Ethics of unprofessional behavior that disrupts: Crossing the line

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Law is necessary because men are subject to passions; if all men were reasonable, law would be superfluous.

Will Durant (The Story of Philosophy)

As chief of surgery, you have been contacted by the managing operating room (OR) nurse about Dr Frank N. Stein’s behavior earlier this morning. Dr Stein, a senior surgeon, has long had a reputation for outlandish behaviors in the OR. He is the impeccable gentleman outside that environment, loved by patients and nonoperating personnel alike. He has an international reputation as a master technical surgeon, operates as efficiently as anyone on the planet, and has the largest practice at the medical center. He has survived beyond the generation of tolerance because he has retained the same OR crew that over the years have calloused enough to regard his scurrilousness as just being Dr S. Today, he crossed the line. Dr. Stein, known for his colorful diatribes, trounced decorum when he ordered the operative team, excepting the anesthesiologist, out of the OR and demanded that a new team be substituted. This resulted from a shouting match with a new circulator when she took issue with a personal insult. The transition was accomplished, causing delays in both Dr Stein’s OR and several other ORs where substitute nurses were commandeered. At least one other faculty surgeon has complained about the inconvenience. In your office, Frank, long a colleague, insists that the nurses involved are assassins and refuses to work with them from this day. What should be done?

A. Assign ex-bouncers to assist him.
B. Get him what he needs. The support people are there for support not to disrupt the surgeon.
C. Survey the nurses, physicians, administrators, and all support personnel to determine institutional relations. If the problem is part of a pattern, require Dr Stein to undertake remediation in professionalism as part of an institutional program.
D. Dismiss Dr Stein from the staff.
E. Make working in a difficult surgeon’s OR voluntary and give combat pay.

In this issue, Dr Whittemore emphasizes the detrimental effects that serious deficiencies of professionalism have on patient care. He provides examples of such morally shocking behaviors as to render the use of “unprofessional” damning with faint praise. He corrects misconceptions of those in the trenches who may well regard others with behavioral problems as eccentric, amusing, or pathetically misguided. Instead, he emphasizes that those behaviors crossing the line damage patient care.

Aberrant outlandish behavior is part of the fading macho surgical stereotype. In the not so remote past of the last century, surgeons were given more latitude in the workplace; one classification involved whether or not surgical instruments became projectiles. Generally, one’s behavior was not reported unless injury or the possibility of injury to coworkers was involved. Crass assertions by surgeons were commonplace and still are in some ORs, albeit with steadily lessening frequency.

Medical professionalism has received much attention recently from statements by medicine’s major professional organizations whose goals are to codify and improve behavioral standards. Extremes such as behaviors that disrupt medical care are not mentioned, just as ethics essays do not routinely discuss why murdering innocents is wrong; their ethical unacceptability should be obvious. Formalized professionalism codes and charters concentrate on dealings with the patients and economic issues, whereas professional disruption is more related to interactions with coworkers, usually without the patient’s knowledge. According to Wilhelm, “Disruptive behaviors include repeated episodes of: sexual harassment; racial or ethnic slurs; intimidation and abusive language; and persistent lateness in responding to calls at work.”

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Although the surgeon is the captain of the team, surgical therapy is dependent on the proper functioning of all the members of the health care team. The introduction of behaviors by members of the team that disrupt the team’s functioning, especially by the captain, clearly is unacceptable. Ethically, this is so because disruptive behavior makes the surgeon’s own ego needs the surgeon’s primary concern and motivation and attempts to make meeting those needs the primary concern and motivation of the other members of the surgical team. However, as Dr Thomas Percival put it when addressing the ethics of potentially disruptive relationships among consulting physicians (one of the most persistent topics in the history of medical ethics), “the good of the patient is the sole object in view.”

Disruptive behavior obscures the patient from view altogether in circumstances in which the ego needs of the surgeon can never plausibly be construed to be more important that the surgeon’s primary responsibility to and for the patient’s health.

We live in an era in which we are skeptical about the connection between behavior and character. In particular, we are skeptical about whether we can reliably infer from good behavior to good character and vice versa. This crisis of manners dates from the late 18th century. Fissell notes that at this time, “medical manners and morals became unglued; no longer were codes of conduct based on courtesy functional.” Despite our skepticism, patterns of disruptive behavior of physicians invite the inference from bad behavior to deficient professionalism (i.e., defects in character). Such disruptive behavior, from the perspective of the ethics of professionalism, is a very serious matter indeed, calling for serious responses by physician leaders.

Option A does en passant have possible merit. A rather famous surgeon, who was legendary in abusing surgical residents, would characteristically announce in the middle of a procedure that “I can whip you with one hand tied behind my back.” Not knowing that a resident had been assigned who had been a successful professional boxer before medical school, the contentious surgeon threw down the gauntlet once more. When challenged, the boxer resident replied, “No sir, it is I who could whip you with but my left hand.” The abuse stopped for the remainder of that rotation but restarted with the following resident. Option A would not work longtime.

Option B allows unacceptable behavior in patient care areas to continue with administrative support. Thus, it is the least ethical answer offered. Option E is a variant of B that is objectionable as well but at least attempts to compensate those most abused.

Option D should be chosen if remedial measures are not effective. The courts clearly support an institution’s right to remove staff privileges when it can be proven that a physician’s behavior disrupts the institution’s ability to provide quality medical care. Management should deal with untoward events differently according to whether they are unique or global.

In setting up an institution-wide program, Dr Whittemore considers disruptive behaviors to be widespread. Is he justified? Data from a national study showed that 74% of health care professionals had witnessed disruptive behavior of physicians. This figure climbed to 86% when only data from nurses were counted. Regarding surgeons specifically, disruptive behaviors were more common in the perioperative area, where 97% of nurses reported witnessing surgeons behaving badly. Surgeons themselves had the thickest skins or greatest forgiveness: only 43% reporting witnessing such events. So it seems that although behaviors have improved with the present generation, a problem remains.

In every published study on organizational team processes involving medical care, there is need emphasized for improvement of the physician’s interpersonal communicative skills.

After the Institute of Medicine publicity regarding medical errors, considerable literature has accumulated emphasizing the need for improvements in communication skills among team members in complex high-risk environments such as the operating room. Direct observation of medical teams treating patients identified errors in 30% of emergency room cases and more than one event compromising patient safety per surgical case. The main cause identified was lack of effective communication in environments with “normally behaving” surgeons.

Dr Stein’s behavior and others like him is just the tip of the metaphorice iceberg drawing attention to an opportunity medicine should not ignore.

Option C emerges as the preferred option. Dr Whittemore outlines corrective measures that have been taken at his institution and places responsibility just where it belongs, on the physicians. He challenges, “Physicians must set an example for others in the institution by behaving professionally and respectfully towards all members of the health care team, acting in concert with institutional policies and statutory obligations, and by taking action when it comes to your attention that others have not done so.”

More to the point, it stands that dysfunctional surgeons captain dysfunctional operating teams and should be viewed by the profession as having incapacities that must be addressed. No surgeon would fail to take decisive action if he noticed a tray of unsterilized instruments being delivered for use to a colleague’s OR. Disruptive behaviors can be just as harmful, without microorganisms to fault, and should be taken just as seriously as a threat to patient well-being and therefore to the medical professionalism of us all.

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