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Managing Unmanageable Physicians: Leadership, Stewardship, and Disruptive Behavior

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Managing Unmanageable Physicians

Leadership, stewardship and disruptive behavior

By Timothy Keogh, PhD and William Martin, MPH, PsyD

One of the more alarming and stressful challenges physician executives face is how to deal with disruptive behavior. Regardless of the type of organization or location, physician executives are accountable for managing disruptive behavior and the associated consequences of this behavior ranging from patient outcomes to minimizing legal risk exposure.

There is no magic bullet. There is no panacea. On the other hand, there are concrete ways to decrease the prevalence of disruptive behavior while at the same time tackling the issue head-on for the benefit of all stakeholders, including the physician who is displaying the disruptive behavior.

Role, rights and responsibilities

Former President Harry Truman is often quoted for saying, “The buck stops here.” This statement applies to every physician executive. At the end of the day, the physician executive is responsible and will be held accountable for both the prevention and expeditious resolution of disruptive behavior by physicians.

Physician executives should position themselves to take the lead in dealing with disruptive behavior, especially as state medical boards and other non-physician health care executives, including CEOs and CNOs, are increasingly taking matters into their own hands.

The ability to minimize and effectively manage disruptive behavior must be built on a foundation of supporting policies, procedures, processes and structures. The absence of this infrastructure places physician executives in the heat of battle without the proper equipment to carry out their responsibilities.

Moreover, the absence of a supporting infrastructure subtly signals to the physician demonstrating disruptive behavior that this will be handled on a case-by-case basis as an individual personnel matter.

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Physician executives would undoubtedly prefer to spend the bulk of their time inspiring great employees and building productive teams instead of struggling with disruptive physician behavior. Explore ways to diminish the frequency and intensity of disruptive behavior in your organization and identify your role, rights, responsibilities and accountabilities as a physician leader.

This approach decreases objectivity and increases the risk of favoring some doctors and not others. In short, physician executives must assert the right to be properly equipped before being held accountable for any outcomes.

Given the role of physician executives as managers and organizational stewards, they must be prepared to carry forth the following responsibilities efficiently, effectively and ethically:

- Distribute, communicate and educate every employee in the organization on the appropriate policies and procedures on disruptive behavior.
- Consult with internal and external experts in law, behavior change and impaired physicians as necessary.
- Monitor all investigations and cases of disruptive behavior to comply with both the letter and spirit of the law.
- Review all allegations and complaints seeking to identify patterns in order to minimize disruptive behavior.
- Update all policies and procedures.

The overwhelming majority of physician executives are accountable for patient outcomes, patient safety and patient satisfaction at both the individual and the aggregate levels.

To that end, any behavior that detracts from patient outcomes, patient safety and patient satisfaction must be addressed. In addition, all managers, including physician

executives, are held accountable for providing a safe working environment, according to the Occupational Safety and Health Act (OSHA) and a “discrimination-free work environment” according to Title VII of the Civil Rights Act, as well as other statutes at the federal and state levels. Also, every organization and each profession has its own set of internal accountabilities.

It is clear that physician leaders will be held accountable for their organization’s vision, mission, values, code of conduct and bylaws, as well as for the standards of proper conduct within the profession of medicine. In short, accountability is more than a set of external statutes and rules. Accountability mandates a call to deliberate action on the part of the physician executive.

Taking action

One of the more challenging tasks facing physician leaders is to know when to intervene and when to sit back and monitor from a distance.

The bad news is that no formula or algorithm exists. However, there are relatively clear signposts that suggest the need to take action. What are these signposts? A useful framework is what we refer to as The Ripple Effect of Executive Action. How does The Ripple Effect of Executive Action work?

1. Identify all individuals, patients and processes that are impacted by the disruptive behavior. The greater the number of individuals impacted, the greater the call to action.
2. Highlight the probable risks to all individuals impacted. The greater the risks, the greater the call to action.
3. Conduct a cost-benefit analysis of acting versus doing nothing. The greater the benefits of acting versus doing nothing, the greater the call to action.



The physician executive is responsible and will be held accountable for both the prevention and expeditious resolution of disruptive behavior by physicians.

4. Select a way to intervene either through coaching, mediating, referring or disciplining.

The next step in deciding to take deliberate action is to face an ugly reality. The ACPE Physician Behavior Survey found that 38.9 percent of the respondents agree that “physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue.”

At a minimum, this finding suggests that four out of 10 physician executives acknowledge the disparate treatment or the inconsistent application of policies and procedures based upon financial factors alone.

Physician executives must decide to uphold the policies and procedures regarding disruptive physician behavior regardless of revenue generated and other demographic or financial factors that may result in favoritism.

In deciding when to act and when to sit back, physician executives need to think about two important leadership questions:

1. What do I unknowingly communicate to others?
2. How can I make sure that I am understood?

Most of us don’t have an accurate answer to the first question. Do people listen to you because of your position and your authority in the organization, or do they listen to you because of the clarity of your statements, the incisiveness of your thinking and the helpfulness of your suggestions?

Most people believe they are listened to because of the latter reasons. But the actual answer may be a combination of the two.

Taking deliberate action begins with deciding to act based on your analysis of The Ripple Effect of Executive Action, then asking

NOW HEAR THIS

Good listening and communication skills are key to dealing with behavior problems

Listeners may be influenced just as much by the way you say things as by what you say. Your style of communication may be more obvious to others than you may think.

When people listen to you, whether they are your colleagues, your staff, your boss or the disruptive physician, they are listening to the words you use, but they are also reading the nonverbal signals you are sending. The tone of your voice, the way you set your eyebrows, the distance of your chin from your chest as you speak and the decibel level at which you speak are all data points your listeners intuitively use to gather meaning.

Those listening to you are probably only vaguely aware that they are monitoring these non-verbal signals, but the signals convey a cumulative message that adds as much as 55 percent to the meaning of your words.

In dealing with a disruptive physician, it is crucial for you to have some insight into your personal communication—both verbal and non-verbal styles. Physician executives are often better at analyzing the behavior of others than they are at analyzing their own behavior.

It is particularly important to understand how your behavior changes when you are tired, hurried or stressed. These internal conditions become obvious to others from your facial expressions, your tone of voice, the volume you use, the brevity of your comments and a range of attributes that are readily apparent to others, but may be less apparent to you.

Some common communication blind spots we frequently notice in others are:

- Cutting people off before they are finished speaking
- Taking too long of a turn when speaking to someone and not letting them get a word in
- Multi-tasking when we should be listening to someone

It is critical that physician executives demonstrate and model a non-judgmental way of listening and making sense of what they have heard in order to select the best approach to resolving disruptive physician behavior.

So the answer to question #1, “What do I unknowingly communicate to others?” is complex and needs some personal insight.

To answer question #2, “How can I make sure that I am understood?” One practical way is to make sure that the listener is “formatted.”

Formatting the listener is an aspect of being listener-centered. It is a check to make sure that you and your listener are on the same page. Just as you cannot copy a

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yourself the above questions to make sure that any action you take will not be misinterpreted—and, finally, listening carefully to hear all sides involved.

Four tools to tackle problem behavior

Physician executives must leverage their best leadership skills to expeditiously resolve disruptive behavior:

- Coaching
- Mediating
- Referring
- Disciplining

The common theme among all four of these skills is to target behavior: first to reduce or eliminate undesirable behavior, second to increase or bring forth desirable behavior.

The focus is never directed toward the person, only toward the behavior. It is far easier to change behavior than it is to change personality.

Coaching is one of the four recommended executive actions that physician leaders ought to undertake. In fact, coaching has increasingly been recognized as a core leadership competency in all industries, including health care.

Recently, the *Harvard Business Review* published a landmark article entitled “Coaching the Alpha Male,” by Kate Ludeman and Eddie Erlandson that suggests that leaders must confront alpha males who display disruptive behavior.

“Organizations become dysfunctional,” the authors say, “when people avoid dealing with a difficult alpha and instead work around him or simply pay him lip service.”¹

The authors advise using the following techniques to coach alphas:

- Capture their attention
- Demand their commitment to change

- Communicate in a way that they understand
- Tell the truth fast and hard
- Ignite their competitive strivings

This does not suggest that all physicians displaying disruptive behavior are alpha males or alpha females. However, when dealing with an alpha personality, here are some suggestions:

- Avoid social talk—Skip the preliminaries. As a matter of fact, alpha types tend to avoid people at work who use a lot of social preliminaries. Too much chitchat makes them crazy. With alphas, a little conversation goes a long way.
- Skip the details—The alpha type is highlight-oriented rather than detail-oriented. Too many details tend to complicate their ability to use their strength, which is quick decision making.
- Bring something to hand over—Use structure in the form of bullet points or a chart, a graph or a table. Alpha types want information they can use right away. They are readily persuaded by data that are presented visually.
- Include steps—Because taking action is a strong point for alpha types, play to their strengths by suggesting a few steps that can be taken right away.

Even with these suggestions, results don't always come right away. Ludeman and Erlandson suggest that those who use the coaching approach should be patient. "Changes in behavior typically begin to show in three to six months as the client harvests low-hanging fruit from our initial coaching effects. Sustained change takes about a year. But the goal of coaching is to change the entire team dynamic, not

simply to treat the alpha as an individual problem."¹

If physician executives can find success when coaching alphas, then coaching other types will be a lot less challenging and distressing.

Mediation is a form of conflict management that is typically used in situations where both parties agree to seek the counsel of a neutral third party who will serve as a guide to assist in reaching a mutually satisfying agreement to resolve specific issues.

Physician executives can play the role of a mediators in certain cases involving disruptive behavior. However, the following conditions must be firmly established prior to assuming this role.

- Both parties must voluntarily agree to participate.
- Both parties must demonstrate earnest efforts toward achieving a mutually satisfying agreement.
- Both parties must attempt to resolve the clearly defined issues using this process alone.
- The physician executive must be able to consistently act as a neutral third party and take ownership for the process and not for the outcome of the process, which belongs to the two parties.

Referring is another option. Similar to what happens in the clinical practice of medicine, referring is not a public declaration of incompetence or lack of caring, but recognition that the patient requires a resource that cannot be provided by the practicing clinician.

This same logic applies to managerial situations. Do not risk attempting to be the Renaissance person as a physician executive.

Depending on the assistance required, some potential experts for referral are human resource professionals, executive coaches both for

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document onto a disk or CD unless the disk or CD is first formatted, you cannot copy or place your words in the listener's head unless you provide clear verbal guidelines to focus the conversation.

In other words, don't assume anything. When it comes to unambiguous communication, the listener needs structure. Before you begin your conversation with the disruptive physician, collect any data that shows the gap between the expected performance of your organization and the physician's actual performance. Base your conversation on that data.

The importance of providing a suitable, conversational format for the listener was shown in an experiment to discover how frequently speakers use formatting.

Linguists Charlotte Linde and William Labov conducted an experiment called the New York City Apartment Experiment.¹ They set up an office in New York City as if they were census takers and asked volunteers to describe the layout of their apartments. They found that 97 percent of the subjects described their apartments in a room-by-room fashion as if they were taking the listener on a mental walking tour through the apartment without regard for how the listener was able to visualize the layout of the rooms.

For the speaker, this mental walking tour was an efficient way to visualize and describe all of the apartment's rooms. For the listener, however, it was quite difficult to visualize the layout. Having never actually seen the apartment, the listener had no context and the speaker did not give any structure to describe the layout of the apartment.

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What did the other three percent of the subjects in this experiment do? These three percent began their descriptions by stating some simple, organizing pattern—a format—around which the listener could mentally view the rooms.

For example, the speaker would say something like, “Well, my apartment is in the shape of a rectangle with the living quarters on the left and the sleeping quarters on the right.” Then the speaker would proceed on to a more detailed description of the layout of the rooms.

By using a geometrical shape to provide formatting, it was easy for the listener to visualize and mentally organize the rooms. There was structure to the conversation. Three percent of the subjects in this experiment did what good communicators do and what physician executives must remember—ground your listener by using a structured conversation that is non-judgmental, mutually understandable and listener-centered.

It is interesting to speculate why only 3 percent of the subjects in this experiment provided formatting when they described their apartments. It may be that for most of us it is difficult to be listener-centered; that is, it is difficult to stop and think about the listener's need for structure.

By Timothy Keogh, PhD and William Martin, MPH, PsyD

Reference:

1. Linde C and Lebow W. “Spatial networks as a site for the study of language and thought.” *Language*, Issue 51, 1975.

the disruptive physician and/or the physician executive, mediators, mental health professionals and attorneys. Regardless of the setting, it is often wise to seek the advice of legal counsel to mitigate legal risks.

As is true with any consultation, it is important to keep the lines of communication open and to collaborate in the assessment, intervention and evaluation stages of this process.

It is particularly important in managerial situations that issues related to confidentiality, conditional employment and other legal matters be clearly identified prior to establishing a relationship with any referral source. It is also important to clarify who the client is because the client may be different from the individual who is paying the referral bill.

Disciplining is the consequential process when coaching, mediating and referring fail to yield expected results, or for those situa-

tions in which the single behavior is so egregious that discipline is the first response.

Disciplining is not to be associated with punishing. They are not the same. In fact, disciplining is a more tailored coaching process in which the physician executive clearly spells out the range of consequences—both positive for demonstrating the expected behavior and negative for continuing the disruptive behavior.

A key success factor when disciplining is to make certain that the physician executive has access to consequences. For example, when coaching and mediating have failed to work, the physician executive may find that the physician displaying disruptive behavior did an end run to neutralize all consequences that the physician executive was about to initiate.

To avoid this problem and ensure access to consequences, go to

your boss and other key stakeholders in the power hierarchy prior to disciplining to make sure that you can impose specific consequences.

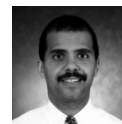
In the end, preventing and managing disruptive behavior is directly proportional to your organization's underlying performance management system and associated policies and procedures.

Physician executives dealing with disruptive behavior should be able to clarify their roles and responsibilities and act accordingly, being careful to act as stewards of organizational resources rather than “lone wolves” against other lone wolves.

Managing disruptive behavior is one of the most stressful and challenging tasks that any physician executive faces, but the rewards of directly addressing this behavior when it first occurs reaps many dividends for patients, for staff and for fellow physicians.



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1. Ludeman K and Erlandson E. “Coaching the alpha male.” *Harvard Business Review*, May, 2004.

R-E-S-P-E-C-T

Bedrock of satisfaction and effectiveness for organizations and individuals

By Timothy Keogh, PhD and William Martin, MPH, PsyD

Aretha Franklin captured the attention of audiences worldwide with her smash hit R-E-S-P-E-C-T. Embedded in the lyrics of this song is a leadership maxim: Find out what it means to me.

The Queen of Soul is telling listeners, including physician leaders, that respect is individually defined. The challenge for physician executives is to find out how each of their direct reports, colleagues and patients defines respect. Then, they must act accordingly.

Consider this case

A physician assistant who reports to one of your physicians at a clinic approaches you for the third time in a month with a complaint. "I know that you must be tired of me coming to you about Doctor X but I am sick and tired of Doctor X not respecting me. Doctor X has no respect for me or anybody else in this clinic."

In this case, Aretha Franklin's lyrics should be the prompt for your response. "In order for me to address this very important issue, it is critical for me to understand what you mean when you say Doctor X does not respect you. Can you give me some examples of when people at work respect you and when they don't respect you so that I can fully understand this from your perspective?"

At this point, most people will share stories with you or list a number of characteristics that demonstrate respect or the lack of it. Based on that information, you have the behavioral expressions of respect for this individual.



Now you are more fully prepared to approach Doctor X with some tailored behaviors that will signal a greater show of respect.

Another way that physician executives approach the challenge of respect is to shape the organizational culture to show that respect is a cornerstone of that culture. Lynn Sharp Paine, author of *Value Shift*, shares the following perspective of culture shaping:

"Managers talk about values as essential for encouraging cooperation, inspiring commitment, nurturing creativity and innovation, and energizing the organization's members about a positive self image.

They seek ideals like respect, honesty, and fair dealing as the building blocks of a high-performance culture . . . [Employees] want to be respected, treated fairly, and recognized for their contributions. They prefer colleagues who are trustworthy and who can be counted on to keep their promises."¹

Moreover, the benefits of taking action will accrue to the group and to the organization and shape the culture for the benefit of the patient.

Reference:

1. Paine LS. *Value Shift*. New York: McGraw Hill, 2003.