The American Journal of Surgery (2015) 209, 65-70

The American Journal of Surgery®

Association for Surgical Education

Effects of disruptive surgeon behavior in the operating room

Amalia Cochran, M.D.*, William B. Elder, Ph.D.

Department of Surgery, University of Utah, 30 North 1900 East, SOM 3B312, Salt Lake City, UT 84132, USA

KEYWORDS:
Disruptive behavior;
Surgeons;
Professionalism;
Qualitative methods

Abstract

BACKGROUND: Surgeons are the physician group most commonly identified as "disruptive physicians." The aim of this study was to develop a conceptual model of the results of disruptive surgeon behavior and to identify the coping strategies used by perioperative staff.

METHODS: Perspectives of 19 individuals of diverse occupations in the perioperative setting were drawn together using a grounded theory methodology.

RESULTS: Effects of disruptive behavior described by participants included shift in attention from the patient to the surgeon, increased mistakes during procedures, deterrence from careers in surgery, and diminished respect for surgeons. Individual coping strategies employed in the face of intimidation include talking to colleagues, externalizing the behavior, avoidance of perpetrators, and warning others.

CONCLUSIONS: Using grounded theory analysis, we were able to elucidate the impact of disruptive surgeon behavior in the perioperative environment. This conceptual model may be used to understand and counter the negative effects of manipulation and intimidation of hospital staff and trainees and to build on current programmatic strengths to improve surgical environments and training.

Although disruptive physician behavior is widely considered a source of concern in the patient care environment, surgeons have been the specialty most commonly identified as "disruptive physicians."[1] This conduct distracts from patient care and negatively affects the morale of the team surrounding a disruptive physician.[1–3] In 2010, The Joint Commission released a sentinel event alert on disruptive physician behavior that elaborated on their 2009 Leadership standard addressing disruptive and inappropriate behaviors; the report includes a lengthy delineation of proposed actions designed to combat these behaviors.[4]

Prior research has sought to define the environmental effects of disruptive surgeon behavior, with the preponderance of this work relying on survey data to draw relevant conclusions.[1–3,5,6] Although this represents an important starting place, the potential means of coping are limited in a survey to options that were not defined by those experiencing disruptive episodes. Furthermore, no prior investigation has examined the coping strategies used by staff who are proximate to disruptive surgeon behavior events. The aim of this study was to develop a conceptual model of the impact of disruptive surgeon behavior in the perioperative environment. Specifically, we employed semistructured interviews and grounded theory analysis to delineate

The authors declare no conflicts of interest.

Work presented during the annual meeting of the Association for Surgical Education, April 11, 2014, Chicago, IL.

* Corresponding author. Tel.: +1-801-581-7508; fax: +1-801-585-6005.
E-mail address: amalia.cochran@hsc.utah.edu

Manuscript received May 9, 2014; revised manuscript August 11, 2014

0002-9610/$ - see front matter © 2015 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.amjsurg.2014.09.017

the effects of disruptive behavior and identify the coping strategies used by perioperative staff.

Methods

This project was designed according to qualitative methodology using a grounded theory approach.[7–9] Through extensive use of interviews, the researchers gain insight into the meaning participants make of a phenomenon within its social context. The paradigms generated from the interview data come specifically from the information shared by the interviewees. Grounded theory analysis is not hypothesis driven but is used to develop a model based on iterative examination of interview data. Participants were not given a definition for a disruptive surgeon but instead were asked to provide descriptions of disruptive behavior in conjunction with their discussion of effects of and coping strategies in response to these behaviors.

Interviews

Interviews occurred over a 9-month period at a single academic medical center. Approval of the local institutional review board was obtained, and all participants provided informed consent for participation in the study. Each interview was digitally audiorecorded and transcribed verbatim. Interviews were semistructured and conducted in a confidential manner by a single interviewer who was unfamiliar with the perioperative environment. Participants were purposively selected to achieve maximum variation with respect to age, sex, and occupation and to increase the likelihood that the varying perspectives would accurately represent differences.[10] New participants were sought until information gathered from interviews no longer expanded or refined the preliminary data.[7]

Interviews detailed participants' experiences of disruptive surgeon behavior in the operating room (OR), with a focus on the effects they ascribed to those disruptive behaviors and how they self-managed during these episodes. Each participant had the opportunity to review and approve her or his transcript for fidelity.[11,12] Both authors had access to and reviewed the interview transcripts.

Data analyses

Data analyses followed a 3-step process involving open, axial, and selective coding.[9] This iterative process concludes with an illustrative model to conceptualize and explain the effects of the disruptive behavior. Both authors met regularly to discuss all aspects of coding until consensus was reached at each step, establishing credibility and groundedness in the data.[13] This also allowed for peer debriefing to triangulate the data. Data were further given credibility through documentation of an audit trail according to grounded theory design.[9,14–16]

Results

Participants

Interviews included a total of 19 participants (scrub technicians, n = 2; nurses, n = 4; medical students, n = 5, surgical residents, n = 4; anesthesiologists, n = 4). All staff were employed in the perioperative environment of a single institution at the time of their interview, and medical students had completed their required surgical clerkship. Participants' ages ranged from 25 to 48, with a mean age of 36. Thirteen interviewees identified as white, 4 as Asian, 1 as black, and 1 as Hispanic. As highest level of educational attainment, 69% of participants had obtained an MD, 21% had a bachelor's degree, 5% had an associate's degree, and 5% had a high school diploma. Participants were evenly divided by sex (48% men and 52% women). All participants equally contributed to the emergent themes identified by the investigators.

Themes

Descriptions of disruptive surgeon behavior by the participants have been reported separately.[17] Study participants described 2 broad themes regarding the effects of disruptive behavior. The first theme described the negative consequences of disruptive behavior, including how interviewees had been personally affected by it. The second theme centered on coping strategies of interviewees and depicted how participants navigated these difficult situations to fulfill their professional responsibilities. The most common effects and coping strategies are described in detail subsequently, with all described effects and strategies illustrated in Fig. 1.

Negative consequences of disruptive surgeon behavior. ***Shifts focus from patient to surgeon.*** The most commonly mentioned effect of surgeon outbursts was a shift in the focus of those in the room from care of the

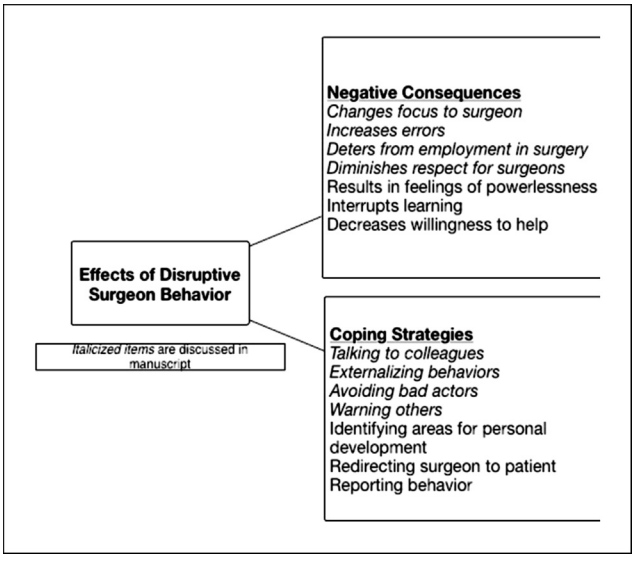

Figure 1 Effects of disruptive surgeon behavior.