Clinical Focus

The Quadrad of Performance: A Leadership Tool for Professional Growth

Michael D. Page[a]

Purpose: Clinical care in all aspects of audiology and speech-language pathology requires a significant and diverse skill set in order to screen, assess, diagnose, treat, and monitor performance of their patients. Communication skills are paramount in all directions of their relationship with patients and coworkers. Additionally, clinicians rarely work in isolation and are most often in a group environment and setting with other peer professionals, as well as affiliated professionals with differing yet complementary multifaceted skills associated with neighboring professions.

Conclusions: The aggregate of skills spans an enormous set. Expectations are high, and much is expected as a clinician and a colleague! While clinical skill and performance are certainly what most hiring managers look for, this clinical focus article will discuss the critical importance of aspects of relationship courtesy and trust. Indeed, these characteristics will be presented as even more critical than clinical skills alone. Four sets of skills will be presented, which the author claims mandatory for all clinical providers. They include *knowledge and competence*, *efficiency and productivity*, *relationships with patients*, and *relationships with peers.*

Clinical care in all aspects of audiology and speech-language pathology requires a significant and diverse skill set in order to screen, assess, diagnose, treat, and monitor the performance of the patients. Communication skills are paramount in all directions of the relationship with patients and coworkers. Additionally, clinicians rarely work in isolation and are most often in a group setting with other peer professionals, as well as with affiliated professionals within neighboring professions.

The aggregate of skills spans an enormous set. Expectations are high, and much is required as a clinician and colleague! While clinical skill and performance are certainly what most hiring managers look for, this writing explores the critical aspects of relationship courtesy and trust. Indeed, these characteristics, known as *primary performance indicators* (PPIs), will be presented as even more critical than clinical skills alone. Four sets of skills characteristics will be designated as mandatory for all clinical providers. They include *knowledge and competence, efficiency and productivity, relationships with patients,* and *relationships with peers.* To be clear, this model is less about the perfecting of these elements and more about *striving* to achieve them, along with their enduring benefits (see Figure 1).

Professionals in managerial and supervisory roles have likely met with dozens, if not hundreds, of clinicians, job applicants, and professional peers through their years of experience! Most could easily write highly compelling stories detailing strengths, weaknesses, sacrifices, trainings, and efforts to not only identify a "best fit" but also to secure the best possible, maintenance-free professional relationship with peers and patients alike. Moreover, the best fit must also present with a superior level of competence, productivity, collaboration, and engagement. After all, who does not want the superstar?

Demand for professional talent remains at an all-time high. Company reputation and stability require it; but most important, good clinical outcomes and patient satisfaction demand it. This writing outlines four primary PPIs for clinical providers, each of which is an essential requirement toward maximizing performance outcomes while managing and mitigating professional risk. The four most influential factors of clinical care compromise the Quadrad of Performance for successful providers. The most successful aggregate of PPIs yields what has often (but perhaps arguably) been attributed to Aristotle as "the whole which is greater than the sum of its parts" (Sententiae Antiquae, 2018). It is the cumulative and

[a]Michael D. Page Au.D., LLC, Salt Lake City, UT
Correspondence to Michael D. Page: michael@mdpage.org
Editor-in-Chief: Patrick Finn
Editor: Judith Brasseur
Received July 10, 2020
Revision received September 14, 2020
Accepted September 15, 2020
https://doi.org/10.1044/2020_PERSP-20-00167

Disclosures
Financial: Michael D. Page is the owner of Michael D. Page Au.D., LLC, a consulting firm for health care, education, and business.
Nonfinancial: Michael D. Page has no relevant nonfinancial interests to disclose.

Figure 1. The four essential characteristics necessary for clinical providers are represented equally: competence, productivity, (relationships with) patients, and (relationships with) peers.

synergistic result of the diverse character aspects within professional talent.

The Quadrad Story

It began with a young clinical manager of a large hospital/clinical practice comprising speech-language pathologists, audiologists, therapists, clinical assistants, and support staff. Considering the intensity of the setting, the urgency of the environment, and the high expectations of the organization, the group was extremely talented in most expected categories. However, over a moderate length of time, a level of discord, adverse culture, and even toxicity began to slither into the group. Toxicity often manifests itself though poor communication, cliques, gossip, rapid turnover, exclusion, and burnout. Those attributes began to take hold and grow among this group.

This disharmony spurred gradual change in professional peer relationships, supervisory relationships, and, to some degree, even patient relationships. The undesirable impact had begun to disintegrate an otherwise harmonious team environment.

The source of the disharmony was identified primarily as one particular clinician who appeared to subtly instigate disruption, gossip, doubt, and discord within his professional peer relationships, to the extent that some of his colleagues now refused to work or collaborate with him. However, others fell victim to his rallying call and marching drum. The more painful part of the disharmony was his lack of awareness of his malignant and contagious behavior.

The impact permeated the shared office space. Attitudes and expressions attempted to take staff meetings hostage, often in subtle ways by unsupportive comments, glances, and body language. His undermining with "meetings after the meetings" became the mantra of his modus operandi. The evolution of the collegial dissonance focused first at the innocuous actions. Those eroded the root of trust between peers and with management and ironically raged in presence of extraordinary clinical competence, exceptional efficiency and productivity, and excellent *patient* relationships.

After many attempts to seek resolution to the disagreeable situation, including lengthy and serious analysis, the manager consulted with a member of the human resource (HR) team. After careful review and consideration of the multifaceted aspects of this challenging situation, the HR consultant had no specific recommendations for assistance, stating, "This clinician is one of your highest revenue-producing providers. He has excellent relationships with patients and is very efficient in his work. You cannot initiate any action toward this clinician without severely affecting your department's bottom line."

While those observations were mostly true, one element was missing. The HR consultant failed to acknowledge the severe impact of his behavior on the professional team. Considering the fact that his collegial relationships were in peril, very few of his coworkers wanted to collaborate with him (while others were magnetically attracted to him), and staff meetings were becoming increasingly polarized because of the unacknowledged negative influence. The manager was extremely discouraged and frustrated with the potential for resolution.

During hours of contemplation and consultation with others, the manager artistically took to paper. He identified with circle shapes the various categories of performance. Within each circle was a brief description of the skill set variety. Through an exhaustive review, the manager concluded that, while excellent performance existed in three categories (*competence, productivity,* and *relationships with patients*), it could not compensate for the lack in the remaining category (*relationships with peers*).

Some clinicians, aware that they may exhibit some deficits, easily justify the deficits with such comments as:

1. "As long as I'm a competent clinician and work well with patients, nothing else really matters."
2. "Look, I was the top of my class! I know what I'm doing!"
3. "I don't care what my colleagues think of me. I'm competent and sharp, had a 4.0 GPA, and graduated magna cum laude!"
4. "My colleagues are probably jealous of the relationships I have with patients."

While *efficiency and productivity, relationships with patients,* and *knowledge and competence* are critical skills, the cost of the lacking skill of *relationship with peers* required analysis. It came down to the cost of trust. "Trust is one of those softer management qualities that people usually believe are good but whose value they have a hard time quantifying" (Lipman, 2017) and for which they know not how to interview. As we are too slowly discovering, these soft skills (trust, compassion, kindness, and more) are the new hard skills.

Simon Sinek (2019) describes the bifurcated and complicated intersection of *trust* and *performance*. In his

professional work with U.S. Navy SEALs, he discovered the secret to the success of the extraordinarily highly performing Navy SEAL recruiting efforts. Also, it is likely not what one might guess. It centers on *trust,* first. Second, it centers on *competence* or *performance*.

Performance is described as the person's behavior "on-the-job," while *trust* is described as the person's behavior "off-the-job." Trust in this context is defined as "reliance on the integrity, strength, ability, surety, etc., of a person; confidence" or the "confident expectation of something; hope" (Dictionary.com, n.d.). In other words, a person's character is equally (if not more) important as their knowledge base. Measuring performance or competence is easier than measuring character. Though no single measure is perfect, the very basics of a clinician's performance can be assessed by the altitudinal outcomes of grades, Praxis scores, situational and scenario testing, professional references, and more.

Assessing character (which includes relationship characteristics) is far different and exceedingly more challenging. "Businesses have never done as much hiring as they do today. They've never spent as much money doing it. And they've never done a worse job of it" (Cappelli, 2019). Indeed, character and trust may be among the single most important hiring criteria ever to be considered.

Sinek (2019) describes further his discovery of the U.S. Navy SEALs' approach to recruiting in the following intersections of *performance* and *trust:*

1. Low performance, low trust.
2. High performance, high trust.
3. High performance, low trust.
4. Moderate performance, high trust.

Low performance, low trust is quite obviously the least desirable hire. This candidate is simply unqualified for any professional position. *High performance, high trust* is the best possible hire. Sinek points out that this combination is nearly impossible to recruit. *High performance, low trust* nearly always yields a toxic leader and a toxic team member but happens to be the most common hire. It is common because most hiring managers are hiring primarily for performance and rarely consider how to hire for trust. If they do consider trust as a critical characteristic, most hiring managers go with a "gut feeling" rather than truly assessing and interviewing for it. Professionals with high performance and low trust exhibit exceptional professional skills and competence, but like the borer insect who thrives on eating at the roots of vulnerable trees, the untrustworthy coworker casually gnaws and feeds at the root of relationship trust (often unknowingly), eventually destroying the trunk and branches of crucial relationships, resulting in the disintegration of the team and its purposes. It is a most devastating demise, experienced by nearly 80% of employees surveyed by *Harvard Business Review* in a monumental study by Housman and Minor (2015).

Harvard researchers (Litzky et al., 2006; MacLean & Behnam, 2010; Robinson & Bennett, 1995) further revealed that 78% of those surveyed said their commitment to the organization declined in the face of toxic behavior, 66% said their workplace performance decreased, and 63% lost time at work by avoiding a toxic coworker. These statistics leave one to wonder about the current work environments across the nation and the long-term impacts of exposure on individuals and organizations. Even relatively modest levels of toxic behavior can result in major organizational costs, including customer loss, decreased employee morale, increased turnover, and loss of legitimacy among important external stakeholders

A most compelling outcome of Stanford School of Business graduate Jeffrey Pfeffer's research is the revelation that toxic workplaces are the fifth leading cause of death in the United States, even greater than diabetes (Pfeffer, 2018). Pfeffer claims that between 5% and 8% of annual health care costs are attributed to the culture and climate of U.S. companies. The actual cost of hiring a highly skilled toxic worker will exceed the benefit of their good characteristics. Simon Sinek (2019) claims it is not worth it. Minor (2015) reports that organizations could lose over $12,000 in costs by replacing one toxic worker, which is almost double the amount an organization gains from hiring a "superstar." A superstar in the top 1% of performers adds $5,303 in increased performance to a company's profit. Reason dictates that if management fails to mitigate and assuage mistrust and toxicity, then management should build a budget line item for those associated costs.

Maybe surprisingly, *moderate performance, high trust* is the intersecting combination that yields the most potential for success, team solidarity, purpose fulfillment, personal potential, and achievement, as well as patient satisfaction. It asserts that once trust is assured, performance can be trained, refined, and harnessed. The likelihood that performance can be improved is much greater than the prospect of cultivating trust. Trustworthiness is a value found at the deepest core of humans and is a characteristic at the highest level of humanity and relationships. While its value is difficult to quantify, the impact of its lack can be measured.

The U.S. Navy SEALs (described by Sinek, 2014, as "the most successful organization on the planet") would rather recruit someone with fewer skills, but higher trust. While most hiring managers today hire for performance over everything else, the U.S. Navy SEALs would adamantly avoid the person with *high performance,* if they exhibited *low trust.*

The Quadrad of Performance

The Quadrad story continued as the manager returned to HR with napkin renderings in hand to focus on the impact of the lacking element, *relationships with peers.* After the discussion, the HR representative agreed to and supported a performance improvement plan (PIP). Consequently, the efforts yielded the formalization of four essential characteristics for the most successful clinicians, and the model was incorporated in the PIP.

The Quadrad of Performance elements are *knowledge and competence, efficiency and productivity, relationships*

with peers, and *relationships with patients and families*. The ideal clinician exhibits accountability for each of the four. For the sake of concise graphic representation, the categories are labeled, *competence, productivity, peers,* and *patients*.

As an overview, this writing will define and detail each of the four elements of *competence, productivity, peers*, and *patients*. Further exploration within each element will include aspects of hiring, performance improvement, annual reviews, and recognition. Supporting stories, as well as examples and experiences, will assist the reader in personal application. Research data are provided to compliment and corroborate.

Competence

Definition of Competence

Competence incorporates its fraternal twin sister of knowledge. Knowledge is simply the accumulation of information, theory, facts, and data. We must not assume that the best evidence of knowledge lies in diplomas, certificates, and licenses (see Figure 2). While required for practice, these credentials only represent the most basic knowledge and cannot guarantee competence. True competence is the ability to apply knowledge contextually. It is the power of professional and clinical decision making. While knowledge is measurable and can be tested, the contextual application of knowledge (competence) is more difficult to assess. Again, never mistake knowledge for competence. It is simply a component of it. The implication of wisdom should be incorporated, as wisdom is the ability to exercise discernment, sagacity, prudent insight, and conscientious judgment. Clinical wisdom incorporates the desirable human virtues of compassion, empathy, insight, and mutual respect.

Hiring for Competence

Hiring for competence is customarily based upon academic performance (grades) and national exam scores (which is usually implied if the candidate possesses a state license). Referral sources can also verify practical competence, primarily from former employers and colleagues. Some employers also employ scenario-based testing commensurate with the specific clinical environment where the candidate would be working. Other considerations may include peer feedback, patient feedback, and skills testing.

Figure 2. *Competence* remains a most critical characteristic and skill, the presence of which never compensates for the lack of the other three characteristics.

Hiring interviews for knowledge and competence can be challenging. The most effective interview style is a reciprocal conversational method. During the hiring interview, one should determine whether a candidate's professional skills are commensurate with the job duties. Some hiring questions may include the following:

1. You've reviewed the job description. For which of the job duties do you feel most qualified?
2. Which of the job duties concern you?
3. Given the duties that concern you, if hired, how would you become proficient in those duties?
4. It seems that you are most qualified in ⟨insert skill⟩. Since that is a professional skill that some of our clinicians do not possess, how would you envision your role in helping your colleagues become more competent in that skill?
5. While competence is a very important skill in this working environment, it is not an exclusive skill. What do you believe to be the other skills necessary to successfully fulfill the role?
6. How do you see yourself among your peers here if you lack a professional skill which they possess?
7. If you could design an educational program for our staff that will help us stay abreast of clinical knowledge, what would that look like?
8. What was the last professional journal article you read, and when?
9. What is your personal educational plan to stay informed of clinical skill sets throughout your career?
10. Given the large number of professional journals, how do you stay on top of your reading and professional study?

As one hires for competence, remember that, although competence is at the top of the hiring list for most, it remains less important than characteristics of trust and demeanor.

Performance Improvement for Competence

Should competence be lacking in any area of professional skills, given the presence of other important characteristics (such as relationships with patients and peers), performance can be improved through continuing education opportunities, online training with device companies, diagnosis and treatment experts, and peer coaching within the organization. A critical part of performance improvement for competence is goal setting, and consideration should be given to use the S.M.A.R.T. acronym (specific, measurable, achievable, relevant, and time bound; Doran, 1981). Regular

follow-up and accountability are critical. Consistency is paramount for all new hires.

Annual Reviews for Competence

The general effectiveness of annual reviews is being scrutinized by several individuals and organizations, including Gallup, *Harvard Business Review*, and *Forbes* (Cappelli & Tavis, 2016; Gallup, 2019; Koulopoulos, 2018; Ryan, 2018). The valid points made by these organizations include the need for immediate and timely feedback, further considering the fact that if feedback is delayed until the end of the year, it is too late for improvement, and managers are holding the improvement hostage for about a year until the subject is able to "pay for it" by a poor review. Wherein lies the effectiveness of a review? Wherein lies the value of lost time between the poor performance and the feedback offered months later? If a clinician is made aware of a skill deficit and demonstrates the improvement, the only aspect of the annual review deserving attention is the fact that the clinician improved a skill set. There is only decremental value in acknowledging the lacking skill 9–10 months later.

Focusing on the positive aspects builds trust and confidence, which should become the primary purpose of reviews. Reviews are an opportunity to help professionals shine, be recognized for their good work, and feel supported by management. Therefore, competence is evaluated ongoing for the benefit of the staff member, manager, and patients. When feedback is expected immediately, it is without surprise and without the concern that the rot of "old issues" will be "exhumed" during the annual review 9 months later. The process of providing immediate feedback builds trust and improves communication.

Corrective Action for Competence

Corrective action for lack of competence may come following a period of ongoing coaching for performance improvement. Corrective action comprises a record of written plans, goals (mutually agreed upon), and attempts for improvement. Corrective action is usually the last resort following a failure in the PIP. Corrective action plans outline a timeline of termination if expected measures remain unmet. Corrective actions are always well-documented, most often involve a representative from HR, and provide ample opportunity for improvement, with swift consequences for expectations unmet.

Recognition for Competence

Recognizing and rewarding competence is critical in all teams, as team members acquire new skills or competencies become elevated. The recognition comes from a careful analysis of skills based upon four questions (Fortress Learning, n.d.):

1. Can this person transfer these skills to new situations?
2. How does this person respond when things go wrong?
3. How does this person cope with changes to the conditions under which the task is being performed?
4. How does this person manage the task as part of the other demands of the job?

Answers to these four questions provide a deeper understanding regarding a person's competency. They are a reminder that competency is not just knowledge. Competency is the ability to apply knowledge contextually and with wisdom and prudent judgment.

Productivity

Definition of Productivity

Since the ability to produce contributes to the backbone and viability of any organization, it, too, is an essential PPI. In the context of many organizations, productivity pertains to revenue generation and financial accountability (see Figure 3). Productivity also includes various aspects of efficiency, organization, and process support and alignment. Employment productivity can be measured in the achievement of revenue projections and/or meeting department goals and deadlines.

Within whatever branch of health care we participate, we are driven by productivity. Whether that is patient contact hours, procedures, therapeutic treatment hours, relative value units, or the like, productivity keeps the boat afloat, adds to job security, and ultimately ensures our patients that we will be there for them tomorrow. Productivity is measurable. Practice data systems employed effectively will provide the necessary analytics for analysis. Additionally, the author's personal and anecdotal experience reflects the idea that many demands for productivity made by nonclinical professionals may be unreasonable.

The story is told of a clinical manager who presented the business operations data in a staff meeting to help staff members understand the business fundamentals of the organization. During the detailed explanation, one clinician

Figure 3. *Productivity* is critical for the practice's sustainability and future. Having skills in productivity may never compensate for the lack of the other three skills.

abrasively commented, "Look, I'm here to provide clinical care for patients. I don't care about the operations or the business side. That's your job! We need to focus on providing clinical care." A short-sighted clinician who minimizes and questions the role of productivity and business operations simply fails to understand their professional role and scope of practice. Just as effective parenting is well beyond the mundane and common tasks, as in professional practice, someone must pay the bills, protect the roof overhead, and plan for the future. While requirements for productivity should not detract from clinical care and outcomes, they are essential to the management and sustainability of a business. No clinician should assume that they are paid for employment to which they do not adequately contribute and for which they are not proactively accountable.

Efficiency is the ability to use resources wisely, manage time effectively, and perform duties within the necessary context of deadlines and time-based expectations. Efficiency also implies the successful achievement of time management. Life balance within the workplace may even play a role in predicting workplace longevity.

Part of an organization's requirements for efficiency are deadline requirements for reports, billing submission, and project obligations. Ultimately, productivity supports the organization, and productivity and efficiency can be measured in a variety of ways, depending on the employment setting. Ultimately, productivity supports the logistical operations of the business. At times, professionals believe that when productivity does not impact patient care, it would be of less importance. However, outcomes of patient care are manifest in the business operations efficiencies, and patient care can indeed be impacted by delayed billing, delayed or incomplete reports, or inadequate project completion. As an example, unless reports are completed in a timely fashion, the patient may be delayed in the next step medical visit with another medical specialty.

The absence of this essential skill would be reminiscent of the old Russian folktale, which became the children's story of *The Little Red Hen* (2015), where the red hen asked for help from her farm animal friends. She asked for help planting the wheat, harvesting the wheat, milling the wheat, and making the bread. At each stage, the farm animals were unwilling to assist the little red hen with all that was necessary to make the bread. However, when it came time to partake of the oven-fresh warm buttery goodness, the farm mates were first in line. The more modern-day analogy is being "in the boat but not rowing." A clinician's efficiency and productivity are an essential element of success, the absence of which cannot be compensated by other skills.

Hiring for Productivity

When hiring, is it possible to know about a candidate's efficiency and productivity skills? Specific questions to former employers may provide insight. Additionally, some thought-provoking questions to the job candidate may also add perspective. Potential hiring questions might include the following:

1. How would you characterize your habits regarding report and billing deadlines?
2. How would your former managers characterize your timeliness practices?
3. What is the impact of efficiency and productivity on patient care and business operations?
4. Can you provide any examples of when you've been late for submitting paperwork or projects and the impact it had on others?
5. How do you believe that principles of efficiency and productivity play a role in patient care?
6. When there is an expectation for revenue production from all clinicians, how would you respond if your revenue goals were not consistently met?
7. How would you describe the natural consequences of poor productivity and inefficiency?
8. Which among your personal strengths would support your efficiency and productivity in your clinical work?
9. Could you describe one of your habits that might be a personal barrier to meeting department goals?
10. How does your efficiency provide support to our support staff?

Performance Improvement for Productivity

Performance improvement for productivity is primarily based on data. When expectations are outlined and agreed upon, the need for improvement becomes simple to assess. The goals are either achieved or not. Certainly, extenuating circumstances arise, but performance improvement is founded upon the degree to which the goals are met. A PIP includes aspects of setting achievable milestones, managing barriers and interruptions, organizing, prioritizing, and communicating effectively.

Annual Reviews for Productivity

Reviewing only annually for productivity is akin to running with an extinguisher to the site of a fire from 9 months ago. As noted previously, the best kinds of reviews are held day-by-day, week-by-week, as needed to provide swift, timely, and helpful feedback. One must only consider the cost of lost time to believe that any other approach could yield better outcomes. Reviews for productivity should be handled at least monthly, with shared transparent reports, reviews, and discussions.

Corrective Action for Productivity

Unlike corrective action for competence, corrective action for productivity is completely data driven. While data are important in every way, consideration of unique individual circumstances is critical to providing a supportive environment, building trust, and increasing camaraderie.

Corrective action should serve as the basis for restoring expectations and providing positive support and encouragement. It is often used as a final communication with anticipated probation or termination.

Recognition for Productivity

Recognizing productivity for many organizations comes in many forms, from gift certificates, gifts, bonuses, or opportunities for special projects. *Forbes* author Kathy Caprino (2019) offered insight into "How Your Employees Want to be Recognized":

1. A new growth opportunity is the most valued type of recognition. Other forms of recognition (salary increases, high-performance ratings, and bonuses) were far less popular.
2. Forty percent of professionals prefer recognition for success over knowledge or expertise, effort, and living core values.
3. Showing appreciation doesn't need to be shared widely to count. Most workers prefer recognition shared with just a few colleagues or delivered privately.
4. Three quarters of workers are satisfied receiving a "thank you" for their everyday efforts as opposed to a gift or celebration.

Other findings in Caprino's (2019) research suggested that "it matters *how* you recognize people, but also *what* you recognize them for and *who* does the recognizing." She discovered further that "if you're not saying 'thank you' to people on a regular basis, you are missing a huge, low effort, no-cost opportunity to make workers feel appreciated. The bottom line is that recognition is performance-based. Not everyone can receive that bonus, and according to *Harvard Business Review*'s author, Mike Robbins, "the recognition must come from senior leaders" (Robbins, 2019). It is the "how" and "what for" that matter most in recognizing productivity.

Relationships With Patients

Definition of Relationships With Patients

Relationships with patients can be seen by most health care organizations as the primary skill for health care providers (see Figure 4). To understand this relationship's importance is to know why author Doug Wojcieszak (2007) claimed that patients do not sue health care providers primarily because of a medical mistake but overwhelmingly because they lost trust in the provider. The basis for ensuring that provider relationships are relationships of trust is not just to avoid litigation but because the trusted relationship is where the patient/provider relationship begins and from which it develops throughout the course of diagnosis and treatment.

Simon Sinek (2019) indicated that trust may be the single most important reason we hire someone, even more so than skill or competence. It is the ability to be trusted and the ability to trust others. That characteristic's value is

Figure 4. Relationships with *patients* are essential in all caring professions. While one may be highly skilled in this characteristic, it may never compensate for the lack of any other skill.

priceless. While the provider/patient relationship of trust is crucial to good patient outcomes, one must undoubtedly respect the patient/provider professional boundary, crossing neither boundary of overengagement nor underengagement.

Examples of overengagement include sharing personal problems with patients, accepting gifts, flirtatiousness, providing special favors, sharing personal or sexual remarks or jokes, or making disparaging remarks about other providers. Examples of underengagement include avoiding or minimizing time with a patient. Underengagement may also include acting aloof or uncaring, decreasing eye contact, chronic lateness for scheduled appointments, or frequently rescheduling.

With some irony, it is patients who first notice acts of underengagement while peers, supervisors, HR representatives, and professional organizations become more sensitive to a provider's overengagement. Both, however, are a boundary violation. Overall, relationships with patients must remain professional, exhibiting a caring, concerned demeanor, while maintaining appropriate boundaries.

Of great importance is the concept that patient relationships are not reciprocal. In personal friend relationships, we behave reciprocally. We exchange time, caring, love, and affection. In professional relationships, we quite literally exchange services for money. As aloof as that seems, the boundary is critical in order to maintain the objective, independent, and unbiased judgment required by providers. It is this demeanor that provides the best possible relationship.

The best relationships with patients and families are those that promote respect, healing, and function within the professional boundaries required to achieve maximum safety and optimize outcomes. The ability to relate to and communicate with patients and their families is essential to clinical care. Personal experience dictates that many patients value this bedside manner more than they value knowledge and competence. Patients might even assume that if

the provider is kind and nurturing, then they also are knowledgeable and competent. That is sadly not always the case. Being nice is not all that matters. Elliott Fisher, MD, cautioned, "Some of the nicest doctors are the least competent" (Associated Press, 2014). While one does not imply the other, this aspect of caring does arise from within the provider and is difficult to teach. It cannot be fabricated. Patients (even children) easily detect lack of sincerity. Should they feel clinicians are disingenuous, the impact may be worse than being downright malicious.

The development of the relationship skill has been shown to minimize risk and litigious actions from patients (Relias Media, 1997). Despite Dr. Fisher's observation, kind and nurturing providers are sued less even when they make a medical mistake. Furthermore, knowledgeable and competent providers who lack the bedside manner may be sued more often, despite their competence. At least, as providers improve their communication skills, they appear to be sued less frequently (Carroll, 2015). Some suggest that laughing and listening more will decrease litigious risk (Relias Media, 1997).

Hiring for Relationships With Patients

How does a hiring manager know that a particular job candidate has compassionate, appropriate, and engaging relationships with patients? Some interview questions may help:

1. Can you relate a few experiences you've had with patients where you felt that you were making a positive difference?
2. Can you tell me about a conflict with a patient or family and how it resolved?
3. How would your coworkers characterize your relationships with patients?
4. What are the top three characteristics of a clinician who has excellent relationships with patients?
5. How would you delineate the appropriate boundaries between patients and providers?
6. What are the potential risks of patient relationships where boundaries are crossed?
7. How would you respond to a patient request that you join them for dinner sometime?
8. How do you build trust with patients and their families?
9. What is the primary reason patients sue their providers? (The answer is loss of trust.)
10. How would you know when a patient relationship had turned personal or nonprofessional?

Performance Improvement for Relationships With Patients

A manager's awareness of a clinician's patient relationships can be increased in a plethora of ways: standard patient feedback mechanisms such as postvisit surveys, on-the-wall card and box feedback invites, complaints, compliments, peer reports, and more. The most important rule in performance improvement is the true old adage "compliment in public, and coach in private." This practice should increase trust, improve relationships, preserve confidentiality, and broaden confidence.

Performance improvement coaching for patient relationships usually originates from individual and scenario-based observations and/or common group observations. For the former, individual coaching is open, honest, quick, and effective. This form of communication is an approach that is often difficult for some managers. While the method of open, honest, quick, and effective communication takes time and practice, it is worth the investment due to the value and impact of immediate feedback. Immediate feedback is becoming the method that may, to some extent, replace many of the formal annual reviews.

Performance improvement should always reflect the following parameters:

1. Identify the issue.
2. Acknowledge the pain point.
3. Convey the impact.
4. Create a plan for repair/resolution/avoidance.
5. Include effective follow-up.

Dattner (2020) outlined the following self-questions for the interviewer of a PIP:

1. What are the goals for the discussion? Outline specifically what the expected outcome of the performance improvement interview is. Is it truly about performance improvement, with one important goal to facilitate the subject's success? If the purpose of the improvement plan is punitive or to encourage the subject to reconsider their employment status, then it should likely be considered a *corrective action* measure (described below), rather than a PIP.
2. Are you focusing on behavior, personality, or both? It is essential to identify exactly what aspect of improvement you are seeking. Attaching suitable examples will help identify and outline the specific focus. As much as possible, remove the emotion of the moment; stay focused on facts identifying quickly what next positive steps are.
3. Are you exercising authority? Depending on the nature of the relationship and infractions, it may, at times, be necessary to exercise the authority vested to coach changes. While it is rarely advisable to be punitive, it is also essential that the subject sees the manager as their superior rather than a peer.
4. Are you conveying the right tone? The tone of voice is essential to ensure understanding. It is recommended (after drafting the communications) that the interviewer practice delivering the message in front of a mirror; practice the extremes of tone; read the communication in an angry voice, an assertive voice, or a self-deprecating voice; and finally attempt to find the tone

that delivers not only the message but conveys a sense of support, approachability, confidence, and commitment to the success of the subject. The vocal practice is enlightening and helps define the undesired tone as much as the desired tone. The activity is helpful especially because the recipient may *hear* a tone of voice that the manager may not have intended.

5. What next? Written documentation should clearly outline the next steps, including specific behavioral changes expected, resources provided to support success, and a time frame for the next review.

Annual Reviews for Relationships With Patients

Annual reviews should include a metric to support and ensure the sacred nature of the patient/provider relationship. This vital metric will be consistently analyzed and discussed not only during the annual review but on an ongoing basis throughout the year. Any highlights of patient relationship difficulty or success should be explained and detailed with immediate feedback. Depending on outcomes, training sessions may be scheduled by a qualified patient relations authority. Clearly, annual reviews should highlight the positive aspects and achievements from the entire year and focus only on lingering unresolved negative issues.

Corrective Action for Relationships With Patients

Corrective action involving relationships with patients usually references a negative or unfortunate adverse event. Most times, these are serious in nature and may have compromised a patient relationship, a patient's health, or a treatment outcome, sometimes due to boundary crossing or violation. Any concern that would generate a corrective action for patient relationships should be directly tied to law, code of ethics, code of conduct, rules, company policy, or other mutually agreed-upon decrees or directives.

Corrective action is impact-evident, specific, measurable, and essential for accountability. Action will usually be taken to protect a patient, clinician, company, financial status, and/or a professional reputation. The specific impact of each aspect is clearly described. Categories of impact are detailed. The patient impact is primary, followed by other impacts, as well as reputation costs. A corrective action's purpose is to protect and drive change, likely with swift and immediate consequences should the requirements remain unachieved.

Recognition for Relationships With Patients

Creating a culture of recognition requires foresight, creativity, connection, and a budget! William Craig (2017) provides three reasons why employee recognition matters:

1. Recognized employees are happier employees.
2. Appreciative leaders are appreciated leaders.
3. When employees feel recognized, they stick around.

According to Gallup (2019), 65% of surveyed employees reported that they received no recognition over the last 12 months, and most workers who leave their jobs cite the lack of recognition as a major concern. Recognition for extraordinary patient care can be one of the most gratifying engagements a manager initiates with the clinician. Moreover, the cost of employee recognition is less than the cost of employee turnover (Newman, n.d.; "The True Cost," n.d.).

Employers who use relatively simple measures for recognizing their employees can actually reduce high turnover rates (Mayhew, n.d.). Recognition is the most meaningful when initiated by various levels of management who spread the good news through multiple outlets, such as personal visits, personal and group e-mail, staff bulletins, staff meetings, and newsletters, and even media recognition when the achievement warrants.

While we know recognition is important, *how* we recognize is just as important as the recognition itself. Determining what kind of recognition an employee finds most meaningful becomes a thriving thread through any recognition model. While some respond well to gifts and bonuses, others respond more favorably to advancements and opportunities for growth.

Ari Kopoulos (2017) suggests 10 specific recognition strategies:

1. Make it personal.
2. Provide opportunities.
3. Magnify recognition.
4. Offer beyond the call-of-duty perks.
5. Motivate with financial incentives (care should be taken within health care to ensure that such motivators do not interfere with a clinician's expected objectivity).
6. Give holiday rewards and bonuses.
7. Facilitate peer-to-peer recognition.
8. Recognize people's passions.
9. Embrace gamification.
10. Use technology and social media to publicize accomplishments.

Overall, recognition becomes one of the most effective ways to improve workplace culture!

Relationships With Peers

Definition of Relationships With Peers

It has been seen before: the couple sitting at a restaurant ignoring one another while immersed in their electronic devices. The apparent discord or lackluster relationship is symbolic of a bored or dysfunctional relationship in a clinical team, and such uninspired connection is equally evident to visiting patients. Just as restaurant patrons notice other dysfunctional patron relationships, patients have a sense of the teams in practices they visit. Patients know a good team when they see it: engaging, happy, enjoyable, and interactive with one another. It is the magic patients feel, and

although they cannot quite say why, they know it when they see it.

Because the Quadrad story centers on the relationships with peers (see Figure 5) and because the noted clinician believed that other skills in other areas would easily compensate for his debilitating lack of this one category, one must consider the overall cumulative impact of each of the Quadrad's elements. Relationships with peers include immediate peers, community peers, and beyond. It is apparent that poor relationships with peers became the core of the dissolution of the team spirit and the esprit de corps of the entire department. Furthermore, research demonstrates that one employee with poor relationship skills, causing toxicity, can influence many other workers, eventually ruining an entire workforce (Gallo, 2016; Torres, 2015; Weinberger, 2019). Relationships with peers and colleagues demonstrate a professional's ability to participate as a team player in the sandbox. Most often, patients notice it as they walk in the office door: how they are greeted and the interaction between professional staff members. The honed ability often translates into a team member's skill and functioning on a group level, building team camaraderie, and developing professional circles of trust.

Since relationships hinge on the primary aspect of trust (see Relationships With Patients section above), trust must become the initial and primary inquiry and focus during any aspect of hiring, performance improvement, reviews, corrective actions, and recognition. The diminution of this key indicator has the potential to create a level of toxicity within the team, a condition that Torres (2015) classifies as "high cost." Indeed, Torres indicates it is better to hire a slightly less qualified professional who will be a better team player. An absence of this key indicator simply cannot be compensated by any other talent or expertise.

Figure 5. Relationships with *peers* become the structure upon which solid and trusting practices are built. Excelling in these relationships alone, however, fails to compensate for the lack of any other skill.

Hiring for Relationships With Peers

As instructed through the research of Harvard Business School's Dr. Francis Frey, Simon Sinek, and others (Frei, 2018; Zenger & Folkman, 2019), hiring for trust is paramount. Its necessity is prioritized above hiring for skills, performance, and competence. It is such a vital consideration that when aspects of professional trust are absent, no other characteristics compensate for or make the hire worthwhile, no matter the skill level. Trust is nearly impossible to teach and train, nor is the workplace where that training should occur. Candidates should enter the hiring arena with trustworthiness already well established.

How does one measure trust? The author measures personal trust based on the answers to the somewhat overly simple hypothetical question, "Would I give you my garage door code or my truck key?" Humor notwithstanding, there are many other more credible ways to measure trust. Some of the hiring questions to consider might include the following:

1. Provide an example with the outcome and impact of when a coworker broke your trust.
2. How would you reassure me and your coworkers that you can be trusted with our names, reputations, and proprietary company information, both in public and private settings?
3. What are the natural consequences of just one act of broken trust in the workplace?
4. Can you provide an example of when someone felt as if you had violated their trust?
5. How would you describe the necessary elements of trust in your peer relationships?
6. How do you develop trust among your coworkers?
7. When and how has gossip played a role in your professional career? How would you describe the relationship between gossip and trust?
8. How would you describe the characteristics of a toxic coworker?
9. How would you know whether you are a toxic employee, and how would you like to be coached if your supervisor thought you exhibited toxic behaviors?
10. In your previous employment, how would the support staff (secretaries, receptionists, billing staff) describe your relationships with them?

Performance Improvement for Relationships With Peers

Applying the fundamental principles of professional values within peer relationships will improve behavior quicker than just the study of behavior will change behavior. PIPs for relationships with peers begin with self-assessment. The effective ones are complemented by an assessment from peers. One highly effective way to exchange peer-to-peer perceptions is the Johari window model (Communication Theory, n.d.). This team-focused activity requires the subject's selection of self-describing positive and negative adjectives from a

closed set of words. The subject also provides permission for the study administrator to survey at least three coworkers of the subject's choosing to use the same lists of adjectives to describe the subject. The findings are compiled into a four-pane window organized into the following categories:

1. Open area: All adjectives common to oneself and others.
2. Blind spot: All adjectives known to others, but unknown to self.
3. Hidden area: All adjectives known to self, but unknown to others.
4. Unknown: All adjectives not selected by self or others.

Using this method, very compelling experiences have been led by the author with teams in a consultative setting. Results tend to provide a grounding impact on team members, as well as a tone of humility and teachability. It is certainly a starting place for discussions and coaching about peer relationships.

Annual Reviews for Relationships With Peers

Relationships with peers are a substantial categorical portion of any annual review. While communications about peer relationships should occur often throughout the year, the annual review provides another opportunity to reaffirm, coach, or recognize excellent behavior. Annual reviews should be replete with a variety of examples, especially positive ones that help, support, build, and encourage. Recognizing positive behaviors has a more positive impact on improving behaviors than constantly highlighting negative behaviors has on eradicating the negatives. Managers should collect throughout the year recognitions from peers about times of helpfulness and support. Some managers include such recognitions for each staff meeting: "Thanks to my coworkers for...," a time where coworkers are publicly recognized by their peers for their good deeds and kind gestures.

Corrective Action for Relationships With Peers

Corrective action for relationships with peers is serious business. As previously described, since the power of one toxic individual is overwhelmingly influential, it is imperative that the corrective phase is short, meaningful, action-oriented, and swift (especially if probation or separation is recommended). Behaviors regarding relationships with peers that require corrective action may include discrimination, bullying, sexual or other harassment, and violence, or threats thereof. While most egregious behaviors qualify for immediate termination, depending on nature, context, and severity, corrective action may be considered.

Recognition for Relationships With Peers

Publicly recognizing clinicians for their relationships with peers serves many purposes:

1. It increases confidence.
2. It elevates the likelihood of retention.
3. It sets a behavior precedent for other clinicians.
4. It creates a model for improving morale and employee engagement.

While it is important to recognize often and frequently, some cautions should be observed:

1. Never provide everyone with the analogous participation trophy when performance differences are distinct and clear.
2. Each recognition must be sincere, measurable, and highly credible.
3. While each recognition should fit within a previously designated recognition model, spontaneously initiated recognitions are also appreciated and effective!

Conclusions

The Quadrad of Performance: A Leadership Tool for Professional Growth is designed as a model for an understanding of the wide variety of characteristics required by practicing clinicians. While it appears all-encompassing and may not allow for any margin of error, it is simply a framework of *striving*, of the great effort to achieve or attain the characteristics that promote wisdom, competence, and strong patient and peer relationships, while embracing all that is necessary to become an active participant in the essential business side of clinical care.

A common misunderstanding among clinicians is that strengths with some professional skills compensate for the lack of another essential skill. While there are varying levels of those skills, the prominence and necessity of each cannot be overstated. To add meaning, consider a different context of the four elements of *competence, productivity, relationship with patients*, and *relationships with peers:*

1. Imagine hiring someone who embodied all of the elements except for *competence*. They were efficient, productive, and had exemplary relationships but had significantly compromised knowledge and competence. Consider the implications of their clinical care.
2. Imagine hiring someone who was extremely bright, intelligent, competent, and fostered all of the relationships necessary for the position but lacked in efficiency and productivity. They were disorganized, consistently tardy with billing, report writing, and project completion. Consider the precedent, the influence on others, and the impact on business operations.
3. Imagine hiring a candidate who was extremely organized, productive, efficient, very bright, intelligent, and with excellent clinical skills and relationships with peers but found great awkwardness in relating to patients, connecting with families, and interfacing during clinical care. Consider the impact on patients and families. Consider the influence on the natural referral system from patients. Consider the impact on the practice reputation.
4. Finally, imagine hiring a candidate who was excellent with patients; competent in clinical skills; and timely

with reports, billing, and projects but whose relationships with peers fostered jealousy, resentment, competition, and toxic undermining. Such was the example in the *Story of the Quadrad.* Furthermore, we now know the impact of such behavior through the research of *Harvard Business Review* and other reputable institutions.

Quantifying clinical characteristics has often provided great challenges for managers and leaders. However, visualizing aggregates, entireties, and using sums may be more effective than attempting to quantify each individual characteristic. While one may argue whether Aristotle originated the thoughts about "the whole being greater than the sum of its parts," we *do know* that the great philosopher said: "Concerning the challenge we just faced about how to describe things in numbers and definitions, what is the reason for a unity/oneness? For however many things have a plurality of parts and are not merely a complete aggregate but instead some kind of a whole beyond its parts, there is some cause of it since even in bodies, for some the fact that there is contact is the cause of a unity/oneness while for others there is viscosity or some other characteristic of this sort" (Stanford Encyclopedia of Philosophy, 2010).

Indeed, each of the four elements of the Quadrad (competence, productivity, patients, and peers) has a "plurality of parts and are not merely a complete aggregate, but…some kind of whole beyond its parts" (Sententiae Antiquae, 2018). It is the well-rounded clinician who will find a thriving professional niche, contribute in ways appearing beyond their capacity, help improve patients' lives, and find joy in their efforts. Indeed, that is the ultimate goal.

Acknowledgments

The author wishes to acknowledge every professional ever engaged for the insight, brilliance, and perspective, even (and perhaps especially) those clinicians, leaders, and peers who pushed, challenged, and tested thoughts, claims, relationships, and intentions. A great acknowledgment goes out to those who undermined, lied, and cheated for the purposes of self-gratification and advancement. The author learned the most from those. The Quadrad is the culmination of the cumulative events and experiences. The acknowledgments come with the hope that each professional encounter leads to support, growth, and positive outcomes for patients and peers alike.

Content from this article was originally presented to the American Speech-Language-Hearing Association meeting in Orlando, Florida, 2019, Session 1393 under the title "Leadership and the Quadrad of Professional Performance."

Adaptation for Academia and Education

Since concepts described in this writing are universal, simply replace "patient" with "student" for a more suitable application to the academic or education setting.

References

Associated Press. (2014, July 20). Most consumers unclear about physician quality, poll finds. *Modern Healthcare*. https://www.modernhealthcare.com/article/20140720/INFO/307209997/most-consumers-unclear-about-physician-quality-poll-finds

Cappelli, P. (2019, May–June). Your approach to hiring is all wrong. *Harvard Business Review*. https://hbr.org/2019/05/recruiting?ab=hero-main-image#your-approach-to-hiring-is-all-wrong

Cappelli, P., & Tavis, A. (2016, October). The performance management revolution. *Harvard Business Review*. https://hbr.org/2016/10/the-performance-management-revolution

Caprino, K. (2019, July 20). Knowing how your employees want to be recognized (and for what) is key to their engagement. *Forbes*. http://orbes.com/sites/kathycaprino/2019/07/20/knowing-how-your-employees-want-to-be-recognized-and-for-what-is-key-to-their-engagement/#28ff3950384e

Carroll, A. E. (2015, June 1). To be sued less, doctors should consider talking to patients more. *The New York Times*. https://www.nytimes.com/2015/06/02/upshot/to-be-sued-less-doctors-should-talk-to-patients-more.html

Communication Theory. (n.d.). *The Johari window model*. https://www.communicationtheory.org/the-johari-window-model/

Craig, W. (2017, July 17). 3 reasons why employee recognition will always matter. *Forbes*. https://www.forbes.com/sites/williamcraig/2017/07/17/3-reasons-why-employee-recognition-will-always-matter/#6ba5619e63c9

Dattner, B. (2020, March 28). The key to performance reviews is preparation. *Harvard Business Review Ascend*. https://hbrascend.org/topics/the-key-to-performance-reviews-is-preparation/

Dictionary.com. (n.d.). *Trust*. https://www.dictionary.com/browse/trust?s=t

Doran, G. T. (1981). There's a S.M.A.R.T. way to write management's goals and objectives. *Management Review, 70*(11), 35–36.

Fortress Learning. (n.d.). *Recognizing competency*. https://fortress-learning.com.au/cert-iv-content/assess/recognising-competency/

Frei, F. (2018, April). How to build (and rebuild) trust. [Video]. TED Conferences. https://www.ted.com/talks/frances_frei_how_to_build_and_rebuild_trust?language=en

Gallo, A. (2016, October 3). How to manage a toxic employee. *Harvard Business Review*. https://hbr.org/2016/10/how-to-manage-a-toxic-employee

Gallup (2019, May 6). More harm than good: The truth about performance reviews. *Gallup Workplace*. https://www.gallup.com/workplace/249332/harm-good-truth-performance-reviews.aspx

Housman, M., & Minor, D. (2015). *Toxic workers*. Harvard Business School. https://www.hbs.edu/faculty/Publication%20Files/16-057_d45c0b4f-fa19-49de-8f1b-4b12fe054fea.pdf

Kopoulos, A. (2017, February 22). *10 Powerful ways to improve your employee recognition*. HRM The News Site of the Australian HR Institute. https://www.hrmonline.com.au/section/strategic-hr/10-ways-improve-employee-recognition/

Koulopoulos, T. (2018, February 25). Performance reviews are dead. Here's what you should do instead. *Inc.* https://www.inc.com/thomas-koulopoulos/performance-reviews-are-dead-heres-what-you-should-do-instead.html

Lipman, V. (2017, January 13). Why trust in leadership leads to better employee performance. *Forbes*. https://www.forbes.com/sites/victorlipman/2017/01/13/why-trust-in-leadership-leads-to-better-employee-performance/#44f587174486

Litzky, B. E., Eddleston, K. A., & Kidder, D. L. (2006). The good, the bad, and the misguided: How managers inadvertently encourage deviant behaviors. *The Academy of Management Perspectives, 20*(1), 91–103. https://doi.org/10.5465/amp.2006.19873411

MacLean, T. L., & Behnam, M. (2010). The dangers of decoupling: The relationship between compliance programs, legitimacy perceptions, and institutionalized misconduct. *The Academy of Management, 53*(6), 1499–1520. https://doi.org/10.5465/amj.2010.57319198

Mayhew, R. (n.d.). *High turnover because of no recognition*. Small Business Chron.com. https://smallbusiness.chron.com/high-turnover-because-recognition-10555.html

Minor, D. (2015, November 9). *Toxic workers*. Harvard Business School. https://hbswk.hbs.edu/item/toxic-workers

Newman, S. (n.d.). *Employee recognition: Countering the high cost of turnover*. Quality Incentive Company. https://qualityincentive-company.com/qic-at-a-glance/recognition-incentive-resources/articles-white-papers/employee-recognition/

Pfeffer, J. (2018). *Dying for a paycheck*. Harper Business. https://jeffreypfeffer.com/books/dying-for-a-paycheck/

Relias Media. (1997, May 1). *Physician bedside manner linked to malpractice suit*. https://www.reliasmedia.com/articles/48843-physician-bedside-manner-linked-to-malpractice-suit

Robbins, M. (2019, November 12). Why employees need both recognition and appreciation. *Harvard Business Review*. https://hbr.org/2019/11/why-employees-need-both-recognition-and-appreciation

Robinson, S. L., & Bennett, R. J. (1995). A typology of deviant workplace behaviors: A multidimensional scaling study. *Academy of Management Journal, 38*(2), 555–572. https://doi.org/10.2307/256693

Ryan, L. (2018, January 14). Performance reviews are pointless and insulting—So why do they still exist. *Forbes*. https://www.forbes.com/sites/lizryan/2018/01/14/performance-reviews-are-pointless-and-insulting-so-why-do-they-still-exist/#56e2a85272d1

Sententiae Antiquae. (2018, July 6). *No, Aristotle didn't write "A whole is greater than the sum of its parts."* https://sententiae-antiquae.com/2018/07/06/no-aristotle-didnt-write-a-whole-is-greater-than-the-sum-of-its-parts/

Sinek, S. (2014, January 9). *Simon Sinek on building trusting teams in the U.S. Marine Corps*. [Video]. YouTube. https://www.youtube.com/watch?v=dQ2vzFKOD5w

Sinek, S. (2019, November 18). *Performance vs trust by Simon Sinek*. [Video]. YouTube. https://www.youtube.com/watch?v=YPDmNaEG8v4

Stanford Encyclopedia of Philosophy. (2010). *Aristotle's metaphysics*. https://stanford.library.sydney.edu.au/archives/win2010/entries/aristotle-metaphysics/

The Little Red Hen. (2015). *Golden books*. https://www.penguinrandomhouse.com/books/67918/the-little-red-hen-by-golden-books-illustrated-by-jp-miller/

The True Cost of Hiring a New Employee. (n.d.). *Undercover Recruiter*. https://theundercoverrecruiter.com/true-cost-hiring-new-employee/

Torres, N. (2015, December 9). It's better to avoid a toxic employee than hire a superstar. *Harvard Business Review*. https://hbr.org/2015/12/its-better-to-avoid-a-toxic-employee-than-hire-a-superstar

Weinberger, R. (2019, August 13). Toxic employees can have deadly consequences for your business. *Forbes*. https://www.forbes.com/sites/allbusiness/2019/08/13/toxic-employees-business-damage/#63d2e3f27440

Wojcieszak, D., Saxton, J. W., & Finklestein, M. M. (2007). *Sorry works! Disclosure, apology, and relationships prevent medical malpractice claims*. AuthorHouse. https://www.google.com/books/edition/Sorry_Works/as__43qo4wYC?hl=en&gbpv=1&printsec=frontcover

Zenger, J., & Folkman, J. (2019, February 5). The 3 elements of trust. *Harvard Business Review*. https://hbr.org/2019/02/the-3-elements-of-trust