

Promoting the Wellness of Physician-Residents: Counselor-Delivered Coaching

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Abstract

Current studies on coaching have largely been process- and outcomes-oriented while lacking a firm theoretical foundation on which to base skills and techniques. Coaching has been utilized in many settings in order to address employee work attitude and well-being. This article explores the effects of counselor-delivered coaching on the wellness of physician-residents. Counselors are trained in many of the skills that organically apply to coaching, and medical education programs can benefit from counselor-facilitated coaching as part of their graduate medical education program. Counselor-delivered coaching also can help residents reduce common stresses, mitigate negative patient outcomes, and avoid burnout. This increase in physician wellness is likely to result in decreased medical errors. For these reasons, the authors explore the use of basic counseling techniques in the context of coaching sessions involving medical school educators and residents, thereby bridging the gap between coaching and counseling. Counselor-delivered coaching may be a valuable resource for reducing physician burnout. Therefore, medical schools and medical practices should consider developing and including counselor-delivered coaching to improve physicians' quality of life and thus, in turn, patient results. Findings from this study support future data-driven studies of counselor-delivered coaching, training opportunities for counselor education programs, and an evolution of coaching techniques.

Keywords: graduate medical education, counselor-delivered coaching, physician-residents

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The medical profession has undergone many paradigm shifts throughout the course of history. Whether they have involved novel treatments and interventions or the integration of new technologies, these shifts reflect the profession's best efforts to provide the best possible medical care to patients. To better inform the education, practice, and wellness of physician-residents, the profession is experiencing a paradigm shift that includes skills from the counseling profession according to precepts outlined in the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements (2015). This article discusses and outlines the need for Graduate Medical Education–focused coaching programs that are delivered by professional counselors. The relative paucity of research in this area and the need for continuing exploration and refinement of such programs are also provided. Accordingly, the article begins with a review of the importance of coaching and reviews the literature regarding wellness in physician-residents, as well as counselor-delivered coaching possibilities.

Literature Review

After medical students graduate, they begin specialty training during their physician-residency. The period of time after medical school and during residency training is called Graduate Medical Education (GME). The residency period can vary in length, depending on specialty. For example, a Family Medicine residency is three years in duration, whereas an Internal Medicine residency requires four years. Physician-residents fulfill crucial leadership roles in the healthcare field and often carry significant responsibilities while they are learning and applying valuable and useful specialist knowledge and skills.

The burden of this work, combined with the normal stressors of medical careers can in fact be harmful to the health and well-being of these physician-residents (Epstein & Krasner, 2013). The

high degree of stress and responsibility experienced during residency can lead to isolation, suicidal ideation, fatigue, anxiety, and depression. A recent meta-analysis examined 167 cross-sectional studies ($n = 116,628$) and 16 longitudinal studies ($n = 5,728$) from 43 countries and found 27.2% of medical students (37,933/122,356 individuals, 95% confidence interval [CI], 24.7% to 29.9%) reported depression or depressive symptoms (Rotenstein et al., 2016). What is more, many researchers have noted how compromised patient care and burnout contribute to a public health crisis (Goitein, 2014; Lee, Seo, Hladkyj, Lovell, & Schwartzmann, 2013; Denson et al., 2016).

Medical Resident Burnout

Physician-residents experience disproportionate rates of depression, alcoholism, and suicidal ideation, leading to elevated levels of everyday stress and, unfortunately, burnout—including experiencing symptoms of emotional and physical exhaustion, a low sense of accomplishment and purpose, and depersonalization regarding patients (Cooke, Doust, & Steele, 2013). Many findings reported in the literature also support the notion that the rigorous requirements of residency training programs place residents at increased risks for experiencing burnout (Guerrasio, Garrity, & Aagaard, 2014; Dyrbye, & Shanafelt, 2016). An analysis of 14,201 responses to the Maslach Burnout Inventory revealed that almost 50% of medical students and physician-residents experienced symptoms of burnout (Dyrbye et al., 2014). Residents reported particularly high averages of exhaustion and depersonalization. For example, as medical school students move into residency, their lives become more stressful: Dahlin, Fjell, & Runeson (2010) conducted a longitudinal study in which they observed student physicians as they transitioned to residency and found that a high degree of anxiety regarding the future was a predictor of postgraduate exhaustion. The findings from this study also suggest that medical students with

higher anxiety regarding workload, long hours, and the volume of information to assimilate may be more likely to experience high levels of burnout as they begin residency.

Not surprisingly, the prevalence of burnout continues at about the same level in residency as compared with medical school (44%–50% of one cohort studied by Pantaleoni, Augustine, Sourkes, & Bachrach, 2014). Clearly, such levels of stress and distraction can greatly affect a resident's ability to perform. In particular, burnout can reduce a resident's self-efficacy and professional competence, undermine their professional development, and contribute to a variety of other personal negative consequences.

Patient Care Affected by Burnout

Multiple studies have suggested that suicide rates for residents are estimated to be six times higher than that in the general population (Hochberg et al., 2013; Rubin, 2014). This speaks to the serious distress and emotional damage that can occur for physician-residents. Consequently, adversity of this magnitude should be expected to influence patient safety and quality of care (Dyrbye, & Shanafelt, 2011). West et al. (2009) conducted a longitudinal cohort study of categorical and preliminary internal medicine residents at the Mayo Clinic in Rochester, MN. Researchers found that medical errors are common among internal medicine residents and typically are associated with substantial personal distress. Moreover, this study found that perceived errors and distress may reciprocally and negatively affect physician-residents. Worryingly, decreased levels of empathy and increased distress were associated with increased odds of future self-perceived errors (West et al., 2009).

Patient safety and unintended medical mistakes continue to be concerns for patients, physicians, and the public at large. In 1999, the Institute of Medicine published a well-known report

suggesting that between 48,000 and 98,000 Americans die every year because of adverse yet preventable events (Kohn, Corrigan, & Donaldson, 2000). James (2013) compared four well-known studies regarding the prevalence of preventable adverse events (PAE). These studies included a 2008 pilot study by the Office of the Inspector General (OIG); a comprehensive OIG study in 2010 (Levinson, 2014); a study by Classen and colleagues (2011); and a longitudinal study by Landrigan and colleagues (2010). Although the four studies did not arrive at a consensus, James suggested that more than 50% of the errors that occur with hospitalized patients may have been preventable by a physician. This figure is notable, but the human and monetary costs of these unintended yet adverse events are broadly significant. The occurrence of PAE that stem from medical errors may be increasing (Rafter et al., 2015). Because of the prevalence and serious nature of the consequences of medical errors, action is needed to prevent PAE and burnout (Shanafelt et al., 2010).

Accordingly, medical educators could ideally take an active role in providing support for physician-residents with respect to self-care, communication, and leadership, along with providing those who are struggling with referrals to the appropriate resources and caregivers. For many GME programs, suitable caregivers may include counselors or other suitable mental health professionals who can provide coaching services.

The ACGME accredits residency and fellowship training programs in the United States. This not-for-profit organization sets standards for US graduate medical education programs. The ACGME has made resident well-being a focus and is challenging GME programs across the country to demonstrate how they promote this endeavor; among other initiatives, ACGME promotes clinical learning environments that are characterized by excellence in care, safety, and professionalism. To demonstrate their dedication to graduate medical education, ACGME

incorporates best practices, research, and advancements across medical education endeavors, including the “creation of a learning environment with a culture of respect and accountability for physician well-being ... to deliver the safest, best possible care to patients”

(www.acgme.org/What-We-Do-Initiatives/Physician-Well-Being).

Physician Coaching

Henochowicz, and Hetherington (2006) described a program for physician coaching that mirrors corporate mentorship programs. Specifically, this study described a mentorship style of in-house coaching from physician leaders for the benefit of less-experienced doctors; topics addressed include the following: procedural and assessment competencies, leadership skills, and navigation of in-house politics. This reflects a rather traditional use of coaching insofar as it focused on competency and self-efficacy rather than leadership and wellness. In light of increasing external pressures, medical programs must provide additional support to help residents develop and maintain a satisfying balance between work and personal lives, along with providing stigma-free programs to reduce burnout (Henochowicz & Hetherington, 2006). For these reasons, an important trend in GME has been to implement various types of coaching programs.

For example, Gazelle, Liebschutz, and Riess (2015) discussed a case study that exemplifies how coaching can provide an opportunity for contemplative introspection, can increase self-awareness, and can provide a collaborative alliance along with a cathartic sounding board.

Specifically, the physician in this study met with a certified life coach to re-embrace his passion for medicine, regulate his emotions, and support his overall wellness with respect to balancing his work and his personal life. Findings from Gazelle et al. (2015) support the hypothesis that coaching may be an effective approach for increasing physician-resident wellness; these researchers, however, concluded that providers of GME still lack research about the efficacy of

coaching in medical settings. Considering the promising outcomes that coaching may have on resident wellness, researchers recommend future studies of coaching in medical settings (Gazelle et al., 2015; Goitein, 2014; Jordan & Livingstone, 2013; Shanafelt, 2012). Although many non-mental health professionals have published articles on coaching, GME providers still face a scarcity of literature that explores the potential contributions of mental health counselors who provide coaching services to physician-residents.

Considerations for Counselors

The notion that counselors may effectively specialize in coaching—and that they must receive appropriate education “in terms of training understanding of core competencies, ethics, and practice standards to successfully add coaching to the services they already provide”—is not new: Labardee et al. (2012) have outlined core competencies, including ethical and practice considerations, needed by counselors for successful coaching. Several studies have identified medical training stressors (Cooke, Doust, & Steele, 2013; Dahlin, Fjell, & Runeson, 2010; Dyrbye & Shanafelt, 2011; Goitein, 2014; Hochberg et al., 2013). These studies referred to topics such as sleep deprivation, the emotional effects of patient encounters, fear of making life-threatening mistakes, and the pressure to excel. For this reason, Wallace (2009) suggested that many residents struggle to find a balance between their work life and their personal life while they simultaneously grapple with issues related to their emotional and physical well-being. Because of the elevated rates of burnout and the suicide risk among physician-residents, this population is likely to benefit from counseling and supportive services. As a result, ACGME require that all residency programs provide counseling services for physician-residents (ACGME, 2007). To fill this need, many programs have instituted a coaching program facilitated

by postgraduate-level counselors. The following section explores the use of basic counseling techniques in the context of a coaching session and is followed by illustrative case studies.

Counselor-Delivered Coaching

This section illustrates how counselors can infuse coaching into their professional activities and identities. Coaching can be defined as a “result-oriented, systematic process in which the coach facilitates the enhancement of life experience and goal-attainment in the personal and/or professional lives of normal, non-clinical clients” (Grant, 2003, p. 254). Although coaching is not counseling, many aspects of both activities in fact overlap (Gazelle, Liebschutz, & Riess, 2015). Like counseling, the overall goal of coaching is to optimize a person’s wellness; for this reason, counselors often make efficient and effective coaches (Williams & Davis, 2002). Like coaching, counseling programs focus on providing counseling students with the skills needed to assist people in meeting their full potential throughout various life challenges (www.cacrep.org). Still, coaching and counseling can involve several distinct activities and procedures. Coaches and counselors have different roles vis-à-vis clients. Coaches work with high-functioning clients in a collaborative effort to help clients to reach their full potentials (Jordan & Livingstone, 2013). A counselor typically provides services to individuals with varying types and extents of mental health concerns by using diagnostic procedures that address the cause of the client’s issue (Jordan & Livingstone, 2013). A coach does not diagnose medical illnesses and typically focuses on solution-oriented activities rather than alleviating physical concerns (Paterson, 2008). In summary, coaches and clients work collaboratively and focus on external issues as opposed to internal concerns (Jordan & Livingstone, 2013). Moreover, the dynamics of coaching sessions are often informal in terms of the usual counselor power differential, reflecting the actively collaborative nature of the coaching relationship (bearing in mind, of course, that counselors are

also taught to be active and collaborative). In fact, contact between sessions is encouraged in order to celebrate successes as well as to reinforce accountability. Finally, most coaching relationships are short term and focus on present and future cognitions. For these reasons, many coaching interventions are solution focused rather than problem oriented (Jordan & Livingstone, 2013).

Despite the differences between counseling and coaching, some styles of counseling are suitable for coaching. Specifically, solution-focused counseling is a goal-oriented collaborative approach that uses structured questions to help the client make changes (Neukrug, 2011). Accordingly, solution-focused counseling is often integrated into coaching skills. Many coaches who use this approach typically focus on the client's strengths and enhancement of their problem-solving skills. Often, a session may focus on what coping methods have worked in the past, why this approach is not being used in the current situation, and how the client can refocus and integrate successful strategies from the past into the present. Coaching typically is integrated with thought mapping, positive self-talk (e.g., empowerment mantras), and homework designed to increase self-reliance (Williams & Davis, 2002).

Counselor-Delivered Coaching and Residents

In a similar fashion, aspects of Rational Emotive Behavioral Therapy (Ellis, 1994) are often used in coaching sessions. During coaching, residents ideally can learn to differentiate between the facts of their situations and their assumptions by identifying and questioning their irrational beliefs (Neukrug, 2011). By increasing their self-awareness, physician-residents can increase their resilience and flexibility to deal with common internal and external stressors in the medical profession.

The hypothetical examples provided below help illuminate the natural kinship of coaching and counseling, and many of the foundational micro-skills illustrated in these vignettes are taught in counselor-training programs and transfer directly into the coaching environment (Paterson, 2008). Skills such as reflection of content and feeling, questions, nonverbal encouragement, and immediacy help resident-physicians increase their self-awareness. For this and related reasons, many residency training programs, including ours at Eastern Virginia Medical School (EVMS), have used counselors as coaches for our residents.

Case studies

EVMS provides counselor-delivered coaching for all residents and fellows. Often, residents or fellows may volunteer for coaching when they recognize that they need to improve their life skills, not only to relieve personal, family, and work stressors but also for personal well-being and growth. In particular, enhancing leadership skills, improving interpersonal communication, self-care, and studying for boards are common reasons why residents enroll in coaching.

Residents and fellows may also be referred to coaching if faculty or the program director has identified growth areas for the resident or fellow. EVMS has also used coaching as a tool in remediation plans for residents or fellows who have been involved in complaint situations or are involved in performance remediation. The following three scenarios illustrate specific ways of using coaching to promote wellness. These scenarios include a referred resident, a volunteer fellow, and a volunteer resident. In all examples, the names, demographics, and situations are hypothetical and do not refer to individuals.

“Sue” is a first-year radiology resident who was referred to coaching after several patients filed complaints about her interactions. The resident often give unwarranted hugs or responded inappropriately when people emoted. The coach and resident worked together to establish the

goals of working on boundaries, empathy, and appropriately responding to people. Over four sessions, the resident recognized that she feels uncomfortable when people emote and immediately wants to “fix it.” The coach helped the resident develop and deploy reflective listening skills and other ways to show and express empathy without crossing boundaries or overtly trying to “fix” the patient.

“Bob” is a 2-year fellow who volunteered for coaching because he wanted to improve his time management, confidence, and ability to work with assertive (“strong”) personalities. Bob disclosed that he has ADHD and, with his coach, he explored his symptoms and activities and identified strategies to combat some of his symptoms in order to manage his time better. The coach also worked with Bob on ways to improve his skills and confidence when presenting to small groups. Finally, the coach and Bob worked on assertiveness and identifying occasions on which he should appropriately stand up for himself in a professional setting. A few months after Bob’s final coaching session, he volunteered to work with the coach to help prepare for his boards.

“Martin” is a second-year resident who volunteered for coaching because he was experiencing elevated levels of stress and was struggling with exams. His coach assisted him in dissecting his schedule with a deliberate focus on time spent studying and time for self-care. They examined Martin’s current situation, what had worked in the past, and why these previous strategies were not working anymore. Through this process, the resident found that adjusting his studying style could give him more time for to recharge emotionally. Specifically, the resident began to use multiple learning styles to prepare for his exams. Because this was a more effective way of retaining knowledge, it allowed him to cut back on his study time and spend more time with his fiancée.

Conclusions

We have explored a relatively underrepresented and underused area of counselor-delivered coaching practice during GME. Counselor-delivered coaching can promote both the wellness and the effectiveness of individual physician-residents and their GME programs, thereby contributing multidimensionally to society at large. This article has identified several gaps in the literature that should be addressed in future studies of coaching effectiveness for physician-residents.

Specifically, the biggest overall limitation in our current knowledge and practice of GME—and thus one of the important limitations of the present study—is the lack of rigorous studies that explore the effectiveness of counselor-delivered coaching interventions among residents. Despite the many overlaps between techniques used in counseling and coaching sessions, few studies examine these techniques in the context of GME and none involve counselor-delivered coaching (Gazelle, Liebschutz, & Riess, 2015; Henochowicz & Hetherington, 2006).

In sum, the gaps in knowledge that we have identified are indicative of certain aspects of counselor-delivered coaching that remain to be fruitfully explored. Accordingly, our efforts toward the fuller elaboration of counselor-delivered coaching include the following: increased quantitative and mixed method studies regarding counselor-driven coaching; exploration of a counselor-delivered coaching certificate; and integrative theories that combine established counseling theories with data on effective techniques used in counselor-delivered coaching. These endeavors would likely entail increased collaboration between counselor education programs and physician-residency programs, which could be fertile grounds for further research endeavors.

Counselor-delivered coaching is a results-oriented approach that could prove valuable to physician-residents and medical organizations. Counselors appear to be a natural fit for the

coaching environment because of their extensive training and experience. For these reasons, medical schools and medical practices should consider developing and including counselor-delivered coaching to improve physicians' quality of life and patient results. Exploratory findings suggest that counselor-delivered coaching may be a valuable resource for reducing physician burnout, empowering physicians to maintain a balance between work and personal life, increasing self-care among physicians, and providing optimal medical services to patients.

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