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FROM THE EDITOR

Bringing Down the Drapes

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For most, the operating room (OR) is a place of mystery, shrouded in sterile drapes. This holds true for patients and clinicians alike, few of whom will ever see the inside of an OR. Depictions of ORs tend to highlight surgeons' unique roles. It comes as no surprise, then, that most depictions of the OR rely on 2 central figures—surgeon and patient.[1] However, these depictions fall short. Modern surgical care is built on a triadic relationship between surgeons, anesthesiologists, and patients.

Surgical patients—who are often anesthetized and chemically paralyzed—are among the most vulnerable patients in health care. Surgeons and anesthesiologists work together in pursuit of common a goal—to care for and protect these patients while they undergo operations that promote and restore health. It is this shared goal that unifies surgeons and anesthesiologists and serves as the foundation for relationships between them.

Relationships between anesthesiologists and surgeons are complex, owing in part to their disparate roles in the operating room. To successfully complete an operation, a surgeon often must focus intently on a specific region of the body or task at hand. This narrowing of perspective begins when the drapes are unfurled, covering up a patient's body with the exception of the surgical site. In contrast, the anesthesiologist's primary focus is maintaining a patient's homeostasis in a fluid, tenuous environment. With induction of anesthesia, the patient often loses their ability to breathe, and the anesthesiologist must quickly master that function for the patient. Additional changes in heart rate and blood pressure occur, and the anesthesiologist must take a holistic approach to monitoring patients' vital functions, awareness, and comfort on a continuous basis for the entire duration of an operation.

This issue of the *AMA Journal of Ethics* examines current and historical relationships between surgeons and anesthesiologists, who can sometimes have different perspectives about what it means to take good care of patients and how to manage complications and crises. It examines ethical questions related to the scope of these different specialists' expertise and authority and their responsibilities during all phases of perioperative care.

During the course of an operation, transitions between anesthesiologists are common for the purpose of relief breaks or shift changes. Today, anesthesia

care is founded on a systems-based care team model, wherein multiple anesthesiologists share the work of anesthesia during a single operation.[2] Surgeons, however, rarely step away from the operating table or take shared responsibility for procedural tasks. Unsurprisingly, these differences in practice contribute to conflicting views on whether breaks and transitions of care have a place in the OR.

One important set of issues pertains to cardiac arrest in the OR, a rare but catastrophic event. Eliciting patients' code status and setting forth a clear plan should a patient have a cardiac arrest in the OR is an essential part of perioperative planning, especially for patients who have a do-not-resuscitate order in place. In the event of a patient cardiac arrest in the OR, surgeons' and anesthesiologists' differing perspectives can influence the management of care in these challenging scenarios.

When something goes wrong in the OR, surgeons and anesthesiologists work together to promote patient safety. Sometimes, despite their best efforts, there are poor outcomes. It is difficult—and often impossible—to determine who is at fault for an error in the OR, with the result that surgeons and anesthesiologists often share responsibility for errors and complications. Unfortunately, surgeons and anesthesiologists may blame one another for bad outcomes, which can hinder an appropriate response to errors that occur in the OR.

While surgeons and anesthesiologists often work in tandem on different parts of a patient's body, sometimes they share the same space. When surgeons operate on the airway, collaborative joint decision making must occur. Yet in such situations, conflicts can take place. These conflicts could be mitigated by cross-training experiences, which foster open communication channels and mutual respect between professions. Unfortunately, these experiences are rare among resident trainees, owing to work-hour restrictions and changing requirements for certification.[3]

In the past, surgeons unilaterally made decisions about postoperative pain control, but this situation is changing. Advances in pain management have allowed anesthesiologists to become significantly more involved in pre- and postoperative care by offering advanced pain management techniques (nerve blocks and epidurals) and multimodal pain medicine management.[4] The creation of enhanced recovery after surgery (ERAS®) pathways, a collaborative effort between anesthesiologists and surgeons, has improved patient outcomes.[5] As anesthesiologists have taken a more active role in managing postoperative pain, conflicts can arise between anesthesiologists and surgeons, who may have different philosophies on how best to manage their patients' pain.

This issue examines the complex, interdependent—yet sometimes strained—relationship between 2 physicians who care deeply for their patient. With different training backgrounds and perspectives come varied thoughts on the

best course of action in a given scenario. A common theme throughout this issue is that improved communication and mutual respect lead to better patient care and outcomes. When anesthesiologists and surgeons have an established relationship, understand the strengths of each specialty, and maintain good perioperative communication, the barriers come down. The unfurled drape becomes a sterile wall, and nothing more.

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