What Blows Up Will Come Down: Leadership Failures in Medical Practices

by Thomas A. Lerner

This article is not about Swedish Hospital, although the title may have led you to a different assumption. The facts, circumstances and consequences of events that have received extensive coverage in the Seattle Times are still playing out in real time, and will be left to unfold with limited commentary here. One need not look to Swedish Hospital for leadership lessons in medical practices and common threads that lead to the implosion of what should be successful group endeavors.

Medical groups do not seek out lawyers for assistance in dividing up profits. Rather, those conversations begin because symptoms of discord have ripened into full blown infections. Colleagues have become suspicious or resentful of each other. Civil communication within the group has waned, or devolved into serial conversations in groups of two or three, behind closed doors. Perhaps a meeting is called of the whole group, and a quick glance around the table finds an empty seat or two, and others sitting with arms folded, as if seeming to hold in the anger or frustration that has been brewing. Those seeking to right the ship look around, wondering "how did we get here?" One finds common threads that lead to these group dynamics. The witches at the cauldron of practice collapse are Complacency, Fear, and Avoidance.

Complacency

The practice seems to be running smoothly. The practice owner has hired some other physicians, with vague promises of future partnership. The practice's billing is mostly all right, although the accounting is being handled internally in a way that makes it difficult to track with precision. The owner has ceded most of the management of the practice to the office manager, who is loyal and fiercely protective of her prerogatives. Everyone is a subordinate to her, including the other physicians whose questions about collection and compensation are responded to with obfuscation or dismissed. The owner is content, working an abbreviated load but enjoying a disproportionate share of the profits. To the owner, all is running smoothly. Then, the employee physicians give notice of their intended departure to open their own practice, where they will have control and earnings commensurate with their efforts. Soon after, a number of mid-levels and key staff quit to follow the departed doctors. Now, the owner is scrambling to meet patient needs and generate revenue sufficient for the overhead taken on when the practice had three physicians rather than one. What happened?

It is a lesson from history, if not business, that autocratic control eventually leads to revolution. It is no secret that physicians appreciate being treated with respect and as peer professionals. Loyalty breeds loyalty. Here, the owner was loyal to himself, and the office manager was loyal to the owner, who had elevated her station. Everyone else was treated as a serf, and at the end of the day, the erstwhile lord of the manor was left to muck out the stables on his own.

The owner suffered from a self-inflicted wound. As long as his income was robust, he disregarded whether the practice environment was satisfying to the other professionals. It would have taken little to avoid this dynamic. Even if the owner was not yet prepared to propose partnership, clear expectations could have been set as to the threshold for when an employed physician would be eligible for partnership, and the financial structure for purchasing a partnership interest. The prospect of partnership may have deterred the departures.

In a similar vein, financial transparency would have gone a considerable way toward instilling confidence that it was worthwhile to stay. The economics of a medical practice lose their mystery quickly when practitioners develop their understanding of how to be both medically and financially productive in their patient care. More than that, however, financial transparency (or substantial transparency) demonstrates the owner's confidence and respect for the employed physicians' judgment and discretion. If that judgment and discretion is lacking, then the physician shouldn't be caring for the practice's patients to begin with.

The loss of mid-levels was also predictable. If the owner was not treating the physicians with respect, it is unlikely that the mid-levels were treated as professionals. With the loss of the physicians, the mid-levels quickly assume that there will be staff cutbacks. The owner has shown no loyalty to them, and their day-to-day relationship is with the physicians they support—the workhorses whose efforts had led to the owner's complacency.

It is often said that the shortest memory is that of a judge, who upon donning robes immediately forgets what it was like to be a practicing lawyer. Owners of a medical practice can be similarly vulnerable and vain, forgetting their experience as employed physicians. Had the owner in this instance showed commitment to his colleagues, there is a greater likelihood that they would have returned the favor, and the practice would not have collapsed in on itself.

Fear

A group builds out a new space with robust surgical suites offering the promise of eye-popping facilities fees. Overhead is steep to absorb the cost of the build out, but that will resolve as additional practitioners join the group. Recruitment becomes a thorny problem, though. The most productive member of the group is accustomed to ruling

the roost, and has assured that the governing organizational documents give him a veto over key decisions. To bring in a practitioner with a mature practice would require ceding that veto right. To bring in a practitioner with a developing practice, the senior physician fears, could lead to a cannibalization of his practice so that the junior doctor is kept busy. A production-based compensation plan, in the short term, could lead to a drop in the senior physician's income, disregarding that in the longer term the junior physician's developing practice will spawn more facilities fees and patient interactions that will ultimately aid the bottom line. Fear of loss of control? Fear of loss of income? Best do nothing.

If you are not moving ahead, you are falling behind. The practice needed to grow not just to thrive but to survive. Unwilling to cede control—and place trust in his partners—and unwilling to share his practice—and place trust in his track record—the senior physician froze. Eventually, the weight of the overhead provoked other practitioners to leave for less expensive practice environments. The senior physician was in command of his practice but could not afford to keep it. Now, another group occupies that new space and with a more confident appreciation of what it needs to make the most of the ASCs, they are making the profits that the senior physician hoped for, but would not take the risks to make happen.

It would be wrong to suggest that the losses here were just financial, too. Amidst the financial strains, the personal relationships among allied professionals frayed. Ultimately, partners ended up only communicating through lawyers. In the collapse, a year's worth of income opportunities were lost.

In any entrepreneurial environment, risk precedes reward. Here, the group undertook the risk by committing to the build out of the new facility, but were unprepared for the next necessary stage of the business plan, which was how to bring additional providers into the fold. One does not become a physician without having demonstrated sustained initiative and drive. Few people with those traits will long be content to be in subordinate and limited roles. Had the senior physician trusted in the reputation he had established through a long career, he (and his colleagues) could have nurtured a new physician through the early stages of building a practice, ultimately leading to much greater income opportunity for all. But fear caused the doctor to pull up

short, the consequence of which was ultimately the failure of the practice.

Avoidance

The biggest rainmaker in the group knows it. Convinced that his productivity assures him a sinecure, arrogance creeps through, first in small ways and then large. It begins by claiming prerogatives in facilities, staffing, or scheduling. It may migrate into pushing for adjustments in the group compensation plan, so that more overhead is allocated on a per capita basis rather than based on production. Productivity can spill over into vanity: greater risks taken in surgical procedures, harsher treatment of staff and subordinates, less patience, no effort at solving problems with training, increasing bellicosity. No one, whether the titular president of the group or any of his colleagues, wants to confront the rainmaker, out of concern that he will leave. But staff turnover increases, and recruitment becomes more and more difficult. Ultimately, enough others in the group find an exit and the practice inevitably folds.

Of the scenarios described above, this may be the most common. In recruitment of practice groups, Proliance has had surprising success in winnowing out the problematic producer, and the remaining group members tend to be more content and more productive even without their formerly biggest rainmaker.

At the outset, this article disclaimed that Swedish Hospital's recent troubles were its subject. But the situation does provide a stark illustration as to the impact of the disruptive rainmaker. In the Ex Parte Order of Summary of Suspension of Johnny Delashaw, M.D. (Medical Quality Assurance Commission Master Case No. M2016-1084), the commission made findings of fact, which concluded in part that:

> *Respondent's behavior towards hospital staff in and out of the operating room was extremely disruptive and below the standard of care.*
>
> *This disruptive behavior includes yelling, swearing, shaking and pointing his finger at others, and making threatening movements towards staff. Respondent stifled the vital free flow of thoughts, comments, and observations by the surgical team in the operating room in regards to patients and their care.*
>
> *Respondent's yelling, threatening, and sarcastic comments in response to the operating team's statements before, during, and after surgery suppressed oversight and caused the operating team to keep their thoughts and observations to themselves, thereby creating an increased risk of patient harm.*
>
> *Respondent further impacted patient safety by discouraging staff from reporting mistakes, oversights, and non-procedural events to the hospital administration. By discouraging these reports, Respondent was ensuring that mistakes and oversights were not tracked and that no corrective or remedial action could be taken to support patient care. Due to the disruptive, and toxic atmosphere surrounding Respondent, many staff members resigned or transferred from the hospital, including a number of long-term, highly experienced nurses. This loss of experienced personnel put patients at risk as there were newer, inexperienced staff on duty without experienced staff on hand to help train them.*

This did not happen without coming to light. But avoidance of management of the problematic rainmaker led to the problem becoming severely exacerbated, disrupting not just a group practice by a much-storied institution.

Avoidance of conflict does not solve problems. It instead nurtures them until they take on explosive force. For the survival of a group practice, the time to intervene is as soon as the problem becomes apparent, while correction is still a possibility. The power of the problematic physician comes from his or her belief that one's productivity overwhelms everything else. That power dissipates when the group chooses to communicate that such a belief is misplaced. In short, the power of the disruptive rainmaker comes from the rest of the group acceding to it, ultimately at a severe cost to the effectiveness of the practice and the professional satisfaction of the group.

Conclusion

An aphorism of organizational dynamics is that everyone overestimates their importance to the success of the organization. The traits that successful physicians bring to their patient care—active listening, empathy, attention to symptoms, and prompt treatment of open wounds—need not be left behind in the examination room, but should follow out into the hallway with each interaction with a professional colleague of any level and of any staff member. Skilled, motivated professionals choose to come to work at places where they will be treated with respect and honored for their contributions. If that is not their workplace today, one way or another they will find a workplace where that will be true. The choice for a group is whether that will be someplace else. ■

About the Author

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