

Clinical Cases

Offensive Music in the OR

Medical students should not fear retribution for speaking up when a senior staff member is behaving in a manner that threatens a professional workplace environment.

Commentary by Rachel Sackrowitz and Kenneth M. Sutin, MD

As Priya, a third-year medical student, and the urology resident wait for the anesthesiologist to sedate the middle-aged patient scheduled for a prostatectomy that afternoon, the attending surgeon enters the operating room and announces that he has brought music to be played during the procedure. This is not atypical; many surgeons prefer to have some music playing in the room while they operate, and Priya expects to hear the classic rock or jazz that has accompanied other operations that she has seen.

She is startled when she hears police sirens and profanities being shouted from the CD player. As the bass line of a gangster rap song starts, the attending surgeon steps out to scrub. While Priya washes and prepares the patient, she is shocked by the liberal use of profanity and racial slurs in the lyrics of the song. She reads the reactions of other members of the operating team as they go about their work, shaking their heads or rolling their eyes. Priya decides that she is not the only one who finds the choice of music inappropriate and turns down the volume of the CD player. Priya would rather have turned the music off all together but hesitates to do so because this was the selection of the attending surgeon on the case.

When the attending surgeon returns to the room, he asks in a confrontational tone, "Who turned down my music? Does this offend someone? If you are offended, just stand up and say so, and I'll turn it off." He looks around at the anesthesiologist, the resident, the scrub nurse, and Priya, who all stand in silence. Priya finds it hard to believe that he cannot sense the discomfort sitting heavily in the room. She cannot believe that he really thinks this music is appropriate. But no one speaks up. No one asks that the music be changed. Seconds later, the surgeon asks the circulating nurse to restore the volume on the radio as he dresses for the procedure.

Commentary 1

Conflicts in Confrontation
by Rachel Sackrowitz

Though the details of this clinical scenario are unique, the fundamental nature of this student's conflict is not. Priya believes that the attending surgeon has created an environment that is profoundly disrespectful to the patient and operating room team but is unsure how best to respond. As the person with the least experience and knowledge, Priya is expected to defer to the clinical expertise of more senior doctors. Because Priya is accustomed to this passive position, she feels uncomfortable questioning the judgment of an attending surgeon. Priya feels pressure to accept his ethical standards and may even doubt the validity of her own reaction.

Initially, Priya turns down the volume of the gangster rap because it violates her professional values. The profanities and racial slurs are obviously destructive to the environment of mutual respect most conducive to team work and patient care. Members of the operating team, likely a diverse group, may feel demeaned, humiliated, or infuriated by

the surgeon's choice of music. Some will interpret the lyrics as reflective of the surgeon's personal views. Priya worries that these emotions will interfere with the concentration and spirit of cooperation essential to a successful surgical procedure. Priya also understands that, by allowing an invasive surgical procedure to be performed on him, this patient has placed great trust in the surgeon and operating room team. The team should acknowledge this trust by maintaining a respectful, dignified environment, even while the patient is unconscious. Finally, Priya objects to the gangster rap on a personal level. She is offended by the lyrics and resents their negative influence on her learning environment.

Despite her sound ethical reasoning, Priya does not admit to turning down the music. Instead, she doubts the appropriateness of criticizing the antagonistic surgeon. If she chooses to assert her own professional standards she will overstep the clearly defined student's role characterized by unconditional deference to more senior professionals. Altruism is tempered by self-interest as fears of humiliation, punishment, and negative repercussions discourage Priya from voicing her disagreement. Though she suspects that similar fears underlie the anesthesiologist's, resident's, and scrub nurse's silence, the possibility remains that others do not find the music equally ethically objectionable. Furthermore Priya wonders if, by publicly confronting the surgeon, she will anger the more senior members of the operating team who deem Priya's reaction inappropriate for a medical student. Clearly, confrontation may not be in her best interest.

As the nurse restores the volume and the surgeon dresses, Priya has a final opportunity to consider possible courses of action. Each option strikes a different balance between respect, patient care, altruism, and self-interest. The path she ultimately chooses will be a reflection of her personal and professional values. A solution that would be tolerable to one person may be intolerable to another, and for any given person subtly different situations might call for radically different courses of action. Confronting the surgeon directly would be tantamount to accepting equal responsibility for the operating room environment. If Priya's personal ambitions require the support of this surgeon or the good opinion of the operating team, the cost of public confrontation may be too high. Priya might consider discussing her concerns with this surgeon or another faculty member privately. Such actions would permit Priya to protect her interests and partially defend her professional values. While this particular patient and team will not benefit, future improvements remain a possibility. Ultimately, Priya may decide to say nothing and follow the lead of the rest of the team.

Though the cost of confrontation is readily appreciated, the long-term price of silence is often overlooked. If moral and ethical integrity are traits highly valued by the medical community, then the development of professional values needs to be an important goal of medical education. Unfortunately the hierarchical structure of medical education, designed to tie responsibility to clinical knowledge, infantilizes its students. Though there is no relationship between moral reasoning and clinical knowledge, students do not feel empowered to confront more senior doctors about unprofessional behavior. Because deeply felt conviction requires a forum for expression, there should not be unconditional deference to medical hierarchy in the realm of professionalism and ethics. However, professional identity and ethical maturity will only become fully integrated when moral responsibility is fully assumed at the beginning of clinical training.

Rachel Sackowitz is a fourth year medical student at NYU School of Medicine. She received a BA in psychology from Amherst College and plans to begin her training in internal medicine next year.

Commentary 2

Profane Music in the Operating Room
by Kenneth M. Sutin, MD

*For the Truth is that we are kind for the same reason as we are cruel,
in order that we may enhance the sense of our own Power.*
-Aldous Huxley

I will share my impressions of this scenario from my perspective as an attending anesthesiologist at an academic medical center. In the operating room (OR), it is rare that a medical student would ever turn down a radio (unless specifically asked to do so); so the fact that Priya did turn down the radio tells me that she was offended by the music's content. Turning down the radio while the surgeon is out of the room is a passive response. It does not deal with the

issue, and a better response would be for the student to ask the surgeon directly to please turn the radio off. Although the urology attending asked if anyone was offended by the music, he should have figured this out from the lowered volume when he returned from the scrub sink. He should have understood this cue to turn off the music. Also, the surgeon is clearly expressing some reservations regarding the music when he asks, "Who turned down my music? Is anyone offended by this?" Failure of the medical student to stand up to the surgeon does not necessarily imply passive approval. The surgeon is in a position of authority, and the student may fear retaliation. The failure of an earlier intervention on the part of the anesthesiologist (or nurse) put Priya in an awkward situation where she felt compelled to intercede. Finally, as a last resort, if the profane music persists, the student has the right to voluntarily excuse herself from the OR. Before leaving, she should explain to the attending why she is leaving and immediately report the incident to the Dean for Medical Student Affairs.

As the advocate for the patient, the surgeon, the nurses, the residents, and the medical students in the operating room, I consider it my personal responsibility and privilege to ensure that the OR environment is conducive to the safe conduct of surgery and anesthesia and to the education of all students. If the radio volume is too loud, it may impair the ability of the anesthesiologist to detect ventilator or monitor alarms that are designed to protect the patient. I always insist that the radio be turned off during critical parts of the anesthesia (eg, induction of general anesthesia). Clearly, it is in everyone's best interest to adjust the volume according to the circumstances. In fact, many hospitals do not permit radios in the OR.

Certainly, if the content of the material being broadcast were of a questionable nature, I would insist that it be changed. If an overbearing surgeon insists on playing offensive music, I would have no other recourse than to turn off the radio, despite any objections. It is my responsibility to ensure that the sanctity of the work environment is preserved. It is too easy for students to subjugate their individual rights to the freedom of expression implicitly demanded by an overbearing music enthusiast. I would not blame the student for not speaking up to the surgeon for fear of retribution. I would blame myself, however, if I did not have the insight to appreciate that situation. Music that contains potentially offensive content should never be played in the private community of the OR. Remember, an awake patient (eg, at the start of surgery or during the entire surgery) may also be offended by the music, and the patient (who may have an altered level of consciousness due to sedatives or opioids) has rights that must be protected. The proper function of the OR requires teamwork and the optimal functioning of all involved in patient care. If a caregiver with a vital role in patient care is distracted by the lyrical content, I must be concerned that his or her performance in the OR may be suboptimal and that there may be adverse consequences.

The atavistic legacy of abusive "indoctrination" to medicine is unacceptable by today's university, hospital, local, state, and federal standards [1]. When I was a resident in training in Philadelphia, I was subjected to abuse on a few occasions. I remember the situations quite clearly, and I recalled thinking that this cycle of abuse must stop, even though it seemed to be a rite of passage. Also, it was made very clear to me that if I said one word, my evaluation for the rotation would reflect my "inappropriate" complaint, rather than my clinical skills and hard work. It was wrong then, and it is wrong today.

Although medical student abuse is wrong, it does occur, albeit much less often than in prior years. According to the Association of American Medical Colleges' 2003 poll of graduating medical students at 125 US medical schools [2], the most common form of medical student mistreatment is public humiliation or belittling; this was reported by 59.6 percent of respondents as occurring more than once. In contrast, only 11.6 percent of respondents reported being subjected to racially or ethnically offensive remarks or names directed at them personally on more than 1 occasion. The identified source of mistreatment was most often the clinical faculty (in the hospital) or the house staff. Fear of reprisal was the most common reason why an episode of mistreatment was not reported (47.2 percent). Acts of severe abuse are much less common now than a decade ago [3].

So what has changed since the time I was a medical student? You can voice your complaint, expect it to be acted on, and not fear retaliation. Just as excessive resident work hours have been reformed, so has there been a significant change and redefinition of what is considered to be unacceptable behavior. Fortunately, I believe we are pretty far along in the process of reforming the culture of medicine that closed its eyes to abuse of subordinate students and junior colleagues.

References

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Kenneth M. Sutin, MD, completed his anesthesiology residency and critical care fellowship at NYU. He is a full-time anesthesiologist, specializing in neuroanesthesiology and critical care at Bellevue Hospital in New York City. He is the director of medical student education for anesthesiology and is actively involved in both medical student and resident education.

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