Session # B6

The Development of the University of Rochester Physician Communication Program and Coaching Academy

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CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Describe how physician communication coaching can enhance patient and family experience of healthcare.
- List the four steps of the coaching process.
- Discuss how coaching affects physician as a person, their self-concept and well-being as a physician, and their ability to improve communication with patients, colleagues, and leadership.

Bibliography / Reference

1. McDaniel, S. H., Morse, D. S., Reis, S., Edwardsen, E. A., Gurnsey, M. G., Taupin, A., ... & Shields, C. G. (2013). Physicians criticizing physicians to patients. *Journal of general internal medicine*, *28*(11), 1405-1409.
2. Palamara, K., Kauffman, C., Stone, V. E., Bazari, H., & Donelan, K. (2015). Promoting success: a professional development coaching program for interns in medicine. *Journal of graduate medical education*, *7*(4), 630-637.
3. Gazelle, G., Liebschutz, J. M., & Riess, H. (2015). Physician burnout: coaching a way out. *Journal of general internal medicine*, *30*(4), 508-513.
4. Deiorio, N. M., Carney, P. A., Kahl, L. E., Bonura, E. M., & Juve, A. M. (2016). Coaching: a new model for academic and career achievement. *Medical education online*, *21*(1), 33480.
5. Kogan, J. R., Hatala, R., Hauer, K. E., & Holmboe, E. (2017). Guidelines: The do's, don'ts and don't knows of direct observation of clinical skills in medical education. *Perspectives on medical education*, *6*(5), 286-305.
6. McDaniel, SH, DeCaporale-Ryan, LN, Fogarty, C. (in prep) COMMUNICATION COACHING FOR PHYSICIANS: Developing a Supportive Culture of Feedback to Sustain and Reinvigorate Clinical Faculty. *Academic Medicine*.
7. McDaniel, S. H., Beckman, H. B., Morse, D. S., Silberman, J., Seaburn, D. B., & Epstein, R. M. (2007). Physician self-disclosure in primary care visits: enough about you, what about me?. *Archives of Internal Medicine*, *167*(12), 1321-1326.
8. Epstein, R. M., Mauksch, L., Carroll, J., & Jaen, C. R. (2008). Have you really addressed your patient's concerns?. *Family practice management*, *15*(3), 35-40.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Overview

- History and growth of coaching program
- What is coaching?
- Coaching variations
- Common coaching challenges
- Coaching feedback
- Q&A

Growth and history

2011-2012: Dr. McDaniel developed program help physician communication and enhance patient and family experience of care

- Related to emerging relevance of HCAHPS scores
- Early coaches were colleagues with experience in medical education and psychotherapy

Susan McDaniel, PhD, ABPP

Colleen Fogarty, MD, MSc

Tziporah Rosenberg, PhD, LMFT

David Seaburn, PhD

William Watson, PhD

Growth and history

2013: Dr. McDaniel coached Ray Mayewski, MD (former George Engel fellow) Senior Associate Dean for Clinical Affairs

- Became mandated for all Chairs of Clinical Departments and many Division Chiefs
- Expanded coaching into Surgery (residents)

Lauren DeCaporale-Ryan, PhD

Growth and history

Andrea Garroway, PhD

2014-present: coaching program available for physicians who want coaching for:

- Their own learning
- Malpractice reduction
- Chair/Chief identified physician to have coaching
- Interpersonal problems with staff/patients

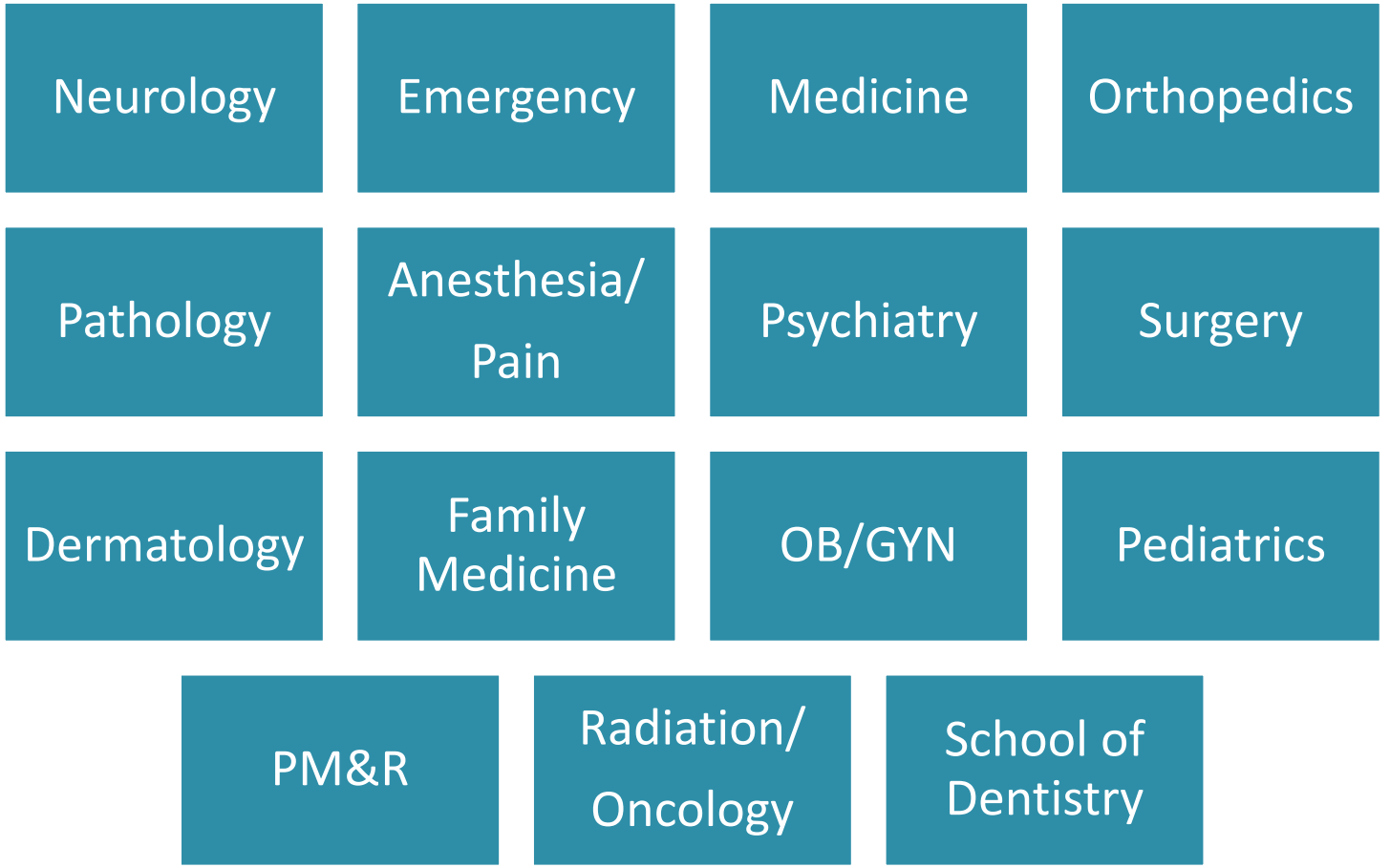
2017: Dr. Garroway hired by Department of Medicine for resident and physician communication coaching

Currently Dr. McDaniel and Dr. DeCaporaleRyan training postdocs to expand coaching program for residents throughout university

- Increased requests from GME for coaching for residents 2016

Numbers and Scope

240 faculty physicians, 34 resident physicians



What is a coach?

"The concept of a coach is slippery. Coaches are not teachers, but they teach. They're not your boss—in professional tennis, golf, and skating, the athlete hires and fires the coach—but they can be bossy…Mainly, they observe, they judge, and they guide."
– Atul Gawande, MD, surgeon and public health researcher

*Often expands quickly into non-clinical situations

What is clinical communication coaching?

Direct observation of clinical and/or interpersonal encounters with patients, families, and work colleagues

Feedback provided that integrates observations, specialty culture, career development, and personal goals

Coaching process

1. Coach and physician communicate to arrange observation time, discuss process, and elicit goals (or facilitated by administrative assistants)
2. Coach observes physician during 4-hour block of clinical time to record physician behaviors and physician/patient/family comments during interaction*
3. Quantitative and qualitative data compiled into written report
4. Hour-long feedback session with coach and physician

*Cambridge-Calgary Patient-Centered Observational Checklist and items from Dr. McDaniel's research

Checklist sample

2. Gather Information

Discover the patient's and family's perspectives ____

Elicit patient concern & view of problem ____

Elicit any family member's view of problem ____

Set agenda early ____

Use open ended questions appropriately ____

Accept the patient and family's views non- judgmentally ____

Speak about other team members/professionals respectfully ____

Sample feedback

“You always elicited the patient’s understanding of the problem, usually by starting with some version of “Tell me what you know” or “Tell me what your last doctor told you about the problem.” This is very important. Many physicians are very good at describing the results of tests in simple language, but they may not ask about what the patient knows or understands about the illness.”

“Consider adding a question such as “Do you have any other concerns?” to surface concerns that may not fit into the category of what they know about the illness or treatment. Sometimes patients and family members have concerns, such as whether they’ll be able to attend a relative’s wedding or hold their new grandson after surgery. Without early prompting, these may come up at an inconvenient time, such as the end of the session when you thought you were finished, or after the fact with a nurse who then must contact you for the answer.”

Sample feedback (cont.)

"Asking patients at least one non-medical question demonstrates an interest in them as people and is another marker of caring they appreciate. These questions also can be informative in providing the psychosocial context of the patient and their illness. You did this with 3 of 4 patients, asking your first patient what she did for work. She said, "business." Ideally you would follow up this somewhat vague answer by asking, "what kind of business?" This shows you were truly interested (it wasn't a perfunctory question), but also tells you if it was anything that could affect her lung functioning."

Sample feedback (cont.)

"Sometimes it is the patient who complains about other health professionals, or the "system" in general. You had a really challenging patient in this regard…Your 2nd patient gave many opportunities to respond to insulting language in the way he described other medical providers. In general, this patient seemed to be pulling for you to agree with him, joining with him as a man, or at least be entertained by his stories and descriptions. It's tough to know how to respond to these put-downs in the moment. I am guessing your chuckling/smiling with him was out of not knowing what to do to stay aligned with the patient and keep the rapport, and yet educate him about what is right and true…

In the end, you seemed to find your footing in your response about Dr. ____. It was terrific; you said: "She's young, she's a really good doctor and she taught me…in all seriousness she's a *great* doctor." This is exactly what you want to do—talk about people's competence, independent of their sex/color/religion, to counter racist or sexist statements. These are some of the most difficult interpersonal communications you'll deal with, but also some of the most important to counter the offensive remarks while staying connected to the patient (i.e., rejecting the behavior not the person)."

ICU

Skills associated with patient satisfaction and quality (McDaniel, DeCaporale-Ryan, & Fogarty, in preparation)

I: **I**ntroduce yourself

C: Ask about patient's and family's **C**oncerns

U: Check for **U**nderstanding

Coaching variations

- Environment
  - Inpatient/hospital rounds
  - Outpatient clinics
  - Surgery
- Personalized goals identified prior to coaching (somewhat rare)
- What's in it for the coach?

Common coaching challenges

Faculty physicians:

- Coaching because of complaints/interpersonal problems
- Range of openness to feedback from seasoned clinicians
- Referral source (e.g., department chair refers entire department vs. problematic behavior vs. self-referred)

Residents

- Coaching as formative or evaluative
- Working in a culture of ‘evaluation fatigue’
- Dual role/relationships

Coaching results

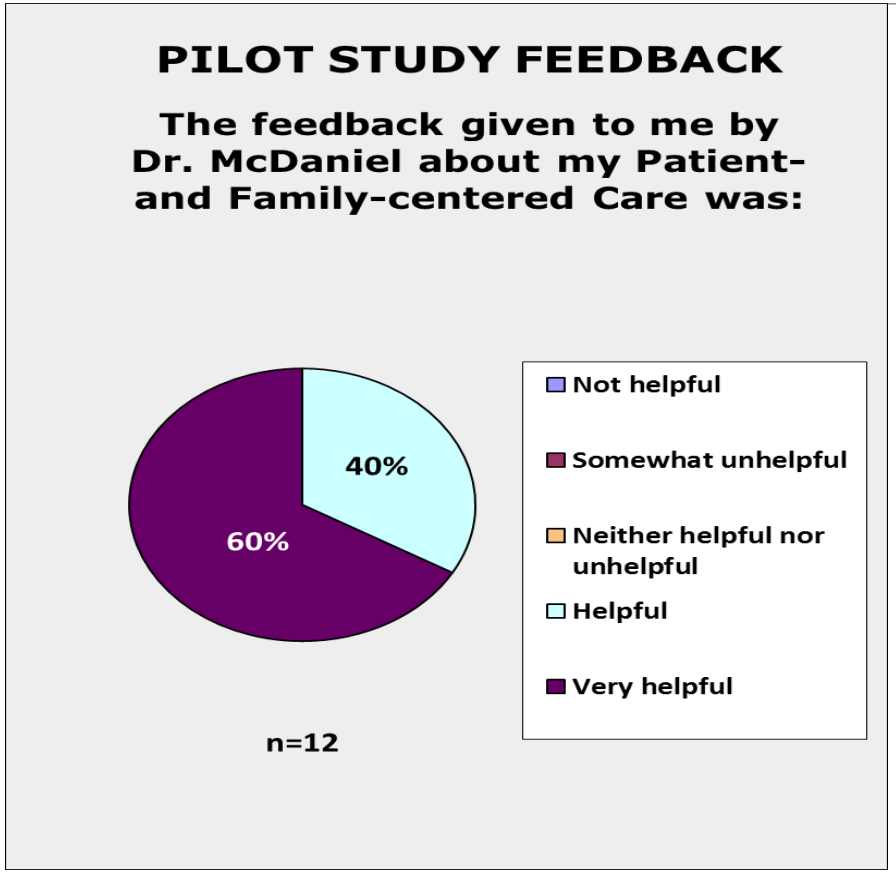
Other outcomes:

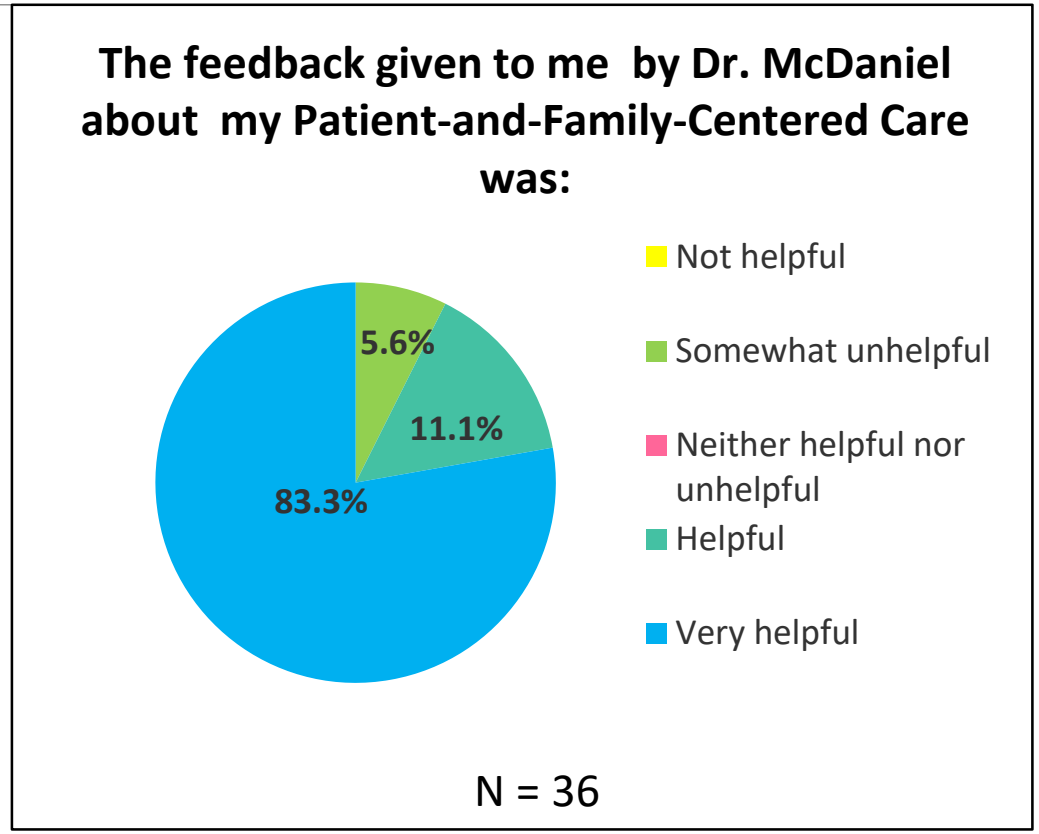
- EAP/BHP referral
- Coaching round 2
- Program development

Future directions

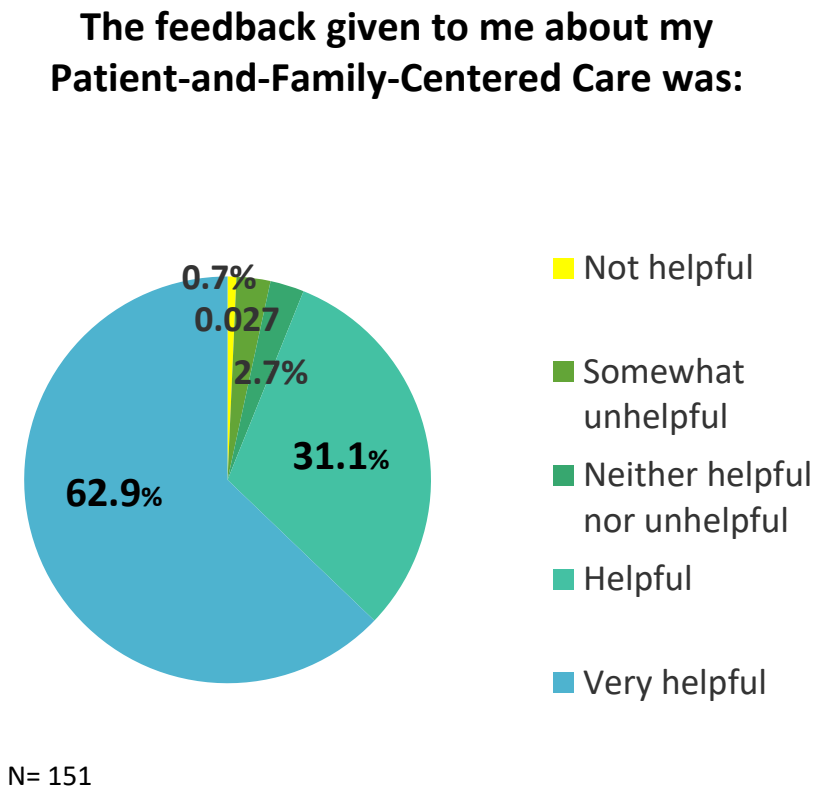
- Bringing general feedback to chairs to address larger systemic issues
- Scaling up the coaching
- Who is the target?
- Who can be a coach?

Coaching results





Coaching results



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She made me realize that I did a lot of teaching, but did not always elicit patients' concerns.

She showed me all the things I was doing correctly and pinpointed some areas that could be tweaked in the future. I think every provider in our department should meet with her.

…I believe this type of experience is valuable since habits (good or bad) creep into communication…Very professional and insightful. I would like to do this again…

Her comments were very objective and specific.

Very helpful indeed, even though it was truthful!

Q&A

"Élite performers, researchers say, must engage in "deliberate practice"—sustained, mindful efforts to develop the full range of abilities that success requires. You have to work at what you're not good at. In theory, people can do this themselves. But most people do not know where to start or how to proceed. **Expertise, as the formula goes, requires going from unconscious incompetence to conscious incompetence to conscious competence and finally to unconscious competence.** The coach provides the outside eyes and ears, and makes you aware of where you're falling short. This is tricky. Human beings resist exposure and critique; our brains are well defended. So coaches use a variety of approaches—showing what other, respected colleagues do, for instance, or reviewing videos of the subject's performance. The most common, however, is just conversation."

- Atul Gawande, MD, surgeon and public health researcher