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Transcript of learning module Dealing with difficult doctors - an audio guide
(Dur: 24' 56")

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Charles: Hello I'm Dr Charles Hall, a clinical editor at BMJ Learning. In this module we discuss how to deal with difficult doctors. Here to talk to us is Dr Jenny King, who is a chartered psychologist in Bristol. Hello Jenny, thanks for joining us.

Jenny: Thank you very much.

Charles: So to start out, what is a difficult doctor?

Jenny: A difficult doctor is generally labelled as such because they are behaving in a way which is causing difficulty for themselves, and other people. So most complaints about doctors tend to be more to do with their attitude and behaviour rather than their clinical incompetence. But these behavioural difficulties will still put patients at risk potentially, and are what other colleagues will find hardest to deal with.
So that means that they then become labelled as difficult. Those sorts of behaviours may include arrogance, rudeness, poor decision making, poor communication, or coping poorly with personal stress, and most commonly inability to work as part of a team.

Charles: Is there a distinction between people who are labelled difficult doctors and those who should really be regarded as doctors who are in difficulty?

Jenny: Yes, it is a very important distinction. Doctors who behave disruptively and display behaviours that cause problems for others are often labelled as difficult. But very often those are doctors that are themselves in difficulty. Those difficulties, which we will come on to talk about, may affect the way that they then treat other people.

So it can be sometimes unfair and unhelpful to label them as difficult. It is really important to get behind what is happening and try and understand what is causing that behaviour.

Charles: So why do we perhaps fail to tackle these areas?

Jenny: Well I think it is particularly difficult sometimes for other doctors, because they fear reprisals. Possibly getting a bad reference if you are a trainee complaining about a difficult trainer. Doctors don’t come into medicine to fight with people or upset them, so they tend to avoid conflict. They think that sometimes tackling it might make the
problem worse. They think it might show up their own inadequacies, and they often feel that they are not in any position to judge other people. They may not think it is their job to tackle it, and very often they just don’t feel they have got the skills to tackle these problems.

Charles: So why are some doctors difficult, or at least why are they in difficulty?

Jenny: Well doctors are difficult for the same reasons as anyone else. For example they may be stressed, they may be ill, they may be struggling to cope. They may be frustrated by the lack of support or resources. They may feel vulnerable in their job, or distracted by personal difficulties and so on. All of these factors can put extra strain on an individual, on a doctor who is working in an increasingly stressful system.

The difficulties with the individual doctor need to be distinguished from problems with the system or the organisation. So a doctor for example may be a perfectly reasonable individual, working in a very difficult set of circumstances. There comes a point for any of us where we can only cope with so much difficulty in the system, and at some point we might react. That is what happens to some of these doctors.

Charles: So lets look in more detail at the causes. So in this case for difficulties that an individual may experience, and I believe there is a mnemonic for remembering this?
Jenny: Yes there is, we have developed a mnemonic, which we call CLADA. So for any doctor whose performance or behaviour is causing concern, we ask firstly, “Do they have the capacity to do the job? So is this a fundamental limitation that is stopping them? Is it a deficit in their learning, do they lack the skills to do the job effectively? Are they perhaps becoming demotivated? Either over aroused in the sense of being too stressed, or just bored.”

So, all of those are problems to do with motivation. Do they have some kind of distraction going on in or outside work? Finally, are they becoming alienated from their environment or their work?

Charles: Okay, so that is CLADA, and so if we start off with capacity.

Jenny: Yes, so capacity is as I say a fundamental limitation, which means that it can’t be changed. So if for example you think of perhaps a doctor that has had an injury which has affected their physical abilities or capacity, that is one example. Some doctors, particularly much older individuals, may be more at risk of cognitive impairment.

That means that they may be less able to memorise or concentrate, or absorb complex information. These sorts of incapacities may be masked very effectively by the doctor, sometimes because they don’t realise for example, their memory is failing them quite badly. They may develop strategies for shielding those difficulties, by for example, shirking duties, becoming increasingly frustrated or disorganised.
Capacity can also extend to personality traits. So of course the big concern that we often come across is the lack of insight, and that can often be a capacity issue. In the sense that if the doctor doesn’t have insight, it is actually very difficult to give them insight, particularly about behaviour. But doctors who have cognitive problems or physical problems in particular, will usually need support to change their job duties or restructure their jobs. They will often need a great deal of support in accepting this, and actually finding some sort of practical, or work around solution.

So in this case it really is very unhelpful, and inappropriate in fact to label them as difficult. Because it fails to resolve the underlying problem. One particular personality trait that we come across in doctors is perfectionism. Now doctors are selected into medicine partly because they are very diligent individuals. Their medical training emphasises the importance of not making mistakes. As they go through their training, they tend to become more and more perfectionist. Sometimes that perfectionism can get overplayed, and become obsessional behaviour. Doctors who suffer from this find it very difficult to delegate, they become extremely critical of themselves and their colleagues. That is a very difficult thing to deal with, and is in some respects a capacity problem that we are now becoming increasingly aware of.

Charles: So if we move on to the second thing, which is learning . . .
Jenny: So learning is one reason also why doctors may get into difficulties. So they may lack the skills or the training for example to communicate effectively with patients. So if they are poor communicators, we have to ask, “Is it that they have never learnt to do this properly, or is there something else going on?” Again, they may mask this very effectively by behaving obstructively, by opting out, by making mistakes.

But learning is really one of the most amenable areas for behaviour change, because you can deal with learning problems through retraining or educational support or coaching. It is much more difficult of course to do that if the problem is to do with capacity.

Charles: Okay, so the third cause, which is arousal, or motivation is probably a better way of describing it.

Jenny: Many doctors at the moment are extremely stressed, and the stress is affecting them to the point that they are becoming demotivated. They will express that by constantly losing their temper, or feeling unable to cope, or just disengage from what is going on. So they lose the motivation and the energy that they might have once had. They don’t show much interest in professional development, and they certainly have real difficulties in coping with change.

These things will manifest as cynicism and as resistance, but again like learning this is eminently treatable if you like. You can help a doctor to rekindle their motivation through, for example, a skilful appraisal, through
constructive feedback, through good mentoring, coaching if necessary.

So if you get the right blend of support along with challenge, and you do need both . . . It is quite possible to remotivate a doctor who is struggling in that area.

Charles: So fourthly, distraction?

Jenny: Yes, now quite aside from any the problems that we have discussed, learning, motivation, etc. Some doctors just are struggling with distractions, often outside of work. So they may have financial, marital, health problems, which are proving to be significant distractions.

So they might come in late, they might go home early, when they are at work they may be struggling to concentrate. Distracted individuals then will often lose focus and are much more likely to make mistakes. Sometimes they struggle to make decisions because they quite literally can’t think straight. They are very reluctant to admit to problems. I think doctors are trained to believe that they can cope and should cope. Very often we find that doctors are dealing with some really quite significant external problems that they don’t feel able to talk about when they are at work.

So their colleagues really need to be on the lookout for early signs of that kind of distress. But distraction doesn’t just happen outside of work, it can also be going on inside work. A trainee for example may be suffering from bullying, maybe distracted by dysfunction within the wider clinical team that is beginning to affect them. So we need
to be aware of all of these factors that could be playing a part in a doctor who is behaving in a difficult way.

Charles: Finally, attitude or alienation.

Jenny: Yes, A in this model is really for alienation. This is really quite a serious problem but sadly now much more common than it used to be. An alienated doctor is not just a cynical doctor. Cynical doctors can be remotivated, alienated doctors tend to be very angry. They really have lost faith and trust in their organisation, and they are starting very often to do damage. To sabotage behind the scenes, and sometimes that is to do with the fact that their values, their personal and professional values conflict so strongly with what the organisation is asking of them. That they feel unable to continue to work productively.

In some ways that is understandable, if you have got different values from your organisation, then it is important to recognise that, and if necessary to go elsewhere. So there is nothing inherently wrong in having different values, where it becomes very dangerous potentially, for colleagues and possibly for patients, is when a doctor stays in the organisation and continues to fight against everybody. That becomes a very difficult issue for their colleagues and employers to deal with.

Charles: So what is the best approach for dealing with difficult doctors?
Jenny: Well one way to approach it is in a sense to reframe the problem. Rather than thinking of the doctor as difficult, if we think about them as being in difficulty, it immediately makes the approach become much more supportive. But it is very important to combine support with challenge. If they are behaving in ways that are causing difficulties for other people, clearly that can’t be allowed to continue. So it is very important to approach these issues with the right blend of firmness and challenge, alongside the necessary support.

So that is the first thing. The second thing it is very important to approach these problems sooner rather than later. To talk about them openly with the individual, and not to sweep the problem under the carpet in the hope that it will go away. Because normally these problems don’t go away, they escalate. They get to a point where it then becomes much more difficult to manage the difficulties with that individual.

Charles: I believe there are several useful skills that can help in dealing with difficult behaviours in a colleague?

Jenny: Yes, well there are three main areas that we could look at. One is listening skills, the second is assertiveness, and the third is not so much a skill as an approach, which is to think about this in the context of the whole team, rather than just the individual.

Charles: So, if we look at levels of listening?
Jenny: Levels of listening is a really helpful way of being able to listen more effectively to a doctor in difficulty. One of the problems that we can often experience when we are trying to help these doctors, is that they feel that nobody has really listened to them. They need to be able to tell their story.

So it is important not just to listen to the words that they are saying. So for example they might say, “Everyone around here is incompetent.” But also to listen to the feelings behind those statements. In this case the doctor might be trying to say, “I am feeling really stressed.” So at that point it is important to respond by saying, “You seem really stressed, you seem really worried.” Then to go to the next level again, which is to really understand the meaning behind what that doctor is trying to say.

So in this case he may be trying to say, “I am really scared of losing control. I am really scared of losing my job.” If you are able to respond at that level, you can often really get to the crux of the issue.

Charles: Secondly, assertiveness skills.

Jenny: Yes, assertiveness skills is actually an absolutely core skill. Dealing with difficult behaviour doesn’t mean being aggressive, or confrontational. It means being assertive, that is being able to confront the difficult behaviour, or the situation, but still showing respect for the doctor.

So if for example I am working with a colleague who I feel is being rude, then using ‘I’ statements, such as, “I feel intimidated when you shout. I feel put down when you
speak to me in that way, or I have noticed that when you speak to the nurses they get upset.” That is one assertiveness skill.

Focusing on the behaviour not the person of course is very important. So saying, “When you ignore the nurses they feel undermined.” Is the behaviour, what you wouldn’t say is, “You are insensitive to the nurses.” Because that is a much more direct attack on them as a person. So stick with the behaviour.

Another assertiveness skill is to be persistent, so the doctor may say, “I really don’t see what the problem is.” If I am being assertive I will say, “I understand that it is difficult, but I have to tell you that there is a problem.” If necessary to repeat that, which in all the assertiveness skills training is often called The Broken Record. “Yes, I know you don’t agree, but there is a problem.” You just keep stating that in as supportive a way as possible.

Charles: So lastly what can we say about the team approach to sorting out these difficulties?

Jenny: Well it may be better sometimes to tackle these difficulties at the team level rather than just focusing all your energies on the individual. We find that it is often helpful to speak to each team member that the doctor is working with. Firstly to get their perception of some of these difficulties, and then to get the whole team together, including the doctor that you are concerned about. Keep them focused on what it is that they are really trying to achieve together as a team for their patients and for their service.
One of the things that often happens with these issues, is people tend to lose sight of what we call the primary task. In other words, what they are really there for, which is the patients. The issues get very focused on personalities and relationships. Often an individual doctor will end being scapegoated. So keeping the team focused on core values, revisiting their goal, their purpose, and then establishing some ground rules for behaviour that will act as a guide for conducting their working relationships.

This sort of approach really allows everybody in the team to talk openly and constructively. If there are deep seated conflicts, sometimes it is helpful then to bring in an external skilled facilitator. But it is really important to be honest about why you are having those team discussions. It is certainly not helpful to use them just to try to spotlight the difficult team member. I have known in some instances where people will hide behind the team to try and tackle one difficult individual. That ends up with the rest of the team feeling very disgruntled. So then you might end up with several individuals in difficulty and not just one.

But of course another route that you can take within the team approach, or one to one, is to look at personality in more depth by using psychometric tests. Personality tests for example, the Myers Briggs type indicator is one measure that is commonly used. Or one of the so called big five personality measures. These can be very instructive for the individual, and a very good platform for a team to talk about their individual differences. We need to bear in mind that we often label people as difficult where in fact they are just different. So being able to talk about and recognise those differences can be extremely helpful for the group.
Charles: Okay, so if a conflict does arise between two specific individuals, are there any strategies that people can employ here?

Jenny: Yes, I think the first thing to decide is whether you are going to manage this in-house, or through some sort of external professional mediation. So there are some decisions to be made about that. If it is an absolutely intractable problem, or a deep seated problem, then it is probably best to get somebody external, who is not seen to have any particular agenda.

But in principle it is really important to get the two individuals to talk to each other about what they need, and to try and dissuade them from just adopting a fixed position. Because when people get into conflict, they adopt a position and they don't budge, but behind that is usually something that they really need. So they might need the other person to listen to them, they might need an apology, they might need to be treated in a different sort of way.

So creating an environment for the two individuals where they can really tell each other what they need, and talk about the impact of the situation and how they would like things to be different. So it is really about encouraging them to talk to each other, to listen, and really listen to each other, so by the end of it they have understood the other person's point of view fully. To point out to them where their perspectives are either similar or different. Then to help them work together towards a solution that is mutually acceptable.
So all of those really come under the umbrella of mediation skills, or facilitation skills. But negotiation, mediation, doesn’t always work. Particularly when you have got personalities that are very different, or perhaps even more importantly, people whose value sets are very different. They realise that they just cannot find a way to reconcile those differences. In these circumstances, it can be very painful, but you have to get the individuals to the point where they take responsibility for the outcome. Because what you don’t want them to do is to end up becoming alienated. Staying, but doing damage as we said before.

But I think with all these things, they are often very complex, there is often a very long legacy, and it is important to just take this one step at a time. But I think that a lot of these issues come down to leadership. These problems need to be tackled very robustly, very supportively but very robustly, often at the highest level of an organisation.

Charles: So in managing a difficult situation, perhaps when there is conflict between two individuals, what pitfalls should doctors be aware of, and how can they avoid them?

Jenny: Well because many of us are quite diffident or reluctant to deal with difficult colleagues, or have these difficult conversations, we may behave in ways that actually make the problem worse. So a big pitfall is to get into what has been called the drama triangle, consisting of persecutor, rescuer, and victim.
So let us imagine that there are two people who are in conflict, and I as the third individual decide that I am going to jump in and rescue these two people and sort the problem out. Very quickly the person who sees themselves as a victim will turn on me, and either start to become very dependent on me to sort the problem, or blame me for not sorting the problem. So I then become the victim, and he becomes the persecutor, and we go round and round the drama triangle. That is a very big pitfall.

But there are other perhaps slightly simpler pitfalls, one of which is colluding with the problem. So you might say to me, “Life is just impossible, everybody is so inefficient and I can’t get the nurses to do anything.” I may collude by saying, “Yes I agree with you, I have had the same problem.” That is very unhelpful, you need to stay detached, stay back from the situation and not collude.

Another pitfall is that you simply duck the issue by saying something like, “Well it sounds difficult, but to be honest we are a bit busy, too busy to discuss this now, we will come back to it another time.” Another pitfall is that you might end up blaming the individual, “If it weren’t for you, I could get my job done much more quickly.” So another pitfall might be the urge to protect the doctor. So you might end up saying, “Well I didn’t tell him what the problem was with his behaviour, because if I did he would never get over it.” Or saying, “He is such a brilliant surgeon, that I am worried that if I told him about what everybody thought, he might want to go somewhere else and then we wouldn’t have his skills here anymore. I don’t want to take that risk.” Now all of those things are forms of collusion, which make the problem worse, or certainly don’t make the problem go away.
Charles: So to sum up, what are the key points about how to deal with difficult doctors effectively?

Jenny: Well firstly, act sooner rather than later. Secondly, be prepared to listen, and don’t jump to conclusions too quickly, until you have heard the whole story. Thirdly, don’t duck the issue, or be tempted to collude with the doctor, by just ignoring or minimising problems. Also, don’t expect to resolve everything straight away. Sometimes you have to play the long game, these problems can be difficult, and they take time to resolve. You have to be prepared to negotiate with the doctor, to be willing to meet the doctor half way where it is possible. But underlining all of this, is the absolute paramount importance of keeping the patient safe. That really has to be the bottom line, that in dealing with doctors in difficulty, or difficult doctors, if they are behaving in a way which is compromising the safety of the patient, or the quality of patient care... then really something must be done, and must be done quickly.

Charles: Many thanks to Dr Jenny King, for further reading and useful resources, follow the links on the next page.

V/O: Thank you for listening to this module from BMJ Learning.

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