Dr. Laura Suttin

CLINICIAN LEADERSHIP COMPASS™

BONUS 01 · THE CALIBRATED CONVERSATION MASTERCLASS

The Leadership Conversation Protocol Script Library

Six word-for-word SBIR scripts for the most common peer-to-leader conversations clinician leaders face. Built to be used the same week you read it.

You're not broken. You were never taught.

The structure is the work. The words are the scaffolding.

Dr. Laura Suttin, MD, MBA, PCC. Practicing family physician. Twenty years as a healthcare leader. ICF Professional Certified Coach. Creator of the Clinician Leadership Compass™.

A $97 BONUS INCLUDED FREE

HOW TO USE THIS RESOURCE

Read the setup. Then run the script.

Each script follows the same structure you learned in the masterclass: Situation, Behavior, Impact, Request. A Hold response is built in for the most predictable pushback.

Read the setup first to confirm the scenario fits. Then run the script. Adapt the specifics (names, dates, metrics, huddle times) to your actual case. The structure is the work. The words are the scaffolding.

Each script is written for a 9–13 minute delivery window. Do not memorize it. Use it as a runway. Once you've run two of these, the framework will take over.

> **A NOTE ON CALIBRATE**
>
> Every script assumes you ran the 60-second protocol before walking in. **Breathe. Name. Anchor.** Without it, the script breaks in the first 30 seconds.

01 SCRIPT ONE
The Underperforming Former Peer

USE WHEN

Someone you used to work alongside now reports to you, and their clinical or administrative output has slipped enough that the team is absorbing the gap.

× THE WRONG OPENER THAT MAKES YOU AVOID IT

"We need to talk about your performance."

SITUATION

"Dr. [Name], thanks for making time. Last [day, specific date], I noticed something I wanted to bring to you directly rather than route through anyone else."

BEHAVIOR

"Over the last 14 days, I pulled the chart-closing data for the team. Your closing rate was 64% within 48 hours. The team median is 91%, and our policy is 90% of charts closed within 48 hours. This is consistent with your rates over the past few months, which have stayed below 80%."

IMPACT

"Three patients have called to ask about the status of their referrals. Because the charts weren't closed, those referrals hadn't been initiated. That is a patient-safety issue and a liability concern. On top of that, the team is fielding the questions, and those patients are understandably getting frustrated with them."

REQUEST

"Going forward, I need your 48-hour closing rate above 85% within the next 30 days. If something is in the way (schedule, panel size, a system issue I can fix), tell me now so I can solve for it. What's making this hard right now?"

HOLD · DEFLECTION (MOST LIKELY)

WHEN THEY SAY

"You're just saying that because you got promoted."

RESPOND

"That's a fair conversation for us to have separately, and I want to. But it's a different conversation than the one we're having right now. Right now I need us to land on the closing rate."

02 SCRIPT TWO
The Disruptive Senior Colleague

USE WHEN

A senior physician (often outranks you in tenure but not on the org chart) is undermining team meetings, side-conversing during huddles, or pushing back at peers in M&M in ways that are eroding team trust.

× **THE WRONG OPENER THAT MAKES YOU AVOID IT**

"I know you have more experience than I do, but..."

SITUATION

"Dr. [Name], I appreciate you carving out the time. Last M&M, I tracked something across three cases that I want to walk through with you."

BEHAVIOR

"During Cases 1, 3, and 4, you cut off the presenter twice in each. Dr. [X] in the first one and Dr. [Y] in the third. The interruptions came on the differential discussion, not on a safety issue. I went back and timed it: the average gap between the resident speaking and you speaking was 8 seconds."

IMPACT

"Two of the residents pulled me aside after. One asked if there's any way to present without you in the room. The other said they're now spending prep time on how to defend the case rather than on the case itself. That changes what M&M is for, and I don't think that's what you want it to be either."

REQUEST

"Going forward, I'd like to land on a norm where presenters get to the end of the differential before anyone breaks in. If you have a question that can't wait, write it down and we'll come back to it. Will that work? Is there something about M&M as it's structured right now that's making you feel like you need to interrupt to be heard?"

HOLD · DENIAL (MOST LIKELY)

WHEN THEY SAY

"That's not what happened. I was clarifying."

RESPOND

"I hear you, and clarifying isn't what I'm naming. What I observed was the timing, the gap between the resident speaking and you speaking. If you have a different read, I want to hear it. And separately, I still need us to align on what we do going forward."

03 SCRIPT THREE
Admin RVU Pushback

USE WHEN

A direct report (or peer-direct-report) is pushing back on RVU targets, productivity expectations, or panel-size adjustments, and the pushback is escalating into team meetings rather than 1:1.

× **THE WRONG OPENER THAT MAKES YOU AVOID IT**

"I know the targets are tough, but corporate set them, not me."

SITUATION

"Dr. [Name], thanks for making time. I want to come back to last Tuesday's section meeting, and the one before it."

BEHAVIOR

"In both meetings you raised the RVU target during open discussion. Once in front of seven colleagues, once in front of nine. Both times, the meeting agenda was a different topic. The first time it ran for 12 minutes. The second, 18. I checked my notes."

IMPACT

"Two consequences. First, we didn't get to the patient-safety item on Tuesday's agenda, and that item has been on the agenda three weeks running. Second, three of your colleagues came to me after, asking whether the targets are actually in play, because the public pushback made them uncertain. That's a credibility-of-leadership problem, not an RVU problem. The RVU question is legitimate. The forum is the part I need to address."

REQUEST

"Going forward, if you have a concern about productivity targets, I need it brought to me 1:1 first. We can absolutely run it through the section meeting after that if it warrants, but not as the opening move. Can we agree on that? And separately, let's put time on the calendar this week to actually work through the RVU question. I want to understand what's not working for you, and I want to be able to take a real answer back to admin."

HOLD · DEFLECTION (MOST LIKELY)

WHEN THEY SAY

"Everyone is frustrated about this, I'm just the one saying it."

RESPOND

"You may be right, and if you are, that's worth knowing. The conversation about whether the targets are wrong is a real one, and I want to have it. But it's a different conversation than the one we're having right now. Right now I need us to land on where that conversation happens."

04 SCRIPT FOUR
Delegating to a Former Friend

USE WHEN
You need to ask a former peer (now your direct report, someone you grabbed coffee with for years before the promotion) to take on a piece of work, a committee assignment, an on-call shift trade, a project lead, and you've been doing it yourself to avoid asking.

× THE WRONG OPENER THAT MAKES YOU AVOID IT
"I hate to ask but..."

SITUATION
"Hey, want to grab ten minutes after clinic? I want to walk something through with you. ... OK, so, the [committee / project / on-call coverage] piece. I want to talk through it directly, because I've been avoiding it."

BEHAVIOR
"I have been carrying [specific item] myself for the last [time period]. I haven't asked you because I didn't want to be the person who suddenly became your boss and then started piling on. So I just kept doing it. That isn't fair to me, and it isn't fair to you either. I'm making a call about your bandwidth and your skillset without checking with you."

IMPACT
"Here's what's happening as a result. I'm at hour 70 most weeks. That's not sustainable, and it's leaking into the clinical side. And I'm also building a quiet story in my head about what you can and can't take on, without you having any input into the story. That's a bad pattern for both of us."

REQUEST
"I'd like you to take the lead on [specific item], starting [date]. That looks like [concrete deliverables]. Realistically, I think it's [X hours per week]. Tell me where that lands with what you have on right now. If it doesn't fit, I want to know, and I want us to talk about what does. Where does this sit for you?"

HOLD · EMOTIONAL FLOODING (MOST LIKELY)

WHEN THEY GO QUIET, LOOK AT THE FLOOR, OR GET VISIBLY HURT
"Right. So... you're not on my side anymore."

RESPOND
"I'm here. I'm not trying to make a power move. I'm trying to undo a thing I've been doing for [time period] that doesn't work for either of us. We don't have to land it this minute. But I do want to land it. What would help right now: taking a beat and coming back to this tomorrow, or talking it through now?"

05 SCRIPT FIVE
A Patient Complaint About a Colleague

USE WHEN

Patient feedback or a formal complaint names a specific clinician on your team, and you need to address it with that clinician without throwing the patient, or yourself, under the bus.

× **THE WRONG OPENER THAT MAKES YOU AVOID IT**

"So... I got an email I have to talk to you about."

SITUATION

"Dr. [Name], I want to walk through something that came in this week. I'm going to read you the relevant pieces verbatim so you have the same information I have, and then I'd like your read on it."

BEHAVIOR

"The patient is [demographics, not name]. The visit was [date]. The note in the complaint reads: '[verbatim quote of one or two specific lines from the complaint, the most concrete and observable ones, not the global judgments].' That's the data I have. I have not made an interpretation of it. I wanted to bring it to you before I did."

IMPACT

"Two things sit on this. One, the patient is asking to transfer to a different clinician inside our practice, and that request is now formal. Two, patient relations flagged this for me because it's the second complaint inside 90 days with similar language. That doesn't mean either complaint is accurate. It does mean we have to talk about it together rather than separately."

REQUEST

"Here's what I'd like. Walk me through the visit as you remember it. Not to defend it, just to give me your read. Then I want us to land on what, if anything, we want to change in how we handle the next one. I'm not bringing this with a conclusion. I'm bringing it because I'd rather we walk into the patient relations conversation having already had this one. What's your read?"

HOLD · DENIAL OR EMOTIONAL FLOODING

WHEN THEY SAY

"That patient was difficult. This is unfair."

RESPOND

"That may be true. Patients can be difficult, and complaints are not always accurate. I know that. What I'm not asking you to do right now is litigate whether the patient is right. I'm asking you to walk me through it so we have a shared read before patient relations comes back to us. Can we do that?"

06 SCRIPT SIX

Telling Staff a Requested Raise Was Denied

USE WHEN

A direct report (PA, NP, MA, RN, scheduler, anyone you supervise) asked for a raise, you advocated for it, and admin came back with no. Now you have to deliver the no without trashing admin or breaking the team member's trust.

× **THE WRONG OPENER THAT MAKES YOU AVOID IT**
"So... I have some news, and I want you to know I tried."

SITUATION

"[Name], thanks for making time. I want to come back to the conversation we had three weeks ago about your compensation. I told you I'd take it up the chain, and I did. I want to give you the answer directly today."

BEHAVIOR

"I brought your request to [admin / dyad partner / HR] on [date]. I made the case using the specifics you gave me: your panel coverage during the staffing gap, your role on the protocol rollout, the [specific metric] you owned. The decision that came back is no raise or adjustment for this cycle. The reason given was [budget envelope / cycle timing / a specific reason, not 'they said no']."

IMPACT

"Here's what I want to name out loud. You asked for something reasonable. You backed it with specifics. The system answered no. That isn't a reflection of your work. It is a reflection of where we are in [budget cycle / system constraint], and I want to be honest with you about that rather than dress it up. I also want to be honest that I'm frustrated about it on your behalf, and that I told them so."

REQUEST

"Here's what I'd like to do next. One, I'd like to put your re-review on the calendar for [specific next review date]. I want to come back with a stronger case, and I want you involved in shaping it. Two, between now and then, I want us to find two or three concrete asks that aren't compensation but matter to you. Schedule. Title. Project ownership. Conference budget. What lands for you?"

HOLD · EMOTIONAL FLOODING (MOST LIKELY)

WHEN THEY GET QUIET, TEAR UP, OR VISIBLY CHECK OUT
"I'm done. I'm looking."

RESPOND
"I hear you. I'm not going to argue with that, and I'm not going to try to talk you out of it in this moment. What I will say is, I want you here. If you decide to leave, I won't hold it against you, and I'll write you the strongest reference I can write. If you're open to staying, I want to work on this with you. We don't have to decide that today."

ONE LAST THING

When to walk away from the script

If, during any of these conversations, the other person discloses something that materially changes the situation, a health issue, a family emergency, a hostile environment they have been navigating, stop the script. Pause. Move to the conversation in front of you. The corrective conversation can wait a week. The human conversation cannot.

You will know this when you hear it. Trust that.

PAIRS WITH

The rest of your toolkit

Bonus 3	**Pushback Response Card**	A printable one-pager for the three pushback patterns: deflection, denial, and emotional flooding.
Bonus 4	**Pre-Conversation Calibration**	A five-minute audio for the parking lot. Breathe. Name. Anchor. Run it before you walk in.
Bonus 5	**Post-Conversation Follow-Up Pack**	The 24-hour, 72-hour, and one-week scripts that hold the agreement after the room clears.