Dealing with inappropriate surgical behaviour

By L.E. and F.A. Rozovsky

Perhaps nothing was going the way the surgeon had planned it. Maybe he had fought with his spouse or a colleague. The bottom line was that the surgeon was in a foul mood, snapping at nursing staff in the operating room. At one point the surgeon became so outraged with the scrub nurse that instead of handing back an instrument to her, he flung it over his shoulder. The scalpel narrowly missed striking a nurse entering the operating room. The nurse "told off" the doctor and he stifled his rage. That was the end of the episode. No reports were filed. No supervisors were informed of the occurrence.

Although the facts may be slightly different, the scenario is sadly familiar to many operating room nurses. Should they grin and "bear it" or should they "fight back?" If they fight back, how should they proceed?

Legal duty

Nurses have a legal duty of care to patients as well as to their employer. If they know or should know of hazardous, abhorrent behaviour on the part of a surgeon, they should report it. The failure to do so might constitute substandard practice. If harm did result from the failure to report, the stage would be set for negligence litigation.

Why action rarely taken

Without some type of guarantee that reporting such episodes will not result in job action, nurses feel uncomfortable notifying supervisors. There is also the fear that despite "job protection," the reported surgeon will make life unbearable for those who take such action. Some nurses also feel that it is up to the surgeon's medical colleagues and not nursing to redress wrongful behaviour. Still others believe that it is useless to make such reports because surgeons are so influential in hospital circles that nothing more than a "slap on the wrist" can be expected. For those who share this belief, it is not worth the hassle to report inappropriate conduct.

The absence of job protection is by far the most serious stumbling block. It is an issue that should be addressed in nursing and hospital management policy and procedure. The medical staff and the hospital board must also be prepared to support a programme which may mean severe sanctions for unruly surgeons.

Where to start

The first step is to determine what procedures and reporting channels are in place to facilitate proper communication of unacceptable behaviour. This requires a total systems review for nursing, medicine, surgery and management. If inadequacies are found, corrective action is in order.

The second step is to review existing nursing contracts and collective agreements to determine if job protections are in place. Job actions should be prohibited unless a nurse makes a report that is malicious or in bad faith with a view toward jeopardizing a surgeon's staff privileges. If protections are not in place, corrective action will be required.

The third task is to deal with agency nurses.

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Some nurses do not work for hospitals but for agencies which supply nursing personnel. If unacceptable situations involve agency nurses, it must be clear that reports are filed with the agency as well as the health care facility. This is a matter which must be addressed as part of contractual arrangements and orientation for agency personnel.

The fourth measure is to put in place a fair, detailed investigatory process. Both sides of a situation must be carefully examined. The principles of natural justice must be observed. This includes the right to a fair hearing, an opportunity to confront accusers, and to have a fair impartial determination.

Fifth, the health facility must have established disciplinary responses it can use when surgeons do act inappropriately. This may include warnings, sanctions, suspensions of privileges or total removal from the medical staff. From the hospital board's perspective, this necessitates careful documentation and evidence to substantiate severe disciplinary action. Operating room nurses who witness scalpel-throwing or similar incidents must be prepared to give written and verbal evidence at privileges proceedings. Without such evidence, the board may be on shaky ground in curtailing or removing a physician's surgical privileges.

Finally, provision should be made for reporting serious infractions to the provincial medical disciplinary body. The surgeon who acts out may be suffering from stress or other problems. The scalpel-throwing may be part of a much broader picture. Viewed in isolation, a hospital may remove privileges. However, if a professional disciplinary body sees a pattern emerge involving one surgeon working in different facilities, more sweeping action may be warranted.

Management refuses to act

Reporting unacceptable behaviour and scalpel-throwing incidents may not be well-accepted by nursing supervisory personnel. Trained in an era when it was not customary to "rock the boat," they may prefer to avoid contentious situations. For the O.R. nurse who was the potential "victim" of a flying scalpel, there may not be any inhibitions on reporting. The real challenge involves the options open to an operating room nurse whose supervisor refuses to take action.

To suggest that staff nurses do an "end round" and go over the head of their supervisors may undermine the latter's authority and credibility. However, management of inappropriate conduct on the part of surgeons should not depend on verbal reports to nursing supervisory personnel.

While a reporting system should include verbal reports to supervisors, it is equally important that written reports be completed and forwarded to administration and the medical director. This is a step which should be taken whether or not a supervisor dislikes "rocking the boat." It means that valuable professional performance information is relayed to senior administrative and medical management who, in turn, are then alerted and prepared to take appropriate action.

Documenting the incident

Effective communication depends upon prompt and accurate reporting and recording information. Those responsible for managing unacceptable behaviour need clear, concise reports which describe the circumstances of the episode.

Personal attacks, suspicions, and conjecture are of little use and may be construed as defamatory remarks. However, the names of witnesses should be included so that senior administrative and medical management personnel can interview them about the occurrence of the incident.

To ensure accurate reporting, several steps should be considered:

1. Teaching personnel how to "write up" incidents involving unacceptable behaviour on the part of professional staff. This can be done in orientation and in-service education.

2. Reports should be written in a timely manner. The longer the time frame between the event and the writing of the report, the greater the likelihood that important facts may be overlooked. It is unrealistic to suggest that there will always be instant recording of events.

Nursing staff may not have time during a hectic schedule to stop and complete a report. However, unreasonable delays of hours or days should be explained in the report. This is important to avoid the suggestions that well after the event the nurse decided to "get" the surgeon.

3. First hand reporting is important. Although a report written up by one nurse on behalf of another

may be quite accurate, it may be viewed as "hearsay" information. To overcome this obstacle to accurate reporting, it is best to insist upon first hand accounts of what transpired in the operating room.

4. All reports should be signed by the individual making such reports. The time and date of the report should also be included.

On the cutting edge

Most hospitals are not going to "jump" at the idea of a reporting system which identifies inappropriate behaviour on the part of surgeons. It smacks of confrontation, an aspect of management most people are inclined to avoid. This is unfortunate since scalpel-throwing is as important as pathology and tissue findings in professional performance appraisals. Both reflect surgical judgement.

One may give impetus to a reporting system to report scalpel-throwing and similar outbursts to the nursing union representative. Since the surgeon's behaviour is making working conditions quite unacceptable, the stage is set for a grievance. Although this may be a backdoor approach to professional disciplinary action, it is likely to be very effective in getting management to take action.

Conclusion

This approach to managing unacceptable behaviour is not likely to be adopted overnight. It takes time to evaluate reporting structures, to train personnel how to make reports, and to teach medical advisory committees, senior management and the board how to handle such information. Physicians joining the medical staff must understand that scalpel-throwing and similar behaviour is grounds for privileges action. For the welfare of everyone concerned, it is up to operating room nurses to insist on such an approach. ■

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Identifying anaesthetic risks in pregnant surgical patients

By Janet Nelles, R.N., B.Sc.N.

The expectant arrival of a newborn is often the most exciting time a family can enjoy. However, pregnancy can precipitate medical conditions necessitating surgery. Trauma cannot be excluded simply because pregnancy exists. Literature suggests that approximately 0.2% to 2% of North American women will undergo surgery for conditions unrelated to their pregnancy. [2,4]

Women of childbearing age are increasingly remaining in the workforce and continue to work until the final stages of pregnancy. The continuing trend for women to assume employment responsibility traditionally held by men, increases the risk for trauma during pregnancy.[1]

This paper will examine special considerations for the pregnant surgical patient, focusing on aspects prior to labour and delivery. The pregnant woman presents the surgical team with special considerations not only for the well-being of maternal health but fetal health as well.

Maternal considerations

A number of conditions may be found during pregnancy requiring surgical intervention; however a few conditions occur more commonly than others. Ovarian cysts is the most common condition necessitating surgery and has been estimated to occur at rates up to 1:2,500 pregnancies.[9]

Acute appendicitis, occurring at a rate of 0.07%, is another more frequent surgical condition. Other medical conditions that may require surgery are:

- intestinal obstruction
- aneurysm, intracranial tumour
- incompetent cervix
- cholecystitis (inflammation of the gallbladder)
- ulcerative colitis
- nephrolithiasis (calculi in the kidney)
- hyperparathyroidism
- pheochromocytoma (cellular tumor of the sympatho-adrenal system)

What presents to the anaesthetist particular concern over the non-pregnant woman? Pregnant women have a number of changing dynamics occurring within. The anaesthetist not only must consider these dimensions but also the developing fetus.

Changes occurring, from the maternal aspect, cover a variety of systems. The gastrointestinal system poses a difficult problem for anaesthesists, particularly for intubation. Due to the expanding uterus, gastrointestinal contents are pushed upwards and are bounded by an increasingly smaller spacial area. The result is for the stomach to eventually assume a horizontal position, with the pylorus displaced upward and posteriorly. This leads to gastric contents being left longer in the stomach.

Research has found that gastric emptying time of a watery meal can be prolonged by approximately 60%, from week 34 onward.[9] Thus, surgically this patient is not a good anaesthetic risk simply because of aspiration and regurgitation factors impinging on intubation.

Muscle relaxants given to enhance intubation efforts multiply risks involved by relaxing protective reflexes, increasing intra-abdominal pressure and relaxing the cricopharyngeal sphincter.[9] This small fact can potentially create long-term effects for the mother, and perhaps death. Studies have shown that as little as 25 ml gastric juice with pH less than 2.5 introduced to the lungs can cause aspiration pneumonia.[8] To reduce this risk, cricoid pressure, which