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In Conversation with…John Banja, PhD

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Editor's Note: *John Banja, PhD, is Assistant Director for Health Sciences and Clinical Ethics and Associate Professor of Clinical Ethics at Emory University School of Medicine. Dr. Banja, whose doctorate is in philosophy, is currently participating in AHRQ-funded studies designed to help clinicians communicate more effectively in emotionally charged situations after errors or unforeseen outcomes. His book, Medical Errors and Medical Narcissism, covers issues around the appropriate, ethical disclosure of medical errors by health care professionals.*

Dr. Robert Wachter, Editor, AHRQ WebM&M: Tell us what you mean by medical narcissism.

Dr. John Banja: 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.

RW: Do you think medical narcissists are largely born or bred? Does the profession attract or make them?

JB: The literature on narcissism suggests that it's probably a product of nurturing more than anything else. This nurturing could occur early in childhood or it could occur in medical school or, most probably, in residency. Robert Millman has discussed a phenomenon he calls "acquired situational narcissism," illustrated by professional athletes and movie stars, whom he has counseled over the years. These folks often are born into socio-economically disadvantaged situations, but in their early 20s, for example, they find themselves millionaires and the center of attention. And they begin to develop pompous, condescending, very self-preoccupied types of behaviors. He believes that it's a function of the situation that they are in. I often think that the physician lives in a peculiar, if not downright unhealthy, emotional environment. First, it's a very stressful world. Second, doctors are often surrounded by people who are overly polite or overly respectful, if not simply genuflective. They're also exposed to individuals who are challenging, irritating, annoying, or difficult—patients projecting their misery and anxiety on them and asking all kinds of challenging questions. Medical narcissism develops as either a poorly regulated response to the adulation (for all the marvelous things health providers know they do) or as an overly defensive response to the countless threats to the professional's self-esteem that occur every day.

RW: Is the main issue in medical narcissism as it pertains to patient safety the inability to recognize or acknowledge an error when it occurs, or is it the inability, once an error is recognized, to confront it and perhaps apologize for it, in the most mature and appropriate way?

JB: The answer depends largely on where on the pathological continuum of narcissism you are. The more pathological in terms of the narcissism, the easier it is for you to say "I couldn't possibly have done that. Someone else is to blame." As I started learning about errors, how they happen, and how complex and multi-factorial they often are, one thing that surprised me was how there is a nugget in virtually every scenario that could be used to spin the story away from the error. You could use this nugget to say, "I don't know that this really was an error," or "I don't really know for sure that this error caused the harm." Or, "I don't know that the harm was all that horrible or all that bad." Or, "I don't know that this was really my fault." Or, "This was somebody else's fault." That opportunity for rationalization is always there, and for the advanced narcissist, he or she almost reflexively takes advantage of it. For most health care providers—in other words, those who are not advanced narcissists—it's more the fear of the malpractice suit, the fear of censure from their colleagues or licensing boards, or the discomfort of embarrassment and humiliation that influences their concealment of error. Research has shown that the feelings of embarrassment and humiliation are often significant barriers to health care professionals acknowledging their errors and discussing them with their patients.

RW: Let's assume that you committed a terrible error and the patient died. I am the patient's family member. Can you disclose and apologize to me in the way that you think it should be done?

JB: Okay, I would say, "Mrs. Jones, this is very difficult for me to tell you and it will probably be even more difficult for you to hear. But an error occurred when your Mom was here at the hospital last week." And I would stop at that point, and wait for her response. If she looked at me in shock and said, "An error?" I would say, "Yes, there was an error in the course of her care. Would you like me to tell you about what happened?" And let's assume she said yes. I would say to her something like, "Mrs. Jones, what happened

was your mother was supposed to receive 10 units of insulin, and there was an error—she actually got 100 units of insulin. And we believe this medication error caused the problems that she had. It caused her heart to stop. It caused our having to take her down to the ICU where, as you know, we were not successful in resuscitating her. I am sorry beyond words, Mrs. Jones, but it would have been wrong to keep this a secret from you. This must be a terrible shock." I would speak slowly and pause between sentences such that if Mrs. Jones wanted to interrupt me she could. But I would tell her virtually everything, because if I don't and she goes to an attorney, that plaintiff's attorney is going to find out everything anyway. So my philosophy is, you either tell them now or tell them later.

RW: In your role as an ethicist, is there a tension between doing it because it's the right thing to do or doing it because you believe that it's the pragmatic thing to do in terms of diffusing the malpractice concern?

JB: Error disclosure is obviously the ethical thing to do. However, I don't stress that very much when I talk to health care professionals because, quite frankly, I don't think that their ethical relationship to a patient is the first thing that enters their mind after a medical error. I think what they think about after an error is, number one, "How can I reverse the harm to the patient?" and, number two, "What's going to happen to me as a result of this?"

When I got into this research back in 2001, I was going around the country talking about truthful disclosure, especially to lawyer or risk management groups; many people looked at me as though I was absolutely mad. I'll never forget, I once purposely sat next to a certain audience member at lunch, because he gave me the dirtiest looks during my talk earlier that morning. At lunch, I said to this person, who I thought was a physician, "I have a hunch I didn't convince you." And he looked at me and he said, "I'm the head of legal counsel here at this hospital, and everything you said this morning was diametrically opposed to everything that I know and have learned about how to handle these kinds of cases." Truthful and comprehensive error disclosure is a paradigm change for health care professionals and legal counsel. But it seems like the medical malpractice groups are buying into this idea that a generous, empathic, compassionate, truthful, ethical disclosure of error may very well contain or limit lawsuits. And systems like the VA and the University of Michigan are reporting significant decreases in their claims frequency and severity after adopting full disclosure policies.

RW: One point you made nicely in your book is that, although institutions obsess over how to handle the errors and whether to have a "blame-free environment," only the patient can absolve the provider of blame. Given that, what is the role of the institution in working with their providers to manage this process of disclosure?

JB: There's a two-pronged answer. Number one, as a provider, in disclosing the error truthfully and ethically to the patient, you have discharged your responsibility to that individual because you have apologized, you have informed the patient, and now the next steps are in the patient's or family's lap. From the standpoint of the organization, though, you must look at this erring nurse, pharmacist, physician, or whomever, and ask, was this individual's act blameworthy and punishable, or not? JCAHO and safety experts talk about creating blameless and non-punitive environments, and that's good. We want individuals to feel that they can report their errors so risk management can look into the organization's latent system failures that may have caused them. However, James Reason and others have made the point that a

totally blameless, non-punitive environment is irresponsible, if not impossible. Some errors will be so egregious and terrible that it would be ethically irresponsible for the institution not to punish the individual.

The challenge for institutions is to look at the conduct of the individual and decide whether or not this is a blamable or a non-blamable act. And where I and some other people have come down in drawing the line that discriminates blamable from non-blamable is, did the individual violate policy and procedure? Because if he or she knowingly, willfully, or recklessly violated policy and procedure, that would seem to me to differentiate punishable errors from the non-punishable ones. Importantly, I do not think that we should look at the outcome of the error in terms of deciding whether to blame or not to blame.

RW: The line of reasoning that disclosure is not only the right thing ethically, but may very well be helpful pragmatically in lessening malpractice risk, presupposes that the patient or family member and the plaintiff's attorney ultimately would have found out about it. But as we know from the Harvard Medical Practice Studies, a lot of errors never reach the light of day. For many institutions and providers, some errors probably would *not* have come to light except for the disclosure. How do you balance that issue, or, at the end of the day, is this really mostly about doing the right thing?

JB: There's no question that, if your institution adopts a policy of comprehensive error disclosure, you're inviting people to sue you. Consequently, I hope we'll have good research that will show us that even though you might get sued a lot, your claim severity—the cost of all the litigation and payouts—will be much more manageable. Also, if you start making these kinds of discriminations in your mind—"They'll never find out about this particular error, but they might find out about this one, so we can conceal the former but we'll have to disclose the latter"—I think you're going down a slippery slope real fast, headed toward nothing but trouble.

RW: There is a tremendous tension between physicians feeling like there's a certain level of empathy that they'd like to express to patients after an error, and some risk managers, who have traditionally said, you're just opening up huge cans of worms that will take us decades to close. Each one, of course, is right from his or her narrow perspective.

JB: Much of this issue has to do with the way the story reflects the moral character of the storyteller. If you give the patient a lawyer-crafted story that doesn't acknowledge that there was an error, that doesn't say there was harm, or doesn't say there was a mistake, but instead you're dancing around the periphery saying, "We had this problem, and we're sorry that it happened," then you're taking a big risk. The patient will walk out of there wondering, "What did he say to me, was there really an error, was there really a mistake?" The more my suspicions are aroused, the more negative I'm going to be toward you because your story is a reflection of you. Patients and their family members absolutely will not tolerate thinking that their physician is being deceptive or is withholding the truth. The very idea is infuriating, so it shouldn't be a mystery why they go to a lawyer.