Conflict and its resolution in the operating room

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Abstract The operating room is a high-stress and volatile workplace where interpersonal conflict can be frequent and at times intense. This article explores some of the common sources of conflict and suggests some remedies.

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1. Introduction

The best general is the one who never fights.

The Art of War
Sun Tzu circa 500 BC

Good commanders never come to an engagement unless they are compelled to by absolute necessity.

The Art of War
Niccolo Machiavelli AD 1521

Conflict1 underlies many interpersonal interactions and group decisions [1]. Several characteristics of the health care environment make it especially susceptible to frequent and potentially intense conflict. Working closely in this setting are a number of highly educated and experienced professionals, optimally all sharing one goal—patient care—but each having a distinct role and responsibility. These individuals bring their unique educational background and differing perspectives to their clinical duties. They frequently hold different personal value systems with widely divergent opinions regarding the type of care to be provided and ultimate patient disposition. Commonly, each are working under different arrangements for reimbursement. In this context, it is not surprising that conflict occurs during the management of 50% [2] to 78% [3] of patients. Thirty-eight percent [2] to 48% [3] of these involved clinician-clinician conflicts. In one study, at least 20% of physician executives’ time is spent dealing with conflict [4].

The potential for interpersonal conflict is especially heightened in the operating room (OR), where a broad range of professionals (physicians, nurses, technicians) have overlapping and, in many cases, poorly delineated areas of responsibility. For example, the OR is the only location within a hospital where two coequal physicians regularly and simultaneously share responsibility for one patient. Decisions involving life and death are routine, and wrong decisions resulting in adverse outcomes are subjected to intense scrutiny and retrospective analysis. Sleep deprivation [5] and production pressure [6] add to what is already a stressful and volatile work environment.
2. Sources of conflict

Conflict can occur between physicians and patients, physicians and families, physicians and nurses, and physicians and physicians. Conflict occurs on a continuum, ranging from minor disagreements and differences of opinion, to personality clashes, to blatant hostility including physical confrontations. In addition to the level of intensity, conflict can be categorized according to duration: acute, subacute, chronic, and interminable.

Differences of opinion are predictably common in complex, high-stakes, high-pressure work environments such as intensive care units [3,7,8], emergency departments [9], and ORs [10]. In these complex and stressful workplaces, interpersonal conflict can emerge from differences in information, values and beliefs, experience, roles, interests, and goals [11].

Incorrect, inadequate, or poorly communicated information is a frequent source of misunderstanding among OR personnel. Breakdowns in communication are among the most common key factors leading to conflict among staff members [12]. Poor communication can readily lead to compromised patient safety [13] and has been identified as a root cause of 35% of anesthesia-related, sentinel events [14]. This most frequently occurs when only one member of the team has access to key bits of data, such as a preoperative laboratory test or consultation. Even when all have access to the same data, different individuals may have different perceptions of the significance, based on their professional experience and role expectations. For example, evaluations of abnormal clotting factors can elicit differing opinions of the appropriate course of action between surgeons and anesthesiologists.

Conflicts arising from role expectations are especially prevalent in intensive care areas of the hospital such as the OR. In most units of a health care facility, there is a well-established pattern of hierarchical decision making, with the attending physician at the apex of the hierarchy. However, this hierarchy is blurred in the OR, where clinical decisions are particularly complex and each of the team members may act as the final authority at various times and in various circumstances [15]. Personality traits commonly found among surgeons and anesthesiologists, such as perfectionism, compulsiveness, and reliance on scientific evidence can make it more difficult for these physicians to acknowledge others’ expertise and to relinquish control [16-18].

A number of ethical conflicts can emerge in the perioperative period, including disagreements involving informed consent [19], do-not-resuscitate orders, or other directives that limit treatment [20], medical futility [21], and end-of-life care [22]. These are particularly problematic because they are invariably complex and involve deeply held moral values for all of the parties involved. In recognition of the growing frequency and intricacy of ethical dilemmas inherent in medical practice, the Accreditation Council for Graduate Medical Education (ACGME) has mandated that all accredited residency programs provide instruction in the ethics of medicine and require demonstration of adherence to ethical principles by their trainees [23]. The ASA has published the *Guidelines for the Ethical Practice of Anesthesiology* and the *Model Curriculum on Ethics* to assist the practicing anesthesiologist in resolving some of these issues [24].

Conflicts of interest are a special category in which research, financial, or other incentives compete with the primary obligation for patient care [25]. One common example of a clinically important conflict of interest may occur when a physician is paid to recruit patients into a study of a product or medical device. When a financial relationship exists with a pharmaceutical company, physicians are less likely to evaluate objectively the safety or efficacy of their product [26]. There are currently no universally accepted guidelines that require disclosure to patients of any competing incentives that may influence their physician’s decision making [27,28].

3. Consequences of unresolved conflict

There are both indirect and direct costs of inadequately resolved conflict. Indirect costs include negative publicity and media coverage, decreased morale, increased disability and worker’s compensation claims, increased turnover, and diversion of limited and valuable resources to dispute resolution, including legal remedies [29,30]. Conflict can exceed incompetence as the instigating event for malpractice claims [31].

Among the important direct consequences of inadequate conflict resolution is an impediment to communication between the involved parties. The need for accurate communication among team members is well recognized in a number of safety-critical industries [32]. The aviation industry in particular, for more than 25 years, has devoted considerable effort toward improving safety through crew resource management that focuses on human factors, such as team coordination and communication [33,34].

Despite the well-documented and dominant role played by poor communication in the occurrence of preventable medical errors, the health care industry has been slow to develop institutional remedies to correct this situation. Howard et al [35] demonstrated the value of teaching anesthesia crisis resource management (analogous to crew resource management) to anesthesiology residents. A 2001 report on preventable medical errors by the Institute of Medicine recommended the development of interdisciplinary team training programs for health care workers that were modeled after those already in use in the aviation industry [36]. More recently, a major reform program geared toward improving patient safety in the Canadian health system singled out information and communication processes as one of the 4 major elements requiring...
improvement [37]. Finally, the ACGME has mandated that
effective communication is one of the 6 core competencies
that must be demonstrated for successful completion of
residency [23].

Probably the most pernicious effect of inadequate
conflict resolution is its corrosive effect on professional
relationships and teamwork necessary for good patient care.
The ability of a group of professionals to work effectively as
a team is a complex process that relies heavily on such
group dynamics as group composition, cultural value
reconciliation, and group cohesion [38]. Successful conflict
resolution has been identified as one of 6 components of
effective teamwork [32].

In the opinion of many anesthesiologists, interpersonal
interactions and conflict constitute the most challenging and
stressful aspects of their job [39]. Conflict in the OR can
contribute significantly to stress and hinder safe and
effective anesthetic care [10].

4. Conflict resolution

Five general mechanisms are commonly used in conflict
resolution: avoidance (or inaction), yielding (or accommo-
dation), collaboration (or integration), compromise, and
competition (or contention) (Table 1) [1,4,40-43]. It is
unlikely that conflict can consistently be avoided in the
OR. Yielding completely can be a valid response when the
conflict is trivial or the individual is not a primary party to
the conflict. Yielding is appropriate when one is aware that
he or she is in error or, for other reasons, will lose in debate
on the issues at hand. Collaboration focuses on achieving
goals rather than meeting demands and is often referred to
as “win-win.” It is the most time-consuming of the
approaches but in return increases the possibility of
sustainable change. Compromise is a backup strategy in
the instance that collaboration has not yet succeeded. In
compromise, both sides make trade-offs with the intention
of equally inflicting pain and gain. In competition, conflict
is viewed as a contest to be either won or lost, and the
individual wants to assure that his or her position prevails.
Competition is appropriate when the issue is of great
importance and the other party is not amenable to any of
the more conciliatory approaches. Competition runs the
risk of further damaging the relationship of the parties
and undermining the actions needed to implement the final
decision.

A few steps specific to the health care environment follow (Table 2):

A. Institutional planning

1. Establish an institution-wide conflict management
program. This will require a concerted organiza-
tional commitment.
2. Build a culture that welcomes the resolution of
normal personal and organizational conflicts. This
must be endorsed by the medical, administrative,
and executive leaders and must be supported
organization-wide.
3. Foster group cohesion. Group cohesion is the
social glue that binds members of a group. Most
successful team ventures, such as spaceflight and
the military, place a high premium on group
processes [38].

B. Personal conduct

1. Anticipate conflict. As previously stated, conflict
is commonplace in the OR.
2. Develop good communication skills. Poor com-
munication is the greatest source of intrateam
conflict [12]. Effective communication requires
that each participant speak clearly, listen careful-
ly, and receive feedback constructively.
3. Accurately identify the precise source of the
conflict. Collect an accurate history of the events
leading up to the conflict. Know who are the
primary players and other stakeholders. This is
frequently the crucial step in understanding and
resolving conflict. In many cases, the emotional
and personal aspects are as important as the facts.

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<td>Application</td>
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<td>Inconsequential disagreement</td>
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<td>Yielding</td>
<td>Own position is wrong</td>
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<tr>
<td>Collaboration</td>
<td>Focus on goals, “win-win”</td>
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<td>Compromise</td>
<td>Unable to reach collaborative agreement</td>
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<tr>
<td>Competition</td>
<td>Issue of great importance, no conciliation possible</td>
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| 8. If confrontation with a colleague is necessary, it should be
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| 9. Have a low threshold for intervention by a third party. |
| 10. If conflict is ultimately irreconcilable, transfer patient care
to an uninvolved colleague. |
It is crucial that this is realized and addressed at the outset.
4. Establish rules of conduct. Disagreements and conflict are to be expected. It is important to separate the individuals and personalities from the problems [41]. Accusations, however accurate, are best avoided.
5. Find a nonjudgmental starting point for the discussion. This requires each party to widen his or her perspective to include all pertinent factors.
6. Establish unambiguous shared standards and common goals. One of the distinctive characteristics of conflict in the OR is the broad diversity of the participants who provide patient care in that setting. Surgeons, anesthetists, nurses, circulating nurses, scrub technicians, and many other health care professionals each has his or her own vantage point on the optimal solution to a clinical problem. In many cases, conflicts arise because the various parties are unaware of the guidelines and protocols that dictate standard practice to their colleagues. All share one common overriding goal, the provision of safe care to the patient. The reaffirmation of the common goal of patient care and the recognition of the legitimate differences in approach frequently go a long way toward reconciling those differences and finding a mutually acceptable answer to the problem at hand.
7. Recognize shared frustrations resulting from inefficiencies within the “system.” Recognition encourages collaboration to resolve the problems.
8. If confrontation with a colleague is necessary, it should be conducted in a private setting. Public confrontations are generally unproductive and too frequently escalate to loud voices and altercations. As best stated by Dale Carnegie [44], “You can’t win an argument. You can’t because if you lose it, you lose it; and if you win it, you lose it.”
9. Have a low threshold for intervention by a third party. This can be a colleague, a consultation from a different specialty (eg, an ethics consultation) [45], or a neutral mediator. This third view can help to depersonalize the issues, defuse tensions, and find innovative solutions [45-47].
10. If conflict is ultimately irreconcilable, the care of the patient should be transferred to colleagues who can address the problems unencumbered by the baggage of the preexisting dispute.

5. Conflict in the operating room

5.1. The “captain of the ship”

A 36-year-old, 100-kg, 158-cm woman has had intermittent abdominal pain for 4 days. In the past 24 hours, the pain has become more intense and persistent, has localized to the right upper quadrant, and has been accompanied by nausea and vomiting. She last ate three hours before arriving in the emergency department.

The general surgeon has made a preliminary diagnosis of acute cholecystitis and feels that surgery should be performed on an emergency basis. The anesthesiologist prefers to delay the surgery for an additional 5 hours. The surgeon asserts that despite the anesthesiologist’s misgivings, surgery should proceed, and that she “is ultimately responsible.”

At the root of many anesthesiologist-surgeon conflicts is the archaic doctrine of the “captain of the ship.” This concept held that the mere presence of the surgeon in the OR subjects him or her to legal liability for any negligent acts involving the patient in that room. The doctrine first appeared in the late 1940s as a result of the then applicable “charitable immunity” doctrine, which prohibited injured patients from suing hospitals. When the charitable immunity doctrine lost credibility in the 1970s, the captain of the ship doctrine soon followed. Most state supreme courts have subsequently taken an explicit position against the captain-of-the-ship doctrine [48].

Nevertheless, remnants of this policy remain intact in the form of “vicarious liability.” This legal doctrine can be invoked if it is demonstrated that the surgeon controlled the actions of the anesthesia care provider. This situation exists when the surgeon is medically directing a nurse or a technician who is administering the anesthetic or when the surgeon dictates the choice or conduct of anesthesia to an anesthesiologist or other licensed, independent practitioner [49].

As is the case in many potential sources of conflict, this situation is best managed by anticipating its occurrence and having clearly articulated policies and procedures in place before the event. The availability of a well-defined nil per os (NPO) policy is important. It will help to identify the established standards and delineate the overlapping areas of responsibility and liability. In many cases, once surgeons are aware of their personal medicolegal exposure, if they were to insist on overriding a written NPO policy, they would be less likely to ignore it and be more inclined toward finding a collaborative solution. The NPO policy should also include those circumstances under which it can be circumvented. In this hypothetical scenario, compromise (allowing for a total of 6 hours of fasting) may be the optimal solution, allowing for both surgeon and anesthesiologist to acknowledge the mitigating circumstances driving the other’s decision. This resolution crystallizes the shared responsibility of overall patient safety and will offer the safest and most effective outcome.

5.2. This case is cancelled!

A 72-year-old, 109-kg, 178-cm man is admitted at 6:30 AM for a total knee replacement that is scheduled for 7:30 AM. He is diabetic and provides a vague history of heart disease, believing that he had a myocardial infarction
6 months earlier, but for which he was not hospitalized. He complains of frequent bouts of heartburn, as recently as earlier on the morning of the scheduled surgery, which resolved spontaneously.

The patient last saw his internist three months ago but is unaware of any significant findings during that visit. The surgeon has been in verbal communication with the internist and was advised that the patient is “cleared for surgery.” The internist’s office will not open for another two hours.

Cancellation or, more accurately, postponement of a surgical procedure for additional evaluation and treatment is among the most frequent sources of conflict between an anesthesiologist and a surgeon. The extent of the preoperative assessment has become something of a moving target in recent years, as pressures for cost control have forced all health care providers to streamline their practices. In many cases, surgical and anesthetic opinions differ as to the optimal preoperative screening for a specific surgical procedure. Even the various national associations of anesthesiologists are unable completely to agree on the indications for and timing of preoperative testing [50]. However, most agree that a thorough preanesthetic assessment will usually identify existing medical conditions and potential anesthetic risk, allow for planning of anesthetic care, and go a long way toward avoiding last-minute decisions and conflict [3,51]. It is helpful if the institution has its own unambiguous grid for recommended preoperative screening studies as a function of patients’ demographics, medical condition, and surgical procedure.

There is no substitute for obtaining all of the necessary information about a patient’s current medical condition. Optimally, both physicians can come to an informed understanding of the fundamental patient safety issues involved and agree to a postponement until the complete medical history is available. Alternatively, if the surgeon has thoroughly discussed and understands the patient’s condition and is willing to document it in detail in the medical record, the anesthesiologist may choose to proceed based on that collaborative solution.

5.3. Resident-attending conflict

A 17-year-old woman is scheduled for knee arthroscopy as an outpatient. The orthopedic surgeon prefers spinal anesthesia, and the attending anesthesiologist has concurred. During the preoperative interview with the patient and her mother, the anesthesiology resident determines that the patient is terrified of several aspects of the planned anesthetic and expresses preference for general anesthesia.

The relationship between a trainee and the attending physician is complex and replete with reciprocal obligations and responsibilities. The attending physician bears the ultimate legal responsibility for the welfare of the patient, but the resident physician is frequently more familiar with minute-by-minute decisions and management [52].

When conflicts arise, a healthy attending-trainee working relationship will exploit the relative strengths of each member of the team and foster a collaborative approach to clinical decision making. When this relationship does not exist, it is most common that the trainee will acquiesce to the demands of the attending, even in the face of strongly held values to the contrary, rather than pursue more confrontational approaches [52,53]. Ultimately, the trainee is disadvantaged by his or her perception (valid or not) of his or her own competence and by his or her reliance on the attending for continued education and support in future job applications [53,54].

5.4. The disruptive physician

A 53-year-old woman requires urgent reduction and repair of an incarcerated femoral hernia. Her surgeon schedules the case by telephone with the OR staff and then arrives to prepare for the procedure.

The surgeon is immediately confronted by the attending anesthesiologist who is enraged because (1) the case was not directly discussed with him, (2) he has other concurrent responsibilities that will conflict with this procedure, and (3) the surgeon frequently takes longer to do a procedure than what has been scheduled. The disagreement rapidly degenerates into a shouting match that is witnessed by the patient as she is being wheeled into the OR area.

The AMA defines disruptive behavior as “personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively.” Disruptive behavior usually takes the form of (1) threatening or abusive language, (2) degrading or demeaning comments, (3) profanity or other grossly offensive language, (4) threatening or intimidating physical contact, (5) public derogatory comments about quality of care, (6) inappropriate entries into medical records, and (7) idiosyncratic requirements imposed on staff that are unrelated to improved patient care [55]. Many of these behaviors are unfortunately familiar to those who work in an OR [56,57].

If uninterrupted, such behavior fosters an unhealthy and dysfunctional work environment, with poor morale and high staff turnover [58]. The quality of patient care invariably suffers, and the health care facility is vulnerable to decreased revenues, heightened financial risk, and potential litigation.

Disruptive behavior is now considered as a form of physician impairment, on a par with substance dependency. The thorny problems posed by disruptive physicians, which were swept under the rug until recently, are increasingly being acknowledged and openly discussed [58,59]. Many, if not most, health care facilities have developed policies and procedures that objectively address the issue of disruptive physicians [55]. However, even under the best of circum-

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stances, confronting a disruptive physician is time-consuming and can be costly for hospital administrators.

Dealing with a disruptive physician in the OR is particularly challenging. The very nature of this physician’s pathology renders futile all reasonable attempts at conflict resolution. The best that can be achieved at the moment of conflict is either avoidance (in this case, finding another anesthesiologist who is prepared to administer the anesthesia) or some form of compromise (consistent with patient safety). Ultimately, this confrontation and other similar events must be discussed in open forum with the responsible department and institutional leaders.

6. Conclusion

Conflict is common in the OR. Successful conflict resolution is an important component of the teamwork necessary for good patient care [32,38]. Resolution of conflict requires mutual respect among teammates, careful listening, adherence to the issues, recognition of differences, and acknowledgment of the emotional aspects of the disagreement. It is a skill that can be learned [13,15]. Conflict that is satisfactorily resolved can be therapeutic for the involved parties and is an important component of good patient care [46].

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