Impact of intensive peer coaching on physician performance

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Naim El-Aswad

Chief Medical Officer and Founder, VSVS, USA

Naim El-Aswad, MD, is a fellow of the American College of Physicians. He has been an internist and emergency room physician for over 20 years. He is the founder and Chief Medical Officer of Vital Signs Vital Skills (VSVS), a coaching and consulting company that specialises in executive, life and wellness coaching. Dr El-Aswad is a national and international speaker, researcher and educator on physician, nursing and healthcare provider and healthcare executive burnout. He is an expert in the field focusing on the use of disease, as well as several online and paper publications on burnout among healthcare emotional intelligence, self-leadership, coaching and self-care in combating burnout. He has co-authored the book *Physician Burnout: An Emotionally Malignant Disease*. Dr El-Aswad has conducted workshops, live and online training modules and one-on-one interventions targeting physician and nurse's burnout, healthcare provider leadership and executive leadership in the healthcare industry. He is currently an adjunct faculty at the University of Houston, providing CME education to physicians and executive leaders on burnout. He is also the co-founder of the VSVS International Coach Federation-accredited ACC-level coaching school for physician performance, which follows the ACSTH pathway. Dr El-Aswad has worked with several clients, including HCA, The Sullivan Group, McGill University, Harris County Medical Society (HCMS), Professional Development Academy (PDA), Methodist Healthcare systems, Memorial Healthcare System, EMCARE and Envision.

Tel: +1-936-662-9068; E-mail: naimmd@hotmail.com

Zeina Ghossoub

Founder and CEO of VieSaine; Chief Wellness Officer VSVS, USA

Zeina Ghossoub, PhD, is a doctor in Human Behaviour and Counselling, a clinical dietitian and a wellness, executive and leadership coach. She is the founder and CEO of VieSaine, a wellness, leadership and coaching centre in Beirut, Lebanon. Zeina is also the Chief Wellness Officer of her coaching and consulting company, Vital Signs Vital Skills (VSVS), located in Spring, Texas. She is the creator of two coaching programmes and schools that focus on physician performance, on the one hand, and individual life and wellness coaching, on the other. Dr Ghossoub is one of the founders and the first president of the ICF Chapter Lebanon. She is also the President of the Executive Women, an international platform for women entrepreneurs and leaders. Her work has earned her the Middle East Woman Leader's Award from the World Women Leadership. Dr Ghossoub El-Aswad has lectured on the national and international stage in her areas of expertise. She has taught at the American University of Beirut, Drexel University, Notre Dame University Lebanon, Cooper Smith Career Counseling College, American University of Lebanon, Lebanese American University and the College of Executive Coaching since 1995. She founded a non-profit organisation (Ghalletna) in 2010 that feeds and clothes families and individuals. A co-author of multiple best-selling books, her professional work is well published and is recognised by the American Medical Association, the Harvard Institute of Coaching, Mayo Clinic, McGill University, Stanford and others.

Tel: +1-936-662-4314; E-mail: zeinag@viesaine.org

Relly Nadler

Co-founder and Chief Coaching Officer VSVS; President and CEO, True North Leadership, USA.

Relly Nadler, Psy.D, educated as a clinical psychologist, has become a world-class executive coach, corporate trainer and author. He is a co-founder and Chief Coaching Officer of Vital Signs Vital Skills (VSVS), a coaching and consulting company that specialises in executive, team and wellness coaching. He is also the president and CEO, True North Leadership, Inc., an executive and organisational development firm. Dr Nadler is a sought-after speaker and consultant on leadership, emotional intelligence, team building, executive coaching and physician burnout. He brings his expertise in

emotional intelligence leadership to all his keynotes, consulting, coaching and training. He has worked with over 225 companies, designing and delivering leadership development programmes enhancing the skills of over 15,000 leaders and managers. Clients have included Anthem, Vanguard Health, McGill University and Methodist Hospital System. A licensed psychologist and master executive coach (MCC), Dr Nadler is the author of seven best-selling leadership and team performance books, eight book chapters and many papers. He is a co-author with Dr El-Aswad and Dr Ghossoub El-Aswad of the book *Physician Burnout: An Emotionally Malignant Disease*. Dr Nadler also has a popular blog on Psychology Today, called Leading with Emotional Intelligence, and a Podcast Leadership Development News with Voice America. He has a free iPhone app, called Leadership Keys, with videos, that guides leaders through ten foundational leadership and management skills. Dr Nadler is a senior faculty member of the College of Executive Coaching, a postgraduate institute, training over 1,500 professionals in executive coaching, since 2001.

Tel: +1-805-455-1722; E-mail: rnadler@truenorthleadership.com

Kevin M. Olsen

Director of Analytics, Envision Physician Services, USA

Kevin M. Olsen is the Director of Analytics for Envision Physician Services, a large multi-speciality medical group with more than 25,000 providers offering anaesthesiology, emergency medicine, hospital medicine, radiology, surgical services and women's and children's health services. His current role encompasses clinical solution decision support through the Office of the Chief Medical Officer, where he heads the launch of quality reporting architecture for large clients and joint ventures. Previous roles with Envision include Manager Clinical Data; Process, Controls and Database Manager; and Senior Financial Analyst. Kevin has more than 20 years of experience in healthcare, quality, education, performance improvement and project management. He has worked for large corporations such as Quintiles, Novartis, Wyeth-Ayerst and PricewaterhouseCoopers. Kevin is a graduate of the University of Florida and a lifelong learner. He has been involved with external organisations that include Auburn University, Perimeter College, U.S. Department of Energy - Princeton Plasma Physics Lab, Thomas Jefferson University, The Advisory Board, American Heart Association, American Association of Physicians of Indian Origin and the University of Miami.

5380 Tech Data Dr, Clearwater, FL 33760, USA
Tel: +1-727-507-3636; E-mail: Kevin.olsen@envisionhealth.com

Sara Sigler

Senior Manager of Clinical Research, Envision Physician Services, USA

Sara Sigler, PhD, joined Envision Healthcare in 2019, where she currently oversees the Envision Healthcare Research Institute. The Envision Healthcare Research Institute is a nationwide clinical research institution at the forefront of building the future of healthcare. Through Dr Sigler's leadership, the Envision Healthcare Research Institute empowers clinicians to solve healthcare's most urgent challenges and ensure that patients continue to receive the highest quality of care. Dr Sigler earned her Bachelor of Science in Biology from the University of Mississippi and her doctorate in Basic Medical Sciences with a focus on Cancer Biology and Drug Discovery from the University of South Alabama, College of Medicine. She completed an oncology postdoctoral fellowship at the USA Mitchell Cancer Institute before moving to the biotechnology industry, where she helped develop novel drug conjugates. Dr Sigler currently focuses her research efforts on improving patient care, physician well-being and healthcare outcomes. She is involved in a multitude of clinical research studies across numerous services lines. Her personal areas of interest include physician well-being, healthcare solution for underserved populations, development of non-addictive pain therapeutics and improving cancer screening and early detection.

1525 West Cypress Creek Road, Fort Lauderdale, FL 33309, USA
Tel: +1-954-939-7715; E-mail: Sara.sigler@envisionhealth.com

Stef Simmons
VP Clinician Engagement, Envision Physician Services, USA

Stefanie Simmons, MD, is a board-certified emergency medicine physician with over 15 years of clinical practice. She focuses on the research, development and implementation of programmes designed to strengthen the relational skills of clinicians, enhance professional well-being among clinicians and engage teams in the practice of medicine. Dr Simmons developed and implemented two unique clinician coaching programmes, one that encourages real-time reflection on performance by practising clinicians and another that intensively supports struggling clinicians during difficult career periods. These programmes were successfully implemented over a national, multi-speciality clinician group. She is an experienced educator, speaker and facilitator who effectively communicates to clinical, leadership and business audiences and is a thought leader regarding clinician professional well-being, patient-clinician communication and clinical leadership. Her graduate and postgraduate medical training were completed at the University of Michigan, where she served as clinical faculty for over a decade. Currently, Dr Simmons serves as the Vice President for Clinician Engagement with Envision Physician Services, a national medical group of over 25,000 clinicians. In addition to relational excellence, Dr Simmons leads the work on professional well-being, including peer support programmes during litigation and adverse events, extensive clinician support during the COVID-19 pandemic, and implementation and measurement of professional well-being initiatives. She serves as core faculty for the Clinician Experience Project through Practicing Excellence, developing professional well-being content for clinicians, and is a board member of the Dr. Lorna Breen Heroes' Foundation, dedicated to protecting the mental health of those on the front line of healthcare.

Envision Physician Services, 2000 Green Road, Suite 300, Ann Arbor, MI 48105, USA
Tel: +1-734-945-4160 E-mail: stefanie.simmons@envisionhealth.com

Abstract Physician performance in patient experience varies broadly. Physicians who are otherwise excellent clinicians may have lower than average patient experience scores and more frequent patient complaints. This raises the question, how do we assist physicians in improving their skills to provide a better patient experience? To address this problem, a team of physician peer coaches were matched with clinicians who were underperforming to local standards as measured by individual patient experience scores or by number and type of patient complaints. The peer coaches worked with their colleagues for six months, meeting on average every other week to review motivation, skills and performance barriers. Clinicians who were paired with trained peer coaches showed significant, sustained improvement in performance as measured by patient experience scores of the coached cohort. Clinician retention also outperformed manager estimates, and clinicians were highly satisfied with the process. It was concluded that physician performance can be positively impacted through peer coaching in a process that is satisfying to the client, improves estimated retention and reduces turnover costs. Peer coaching benefits patients, clinicians and hospitals by improving the experience of both patients and clinicians and supporting a stable clinician group. Coaching programmes are reproducible and measurable and produce short- and long-term results. Emergent themes recognised by coaches included not only skill development but also professional well-being and personal renewal activities. As clinicians face increased challenges to professional well-being personal and employer-based coaching programmes are one way to mitigate the risk to patients and clinicians.

KEYWORDS: patient experience, coaching, performance, well-being, retention, engagement

INTRODUCTION

Patient experience is impacted by many factors: the flow of patient care, the surroundings, the expectation of the patient and, importantly, the communication and connection between the clinical team and the patient.[1–3] In 2018, a large US national medical group decided to pair their clinicians who were struggling with their communication, as measured by patient experience surveys, with a peer coach. The theory was that an intensive observation and feedback intervention, augmented by coaching discussions, would improve their performance. A small group of peer coaches had initial training in observation and feedback as well as the basics of motivational coaching. A process of referral, assignment and regular communication between the clinician and the coach was developed. The coaches noted several themes contributing to the performance gaps of their clients that included a mismatch between the training and practice environment; an incompletely developed skill set with respect to leadership and communication; and personal and professional fatigue with symptoms of burnout.

The coaches, who were physicians chosen for their interpersonal skills and outstanding patient experience performance, were able to provide feedback on the skill set needed and, to a certain extent, the regional and site variation in patient expectations. Through the process of discovery, the coaches found that the clients needed guidance and training not only in these skills but also in some of the factors contributing to the poor performance, including well-being and connection to mission. When it came to personal and professional well-being, the coaches needed additional training to be able to intervene.

According to the World Health Organization (WHO), burnout is a '[s]yndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. There are three dimensions of burnout: Feelings of energy depletion; Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; Reduced professional efficacy'.[4] Unlike other mental health diagnoses, burnout is mostly an occupational phenomenon and, as such, is closely linked to the work environment, autonomy and efficacy of the employee.[5] The effects of burnout on the personal and professional lives of physicians are very well documented. Burnout can lead to increased judgment towards patients, decreased clinical skills and abilities, hostility and difficult relationships with patients and staff, adverse outcomes for patients, physical illness for clinicians and disengagement with work.[6] The challenge of the healthcare community has been not only to accept the presence of this burnout pandemic but also to develop an approach that both prevents and mitigates its effects. Because professional well-being occurs within functional systems, interventions are necessary at each system's level. In addition to addressing societal, institutional and team factors, individual skills and resilience can be impactful.[7] Clinician coaching clients in this study were not formally assessed for professional well-being, but aspects of energy depletion, mental distancing and cynicism were both observed by the referring clinician managers and peer coaches and also identified by the physician clients. Coaching has been shown to help physicians on an individual level address their professional well-being and its antecedents.[8–10]

According to the International Coach Federation (ICF) (2014), a coach is responsible to help the client '[d]iscover, clarify, and align with what the client wants to achieve, encourage client self-discovery, elicit collaborative and client-generated solutions and strategies, and hold the client responsible and accountable'. The ICF defines coaching as 'partnering with clients in a thought-provoking and creative process that inspires them to maximise their personal and professional potential. The process of

coaching often unlocks previously untapped sources of imagination, productivity, and leadership'.[11]

The beneficial effects of coaching have long been seen in the business world. Coaching has been used in the wellness world as well. Health coaching can improve and have a positive impact on chronic disease interventions.[12] Life coaching improves self-efficacy and self-empowerment.[13] Health coaching is essential for changes in health-related behaviour.[14] Further, remote coaching using either telephone coaching[15,16] or internet-based coaching[17] and use of other mobile technologies[18] is a cost-effective, efficient and productive way of enhancing physical activity and diet and maximising multiple health behaviour changes usually comparable to in-person formats. Coaching is also being advocated for teaching medical students and in medical curricula.[19]

COACHING IMPLEMENTATION AND DATA COLLECTION

Fourteen physician coaches underwent a 40-hour coaching training programme over six months that included patient experience training with a clinician experience lens, cultural sensitivity training and grounding in observational coaching. An outside vendor assisted with the coaching programme and added content on a thorough and detailed understanding of burnout, its causes and its internal and external manifestations. This was followed by targeted and focused coaching modalities that centred on physician performance and navigating burnout. These modalities included the sciences of emotional intelligence, strategies for resilience, approaches to self-care and well-being, nuances of self-leadership and the leadership of others and the introduction and establishment of coaching to deliver these services to clients.

The training programme was divided into two formats: live-in person training that was conducted over two separate sessions and online web-based training. Each live session was two days long. During those two days, the coaches in training underwent didactic as well as interactive format training. Emphasis was placed on the theoretical approaches as well as the practical applications. Experiential team building was included in the training to build camaraderie. These two live sessions were conducted six months apart. In between, the group met once a month through a web-based software for 2 hours and discussed theoretical and practical applications of the programme. The participants had to complete assessment and evaluation forms that ensured their knowledge and ability to apply their training. Once training was completed, the participants started receiving referrals from local and regional medical directors.

The physician peer coaching programme was developed to support clinicians who were at risk of termination owing to patient experience performance or communication skills as assessed by local and regional managers. Referrals to the programme were made on a gestalt basis that included individual patient experience scores as well as patient and team comments and complaints. At referral, managers were asked to estimate the chance that the clinician would be terminated owing to communication task performance without coaching. Estimates ranged from 0 to 100 per cent but averaged 51 per cent. In the study period lasting from (January 2019 to October 2020), 90 clinicians were referred for peer coaching. Each coaching relationship lasted for six months with coach-client dyads meeting on average twice a month for one hour. On completion, the coached clinician was asked to fill out a satisfaction survey. Retention was measured six months after the coaching relationship was complete. Patient experience data was retrospectively collected for six months pre-coaching, six months during coaching and six months after coaching (a total of 18 months of data).

METHODS

A retrospective evaluation was done on a cohort of ten physicians for whom there was sufficient patient experience survey data available (Press Ganey (5,325 responses)). The evaluation looked at three distinct phases: six months prior to coaching initiation, six months during coaching period and six months after coaching completion. The overall performance of the patient experience survey 'Doctor domain' top box was as follows: 57.68 per cent, 62.80 per cent and 68.31 per cent for the respective periods. These results correspond to approximately the 8th, 18th and 39th percentiles using benchmark data for the United States during the study dates.

The location effect on Press Ganey scores has been well documented in the literature.[20–22] To eliminate the location effect, the analysis used only data based on the same provider at the same facility during all the measurement periods. Other variables such as patient demographics were uncontrolled. A reference data set of 500 providers from the same health system was grouped into 50 cohorts to see if a statistically significant improvement had occurred within the coached cohort group. Excel was used to perform statistical analysis. p-values were calculated using a two-tailed Z-test after confirming that data conformed to a normal distribution. Physicians referred to the coaching programme received an internally generated satisfaction survey after the six-month programme was complete. Satisfaction was measured on a 5-point Likert scale.

On referring a clinician to the programme, leaders were asked to estimate the chance of clinician termination without coaching. At the end of the study period, actual terminations were measured. Excess retentions were calculated by taking the difference between expected and actual terminations.

OUTCOMES

Three outcomes were noted: clinician performance, clinician satisfaction and clinician retention.

The long-term clinician performance, as measured by patient experience survey after coaching completion, had a statistically significant improvement of 10.6 per cent ($p=0.0023$) when compared with the performance from six months prior to the initiation of the coaching programme. The immediate performance gain during the coaching period versus the prior six months was not statistically significant at 5.1 per cent ($p=0.165$).

Physicians referred to the coaching programme received a satisfaction survey after the six-month programme was complete. The survey had a 21 per cent return rate. Of the coached physicians who returned their survey, 73.7 per cent were 'very satisfied' and an additional 21 per cent were 'satisfied'. Only one respondent (5.2 per cent) was 'neutral', and none were dissatisfied. Nearly 80 per cent were ready to recommend the programme to a colleague.

In the 90-clinician cohort, based on initial leader estimates, 46 terminations were projected. Actual experience showed 9 terminations, or an excess retention of 37 clinicians. In the United States, it is estimated to cost on average US$400,000 to recruit a new clinician.[23–25] By preventing 37 turnovers, US$14.8m in additional costs were saved.

DISCUSSION

This programme is unique in its integration of coaching, peer support and feedback techniques. The aim of the programme is to help develop physician coaches that can not only connect with their fellow physicians but also be well versed in providing feedback and helping them develop solutions in a coaching approach. This programme was piloted with the hope

of providing a humanistic and financial return on investment by improving experience for patients, helping clinicians at a difficult stage in their careers retain their jobs, and providing a stable clinician team for hospitals and employers. By significantly outperforming leader estimates of turnover (9 clinicians versus a projected 46), it was shown that there were both a humanistic benefit of retaining clinicians in their practice of choice and a financial benefit of preventing turnover costs, including recruitment, onboarding and per diem pay during employment gaps.[26] The estimated cost savings do not consider the added benefits of retaining the physicians, stabilising their work environment with less turnover and potentially having a positive impact on physician performance that could theoretically lead to less clinical errors, decreased risk of liability and lawsuits and overall improvement in efficient clinical outcomes. Although direct patient health outcomes were not measured as part of this study, improvements in patient experience scores for the coached cohort showed a benefit to patients through improvement in their perception of care. The coached clinicians were also satisfied with the process. This is notable since initial participation in the programme was dictated by the clinician's leader and was not self-sought.

This evaluation was designed as a quality improvement project and, as such, has some limitations. Firstly, adequate patient experience data for all participants could not be collected, so only a subset of the total coached cohort is represented in the patient experience findings. Leader estimation of retention at the time of referral is a fully subjective measurement meant to assess a gestalt that includes performance, local climate, staffing needs and additional factors. The measure was determined at the beginning of the programme and was applied consistently throughout the study period. The 21 per cent survey return from coaching participants was low. The surveys were not anonymous and were only sent once.

When physicians are faced with burnout, they are asked to 'adapt' and thrive in their demanding environment. Physicians often face demands and expectations to change, focusing mostly on their clinical performance, interaction with patients, staff members and other colleagues. Clinicians are also expected to comply with institutional and national metrics. Often, the referred physicians had problems with all these issues: communication, patient experience metrics and patient complaints. These physicians were referred to the developed programme to help them change and conform to the required standards and metrics. Because change is what is expected, the coaching approach was used. Coaching has been shown to be an effective approach to help clients create sustainable change. By tying change to intrinsic motivation, coaching has emerged as an effective feedback, teaching, training and development tool.[27–30] With respect to peer support and feedback, the benefits of such programmes have also been well documented with their positive impact on burnout.[31,32]

According to Lawson, there are four pillars of health coaching: mindful presence, self-awareness, being in a safe and sacred place and authentic communication. 'We must promote health coaching's practice and its principles as both an example and a force for change within a system of healthcare that is struggling to create greater accessibility, effectiveness, and sustainability.'[33] Where Lawson was discussing disease and patients, these principles also apply to the physicians and their wellness with regard to burnout. To ensure that the pillars of health coaching are satisfied, the coaching programme was designed using emotional intelligence, self-care and wellness, self-leadership and resilience training.

The relationship between emotional intelligence and burnout is such that

people high in emotional intelligence, people coached in emotional intelligence and physicians who practise emotional intelligence are less burned out and can cope with the change needed in their environments.[34–36] Self-care and wellness interventions using cognitive behavioural therapy and mindfulness techniques have been shown to assist physicians in attaining wellness and promoting behavioural changes.[37] Professional coaching is a successful approach to promoting physician wellness and is recommended as a viable intervention method for burnout.[38] Measures that promote resilience through connectedness and meaning at work are also solutions to combating burnout.[39] In a landmark publication by the *New England Journal of Medicine*, reviewers shared the importance of coaching and its impact on physician wellness and burnout through resilience training and stress management.[40]

CONCLUSION

Peer coaching improves physician performance in patient experience, is favourably received by clinicians and improves clinician retention. Improved patient experience has intrinsic reward through addressing the mission of medical care. Patient experience can also impact market share in choice-driven markets, and in the United States performance is directly financially incentivised through the government. One of the concerns early in the roll-out of the programme was that clinicians would be reticent to participate and that participation would be an additional burden on clinicians already experiencing burnout. The high degree of favourability that participants report as well as the protective nature of their increased job retention shows benefit accruing directly to clinicians who participated. Clinician retention increased dramatically, reducing turnover costs to the organisation, promoting a stable clinician group and minimising disruptions in individual clinician lives. The impact of this programme, therefore, is that it benefits patients, clinicians and organisations. Hippocrates said: 'Declare the past, diagnose the present, foretell the future'. The literature has succeeded in the first two. There is yet to be consensus on what the future looks like, but given the results of this programme, it appears that coaching and peer observation are not just viable options but perhaps necessary ones that need to be incorporated at all levels of education and professional practice. It is no longer a question of what the future will hold but more a question of how it will hold these interventions. These approaches work. It is high time that we found the solutions and paths to implement them in physicians' personal and professional lives.

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