Coaching in Health Care:
The Patient-Physician Relationship and
The Role of the Physician Leader

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During the 1990's managed care became the model for healthcare delivery in the US with the goals of delivering healthcare to a greater number of patients at reduced costs. Although the goals were laudable, the increased number of patients receiving healthcare and decreased reimbursement to physicians has resulted in less time per encounter, thereby weakening the patient-physician relationship. In this article, professional coaching skills are presented that show how to regain the quality of the physician-patient relationship, as well as prepare physicians for the new leadership roles required in the changing world of health care.

The Physician-Patient Relationship

The coupling of finance to healthcare delivery in the managed care model was intended to control the costs of healthcare and make healthcare accessible to more people. These objectives have resulted in fundamental changes in the patient-physician relationship. An unintended consequence of this altered relationship is a loss of trust between the patient and their physician, resulting in less successful patient outcomes and greater healthcare expenditures. The challenge is to mitigate this unintended side-effect to the patient-physician relationship. We will show that the successful application of business coaching to physicians will restore patient-physician trust leading to a stronger relationship, more successful patient outcomes and reduced healthcare expenditures.

The ideal patient-physician relationship is based on four tenets. The first is effective and equal communication, in which each party clearly values and understands the other. Second, the physician must display empathy and emotional support for the patient. Third, the physician must view the patient as a "whole" human being and not just a person with a malady. Ideally, the physician knows something about the patient's background that forms the patient's personality. The first three principles form the foundation of the fourth: mutual trust. The physician and patient, by fulfilling the first three tenets, will develop the mutual trust that binds the relationship to ensure its success.[1] [2]

In all fairness, before managed care became the dominant healthcare delivery model in the US, patient-physician relationships were not always ideal. In managed care, the patient-physician relationship was further weakened primarily due to the decrease in time patients and physicians interact. Physicians who participate with managed care spend less time with their patients.[3] Also, physicians offer less explanation to the patient of their health problem and medical care.[4] Poor indicators of effective communication.

This change in their relationship has also resulted in changes to each of the parties, and not for the better. The physicians' pressure to see a greater number of patients have led to an increased stress level.[5] In a survey of 2,700 physicians, Shapiro and associates showed a direct correlation of the percentage of managed care patients in a practice with a physician's stress level. For patients, since medical decision making is related to the length of office visits, the decreased time results in patients having a decreased role in their medical decision process.[6]

The quality of the patient-physician relationship is directly correlated to the success of the outcome of care for the patient. In 1998, Safran and associates evaluated seven defining elements of the primary care physician relationship with their patient. Three of the defining elements are of particular interest, as they are at the core of the patient-physician relationship: physician interpersonal care of the patient, physician knowledge of the patient and patient trust of the physician. In this study of over 6,000 patients, researchers correlated these defining elements to three outcomes of patient care: patient adherence to the primary physician's advice, patient satisfaction and improved health outcomes.[7]

The study showed physician knowledge of the patient and patient trust of the physician strongly correlates with patient adherence to the recommended treatment. In practical terms, the physician who treats the patient as a "whole" person, partnered with the patient who trusts the physician, yields a strong bond that translates into the patient being up to three times more likely to follow the physician's advice.

Patient trust was also a strong factor in satisfaction with the physician. Patients in the 95th percentile level of trust were five times more likely to be completely satisfied with their physician versus patients with a median level of trust. After thoroughness of the physical examination and integration of care, knowledge of the patient, trust and interpersonal care were the defining elements strongly correlated with improved health outcomes. Simply stated, a satisfied patient trusts his or her physician and in turn, is more likely to follow the physician's advice, resulting in a better care outcome for that patient.

Additionally, some well designed studies strongly link healthcare costs to the quality of the patient-physician relationship. Patient-centered communication is a style that rests on the four tenets discussed earlier. Those with a greater measure of patient centered communication had less diagnostic healthcare expenditures, resulting in less total dollar costs of diagnostic testing, ambulatory and hospital care. The corollary was also true: physicians with a lower measure of patient centered communication had greater expenditures.[8] In other words, a strong patient-physician bond means lower diagnostic healthcare costs due to improved communication between the patient and the physician.

Perhaps the best area to illustrate the importance of the physician-provider relationship is in medical liability claims. Here, the physician's communication skills are paramount to whether or not he or she will be sued. In a study of malpractice settlements, awards and costs, 75-85 % were attributed to only 2–8 % of the internists, surgeons and obstetricians.[9] Why are a small minority of practitioners receiving such a large majority of malpractice suits? Numerous studies demonstrate that a physician's lack of communication skills, not involving a patient in his or her healthcare decisions, and lack of interpersonal care of the patient are all characteristics of the

physicians who repeatedly suffer multiple claims.[10] [11] [12] The less satisfied the patient is with the physician's interpersonal care, the more likely the patient is to initiate a suit. In a review of plaintiff's depositions, Beckman and associates showed that 71% of malpractice claims were due to a break down in patient-physician communication.[13] Clearly, physicians who communicate and have an effective rapport with their patients are less likely to be involved in a malpractice suit. Similarly, trust is another patient determinant as to whether or not they will initiate a malpractice suit.

Professional Business Coaching and the Physician

For purposes of this discussion, professional business coaching is a dialogue between a client and a coach, focused on the client, in order to address gaps in performance and improve outcomes. Using active listening, a coach is trained to listen and observe a client, allowing the coach to ask thought provoking questions of the client. These questions help clients "see" a situation or dilemma from a different perspective, a process called reframing. In reframing, not only is the situation viewed from different perspectives, the different emotions associated with each of those perspectives is discerned. Thus, the client's emotional awareness, often called emotional intelligence, is reframed. It is in this process that the coach helps the client elicit solutions and strategies for confronting a situation or problem.

Individual Coaching in Health Care

Due to the recent explosion of coaching in the business community, much has been written about the benefits of coaching. While not specific to physicians, a study commissioned by the International Coach Federation detailing the benefits of business coaching. In this 2009 study performed by Price Waterhouse, a total of 2,200 clients from 64 countries were surveyed. Four benefits were consistently noted to have a direct bearing on the new skill set physicians must master: relationships, communication skills, interpersonal skills, and work performance (figure 1).[14]

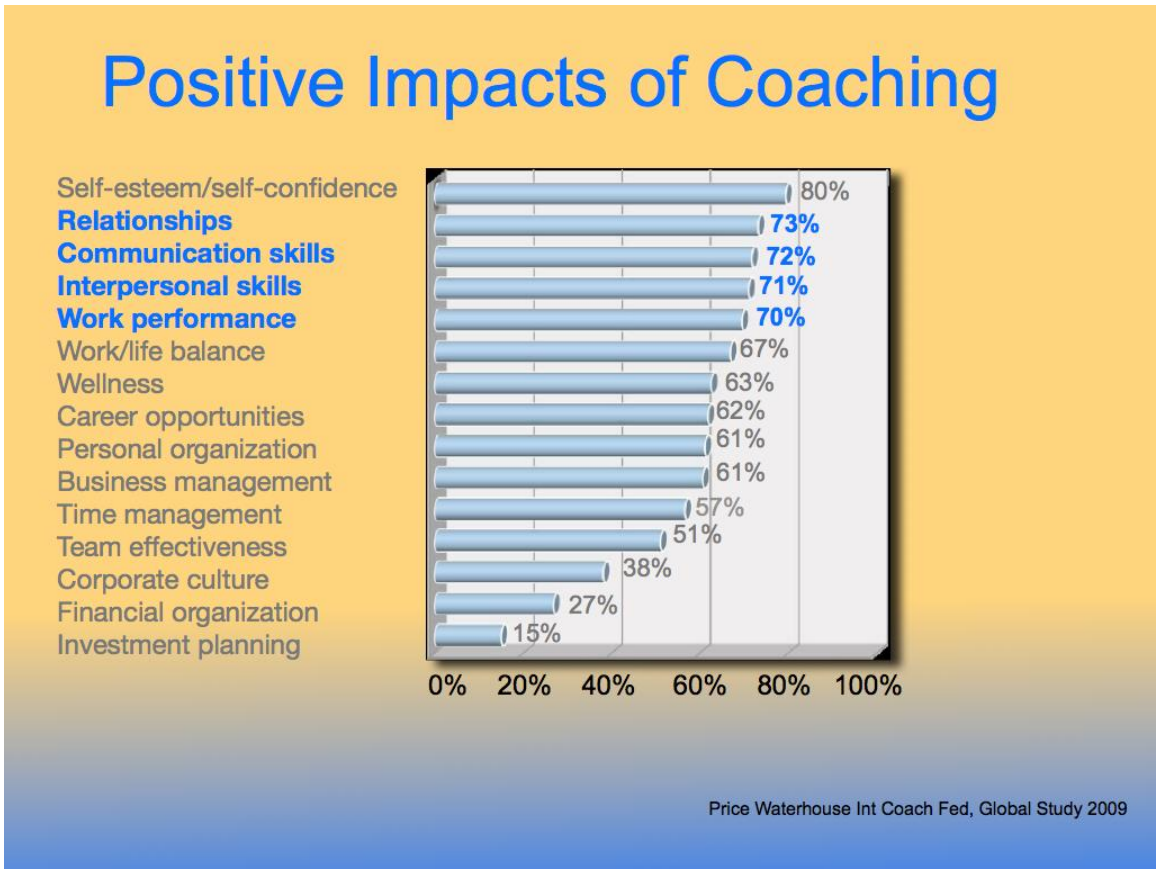

Fig. 1: Positive Impacts of Coaching

This bar graph of the ICF Global Coaching Study illustrates the positive impacts noted by the 2,200 participants. For example, 72% cited improved communication skills as a positive impact of coaching.

With coaching, physicians permit themselves to move from a survival and fear-based mindset to one of self-awareness. The coaching process facilitates physicians' self-awareness as they recreate meaning in their lives and careers that have been shattered by managed care and healthcare reform. They attain the emotional intelligence needed to reexamine and refocus on why they chose a career in healthcare: to connect with and help people. Moreover, as shown in the ICF study, coaching will help physicians improve their communication skill sets—resulting in stronger relationships with their patients and coworkers. Other valuable benefits of stronger physician relationships with patients and coworkers have been persuasively documented (see table 1).[15 16 17] The positive outcomes for society are a decrease in preventable medical injuries and deaths with a reduction in healthcare costs. Society also gains due to improved overall

productivity from a decrease in lost workdays from illness. For physicians, the improved communication skills result in a decrease in medical liability exposure and improved career satisfaction.

Patients	Physicians	Society
Improved Patient Satisfaction	Improved Communication Skills	Decreased Medical Injuries & Deaths
Improved Patient Adherence	Decreased Medical Liability Risk	Decreased Healthcare Costs
Improved Medical Outcomes	Improved Career Satisfaction	Increased Productivity

Table 1: The Benefits of Coaching Physicians

Group and Team Coaching in Healthcare

Coaching a physician can be performed individually, in a group or in a team. Individual coaching is performed one on one between one coach and one physician. Group coaching is performed with a coach and 6 – 8 physicians who share common characteristics, but do not necessarily interact with one another. Team coaching applies to an intact medical unit that functions together cohesively with a purpose. Since the coach is working with more than one person, both group and team coaching are more cost efficient than individual coaching. Team coaching can be applied in any functioning healthcare unit—including healthcare institution, medical offices or hospital emergency rooms. Given that communication errors are a root cause of greater than 50% of preventable medical injuries and deaths,[18] coaching the healthcare team has been shown to decrease these preventable injuries. Development and implementation of Quality Improvement initiatives is also an ideal situation for team coaching. Team coaching will not only greatly accelerate the acceptance of the QI policy with a system-wide cohesive message to the staff, but also more effectively address the resistance of physicians to change.

Developing Physician Leaders as Coaches

Although physicians and hospitals are stakeholder partners in the new landscape of healthcare reform, they operate from significantly different structural bases. Physicians operate as an

independent heterogeneous group that tends not to function in a cohesive integrative manner, whereas hospitals represent business entities that are cohesive. This contrast presents two major challenges to their future relationship. The first challenge, poor communication, stems from the disparate nature of physicians. A poorly organized group is much more prone to miscommunication and poor data exchange than one which is well organized. Effective communication is absolutely necessary to obtain the high levels of successful patient outcomes mandated in a value-based purchasing model that seeks to maximize reimbursement and profits.

The second challenge is the capability of physicians to accept the standardized treatment modalities necessary to have system-wide cost efficiencies in healthcare. Physicians must transition from a group of independent practitioners with many solutions to the same problem, to unified stakeholder partners willing to accept standardizations in healthcare. Consequently, a new communication skill set is required for physicians to be successful in the future. Physicians must not only maintain competent clinical skills. They must now add the competency of working well with benchmark treatment modalities.[19]

The Physician Leadership Development Program

We wish to illustrate the nature of these challenges that physicians confront and the way in which coaching can be of assistance to these physicians by offering a case study. We describe a program that has been created to develop hospital-based physicians into physician leaders. This program was initiated at a large full-service hospital that is part of a $2 billion public and private healthcare system in the Midwest region of the United States. Ten physicians participated in the three month program. They were all members of a larger 21-member hospital physician team. The ten member team (representative of the larger group) consisted of seven hospital physicians, a nurse practitioner, a clinic manager and the hospital's Chief Medical Officer.

The Physician Leadership Development Program (PLDP) was sponsored by the Chief Medical Officer with an external third party contracted to deliver the three phases. Phase I, the Assessment Phase, had two parts. Part one was designed to define the program's objectives by interviewing and coaching the Chief Medical Officer and the Chief of the Hospital Physician Program. There were two defined objectives. The first was to identify and resolve issues

preventing the hospital physicians from working effectively and communicating as a healthcare team, as well as preventing physician-physician integration. The second was to develop hospital physicians as leaders serving as role-models for the entire hospital's medical staff, and to develop a physician-leadership architecture.

The second part of phase I was an individual interview of the ten team member participants. They were asked the following four questions:

1. What does being a physician, nurse practitioner, clinic manager leader mean to you?
2. What qualities must a physician, nurse practitioner, clinic manager leader possess?
3. How does a physician, nurse practitioner, clinic manager leader lead?
4. What are the opportunities and challenges for you as a physician, nurse practitioner or clinic manager leader?

Phase II (the Team Building Phase) occurred over a two day weekend period held outside of the hospital work environment and consisted of four parts. The first part, the kickoff event took place on Friday evening over an informal cocktail hour and dinner to not only introduce the agenda for the weekend program, but also enable the participants to socialize outside the work environment. Frequently, due to the demanding work, healthcare practitioners rarely "know" their fellow workers. Additionally, healthcare teammates rarely meet face-to-face, due to the necessity of working different shifts to provide 24 hour round-the-clock patient care. For these reasons, an initial social event seemed important to the group's members.

The following morning began the second part of Phase II where team building, peer-to-peer collaboration exercises and self-administered personality assessments in teams of two were performed. The concept of physician leadership was introduced at the conclusion of part two just before lunch. Again, it seemed important to allow the team members to get to know each other outside of their work environment, thus the lunch was held in an intimate private restaurant setting to foster conviviality.

Part three began after lunch and focused on applying the collaboration and coaching skills acquired earlier to form an action plan that would address the program's objectives: effective communication of the healthcare team and hospital physicians serving as physician leader role-models for medical staff. Part four began the following morning with a summary of the actions necessary to meet the agreed-upon goals to fulfill the objectives and to assign participants specific tasks.

The month following the weekend retreat consisted of Phase III, known as the Presentation Phase. During this time, participants wrote the healthcare team's documents to meet the program objectives, with coaches facilitating the process only when necessary. At the four week conclusion, the documents were presented to the remainder of the 21 member hospital physician team.

Impact of Physician Leadership Development Program

Two different sets of significant outcomes attest to the return-on-investment of the PLDP on the hospital-based physician program. The first set of outcomes concern actions that were immediately taken. The second set of outcomes concern actions that are still in the process of implementation due to their transformative nature.

The immediate outcomes originated from the action plans developed during the PLDP meeting. The program's objectives were as follows:

> *Objective I: Physician-Physician Integration.* Several problems areas were identified causing a lack of communication and cooperation between the hospital physician team. These problems were resolved with specific written policies generated by the coaching program's participants. Examples of written policies to improve communication between physicians that directly improved patient care are:
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> 1. A Patient Hand-off Policy leading to improved patient continuity of care at daily and weekly shift changes
> 2. A Hospital Physician On-Call Scheduling Process that clearly defined on-call responsibilities leading to full staffing for all shifts

3. A Patient Admission Process ensuring hospital physicians remained in the hospital throughout their entire 12 hour shift

Additional proposals discussed to enhance physician-physician integration dealt with topics such as: improving monthly hospital physician meeting attendance, raising patient satisfaction scores and enhancing new hospital physician orientation and re-orientation program. At the conclusion of this three month coaching program, the participants were writing policy to deal with these additional proposals.

Objective II: Develop Physician Leadership Architecture. As a direct result of the coaching program, a policy was written to build a hospital and community awareness program for the hospital physician team, which served to focus attention on the hospital physician team members. Spotlighting the qualifications and accomplishments of the hospital physicians in the weekly hospital newsletter read by the staff, patients and community is one example of calling attention to their leadership role in the medical center. Additionally, one can reasonably assume the written policies and proposals originating from the coaching program would exhibit the hospital physician team as an exemplary program in the hospital; thus, members of the team became physician leader role-models. Certainly the hospital physicians felt empowered due to the program—as evidenced by comments such as, "I am now proud to be a member of this team." Physicians are quick adaptors at applying leadership skills to serve as an excellent framework to develop physician leaders.

The Transformation Outcomes occurring during Phase III included newly acquired leadership skills, such as providing vision, asking questions about other points of view, and listening for understanding and alignment. Furthermore, the program's participants began to question the fundamentals of the hospital-based physician program itself. Some of the questions asked were:

1. Is the hospital-based physician program equitable to all participants? If not, how can we make it more equitable?
2. Who is the hospital-based physician program serving, us or our patients?
3. How can we make the program more patient-centered?

These questions, along with others shook the foundation of the hospital-based physician program resulting in an entirely new initiative to transform the program so that it might better serve the hospital's patients. At the present time, nine months since the conclusion of the PLDP, the framework of the redesigned hospital-based physician program is almost complete and the implementation process soon will begin.

Conclusions

The steps necessary in the successful transition to stakeholder partners for physicians is, first, physician-physician integration into a cohesive group, followed by physician development to leadership roles. Our case study of a ten member hospital physician leadership development program within a larger hospital-based physician group, illustrates the application of our Physician Leadership Development Program to facilitate both steps in a physician's transition. Two groups of outcomes resulted from this case report. The immediately enacted group of outcomes clearly demonstrates physician-physician integration and the development of a physician-leadership architecture. The second group of outcomes, redesigning the hospital physician program, illustrates the transformative nature of physician leadership.

In this article we have shown the importance of rebuilding the patient-physician relationship which has been detrimentally altered by managed care. We have shown that professional coaching expertise can be utilized in a cost effective manner to improve the patient-physician relationship resulting in more successful patient outcomes with reduced healthcare costs. This expertise can be directed toward the enhancement of leadership skills among physicians, in response to the changing role of the physician in the US healthcare landscape from one of stakeholder to one of stakeholder partner.

Endnotes

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