DOCTOR'S CROSSING
CARPE DIEM PODCAST
BY HEATHER FORK, MD, MCC

TRANSCRIPT

EPISODE 138 Is Your Communication Style Helping You Or Hurting You?

With guest Dr. Ryan Bayley

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RB: "The problem is not the uncomfortable emotions that are showing up. It's how you're trying to control them. It's sort of our response to them."

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hello there and welcome back to the Doctor's Crossing Carpe Diem podcast. You're listening to episode number 138. I talk to a lot of different physicians and hear about the challenges they encounter in the course of caring for patients, interacting with staff and colleagues, and being under significant stress.

Some physicians will tell me about how they might get stressed and lose their temper when something or someone is compromising their ability to care for patients. They

might be told your communication style is abrasive or unprofessional. They might be labeled disruptive and even be terminated from their job.
On the other hand, a lot of physicians tell me that they may have trouble speaking up in meetings, giving constructive feedback to staff or talking to a more assertive physician. They're afraid to say what they need to say and worry about other people's perceptions and responses. They don't want to be perceived as difficult or compromise relationships.

In different ways our communication style can significantly impact our effectiveness and enjoyment of our job, and can also influence our career path. Because I want you to be able to thrive in whatever your career setting and good communication skills are so important in any job relationship, I am excited to have an expert guest here to dive into this topic.

To help us out today is a friend and colleague of mine, emergency medicine physician, Dr. Ryan Bayley. Dr. Bayley is the founder of Bayley Coaching Solutions, a physician focused executive coaching and consulting firm. He is often consulted to help with physicians who have been labeled disruptive or who have boundary issues or other interpersonal challenges.

Dr. Bayley is a nationally recognized speaker, as well as a consultant to large healthcare organizations and has recently published the book “Physician Non Grata: A Survival Guide for Clinicians Around Poor Communication, Boundary Issues, and Disruptive Behavior.”

Ryan is going to share some scenarios of how physicians can get into trouble with their communication styles, as well as how on the other end of the spectrum they can disempower themselves by not speaking up. He'll be offering advice for physicians with either of these communication styles to be more effective and impactful in their interactions. It is my distinct honor and pleasure to welcome Dr. Ryan Bayley to the podcast. Hey, Ryan, how are you?

RB: I'm great, thank you, Heather, and thank you for having me. It's been a while since we've seen each other. I feel like with COVID we would cross paths a little more frequently and not so much since. So, it's great to see you.

HF: Likewise. I remember I met you at the SEAK Non-Clinical Careers conference, and I don't think at that time you were specifically focusing a lot on disruptive physicians. I'm really curious if you could tell us how you got into this specialty niche.

RB: Yes. This niche was really an unexpected development, to be honest. As we've talked about before, not unlike you, I imagine I got into coaching because I saw a lot of suffering around me. A lot of physicians whose hard work was not translating into fulfillment. At the end of the day, a lot of burnout, and I had wonderful personal experiences with coaching, and so decided to become a coach. And thought I would do work around burnout, career development, non-clinical transitions, and I do that work. I still do that work.

At the same time, what started happening is I started to get some referrals from medical boards and state physician health programs. And what was interesting is those referrals were never really for burnout, but rather for a specific behavior. I would get someone referred to me who "did not play well with others" or was engaging in conversations that made other people uncomfortable or were creating a lot of friction in the workplace.

And when I would work with these physicians, I would see that, yeah, sometimes these behaviors are manifestations of burnout for sure. But I also started to notice there was something else going on at a kind of a bigger level. And what I think that is, is that there's been a massive shift in the last five or 10 years in terms of what's expected around physician speech and behavior. The standards to which we're held with each other, with our patients, and also just the ramifications for what happens when there's relatively small points of friction. Those ramifications are a lot bigger.

Five or 10 years ago if you upset a nurse, if you were condescending to a nurse, that nurse would go to their clinical supervisor who would go to your supervisor who would pull you aside and kind of slap you on the wrist and say "Do better."

Now that same nurse is probably going to go to a nonclinical administrator or to HR, and that's far more likely to trigger a more formal and aggressive response that can really end up being quite uncomfortable or career threatening for you. And I think a lot of us don't realize the jeopardy that this represents, and a lot of us don't have those sort of nuanced skills that are needed to navigate all these kinds of nonclinical interpersonal challenges that just come up every day with people. And these skills were not modeled, or at least they weren't for me in my training.

So, this sort of became a niche for me and I worked with a lot of individuals and then that sort of lent itself to keynotes. And as you mentioned, I just wrote a book on this. And I do a lot of workshops for organizations.

HF: Well, I think it's a fascinating area, and I have to tell a little funny story about myself in that. When I first started coaching, I heard about a workshop for disruptive physicians and I just get enthusiastic and sometimes I forget, maybe my own boundaries. And so, I emailed them and I said "Oh, I just started coaching and I'm working on the wellness committee at the Texas Medical Association. I'd love to come and observe this workshop."

I didn't hear much back, but then I get an email from the person's assistant and she said she wanted to meet me at Panera Bread in Austin. Well, they were in Houston. So, it's like, "Oh, wow, this is so exciting. They're going to want me, blah, blah."

I meet her there, and her body language and her attitude was really funny. And what I realized is that they thought I was trying to steal their methods or I don't know, had

some different kind of agenda. And so, the doctor who's running that workshop sent her down a three hour drive. I finally got her to admit that he told me to come down and check you out and see what was going on with this woman.

But I was just curious because I think this is a fascinating area. It's not what I coach on. This is really not my wheelhouse, but I think you're doing a great service. And so, I'm really glad to have you here today to help our dear physicians who are under a lot of stress to be able to communicate more effectively so it can be better for them, but also so they don't get in trouble.

RB: Yeah. That story is really funny. It sounds like a little more reconnaissance or something.

HF: Yes, yes.

RB: But that does sort of hint at something that I think most physicians have no idea that exists, which is that there is this sort of I don't want to say hidden system because that makes it sound a little nefarious, but there is this sort of system out there that deals with complaints against physicians, and it's a system that includes medical boards and hospital executive committees, as well as a lot of private entities. And it is a very elaborate system that's existed for decades.

And it takes a relatively small infraction to find yourself sort of immersed in the system. And I don't think we'll get into a lot of detail today about it, but I do write about it in the book that it's a system that no one ever mentions when we're in medical school, but it's very complex and very hard to navigate and you want to do everything you can to avoid finding yourself interacting with this system. It's an ounce of prevention, pound of cure type of situation.

HF: Absolutely. Now, you had mentioned, when I came up with this idea of talking about not just physicians who are maybe being a little bit overly assertive, but also physicians who

have difficulties speaking up, if we could address both of those, and you said something really interesting. You said they're actually not as different as you might think, or the reasons underneath having difficulties at both ends of the spectrum. So, how would you like to approach this? Do you want to do them separately, do them together?

RB: I think maybe together, to be honest. In my work, the people who are being referred to me obviously are the people who've been labeled as problematic. And so, the big communication issues I'm seeing tend to be incivility, verbal incivility as well as people who are being labeled as disruptive. And often that's actually a function of them trying to advocate. They get sort of labeled, it's this like disruptive advocacy that physicians sometimes inadvertently engage in. But you're absolutely right.

In the other half of physicians I work with people who come to me of their own accord a lot of those physicians are burned out and frustrated with the system and they often struggle with the opposite problem, which is a lack of self-advocacy and a lack of engaging in communication.

At the end of the day, sort of the root causes of those are more similar. Yeah, I think we can kind of talk about them almost in parallel. But those are kind of the big three issues I see. Again, the incivility, the disruptive label which is usually a result of being so overly advocacious. I don't think that's a word, but too much advocacy or going about it the wrong way. And then not advocating enough, I guess would be the third.

HF: And advocating for yourself. Yeah. Excellent. So, let's look at some of the root causes.

RB: Yeah. And this is where we're going to get a little shrinky. I'm certainly not a therapist, but there is a little gray area sometimes I think with coaching.

HF: Absolutely. Now you can get as shrinky as you want here. We're very touchy feely.

RB: I think pretty much all poor communication, whether we're talking about communication that's overly abrasive or the lack of communication, failing to communicate when perhaps we need to. A lot of it just comes down to discomfort with emotion.

I think as physicians, we're very rational people. We tend not to put a lot of stock in emotion. We're not supposed to be emotional. We're certainly not supposed to be emotional at work. And emotions are seen as kind of a negative thing in our world. But the truth is we spend our days immersed in emotion. Our own emotion as well as the people around us, our colleagues, our patients. And until you're very comfortable with the emotion that shows up, the good and the bad, it's very hard to communicate effectively.

There's a book called Crucial Conversations by Joseph Grenny, and it's a very famous book on communication. And I think he makes this wonderful point. This gets to what you were just saying about these problems not being as different as you might think. He says that whenever we're sort of in a high stakes situation and stressed out, that we tend to engage in one of two ways. Either what he calls violence or silence.

And really that's kind of another way of saying fight or flight. When we're very uncomfortable with our emotions and we're very uncomfortable in a communication situation, the two ways we tend to go are violence, which is we tend to engage aggressively, either belittle someone or push back, try to shut down their emotions or sublimate our emotions into anger. We try to look good and be right and come out on top. And that's kind of the fight response. Or we tend towards silence, which is sort of the flight response where we just kind of shut down and we don't engage.

And both of those are really just an attempt to get away from the discomfort that we're feeling in the situation. It's a very rational fight or flight instinct. And so, what's interesting is these two completely opposite appearing problems are really just the same

problem, which is we're very uncomfortable with what's showing up internally. We're dealing with it in two different ways, but the discomfort is the problem.

And that's what's so fascinating, and I think this is a real "aha" moment sometimes with people I work with is the problem is not the uncomfortable emotions that are showing up, it's how you're trying to control them. It's sort of our response to them. And so, you kind of have to get a handle on your discomfort with these situations before you can really effectively communicate regardless of which end of the spectrum you find yourself on.

HF: That is brilliant Ryan. I love it. I love it. And it makes a lot of sense especially when we think about personality type. For example, the type eight, when we talk about the Enneagram, is called the challenger or the leader. They're often the physician who is often a surgeon who feels like he or she is just taking great care of the patient.
And this is a classic thing you hear about eights, is that they will think they just had a passionate discussion with someone and then the other person will be like, "Oh my God, I can't believe we had this argument." And they see things differently.

And then on the other end of the spectrum is the peacemaker, the type nine, they go along to get along. So, conflict is really hard for them, but underneath they're actually building up a lot of anger. So when they do blow, they surprise people, they broadside and they're like, "Oh my god, this doctor who is like, Mr. Mild-Mannered, whatever, just blew the roof off."

But you're right, it's that emotion that's challenging. So, let's take each of those examples and maybe you could give each of those types a way to work through how do they handle these emotions because they're doing it differently.

RB: Yeah. I actually use a very similar exercise for either type. And again, this is a classic sort of cognitive behavioral therapy exercise. It's used a lot in coaching. But it's sort of a

variation of the A, B, C, D type exercise. So when someone finds themself either repeatedly having friction filled interactions or repeatedly shutting down when they don't want to be in some type of communication situation, what I'll have them do is just kind of start observing that. And they just make a little spreadsheet and four columns, A, B, C, D. And the A column is just the activating event or the action. And you just write down the situation very objectively. Like "I was in the doctor's lounge and so-and-so said X." It's just what a fly on the wall would've seen and heard. You just keep it very simple.

And then B is a sort of belief or brain. What was going on in your mind? B is all about what thoughts came up for you when that happened. What were you thinking, what were you feeling? What was your interpretation? What meaning were you creating about the situation?

And then C is the consequence. C is just how'd you react. Again, what would a camera or a fly on the wall see you do? What did you say? And then D sort of disputes that. And what I mean by that is sort of then after looking at this, you kind of ask yourself, "Well, what would it mean if I didn't do that?" The OR tech came up to me and said we can't start the case. That would be the action because they can't find the consent. And then B would be like, "Oh my God, they lost the consent again, they're making this up. They're always trying to slow my cases down." All the sort of narrative that you fill in.

And C would be that you barked at the OR tech. You kind of yelled at him or her, you belittled them. And then D you're kind of asking yourself, "Well, what would it mean if I didn't do that? What would it say about me as a physician?" And this is the really interesting part because you often find yourself getting to kind of the root cause of why are you actually engaging in this behavior? And what's really interesting about this is when you start doing that, you start kind of tapping into these sort of stories you have about yourself, about why you have to do these things in the situation.

And they usually start filling a couple of very predictable categories. For example, if you're the aggressive type, you start to realize when you do this exercise that chances are a lot of this is about your unrelenting standards and your perfectionism. There's probably like a hyper criticalness to it and a fear of not meeting those expectations. You may have a little entitlement that's kind of driving it like "I'm a physician, I work so hard and therefore things should be this way."

Or if you're the silent type, there's probably a lot of conscientiousness there. I can't speak up or I have to do this for others. You may be mistaking self-care for selfishness, you may have a little imposter syndrome, which I'm sure you've addressed in other podcasts or in your coaching.

But the point is, as you do this exercise, you're going to come back to the same couple themes and you're going to start recognizing, "Wow. In all these situations, even though the specifics may be very different, I keep coming back to these core themes." And you'll sort of realize you have these buttons that are getting pushed.

And the reason this is so important is because for most people who are struggling in this situation, there's the stimulus and then you're reacting. And there's all this brain chatter that's going on in between that you're not even aware of because it's just a stimulus reaction.

But if you do exercises like this, you sort of slow that down. You create a little gap between stimulus and response and in that you actually start to get a little control. And once you can start labeling what you're thinking, you start to be able to do it in real time. You do this exercise at the end of a day, you look back at one or two friction filled moments and you do this exercise.

But what happens is as you do this exercise, it only takes about a week or two, you start to be able to do it in real time and actually sort of slowing down in the moment so that

you're not so reactive. And honestly, that's like 90% of the game. If you can just sort of slow down that reaction so that you're actually thinking just for a split second and not getting sort of sucked into that rut that you have in terms of how you respond in these situations, that gives you a chance to kind of pivot and do something different.

I think that's very shrinky, that's a very sort of introspective exercise and I know physicians prefer tools and rubrics and algorithms and they kind of want something a little more concrete. But I think that introspective work is really critical. And I always start with that because if you don't understand why you're getting so irritated, if you don't understand the story that's going on in your head in these situations, it's going to be really hard to change your behavior.

HF: Yeah, I want to dive into that a little bit more, but first we're going to take a quick break so I can share some resources and then I'll be right back.

If you are applying to a nonclinical job, it's a great idea to convert your CV to a resume. A well-crafted resume helps recruiters see why you are the right person for the job. My resume kit is a downloadable PDF that walks you step by step through creating an impressive resume of your own. You'll have everything you need, including templates and a bonus on writing a winning cover letter. To get immediate access to this kit that I use with my coaching clients, go to doctorscrossing.com/resumekit or simply go to the Doctor's Crossing website and hit the products tab at the top of the page. Now back to our podcast.

All right, we are back here with my lovely guest, Dr. Ryan Bayley, and we're going to come in with some specific examples in a sec. But I just wanted to say, Ryan, you are not being shrinky by talking about these things. This is something we really should learn in grade school. We should start learning how to manage our emotions and the advice is fantastic. And I find that the physicians I work with really want to learn these

interpersonal skills and they have no problem looking at themselves and doing the self-observation. So, I'm really glad you brought it up.

Now to get real concrete here. I'd love it if you could give us two examples. The first one where a physician may be saying something that's offending someone else and they think it's fine. What actually would they do differently?

RB: Sure. Starting with, let's say an overly aggressive example. Typical surgical example. Surgeons in the OR, stressed in the middle of a case and perhaps a scrub tech has multiple times handed the surgeon the wrong instrument. And the surgeon just snaps back at them and is like "I've told you so many times, this is not the instrument. This is what I need now and I need you to listen more to me."

We see that, we hear that all the time, but going back to some of those ideas we talked about, like the A, B, C, D idea and that uncomfortableness with emotion, think about what's happening there. A lot of what the surgeon is saying is about making himself feel better. That's him kind of sublimating some of that discomfort and some of that fear into anger. Because it feels good. It's about him trying to control his discomfort and not really about beneficence for this situation. It's not really about making the situation better. It's really actually about him just trying to control his own discomfort.

If you go through those exercises, you start to realize you have that tendency, then you might not get so hooked in the moment. And then what you can do is you can sort of pivot to a couple strategies. So, one is to just stay factual. If you don't make it about yourself, then it's easier to drop that language. And so, you won't say, "Oh, I told you not to do this, or I've told you so many times."

HF: "What's the matter with you?"

RB: "What's the matter with you?" Instead, you can just sort of be much more factual and keep it about yourself. Take the U language out of it and just say I. Like "I'm sorry I don't need this, I need that. Can you please hand that to me now?" Just navigate the situation very factually, avoid the sort of you and the judgmenty language and then you can always deal with it after the fact. Maybe when you pull that tech aside later you realize there's an educational issue and maybe there's an opportunity to educate that person in a less condescending way.

But really is it about your control of your discomfort or is it really about being beneficent to the situation? And I think going through these exercises, recognizing your own tendencies, once you realize that a lot of this language is about control and you kind of get past that, then it's so much easier to pivot to beneficence. And then your language just has a tendency to automatically change once you start thinking about "How can I be beneficial to this situation?"

HF: Excellent, excellent. And I love how you said hook because we often have an emotional hook and we get a dopamine hit, even if it's an uncomfortable emotion when we do something like pop off at someone, it feels good in the moment. All right. And I think you have an example for someone who maybe has trouble speaking up.

RB: Right. Let's say you're in a clinic and you've got maybe a new nurse or CNA who's not rooming patients quickly or appropriately and you want to say something, but of course, that's going to be uncomfortable. And so, you decide not to say something. And that's the emotional hook is opting out, right? Because once you decide to avoid conflict, that feels really good. That's the dopamine hit is you get out of the uncomfortable situation.

HF: For the moment.

RB: For the moment. And you and I both know that the moment is going to come up again and again and eventually it's going to come to a head. So, it's not workable, but it feels

good in the short term. But part of it is realizing that it's not going to work in the long term, but if you do have to have that conversation, kind of like the example we just gave, starting with factual language and specific language is usually the way to go. So, you want to say to that person "Hey, I'd like to talk to you about something" and then give a very specific description of what you're trying to say.

So, don't speak generally, like "You're always behind on patients" or "You're always putting patients in the wrong room." You want to say "I noticed on this specific instance, you put this patient in the wrong room. And then the next day you did this exact thing this way."

You want to give one or two concrete examples, keep it to the most recent examples and then again, don't make it about them. Make it about you. Be like I really need this to happen for this reason. And again, be very factual throughout the whole thing. And once you've stated the facts as to what's happening and once you've said what you need without using any "you" language, meaning referring to them, then sometimes you can take their perspective too.

Sometimes it's really good after you've sort of said what you need to say "But I want to know, is that what you intended or do you see it differently? Or is there something missing here that would help me understand better what's happening?" Because oftentimes you'll be surprised at the answer to that, but also it brings them into the conversation and makes it less adversarial and it makes it seem like you're both problem solving together.

But again, it's sort of the same ideas as the first example. Sticking with factual language, focusing on beneficence, avoiding "you" based language and that'll kind of get you through both situations regardless of what tendency you have.

HF: Yes, I love those examples and it reminds me of something, I don't know if I read it in the Crucial Conversations book or somewhere else, where it says "Seek first to understand before being understood." And I think that helps us think, "Oh there's another part of this equation, let me understand their perspective, then I can also share mine and we can kind of come to an understanding about our interactions." Those are lovely examples. I'd love to go on and on with this, but I know we're getting close to time here.

Ryan, could you let folks know how they can get in touch with you and find your resources and also your book, which I thought was excellent?

RB: Sure. Yeah, and thank you for the plug on the book. Of course. My website is the easiest way to get ahold of me. It's solvingcareers.com. And it's Bayley Coaching Solutions. And again, I do work with individuals and organizations, but that is the easiest way to get ahold of me and learn more about what I do.

The book again is called Physician Non Grata and it's a survival guide for clinicians, not just physicians, but really all clinicians around communication, boundaries and disruptive behavior. You can get that on Amazon as either a paperback or Kindle. And it should be available through Barnes & Noble within the next month also in both paperback and electronic formats.

HF: Wonderful. I'll make sure to put all those links in the show notes, including the Crucial Conversations book, which I love, and also your book. And also I want to have you come back and talk about the disruptive physician and how we can avoid getting this label because as we talked about before we started recording, these infractions are a lot more minor than we think they are, but they can be career devastating and ending.

I'll definitely like to have you back. And to my dear listeners, thank you so much for being here. Please share this podcast to anyone you think it could benefit, and we'll have Ryan back. And even though I didn't get to go to that disruptive physician workshop, we

get to have Dr. Ryan Bayley personally on the podcast. So, thanks so much for listening and don't forget to carpe that diem. I'll see you in the next episode. Bye for now.

You've been listening to the Doctor's Crossing Carpe Diem podcast. If you've enjoyed what you've heard, I'd love it if you'd take a moment to rate and review this podcast and hit the subscribe button below so you don't miss an episode. If you'd like some additional resources, head on over to my website at doctorscrossing.com and check out the free resources tab. You can also go to doctorscrossing.com/free-resources. And if you want to find more podcast episodes, you can also find them on the website under the podcast tab. And I hope to see you back in the next episode. Bye for now.

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Podcast details

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