a wide variety of professionals: physicians of different specialties, nurses, technicians and support personnel, many of them with poorly defined levels of responsibility. Besides, it is the only hospital area where 2 physicians (the surgeon and the anesthesiologist) share in a regular and simultaneous way the management and responsibility of one particular patient. Decisions involving life and death are routine and adverse outcomes are the target of intense retrospective analysis. Fatigue, sleep deprivation and pressure on production and outcomes are also points to be considered [3].

Professionalism and Ethical Principles

Team approach is essential for patient care. Surgical and anesthesia teams work hand in hand at every case, be it elective or emergency, low or high complexity. Mutual respect among all healthcare providers in the OR should be the rule and excellent communication between surgeons and anesthesiologists warrants patient safety and good outcomes. Competence and diligence, law, ethics and concern for patient safety in the OR should be important considerations for all the members of the team. This is the concept embodied in the professional way of doing things.

So, what should be understood by professionalism? 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]. A profession is a group of individuals who are bound by a common ethic or code of conduct.

The figure of John Gregory (1724-1774), a product of Scottish iluminism, must be credited as the one who allowed the transformation of Medicine from a trade into a real profession. He was the one to introduce the foundations 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. In that sense, both the surgeon and the anesthesiologist are committed to be "the person having duty, created by his or her understanding to act primarily for another's benefit in matters connected with such undertaking.

The concept of the surgeon and/or anesthesiologist as the patient's moral fiduciary can be captured in the following reflections:

- the surgeon/ anesthesiologist should make the protection and promotion fo the patient's interest the primary consideration in the surgeon/ anesthesiologist - patient relationship as well as in surgical research and education

- the primary committment holds self-interest in the background and makes it a systematically secondary consideration

- Self- interest is thus blunted and not permitted to generate the "vice" of selfishness in the surgeon or anesthesiologist professional charácter, making the fiduciary's role morally demanding.

The questions about what constitutes good professional practice in the field of Surgery concern surgical ethics rather than surgical technique. A similar situation applies to Anesthesiology. Ethics remains at the center of the competency of professionalism. The issue of surgical professionalism has been addressed widely by different American College of Surgeons' Presidents. Copeland mentioned the importance of a surgical way of life and defined it as the art and practice of surgery staying continually in conscious thought [6]. McGinnis quoted Haile Debas stating: "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 characteristics that differentiate professions from occupations" [7]. In the field of Anesthesiology, Ralph M Waters (1883-1979) may be considered as the foremost contributor to the development of professionalism in Anesthesiology. He considered the following issues as critical: a systematic body of scientific knowledge, the establishment of scientific organizations and a continuous improvement in clinical practice, represented by high level anesthesia training programs [8]. Henry Beecher, born as Harry Unangst (1904-1976), was also a significant contributor to professionalim and medical ethics. His role was pivotal in medical research and innovation [9].

Professionalism is the basis of Medicine's contract with society and should be guided by three principles:

- The preeminence of patient welfare: this is the consequence of the application of fiduciarism to the physician/ patient relationship.

- Patient autonomy: surgeons and anesthesiologist should be honest to their patients and empower them to make informed decisions about their treatment. Nonetheless there are clinical situations which leave room for paternalism, such as trauma patients or patients unable to make decisions on their own (respiratory support, hemodinamically unstable, etc) and without surrogates.

- Social Justice: Aristotle first conceptualized justice as ''the rendering to each individual of what is due to him''. Justice is interpreted as the fair, equitable, and appropriate treatment of what is due or owed to persons. More recent influences in biomedical ethics originate from John Rawls' "A Theory of Justice" [10].

Other elements inherent to a profession include the acquisition of special knowledge and skills, advanced and continuing education, ethics and the evidence of competence. The essential characteristics of professionalism include these tenets:

Accountability: the physician is responsable for his performance holding liability for his or her practice

- Competence and diligence
- Humanism, integrated by a measure of integrity, compassion, simpathy and effective and proper communication
- Ethics

The compound of professional responsibilities include, amongst others, the following:

1. Professional competence
2. Scientific knowledge
3. Honesty with patients
4. Patient confidentiality
5. Appropiate relationships with patients
6. Improvement of the quality of care
7. Improvement of the access to care, making it universal
8. Fair distribution of limited resources
9. Maintaining trust by managing conflicts of interest
10. Professional responsibilities

The principles of biomedical ethics as defined by Beauchamp and Childress have become one of the most widely used frameworks for considering bioethical issues and analyzing ethical situations in Medicine [11]. These four principles are:

- **Autonomy:** since there is no physician- patient direct encounter we must stick to the autonomy of the surgeon and the anesthesiologist in his or her role. Autonomy, which derives from the greek root autos (self) and nomos (rule, governance, law) makes reference to the original self determination of city states in Greece.
- **Beneficence:** stands for acts of mercy, kindness and charity and involves the principle of acting with the best interest of the other in mind
- **Non Maleficence:** based on 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 of risk imposition, both law and morality recognize a standard of due care that determines whether the agent who is causally responsible for the risk is legally or morally liable as well. On the other hand, negligence is the absence of due care. It involves a departure from the professional standards that determine due care in given circumstances. The concept of negligence covers two situations: a) intentionally imposing unreasonable risks of harm (advertent negligence or recklessness); and b) unintentionally but carelessly imposing risks of harm (inadvertent negligence). In defining negligence, we concentrate on a behavior or misdemeanor that falls below a standard of due care that law or morality establishes to protect others from the careless imposition of risks. These elements are essential in the professional model of due care: 1. The professional (surgeon/ anesthesiologist) must have a duty to the affected party; 2. The physician must breach the duty; 3. The affected party must experience a harm, and 4. The harm must be caused by the breach of duty. Professional malpractice is an instance of negligence that involves not following professional standards of care. The line between due care and inadequate care (that which falls below what is due) is sometimes and often difficult to draw.
- **Justice:** refers to the adequate allocation of resources.

The ethical duties of the surgeon and of the anesthesiologist have ground on these considerations:

- There is an implicit social and moral contract within the members of the surgical profession, which includes the physician's responsibility to society, to Surgery as a whole and to the self regulation of the surgical and anesthesia profession

- The professional obligation uses the body of scientific knowledge entrusted to surgeons and anesthesiologists to the service of others

- The ideal situation should be that of a public trust in the role and performance of both the surgeon and the anesthesiologist, but it is the public concern to know if the health care delivery system is addressing its moral and ethical responsibilities.

The Surgeon- Anesthesiologist Relationship

Traditionally the surgeon's responsibility has been assimilated to that of the captain of a ship and this was the ruling doctrine to judge surgeons' behavior and liability in the OR, considering him or her responsable for those assistants under his or her supervision. The underlying root for many conflicts between surgeons and anesthesiologists is centered on who holds more power in the OR. This legal doctrine, a variation of the "borrowed servant doctrine" considers that during any surgical procedure the participating or active surgeon is liable for all actions performed in the course of the operation and by anyone in that place. In early stages, the surgeon was considered the owner of the patient and the anesthesiologist, one of his dependents [12].

The doctrine was coined in McConnel v. Williams, 361 Pa. 355, 65 A.2d 243, 246 (1949), in which the Supreme Court of Pennsylvania ruled "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...". This doctrine was popular for a long while and assimilated in other judicial systems. but its viability has diminished for several reasons. In "Truhitte v. French Hospital", 1982 128 Cal. App. 3d 332, 348, the Court explained that "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".

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." The effect of such rulings was that physicians were less likely to be held liable for the negligence of hospital employees and staff. Nowadays the surgeon requires collaboration from hospital employees and staff who are not dependent or employed by the physician. In this role, fits the figure of the anesthesiologist who also benefits from professional and scientific autonomy. The surgeons have no affirmative obligation to control the substantive course of the anesthetic process in hands of the anesthesiologist. Surgeons are not liable for the acts of an anesthesiologist, the courts will only examine the degree of control the surgeon exercised over the anesthesia administrador, bearing in mind the scientific autonomy of the last one.

But when the surgeon discovers a non employee negligence during the course of care delivery and fails to correct or otherwise prevent the adverse consequences of that negligent act, he or she can be held liable. In the OR, the surgeon should only supervise that the anesthesiologist does not abandon the patient or move away from the OR without being essentially covered.

There has been a change in the status and the role of the anesthesiologist, resulting in a gradual overstepping on the field of influence of a surgeon. Anesthesiologists provide the benefits of unconsciousness and sedation, analgesia, relaxation and more recently are trained to resuscitate a patient and provide life sustaining measures and/ or treatments so that the surgeon can perform his or her job. Since both are professionals, surgeon and anesthesiologist must work as a real team, working jointly during the pre, intra and postoperative stages. The target is to warrant the best quality of care, the highest patient safety level and the top outcomes. This shared activity demands a clear definition of roles and a mutual respect of competencies. If both figures need to be adequately trained in order to achieve competency and diligency, there is an implied ethical contract on both sides as professional individuals: they are competent to perform the duties they undertake in everyday OR activity with due care and skill. Anesthesia is a unique medical specialty, which has long been considered a "behind the screen" field with no direct patient relationship. The anesthesiologist provides care to a patient who primarily is referred by a surgeon in order to be under control during the surgical procedure. The anesthesiologist care lasts during the peroperative period, relatively short and after the immediate post procedure recovery, this relationship ceases and the the care is again supervised by the surgical team.

So, along with support staff, many times the inmediate postoperative patient's outcome depends on how well the surgeon and the anesthesiologist work together and go along with each other. Sound ethical practices in the OR are a must and this must be understood by all those involved in patient care.

Conflicts in the OR

The health care environment is particularly prone to conflicts, frequently and of severe potential many times. It is not surprising that conflicts occurs during the management of 50% to 78% of patients, 38% to 48% of these involved physician- physician conflicts [13,14]. The potential for interpersonal conflicts is especially heightened in the OR where a broad range of professionals perform their tasks with overlapping and many times, poorly defined areas of responsibility. Besides, the OR is the only area within a hospital where two co-equally leveraged physicians regularly and simultaneously share responsibility for one patient, and are mutually exclusive: one cannot perform his or her task without the other: the surgeon can not perform a surgery without anesthesia backup neither the anesthesiologist can put a patient to sleep if a surgeon is not ready to perform the case.

A conflict may be considered as a state of disagreement or disharmony between persons or ideas; a clash between opposite ideas or positions. It usually causes an emotional or mental disturbance among those individuals suffering the clash. The potential conflicts in the OR flourish not only between surgeons and anesthesiologists, but also between any of these two specialists and other OR personnel. In this last situation, the most frequent categories are: harassment and disruptive behaviour. The OR leadership should be particularly clear in the code of conduct to be followed and uncomprising in its correction. The implementation and enforcement of OR policies and rules require the cooperation and submission of all those envolved in patient care. Conflicts in the OR can compromise safe and effective surgical and anesthetic care, a successful conflict resolution will impact in better patient care and safety, improved quality and better outcomes.

The leading causes of conflict between the 2 professions include personal and cultural factors. Among the first, the following can be mentioned:

- Poor communication and poor communication skills
- Different personality traits. Personality traits commonly found in surgeons include perfectionsim and compulsiveness. Surgeons are many times perceived with negative connotations as dominating, cold, impersonal, impatient, aggresive, arrogant, authoritative, egotistical.
- Different values and beliefs
- Poor social interaction
- Lack of appreciation by the opposite field
- Staff shortage
- Different models or arrangements of salary and /or reimbursement

It should be emphasized the increasing severity of patients who undergo increasingly more complex and critically surgical procedures. This also brings to the field of conflicts, different views regarding: futility and appropiate versus inappropiate standard of care, DNR orders in the OR and advance directives [15]. The care of Jehovah's Witness patients also engenders further discussions.

OR cancellations and delays represents the most frequent Achilles heel. The incidence of cancellations due to anesthesia is around 2 to 14% of cases, but can reach 21.8% in a tertiary center [16]. The most common causes are: need for additional tests, shortage of blood, food intake, lack of assurance regarding adequate postoperative care (unavailability of Intensive Care Unit), need of preoperative additional consultations, absence of adequate equipment and poorly controlled systemic diseases.

Some simple measures to improve the relationship and prevent potential conflicts include:

- Agreement regardind the appropiateness of surgical patients' schedule. It is mandatory to work on an agreed-upon methodology for adequate scheduling of "difficult" patients or with comorbidities. When there is disagreement, it should be avoided to make this a personality conflict and a second opinion should be asked for.
- Start cases on time and prevent unduly delays, anesthesiologists should arrive early to get the patient ready and surgeons should not be late. The OR leadership must be proactive dealing with chronically late physicians, either anesthesiologists or surgeons
- Truthfulness regarding scheduling and being honest with respect to the duration of a procedure. Though there may be intraoperative and unpreventable complications, when a case should last 2 hours it should not take 4 or 5 hours, exception made of a hazard. It must also be taken into account the different settings: in academic practice, teaching and learning are mandatory for the surgical and anesthesia training programs while private practice differs considerably.
- Share and consult on decisions. Get the anesthesia team on board the surgical department: try to include anesthesiologists on important decisions such as introducing a new technology or a surgical innovation [17].

Whenever ethical conflicts arise in the OR, their resolution include a clear observance of the ethical principles, which have been described previously. The interprofessional relations bewteen a surgeon and his or her colleagues are very important to guarantee the highest surgical patient care. Team medicine has become the rule and surgeons have a responsibility and a duty to work appropiately with colleagues, starting with anesthesiologists.

The ethical performance of surgical procedures in an accredited setting mandates an environment in which all participants (patients, staff, colleagues, residents, students and all the other health care professionals) are treated with due tolerance and respect. Specially discrimination on any field (race, age, gender, sexual preferente, disability or religion) and harassment must be banned in the everyday activity and the report of such situations should be notified to the proper authorities in order to ensure measures of correction and/or punishment.

Conclusions

A list of 10 key elements to enhance a better surgeon/ anesthesiologist relationship in the OR which may profit patient safety and also useful for conflict prevention and resolution follows:

1. Awareness of the organizational culture in the institution is mandatory. Once you are known, you can introduce change and improvement, but always in a mannerly way.
2. Be helpful, nice and polite to people. Be cordial and easy to work with. Do more than what is expected from you.
3. Take work seriously, you make everyday decisions on other's life and wellbeing. Try to prevent errors and be gentle with others' ones.
4. Keep clear and precise communication, verbal and written. Be prompt replying to e-mails, whatsapps and text messages. Show courtesy to others
5. Do not treat your leadership as an adversary
6. Being reliable is a great asset!
7. Be flexible and do not get angry for others. Do not complain

for every detail not fulfilled. Stay one additional hour and get that assignement due on time

8. Teach your residents, as others have done with you
9. Getting critical feedback in the M & M conference is not a personal issue. Do not get angry or defensive: it will make you look less professional. Recognize your mistakes and do not be so stern on others'.
10. Be ethical to patients, to your colleagues and to the rest of the personnel and the society where you perform your practice

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