SPECIAL ARTICLE

Critical Role of the Surgeon–Anesthesiologist Relationship for Patient Safety

Jeffrey B Cooper, PhD

Teamwork is now recognized as important for safe, high-quality perioperative care. The relationship in each surgeon–anesthesiologist dyad is perhaps the most critical element of overall team performance. A well-functioning relationship is conducive to safe, effective care. A dysfunctional relationship can promote unsafe conditions and contribute to an adverse outcome. Yet, there is little research about this relationship, about what works well or not well, what can be done to optimize it. This article explores functional and dysfunctional aspects of the relationship, identifies some negative stereotypes each profession has of the other and calls for research to better characterize and understand how to improve working relationships. Suggestions are given for what an ideal relationship might be and actions that surgeons and anesthesiologists can take to improve how they work together. The goal is safer care for patients, and more joy and meaning in work for surgeons and anesthesiologists. (J Am Coll Surg 2018;■:1–5. Copyright © 2018, the American Society of Anesthesiologists, Inc. Wolters Kluwer Health, Inc. All Rights Reserved.)

TEAMWORK among the members of the operating room team is one of the most critical elements in perioperative patient safety. Yet, it may be that the greatest portion of the variance for the effect of team performance on outcomes and safety is associated with one dyad in the team: the relationship between the surgeon and the anesthesiologist. My hypothesis derives from personal observation, informed by the work of Diana McLain-Smith, who has identified the relationship between dyads in teams as essential to their success or failure.[1] If it is true that leadership dyads are *a* or *the* key element in safety, quality, and/or effective function of operating room teams, then the dyad of the surgeon and the anesthesiologist is the dyad we should seek to understand and optimize.

I can find little research about this relationship in the literature. How do anesthesiologists and surgeons view each other? What do they expect of each other? Do their values differ and if so, in what ways and how might that affect their ability to make the best decisions for a patient? How does their effectiveness as a dyad in the larger team impact the function of that team? When the going gets tough, what is it about that relationship that will contribute to success or failure? And, if the relationship is critical to safety (patient and caregiver) and it is sometimes or often dysfunctional, what can be done to improve its performance?

I believe that greater understanding of the dynamics of the surgeon–anesthesiologist relationship will lead to interventions that will improve it and have the effect of increasing patient safety and the quality of perioperative care. To that end, I address the questions previously noted and suggest actions to work toward making the relationship optimally effective whenever this dyad is at work. The triad relationship of surgeon–nurse–anesthesiologist and others are also critical to ensure safety, effectiveness, and quality. Yet, the dynamic between the two physicians who sometimes share, yield, or compete for leadership has a power to enable or thwart success that may transcend that of the other dyads or multiple, simultaneous interactions.

WHAT DO WE KNOW ABOUT THE SURGEON–ANESTHESIOLOGIST RELATIONSHIP?

In this context, "relationship" is about how well two people get along, how much they respect and trust each

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other and each other's opinion, how much they rely on each other for advice, how likely they are to keep each other informed of actions impacting their dyadic partner. There is literature that speaks to some empirical aspects of the surgeon–anesthesiologist relationship.[2-6] Communication and conflict have been examined and suggestions given for addressing both.

Conflict in the operating room between individuals—mostly between the anesthesiologist and surgeon—is a significant concern and has been experienced or witnessed by almost everyone who works in an operating room. While conflict related to professional decisions is to be expected and healthy if managed well, personal conflict is not healthy and never in the best interest of the patient. Due to the vagaries of work and of human beings, conflicts can arise even when there is a generally healthy relationship between the parties. Often it may be a visible and potentially destructive manifestation of a suboptimal or toxic relationship. Whether the conflict is problematic depends on how it arises and then how the individuals manage it. Too often, that is not done well.

The duration of the surgeon–anesthesiologist relationships is variable—sometimes the individuals have only just met; other times they have worked together for a long time. Familiarity sometimes provides shared trust that helps to defuse conflict; other times it forms an entrenched dysfunctional relationship and distrust.

Some aspects of communication, perceptions of roles, differing mental models, the tone set for enabling speaking up, and related issues have been addressed in numerous studies, most notably by Lingard *et al.*,[2,3] and also by others.[6-9] In none of these articles is there an emphasis on understanding of the roots of the surgeon–anesthesiologist dyad functionality and dysfunctionality or how to improve it.

Unfortunately, little is written about effective relationships in health care, especially exemplars of good working relationships, which are more likely to be common in some settings than in others. There is reason to believe that these contribute greatly to quality, safety, and efficiency.

PERSONAL OBSERVATIONS

I was drawn to this topic by personal observations and conversations with anesthesiologists and surgeons over my many years in patient safety and quality. Since I'm not a physician and have not directly experienced the behaviors from one "tribe" as a member of the other, perhaps my perspectives are flawed in some ways. (The term "tribe" can be used to describe the different professions in the operating room, *eg*, surgeon, nurse, anesthesiologist, surgical technician. For insight about how tribal instincts and behaviors can be destructive between tribes, and for society, see Junger[10]). Yet, by being an observer of both without that inherent bias, perhaps I have a perspective that the members of either tribe generally do not. Admittedly, most of my experiences have been with anesthesiologists, yet I've had enough similar conversations with surgeons to notice patterns, concerns, and hypotheses.

Observation 1: When the dyad is highly functional, it greatly serves the interest of the patient; each can help and "rescue" the other. And a good working relationship creates a much more pleasant working environment (for all).

Observation 2: When the dyad is dysfunctional, it can—and does—sometimes lead to harm and often creates an unpleasant, and sometime toxic, working environment.

Observation 3: Each side of the dyad has some perceptions of the other that are derogatory. If I were to ask each what they think about the other specialty in general, the first response would include some statements that are complimentary. (Corollary: when acting together, both may share common stereotypes of other physician tribes.)

Observation 4: Each side of the dyad sometimes attributes motivations to the other that are not solely in the best interests of patients.

While I am not aware of empirical data to support the following characterizations, I offer some Examples of attitudes I've gleaned about how each side of the dyad sometimes perceives that the actions of the other may not be in the best interest of the patient.

Anesthesiologists' Negative Perceptions of Surgeons

Some negative perceptions of surgeons by anesthesiologists include: failure to be knowledgeable about "medical" or "anesthesia-related" (as opposed to surgical) issues; failure to perceive or acknowledge the extent of blood loss; consistent underestimation of surgical time; failure to be forthcoming to patients and families about the likelihood of success and magnitude of difficulty in recovery after surgery; failure to adequately consider patient health conditions and patient desires; and discouraging speaking up by others about safety concerns.

Surgeons' Negative Perceptions of Anesthesiologists

Some negative perceptions of anesthesiologists by surgeons include: more concerned with finishing their day on time than serving their patients' needs; unreasonable eagerness to cancel a procedure based on unjustified concerns; unappreciative of the need to maintain