

Open School

Case Study: Mutiny

(<http://www.ihl.org/education/IHIOpenSchool/resources/Pages/Activities/Mutiny.aspx>)

Dr. Paul Griner, Professor Emeritus of Medicine at the University of Rochester

Facilitator Instructions

- Distribute the **Participant Version** of this activity to your Chapter or group members.
- Ask participants to read the Case Study or read it aloud together.
- Once everyone has read the Case Study, take time to reflect individually, and use the questions below to guide a group discussion.
- After your group's discussion, read the commentary from Dr. Griner.

Learning Objectives

At the end of this activity, you will be able to:

- Describe how poor leadership can lead to low staff morale in a health care setting.
- Describe how poor leadership can potentially lead to patient harm.
- Explain why it can be difficult to speak up when someone in a position of power displays unsafe behavior.

Description

The behavior of a superior starts to put your patients at risk. What would you do? The University of Rochester's Dr. Paul Griner presents this case study.

Related IHI Open School Online Courses

- [L 101: Becoming a Leader in Health Care](#)
- [PS 103: Teamwork and Communication](#)
- [PS 106: Introduction to the Culture of Safety](#)

Key Topics

Workforce satisfaction and retention, communication, teamwork, connect leaders to the front line, culture of safety.

I was one of 10 specialists in Internal Medicine at a large Air Force hospital. We found the chief of medicine, a pulmonologist, to be dishonest, lazy, and a poor physician. In short, we found it impossible to work with him. Most of our group had come from high-quality residency and fellowship training programs and we had all entered the service through something called the Berry Plan, a program that allowed young physicians to defer their draft obligation until they had completed their training. In other words, we were all two-year people. While we were committed to meet our draft obligation, all of us intended to return to civilian life.

As our first year proceeded, my colleagues and I became increasingly concerned about the deficiencies of our chief. His practice of medicine was so poor that patient safety became a serious concern. He was often absent, which forced us to see the patients that were scheduled for him in addition to our own. Finally, one Saturday morning, we got together and agreed that we could not, in good conscience, continue to work with him. In the armed forces, to proceed with such a position against one's commanding officer is recognized as mutiny. We were very much aware of this. But we also knew that our position was based on our concern that this man was incompetent and should not be taking care of patients.

During the next few weeks, we were careful to document episodes of poor care, unscheduled absences, and lack of professionalism (e.g., lying). We took our case to the hospital commander, who was a full colonel and a physician. He listened, respected our concerns, and accepted our documentations of the chief's deficiencies. He did not challenge us for the position we were taking nor did he indicate what his next steps, if any, would be.

We went about our work. About two months later, we were informed that our chief was being transferred to a small hospital in England. We were both pleased and dismayed. While our concerns had been addressed, they had simply been transferred to another location. The staff at the hospital in England would be faced with the same issues we had been dealing with. The chief was replaced by an excellent general internist and good manager who we enjoyed working with for the remainder of our tour of duty.

Three years later, my wife and I were in London on a trip. We were enjoying dinner at a quiet restaurant when I looked up and saw the face of the chief that had been removed. He was eating dinner alone. Our eyes met and he rose, came over to our table, and greeted us warmly. He indicated that he was no longer seeing patients but, as a career air force officer, was happy in his administrative work. We chatted for a while and then he left.

Later that evening, as my wife and I were reflecting on this brief interlude, I concluded that two good things had come from his transfer: One was that he was no longer seeing patients. The other was that he appeared to have gained some insight into his weaknesses. I slept better that night.

Discussion Questions:

1. These issues of poor leadership obviously surface in the civilian life, as well. Under what circumstances would you feel justified in reporting your superior for providing unsafe care?
2. If you're a student, how does that impact your ability to feel safe when reporting an unsafe act?
3. How about if you're a nurse and you're reporting about a physician? Or vice versa?
4. Can you think of any situations when you would stay quiet when you saw a superior providing unsafe care?
5. Do you have any personal experiences with bad leadership that you'd like to share?

Facilitator, feel free to adjust these questions and/or add your own. After the group has finished its discussion, read aloud the following commentary from Dr. Griner:

The armed forces have come a long way since World War II and the Korean War in allowing soldiers to state their case for the removal of an incompetent leader. I would hope that today an officer who risks harm to his colleagues or men under him would be relieved of his responsibilities, not just transferred laterally to another command.