Disrespectful behavior - by physicians and health-care institutions - endangers patients and stalls progress toward reducing medical errors

Almost 20 years after bringing the subject of medical errors out of the closet, patient safety advocate Lucien L. Leape, MD, is spotlighting the dangerous culture of disrespect - especially disrespectful behavior by physicians -- that permeates health care.


“Central to this culture is a physician ethos that favors individual privilege and autonomy -- values that can lead to disrespectful behavior,” writes Dr. Leape, a health policy analyst and adjunct professor in the Harvard School of Public Health.

This ingrained sense of physician privilege and status, he believes, “has a toxic impact on patient safety.”

Dr. Leape published a seminal article on medical errors in 1994 in JAMA. According to the Agency for Healthcare Research and Quality (AHRQ), Dr. Leape’s subsequent studies and commentaries helped shift the responsibility for medical errors from “bad people to bad systems, and paved the way for the 1999 Institute of Medicine report ‘To Err is Human,’ which he helped write.”

From Systems to Individuals

In a 2006 AHRQ interview, Dr. Leape acknowledged that his focus was shifting from the role of systems to the role of individual doctors in reducing medical errors. “It seemed to me that there were enough people carrying that (systems) ball that I could back away from it. But there were other areas that we were not paying any attention to.

“Although I’ve been outspoken about ‘it’s not bad people, it’s bad systems,’ the fact is that we do have some people problems. I don’t think they’re bad people, but certain problems are totally ignored,” Dr. Leape said.

In his 2012 JAMA article, Dr. Leape brings these problems out of the shadows and takes an unflinching look at physicians who behave disrespectfully but are also treated with disrespect by their institutions.
The Exception, Not the Rule

“The vast majority of physicians treat others respectfully most of the time; however, some do not,” Dr. Leape writes. At the same time, “Physicians dominate the culture and set the tone. Therefore in this discussion we focus on physicians.”

Dr. Leape cites a recent national survey in which two-thirds of responding physicians witnessed other physicians disrupting patient care at least once a month. In another study, “One in nine reported seeing disruptive behavior every day.”

Disturbing Side Effects

The repercussions of disrespect endanger patient safety on many levels, according to Dr. Leape. “Lack of respect poisons the well of collegiality and cooperation, undermines morale, and inhibits transparency and feedback. It is a major barrier to health care organizations becoming collaborative, integrated, supportive centers of patient-centered care.”

Specifically, this culture predisposes physicians to treat nurses with disrespect and spills over into dismissive treatment of patients. Students and residents are also targeted. “‘Education by humiliation’ has long been a tradition in medical education,” according to the JAMA article.

Systems: Off the Hook?

Throughout his career, Dr. Leape has been a strong proponent of systems-based approaches to reducing medical errors. His recent emphasis on disrespectful behavior, especially by physicians, does not let systems off the hook. Ultimately, he believes, “Responsibility lies with the health care organization that supports and tolerates disrespectful behavior.”

At the same time, Dr. Leape appeals to individual physicians to challenge not only “outbursts of outrageous, aggressive behaviors” but “subtle patterns that are so firmly embedded in our culture as to seem normal.”

Nurses as Targets

One longstanding pattern involves physicians demeaning or humiliating subordinates, especially nurses. A literature review of research conducted since 2000 produced 10 studies of abusive treatment of nurses. In four of those studies, more than 90 percent of nurses reported they had experienced abuse.

In another large study, 31 percent of nurses knew a nurse who had left the hospital because of disruptive physician behavior.

Medical students are also vulnerable to disrespect -- from faculty, house staff, nurses and others. According to the AAMC, 14 to 17 percent of graduating students report experiencing or witnessing some form of mistreatment. Other studies found 53 percent of medical students experienced burnout, and 14 percent suffered clinically significant depression.

These studies confirm, “that the environment in many of our academic medical centers and medical schools is sometimes hostile and quite toxic,” according to Dr. Leape. Women seem more vulnerable to disrespect than men, and disrespectful behavior toward students seems to be more common in clinical settings, especially high-stress areas such as operating rooms and emergency departments.

“In our experience,” notes Dr. Leape, “students indicate that they seldom report disrespectful acts because they are concerned about being seen as troublemakers and fear reprisal or vindictive retaliation such as a lower grade.”
**Double Jeopardy**

Episodes of disrespectful behavior often have immediate and downstream consequences: damaging to the recipient and dangerous for patients.

In the recipient, the disrespectful behavior may trigger intense feelings, such as humiliation. These feelings can damage professional performance and judgment.

“Everyone suffers in an atmosphere of intimidation,” according to Dr. Leape. One rational response is to avoid the person inflicting the hurtful behavior, making teamwork “another casualty of disrespect. When communication on the health care team is limited, the loser is the patient.

“Disrespect is a learned behavior, and students often learn it from their role models, the faculty,” says Dr. Leape. “Many students will emulate the behavior they see, ensuring a never-ending cycle of disrespect.

**The Perfect Storm**

Disrespectful behavior can be caused by endogenous factors (related to the individual) and exogenous factors (related to the environment), reports Dr. Leape.

In individuals, certain personality characteristics -- and professions -- may predispose a person to disrespectful behavior. The practice of medicine, for example, demands a tremendous commitment of time and energy as well as a high degree of self-involvement. In some individuals, this may accentuate narcissistic character traits such as superiority, authority, perfectionism and self-absorption.

“For some,” Dr. Leape suspects, “these narcissistic characteristics may be essential to mastering the highly complex demands of practice and achieving self preservation in a stressful environment.”

**Medical Narcissism** (*see sidebar on Medical Narcissism*)

Few physicians exhibit these characteristics to the degree that would be classified as pathological narcissism, according to John Banja, PhD, author of Medical Errors and Medical Narcissism. In research cited by Dr. Leape, Dr. Banja observes, “Many physicians and other health professionals nevertheless demonstrate a kind of muted or closeted narcissism whose associated behaviors serve as a form of self-protection when their feelings of adequacy, control, or competency are threatened.”

**“The Way We Do Things Here”**

While Dr. Leape encourages physician accountability for their own disrespectful behavior, he recognizes that workplace culture also plays a powerful role. “The culture of an institution -- ‘the way we do things here’ -- defines acceptable and unacceptable behavior,” writes Dr. Leape. “That culture, in turn, is influenced heavily by the customs and mores of society at large.”

Dr. Leape believes a “culture of aggressive crudity has taken hold in the past 10 to 20 years” and “a certain degree of demeaning disrespect has been elevated to a normal style of communication that is tolerated and that elicits little comment.”

Predictably, he says, “some of this society-wide tolerance for disrespect spills over into health care.”

**Health Care’s Hierarchal Nature**

Disrespectful behavior also thrives in a hierarchical, authoritarian, status-based culture such as health care. “Disrespect, which is closely tied to status, usually flows down, not up,” Dr. Leape observes. “Medical students rarely are outwardly disrespectful toward their professors, house officers toward their seniors or their attending physicians, or nurses to their supervisors because of the likelihood of repercussions.”
But the “department chair or world-class cardiac surgeon can often ‘get away with’ conduct that is not tolerated among those lower down the ladder,” he notes.

**Stress Factories**

But the key exogenous factor fuelling disrespectful behavior? “The stressful environment of modern hospitals, in particular large academic teaching centers, where many people work unduly long hours, have unreasonably heavy work loads, and experience multiple conflicting demands on their time and psyche,” says Dr. Leape.

He goes on to identify production pressure -- and the U.S. business model of health care -- as a key source of stress in the health care environment.

“Short outpatient appointments, shortened hospital stays, and increasingly complicated, sometimes dangerous procedures mean that pressured staff are often performing at the edge of their comfort and competence,” Dr. Leape writes. “As a result, there can be loss of continuity of care, and too little time is left for the courtesy and respect that are essential for good patient care and a work environment that is comfortable and humane.”

But other industries, such as commercial aviation, have managed to create “supportive and satisfying work environments in spite of production pressures and complex regulatory and documentation requirements,” Dr. Leape reports.

“A first principle is to guarantee the workers’ physical safety and psychological safety,” he says. “Such focus on and concern for the workforce are conspicuously absent at all levels in many, perhaps most, health care organizations.”

*To read more,* see “A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians” by Lucian L. Leape, MD, Miles F. Shore, MD, Jules L. Dienstag, MD, Robert J. Mayer, MD, Susan Edgman-Levitan, PA, Gregg S. Meyer, MD, MSc, and Gerald B. Healy, MD, in *Academic Medicine* 2012; 87:845-852 or link to:

http://journals.lww.com/academicmedicine/Fulltext/2012/07000/Perspective___A_Culture_of_Respect___P art_1___The.10.aspx

*See also,* “A Culture of Respect, Part 2: Creating a Culture of Respect” in *Academic Medicine* 2012; 87:845-852 or link to:

http://journals.lww.com/academicmedicine/Fulltext/2012/07000/Perspective___A_Culture_of_Respect___P art_2___.11.aspx

*To read more,* see: www.webmm.ahrq.gov/perspective.aspx?perspectiveID=19

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**A Dictionary of Disrespect**

“Disrespectful behavior takes many forms,” according to Dr. Leape and his colleagues, whose collective personal experience suggests the following classifications:

**Disruptive behavior** is defined by the Ontario College of Physicians and Surgeons as “inappropriate conduct, whether in words or action, that interferes with, or has the potential to interfere with, quality health-care delivery.” The general consensus is that about 5 percent of physicians fall engage in disruptive behavior, but their detrimental influence far outweighs their numbers.”
Examples of disruptive behavior, which may be directed at anyone, including colleagues, include:

• profane, insulting, abusive language
• temper tantrums
• throwing objects and/or breaking things
• violations of physical boundaries
• loud or inappropriate arguments
• demeaning comments or intimidation
• jokes about race, ethnicity, sexual orientation, physical appearance or socioeconomic status
• simple rudeness
• censuring colleagues in front of staff or patients
• bullying
• insensitive comments about a patient’s medical conditions

**Passive aggressive behavior** involves actions that seem normal on the surface but often conceal anger, negativism, and intent to cause psychological harm. “We know of no studies taken to quantify these behaviors,” Dr. Leape concedes, “but we have encountered widespread agreement among clinicians that such behaviors are not rare.” People who demonstrate this pattern are often unreasonably critical and blame others for their failures.

**Passive disrespect** is not formally included in the definition of disruptive behavior – but it should be, according to Dr. Leape. Examples of passive disrespect include chronic late arrival at meetings or resistance to safe practices such as hand washing. Colleagues tend to accept these behaviors as difficult but not malevolent.

**Dismissive treatment of patients** – such as talking about but not to the patient -- is difficult to quantify in data. But “anecdotal evidence abounds,” says Dr. Leape. “Such behavior violates the fundamental obligation of the physician to provide support and healing.” With patient feedback now required by the Centers for Medicare and Medicaid, “these sentiments are now beginning to be captured in a systematic fashion.”

A mild form of dismissive treatment might be addressing patients by their first names without seeking permission for this level of familiarity. The most egregious form of patient disrespect, according to Dr. Leape, is failing to fully inform and apologize to the patient when things go wrong, and the physician, or system, has failed.

**Systemic disregard** includes attitudes so firmly entrenched that they seem normal and are not recognized for the disrespect they represent. “A classic example is waiting,” according to Dr. Leape. “Everyone...seems to accept the fact that patients should wait for services. Making a person wait, however, sends the unambiguous message that the physician considers his or her time more valuable than the patient’s.”

Another form of covert systemic disrespect is the failure to inform patients fully about their care: the reasons for tests, the significance of test results, their options for diagnosis and treatment. These omissions violate of patient’s right to information and disrespect his or her ability to understand and make decisions.
A different yet very damaging form of systemic disrespect victimizes hospital staff and students. They are often subjected to hostile working conditions: unduly long hours, sleep deprivation, and excessive workloads – all known to cause medical errors and patient harm. Over scheduling is likewise disrespectful to physicians, depriving them of the time needed to do a professional job.

(Sidebar)

**Medical Narcissism**

In an AHRQ interview, John Banja, PhD, author of *Medical Errors and Medical Narcissism*, offers a glimpse of the attitudes and behaviors that led him to coin the phrase “medical narcissist.”

“I see two kinds of narcissists in medicine. The first is a representative of what is an increasingly bygone era. This is the “advanced” narcissist: an arrogant, imperious, prima donna physician around whom the world turns. We can all recognize this person, and while I am told they are still around, I rarely meet one.

The second kind is much more common. This is the very bright, compulsive, hard-working individual who lives in a very stressful world, who carries entirely too much stuff around in his or her head, who -- and this is a great tragedy -- is immensely self-preoccupied or internally focused with all that needs to be done, whose baseline emotional state is one of mild to moderate anxiety, and who has forgotten to be empathic.

That lack of empathy is his or her outstanding trait. It is not that this person wants to seem distant or uncaring, or rude or arrogant. Rather, his or her adaptation to the environment has resulted in a set of coping behaviors that seems to exclude patients and their families. This is a person who has forgotten how to listen, who is used to dominating conversations, who interrupts constantly, who uses technical language that patients cannot begin to understand, and who always seems to be in a hurry to be somewhere else.

This physician has forgotten how to monitor his or her relational skills. This person’s narcissism consists in his intense experience of himself. He “feels” himself and his world intensely, so that when an error comes along, two things happen: first, the natural self-protectiveness that any of us feel when we’ve screwed up is particularly aroused in this person (so that he might search for a way to rationalize or excuse the error to avoid its disclosure), and second, if he does discuss what happened to the harmed party, his poorly developed relational skills may trigger an empathic disaster.