LETTERS

On Combat Anesthesia

To the editor: I was reading the article on combat anesthesia, August 2015, Vol 83, No 4, pages 247-253. There is a comment in the article on page 251, about Role VI care; I believe the authors meant to state Role IV care. Also, in the paragraph on page 250: "In the military, nearly everyone knows his or her blood type; it is on everyone's dog tag (although it is wrong about 4% to 10% of the time) ..." I did not see the authors' reference(s) for this statistical data. I was wondering if the authors could provide their reference(s) used for this statement.

Karl Kammer, MSN
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Response: We thank Karl Kammer, MSN, for his letter. He was indeed correct noting the reversal of the roman numerals. Regarding the second part of the letter asking about the 4%, it is noted in two sources; first the Army's practice guideline[1] for whole blood transfusion and from the primary source in 1999[2]. This is the last time it was measured. *Military Medicine* published the paper in November of 1999, titled "Blood Type Discrepancies on Military Identification Cards and Tags: A Readiness Concern for the U.S. Army" by Rentas and Clark.

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REFERENCES

1. US Army CPG. Fresh Whole Blood Transfusion; Reviewed October 2012; approved October 2012; Fresh Whole Blood Transfusion. Oct 24, 2012.
2. Rentas FJ, Clark PA. Blood type discrepancies on military identification cards and tags: a readiness concern for the U.S. Army. *Mil Med.* 1999;164(11):785-7.

DISCLOSURES

The authors have declared no financial relationship with any commercial interest related to the content of this letter. The authors did not discuss off-label use within the letter.

Hazardous Intraoperative Behaviors: What's at Risk?

To the editor: Healthcare today has become a very intricate environment in which expectations are inherently high within the intraoperative setting. The environment has increasingly presented with disruptive employees acting hostile toward one another, which can lead to devastating consequences for the safety of patients and healthcare workers.[1] Within the healthcare profession, nurses are 16 times more likely to experience workplace violence than any other profession.[2] Hazardous behaviors within healthcare have become such a crisis that in 2008 the Joint Commission instituted policy for hospital organizations to eradicate disruptive behaviors threatening the performance of healthcare professionals.[1]

Often very ambiguous in nature, the clarity to which harassment and bullying occur may be difficult to identify, but may coincide with the perpetrators' lack of aptitude, fatigue, insecurity, or personal social complications.[3,4] Methods of bullying are abstruse, occurring throughout a period of time and usually conveyed at a psychosocial level. Research has demonstrated that being targeted with hostile and rude behavior impairs cognitive skills, thus compromising work performance.[1] Therefore, the Joint Commission has expressed there is a responsibility on the part of healthcare representatives to confront hazardous behaviors among staff at every level of an organization to avoid jeopardizing patient care.[5]

One would expect nurses to be compassionate individuals who interact well while achieving a common goal of patient care; however, given increasing responsibilities, this environment has become commonly septic in nature. Trapped within a dichotomy represented through a paucity of autonomy, it is the oppressed nature of nursing that is expressed through situational passive aggression.[6] Thus, the environment can sometimes foster a culture of gossip, backstabbing, and intimidating hostility, among nurses. Healthcare organizations are now on notice to quarantine hazardous behaviors, which disrupt quality care while undermining a culture of safety.

The theory that nurses eat their young is a far too common accepted culture within nursing; it is emotionally unintelligent and counterintuitive to the profession. In a study conducted by the AANA, it has been reported that students' anxieties can rest upon perceptions of clinical preceptors' teaching styles with varying attitudes toward them.[7] Verbal abuse has been reported by 69% of student registered nurse anesthetists, which contradicts the Council on Accreditation of Nurse Anesthesia Educational Programs requirement that healthcare teams

support student registered nurse anesthetists.[8] The behavior of clinical instructors who inhibit the development and progression of students with constant criticism is attributed to a bully's own insecurity.[4] When students perceive clinical instructors as impolite or unapproachable, students' anxiety levels increase, which makes it difficult to concentrate within the clinical setting.[7] Often justifying hostile behavior while displaying a lack of emotional intelligence, clinically experienced nurses condone their own hazardous and critical behaviors towards new nurses as concerns for patient safety.[6] For resolution to occur a complaint must be made—without reprisal—to correct hazardous intraoperative behaviors. Collaboratively improving relations between OR staff requires incorporating a high sustainable level of emotional intelligence that mitigates negative occupational stress while improving institutional performance.

Emotional intelligence is not always associated with cognitive intelligence, achievements, or aptitude; rather, it has been represented as cumulative life skills encompassing the ability to handle particular stressors within relationships and working environments.[6] Furthermore, the AANA requires CRNAs to optimize patient safety and to enhance collaborative team models to facilitate organizational success.[2] Thus, elimination of a culture of silence toward hazardous intraoperative behaviors is essential to sustaining a cohesive, collaborative, team approach to patient care. By embracing emotional awareness of others, healthy intraoperative relations between staff can increase rates of quality outcomes and patient satisfaction, while improving the nursing profession. Therefore, coping involves using emotional intelligence combined with the resilience necessary to develop support for others while improving patient care. The primary principle: Tomorrow's jobs depend on today's quality.

REFERENCES

1. Levine A, Mclver M. Play nice: the impact of rude behavior on quality of care. *Emerg Phys Monthly*. Available at: http://epmonthly.com/article/play-nice. Accessed April 29, 2016.
2. American Association of Nurse Anesthetists. Promoting a culture of safety and healthy work environment: practice considerations. 2015. Available at: http://www.aana.com/resources2/professional-practice/Pages/Promoting-a-Culture-of-Safety-and-Healthy-Work-Environment.aspx. Accessed April 29, 2016.
3. Longo J. Combating disruptive behaviors: strategies to promote a healthy work environment. *Online J Issues Nurs.* 2010;15(1). Available at: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol152010/No1Jan2010/Combating-Disruptive-Behaviors.html. Accessed April 29, 2016.
4. Hamlin L, Gilmour D. Bullying and harassment in perioperative settings. *Can Oper Room Nurs J.* 2005;23(2): 19-23.
5. Pisklakov S, Tilak V, Patel A, Xiong M. Bullying and aggressive behavior among health care providers: literature review. *Advanc Anthro.* 2013:179-182.
6. Littlejohn P. The missing link: using emotional intelligence to reduce workplace stress and workplace violence in our nursing and other health care professions. *J Prof Nurs.* 2012;28(6):360-368.
7. Smith C, Swain A, Penprase B. Congruence of perceived effective clinical teaching characteristics between students and preceptors of nurse anesthesia programs. *AANA J.* 2011;79(4 Suppl):S62-S68.
8. Elisha S, Rutledge DN. Clinical education experiences: perceptions of student registered nurse anesthetists. *AANA J.* 2011;79(4 Suppl):S35-S42.

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