Death on the table: How Do Operating Room Staff Experience Intraoperative Deaths?

Abstract

Background: Intraoperative deaths, though statistically rare, may evoke varied emotions among operating room (OR) staff that remain underrecognized and inadequately addressed.

Aim: To synthesise and summarise the qualitative evidence regarding experiences of surgeons, anaesthetists, and nurses following patient death in the OR. A secondary aim is to unpack strategies to support OR staff following an intraoperative death experience.

Design: Narrative review of qualitative studies.

Data sources: Peer-reviewed databases (PubMed, EMBASE, CINAHL, Web of Science, Scopus, and Cochrane Review Library) and grey literature sources (such as thesis databases) were extensively searched for peer-reviewed primary studies and non-peer-reviewed literature respectively reporting on intraoperative deaths or deaths occurring in the OR.

Results: Five qualitative studies were retained. The synthesis revealed that unexpected OR deaths or those deaths perceived as sudden or preventable evoked more severe and enduring psychological repercussions, marked by guilt, hypervigilance, emotional and moral distress. In contrast, anticipated fatalities, particularly in patients with advanced illness evoked less intense emotions, but not eliminating emotional tolls. The findings revealed divergent coping mechanisms among OR professionals: surgeons often engaged in meaning-making or employed emotion- and problem-focused strategies to process loss. In contrast, anaesthetists described emotional desensitization over time. Nurses, meanwhile, navigated a pervasive culture of silence.

Conclusion: The emotional toll captured in this paper underscores urgent needs for interventions, such as team-based debriefing support, alongside systemic reforms to normalize vulnerability and integrate emotional stewardship into institutional policies. Addressing this is not only ethically imperative but critical to sustaining a resilient workforce and ensuring patient safety in an era of escalating surgical demand.

Keywords: Healthcare practitioners; Intraoperative death; Operating room.

What is already known about this topic:

- Intraoperative deaths represent devastating occurrences in surgical practice with profound clinical and emotional consequences
- The operating room remains a high-stake, emotionally charged environment with a focus on saving lives.

What this study adds:

- Although emotional responses seem to vary based on the patient's condition, emotional toll remained a significant feature.
- Despite the teamwork practiced in the operating theatre, dealing with intraoperative deaths seemed to be a personal experience.

How this study might affect research, practice, and policy:

- Team-based debriefing support may be included in routine support for operating room staff following an intraoperative death.
- Institutional policies need to emphasise emotional stewardship for operating room staff.

Introduction

Intraoperative deaths, sometimes referred to as death on the table, describes the death of a patient in the operating room during anaesthesia or surgery [1]. Though previously considered rare, intraoperative deaths represent devastating occurrences in surgical practice with profound clinical and emotional consequences [2]. While comprehensive global data on these events remain scarce, available estimates from high-income countries suggest an intraoperative mortality rate of 0.5–1 per 100,000 [3]. Contrasting these figures, a large U.S. study analysing the National Anesthesia Clinical Outcomes Registry reported significantly higher rates, with intraoperative cardiac arrest occurring in 5.6 cases and death in 3.3 cases per 10,000 surgeries [4]. Notably, a 4-year population-based analysis in China's Hubei Province (population 59 million) documented an intraoperative mortality rate of 6 per 100,000 [5]. Though this rate exceeds those in high-income country benchmarks, it reflects substantial progress in surgical safety when contextualized against China's heterogeneous healthcare landscape, which encompasses both cutting-edge academic hospitals and under-resourced regional facilities [6].

The operating room (OR) within the clinical setting represents a high-stakes, high-pressured environment where healthcare providers (HCPs) engage in and deliver life-saving interventions [7]. These teams are trained to manage critical scenarios with technical precision, yet patient death in this setting introduces profound emotional and psychological challenges [8]. Unlike other clinical areas, such as palliative care or intensive care units (ICUs), where death may be anticipated, intraoperative mortality is often sudden and unexpected, occurring despite maximal intervention [9]. This unpredictability, compounded by the OR's culture of stoicism and efficiency, places unique demands on HCPs, who are expected to maintain composure and swiftly transition to subsequent responsibilities [10, 11].

Though intraoperative deaths may seem rare, its occurrence can have profound impact on the healthcare providers. An intraoperative death that occurs on the end of the needle due to drug overdose, sub-standard preoperative assessments and preparations or other technical errors often collapses the temporal and spatial distance between intervention and outcome, creating guilt and a visceral linkage of intent, action, and consequence wherein the clinician's role as a healer directly conflicts with their unintentional role as a harm agent [12, 13]. Even when actions are temporally and spatially more divorced from the patient's death, there may still be a measure of guilt among OR staff. While the emotional toll of intraoperative death on OR teams is universally significant, emerging evidence suggests nuanced differences in psychological and systemic impacts depending on whether the event was anticipated. Some studies posit that all intraoperative fatalities, regardless of predictability,

trigger profound distress among staff [13, 14]. However, other studies have argued that unexpected intraoperative deaths impose a uniquely severe psychological burden compared to anticipated fatalities [10, 15]. While intraoperative mortality remains an occupational inevitability for many operating room (OR) teams, emerging evidence challenges the assumption that all such events uniformly induce psychological sequelae or compromise clinicians' capacity to maintain anaesthetic safety [12, 13]. Just as there is likely to be considerable heterogeneity amongst OR staff in terms of the amount of stress felt after an intraoperative death, there is also likely to be a substantial variation in their ability to cope with that stress [12, 13]. Thus, the psychological aftermath of intraoperative mortality can be argued to exhibit marked variability among operating room (OR) staff, manifesting not only in the intensity of acute stress responses but also in the capacity to functionally process these experiences.

Despite the notable variations highlighted above, existing studies reporting on service providers experiences following either expected or unexpected patient death have however focused significantly on other traditionally non-palliative care settings such as the emergency department [16-18] and intensive care units [19, 20] emphasizing themes of grief, guilt, and burnout. The OR's distinct environment, marked by its curative intent, team-based dynamics, and reliance on skilful resuscitation expertise with life support machines coupled with technical mastery, where the patient is required to spend few hours could potentially lead to distinct experiences if the patient dies [21]. Preliminary studies suggest OR staff may experience "second victim" syndrome, a phenomenon where healthcare providers endure trauma after adverse patient outcomes [11, 22, 23]. What is more, the OR's steep hierarchical structure and norms, may inhibit speaking up about concerns, exacerbating isolation [24, 25].

Despite the critical role of OR service providers in managing surgical cases including lifesaving emergencies, there is a striking lack of synthesized evidence on their experiences following intraoperative deaths. This gap may hinder the development of targeted support strategies, leaving healthcare providers working in the OR. Existing institutional responses, such as debriefing protocols or counselling services, are often generalized rather than tailored to the OR's unique stressors, rendering them inadequate [9, 11, 21, 23]. Furthermore, the rarity of intraoperative deaths, compared to mortality in other settings, may obscure their cumulative psychological impact, particularly when compounded by perceived medical errors or systemic failures. To guide further studies, this perspective/ review of qualitative evidence sought to bring to the fore OR practitioners' experiences following intraoperative deaths to ascertain thematic patterns, and highlight possible recommendations.

Methods

Review design

This study employed a narrative review approach with a focus on qualitative studies published in English and reporting on intraoperative deaths regardless of the setting. The narrative review approach is flexible and appropriate for synthesising and summarising existing research on a particular topic. It is appropriate for under researched phenomenon to gain practical insights. Considering the limited studies in examining intraoperative death experiences and the need to gain practical insights regarding how to support OR staff, the narrative review approach was considered appropriate [26]. Though narrative reviews are usually unstructured, we aimed to ensure transparency and rigour.

Data sources

PubMed, EMBASE, CINAHL, Web of Science, Scopus, and Cochrane Review Library were extensively searched for peer-reviewed primary studies reporting on intraoperative deaths or deaths occurring in the OR. Considering the focus of narrative review capturing the most salient concepts of all that is known about a phenomenon, it offered the inclusion of grey literature. Thus, the authors also searched MedNar, OpenGrey, ProQuest, Trove, and Agency for Healthcare Research and Quality for grey literature on experiences with intraoperative deaths.

Search strategy, inclusion and exclusion criteria

The search terms formulated with the assistance of our faculty librarian are as follows: “intraoperative death OR intraoperative catastrophe OR IOD OR death on the table” AND “healthcare professionals or healthcare workers or healthcare providers” AND “experiences or perceptions or attitudes or views or feelings”. Regarding inclusion criteria, all databases were searched from 2000 to 2024 for studies reported in English regarding intraoperative death/ OR death experiences using any qualitative or review design. Primary studies reporting on death experiences in other phases of the perioperative journey (such as postoperative period) were excluded since the current review focused on the intraoperative phase.

Screening and synthesis

Following the extensive database and grey source search undertaken by the author, all identified studies were pooled to EndNote X8 for initial screening and de-duplication. Title

and abstract screening were undertaken to ascertain if the studies met the criteria for inclusion. All studies that did not report data during this phase were excluded and the remaining studies proceeded to the full-text stage. At the full-text stage, full versions of the studies were retrieved with the assistance of the faculty librarian. To unpack the intraoperative death experiences of healthcare staff, the authors read and re-read all the selected papers noting phrases related to the phenomenon following which a narrative synthesis was undertaken.

Results

Five studies [22, 27-30] and one thesis employing qualitative methods [21] were retained and included in this mini-review. The studies included the following OR staff members: anesthetists [21, 22, 28, 29], surgeons [21, 27, 30], and nurses [21]. The narrative synthesis is presented below. To ensure rigor, verbatim quotes from the original studies are included as well.

How do Operating Room staff experience intraoperative deaths?

Intraoperative deaths, often sudden and unforeseen, exerted profound emotional and psychological tolls on operating room (OR) staff. A South African study of anaesthetic registrars revealed intense feelings of guilt and personal responsibility following such events, despite participants expressing a willingness to resume duties immediately as captured in the exemplars by one participant [28]: "*I think the biggest question in my mind was whether it was the right choice of anaesthetic. That for a long time still worried me; up until now it still worries me" (page 7).* In addition to the feeling of personal responsibility and guilt following the death, their accounts underscored a dissonance between professional resolve and diminished well-being, with many struggling to function effectively post-incident, including being hypervigilant [28]: "*But for that case, the level of stress and the level of anxiety — I double- checked, triple-checked the machine, the equipment, I was watching the surgeon like a hawk ... it was excessive. I think it was spill-over from the night before, and it was actually something that persisted for a few days*" (page 7). Similarly, U.S. anaesthesiologists reported persistent anxiety and intrusive memories of the event, even in the absence of procedural errors [22].

Surgeons are not immune to this trauma: research in England found that intraoperative deaths triggered profound guilt, remorse, and regret which seemed to linger on long after the initial incident [27]: *"There are patients I still have nightmares about because I feel I let them down and could have done better. Those will be with me until the day I die"* (page 281). Further to the presence of these emotions, it was observed in another Australian study that The cause of a patient's death profoundly influenced how the surgeons rationalized these experiences.

Perioperative deaths, those occurring during or shortly after surgery, were often internalized more deeply, as the patient remained under the surgeon's direct care. In contrast, fatalities linked to disease progression were generally viewed as more anticipated or reflective of treatment limitations, evoking less personal accountability [30]. Yet, only a minority of surgeons reported diminished responsibility or greater acceptance in such cases. When reflecting on patient outcomes, surgeons drew a clear distinction between deaths stemming from advanced terminal illnesses and those resulting from trauma or medical errors [30]. The latter scenarios were described as more emotionally resonant and ethically complex, leaving a lasting impression due to their perceived preventability [30]. What is more, surgeons also predominantly reported emotions such as grief, frustration, disappointment, and disbelief, with some also expressing regret over clinical decisions or a lingering sense of professional failure [30]. Yet, these feelings coexisted with an acknowledgment of mortality's inevitability in cases of terminal illness. Emotional responses varied significantly based on patient demographics: deaths of younger individuals often provoked more pronounced distress, perceived as untimely and unjust, while fatalities among older patients, particularly those viewed as having lived fulfilling lives, were met with greater acceptance and less anguish. This contrast underscores how perceptions of a patient's life stage and lived experiences shape clinicians' emotional engagement with mortality.

Further to the above, another Canadian study exploring the aftermath of intraoperative deaths among nurses, anaesthetists, and surgeons also revealed a complex interplay of grief, guilt, and silence [21]. Participants described overwhelming emotions including powerlessness, regret, and anxiety that intensified when they had pre-existing relationships with the patient [21]. Surgeons, in particular, framed their anguish through a lens of ultimate responsibility for the patient's well-being. Surgeons grappled with regret, compounded by a perceived duty to safeguard not only the patient but the entire surgical team [21]. In contrast, nurses and anesthetists often rationalized deaths as non-failures if exhaustive efforts were made, reflecting divergent coping mechanisms within the same team [21]. Despite these differences, a pervasive culture of silence emerged, stifling open dialogue about the emotional toll of such events [21, 30]. All participants reported lasting repercussions, including insomnia, eroded professional confidence, strained personal relationships, and prolonged grief, underscoring the systemic neglect of psychological support in high-stakes environments. The findings illuminate a critical paradox: even in collaborative settings, emotional isolation persists, leaving clinicians to navigate trauma alone [21, 30]. The paradox of collaborative care environments fostering emotional isolation is stark. While intraoperative deaths occur within teams, support systems remain individualistic and ad hoc. Peer reviews, though designed to ensure accountability, often fail to mitigate blame or guilt, as seen in Canadian anaesthetists

who felt unjustly scrutinized despite exoneration. The private expression of emotions is captured in the words of a surgeon [30], a registered nurse [21], and an anaesthetist [28] respectively as captured below:

> *''… it's never really concerned me that the families may see me upset, but you try not to become a blubbering wreck, because that's not a very good professional model, but at the same time I think it is actually okay to be affected by those things, but you do to some extent try and do it in your own space, rather than with families.'' (Surgeon 9, page 939)*

> *"Maybe you don't want to be that person that's requesting the debrief, that's asking for support resources for whatever reason. Um, maybe I've felt like because nobody else has brought it up maybe that I shouldn't be so bothered by it, so I won't bring it up either". (Sophia, RN, page 111)*

> *"'I've, in my 7 years, had one debriefing session for a trauma case'; 'No management input, no consultant input, no departmental input. You just did the next case'; 'I think [debriefing] would have made a huge difference, because I think I was questioning myself and no one in that circle who could understand the scenario was there to speak to me on that level'; 'I think the most important thing is the learning experience you can take from this; as long as you can learn from things, that makes it a lot easier to deal with'; 'You'd get your compassion through chatting to your friends about similar experiences. I think that's part of debriefing.' (Anesthetist, page 8)*

Strikingly, even when peer reviews or mortality analyses absolved clinicians of blame, as seen in a Canadian study, anaesthetists described enduring devastation, with some internalizing perceived blame or reliving the event for over a year [29]. Collectively, these findings illustrate a pervasive, cross-disciplinary struggle among OR professionals, where the collision of sudden loss, perceived failure, and institutional culture amplified emotional distress, often lingering long after the event itself. The collective findings from global studies underscore the profound and multifaceted psychological toll of intraoperative deaths on healthcare professionals (HCPs), transcending geographical and disciplinary boundaries. A recurring theme across contexts is the burden of perceived responsibility [21, 27, 30]. This concept, while motivating excellence, becomes a source of regret and guilt when outcomes defy intervention, reflecting a dissonance between professional ideals and the unpredictable realities of surgery. Notably, coping mechanisms diverge across roles. Nurses and anaesthetists often rationalized deaths as non-failures if maximal effort was exerted, a mindset that may buffer against guilt but does little to address underlying grief [21].

Over time, OR staff expressed feelings of desensitization to intraoperative deaths wherein they felt able to deal with the situation better, rationalize it better, and not become emotionally involved [21, 28, 30]. In one study, surgeons highlighted the impact of dealing with

intraoperative death and dying as becoming more aware of their own mortality [30]. Meaning making (ability to identify positive aspects in the presence of death), experiencing personal growth over time, and engaging with problem-focused coping strategies also emerged as key coping strategies among anesthetists [28] and surgeons [27, 30]. Although some form of peer support or audit may exist, surgeons and anaesthetists highlighted that structured clinical or audit meetings to review patient deaths were predominantly focused on scrutinizing professional accountability and potential liability, rather than serving as a forum for processing personal emotions or reactions to these losses [21, 27, 28, 30] . These discussions prioritized evaluating clinical decisions and outcomes, often sidelining the psychological toll of mortality on the care team.

Discussion and Recommendations

The findings underscore the complex and context-dependent nature of intraoperative mortality experiences. Rather than a uniform phenomenon, clinicians' responses are shaped by critical factors such as the predictability of death and patient-specific variables, including age and clinical trajectory. Unexpected deaths—those perceived as sudden or preventable—may evoke more severe and enduring psychological repercussions, marked by guilt, hypervigilance, and moral distress. In contrast, anticipated fatalities, particularly in patients with advanced illness, often align with clinicians' frameworks of inevitability, moderating but not eliminating emotional tolls. This dichotomy highlights how the interplay of circumstance and perception mediates the human cost of surgical practice. Together, these create a need for culturally sensitive interventions to mitigate trauma, foster resilience, and sustain workforce well-being. Drawing on global evidence, the following recommendations outline a holistic approach to addressing this crisis, prioritizing proactive support mechanisms, cultural transformation, and institutional accountability.

Proactive support mechanisms

The limited to non-availability of support mechanisms for surgeons, anaesthetists, and OR nurses was resonated across the studies included in this mini-review. Peer support remained limited and audits emphasised clinical decisions/ outcomes rather than the emotional/ psychological toll. Together these findings highlight a great need for proactive support mechanisms. That is, there is a great need to build systems to guarantee emotional stewardship of OR staff. As a starting point, healthcare institutions must recognize that the aftermath of intraoperative deaths extends beyond clinical audits to encompass human vulnerability [22, 23]. Structured debriefing protocols tailored to the unique circumstances of intraoperative deaths and led by mental health professionals, should be mandated following

such events. These sessions would provide OR teams with a safe space to articulate grief, guilt, or anger without fear of professional repercussion [24]. Also, psychological support can be integrated into existing mortality audit reviews/ meetings to reframe these forums as opportunities for healing, not just error analysis and shifting of the blame of causation. This form of counselling support may be particularly helpful in instances of unexpected intraoperative deaths considering that the emotional impact may be more pronounced in this instance. To do this, psychological support should be seen as complementary to rather than competitive with error analysis wherein such support is scheduled as a distinct section after the main mortality audit review/ meeting delivered by appropriately trained staff. By coupling clinical case discussions with access to counselling services, institutions signal that emotional well-being is as critical as technical proficiency. Post-event debriefing and informal discussions as a form of peer support may also be beneficial regardless the intraoperative death was expected or unexpected [28]. If practicable, OR staff affected profoundly by the incident may be offered a brief leave period to process the incident and recover before returning to normal duties. This recommendation is not presented as a one-size-fit-all approach, but can be considered as a strategy to support OR staff who may need it.

Ongoing training/ education is also greatly warranted to equip healthcare staff with the skills to navigate the emotional realities of working in the OR. Indeed, medical/ surgical/ nursing training programs may often neglect the emotional dimensions of adverse outcomes. Embedding modules on grief, guilt, emotional management, and coping strategies into healthcare professional training curricula would better prepare trainees for the realities of OR work. Simulation-based scenarios could play a pivotal role here: rehearsing intraoperative deaths in controlled environments would allow teams to practice emotional responses, communication, and collective processing under stress. By normalizing these conversations early in careers, institutions can cultivate a generation of clinicians adept at balancing technical mastery with emotional resilience.

Cultural transformation

Further to the above, there is a need for a paradigm shift to dismantle the culture of silence in the OR [1]. The pervasive culture of stoicism in the OR has the potential to perpetuate emotional isolation. To normalize vulnerability, institutions must launch campaigns reframing resilience as the courage to acknowledge grief, not suppress it [25]. This may begin with OR staff undergoing trauma-informed training to model empathy, recognize distress, and foster team cohesion during crises. For instance, a surgeon openly discussing their regret after a patient’s death could catalyze broader cultural change, demonstrating that strength lies

in solidarity, not silence. Concurrently, redefining “success” in surgical outcomes to include non-technical skills such as communication, emotional stewardship, and teamwork would reduce OR staff overidentification with clinical results. Performance evaluations that reward these competencies could alleviate the paralyzing guilt.

Institutional accountability

Also, there remains a great need for systemic accountability which prioritizes long-term well-being of staff. Current systems seem to focus narrowly on error prevention, neglecting the human cost of adverse events. Institutions must implement longitudinal tracking of service providers mental health following intraoperative deaths, using anonymized data to identify possible trends in burnout or attrition. This would enable targeted interventions, such as counselling referrals or workload adjustments, before distress escalates. Additionally, hospitals should mandate psychological support as a core component of patient safety framework to promote the well-being of the staff. Funding for such institutional support may be borne by the hospitals to affirm their support to promoting the well-being of their practitioners. For example, Canadian anaesthetists in Todesco et al.’s study, who internalized blame despite exoneration, highlight the inadequacy of peer reviews that focus solely on error finding. Systemic accountability requires embedding emotional care into institutions, treating it as inseparable from clinical excellence.

Limitations

While this mini-review offers valuable insights, several limitations warrant consideration. First, although the streamlined approach efficiently synthesizes key concepts, it inherently lacks the methodological rigor of traditional systematic reviews such as formal quality assessments or critical appraisal of evidence. Consequently, the conclusions drawn should be interpreted as preliminary rather than definitive. Second, the inclusion of qualitative studies, while enriching contextual understanding, introduces constraints. By prioritizing depth over breadth, these studies often feature small, context-specific sample sizes, limiting the generalizability of findings. Additionally, all included research originated from high-income countries, which restricts the applicability of results to low- or middle-income settings where socioeconomic, cultural, and infrastructural differences may significantly influence outcomes. These limitations underscore the need for caution when extrapolating findings and highlight opportunities for future research, including expanded systematic reviews with robust quality criteria and studies in underrepresented regions to enhance ecological validity. It is also worth mentioning that the suggested interventions presented here need further testing to ground their effectiveness in existing evidence.

Conclusion

Intraoperative deaths represent a critical juncture where the technical demands of surgery collide with the emotional vulnerabilities of OR staff. The synthesis reveals a universal, yet often invisible crisis regarding emotional issues particularly when death was unexpected. Although anticipated fatalities, particularly in patients with advanced illness may evoke less intense psychological response, it does not necessarily eliminate the emotional tolls affirming the need for support systems. Current systems, focused narrowly on error prevention, fail to address the human cost of these events, perpetuating cycles of burnout and attrition. The recommendations outlined here advocate for a paradigm shift: redefining OR success to include emotional resilience, fostering collective accountability, and dismantling the stigma of vulnerability. By investing in systemic support and cultural transformation, healthcare institutions can honour the duality of practitioners' roles—as both skilled practitioners and emotionally complex persons.

Declarations

Ethics approval and consent to participate: Not applicable

Competing interests: The authors declare no competing interests.

References

1. Kofke, W.A., *7 Intraoperative Catastrophes.* Neurocritical Care Management of the Neurosurgical Patient E-Book, 2017: p. 71.
2. Gallastegi, A.D., et al., *Intraoperative deaths: who, why, and can we prevent them?* Journal of Surgical Research, 2022. **274**: p. 185-195.
3. Pollard, R.J., et al., *Perianesthetic and anesthesia-related mortality in a southeastern United States population: a longitudinal review of a prospectively collected quality assurance data base.* Anesthesia & Analgesia, 2018. **127**(3): p. 730-735.
4. Nunnally, M.E., et al., *The incidence and risk factors for perioperative cardiac arrest observed in the national anesthesia clinical outcomes registry.* Anesthesia & Analgesia, 2015. **120**(2): p. 364-370.
5. Wang, Y., et al., *Anaesthesia-related mortality within 24 h following 9,391,669 anaesthetics in 10 cities in Hubei Province, China: A serial cross-sectional study.* The Lancet Regional Health–Western Pacific, 2023. **37**.
6. Medellin, S. and D.I. Sessler, *Preventable anesthetic deaths are not the major perioperative problem.* The Lancet Regional Health–Western Pacific, 2023. **37**.
7. Serou, N., et al., *Surgical incidents and their impact on operating theatre staff: qualitative study.* BJS open, 2021. **5**(2): p. zraa007.
8. Wallace, L., et al., *Assessing operating theatre efficiency: a prospective cohort study to identify intervention targets to improve efficiency.* ANZ Journal of Surgery, 2021. **91**(11): p. 2382-2388.
9. Rodger, D. and H. Hartley, *Understanding Intraoperative Death.* Fundamentals of Operating Department Practice, 2022: p. 432.

10. Abhyankar, R., A. Meshel, and B. Hyers, *Navigating the Aftermath of an Unexpected Intraoperative Death.* ASA Monitor, 2024. **88**(12): p. 17-19.
11. Clegg, I. and R. MacKinnon, *Strategies for handling the aftermath of intraoperative death.* Continuing Education in Anaesthesia, Critical Care & Pain, 2014. **14**(4): p. 159-162.
12. Smith, I.C. and M. Jones, *Surgeons' attitudes to intraoperative death: questionnaire survey.* BMJ, 2001. **322**(7291): p. 896-897.
13. White, S.M., *'Death on the table'.* Anaesthesia, 2003. **58**(6).
14. Attri, J., et al., *Perioperative death: Its implications and management.* Saudi Journal of Anaesthesia, 2016. **10**(4): p. 436-439.
15. Kable, A., R. Gibberd, and A. Spigelman, *Adverse events in surgical patients in Australia.* International Journal for Quality in Health Care, 2002. **14**(4): p. 269-276.
16. Bayuo, J., et al., *Palliative care interventions for adults in the emergency department: A review of components, delivery models, and outcomes.* Academic Emergency Medicine, 2022. **29**(11): p. 1357-1378.
17. Bayuo, J., et al., *"Resuscitate and Push": End-of-Life Care Experiences of Healthcare Staff in the Emergency Department–A Hermeneutic Phenomenological Study.* Journal of Palliative Care, 2022. **37**(4): p. 494-502.
18. Reuter, Q., et al., *Emergency department-based palliative interventions: a novel approach to palliative care in the emergency department.* Journal of palliative medicine, 2019. **22**(6): p. 649-655.
19. Bayuo, J., et al., *"Hanging in a balance": a qualitative study exploring clinicians' experiences of providing care at the end of life in the burn unit.* Palliative medicine, 2021. **35**(2): p. 417-425.
20. Bayuo, J., et al., *The role of palliative care in burns: a scoping review.* Journal of pain and symptom management, 2020. **59**(5): p. 1089-1108.
21. Hartley, H., *Intraoperative death: the untold stories of perioperative teams*. 2018, Université d'Ottawa/University of Ottawa.
22. Gazoni, F.M., M.E. Durieux, and L. Wells, *Life after death: the aftermath of perioperative catastrophes.* Anesthesia & Analgesia, 2008. **107**(2): p. 591-600.
23. Rohrbaugh, S.A., *A Phenomenological Approach to Understanding the Lived Experience of Certified Registered Nurse Anesthetists (CRNAs) following an Intraoperative Patient Death*. 2023: The Catholic University of America.
24. Weller, J.M., *Hierarchy in surgeon–anaesthetist relationships*. 2024, Elsevier.
25. Pattni, N., et al., *Challenging authority and speaking up in the operating room environment: a narrative synthesis.* British journal of anaesthesia, 2019. **122**(2): p. 233-244.
26. Elfar, J.C., *Introduction to mini-review.* Geriatric Orthopaedic Surgery & Rehabilitation, 2014. **5**(2): p. 36-36.
27. Arnold-Forster, A., *'A small cemetery': death and dying in the contemporary British operating theatre.* Medical Humanities, 2020. **46**(3): p. 278-287.
28. Jithoo, S. and T. Sommerville, *Death on the table: anaesthetic registrars' experiences of perioperative death.* Southern African Journal of Anaesthesia and Analgesia, 2017. **23**(1): p. 6-10.
29. Todesco, J., N.F. Rasic, and J. Capstick, *The effect of unanticipated perioperative death on anesthesiologists.* Canadian Journal of Anesthesia, 2010. **57**(4): p. 361.
30. Zambrano, S.C., A. Chur-Hansen, and G.B. Crawford, *How do surgeons experience and cope with the death and dying of their patients? A qualitative study in the context of life-limiting illnesses.* World Journal of surgery, 2013. **37**: p. 935-944.