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

TRANSCRIPT

EPISODE 143 Are You At Risk Of Jeopardizing Your Ability To Practice?

With guest Dr. Ryan Bayley

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RB: "I think people just don't understand how it's really these sort of minor infractions, these minor misinterpretations of speech or behavior that end up having these very big consequences."

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 and welcome back to the Doctor's Crossing Carpe Diem podcast. You're listening to episode number 143. It takes a lot of time and sacrifice to earn the privilege of owning a medical license. If we are looking at 11 years of education and training, which is often the minimum, we are talking about 96,360 hours.

Unfortunately, there are things we could do in less than a minute to cause us to lose forever that hard earned license. I'm not talking about malpractice or selling narcotics in the back alley. I'm referring to behaviors that may not seem that out of line or

warranting such drastic consequences such as disciplinary action, probation, and loss of one's license. This could even be doing what we think is necessary to take good care of our patients.

To help us better understand some of the potential risks to our medical license and how to avoid getting into trouble, we have executive physician coach Dr. Ryan Bayley joining me on the podcast. Dr. Bayley was a recent guest for episode 138 - "Is your communication style helping or hurting you?"

I wanted to have Ryan back so he could share some stories of how physicians have found themselves unexpectedly facing disciplinary action and other negative consequences so we can be more aware of the potential pitfalls and safeguard our ability to practice medicine.

As I mentioned in the earlier episode, Dr. Bayley is the founder of Bayley Coaching Solutions, a physician focused executive coaching and consulting firm. Ryan is often consulted to help 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 he has recently published the book "Physician Non Grata: A Survival Guide for Clinicians Around Poor Communication, Boundary Issues, and Disruptive Behavior."

Without further ado, it is my distinct honor and pleasure to welcome Dr. Ryan Bayley back to the podcast. Hey, Ryan. Welcome, welcome back.

RB: Hi, Heather. Yes. Thank you for having me back. It's great to be back so soon. Yeah, I'm really excited to have this conversation because I think there were some perhaps loose

ends in the previous one, or at least some directions we could have gone in, and I think there's a lot more to be said.

HF: Well, thank you. And I've gotten great feedback on your earlier episode. I had a surgeon reach out and he said, "Oh my gosh, where was Ryan when I needed him 20 years ago?" And he sent it on to some other folks. You're really helping physicians stay out of trouble and we don't want anyone to lose their license. That's a terrible thing.
So, let's begin with a story perhaps of something that may have happened to a physician along these lines where they weren't expecting some bad consequences.

RB: Yeah. The story I'm about to give may sound a little vanilla, but that is the point. I think people just don't understand how it's really these sort of minor infractions, these minor misinterpretations of speech or behavior that end up having these very big consequences.

A story that I always think about, it's really an amalgam of two physicians just to protect names and identities, but it's the story that I opened the book with, which is a general surgeon and a community practice, been there for over a decade, well-liked, the surgeon that any staff member would go to if they had an issue or with themselves or their family member, and technically very well respected. One day gets called into the office of his clinical supervisor for his group, his "group's boss."

And he doesn't think anything of it until he walks in and he sees that not only is his supervisor or his partner there, but also the chief of staff for the hospital. And the first words out of his partner's mouth are "We've had a complaint." And he immediately starts thinking about cases that technically did not go well in the last couple weeks. And so, he says, "Well, what patient?" And his partner says, "Well, it's not a patient, it's a colleague." And at that point he's just kind of blindsided. He can't think at all about of any interaction that was particularly negative with a colleague. Again, he thinks of himself as well-liked, he's been there forever.

So, he starts asking details and what he starts getting is kind of stonewalled. All of a sudden the chief of staff is like, “Well, we can't tell you any details. We can't reveal anyone's identity because they have a right to privacy and we just need to look into this, so we're just going to send you home.” And even though the word suspension is not mentioned, he's essentially administratively sent home for a day or two so they can figure this out.

And all of a sudden, he's thinking, “Well, what do I do about my patients tomorrow and what do I do about my cases the next day?” And they make it sound like a small deal, but that's huge for a physician. And so, he goes home and he is trying to figure out what am I going to tell my partner and racking his brain.

Long story short, he comes back a couple days later when he is told to come back and this time it's his supervisor and the chief of staff as well as the hospital lawyer in the room. And they start talking about the case and basically saying the PA in the case who was the surgical assist thought that in this particular case you were a little verbally aggressive, particularly when the patient wasn't doing very well, when the surgery was getting a little tense. They start throwing around words kind of like boundaries issues and disruptive behavior.

The PA who happens to be a female also felt that his behavior after the case was a little inappropriate because in his mind, he thought the PA was upset. He kind of went up to her, stood behind her to comfort her, maybe put his hand on her lower back. The PA thought that that was inappropriate.

And at that point he's about to mount a defense, but then starts realizing in the conversation that they're also not particularly interested in his perspective of anything. And he starts to realize that this isn't really a fact finding meeting, but more the conclusion of the whole process.

And all of a sudden, they start talking about performance improvement plans and zero tolerance policies. And next thing you know he's got a piece of paper in front of him that he has to sign, and it's a performance contract and behavioral contract. And either he can sign it or he can fight it, but it becomes pretty clear that if he fights it, he is not going to have privileges for days, if not weeks, until this process is resolved.

So, he goes ahead and he signs it thinking this is the quickest way to put things behind him. But what he doesn't realize is that is just the beginning of a domino effect where he finds himself interacting with the state medical board as well as the state physician health program over a process that takes almost 12 months. And at the end of it, he's required to attend classes and work with a coach and literally it's costing him thousands if not over $10,000. Plus the whole time he's wondering if he's going to have a job tomorrow.

And that is such a typical story that I hear where the physicians are doing behaviors that are not the sort of overtly horrible behaviors that I think most of us think of that would get us in front of the medical board. They're not defrauding anyone. They're not overtly sexually harassing someone, but they are having these little interpersonal frictions. And we're in an environment where there's just zero tolerance for that. And we can talk about why that is more if we want to, but nonetheless, it is what it is.

And so, these sort of relatively small interactions, how you speak, how you use your body language are landing physicians in big trouble. And it's often also for reasons we can talk about, it's more of a guilty until proven innocent process. It's also a process that does not have the transparency and due process that a lot of us expect going into it. And so, physicians really get blindsided and find themselves in this almost Kafkaesque system that they're trying to navigate that has real impact both financially and can cause them to lose their license.

HF: I remember reading that story at the beginning of your book, and your book is excellent, by the way. I highly recommend it.

RB: Thank you.

HF: And it was chilling to think of, here's this guy, he sounds like he was just under stress and it's really easy to lose your temper or be sharp or say something in a different tone when you're worried about the patient. And so, I hear that a lot, and I think before, like you said, it was more acceptable. You're a surgeon, this is what you do, and people didn't report you with the frequency that happens.

Now, as you were telling the story, one thing that came to my mind was "What are our rights?" And it seems like in so many situations we have all the responsibility, but we don't really have a lot of rights here. I'm curious what actually is a physician's right in this situation?

RB: Very little, and I don't want to portray myself as a lawyer, but I've had this part of the book vetted by lawyers. What I think the problem is, if we hear that someone's made a complaint against us, we assume a certain burden of proof and a certain level of due process. And a lot of those assumptions that we make, we make from what we know about criminal law, or if we've been involved in malpractice, we may make some assumptions based on what we know from civil law.

But all of this falls under administrative law. You have these entities like medical boards, like hospital privilege committees that are administratively self-empowered to be judge, jury and executioner. And they don't have to follow due process as you and I expect it. There has to be some due process in that their actions have to be predictable and consistent.

But the level of transparency, we have no right to transparency. I have worked with so many physicians who 12 months into this process still don't really know who even complained about them or have a good sense of what the complaint really was. They're just told very vague things like someone said that you were disruptive, which makes it very hard for me as a coach to know what to coach, but also is horrible for them.

HF: How do you learn from the experience?

RB: Right. You have no right to confront your accuser. There's no guilty until proven innocent. There's no beyond a reasonable doubt, it's really almost a guilty until proven innocent type situation. If someone says you behaved poorly, communicated poorly, you violated their personal space, you made them feel uncomfortable, it is going to be very hard for you to disprove that.

HF: Right. That's subjective. A lot of that's subjective.

RB: Right. It's subjective and again, the sort of tie goes to the person making the complaint, whereas maybe like you alluded to historically, maybe physicians were given more benefit of a doubt, or maybe the hospital just didn't want to deal with it and ignored it. But now with hospitals being parts of large corporations and with the incorporation of standard HR practices that there's just zero tolerance and the hammer comes down. It used to be if a nurse didn't like what you did, they would report it to their supervisor, who would talk to your supervisor, who would maybe say something to you.

But now that same complaint goes to HR or it goes to a nonclinical administrator and it generates a very predictable and severe process and you find yourself in front of a privileges committee.

And this isn't necessarily a bad thing. In some respects physicians have probably gone away with a lot of very poor behavior historically. But it is a very severe process. And the

peril that you face is very great. And I think that's what physicians just don't appreciate now.

HF: Yeah, I was just thinking that yeah, there's definitely behavior that needs to be addressed. And I'm sure you've seen it in training and I saw it too, so it's a good thing. But we can also go overboard. I know that this is an amalgam of several stories to protect identities, but could you speak to what you've actually seen in terms of when there's something like this where it might be the behavioral is a little intimidating, or the doctor's under stress? What's the range of consequences that you've seen?

RB: Right. And this is so institution specific, and it also just depends on who makes the complaint and where they send it. But usually what happens is the complaint gets handled internally. You end up finding yourself in front of what they call professional standards committee or hospital privileges committee. And usually at the organization level, you're going to end up with a zero tolerance contract, a behavioral contract that you're going to sign. They're often going to assign what's called a workplace monitor, which means someone who kind of checks in on you and is responsible for monitoring your behavior in the actual day-to-day clinical realm.

And then a lot of these hospitals, and I think some of this is out of good intent, but I also think some of it's out of sort of managing legal risk. They usually refer you to the medical board or the state physician health program, and most people know what a medical board is. I'm assuming we all know what a medical board is, but a lot of physicians don't know about state physician health programs. And those are programs that decades ago were created to help physicians deal with substance abuse.

But what's happened over time is they've become the catchall for all types of psychopathology like anxiety, OCD, ADHD affecting work, but also they're now the catchall for these kind of less intense interpersonal problems. Things that sort of fall on the spectrum of emotional intelligence. A PHP, a physician health program will have a

whole process unto themselves for assessing you and usually assigning recommendations, which are often to work with a coach or to take their courses out there, specifically geared at physicians. And if you opt not to do these things, you're seen as non-compliant.

And on the good end, usually you come out of it being under some type of probationary status for 12 months, having to take thousands upon thousands of dollars' worth of courses and working with a coach. And then eventually, 12 to 18 months later, it might be behind you and you might be under less scrutiny.

But that's the best case scenario. The worst case scenario is the medical board can issue a public letter of I guess not contempt, but a public notice, what they call a public letter, or they can go so far as to suspend your privileges temporarily, permanently. And also what people don't realize is there's a lot of automatic reporting criteria to the national provider database. And so, sometimes if you have issues at your hospital level, let's say you lose your privileges, if your hospital accepts Medicare and Medicaid, they have to automatically report that to the national provider database and that follows you forever.

HF: Yeah. You don't want that for sure.

RB: You don't want that because every time you apply for privileges, a new job, malpractice insurance, there's going to be this line item that you lost your privileges for fill in the blank. Sexual harassment, disruptive behavior. Whatever the hospital chooses to write on that line item is what's going to get stuck there in perpetuity.

HF: Yeah. And it sounds like you don't have a lot of recourse for this.

RB: Yeah, for example, like the national provider database. The only way you're getting that altered is a court action. And some physicians I've worked with have fought these things in court. And the problem with that is, for one, it's going to take years. Easily two years

at a minimum. And in that time, it's going to be very hard, although maybe not impossible, but pretty difficult for you to find other gainful employment. And there's also just no guarantee that you'll prevail. There's no guarantee that on the backend you'll recoup enough money in terms of damages to make it worth that whole process and so there isn't a lot of recourse and there is some criticism of the system out there, but it's the system that exists.

HF: Yeah. And I feel like we're in a lot of traps in different ways here, but information is powerful knowledge. So you're here to help us, and I want to ask you about another story or situation, but before that, I want to take a short break to share a resource. So hang tight, we'll be right back.

All right, my dear listeners, I wanted to give you an email address. And this is an email address for the Doctor's Crossing and it's team@doctorscrossing.com. You can use this email if you'd like to recommend a podcast topic that you'd be interested in hearing, if you have any questions or comments you'd like to make. You can also email us if you'd like to get on our email list, because every week I send out an email, sometimes I tell a story or include some different content when I am announcing the podcast of the week.

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Alright, we are back here with our wonderful guest, Dr. Ryan Bayley. Ryan, I would love it if you could give us some other examples of things that doctors might do to get in trouble and maybe share another story.

RB: Sure. I think of this is really falling into one of five areas. 90% of the physicians I've worked with, I can kind of clump their issue into one of five problem areas. And one that we kind of already touched upon is incivility.

Incivility obviously being brusque with someone, being threatening like, "I'm going to write you up." Being passive aggressive. I think we all know that we all have seen this incivility, we all saw it in our training. But sometimes we forget incivility is somatic, meaning your body language. So, it's how you violate someone's space, how you roll your eyes at someone so it doesn't have to be verbal and a lot of physicians get in trouble for sort of nonverbal aspects of their interaction.

And also incivility can be what you don't do. Opting out. Always disappearing when a problem's arising or turning your back on someone and walking away. That is just as much incivility as far as your organization is concerned as some of these verbal things. So, that's one big area, incivility.

Another one is just casual conversations. We can't talk about a lot of things at work right now. And whether you think that's right or wrong, it is what it is. And I tell people I have what I call the Fox News, MSNBC rule, which is, if Fox News and MSNBC disagree on something, don't talk about it at work.

HF: That's a great rule. Anything controversial.

RB: Yeah. Anything. The problem with physicians is you work 60, 80 hours a week plus another 10, 20 hours non compensated time. If work is all you do, work has to be your everything. It has to be the place where you vent and flirt and talk about your in-laws and complain about the zeitgeist. But the reality is work just can't be any of those things. Maybe it used to be able, but no longer. That's the second area, just sort of casual conversation.

The third area is touch. You just need to realize that almost every organization has a zero tolerance touch policy. You have no defense if someone complains about the way you touch them, no matter how benign you think it was. It's zero tolerance.

The fourth area is really e-communication and all these ways that we interact, not just social media, but electronic texting has a lot of issues in terms of our ability to be misunderstood. There's lots of pitfalls with the EMR, not just the classic HIPAA ones that we imagine.

And then the fifth area is what I call disruptive advocacy, which sometimes we just feel like we're advocating for the patient. Sometimes we push back against administration because we see something that they're doing is stupid and that's okay. But it's how you push back.

10 years ago if an administrator wanted to shut you down, they would bring up patient safety. That was like the ultimate trump card where they could just get you to stop talking. Today it's disruptive. If they don't like what you're saying, they just label you disruptive and that neutralizes you, and then they can put you in some type of administrative process. And so, you have to be very careful about how you advocate and push back against the system.

HF: It sounds like a landmine out there. I mean, I'm a hugger. I hug people. And also I remember at this networking event, I was talking to this gentleman and I put my hand on his shoulder. I'm like, it's like I'm not Italian, but they would call me Forkarini because I'm kind of like a motive. And you don't know. They're right. You can interpret things one way and someone else can have a completely different picture of what just happened.

RB: Yeah. And in so many of these cases, a lot of it comes down to new faces. And what I mean by that is a lot of these interactions are between a physician and someone they

did not perhaps know or work with as long. So, it used to be if you worked in a community hospital, everyone else worked there for a decade just like you did. And you knew everyone. You knew their kids. You probably went to the same church, whatever.

Now when you think of how much turnover there is, you think of how much locums work there is. Every time I go to the ER, it's a new nurse. New nurses. And those people don't know you and you don't know them. And that is a setup where these things are even more likely to happen.

HF: Oh, absolutely. It's not really like this small town feel anymore. Do you have a short story that you would like to share?

RB: Sure. An orthopedic surgeon, there was a CRNA he often interacted with that he really liked. She was a female. She went out on medical leave to get a breast augmentation. And when she came back, he made a comment about something along the lines of, "Oh, they did good work." And he made that comment in front of a few colleagues to the nurse who he thought he had a very open relationship with. She had talked with him about the upcoming procedure.

Now, when I say that, most people cringe. I don't think any of us are surprised that something would come of that. I think most of our radar is perked up enough that we know that the second he opened his mouth that way that was not going to go well.

But what ended up happening to him is she complained to the hospital. The hospital said he'd have to go in front of the executive committee. He had thought about maybe doing less cases at this hospital anyway because he worked at a few different hospitals and this one wasn't working out very well. So he just decided not to renew his privileges. What he didn't realize is that if you don't renew your privileges while under an administrative action, it's automatically reported to the national provider database.

HF: Oh my gosh, terrible.

RB: Six months later he was trying to get a locums job and he was denied because he has this item on his NPDB that says resigned privileges while under investigation for sexual harassment. And he can't disprove that because it's true. He did resign. He did voluntarily give up his privileges while under investigation for what the hospital considered sexual harassment. He was never proven, but it didn't have to be. It's just factual reporting that he resigned, but it looks and sounds horrible.

And for years as I was working with him, he just never could get a good job. Or he'd get a job, but then he'd run into credentialing issues or practice insurers would not carry him. It also got automatically reported to the medical board, which meant it automatically got referred to the PHP, which created a whole new process and coaching requirements. And he basically lost his career. He never really had a viable career after that. He could only really work for kind of the dregs. He could only work for really rural institutions that were willing to overlook some of this stuff. But it meant he was commuting hours and hours a week.

HF: That's sad.

RB: Yeah.

HF: There's that split second in less than a minute things started falling apart.

RB: Yeah. And let me be clear. He screwed up. That story is a little egregious. He said a really dumb thing. I'm not trying to defend him in any way, but I do think that that level of punishment was maybe disproportional. There's no opportunity. There's no restorative opportunity there. He couldn't come back from that, it was entirely punitive.

And I think that's what people don't realize is that all of these processes, whether the intent is to be punitive or not, that's kind of what ends up happening. And so, even these small or smaller less intense behaviors are literally resulting in loss of licensure or inability to work despite having a license, which is what I see a lot, is no one will touch you even though you still have a license in good standing and it just follows you forever.

HF: Uh, it's painful to hear these stories. In the little bit of time we have left, do you have some suggestions for how we can even look at ourselves? Because I know I have clients who tell me some of these stories about advocating for their patients, and when they tell the story, you can tell that they feel like they're doing what they're meant to do. Be a doctor. And they may be thinking, "Well, I know some doctor that's really doing this and they're going to be in trouble." But sometimes we have blinders on to exactly how we're coming across or where our own slippery slope is.

RB: Yeah. I think every one of us has seen so many doctors so much worse than anything we would do, that we always think we're in a better spot than perhaps we are. I remember as a med student, I watched a fellow punch an attending in the face in the OR. And I'm like, "Well, I would never do that. I must be okay."

And yet I think we do all have blind spots. It's tricky, right? Because the definition of a blind spot is you can't see it. But I do think the more you read about these cases and there are a lot of places online where you can sort of read about what PHPs and med boards are doing.

The more you know about concrete examples of how people are getting in trouble, you can start to see those pitfalls. I do think it all comes down to communication. And there are wonderful books and courses out there. A book I like is called Crucial Conversations. It's one that I have sort of cannibalized a lot from for my coaching.

HF: I love that book and we'll definitely link to it again. It's a great book. It's a classic.

RB: Yeah. And there are courses out there. There are a few organizations around the country that run physician specific courses on communication and boundaries. And I think even if you think it doesn't apply to you, these courses are really worthwhile and you do get CME for them. And a lot of them now, since COVID, you can take virtually.

And if you're going to be paying for some CME anyway, this could be career saving CME. You probably don't need to read about how to manage hypertension for the hundredth time. You're perhaps better off taking one of these courses. And so, I don't have any relation with these organizations, but there's one in Kansas called Acumen. There's one called CPEP. Vanderbilt has a few of these courses. UCSD has a few of these courses.

And it's money well spent. A lot of physicians I work with are mandated to these courses while they're also mandated to working with me. And they do get a lot from these courses.

There's also something called a 360, which is a little tricky to do, but it's a specific type of assessment. And there are some companies that do it where basically they send emails out to your peers and your subordinates, and in some cases, even your patients. And you get this blind feedback about your communication, about your interpersonal skills. There's one I think called the Pulse 360, which I think is through Boston. They're labor intensive, but they can provide a lot of insight as well. So, if you're willing to look, you can find resources.

HF: And that could be great, even if there aren't any real issues, because we can always improve our communication and our interaction. And you might also find out you're getting all this great feedback too. And that never hurts, to know what we're doing well.

RB: Yeah. If you spend the money and it all comes back roses and very flattering, then that's still very good information to know. But chances are there's going to be something that's going to be helpful.

HF: Yeah. We all have something.

RB: You just have to be open. And also with trusted colleagues sometimes you can just have a very blunt conversation and say "Be honest with me."

HF: Yeah. Because when we're stressed, we get reactive, and when we're reactive, we lose control. And that happens to every single one of us. And we're not as much in choice over what we say or do, so it's just learning for self-management, which can have ramifications when we come home and we're stressed and stuff is going on at home.

RB: Yeah. And everyone around us is stressed too. Colleagues, patients. There's a lot of good neuroscience that when you're stressed, your likelihood of misinterpreting or assuming the worst when interacting with someone is very high. And you combine that with the fact that you don't know a lot of these people and you're stressed yourself and it's just this perfect storm.

HF: Exactly. Well, this has been a wonderful conversation. I really appreciate you coming back to help us out. I'm sure people will be interested in knowing more about how they can get in touch with you and find out about your book. So, I'd love it if you could share.

RB: Sure. My website is really the best way to find out more about what I do and get in touch with me. It's solvingcareers.com. Just one word, solvingcareers.com. It's also called Bayley Coaching Solutions, if you Google it. And the book that I just published this spring is, as you mentioned, called Physician Non Grata. And it's available on Amazon as both a paperback and a Kindle, and will be available on Barnes & Noble momentarily.

HF: And there are great tips and advice in that book for communicating. So, you don't have to walk around with that book covered up with papers so no one thinks you're reading this book. I think it'd be good for any of us.

All right, Ryan. Well, thank you again so much for coming on the podcast. I really appreciate you.

RB: Great. Thank you for having me again. It was great.

HF: You're very welcome. All right, my dear friends, thank you again for listening. And if you want that email to reach out to us, it is team@doctorscrossing.com. We'd love to hear comments, questions, ideas for future podcasts and just to know you're out there. Thanks so much and don't forget to carpe that diem. I'll see you in the next episode. Bye for now.

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Podcast details

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