

Surgeon–Anesthesiologist Relationship for Patient Safety: Prospective Study



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Abstract: Differences in information, opinion, values, experience, and interests between a medical surgeon and an anesthesiologist resuscitator can occur when working in environments with high pressure such as operating rooms, which can trigger conflicts. The objective of our study is to assess the perceived causes that trigger their conflicts. **Materials and Methods:** This is a prospective observational study conducted within the operating theater department of the Military Instruction Hospital Mohammed V Rabat (HMIMV). **Results:** 41 anesthesiologists and 38 surgeons participated. Personal and organizational causes were the most common. For surgeons, the most frequent cause of the conflict was delayed anesthesia startup (71%) while anesthesiologists considered lack of communication the most important cause of conflict (82%). We noted that participants of all levels agree that lack of communication and personality traits are the most frequent causes of conflict in the operating room. **Conclusion:** The causes of conflicts between surgeons and anesthesiologists in our study are similar to those found in the literature. Clear guidelines about the most common causes of conflicts will reduce their frequency and allow them to be managed well.

Keywords: Causes, Conflict, Surgeon, Anesthesiologist, Operating Theatre.

I. INTRODUCTION

Conflicts between medical personnel in the hospital environment and care structures have been found in recent studies of the management of the burden of patients in fairly high proportions [1,2]. In hospital care structures, the operating room in particular remains one of the structures most conducive to conflicts between staff. It is the most complex and critical workplace, added to that the heavy workload [3] and the pressure of performance [4]. The objective of our study is to assess the perceived causes that trigger conflicts between surgeons and anesthesiologists, in particular, the predictors of these conflicts as they are mutually perceived by the two groups, their resolution, and the way of avoiding these conflicts.

II. MATERIALS AND METHODS:

This is a prospective observational study conducted within the operating theater department of the Military Instruction Hospital Mohammed V Rabat (HMIMV).

We included in our study All anaesthesiologists-resuscitators and surgeons working or having recently practiced at the HMIMV through an audit on the causes of conflicts in the operating room.

Our study was based on an online questionnaire. Surgeons and Anesthesiologist-Resuscitators were invited to all surgical departments and to the anesthesia-resuscitation center of the HMIMV. The document was put to them as an electronic link.

We had set a deadline of 10 days to receive responses beyond this period the link has been deactivated.

Data were entered and analyzed using the Excel program.

To probe the causes of conflicts the following data was collected:

- Personal information: age, sex, family situation, seniority, specialty, and status.
- Cause of conflict:
 1. Causes related to personnel.
 2. Causes related to the patient.
 3. Organizational causes.

III. RESULTS

The average age of the participants was 31.2 years with a clear male predominance at 81%; a sex ratio of 4.2. the distribution of participants according to the age group is shown in [Figure 1](#).



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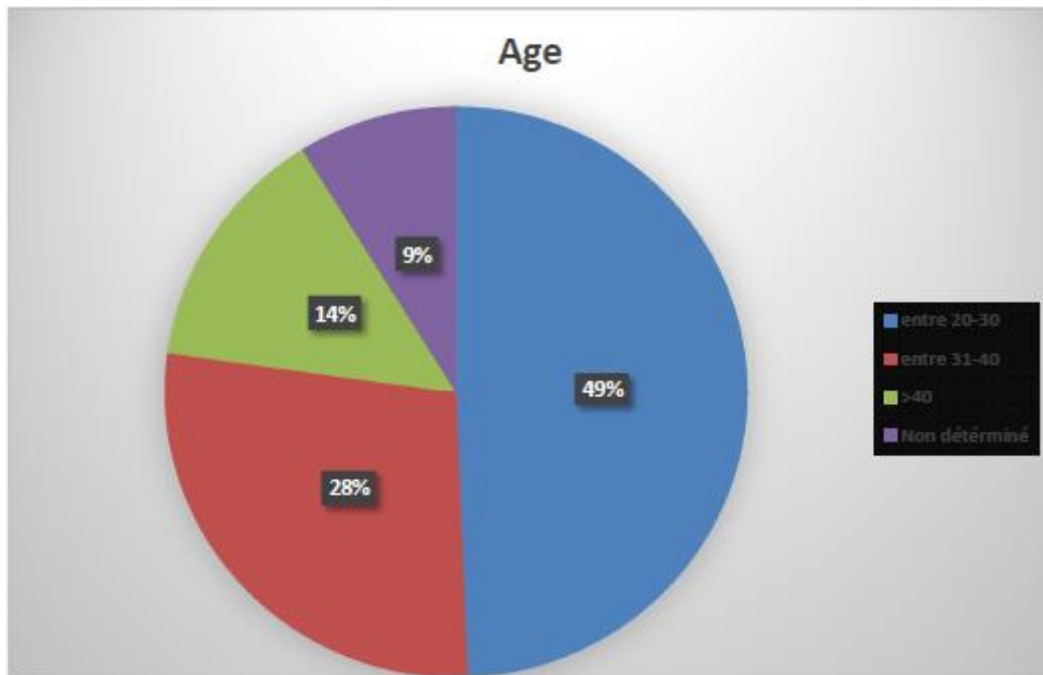


Figure 1: Distribution of Physicians by Age Group.

The number of anesthetist-resuscitators who had accepted to respond to our audit was slightly higher than the number of surgeons: 41 anesthetists (52%) versus 38 surgeons (48%). The distribution of participants according to their seniority is shown in (Figure 2).

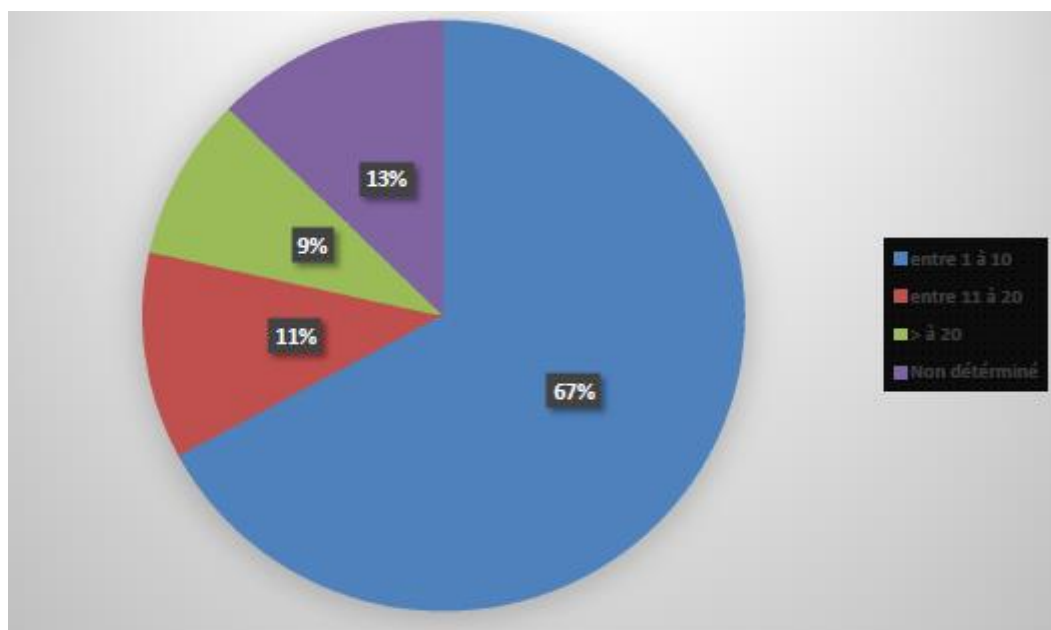


Figure 2: Distribution of Participants According to Their Seniority

The top three areas of potential causes of conflict were different between anesthetist-resuscitators and surgeons. Regarding the causes of staff-related conflicts: 60% of surgeons think that it is due to personality characteristics, while 82% of anesthetists-resuscitators who have participated in this audit think that it is linked to the lack of communication. The lack of appreciation is felt more by surgeons than anesthetist-resuscitators 39% VS 14%. On the other hand, surgeons were more likely to complain about the unavailability of the anesthetist in the operating room (52%). the delay in starting anesthesia (71%) and the failure to assess the patient in time by the anesthetist to inform the surgeon of the feasibility of anesthesia (65%) were

important causes of conflict. The anesthetist-resuscitators find that failure to comply with the instructions given to nursing staff in service is an important factor in the conflict (75%). Also programming and exceeding the operating time slot by the surgeon by 60% were significant conflict triggers. Concerning patient-related causes, both groups agree that ignorance by patients of the role of the anesthetist is a cause major for poor working relationships (47% of surgeons vs 48% of anesthetists).



Another patient-related factor is the patient's pressure on the surgeon who is a determining factor in conflicts from the point of view of 47% of surgeons. Participants of all statuses believe that the absence of communication and personality characteristics are the most conflict-inducing factors.

Other programming factors agreed upon by people of all statuses are the exceeding of the operating time slot by the surgeon, and the failure to assess the patient in time by the anesthesiologist to warn the surgeon of the feasibility of anesthesia (Figure 3).

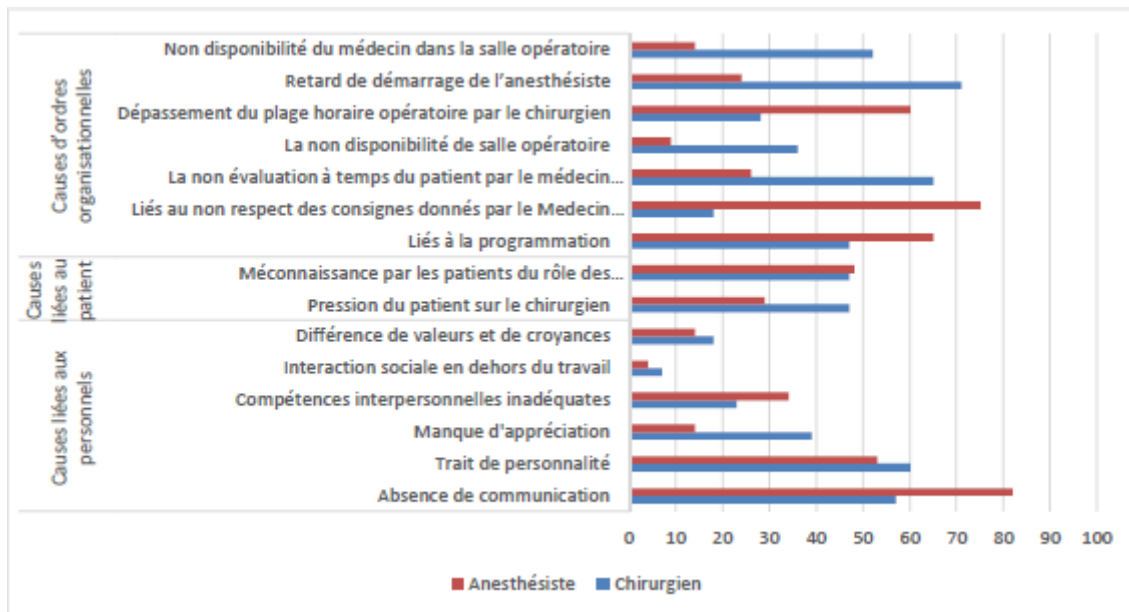


Figure 3: Causes of Conflicts Between Surgeon and Anesthetist According to Specialty

IV. DISCUSSION

Differences in information, opinion, values, experience, and interests between a medical surgeon and an anesthesiologist resuscitator can occur when working in environments with high pressure such as operating rooms, which can trigger conflicts [5], [6]. Conflicts can range from minor disagreements to clashes over personality and sometimes to physical confrontations [7]. The operating theater then becomes an unstable and conducive environment for conflicts between personnel which are likely to erupt at any time 38% [2] to 48% [8] of these conflicts occur between clinicians. Several studies have reported that at least 20% of the time of the medical staff was devoted to the management of these conflicts [2]. Almost all of the respondents to our study consider that there is an organizational or personal component to conflicts between surgeons and anesthesiologists, the patient-related component is not considered unanimously as one of the causes of conflicts, which is consistent with the results of the series of Shams and Al-Wadani. [9] Personal factors such as lack of communication and personality characteristics were frequently reported by anesthesiologists as well as by surgeons as influencing working relationships in our series and the series of Shams. Lack of appreciation is reported more by surgeons than anesthesiologists, and overall, this is not a major cause of conflict, unlike the series of Shams. Social interactions outside of work and differences in values and of beliefs pose less of a problem for our practitioners compared to those of the series of Shams.

In the present study, surgeons and anesthesiologists have points of completely different views about patient pressure on the surgeon: half of the surgeons compared to a few

anesthesiologists perceived significantly patient pressure as a major issue. This joins the results of the series of Shams and Al-Wadani [9]. On the other hand, most of our anesthesiologists and surgeons have felt that patients' lack of knowledge of the role of anesthesiologists in medical care is a concern. While in the series of Shams and Al-Wadani [9] found that only anesthesiologists found the ignorance of patients of the role of anesthesiologists as a potential cause of conflicts. Education of the individual patient and the general public is necessary [10]. In our study, factors related to the organization such as the unavailability of the doctor, the delay in starting anesthesia, and the patient's non-evaluation in time by the anesthesiologist were identified by surgeons as major causes of conflicts and poor working relationships, while exceeding the scheduled operating time slot, conflicts related to the scheduling of operations, non-compliance with the anesthesiologist's instructions were the most frequently reported causes of conflicts by anesthesiologists. This partly agrees with Shams' series [9]. Although in their series, surgeons more than anesthesiologists consider conflicts linked to programming to be very frequent. Our results could be explained by the personality characteristics of the surgeons, often described as dominant and centralized in making decisions [2]. Numerous studies assessing the problem of operating room cancellations have indicated that anesthesia-related incidence is 2-14% of cases but could be as high as 21.8% in a tertiary care setting; the most common cause is patient safety, for example, poorly controlled systemic diseases [11], [12].

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Cancellations can reach up to 18.2%, mainly due to unplanned procedures and the overbooking of operating rooms [13].

Ideally: the surgeon and the anesthesiologist should work in perfect harmony, setting aside their personal needs for safety and patient well-being. Surgeons and anesthesiologists need to better understand the demands and constraints on their professionals' respective goals, both for patients in general and for any other patient. This should be done sufficiently in advance to allow time for

for these concerns to be addressed. Everyone would be open and encouraging to hear perceptions and opinions of the other, even when it seems to encroach on his own areas of expertise [14].

V. CONCLUSION

the present study has identified numerous causes that are perceived to contribute significantly to conflict and disrupted working relationships between surgeons and anesthesiologists. Some of these causes were the same for participants in both groups, such as the absence of communication, personality characteristics, and causes related to surgical programming. Clear guidelines about the most common causes of conflicts will reduce their frequency and allow them to be managed well.

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