The Royal Society of Medicine **Daedalus Trust**

Notes from Session 3: Preventing and responding to hubris: individual approaches

Doctors, power and their performance

Professor Alastair Scotland
Founding Director (2001-2011) National Clinical Advisory Service (NCAS)

Prof Scotland began by reminding the audience of the case of Harold Shipman who abused his position of power and may have had more than 250 victims. All practising doctors are in positions of power and are ascribed this power from various sources including the doctor patient relationship, the law, the way health services are structured, and in the attitude of patients and society. Medical regulation itself underpins and enhances this power gradient.

Contracts are needed to balance the power of doctors, creating a more equal relationship between the profession and society, and between individual practitioners and those they work with. When things go wrong courts often collude in taking doctors views on board, reflecting and enhancing apparently inappropriate power gradients.

The various medical scandals of the past raise questions as to whether poor performance was tolerated more than it should have been, and whether UK healthcare was able to learn from its own mistakes. The systems for responding to failures are outdated, unwieldy, bureaucratic, excessively legalistic, adversarial and court-like. Added to that is the media response, which tends to focus on blame, making it difficult or impossible to separate out individual failure from system failure and incidents which were due to no particular fault.

The response to this has been in three-phases. Phase 1 was about moving accountability centre stage, underpinned by new central governments bodies. Phase 2 has been about modernising employment and HR practice, whilst Phase 3 has been about reforming professional regulation for all clinical staff groups.

The quality and regulatory field is very complex, with many quasi regulatory arm's-length bodies mostly created as one-off 'fixes'. Modern healthcare is high impact, high risk and lacking recognition as a team effort, not just the sum of the parts. A simpler landscape with clear rules and an integrated approach to regulation and governance is needed.

International evidence suggests about 1% of any population of doctors get into difficulty each year to a degree that requires outside help. UK figures are similar. Certain groups are more likely to be referred: older doctors, consultants, men, non-white doctors qualifying outside UK (in secondary care), and lone practitioners (vs. those in practices of four or more).

Psychiatrists obstetricians and gynaecologists and general practitioners are significantly more likely to be referred than other groups. Anaesthetists, General Medicine group and Public & Community health practitioners are significantly less likely to be referred than others.

Prof Scotland described a performance triangle, adapted from Jacques et al. where clinical knowledge and skills are seen alongside behaviour, work context and health as the four main areas in which the performance of doctors can be deficient.

The performance triangle

Adapted from Jacques et al, Québèc

The most significant factors found when referred to doctors have been assessed were behavioural (94%), organisational (88%) and clinical skills (82%).

There were two particularly interesting aspects to behavioural deficiencies. The first is as cited by Hogan & Hogan and King, whereby various strengths become weaknesses.

Behavioural factors – strengths becoming weaknesses

STRENGTH		DYSFUNCTIONAL BEHAVIOUR
Enthusiastic	Moving away from others	Volatile
Shrewd		Mistrustful
Careful		Cautious
Independent		Detached
Focused		Passive-Aggressive
Confident	Moving against others	Arrogant
Charming		Manipulative
Vivacious		Dramatic
Imaginative		Eccentric
Diligent	Moving towards others	Perfectionist
Dutiful		Dependent

Source: Hogan and Hogan (1997, 2001); King (2008)

The second is as cited by King, whereby actual behavioural findings were not as expected in ways that are seemingly counterintuitive.

Behavioural factors – findings can be counterintuitive

WHAT WAS EXPECTED	WHAT WAS FOUND
More emotionally reactive	Somewhat more reactive
More introverted	More introverted
Less open	Less open
Less agreeable	Much MORE agreeable
Less conscientious	Similar to the working population
More arrogant	More perfectionist and more dependent
Unmotivated	Motivated
Stressed	Resilient (based on US norms) – but Stressed (based on UK working pop)
Low self-awareness	Low self-awareness
Weak influencing and leadership skills	Weak influencing and leadership skills

Source: King (2007, 2009)

Behavioural findings that were most relevant to the topic of hubris were that doctors tend to be patient-focused to the exclusion of wider considerations, diligent to the point of perfectionism, confrontation averse, poor influences, low self-awareness, receptive to ideas, but resistant to changing their own ways of working.

The likelihood of change is predicted by whether doctors have sufficient stability of personality and perseverance, whether they are sufficiently self reflective and insightful, whether they are motivated to change themselves, and whether the context is supportive of such change.

Doctors who practice in a dysfunctional way are rare but where they exist have a high impact on patients and the wider health team. Disruptive and one might say hubristic behaviour is a significant element of dysfunction. The U.K.'s experience of tackling this challenge has been one of repeated creation abolition and re-creation of external agencies. The focus needs to shift from failing practitioners to failing organisations and systems.

In the future we need a simpler regulatory landscape with clear rules that are auditable, better integration of regulation and governance, and more sensitive and specific systems to support frontline governance.

Respondent

John Rowson

Director, Social Brain Project, Royal Society of Arts

John Rowson began by citing Paul Watzlawick and his notions of first and second order change. Watzlawick described a first order change as change that appears to be common sense or "more of the same", whereas the second order change often appears weird, unexpected, puzzling or paradoxical.

He also talked about the notion of a psychological immune system, which acts to prevent change – even change that we may wish.

He cited the work of Ian McGilchrist on the distinct personalities of the left and right brain and how this goes beyond previous simplistic notions of hemispherical specialism in the brain. He mentioned that a left hemisphere bias is commonly associated with hubris, and that hubris may also be related to tempo — we are too busy to find time to reflect.

He concluded by mentioning the work of Edgar Schein, in particular his concept of career anchors and how in the health service these are likely to differ between clinicians and managers.