Rule-Breaking Rainmakers

High-maintenance + high-revenue = HR headaches.

Everybody has a favorite human resources horror story, but Jeffry Peters tells one that makes hospital CEOs break out in a cold sweat.

The director of a busy operating room (read: major profit center) got on the wrong side of the hospital's human resources department. "They were finding sort of mundane things to criticize her for," says Peters, president of Surgical Directions LLC, a Chicago-based consulting practice. "She had a lower infection rate for her acuity index than the Cleveland Clinic and Johns Hopkins, but they didn't like the process she used to track it, so they gave her a poor evaluation."

Which prompted the nurse to evaluate her options.

"She was respected by the surgeons," Peters says. "So when she was called up by the neighboring hospital, she went there and took 5,000 cases with her."

Ouch.

Such mangled maneuvers make HR a favorite whipping boy. But Barbara Palmer, president of the Chicago-based American Society for Healthcare Human Resources Administration, says hospital HR executives have to weigh the hidden costs of rule-breaking rainmakers. Depending on their particular peccadilloes, problem-makers can cause staff turnover, hinder nurse recruitment, wreak havoc with regulators or expose the hospital to lawsuits.

"Just because a person can bring in the dollars, organizations tend to tolerate the person's behavior," says Palmer, also corporate vice president of human resources at Botsford Health Care Continuum in Farmington Hills, Mich. "When you have a high-revenue-producer who does not want to play by any rules, you are in a bind."

Then again, some say the rules are the problem. "You can't evaluate the nurse who runs a $350 million business the same way you evaluate a nurse who runs a med-surg floor," Peters says. "There needs to be an understanding that generic standard processes don't always work."

Get creative

When dealing with high-dollar darlings—whether they are affiliated physicians or staff members who influence physician referrals—HR executives should stop thumping their policies and procedures manual long enough to do some creative thinking.

So says Cynthia Marcotte Stamer, a healthcare attorney at Glast, Phillips & Murray in Dallas. "Whether it's nurses, doctors or housekeeping, the key is to ask yourself, 'What is it they need to do, and what is the reason they aren't doing it?'" she says. "Once in a while, it's because they are idiots, and when you have idiots, you fire them. But when there's a repetitious or widely occurring problem, you have to think, 'What is the disease, and what can we do to cure the disease?'"

In most hospitals, affiliated physicians do not come under the purview of the HR department, but that's not always the case. Palmer says the chief medical officer calls on her department to keep both employed and affiliated physicians focused on the hospital's goals. So when nurses rebelled against a problem physician—one of the top revenue generators on the medical staff—she met with the CEO, CMO and legal counsel to discuss their strategy. A breakthrough came during hard talks with the doctor when they discovered he was motivated by patient-satisfaction scores. Showing his deteriorating results and their relationship to his problem behaviors was the first step to change.

—LOLA BUTCHER

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OTHER CURES FOR PROBLEM-MAKERS

- **A 360-degree performance review for individuals who work in a certain department or function.** Ken Kruger, president of the New York-based Healthcare Human Resources Consulting Consortium LLC, says such reviews provide feedback from colleagues that may prompt a problem performer to see his or her actions in a new light.

- **Executive coaching.** Armed with a Ph.D. in organizational psychology or a related discipline, a coach may show a high-value individual new ways to handle situations that repeatedly cause problems, Kruger says.

- **An alternative that serves the hospital's interest.** Stamer once solved a hospital's headache by convincing its CEO to hire medical clerks to shadow physicians who were notoriously bad about documenting treatments. At the end of each patient encounter, the clerk asked the physician to review the chart for errors, make changes as needed—and sign it.