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THE DISRUPTIVE MEDICAL PROFESSIONAL

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Our medical culture has seen a shift in approach over the last several decades with respect to performance improvement and how we view ourselves as a collective system rather than as a group of independent individuals. Concomitant with this shift has been a decreased emphasis on individual “blame” and an increased emphasis on systems issues and the notion that most problems in the healthcare industry are not the result of inattentive or bad behavior on the part of just one person but rather are because of systems flaws.

Recently, the pendulum seems to be swinging back more toward a renewed focus on individual accountability. Anthony Whittemore, the immediate past president of the American Surgical Association, chose for his recent presidential address a discussion of this issue. The title of his talk was “The Competent Surgeon: Individual Accountability in the Era of “Systems” Failure” (Whittemore 2009). Drawing from his decade-long experience as the Chief Medical Officer of Brigham and Women’s Hospital, Dr. Whittemore made a number of observations about performance improvement and individual responsibility. A quotation from his address appears below:

“The notions of a “blame free environment” and a “nonpunitive culture” have crept into our everyday vocabulary reflecting a noble effort to encourage open reporting of adverse events... That preoccupation with the system, however, tends to exonerate individual responsibility.”

Dr. Whittemore’s address and the quotation above nicely capsulize this shift back to a notion of increased individual accountability, a shift that marks not only a somewhat different approach to performance improvement but also an increased scrutiny of our behavior as medical professionals.

The Joint Commission for the Accreditation of Health Organizations has been part of the shift. Effective January 1, 2009, several new JCAHO standards were promulgated in this area (The Joint Commission 2008). One dictates that a hospital or health organization must have a code of conduct that defines acceptable and unacceptable behaviors by its members. Another new standard mandates that leaders of a health organization or hospital create a process for managing inappropriate behavior. The Joint Commission also made a number of specific suggestions about disruptive and inappropriate behavior. They suggest a zero tolerance policy for particularly egregious acts of disruptive behavior. They also mandate that with respect to inappropriate behavior and discipline, everyone be treated the same and that no distinctions should be made between physician behavior and non-physician behavior or between senior members of the healthcare team and junior members of the healthcare team (i.e. attending physicians should be treated the same as medical students and house staff officers). Finally, they insist that non-retaliation policies be in place so that anyone reporting bad behavior is not subject to overt or covert retaliation. This is the first time that the Joint Commission has specifically recognized this sort of thing in its standards.

One of the particularly difficult things about disruptive behavior in the medical workplace is that those who are being disruptive are often unaware that they are a problem or at least are unaware of the magnitude of the problem they create. Sometimes the disruptive behavior is due to an organic illness. Dr. Whittemore in his 10 years dealt with cases of normal pressure hydrocephalus, Alzheimer's disease, malignant hypertension, and Parkinson's disease. He also had occasion to deal with several cases of Executive Function Disorder, a disorder characterized by difficulties with memory and simple fact processing. Perhaps surprisingly, there are occasional individuals working with us who over time lose the ability to do very simple mental processing tasks. Because the worsening of this problem is insidious and in many other respects the person can function reasonably well, figuring out that this is the cause of someone's disruptive behavior or poor performance can be difficult.

Substance abuse and psychiatric illness are also present in the medical workforce just like they are in the rest of society. The most common psychiatric disorder in Dr. Whittemore's experience was manic psychosis, which not surprisingly can lead to major disruptive behavior. Other more subtle psychiatric disturbances such as hypomania and depression were also present, however, and would arguably be more difficult to detect. The main take away point is that psychiatric illness is another potential cause of disruptive behavior.

The single most common entity that Dr. Whittemore dealt with when it came to disruptive behavior was an entity called malignant narcissism. Malignant narcissism is described in the DSM-IV as characterized by the following: grandiose self-importance, entitlement, lack of empathy, arrogant and haughty behavior, unlimited feelings of success and power, the feeling that one is special and unique, interpersonal exploitation, the requirement for excessive admiration, and envy (Holdwick 1998). Some might say that these are all common characteristics of surgeons and that some of them at least are requirements for survival as a surgeon! The diagnosis of malignant narcissism is only made, however, when most or all of these characteristics are present and excessive. Most of us can probably think of someone off the top of our heads who might fit the description of a malignant narcissist.

There have been a number of attempts to measure the frequency of disruptive behavior and its effects. A 2003 survey of 50 hospitals of various types (Rosenstein 2005) found that approximately 60% of those questioned were aware of potential adverse effects related to disruptive behavior and nearly 80% felt that these could have been prevented if individual behavior had been better. Approximately 20% knew not only of potential adverse events but actual specific adverse events that had occurred because of disruptive behavior. Further, overwhelming majorities of those questioned felt that disruptive behavior increased stress and frustration, made it more difficult to concentrate, reduced team collaboration, communication, and information transfer, and impaired the physician-nurse relationship. Similar majorities felt that disruptive behavior could lead to errors and adverse events and was deleterious to patient safety and patient's satisfaction. A full 25% felt that disruptive behavior increased patient mortality rates. While everyone questioned felt that disruptive behavior was a problem, health care administrators consistently rated disruptive behavior as somewhat more problematic than did everyone else queried.

If we accept that our medical culture is gradually swinging back towards an emphasis on more individual accountability for behavior, that bad behavior can be due to a

variety of causes, and that bad behavior has an effect on the collective mental health of the workplace and probably has an effect on outcomes and patient satisfaction, what can we do about it? There is no single answer because there are so many etiologies for disruptive behavior. A couple of general principles and observations, however, are worth remembering. First, many disruptive individuals don't have insight into the fact that they are disruptive and that their disruption is a problem. Babinski in 1914 coined the term anosognosia to describe this lack of insight of a disability. It comes from the Greek "nosos" meaning disease and "gnosis" meaning knowledge with the preceding "a" denoting without. Not only is the individual often unaware of the problem but it is very common for them to cite as a grounds for their behavior a dedication to the best possible patient care. The frequent implication is that their dedication to that cause is greater than everybody else's. Knowing at the outset that a disruptive medical professional may not have any insight into the nature of the problem should be helpful.

Making anonymous evaluation comments and forms available to the medical professional in question can sometimes help, especially if they can see how they are doing and are seen relative to their peers. Other admonitions made by experts in this area are to document everything (no great surprise there), to have one-on-one conversations but not to expect a uniformly great response, to liberally mandate counseling if you have the power to do so, and finally to not be bashful about restricting privileges/activities or even terminating those who after stepwise intervention cannot improve. Nearly all of current management philosophy argues that egregious disruptive behavior should not be allowed to continue in the workplace, even if that means terminating a very productive individual.

In summary, there seems to be something of a shift away from an emphasis solely on systems issues to more of an emphasis on individual accountability. The JCAHO has taken on this cause. Disruptive behavior can be due to certain kinds of personality traits but also can be secondary to organic or psychiatric disease as well as to drug or alcohol abuse. One of the more common described personality disorders behind disruptive behavior is the entity dubbed by psychiatry as "malignant narcissism". Disruptive behavior has definite process consequences (stress, anxiety, decreased communication, etc) and probably has outcome consequences as well (increased morbidity/mortality). Stepwise and increasing intervention is the best approach.

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