Personal support 4: Helping each other deal with tricky relationships

Anita Houghton continues her series of articles on personal support with advice on how to deal with difficult relationships

If there is one thing that causes more problems at work than anything else it is people. People who work for you, people you work for, patients, clients, colleagues, managers, relatives—you name it and they can cause problems. People are also likely to provide many of the highs of work when things go well, so trying to convert people problems into people solutions can pay great dividends.

There is much talk about “dealing with difficult people” in books, tapes, and seminars. However, in practice there is no clear dividing line between difficult and non-difficult people, and in most cases the difficulty lies in the situation rather than the person. However, if you take a statistical view, you could say that about 5% of all people are outside the normal range of “difficulty,” by definition.

Below is a model for diagnosing “difficult people.” If you do the test and find that someone has a full house of 3 Cs, then you need to ask yourself, “What are the chances that they are going to modify their behaviour for me?” With normal people there is a good chance that they will respond to reasonable and kindly behaviour. If in doubt, they should just guess.

The following coaching technique will help to gain insight in any interpersonal difficulty, especially where there is a difficult situation rather than an inherently difficult person. The first step with any problem must always be diagnosis and desired outcome, using the questions in my previous article.

Once you have helped your co-mentor to clarify the problem and their outcome, you can help them move forward using this powerful technique.

Seeing the problem from different perspectives

The root of nearly all conflict is our tendency to see situations from only one angle—our own. This exercise will help you to guide yourself or your co-mentor through three different perceptual positions:

- First position: How the situation looks from where I stand
- Second position: How the situation looks from where the other person stands
- Third position: How the situation might look to an observer.

It’s best done in a room where there is space to place each position.

Example

Derek is clinical director for medicine, and he is having trouble with a consultant in his directorate, Philip, whose clinic numbers are considerably lower than those of his colleagues. As a result, his waiting times are well over the 13 weeks the management would like. The medical director has been made aware of this problem and has asked Derek if he could look into it. Derek feels extremely uncomfortable about this. Philip is older than he is, and has been in post much longer. Also, he’s known to be aggressive when confronted and has a low

Diagnosing difficult people: the three Cs

(1) Does this person Cause trouble? Is this just a disagreement or conflict of values, or has this person actively produced the situation?
(2) Is this person Consistent? Have they caused trouble before; do they tend to cause trouble wherever they go?
(3) Is there a Consensus? Does everybody agree that this person consistently causes trouble?
regard for medical managers. Derek hasn’t a clue how to handle the situation, and he is afraid he’ll bungle it and damage his relationship with Philip permanently.

His co-mentor helps him to clarify what he wants to achieve, and Derek says he’d like to find a solution to the waiting times while maintaining a good working relationship with Philip. His mentor then takes him through the process.

Adopting the anthropologist’s position first (3), after a few moments’ thought Derek says:

“I see two people who are both being pressurised by the same system. One is older, not too far from retirement, and he’s worn out. He’s probably cut down the number of patients he sees because he no longer feels able to deal with people at the rate he used to. Or perhaps he just doesn’t want to. Also, he’s got some problems in his private life, so work is probably not his top priority at the moment. He needs criticism at the moment like a hole in the head . . . actually, he needs some support.

“The other person (me) is nervous. He hasn’t been clinical director for long, he wants to do a good job, but he doesn’t feel comfortable with tackling a colleague on his clinical performance. He feels angry with the pressure to meet targets, and privately believes that he should be seeing fewer patients himself.”

He then gains even more insight from standing in Philip’s position (2), and again in his own (1). Once he has been in all the positions, and now back in the anthropologist’s shoes, he suddenly finds himself much better able to plan this meeting. He advises Derek (himself) to take a supportive and inquisitive approach with this man, rather than confront him with the data, and this is actually much more Derek’s style anyway.

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Tips on...

Submitting specimens for histopathology

Submitting a specimen for histopathology is a request for a consultant opinion. For this opinion to be effective, accurate identification and good preservation of the specimen are essential. Providing good clinical details is vital as the histopathological findings are interpreted in the clinical context. Withholding pertinent information is similar to expecting a colleague to manage a patient without allowing them to take a history. If these requirements are not met, it may be impossible to provide a clinically relevant report.

Forms

- All specimens must have a request form that is completed clearly and legibly without arcane acronyms
- The form needs at least two separate patient identifiers, three are preferable: typically the patient’s name and date of birth or hospital number, or both
- The identifiers should match those on the specimen pot
- The form should have a contact number. The number should be for somebody who knows the case and can answer questions
- The form must state:
  - The precise nature of the specimen(s)
  - The procedure
  - The clinical findings and reason(s) for the procedure
  - Relevant radiological data (especially bone, soft tissue, and lung)
  - Relevant findings during the procedure—for example, tumour adhesion to adjacent organs
  - The importance of any markers, such as sutures
  - Any previous pertinent histology (including all malignancies)
  - Any radiotherapy/chemotherapy
  - The clinical diagnosis.

Specimens

- The identifying label should be put on the pot not on the lid. Lids may be inadvertently transposed between pots
- The specimen pot should be large enough to contain the specimen without distorting it
- The ideal volume of formalin is at least 10 times that of the specimen. With large specimens this may not be possible, but the formalin should at least cover the specimen
- If there is insufficient formalin or no container of adequate size is available, the histopathology department should be informed and the specimen dispatched immediately. This will give the laboratory the opportunity to take steps to rectify the problem promptly.

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Other ways to enhance interpersonal relations

- Improve your understanding of your personality, and how it differs from others, by taking the Myers-Briggs type indicator
- See how you operate in teams by taking the FIDO-B instrument. This measures your inherent preference in teams for levels of autonomy and control when working with others, together with your desired levels of intimacy with the people you work with. Comparing your preferences with others in the team can shed much light both on difficult and productive relationships

1 Houghton A. Personal support 2: How to make the most of a mentorship relationship. BMJ Careers 2005;330:257.

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