

*How to deal with*

# THE DISRUPTIVE COLLEAGUE

*faculty member or resident*

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**Nothing to disclose!**

# My Philosophy:

- Inductive reasoning – learn from examples.
- Learn from *my* mistakes.
  - 21 years worth.
  - Be original: Come up with your own new ones.
- ***“Those who refuse to learn from the past are condemned to repeat it.”***
  - *Georges Santayana*





*Some of this may seem obvious, but.....*



Houdini's final undoing

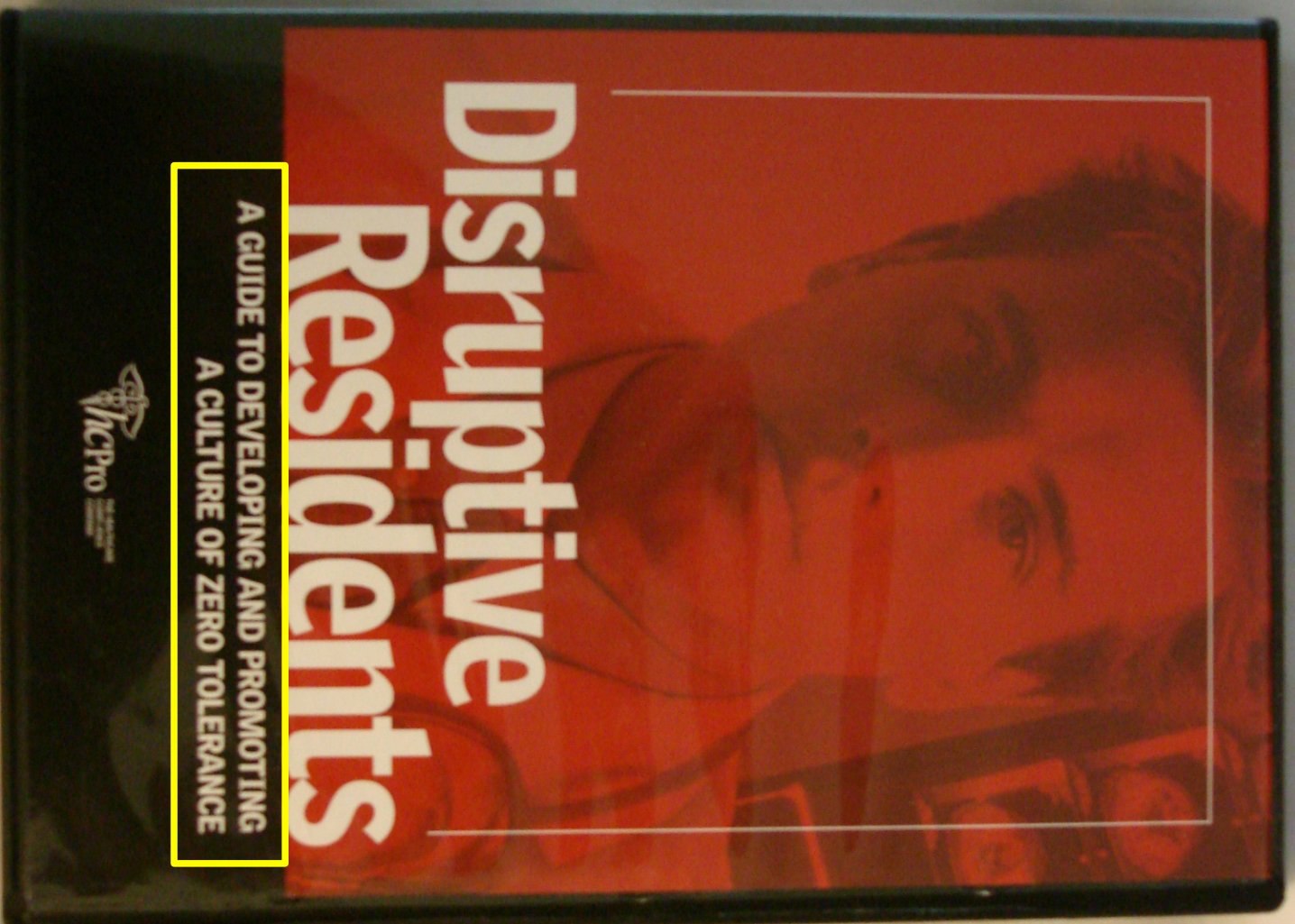
# What is a disruptive colleague?

- Trouble maker? Irritating? 10/90 rule?
  - *Be more specific.*
- The DC is someone who:
  - Negatively impacts resident training, patient care, department morale, OR.....
  - Causes breakdown of the team relationship that can compromise efficiency & safety, OR.....
  - Impacts extra-dept relationships (e.g., surgeons).

***One rotten apple.....***

Outside resources  
are available!

**We will use  
some of this.**



# Example #1:

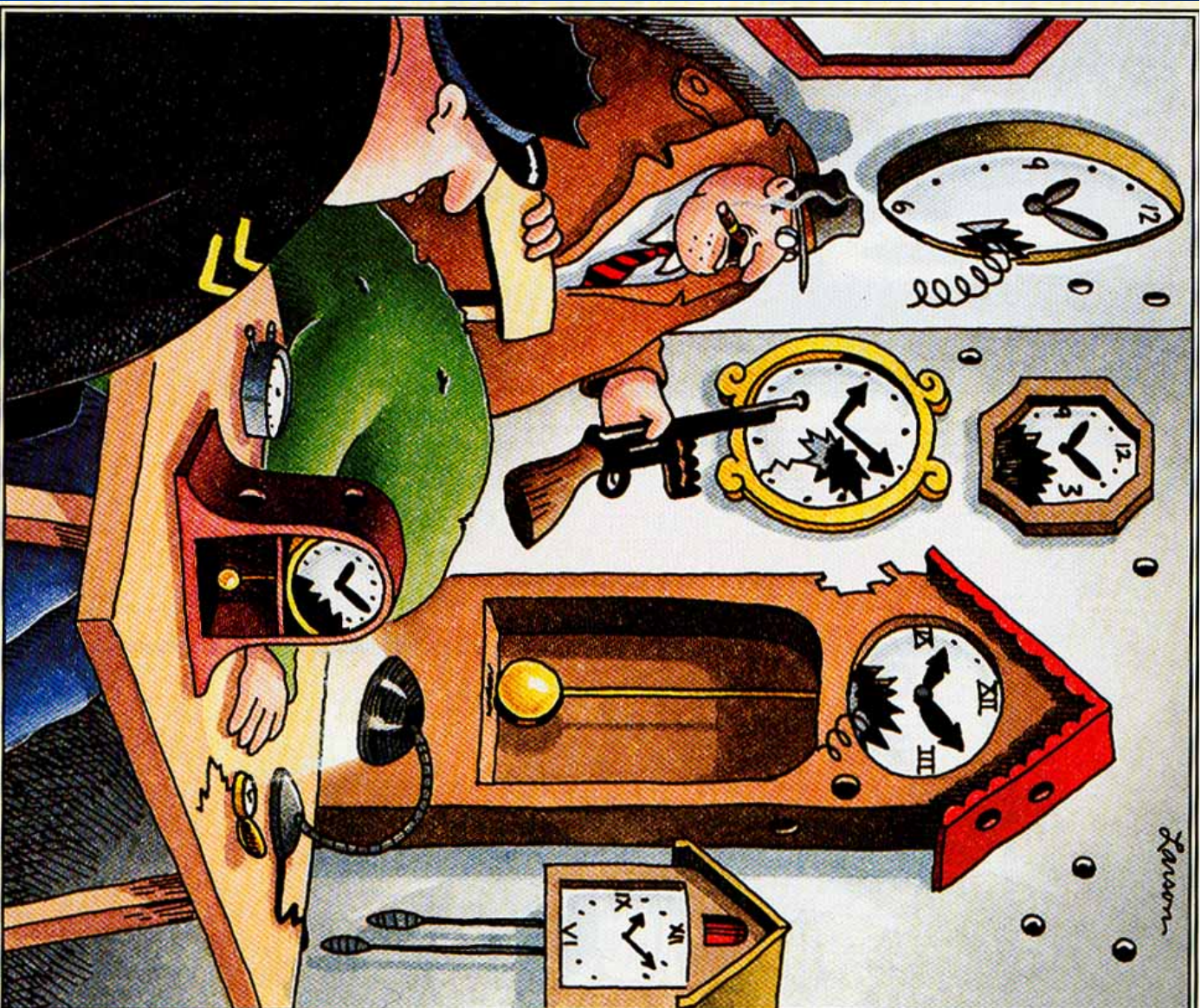
*The following stories are ALL TRUE!*

- Neurosurgery attending turns up boom box at start of case.
- Anesthesia resident X asks for volume down.
- Neurosurgeon ignores request.
- Resident X: *"If you don't turn down that f@\$%&# boom box, I will shove it where the sun don't shine."*
- Typical interaction with X. (Behavior pattern.)
  - *Who BTW was 6'2", 220 lb, a former navy*

*SEAL.*

Goal: Develop a *systematic* approach to these problems!

# OODA!



“We’ve got the murder weapon and the motive ...  
now if we can just establish time of death.”

# The “OODA Loop”

Developed by John Boyd for air combat,  
but applies to any “real-time”  
decision process.

## “30-second Boyd”

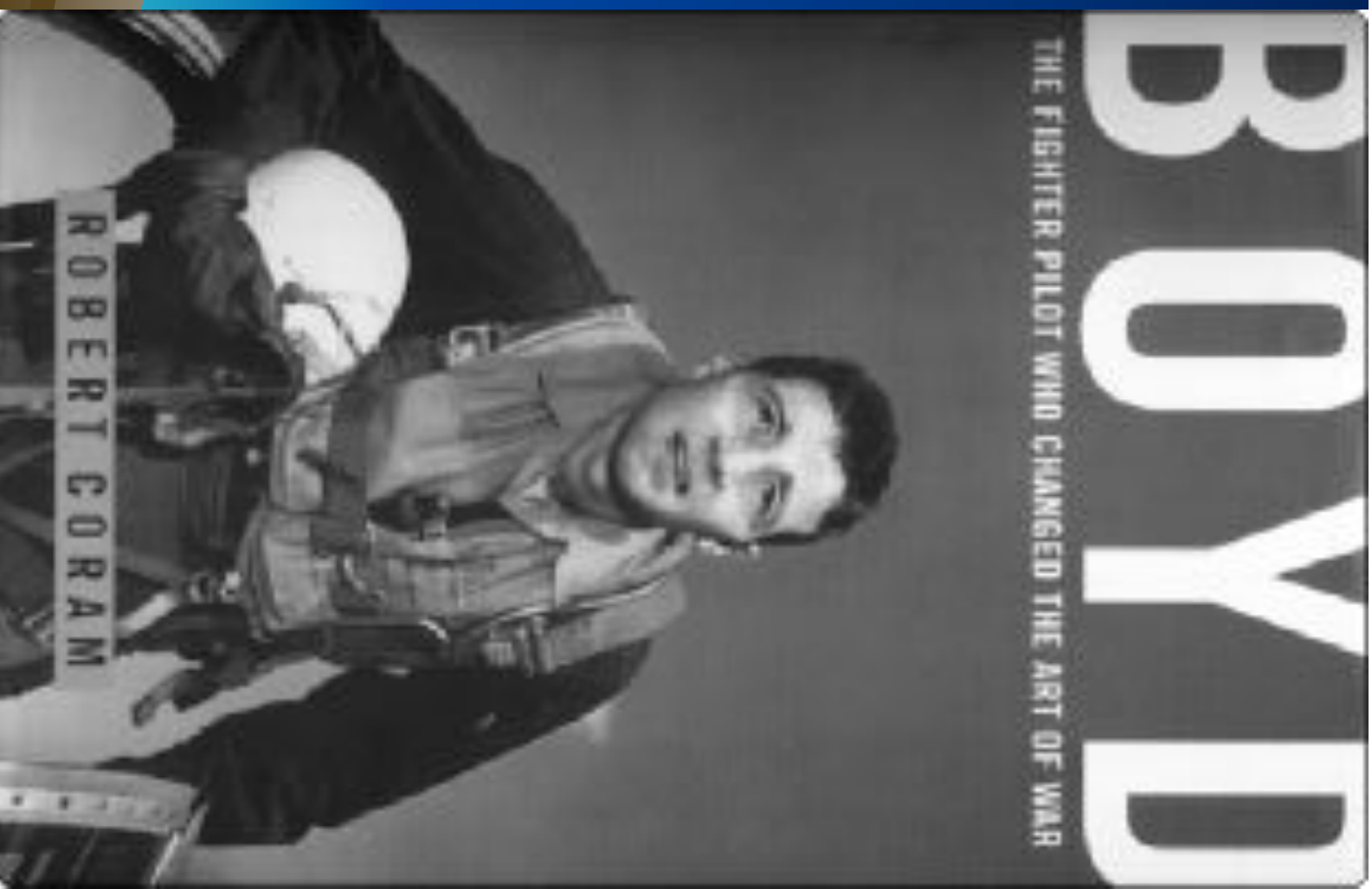


Coram R:

Boyd: The Fighter Pilot Who  
Changed the Art of War. Little-

Brown, New York, 2002.

*Available on Kindle too!*



# Boyd's "OODA Loop"

We do this subconsciously, but if we do it systematically it will work better.

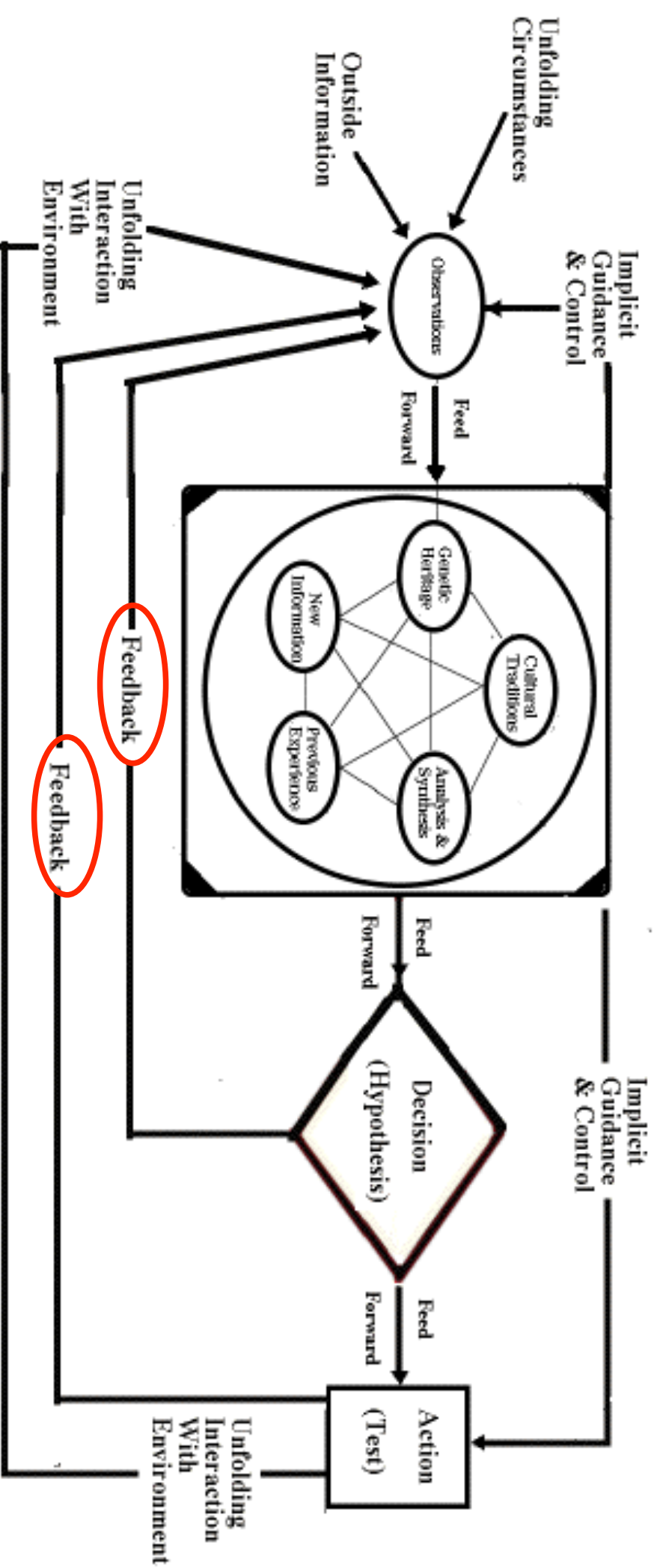
*Put yourself in their shoes!*

Observe

Orient

Decide

Act

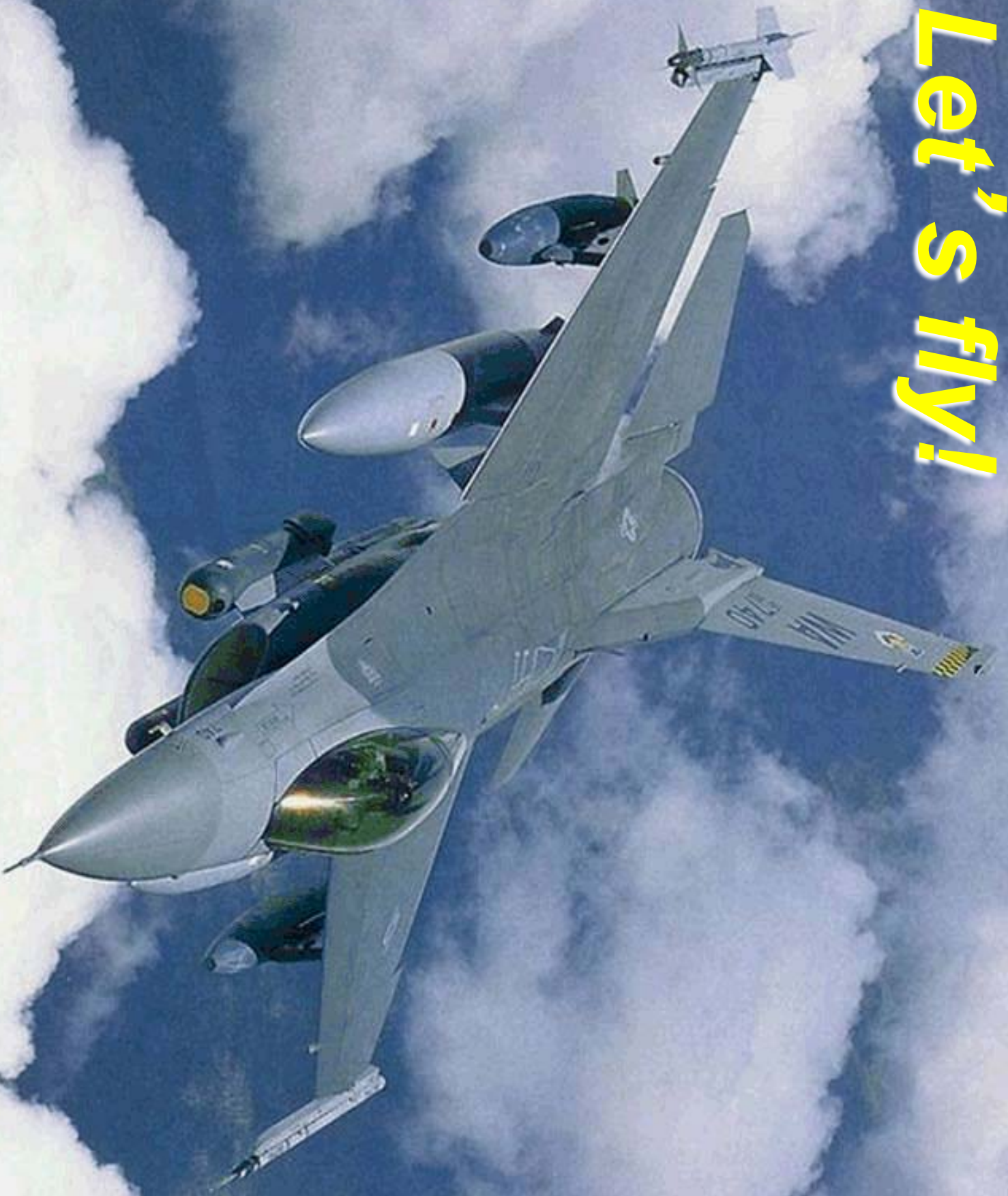


John Boyd's OODA Loop

# REFERENCES

1. Coram, Robert: “Boyd, the fighter pilot who changed the art of war.” Little-Brown, New York, 2002. (*Paperback, Amazon.com*)
2. Hammond, Grant T: “The mind of war – John Boyd and American security.” Smithsonian Inst. Press, Wash DC, 2001.
3. Ford, Daniel: “When Sun-tzu met Clausewitz: John Boyd, the OODA Loop, and the invasion of Iraq.” Warbird Books, 2009.
4. Richards, Chester W: “Certain to win: the strategy of John Boyd applied to business.” Random House, New York, 2005.

Let's fly!



# STEP 1: Get all sides!

## (Observe)

- Obvious, but often forgotten.
    - Maybe Resident X was provoked.
    - Neurosurgeon was a real a-----?
    - Mitigating factors – death, illness, sleep loss?
  - Interview third party witnesses. **Now!**
    - Everyone in OR #11 witnessed Example #1.
    - Do the witnesses have bias?
- RECORD EVERYTHING!**

# STEP #2: Patterns?

*Orient: Get in other person's shoes*

- Is this an isolated, unique incident? (No.)
- If other incidents....
  - What were the common features?
  - Anger issues? (YES!!!!)
  - Honesty issues? (Not really.)
- Look for motives! What was X's *motivation, purpose or expected outcome?*
  - Never figured that out.

# Example #2:

**Message: don't get blind-sided!**

- Two residents ask to meet with chair.
  - Reason given: *“It’s personal.”*
- Resident A and B enter my office, with wives.
  - Well, OK, maybe it’s a family issue.
- Resident A points at B, says:
  - ***“He is having an affair with my wife.”***
  - Actually used different terminology.
- Awkward silence.....pondering response.

# Don't get blind-sided (2)

- I look at Resident B, and ask: “Is this true?”
- B: “Yep.” (Everyone is studying floor.)
- I feel very bad for all five people in the room, but *what should I say?*
- **Options?**
  - I’m thinking fast, wishing I were anywhere else.
  - So I jump immediately to....

# Step #3: Hypothesis/Diagnosis

## (Decide)

- If isolated incident, counsel and move on?
- If a *pattern* of behavior:
  - Personality disorder? (‘Don Juan Syndrome’?)
  - Anger management?
  - Expected future if untreated? Tolerable?
- Get help in your diagnosis! *Now*.
  - Make use of on-site counseling and psychiatric resources.

# Step 4: Intervention/Treatment

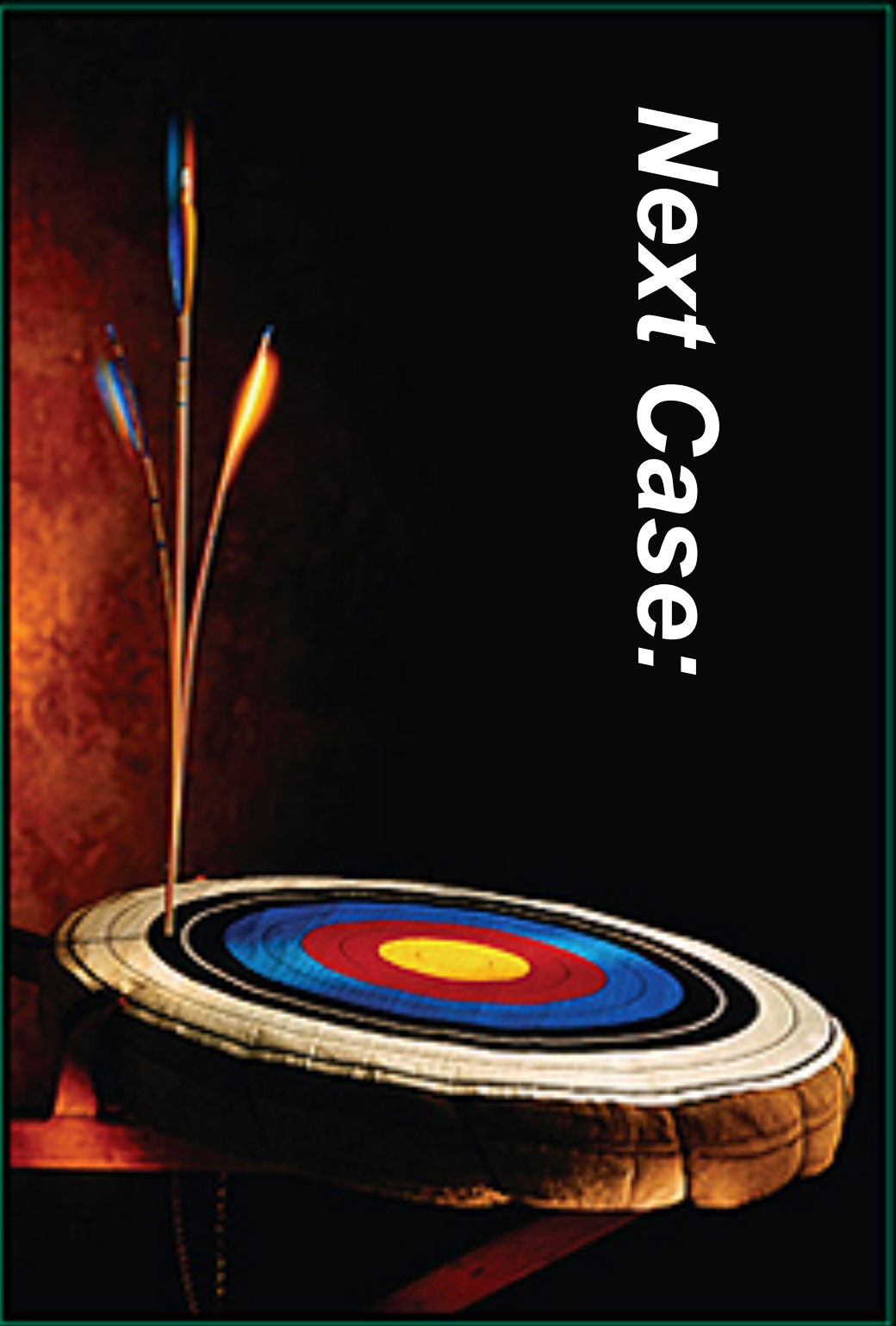
(Act!)

- If behavior has potential for further dept disruption, *intervene now!*
  - Remove problem if not easily solved.
  - Not so easy today – *residents/faculty have rights.*
- Back to EXample #2:
  - After counseling of all four (with experts), things quieted for a while, then....
  - Vandalism to cars.
  - Taunting, spreading rumors, etc....
  - Resident A (the victim) left program. **Bad Outcome!**

# Lessons of Example #2:

- Chair convinced self that problem could be treated, solved to keep everyone happy.  
***It could not!***
- “You can’t please everybody” -- R. Nelson
- In retrospect:  
***Don Juan should have been removed!***
- This was a personality disorder, not compatible with health of the department.
- ***Question is HOW? On what grounds?***

**Next Case:**



**CONSISTENCY**

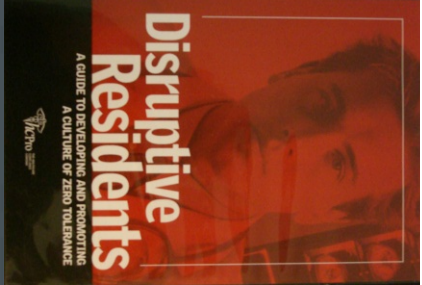
IT'S ONLY A VIRTUE IF YOU'RE NOT A SCREWUP.

# Example #3

## The Really Obnoxious Resident or Faculty

- Usually intelligent, clinically sound, extroverted, self-assured.
- And..... *narcissistic*, egocentric, lacking self-insight, overbearing.
- Here is how **NOT** to conduct an interview in response to a complaint about this person:





# Example #3:

*Message: be proactive, look out for whole dept.*

- Resident C is intelligent, skilled, a ‘resident advocate’.
- *But, C is always highly critical of:*
  - Attendings, especially chair.
  - Other residents.
  - Hospital, surgeons, etc...nothing good enough.
- Chief residents are selected by an advisory vote of residents, then approved by faculty.

# Example #3:

*cont'd.*

- C “campaigned,” won chief election by a one vote plurality.
- Chair interviewed C, regarding his mission, goals, strategies as Chief Resident.
- C tried to take control of the interview.
- C made it clear (*thankfully*) that he would be major trouble – he was “on a mission to right all wrongs.”
- Options? *What’s my BATNA?*

# After Orient, think “BATNA”

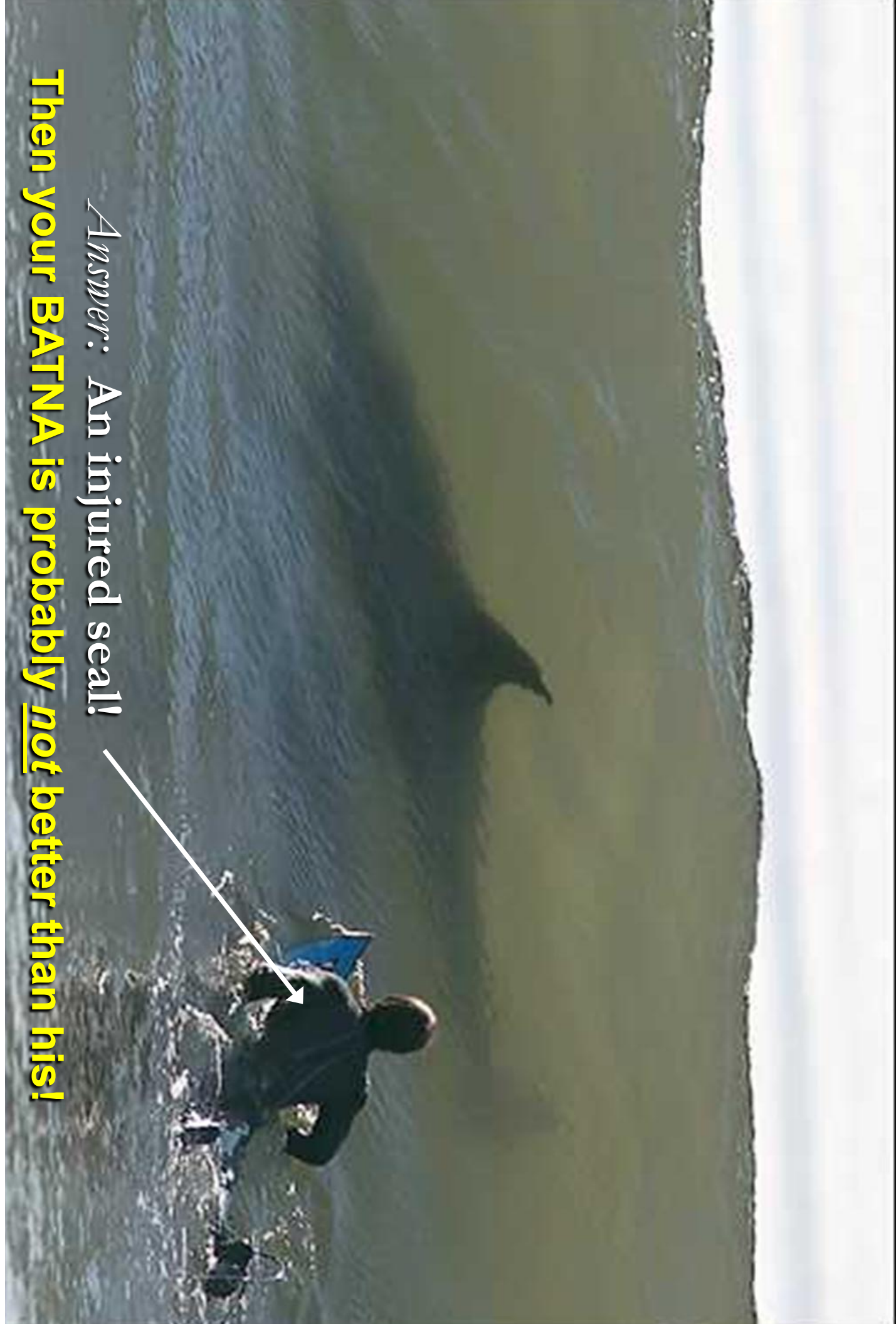
## Best Alternative to Negotiated Agreement

- If negotiations fail:
  - What is your best alternative?
  - What is the other party’s?
- Who has the better BATNA?
  - This will determine your negotiating stance.
- Do both parties understand their BATNA’s?
  - If the other side’s is better than yours, do they know it?  
*If not, keep your mouth shut!*
  - If your BATNA is better, make sure the other side knows. (*Donald Trump?*)

**ORIENT: What do you look like to the other party?**

*Answer:* An injured seal!

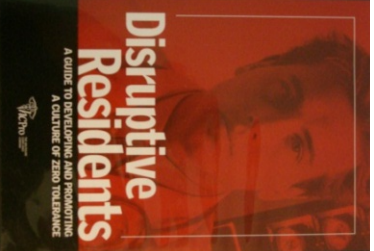
**Then your BATNA is probably not better than his!**



# Back to Resident C,

using OODA Loop

- We have Observed his behavior; we are Oriented (*he wants to change the world*).
- DECIDE:
  - Dx: Narcissistic personality disorder (*confirmed by ψ*).
  - *Therefore*: this ain't gonna work.
- ACT:
  - Overruled vote (which is advisory) and selected next highest candidate.
  - Explained to C why this was in the best interests of dept. *Fun?*
- OBSERVE: As expected, C made trouble for the remaining 14 months of residency.
  - *But that beats the alternative!*



**Interview with “Resident C”  
a much better start:**

# Example #4: Abusive Faculty

## Another Tool: PWBC

- Dedicated, hard-working, skilled and knowledgeable, won teaching awards.
- “High-strung” perfectionist with high standards for residents → *abusive, harassing, demeaning*.
- Multiple 1:1 counseling sessions → *better for a while; then relapse. WHAT TO DO?*
- *Brainstorm: Send to PWBC (a.k.a. IPC)!*
  - Evaluated by peers in other depts.
  - Psych eval and counseling.
  - Consequences of behavior made very clear.

- *Result: WOW!*

KIDS EXCHANGE

FAIL

Our most clever ideas may have unintended consequences.

# PEARLS: *Do's and Don'ts*

- DO have a professional behavior policy; be sure everyone gets it.
- DO intervene early: DON'T ignore even isolated episodes. *One rotten apple.....*
- DON'T allow the subject to take control of the interview. *Be the boss!*
- **BATNA**: DO make the subject understand the consequences to *him/herself*. These are smart people!

*If his/her BATNA is 'Donald Trump', .....*

# CONCLUSIONS

- When you've seen one "difficult colleague," you've seen ONE.
- *BUT*, there are common features, and we must learn from our mistakes. *You've seen mine – let's talk about yours!*
- *Use a systematic approach:* I recommend **OODA** Loop, combined with **BATNA**.  
Allows you to adapt to changing situation.
- *You stay ahead of your airplane, so that you will be flying this.....*

# F-22 "Raptor"



Instead of this.....



**THE END**

**Thank You!**



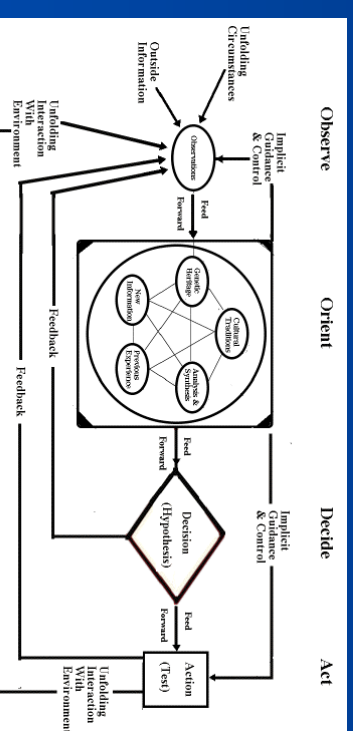
# How does OODA work here?

*Think of Examples #2 (Don Juan)  
& #3 (Change the World)*

- OBSERVE: Listen carefully, watch body language, get all data possible. *Keep records.*
- ORIENT:
  - *In air combat, this is “what is my enemy thinking, what will he do next?”*
  - What motivates the problem behavior? Why?
  - Are their cultural factors? (Yes!)
  - Where is this leading? What will he/she do next? Possible endpoints?
  - *SJB*: Compare your “BATNA” with his/hers.

# OODA for Anesthesiologists (2)

- DECIDE: Based on “OO”, make diagnosis (hypothesis) after considering all alternatives.
- ACT:
  - Consider possible consequences of action.
    - Some actions can make things worse.
    - Useful actions (*tests*) will get you more information as well as help solve problem.
  - Do it! *But even while doing it, you start to.....*
- OBSERVE: *and you start the loop again.*





**Barker's 1987 Beechcraft F-33**  
*not much good for combat,*  
*so I want you to be flying this:*



**“ And now, for something completely different!”**