

Consequences and potential problems of operating room outbursts and temper tantrums by surgeons

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Abstract

Background: Anecdotal tales of colorful temper tantrums and outbursts by surgeons directed at operating room nurses and at times other health care providers, like residents and fellows, are part of the history of surgery and include not only verbal abuse but also instrument throwing and real harassment. Our Editor-in-Chief, Dr. Nancy Epstein, has made the literature review of "Are there truly any risks and consequences when spine surgeons mistreat their predominantly female OR nursing staff/colleagues, and what can we do about it?," an assigned topic for members of the editorial board as part of a new category entitled Ethical Note for our journal. This is a topic long overdue and I chose to research it.

Methods: There is no medical literature to review dealing with nurse abuse. To research this topic, one has to involve business, industry, educational institutions, compliance standards and practices, and existing state and federal laws. I asked Dr. Rosanne Wille to co-author this paper since, as the former Dean of Nursing and then Provost and Senior Vice President for Academic Affairs at a major higher educational institution, she had personal experience with compliance regulations and both sexual harassment and employment discrimination complaints, to make this review meaningful.

Results: A review of the existing business practices and both state and federal laws strongly suggests that although there has not been any specific legal complaint that is part of the public record, any surgeon who chooses to act out his or her frustration and nervous energy demands by abusing co-workers on the health care team, and in this case specifically operating room personnel, is taking a chance of making legal history with financial outcomes which only an actual trial can predict or determine. Even more serious outcomes of an out-of-control temper tantrum and disruptive behavior can terminate, after multiple hearings and appeals, in adverse decisions affecting hospital privileges.

Conclusions: Surgeons who abuse other health care workers are in violation of institutional bylaws and compliance regulations and create a hostile environment at work which adversely affects efficient productivity and violates specific State and Federal laws which prohibit discrimination based on race, color, sex, religion, or national origin.

Key Words: Compliance, discrimination, employment, federal laws, harassment, hospital privileges, hostile, sexual, state laws

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INTRODUCTION

The history of surgery abounds with tales of angry and difficult senior surgeons who abused any person who, because of physical proximity, became the object of their fury. Many of us find amusement in retelling these anecdotes after we have escaped to the relative safety of rank or distance but remember that we passed the ring of fire and escaped injury. In the operating room, the abusive outbursts were commonly directed at the scrub nurse who was expected to stand mute and take it. I specifically do not want to name the offending surgeons who not only used words but also threw instruments to the floor and occasionally at the nurses. Their aim happily was often spoiled by their rage but occasionally hit its intended victim. Most of us in academic medicine know about a famous chair of neurosurgery in the Midwest and another famous chief of surgery in New York whose statue adorns the lobby of a major medical center as chronic offenders. Younger surgeons often took on the traits of their teacher and I vividly remember a chief resident who was described by our "CHIEF" with some admiration as someone who could slam a curtain. I myself had less luck with attempts at dominant behavior in the operating room. As a young surgeon, I once irritably instructed a very young scrub nurse that I wanted only blind obedience in my operating room. For the next 35 or so years, when she was an operating room director and I was a surgical chair and we were friends, she never once let me forget the stupidity of my outburst which was told and retold accompanied by gales of laughter at my expense over and over again. I am a quick learner, so I never repeated anything like that again.

Tolerating this abysmal behavior is thankfully no longer accepted. Public abuse of operating room personnel can, and should, be stopped instantly by surgical chiefs, medical staff officers, and administrators. It is more difficult to stop private discussions which border on abuse and insults, but education through mandatory conferences dealing with sexual abuse and a hostile work environment should and will help. Both industry and colleges and universities have required, compliance mandated, sessions to prevent violations of real and at times oversensitive and perceived, rather than intended, offenses.

This paper will examine the industry and institutional standards and existing state and federal laws which may potentially apply and represent a risk for the offenders.

INSTITUTIONAL BYLAWS AND PRACTICES

Every institution providing health care, be it a major medical center or a local community hospital must, as part of its incorporation and accreditation documentation, provide a set of bylaws of the governing body and the

medical staff. All of the bylaws have a section dealing with ensuring and supporting a productive work environment. The specific wording may differ from institution to institution, but the meaning of the bylaws is uniformly clear, and that is to promote a healthy, cooperative, and safe environment for patients and staff alike.

Regulatory agencies, i.e. the Joint Commission for Accreditation of Health Care Organizations (JCAHO), also known as The Joint Commission (TJC), State Medical Boards, and the federally mandated National Practitioner Data Bank have established requirements for handling and reporting of disruptive behavior by physicians. The JCAHO recommends that disruptive physicians be educated and that the focus of handling disruptive behavior should be based on rehabilitation rather than punishment. JCAHO regulations do recognize that at times, after attempts at rehabilitation have failed, suspension, abridgement, or revocation of hospital privileges are the only options remaining to the institution. At that time, reporting of the decisions to the State Licensing Board and the National Practitioner Data Bank is mandatory.^[5,7]

Specific forms of disruptive behavior listed are:^[5,7] (1) degrading comments or insults, (2) inappropriate joking, (3) profanity, (4) physical assault, and (5) spreading malicious rumors.

The JCAHO, in other words, recognizes and condemns abusive behavior in the operating room and elsewhere in the hospital environment. Insulting language or descriptions involving a member of the health care team or the spreading of malicious rumors about colleagues, out of the immediate institutional environment, would qualify as being disruptive behavior.

Large businesses, industry, and educational institutions have a long history of needing to deal with complaints about discriminatory practices. In industries where the majority of workers are women and many supervisors are men, an allegation of sexual harassment is not unusual. To be defined as sexual harassment, the behavior does not have to be a request for sexual favors. Offensive comments about, or interpreted to be about, women are sufficient to be labeled sexual harassment. In an environment where the majority of nurses are women and the majority of surgeons are men, it is not difficult to imagine that the person at the receiving end of a barrage of insults decides that she was a victim of sexual discrimination.^[6,14]

In order to meet corporate compliance regulations of the Equal Employment Opportunity Commission (EEOC) and reduce liability of harassment claims, a company (educational or health care institution) must train employees and supervisors, require employees to report harassment, thoroughly investigate all reports, and

take corrective actions.^[5,6] Many institutions, including colleges and universities and major medical centers, have instituted mandatory training and education which is conducted on an yearly basis. There are multiple providers of compliancy training to assist organizations to meet the requirements and be proactive in preventing or ending a hostile work environment. Inactivity represents a real liability financially and a potentially devastating public image risks affecting the success of the institution, be it a business, hospital, or university.

FEDERAL ANTI-DISCRIMINATION LAWS

The Federal EEOC is charged with enforcing all the federal laws prohibiting job discrimination.

For the purpose of this paper, the most significant federal law is Title VII of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, religion, sex, or national origin. As a corollary to the 1964 Civil Rights Act is the Civil Rights Act of 1991, which among other provisions provides monetary damages in cases of intentional employment discrimination.^[4]

It does not take much imagination to see how this can be applied to nurse abuse in the operating room by surgeons.

STATE ANTI-DISCRIMINATION LAWS

Many states have adopted anti-discrimination legislation which, to some extent, is similar and even mirrors the federal laws. The most specific is California AB 1825 which requires employers of 50 or more employees to provide all supervisory employees with formal education consisting of 2 hours of sexual harassment prevention^[13] every 2 years. The final regulations were issued by the California Fair Employment and Housing Commission (FEHC) which published the finding that failure to comply with AB 1825 will open the door to sexual harassment lawsuits and make it harder to prove in court that the (your) organization took reasonable steps to correct sexual harassment.

A similar law in Connecticut requires that all supervisory personnel be given 2 hours of harassment prevention instruction within 6 months after becoming a supervisor. Additional training within 3 years is encouraged.

Maine Title 26, Section 808 requires that employers of 15 or more employees train all their employees about workplace harassment and discrimination within 1 year. The specifics of the training are not defined.

Other states have approved anti-discrimination laws, but training is not required for compliance. Federal anti-discrimination rules and training requirements apply in all states.

ATTORNEY ADVERTISING

It is only necessary to open a yellow page phone book or access Google or any other search engine to find advertising from multiple law firms seeking clients. The law firms promise to address potential discrimination claims using state and federal courts. Nearly all of the firms offer a contingency fee arrangement, or a no risk to the client lawsuit alleging, among other complaints, sexual harassment, the creation of a hostile work environment, and employment discrimination. In view of the media-publicised hostile work environment, sexual harassment, and employment discrimination awards, it is a surprise, not an expectation, that some operating room nurse has not thought about how to respond to an aggressive surgical attack instead of ignoring the torment. Sooner or later, however, this is bound to happen.

DEFENDING HOSTILE WORK ENVIRONMENT CLAIMS

There are two separate areas of potential problems for the abusive surgeon which may call for a legal defense. The first one is the institution and the second, a court of law. Only two theories are available to the defense.

1. What Dr. X said does not meet the “severe or pervasive” definition of harassment laws. He didn’t mean it. He is sorry. She is oversensitive and he was just talking and making a joke.^[9] This defense theory can be best described as the “I didn’t know the gun was loaded” defense.
2. This claim represents a violation of my First Amendment rights of free speech.

This line of defense has a more substantial chance of success. Professor of Law at UCLA, Eugene Volokh, has written extensively about Freedom of Speech and Workplace Harassment Laws.^[9] He reported a big free speech win in the Ninth Circuit Court of Appeals in the Huffington Post.^[19] The court opined that in an academic community, a professor’s expression on a matter of public concern (even if offensive to some) does not constitute harassment.

DISCUSSION

This paper aims to address the questions: “Are there risks and consequences when spine surgeons mistreat their predominately female operating room nursing staff/colleagues and what can we do about it?” It became quickly obvious to us that this could not be handled in the same manner as our usual literature search. Medical literature does not address abusive behavior problems except obliquely. Even nursing literature tends to shy away from this topic. We had to turn to industry and the law to answer these questions.

Gender discrimination at work has been described in *Psych Central News*, an internet psychology journal.^[10] In *Forbes Magazine*, an excellent article by Michael Morris and Susan Fiske quoted Susan Fiske's keynote address at the Columbia Business School Conference in 2012. Dr. Fiske is a Princeton University psychologist. The theme of the conference was that despite decades of activism, legislation, and human resources programs, discrimination at work continues unabated but manages to hide itself better.^[8]

Many of us are products of training programs which profess to practice the Socratic Method of Education.^[1,3] This educational theory is based on teaching by dialogue rather than lectures and is very appealing until it becomes a method of practicing resident abuse at Grand Rounds. The fellows, who are at times leading the conferences, are expected to follow the example of the Chief and actively participate in resident hazing in order to "make men of them." Small wonder that after this education, some of us turn to nurse and colleague abuse, particularly if they are women and appear to be defenseless.

The term "sexual harassment" was used for the first time in 1973 in a report to the President and Chancellor of MIT about various forms of gender issues. It may have been used by various women's groups as early as 1970.^[11,12] It is essential to understand that sexual harassment does not have to include demands for sexual favors. It is sufficient that it can be interpreted as being gender specific and severe and pervasive. Employment discrimination law recognizes several protected categories. Among the 16 categories listed, Sex or Gender and Gender Orientation are pertinent to this paper.^[9]

Professor Volokh, in his excellent paper in the *Georgetown Law Journal*,^[20] describes the fact that the law's vagueness increases its breath and makes it open to interpretation. He advises to stay wide of the unlawful zone and eliminate any possible offensive behavior and severe and pervasive practices to create a hostile or abusive environment at work. If an employer continues to question his attorney to describe specific potential consequences of violations of the law, Professor Volokh advises counsel to answer: "We won't know until it gets to court." That is exactly the potential fate of the surgeon who insists on abusing co-workers.

A complaint to the governing body of the institution (hospital, medical center) leads to a hearing by a medical staff committee. Depending on the seriousness of the complaint, the resolution may be dismissal of the complaint or may include a number of remedial actions up to and including revocation of privileges. When that happens or when a suspension or abridgement of privileges is recommended, the case invariably will end up in court. It would be unusual to have operating room nurse abuse alone result in a penalty so severe that a report to the National Practitioner Data Bank and the State Board of Medical Examiners becomes mandatory.

Any adverse decision about clinical privileges meets the mandatory reporting criteria in every state.^[5,7] To result in privilege abridgment, or more, the physician would have to be considered a disruptive physician whose continued presence on the medical staff would interfere in quality health care delivery. Very few judges are likely to reverse that kind of decision.

During my tenure as a Department Chair, President of the Medical Staff, and Chair of the Medical Board (Medical Executive Committee), and my many years of membership on the Executive Committee of the Board of Governors of the University Hospital, we had several instances dealing with impaired physicians and only one instance when a revocation of privileges was recommended because of disruptive behavior. The physician who came under review did not just abuse operating room nurses, but also engaged in hostile and threatening behavior in other areas of the institution.

Most industries recognized some time ago that it is not a good business practice to use gender-specific names and terms which part of the workforce might find demeaning or offensive. Both I and Dr. Wille, as professional pilots, experienced this alternate terminology when we were directed to change the name of "cockpit" to "flight deck" and "stewardess" to "flight attendant". It was only after the change in name was official that most of us recognized the potential problem which could be interpreted as contributing to the creation or maintenance of a hostile work environment.

The First Amendment to the Constitution, adopted on December 15, 1789, simply states: Congress shall make no laws respecting the establishment of religion, or prohibiting the free exercise thereof, or abridging the freedom of speech, or of the press, or the right of the people peacefully to assemble, and to petition the government for redress of grievances. In the beginning, the First Amendment applied only to the federal governments, but in the 20th century the Supreme Court incorporated the Establishment Clause which made the amendment apply to the states as well.^[15-18]

It is the First Amendment freedom of speech clause which is used to defend most of the verbal harassment complaints which are the discussed in this paper.

CONCLUSIONS

There are indeed potential risks and consequences of operating room nurse/colleagues abuse and these include violation of institutional and medical staff bylaws and violations of Title VII of the Civil Rights Act of 1964 with potential monetary awards which are not covered by most malpractice carriers. If the awards include punitive damages, they are designed to punish and are not recoverable from any insurance held by the defendant.

Finally, for those surgeons who have a self-value far in

excess of what any nurse has, it is worth to consider the following as a valuable lesson of what the world thinks of nurses: On the retirement of Lieutenant General Eric B. Schoemaker, MD, PhD, as the US Army Surgeon General, President Obama nominated and the US Senate confirmed the appointment of Major General Patricia D. Horoho as the US Army Surgeon General. General Horoho served as the Commanding Officer of the Army Nurse Corps and Assistant Surgeon General prior to being given the Army Medical Command. On December 5, 2011, General Raymond T. Ordierno, the Army Chief of Staff, promoted Major General Horoho to Lieutenant General and administered the oath to swear her in as the Army's Chief Medical Officer. General Horoho is the first woman and the first nurse to serve as the Commanding Officer of the Medical Corps. Think about that the next time you decide to abuse a nurse or a woman colleague.^[2]

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Commentary

Along with female surgeons, nurses have historically tolerated abuse. I remember being in surgery as a scrub nurse, and somehow I misinterpreted the surgeon's muffled voice when he requested an instrument. I inadvertently gave him the wrong one, and he threw it at me. Fortunately, it hit a few machines instead of me. I, of course, was frightened, embarrassed, and could not wait for my 3-month rotation to end. It discouraged me from ever wanting to pursue working in the OR as a career.

As an aside, in the early fifties, I was a student nurse in a hospital known for cardiac surgery. I was permitted to observe a world-renowned cardiac surgeon operate on a 5-year-old girl. She died on the table, and his first words were that anesthesia killed her. I never forgot that. Needless to say, these two experiences kept me from ever pursuing the OR as my career. I went on to have a very exciting, diverse, and rewarding career. Throughout those years, I was working in the community more than performing hospital-based nursing. Ironically, I eventually went to work in a cardiac hospital to upgrade my inpatient skills. It was interesting to note that little

had changed in the surgeon–nurse relationship. I do believe that as the author of this paper points out, the senior surgeons were better role models and were more willing to teach. I think the surgical trainees/residents/fellows were impossible, and spent more time trying to seduce the young nurses than they did in learning from the senior staff. I was blessed to marry a world-renowned neurosurgeon who always believed in mentoring nurses and was well accepted by them in the years I knew him. I am at a loss as to how the more mature senior surgeons can reach the younger trainees as we live in such different times and acceptable "behavioral protocols" are difficult to maintain.

I applaud the author for creating these guidelines. They are so sorely needed in today's times to restore respect which, as you know, is lacking at many levels. I am honored that you invited me to comment.

Renee Steele Rosomoff

Commentary

Having been accused of things from both male and female nurses in and out of the OR, the one issue that chaps me is that there is no penalty for falsely accusing physicians. I'm happy to take the penalties of my actions or reactions. But in today's climate – where being a disruptive physician can be potentially career ending – false accusations that do not stand up to the review process need to be dealt with as seriously as the person who was accused of being disruptive. The review process is the key and must be thorough and unbiased. Nurses

with known psychiatric histories should not be allowed to continue to threaten physicians or other nurses without some sort of reprimand or repercussions. Accountability for your actions from both parties is essential.

I do not see this as a sexist issue, but as one of the systems protecting the psychologically fragile accuser and letting them off “scot-free.”

Surgeon, name withheld

Commentary

I can contribute an incident that happened with a neurointerventionalist that I worked with a few years ago. This physician was out of the office sick one day and I received a call from a family medicine attending physician asking whether a patient could be added to the schedule for an angiogram (I coordinated the schedule). I normally would have ok'd this as there was room on the schedule, but since the physician was sick, I did not want to add to the schedule in case he cancelled his procedure schedule. I knew the two physicians had a cordial relationship, so I suggested she page him directly with the question.

Later that evening at home, I received an irate phone call from the physician, (not a page, he called me at home!) screaming that I was “lazy and irresponsible.” He went on to scream that he was at home sick and shouldn't have been bothered with this. He said I was “too stupid to make a simple decision.” Now, of course, had I ok'd this addition, he would have screamed at me as well, as he was this type of person. I did document this to HR and left the department soon after.

Nurse, name withheld

Commentary

From my perspective as a physician and neurosurgeon for almost 50 years, I too have seen this behavior. Usually, it is a personality disorder. It is a childhood temper tantrum in the operating room that goes unpunished, and therefore is rewarded behavior. It is bred by a circumstance where a surgeon is in total control in the operating room, and thus feels empowered over all people to do what he or she wants. There are no rules except the surgeon's rules. In all my experience, I have never seen an operation improve when the surgeon acts in an inappropriate manner. It is also a reflection of the frustration of the surgeon with his or her failure, a situation for which they will blame others. This is a product of being cloned as an obsessive-compulsive student, and one from whom perfection is demanded (we learned early on in medical school not to accept failure). This behavior is also a result of poor planning for surgery, as well as poor individual social skills – a problem related to poor selection of people to become doctors.

never be tolerated. I never allowed this behavior and always disciplined the surgeon immediately when it occurred. I tried to set an example of equality of treatment for all in the OR or hospital. Why does one behave differently in an operating room than outside of one? There is no good reason for that behavior. It is a problem we see with children who are undisciplined and have no boundaries. Does that circumstance happen today in society? Have we come to the point where we need to have rules for behavior? Unfortunately, this is true in many areas of society today, and more so in the last 40 years of the 20th century.

I applaud the authors for tackling a challenging topic that no one ever talks about – but should.

Jim Ausman

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In my opinion, then, it is multifactorial. But it should

Commentary

The continued abuse of female operating room staff/colleagues is not supposed to be tolerated in this day and age. Nevertheless, although one might wish to couch verbal abuses in the more glorious and demure language of Jane Austin's "Pride and Prejudice," we are alternatively privy to forthright slurs, demeaning language, and outright degradation.

This "ethical note" was in part prompted by the author's recent review of the hospital's patient care manual. Of interest, in it they state that amongst other objectives, the standard for Medical Staff conduct (the "Policy") is to "promote a safe, cooperative, and professional healthcare environment," and not to promulgate behaviors that "affect the ability of others to do their jobs, or create a hostile work environment." The manual in fact emphasizes that staff should be treated with "courtesy, respect, and dignity," or the Medical Staff will deal with the situation in a "consistent, equitable manner." The manual even goes on to define unacceptable, disruptive conduct as "including attacks (verbal or physical), or making threatening remarks." Certainly, the lines between verbal abuse and sexual harassment become increasingly blurred.

Despite these "protections," many of our male spinal surgeons resort to intimidation and insult. Counterintuitively, this predominates not in our older colleagues who have matured and learned the new ways, but rather typically applies to the younger and more immature surgeons. Personally, I had a recent interaction with a colleague who was trying to intimidate me. As

background, I am not only his senior colleague, but also a full clinical professor of neurosurgery – a rank that he did not share! More importantly, what do we do about our nursing colleagues who have to put up with intimidation and more flagrant insults/abuse with substantially less to defend themselves? Unfortunately, the whistle blower rule simply does not work; many formal complaints go minimally recognized or unaddressed, and typically backfire on staff. Most critically, the whistle blower rule is ineffective at best and at worst leaves staff even more unprotected. This means that staff tries to ignore inappropriate behaviors and tries to treat it as business as usual: in short, staff has given up on change.

So, in *SNI: Spine*, what can we do about it? We invite you or your nursing staff to give specific examples of nurse abuse from institutions across the country. However, one of my main questions is what the experienced and mature spine surgeons in leadership positions can do to influence the ongoing behavior of our typically misbehaving younger colleagues? How do we recreate the appropriate role models?

In this introduction to the new ethical notes section, I am asking whether you, my colleagues, have some recommendations or answers.

Nancy E. Epstein

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Announcement

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