



Assessing the feasibility and acceptability of a peer-based communication coaching model among hospital clinicians

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ABSTRACT

Objective: Communication coaching shows promise for improving clinician communication yet few have assessed the feasibility of having peers coach each other. We conducted a proof-of-concept study to test the feasibility and acceptability of a peer-based communication coaching program in an inpatient setting.

Methods: We trained three clinician communication coaches (two physicians and one physician assistant) and randomized half of the 27 clinicians working on the general medicine floor to receive coaching. The coaching involved shadowing and providing feedback on real-time encounters with patients. We collected data on feasibility of providing the coaching, quantitative and qualitative ratings of acceptability of the coaching both from the clinician and the coach perspective, and clinician burnout.

Results: We found the peer coaching to be feasible and acceptable. Quantitative and qualitative reports support the merit of the coaching; most clinicians who received the coaching reported making changes in their communication. Clinicians in the intervention arm reported less burnout than those who did not receive the coaching.

Conclusions: This proof-of-concept pilot showed that peer coaches can provide communication coaching and that clinicians and coaches viewed the coaching as acceptable and might change communication. The coaching also seems to show promise on burnout. We provide lessons learned and thoughts about how to improve the program.

Innovation: Teaching clinicians to coach each other is innovative. We conducted a pilot that shows promise for feasibility, acceptability of clinicians coaching each other to communicate better, and a signal that it can help improve clinician burnout.

1. Introduction

High quality care relies squarely on effective patient-centered communication between clinicians and patients. Evidence links effective communication to important patient outcomes, such as improved patient experience, better adherence to recommendations, improved safety, greater satisfaction [1], and fewer malpractice suits [2-4]. Clinician communication has been taught in medical school and residency for some time [5,6], though has not been emphasized strongly until the last decade [7,8]. The most effective communication teaching methods include face-to-face courses [9] and interactive computer programs [10]. Those with the greatest impact contain two critical components used in teaching communication: allowing clinicians to practice effective communication techniques and providing them with tailored feedback. Only with observed performance and feedback do

clinicians get an accurate sense of their own behavior [11], what they are already doing well, and what they need to improve.

A promising way to teach communication that is maximally convenient for clinicians is *communication coaching*: shadowing clinicians during actual encounters and giving feedback. We and others have conducted several pilot trials in which we taught communication via coaching and found that we could improve communication skills and patient experience/satisfaction [12-16]. Further, theoretically, the praise-based approach of the coaching might help clinician resilience or reduce burnout [17]. Indeed, our work shows that communication coaching reduces burnout in part due to the positive, empathic, strength-based approach that coaching uses [12]. All of these trials, however, have relied on only a few coaches outside of the healthcare team, which has limited sustainability once the outside coaches complete their coaching. Teaching clinicians within the system to coach each other increases the ability both to implement and sustain

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coaching due to the ease of being able to coach while on service together. To our knowledge, few have attempted to evaluate clinicians providing communication coaching to each other [15,18,19]. Thus, we wanted to conduct a pilot to assess the feasibility (i.e., could peers provide coaching to each other) and acceptability (i.e., how did the clinicians and coaches view the coaching) of having hospital physicians and advanced practice providers (APPs) coach their peers to communicate more effectively. Based on our prior work, we also examined whether there was a signal that communication coaching improved burnout.

2. Method

2.1. Study setting and population

We conducted the study in a hospital that is linked to a medical school and has trainees. The Medical Director told the clinicians who provided care to patients in the hospital (physicians/hospitalists and APPs) that they were participating in a communication coaching quality improvement project. The Director nominated two physicians and one APP who they believed would be effective communication coaches based on their communication skills and their positivity. Dr. Pollak, a communication coach who is VitalTalk™ trained and has 10 years of experience teaching Motivational Interviewing and emotion-handling skills, spoke with each candidate to gauge their communication proficiency and determine why they wanted to be a coach. One of the physicians was a senior clinician, the lead nocturnist; she shadowed the nocturnists. The other physician was a junior clinician who shadowed the physicians during the day shifts. After discussions with the Medical Director and the coaches, the team decided that physicians should only coach physicians and the APP should only coach APPs due to the power differentials between the two clinical roles. The Medical Director provided a small incentive for the coaches by releasing them from one shift per month to do the coaching. Even though it did not cover all of their time required for the coaching, it did help make it possible for the coaches to provide the coaching. For the rest of the clinicians who were not coaches, we used a random number generator to randomize all clinicians to either the intervention arm or the control arm. This study was determined to be exempt by the Duke University Health System IRB given it was a low risk study.

2.2. Training of coaches

Dr. Pollak first met with all of the coaches to review the coaching protocol. Some essential elements were the focus on praising effective communication, how to teach interactively, how to help clinicians feel comfortable being watched, and modeling effective communication when coaching. Then, she met with each coach individually for an hour to provide an in-depth explanation of the skills they were teaching (WISER described below in Intervention section) and how to teach it to clinicians. She modeled an interactive style of asking clinicians their knowledge of each of the skills and why they thought the skill was recommended. First, Dr. Pollak explained WISER to the coach as if the coach was the clinician. Then, they reversed roles where the coach presented WISER to Dr. Pollak as if she was the clinician.

Then, each coach shadowed Dr. Pollak as she coached a clinician for two encounters. Dr. Pollak and the coaches transcribed the encounter in real-time because an essential element of providing feedback involves clinicians seeing their exact words. Dr. Pollak taught the coaches how to code clinician communication in real time. After the coaching was done, Dr. Pollak and the coach debriefed about what they saw her do and Dr. Pollak added the tools she used. Then, Dr. Pollak shadowed each coach while they coached and then provided feedback about what they did well and what they can improve as coaches. Dr. Pollak showed the coaches the emails she sent and taught them how to write them. The coaches met with Dr. Pollak monthly until the coaching was complete (with a break when the COVID pandemic began and coaching was paused for six months) to review

progress and what was going well and what the team needed to trouble shoot.

2.3. Intervention

The coaching intervention involved three sessions between the coach and each clinician: 1) 1:1 didactic session, 2) coach shadowing two inpatient encounters, and then 3) coach shadowing two inpatient encounters again. In the didactic session, the coaches described the skills represented by WISER (see Fig. 1). The focus was on 1) sitting down and making eye contact with all in the room, 2) open-ended questions (cannot be answered with a yes-no), 3) reflective statements (repeating or paraphrasing what patients said to show active listening), 4) emotion handling skills (i.e., Name emotion and the “Wish statement” “I wish things were different”) [20–22], and 5) “What questions do you have?” [23]

The coaching model uses interactive teaching methods that enhance learning and focuses on adult learning principles that involve reinforcing behaviors done correctly and offering suggestions for minor “tweaks” when communication could be improved by the use of the skills. The coaching is strength-based and relies on praise to teach and to increase self-efficacy. The coaching involved shadowing each clinician two separate times for two patient encounters each time when they were on service. In past coaching studies, clinicians provided feedback that they valued being coached two separate times so they could incorporate the learning and show improvement [13,24]. Also, providing real-time coaching while providing care in the hospital allows the clinicians being coached to incorporate feedback from one patient encounter immediately in their next patient encounter. The coaches took notes during the encounters and met with clinicians briefly and immediately after the encounter and provided feedback. After each of the coaching sessions, the coach emailed the transcripts and included a list of what the clinician did well (included 6–10 skills) and what needed to be tweaked (included at most 2 skills).

2.4. Control

Clinicians randomized to the control arm only completed surveys and did not receive coaching.

2.5. Data collection and measures

Clinicians completed a baseline survey that included demographic data, a description of prior communication training, and the Maslach Burnout Inventory [25]. Both intervention and control clinicians completed a and a final survey where intervention clinicians reported their impressions of the intervention and its impact on their communication. We conducted two separate, informal post-intervention zoom sessions with intervention clinicians and also with the coaches to assess what was helpful and what could be improved. Dr. Pollak led the sessions and recorded answers as the clinicians and coaches spoke.

2.6. Measures: primary outcomes: feasibility

To assess feasibility, we calculated the percent of times we reached the goal of the coaches being able to coach each clinician two separate times for two encounters each. We could not stipulate a length of time for the shadowing or the time in between sessions as there is much variability in the clinicians’ schedules and in the acuity of patients in the hospital.

2.7. Acceptability: quantitative and qualitative from clinicians and coaches

We assessed acceptability in several ways. First, we assessed it quantitatively via surveys. We asked clinicians if they made changes to their communication (yes-no) and whether they would recommend it to a colleague (1 = Would not recommend and 5 = Definitely would recommend). We also assessed it qualitatively both from clinicians and from coaches. We met with intervention clinicians (five attended) and asked

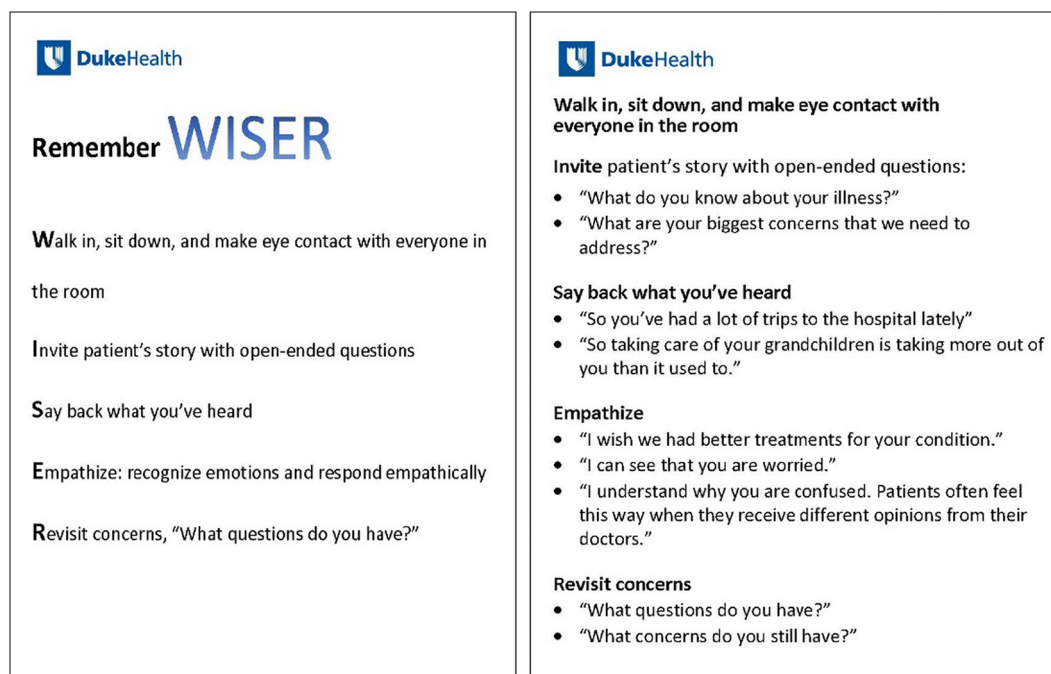


Fig. 1. WISER pocket card.

them what was helpful and unhelpful about the coaching. We also conducted a qualitative session with the three coaches where they were asked what worked well and what could be improved about the coaching.

2.8. Analyses

To determine feasibility, we determined *a priori* that if coaches could shadow 75% of the clinicians two times, that would signify that the coaching was feasible. In terms of determining acceptability, we specified *a priori* that 75% of clinicians would report that they made a change in their communication and 75% would give it a “4” or “5” that they would recommend the coaching to a colleague scale. Our sample was too small to conduct inferential statistics. Rather, we report descriptive statistics for these measures as well as for the burnout measures. For the interviews, we did not conduct extensive qualitative analyses on these interviews but rather content coded responses to examine common themes among the respondents.

3. Results

The demographics of the participants are in Table 1. We were able to collect follow-up surveys from 26 of the 27 participants (96%).

3.1. Feasibility

Coaches were able to provide two separate coaching sessions to 82% of their assigned clinicians (14 out of 17 randomized into intervention arm) and only one coaching session to 6% of their assigned clinicians (1 out of 17). 12% (2 out of 17) withdrew without being coached.

3.2. Acceptability: quantitative

Most of those who were coached (70%) reported making changes in their communication as a result of the coaching. Half would recommend the coaching to a colleague (50% gave it a “4” or a “5”). Participants’ average score on recommending was 3.3 (CI = 2.7–3.9) on the 5-point scale.

Table 1
Demographics.

Characteristics	Overall (N = 27) M (SD)/N(%)	Coached (N = 13) M (SD)/N(%)	Not coached (N = 14) M (SD)/N(%)
Female (%)	16 (59)	8 (62)	8 (57)
Race (%)			
White	10 (37)	5 (38)	5 (36)
Asian	13 (48)	6 (46)	7 (50)
Black/African American	3 (11)	1 (8)	2 (14)
Others	1 (4)	1 (8)	0 (0)
Hispanic or Latino (%)	0 (0)	0 (0)	0 (0)
Service line work most closely with (%)			
General Medicine	23 (85)	9 (69)	14 (100)
Oncology	4 (15)	4 (31)	0 (0)
Providers (%)			
Nurse practitioner	1 (4)	0 (0)	1 (7)
Physician Assistant	3 (11)	1 (8)	2 (14)
Physician	23 (85)	12 (92)	11 (79)
Received any training in communication before (%)	17 (63)	6 (46)	11 (79)
Direct patient care hours per month (inpatient) (M, 95% CI)	178.7 (111 – 246.4)	223.5 (77.8 – 369.1)	137.1 (117.6 – 156.7)

Table 2

Clinician satisfaction by arm (Maslach Burnout Inventory); Medians presented to remove bias from outliers.

	Intervention Baseline n = 13 M (SD) Median	Intervention Follow-up n = 13 M (SD) Median	Control Baseline n = 13 M (SD) Median	Control Follow-up n = 13 M (SD) Median
Depersonalization (range 0-30) ^a	6.7 (3.2) 7.0	4.5 (4.2) 4.0	4.7 (4.4) 3.0	6.0 (4.4) 5.0
Emotional exhaustion (range 0-54) ^a	21.9 (12.6) 26.0	23.5 (13.6) 21.0	18.0 (10.6) 15.0	20.6 (10.4) 19.0
Personal accomplishment (range 0-48) ^b	38.2 (5.3) 38.0	36.8 (6.2) 37.0	39.2 (4.2) 39.0	37.2 (10.0) 39.0

^a A higher score indicates less satisfaction.^b A higher score indicates more satisfaction.

3.3. Acceptability: qualitative from CLINICIANS

The five clinicians who attended the session to give qualitative feedback on acceptability of the coaching gave a variety of answers. All commented that it was helpful. Some themes and exemplar quotes from their discussion are, “Being watched was helpful,” “Nice to have things reinforced,” “Coaches were positive,” and “Having two sessions spaced out solidified learning.” None said the coaching was not helpful. When asked what could be improved, clinicians said, “Need a booster,” “Would help to be coached by someone who is not my boss,” and “Would be great for us to observe others communicating and be coaches.” None of these criticisms were about the coaching not being helpful. They were all ways to improve the coaching.

3.4. Acceptability: qualitative from coaches

When asked what they thought went well about the coaching, coaches said they felt that being a peer helped put their colleagues at ease and also allowed them to be flexible as they understood each other's schedules. Coaches also appreciated being able to shadow a coach and be shadowed themselves to learn the method, particularly focusing on positive feedback as that helped allay colleagues' fears that they would be critiqued. The coaches also noted that coaching actually improved their own communication. Not only did seeing their peers communicate help, but teaching WISER to others has made them more conscious of using WISER in their own communication.

Coaches also listed some areas of improvement. Familiarity with colleagues helped the coaching but also caused some uneasiness when they were with their colleagues after they had coached them as their colleagues now viewed them more as supervisors than as colleagues. Being shadowed and coached requires vulnerability. Once the coach viewed their peers communicating and gave them feedback, some of the coaches detected some discomfort from their colleagues that was not present prior to the coaching. This was noted by clinicians also (see above). Some of the younger coaches found the power differential of coaching more senior clinicians challenging as the senior clinicians struggled with the concept that the younger coach could teach them. Some clinicians worried they had been singled out to receive the coaching even though it was randomly assigned. And finally, coaching in an already stressed environment was challenging and time consuming for coaches especially as some of this happened during the COVID-19 pandemic.

3.5. Burnout

Intervention clinicians demonstrated a slight improvement in mean depersonalization scores while control clinicians demonstrated a worsening. Clinicians in both arms had higher mean ratings for emotional exhaustion post-intervention than at baseline, but the increase was higher for clinicians in the control arm. There were outliers though in the sample. When looking at the medians that are not sensitive to outliers, clinicians in the intervention arm had a decline in emotional exhaustion from baseline to post-

intervention whereas those in the control arm had an increase. Both clinicians in the control and intervention arms had slight decreases in personal accomplishment post-intervention, but those in the control arm had a bigger decrease than the those in the intervention arm (Table 2).

4. Discussion

4.1. Discussion

To our knowledge, this is the first attempt to have clinicians who do not have prior communication training to provide communication coaching to their peers. We learned valuable lessons from this pilot. Overall, the coaching was feasible, and clinicians viewed the coaching positively based on both the quantitative and qualitative acceptability assessments. Most of the clinicians said they made changes to their communication based on the coaching. Further, there appears to be a signal of buffering or helping reduce burnout among those coached. Finally, the coaches gained much from coaching others.

Clinicians viewed the coaching positively based on their survey responses. Even though we did not meet both of our *a priori* quantitative acceptability metrics for this pilot, many would recommend it to a colleague. Clinician perceptions were not quite as positive as we have found in our previous studies [12,13,16,26]. We believe the ratings are lower for several reasons. First, this was the first coaching study in which we did not ask clinicians to volunteer. In prior studies, we only coached those who agreed to be coached, which creates a selection bias and eliminates those who do not want to be coached. Second, one of the coaches were not as senior as those who they coached. This might have led to some feeling that they knew better than the coaches, even though the coaches had been trained. However, our qualitative feedback supported the acceptability of the coaching. This feedback was given by those who could attend the feedback session, which might have produced somewhat biased results. Despite these hurdles, clinician overall quantitative and qualitative ratings of the coaching were decent given these challenges.

We did meet one of our *a priori* acceptability criteria. Most of the clinicians who were coached reported making changes to their communication as a result of the coaching. This is notable given clinicians did not volunteer for the study yet reported making changes. This result might indicate that these peer coaches helped clinicians continue using the effective communication tools they had already been using and use new tools they had not been using.

Further, there was a signal that those who were coached reported better burnout scores than those who were not coached. This has been the most consistent finding from all of our prior coaching studies. We argue that because of the strength-based approach of the coaching where the coaches mostly provide feedback on the positive communication they witness, those coached feel supported and bolstered. Coaching represents a stark departure from the “problem-list” philosophy of medicine where we look for what is wrong and try to fix it. Coaching looks for what is right and reinforces it while still giving small pieces of feedback to improve. In each coaching study, this one-on-one approach seems to have an effect on how clinicians feel about patients and about their work.

Finally, all three coaches reported that coaching others and viewing others' communicating made them stronger communicators and that their communication continued to improve the more they coached. Also, even though it felt daunting at the start to transcribe and code in real time while shadowing others, their doing this helped them see communication differently and thus, view and improve their own communication. Coaches and clinicians who were coached felt all should have an opportunity to view others communicating as a way to improve ones' own communication.

This study has limitations. This study represents a small sample of only 26 clinicians in one hospital. We conducted this study during a pandemic, which altered both the training of the coaches and how and when we could shadow as there were limits about how many people can be in rooms with patients. Further, healthcare workers are experiencing additional stressors during the COVID-19 pandemic that may contribute to burnout such as safety concerns, longer work hours, financial worries, and dwindling supply of hospital resources. Therefore, the COVID-19 pandemic may have made burnout scores worse, particularly in the control arm. Finally, we did not collect data on actual clinician communication and do not know whether the coaching improved communication.

4.2. Innovation

Although some have tested a communication coaching intervention, few have attempted to teach hospitalists to become communication coaches and to provide coaching in real-time during inpatient encounters. We believe this proof-of-concept pilot moves the field forward as it is attempted to teach clinicians embedded in the health system to provide the coaching.

4.3. Conclusion

This pilot study shows promise for teaching clinicians who do not have expertise in communication how to coach their peers. Even though the impact was less than those found when a professional coach providing the coaching, the results indicate that teaching clinicians to coach is feasible and acceptable and might positively impact clinician outcomes.

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Ethical approval

The study was determined to be exempt by the Duke University Health System IRB.

Disclaimers

None

Previous presentations

None.

Declaration of Competing Interest

None.

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