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CORRESPONDENCE

Physical and psychological abuse in Canadian operating rooms

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To the Editor,

A range of operating room behaviours can be detrimental to both team members and patients.[1] We recently developed a scale measuring exposure to behaviours that show disrespect toward another person and result in a perceived threat to victims and witnesses.[2] We call these "negative intraoperative behaviours." Alongside this scale, we surveyed clinicians regarding physical abuse and several types of psychological abuse in the operating room. The Canadian Department of Justice defines *physical* abuse as any form of assault, where "someone uses force or the threat of force on someone else without that person's consent."[A] In contrast, they define *psychological* abuse as when "a person uses words or actions to control, frighten or isolate someone or take away their self-respect."[B] These actions may take place in either "a pattern of behaviour or…" as "a single incident."[A] Although abusive behaviours were not part of the final negative intraoperative behaviours scale, they are important stand-alone outcomes. A contemporary examination of abusive behaviours in Canadian operating rooms is needed. Such behaviours are therefore the subject of this short communication.

The project received ethics approval (May 2013) from the Health Research Ethics Board at the University of Manitoba. The survey was distributed to professions working in the operating rooms in Canada from July 2013 to July 2014. Several perioperative organizations, including the Association of Canadian University Departments of Anesthesia, Operative Nurse's Association of Canada, Canadian Society of Clinical Perfusion, Canadian Association of General Surgeons, and Canadian Federation of Medical Students, helped distribute the survey. We present responses from 1,540 intraoperative clinicians, including anesthesiologists (n = 362/2480, response = 15%), nurses (n = 305/2600, response = 11%), surgeons (n = 386/9671, response = 4%), technicians (104/319, response = 17%), and senior medical students (n = 383/1922, response = 20%) across Canada. The sampling frames for all groups except surgeons were either prespecified by the distributing association or estimated based on the size of the association membership. With surgeons, the denominator could not be reliably estimated because of "viral" distribution of the link to surgeons of other subspecialties. To be as conservative as possible, the sampling frame was therefore assumed to be all surgical specialists in Canada. This number was taken from a 2014 report issued by the Canadian Medical Association. Respondents reported the frequency with which they had witnessed others or had personally experienced abusive behaviours, including physical assault, personal space invasions with the intent to intimidate, or verbal threats. By combining the witnessed and personally experienced exposure, we determined the number of respondents who

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[A] *Department of Justice Canada*. What is abuse? Abuse is wrong. Ottawa, Ontario: Department of Justice; 2009. Available from URL: http://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/aiw-mei/pdf/Abuse_is_Wrong.pdf (accessed May 2016).

[B] *Department of Justice Canada*. Forms and types of violence. About family violence. Ottawa, Ontario: Department of Justice; 2015. Available from URL: http://www.justice.gc.ca/eng/cj-jp/fv-vf/about-apropos.html (accessed May 2016).

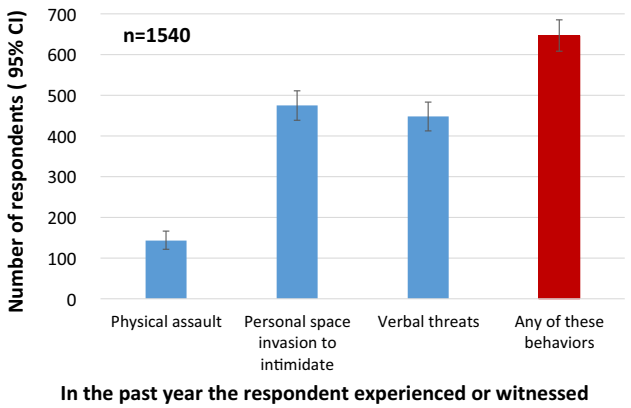

Figure Percent of respondents reporting any physical and psychological abuse in the operating room (with the Clopper–Pearson confidence interval).

had been exposed to each example of abuse during the past year (Figure).

Our study demonstrated that hundreds of clinicians observe abusive behaviours in Canadian operating rooms. Abusive behaviours, especially physical assault, should never occur in any workplace because of the potentially harmful effect on victims and witnesses. When such events occur in a medical context, however, they are especially concerning because of their potential to undermine patient care. Incidents of abuse are likely to disrupt professional relationships,[1] communication,[1] and the diagnostic and procedural performance of operating room teams.[3] It places patients at an increased risk of morbidity and mortality.[4] As caregivers and patient advocates, operating room team members have a duty to act in a manner that is conducive to good patient care.

Institutions must take further actions to prevent these behaviours and create a culture of respect and safety. These efforts should include raising awareness about abusive behaviours in the operating room and their detrimental effects; increasing "soft skills" training, especially regarding conflict resolution, communication, and de-escalation techniques; and finally, instituting and enforcing a respectful workplace policy.

Conflicts of interest None declared.

Editorial responsibility This submission was handled by Dr. Gregory L. Bryson, Deputy Editor-in-Chief, *Canadian Journal of Anesthesia*.

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