

*Toxic offices take a toll on everyone, including your patients.
Here's how to improve your practice's health.*

THE DANGER OF A DYSFUNCTIONAL MEDICAL PRACTICE

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Covered in *FPM* Quiz



In my job as a consultant for stressed-out physicians, I hear all kinds of stories about practices gone astray. Here are three recent ones:

- Dr. Taylor's problems at work bothered him most at night, when he struggled to sleep. His colleagues, the doctor felt, were arrogant and consumed with greed. Dr. Taylor, in turn, was filled with resentment.

- On Dr. Garcia's first day at his new practice, another physician pulled him aside to talk about a colleague's clinical incompetence. This badmouthing, it turned out, was a typical conversation held with all new members.

- In Dr. Miller's office, the senior partner insulted anyone who praised others or even offered a hug after a partner survived a difficult call schedule.

All of these doctors, whose names have been changed, have two things in common: They were all part of dysfunctional practices, and they all came to my office at the Center for Professional Well-Being for help. With some coaching, they were able to improve their lives, and I wanted to share the solutions for family physicians who might be in similar situations.

A common problem

All of us at some point have encountered dysfunctional individuals. Everywhere they

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go, havoc follows. A dysfunctional practice is marked by that same chaos, and it comes with a human cost.

I define a dysfunctional practice as one that enables inconsistencies and interpersonal abuses, harming the emotional and professional health of those who work there. It is a toxic work environment.

Such an office can include poor organization, tyrannical or impotent leadership, and demoralizing attitudes. Conflict is the norm. Complaints pervade conversations. Gossip and unclear communication seem to be the rule. This behavior heightens turnover, undermines morale, reduces cooperative behavior, diminishes productivity and increases the risk of substandard care. Physicians and others leave prematurely or try to adapt, which usually generates enough stress to cause burnout. In extreme cases, I've seen it advance to the point of disability.

Causes of toxic practices

Toxic practices are the result of multiple converging factors (see "Causes and Consequences of Toxic Practices," page 42); however, three causes are most common:

First, no one is truly in charge of the practice. Toxic practices are fueled by ignorance and fear because their leaders don't know how to promote a mature, interdependent practice. Individuals' expectations for one another are not identified or validated. Ownership of a problem is usually pushed onto associates.

KEY POINTS

- Dysfunctional medical practices, which contain glaring deficiencies, poor conflict management and ineffective communication, are common.
- Unmotivated employees and frustrated patients are the result of such practices. In the worst situations, the health of both groups can be at risk.
- Dysfunctional practices can be fixed. It's a slow process, but following a step-by-step plan can lead to a healthy office.

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Good doctors often try to get out of toxic medical practices, where there is a higher risk of substandard patient care.



Many dysfunctional practices have a leadership vacuum, allowing a few individuals to dominate everyone else while problems go unaddressed.



If a practice doesn't have a clearly defined vision, the people who work there won't share a sense of purpose.



Patients will begin to suspect that something is wrong when their requests are either ignored or dealt with curtly.

Physicians and others either leave prematurely or try to adapt, which usually generates enough stress to cause burnout.

Disruptive partners don't respect the manager, do not accept coaching and usually are not confronted because of their status.

Second, because no one is clearly in charge, the ambiguity takes over. Individuals with strong control issues see the practice as their personal fiefdom and use their power to intimidate others into an authoritarian model. These individuals may resist others' input because of cultural or personal reasons. These people may use toughness or tyranny to escape their own fear of being controlled by someone else. They are seen as despots who view all relationships

practice cannot.

Your patients will sense that something is wrong. In a worst-case scenario, their care could suffer, despite your best efforts to preserve your clinical integrity. Even if their health remains fine, your patients will transfer out of your practice or become hypercritical.

Some of the patient-related problems are easy to spot. Difficult patient requests become too troublesome and are ignored. Even routine patient requests may be neglected. When patients do hear from the practice, communications are often curt. ►



There is a greater likelihood that mistakes will be made if doctors are afraid to voice their thoughts about clinical care differences.



Innovative thoughts about improving a toxic practice are rarely mentioned because of the implied threat of personal attack.



In an ideal practice, everyone is familiar with assertive communication, which promotes equality in human relationships.



It might seem like a small thing, but giving regular performance appraisals can promote your practice's mission and goals.

Less obvious problems might pose the most danger to your patients. They can suffer when positive feedback is missing or performance appraisals are put off. Observations or hunches that can sometimes solve a mystery illness are not swapped in a dysfunctional practice. Even the benefits of attending CME programs are not shared in partner meetings.

A day in the strife

A dysfunctional office can wear out its members in endless ways, whether they're new to the practice or have been around for years.

Disorder rules. Policies and roles are either not clarified or are changed at a whim. Expectations are unclear and unrealistic. Discussion of the vision and development of an agreed upon strategic plan is avoided. Employees are subjected to impulsive requests, have no sense of stability and feel compelled to conform to arbitrary control. Their professional self-esteem is dependent on unpredictable forces. They take out their stress on other colleagues, patients or family members.

Physicians avoid perfectly appropriate discussions about clinical care differences or dangers because they're afraid of conflict or being shamed. Mistakes may become more prevalent. Each physician maintains his or her own style to the detriment of office efficiency and quality patient care.

Staff ideas are rarely heard or elicited. Morale decreases. Staff quit, leaving the

practice understaffed. Loyalty is rewarded regardless of merit. The staff emulates the attack mode of the leaders. Reduced cooperation and inefficiency permeate the practice. What's best for the practice becomes secondary to keeping your job.

Those with innovative ideas keep them to themselves because of the implied threat of personal attack. Trial and error isn't allowed.

Faultfinding becomes the unintended obsession. Planning for the future, or efficiently managing the present, is not a priority. In such a practice, the physician who routinely is late, writes illegibly or controls the environment with his or her "good" or "bad" days is allowed to persist.

In a dysfunctional practice, peer appraisal and civil disagreement are not sanctioned. Greater anxiety is promoted. Denigration of topics such as stress management and well-being are put down and put off.

Dysfunctional practices do not reward collaboration and interdependence. In cardiology or radiology practices, invasive and noninvasive specialists are pitted against each other. Prestige, income generation or case selection reinforce differences rather than blending into a whole group.

Helpful solutions

Breaking the cycle of dysfunction within a medical practice takes great time and effort, but it can be done. Here are some strategies that, though they may sound simple, have helped other practices.

CAUSES AND CONSEQUENCES OF TOXIC PRACTICES

No two toxic practices are alike. Some have a handful of issues to address; some have dozens. All of them, however, are capable of driving good doctors into silent indifference or out the door. Here are some of the most common causes and consequences of a dysfunctional office.

Causes	Consequences
<ul style="list-style-type: none"> Persistent disruptive behavior, whether by a partner, an administrator or a staffer Abusive management Ineffective communication skills Inadequate negotiation and conflict management skills Undiagnosed or untreated illness Lack of cultural integration Disregard for practice management or legal advice 	<ul style="list-style-type: none"> Heightened turnover and tardiness Lowered morale Stifled creativity Increased burnout Diminished patient care Increased malpractice risks Decreased collaborative problem-solving Ineffective long-range planning Unresolved contentious policies Pervasive gossip and blame-casting Increased entitlements to counteract the instability Limited feedback and discussion

1. Communicate openly and regularly.

If you want to begin healing a toxic practice or ensure one doesn't deteriorate, your first step is to open clear and honest lines of communication. The pervasive disorder in a dysfunctional practice leaves no time or opportunity to consider important practice issues. At a time when doctors should be asking critical questions such as "What's not working well within our practice?" and "What will happen if we can't agree on a common vision?" they're not even asking one another "What are you up to this weekend?"

If you don't confront your communica-

I often recommend that these small groups set up a retreat to begin their discussions. Working outside of the toxic environment is the best way to think clearly and assess what needs to change.

When your subgroup meets, you need to define three sets of expectations:

Behavioral – how members are expected to make the office a better place to work;

Practice – how members are expected to make the office a better place to be a patient;

Interpersonal – how members are expected to interact with one another.

These expectations will differ slightly

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If your colleagues can at least agree that your practice needs improvement, a small group should be charged with establishing a policy of professionalism.



It is critical to learn dispute settlement skills for times when your new office policy cannot resolve a conflict.



Despite your best efforts, there will be problems that require outside help. It is critical that any third party you bring in understands the culture inside a medical office.



When you're going through the budget process, make sure you allocate enough time and money for staff training and development.

Even if their health remains fine, your patients will transfer or become hypercritical.

tion woes, outsiders will. Patient advocacy groups are demanding better interpersonal skills from their doctors. Attorneys will hold the practice liable for tolerating disruptive behavior by members.

I recommend training your practice members in assertive communication, which involves a commitment to promoting equality in human relationships. Everyone is presumed to have an opportunity to win, and no one is set up to lose. Individuals communicating assertively act in their own interests, clearly expressing their issues and personal priorities. Assertive individuals respond to praise or anger honestly. They do not deny the rights of others to say what they feel and do not support unfair criticism of others. These skills can be taught.

A key part of communication is giving and receiving feedback. Management consultants Drs. Irwin Rubin and Raymond Fernandez stress the importance of having effective feedback systems.¹ Clear feedback promotes a clear vision and a plan for carrying out the practice's mission and goals. In a healthy group, ownership and responsibility can be spelled out. Performance appraisals are expected and implemented. Individuals who are underperforming are helped or dismissed.

2. Clarify expectations. The next step is to establish written policies that spell out your practice's expectations for all employees. To make it easier logically, it's best if a small group works on establishing your office's professionalism criteria and then presents it to the entire practice.

from practice to practice, but I have provided some sample criteria to get you started in "Establishing expectations" on page 44.

When your subgroup has agreed upon your practice's professional criteria, it's time to present your policy to the group. It's up to you whether the subgroup's work will be presented as the new law of the land, or whether you'll allow room for debate. Either way, the next phase of your transition to a healthy practice promises to be the real test.

3. Establish a protocol for grievance resolution. Even if everyone signs off on your new office policy, there are bound to be conflicts that it alone cannot resolve. For these times, it is critical to learn negotiating skills and conflict management. In some cases, you might need to hire mediators. Conflict is rarely irresolvable; by using dispute settlement skills, amicable resolutions can usually be reached.

A grievance process needs policy enforcement. Internal and external parties need to be comfortable with conflict resolution as a process. Where no dispute resolution process exists, seniority, productivity quotients, style or disruptive behavior favor abuse. Sometimes administration has to insist on a grievance policy because of intimidation or misuse within the program. I've seen cases in which the practice administrator gave up on ever getting the partners to agree because it was "a doctor problem."

Long-standing or late-stage problems may need evaluation by a third party who understands the culture of medical practices. ►



Retreats are a great way to improve your practice, whether you're getting away to create an office policy or taking time later in the process to promote training in conflict management.



If you're convinced that your practice is beyond help, it might be time to think about developing an exit strategy.



If you want to stay put and work to fix your practice, don't be afraid to share your thoughts with your colleagues. Many probably feel the same way.



Practices that work hard correcting problems end up being a healthier place for everyone who works there – and for their patients.

4. Invest in your group. Back up your practice's words with bucks, setting aside the necessary time and money for training and development. Encourage physicians to attend not only CME events but also courses in personal or professional development, such as spousal communication, parenting, coping with medical malpractice and stress management.

You should also spend some time each year away from the practice as a group. Retreats devoted to the essentials of a healthy practice (cohesion-building, effective teamwork, etc.) are another way to promote training in conflict management.

A last resort

Unfortunately, there may be times when all the confrontation and communication in the world won't cure a toxic practice. If you're in such a situation, it's time to develop an exit strategy.

With all the opportunities out there for family physicians, it may be wisest to begin self-care and look for another work situation. You'll probably feel guilty for leaving the practice understaffed temporarily, but why stay in a hostile environment?

It can take time, but you will find a healthier practice situation. The AAFP Placement Services program may be a good place to start: <http://www.aafp.org/placement.xml>.

The road to recovery

These days, Dr. Taylor is sleeping well, Dr. Garcia no longer has to endure badmouthing, and Dr. Miller is free to compliment his co-workers.

Getting to where they are today wasn't easy. Disruptive individuals are difficult to confront and hard to change. But by getting their practices to focus on their problems, whether caused by individuals or a collective ignorance of unprofessional behaviors, they now work in offices that are at least trying to foster a collaborative and synergistic culture.

If you work in a dysfunctional practice, don't be afraid to dream of an office where morale is high and turnover is low, where everyone feels empowered to suggest, create and take responsibility.

Others probably feel the same way you do. Take a chance and begin talking to your colleagues about improving your practice. The alternative is more time in a toxic environment. Practices that correct deficiencies and encourage assertive communication, conflict resolution and a professionalism policy promote optimal health for patients and providers. **FPM**

Send comments to fpmedit@aafp.org.

1. Rubin IM, Fernandez CR. *My Pulse is Not What It Used to Be: The Leadership Challenges in Health Care*. Honolulu: Temenos Inc.; 1991.

ESTABLISHING EXPECTATIONS

The most effective way to reach disruptive members of your practice is to establish a written policy of how each member is expected to behave. Here are some sample criteria that could form the foundation of your practice's new or revised policy.

Behavioral	Practice	Interpersonal
<ul style="list-style-type: none"> • Exchange appropriate feelings • Seek feedback regularly • Use dispute settlement skills • Listen to problem-solving suggestions • Base decisions on short- and long-term goals • Base rewards on practice goals • Use appreciation and praise honestly • Focus on clear, quantifiable strategic planning goals • Assist in implementing performance-appraisal systems 	<ul style="list-style-type: none"> • Obtain appropriate consultations • Use direct and effective communication • Arrange for appropriate coverage when not available • Complete medical records in a timely fashion • Disclose potential conflicts of interest • Participate in the identification of colleagues who need assistance • Voluntarily participate in clinical and behavioral reviews • Refrain from fraudulent scientific practices 	<ul style="list-style-type: none"> • Refrain from shaming • Refrain from sexual innuendoes • Comply with sexual harassment policy • Refrain from using sarcasm and abusive language • Address concerns about clinical judgments privately • Refrain from criticism of staff in front of others • Refrain from using the medical record to attack others • Comply with "assertive listening" criteria when others are speaking