

# COACHING: A USEFUL APPROACH TO DISRUPTIVE BEHAVIOR

■ Keith Marton, MD, and Karl Pister

### In this article...

*Using a formal assessment process, regular coaching sessions and — in some cases — periodic feedback from colleagues, a success rate of 78 percent was achieved in mitigating disruptive incidents.*

### PHYSICIAN LEADERS ARE CHALLENGED WITH

leading highly capable individuals who are used to success and independence. Success within the field is generally defined by individual expertise and not that of a collective enterprise.

Although that philosophy might be changing through a slow culture shift, it would be safe to say that, by training alone, physicians are encouraged to take individual responsibility for their education and accomplishments and do not rely on others for their successes. That approach has led to amazing medical achievements and outcomes, but it can lead to opposite results when working in today's medical environment. Disruptive behavior can be seen as an extreme example of some physicians' lack of training on how to work with others.

Steps to prevent disruptive behavior have been well-worked out and described,<sup>1-3</sup> although we are unaware of data that describe the effectiveness of these measures. Nonetheless, it makes sense that hospitals and other health care organizations have developed:

- A working definition of disruptive behavior.
- A professional code of conduct.
- A process for identifying disruptive behavior.
- A policy and procedure for addressing disruptive behavior.

Moreover, the literature is rife with descriptions of the quality and safety risks inherent in allowing disruptive behavior.<sup>4-6</sup> These risks, plus the regulatory and legal environment, have led to the development of a large number of treatment programs for addressing disruptive behavior.<sup>7</sup> Although these programs offer a variety of approaches to ameliorating disruptive behavior, they only occasionally, and in passing, mention coaching as a tool.

**CONFLICT AVERSE** — Unfortunately, it has been our experience that many medical communities often are conflict averse when it comes to addressing concerns regarding behavioral disruptions when they do occur. It is only when behavior reaches an egregious level that help is sought. Such behavior is often, at that point, too far gone to be able to remediate.

Often, the result is termination of staff privileges and probable reporting to the National Practitioner Databank. The individual might be willing, but the worksite is not willing to accommodate the possibility of improvement. Even when help is sought, it often takes the form of coursework or short-term counseling. Again, we are unaware of much data supporting these kinds of interventions.

Instead, early intervention with behavioral situations, as with good medical treatment, has the potential to produce much more favorable results.

It's important to remember that we're talking about behaviors, such as profane or disrespectful language, insulting others, throwing objects, bullying others, use of insidious

intimidation or inappropriate sexual comments. These behaviors, typically exhibited by a small proportion of physicians or other clinicians, are nonetheless common enough that almost all physician leaders have had to deal with them.<sup>8</sup>

There are those physicians whose behavior is based on mental health issues, such as drug or alcohol abuse or depression. Those are not candidates for coaching. Coaching is for healthy individuals who need direction and education regarding what industry has labeled “soft skills” or emotional intelligence. Although it may seem to be common sense, it is, as the American humorist Will Rogers stated, not common practice.<sup>9</sup>

Coaching is beneficial since it allows the physician to access one-on-one focus on specific behavioral change. There is evidence that the one-on-one aspect allows for better capture of new information and behaviors.

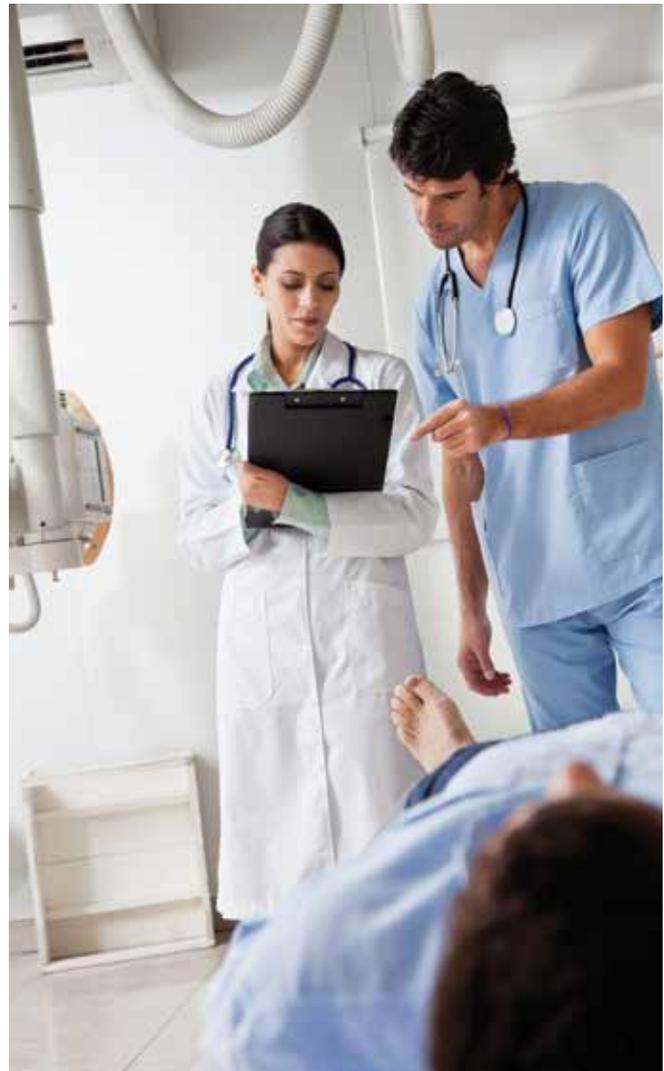
Renowned author and physician Atul Gawande wrote an excellent article on coaching in which he discussed the role that coaching can play for educated people, in particular, physicians.<sup>10</sup> He noted that a workshop setting in an educational environment resulted in a 10 percent implementation of new material. Practice settings within the workshop with personalized feedback resulted in a 20 percent implementation. When coaching was applied, where the person met with the coach, using the information the workshop provided and receiving immediate feedback, implementation was at the 90 percent level.

It also is financially beneficial to the organization. One study indicated that the costs incurred to address medical staff turnover can be more than 5 percent of an annual operating budget.<sup>11</sup> In today’s health care environment, few institutions can afford this type of unnecessary impact to the bottom line. On the other hand, a coaching engagement will cost a fraction of this amount.

**COACHING PROCESS** — The coaching process is very straightforward. A situation is identified that would benefit from this outside perspective. At this stage, senior clinical leadership is typically involved. The physician who needs help must have a clear understanding of the situation and the parameters that leadership is placing on the coaching.

If coaching is to be successful, there must be clear descriptions of the behavior in question and what the required path will be for improvement. The physician is then connected with people who are qualified to coach. It is imperative that the physician is given the liberty to choose who they would like to work with during this process. The less punitive the physician feels the coaching to be, the better the outcome.

An accurate assessment is crucial to the success of coaching. This can include a written 360 instrument, such as the Checkpoint 360,<sup>12</sup> and oral interviews with what are called stakeholders. These are individuals chosen by the physician and the coaching sponsor with whom the coach can speak to gain an insight into what positive aspects the physician brings to his work, what areas of improvement exist and what the goals of the coaching would ideally be. Nine to 12 individuals would be ideal in order to provide a cross-section of perception. This is confidential feedback that is used by the coach



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to establish patterns and provide feedback throughout the coaching process.

With the assessment data in place, the coaching begins. A typical schedule involves meeting twice a month from one to two hours. The more specific the behavioral focus and the more immediate the feedback, the better.

A useful method with clients involves providing physicians who are being coached with pre-printed cards with their name, the behavior being developed and three different questions regarding their behavior change. The cards can be handed to those with whom they are working.

So far these cards have been used in clinic settings as well as operating rooms. The results are markedly positive. Not only does this particular tool provide the instant feedback that solidifies behavior change, it builds the confidence of those around the physician that the coaching and change process is an active and involved one.

Additionally, it is useful to consider that these behavioral changes are seen within the overall context of being a physician leader. Many physicians seem to have forgotten the inherent role of leaders that society provides them. Change is described not as new behaviors that need to replace old ones; instead it is presented in the context of a new language. This concept reduces much of the resistance to change. Multiple times clients have achieved great success once that is realized and leadership attributes are coached and refined.

Over the past few years, one author has coached many physicians, nurses, and health care executives. Thirty-one percent were health care executives, 26 percent were surgeons, 9 percent were nurses and 5 percent were primary care providers. Internists, anesthesiologists, obstetricians/gynecologists, neurologists, hospitalists comprised 3.5 percent each, and dermatologists, radiologists, pathologists, cardiologists, and ophthalmologists comprised 2 percent each.

Of these individuals, 74 percent were retained by their organizations, and 26 percent were either terminated or chose to resign. Twenty-four percent of the successful coaching engagements resulted in the individuals being chosen for department leadership positions as their careers progressed. This does not speak to the coach's ability as much as it does to the highly effective formula of bringing very intelligent and motivated people into an environment where their intellect and abilities are respected and provided with favorable and successful alternative behaviors.

Every two to three months the stakeholders have a brief interview with the coach. This allows more data to be obtained, since many times the stakeholders may not be part of the immediate feedback process described above. There are some coaching models that indicate that coaching should last one to two years, although within six months significant change can occur and then be solidified over another few months.

We believe that success can be fairly well predicted within a short time, based on the coachability of the client. If self-awareness and desire are in place with a physician, then success is highly likely. Conversely, if the physician persists in denying his or her role in creating problems or feels as if he is a victim of the behavior of others, the coaching is more likely to fail.

Physician leaders should take heart in knowing that coaching is a strong tool in the leader's toolbox that can be used in a variety of settings resulting in cost savings, retention of excellent clinicians, and ultimately raising the level of patient care.



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