Coaching Physicians

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How much of a coach's frustrated "What is it about physicians?" is generated by preconceived assumptions rather than by remaining curious? I am a physician and, as with most people, our views of ourselves and our beliefs in what we project to others may vary wildly with what people see.

We're a culture.

Before you visit another country, most of you read books and articles about the culture, interested in what is new and different in that foreign – to you – destination. The differences invite more exploration. What would it be like if you approached coaching physicians as if you were entering the Republic of Medicine?

In the rest of this article, I'll highlight a few of the troubles common to physicians based on our professional culture – as well as a few of the methods I've found especially effective in working with other physicians because of our culture.

Imposter Syndrome Infections

When I first finished my residency, I felt like a fraud (and thought I was the only one who felt this way). Soon enough I discovered that doctors have a high incidence of Imposter Syndrome. Ultimately, over time and with practice, we realize our training did prepare us and we can be competent clinicians. Sometimes, specific moments stand out.

During my year as an emergency department physician in a ski resort a woman came in with a sore throat. As I was working through the diagnosis, she stopped breathing. I remember her lying on the gurney, turning blue. I immediately shifted from the steady rhythm of a routine work-up to emergency mode – focused and fast.

She required an emergency tracheotomy (making a hole in the trachea, or breathing tube). We had neither the equipment nor the specialists to stabilize her long enough to figure out what was going on. We loaded her into a helicopter, flying her from our rural town on the eastern side of the Sierra Madre to a fully equipped trauma center.

As I think back on this I recall traits necessary in an emergency situation. Clear, focused thinking and being calm in pressure-fueled situations are critical. I didn't have time to say, "Oh, I've never done this before. I don't know how to do it."

I still have the letter from that woman thanking me for saving her life. It's like penicillin to the infection of the Imposter Syndrome – not a cure-all but definitely a strong broad-range ego antibiotic.

Leadership Anemia

Managing a patient with only hypertension or managing a patient with only diabetes is much simpler than managing a patient with both conditions. Caring for patients, especially with chronic diseases and comorbidities requires a team. Some medications for hypertension are not recommended to be used in diabetics, and diabetics with hypertension may need additional medications. In such a case, the care team could include a primary care physician, a cardiologist, an endocrinologist/diabetologist, an ophthalmologist, a nephrologist, perhaps a surgeon, a diabetes educator and a nutritionist, each of whom *may* be communicating asynchronously with the others. Or not.

Hospital medical errors are now the third leading cause of death in the US. Poor communication is one of the leading reasons for preventable errors – often during the time when the care of a patient is handed off to the next physician or team.

Research bears this out. Skills important for physician leadership include managing the team, creating a vision, and communication. These are even among the required Core Competencies for Entering Medical Students. Yet, regretfully, the teaching of these Competencies may not be connected to the implementations, nor to the

demonstrations, by the attending physicians who work with medical students from the clinical side. In other words, book learning isn't always congruent with on the job training.

Asymmetric Growths: Technical Focus Over Personal Growth

Where might we as physicians differ from non-physicians? In social skills we may be developmentally delayed. We focus on getting excellent grades at university so we are accepted into medical school. We then have to learn a new language in a year or two while we're meeting patients, introducing ourselves as "Doctor" and feeling inadequate (there's that Imposter Syndrome again!). When we are fully fledged doctors we jump directly into practicing medicine – into being the Expert – without having time to experience what it's like outside medicine.

During this time many of our non-physician colleagues are feeding us their admiration, whether real or acted. This external affirmation can combine with Imposter Syndrome in a toxic mix of arrogance and insecurity.

And then there's general Emotional Intelligence. Physicians may be deeply focused on understanding others in terms of making a diagnosis, but often not as relates to managing the relationships between patients and physicians. We may not have nuanced understandings of ourselves, nor understandings of how to manage our emotions and interactions with others. The authors of one article interviewed ten randomly selected department chairs and observed the following.

> Emotional intelligence and its concomitant skills are the most essential competencies for leaders to succeed in academic institutions. The ten chairs emphatically stated that this ability was fundamental to their success and its absence was the cause of their failures. They suggested that the absence of emotional intelligence often resulted in the demise of chairs and contributed to the high turnover among colleagues.

Need for Support to Change

Physician leaders cite emotional and psychological support as the most valued type of leadership training, with a "series of 'strategic' interactions . . . about specific professional issues rather than longitudinal mentoring." *Looking for targeted mentoring was more likely to be found in established physician leaders. Aspiring physician leaders often look for a single mentor.*

Coaching Interventions Particularly Useful with and for Physicians

The good news is that, just like there are some common troubles in the Republic of Medicine, there are some commonly effective interventions as a coach. My physician coaching practice focuses on the human side of leadership and management – e.g., conflict management, motivating others, team building, understanding and maneuvering through organizational politics, realizing and appreciating value and personality differences, negotiation techniques, and getting and giving feedback. These are all crucial leadership skills that are deeply affected by the traits I've observed above.

In common with other industries, medical organizations are often interested in goal-directed coaching, with measurable milestones along the way to meeting each goal. Goals were included in the Community of Champions, the leadership development and coaching program I envisioned and developed for the Veterans Health Administration. I encouraged participants to partner in organizational goals, justifying the time and money spent by their facilities on the program. In sum, they focused on the question: what is the measurable value you offer to your clients and their organizations? Here are some of the tools that help them achieve that value:

1. Role playing and reflection

Watching leaders in action shows physicians what works, and what doesn't. My clients find role playing and reflection to be a proxy for watching leaders. During role playing, it's easier to be in the moment with their emotions because they are in supportive, nonthreatening situations with a coach. (This returns us to the

previously cited article wherein emotional support was the most valued activity provided by mentors.) Among other things, role playing helps my clients understand how others may respond to and feel about various actions.

Several months ago one of my clients mentioned his new boss seemed eager to be done with their regular appointments, rushing him through with "I know, I know" and looking at his watch. My client looked at me, paused in a moment of obvious self-reflection, and said, "Oh. Now I get it." He was thinking about feedback I had given him during a previous session when I shared my observation that my client always seemed to be in a hurry.

He thought more about his reaction to his new boss. "How's that working for you?" I asked. I could not have asked for a better set up. This interaction was role play for real.

2. Leveraging Data and Facts to Create Logical Context

As I wrote in my previous article, for those of us trained in the scientific method, coaching often starts with data. This could be an internal or external 360 assessment, a self-generated instrument such as the VIA Survey of Character Strengths (free online assessment), Strengths Finder, Hogan or others. Personality inventories, strengths and weakness analyses, values and motivations all may reveal information useful to physicians in moving to leadership roles.

I prefer assessments that highlight strengths. The current literature on leadership development indicates developing one's strengths is a more effective path than spending time and energy in developing weaker areas. I encourage my clients to work with those professionals who complement their strengths, rather than working with those who are similar. It provides another route to reducing the possible impact of their weaknesses and it reduces the homogeneity of perspective that can lead to group think.

My preference is for interview 360 assessments rather than online assessments. I get richer, more nuanced information and interviewing others kickstarts the change

process for my clients. Later, I can check back with the folks I've interviewed to see how my coaching client is doing. I write a straightforward, bulleted report that contains examples of behavior either supportive or critical (if unidentifiable as to source) with interviewees' comments from observing or experiencing the coaching client's actions.

In addition, I recommend my clients tell their colleagues they are being coached, and ask for feedback. There are at least two reasons for this. First, it engages others in the process. Second, coaching in medicine has often been for "problem children," or "disruptive physicians." We've moving to coaching as something for high potentials and for those at the top who would like a trusted advisor.

3. Let Science Do the Talking

Developmental delay and emotional intelligence level are reasons to consider a developmental approach when coaching physicians. A fellow coach suggested I not share adult developmental theory with physicians because "it will depress them."

My experience is the opposite. When my clients learn about adult developmental theory they lean forward and ask for more details

"You mean I can improve?" they often ask, happy and astonished that science tells them there is hope for some of their secret fears. Adult development theory fits in with our medical training in infant and child development. They have changing over time in common.

After one of my clients learned about adult development theory, he said, "I think my 11 year old daughter is farther along than I am." That was the beginning of another level in his leadership development, in his moving from either/or thinking to both/and.

As an executive coach for physicians in leadership roles my job is to offer clarity and hope – to be an Ambassador to (and from) the Republic of Medicine.