CW
Coaching World
ISSUE 8 November 2013

Coaches & Communication

A coach cannot create awareness for the client. Find out why on **page 33**.

The Communication Cure

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Communication within healthcare has received a great deal of attention since the publication of the Institute of Medicine's landmark 1999 report, "To Err is Human: Building a Safer Health System," which documented that between 44,000 and 98,000 patients die each year due to medical errors. Efforts aimed at improving communication among patient-care professionals have included interventions, such as daily huddles and the use of a script to enhance communication between physicians and nurses. Poor communication was found to be the greatest contributor to medical errors.

"Improving Physician-hospital Alignment: Key Drivers and Essential Attributes," a 2008 whitepaper published by the healthcare-industry solutions provider HealthStream, Inc., examined drivers for physician satisfaction and found two of the top five to be active communication and collaborative decision-making. Coaching is playing a more active role in the healthcare environment as it demonstrates its impact on sustainable behavior change for key leaders and teams.

This article uses a case example to illustrate how coaching can develop physician leaders and improve communication across disciplines. It also provides a framework for using coaching within the healthcare setting.

The Physician

Dr. F. is the vice president of quality at a large, suburban hospital system. He practiced surgery when he was in the military and has a long history of excellence in clinical care. He is passionate about quality outcomes and evidence-based care and believed he could have a greater impact on driving quality outcomes as an administrator. Dr. F. was referred for Leadership Coaching as his CEO received increasing complaints from physicians and nurses about his abrupt, curt and seemingly rude communication style. He was perceived as critical and judgmental; as a result, nursing and physician leaders tended to avoid interactions with him. Although he would often say that he wanted direct feedback, other leaders and direct reports felt uncomfortable providing this, worrying about the response they'd receive. Dr. F. wanted decisions to be made immediately, which often conflicted with the process of getting feedback and approvals within his organization. In his new position, Dr. F. often had to speak to physicians about improving their quality of care and on-time surgical starts. These discussions were complicated by the fact that many of these physicians had been peers to Dr. F. when he was a practicing clinician.

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The Transition

Dr. F.'s story illustrates some common issues faced by clinician leaders adjusting to their new roles.

Leadership Transitions: Clinician to Administration	
Clinical	**Administration**
Problem focus	Solution focus
Rapid assessment and intervention	Complex problems requiring collaboration
Solo expert	Many experts
Immediate feedback and gratitude	Slower feedback cycle and more frequent complaints than appreciation
Strive for perfection	Strive for "good enough" and dynamic response
"All about my success"	All about the organization's success

The above table illustrates some of the more common transitions physicians experience as they move into leadership roles. In a 2011 O'Brien Group whitepaper, Gordon Barnhart terms this phenomenon "physician whiplash." Although quick assessment (judgment) and intervention work when caring for patients who have life and death issues, the world of administration requires a big-picture view and the involvement of many stakeholders and experts. Physician leaders are at risk of interpreting the time it takes to get feedback from others and implement change as "slow," "bureaucratic," and inefficient. This attitude can interfere with their ability to influence and collaborate with individuals whose support is needed to impact change.

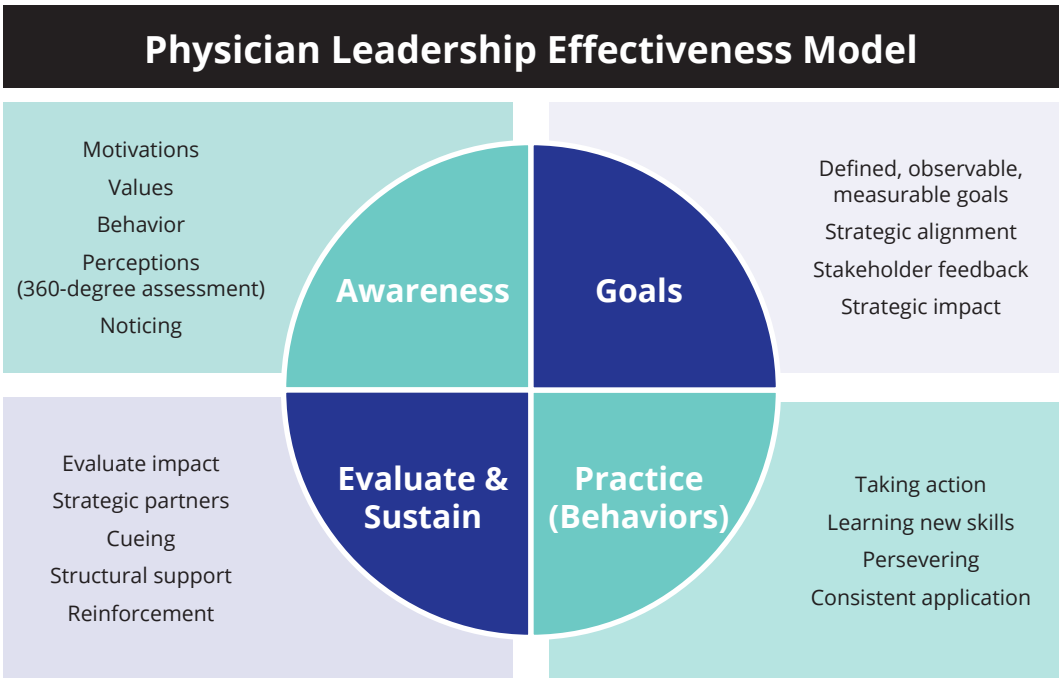
The Coaching Model

In working with physician leaders, the coaching model that I have found effective is AGPE, which stands for "Awareness, Goals, Practice, and Evaluate and Sustain." The model works from the inside out, recognizing that our beliefs, emotions and subsequent behaviors impact results. As Alexander Caillet describes in his Thinking Path model, our thoughts impact our emotions, and our emotions impact our behavior. Our behavior determines our results.

As coaches, we create awareness through behavioral and motivational assessments as well as through 360-degree feedback surveys. Tools that I have used to great effect include the Strength Deployment Inventory and Portrait of Personal Strengths, which allow for a memorable and quick understanding of differences in motivations and ways to communicate and manage conflict. As my clients learn how to better influence others, it is critical that they learn to make it about the other person as opposed to focusing on their own agenda. In working with physicians, I have found interview-based 360-degree feedback surveys rich in the stories they provide, as well as indisputable from a "data" perspective. Clients are less likely to question the validity of data when it comes directly from their peers.

Phase two looks at the client's goals and is often the first time that someone has provided a safe space that is "all about them." For many physicians, this is the first time that someone expresses interest in knowing who they are in totality, without any other agenda. For clients who have dedicated most of their lives to being perfect and "getting it right," coaching provides the opportunity to be vulnerable and imperfect. Goals are established that are measurable and meaningful to the client and, if applicable, the sponsoring organization.

Once goals are identified, a plan is created that includes the rehearsal of new skills and behaviors. Using client language, we call these "small tests of change" to encourage experimentation



and "play." The world of healthcare can feel heavy, and encouraging a spirit of play and improvisation can break down the well-honed habit of negative judgment and perceived failure. Leaders practice different ways to manage conflict, such as asking versus telling, and practice making direct requests for what they want instead of complaining about what they don't have. Nonverbal approaches (body practices) are very effective in creating awareness and improving emotional agility and leadership presence. For practitioners who like to see immediate results, somatic practices can be instrumental in creating an immediate result.

Finally, the coach partners with the leader to evaluate the effectiveness of new behaviors on desired results, adjust the plan accordingly, and identify key partners within his or her own environment that can help sustain and hardwire new skills.

The Outcome

Because Dr. F. was not self-referred, I was concerned about his ability to own his behavior and not blame others. I scheduled a two-day, in-person meeting to learn about his life story, review assessment results, and identify specific and measurable goals for our coaching. We also met with the CEO to validate focus areas and hear his perspective on desired outcomes.

After some discussion, Dr. F. was able to embrace the opportunity to learn how to be a more effective leader. He was surprised that no one had provided him direct feedback, and we were able to use that as a platform to talk about whether he made it easy for others to give him feedback or behaved in ways that pushed people away.

As we worked together through weekly and biweekly coaching calls, he was able to use actual interactions to practice new behaviors and improve relationships. We would review scripts for crucial conversations and role-play as desired. He practiced inquiry to determine others' priorities and was able to establish stronger partnerships with key leaders across the organization. I will never forget his exuberance in sharing with me his success in partnering with a previously contentious medical director by finding out what mattered to that physician and putting desired changes within the context of the physician's goals.

Dr. F. had been promoted to vice president of quality to further the hospital system's safety culture. As a result of coaching, he also cultivated a culture of safety where interpersonal relationships were concerned. Through coaching, Dr. F. realized that his strength in establishing high standards was also his liability, causing his colleagues and subordinates to perceive him as critical and judgmental. He learned to see that others needed recognition and pats on the back, though that was not what motivated him. With a coach's support, Dr. F. even "managed up" the hospital system's CEO, who grew to appreciate his strength in holding others accountable, a trait the CEO was trying to cultivate in himself. As Dr. F. became more able to form strong partnerships, physician and nursing leaders became less apprehensive in approaching him. As a result, he was effective in facilitating quantitative improvements in quality measures, including readmission rates and hospital-acquired infections.

Coaching can have a real and tangible impact on improving communication within healthcare. By impacting perceptions and attitudes of key leaders and teams within healthcare, coaching provides sustainable change that can impact patient safety and the culture of healthcare. CW