Families, Systems, & Health

ISSN: 1091-7527

2020, Vol. 38, No. 2, 184–189
http://dx.doi.org/10.1037/fsh0000491

BRIEF REPORT

A Physician Communication Coaching Program: Developing a Supportive Culture of Feedback to Sustain and Reinvigorate Faculty Physicians

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Introduction: Physician–patient communication involves complex skills that affect quality, outcome, and satisfaction for patients, families, and health care teams. Yet, institutional, regulatory, and scientific demands compete for physicians' attention. A framework is needed to support physicians continued development of communication skills: Coaching is 1 such evidence-based practice, and we assessed the feasibility of implementing such a program. ***Method:*** Participants were 12 physicians, representing high and low scorers on the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey. We added items to capture empathy and family experience to the Calgary−Cambridge Observation Guide for the Medical Interview. Coaches observed communication associated with patient satisfaction and quality measures: *introductions* (I), asking about *concerns* (C), and check for *understanding* (U), or ICU. Participants received a report describing their communication behaviors, emphasizing strengths, and identifying areas for improvement. ***Results:*** Scores on the ICU significantly discriminated between low and high HCAHPS scorers, physicians from surgical and cognitive specialties, men and women. We collected anonymous feedback regarding the value of this training; participants recommended expanding the program. ***Discussion:*** Based on physician endorsement, experienced coaches are expanding the coaching program to physicians throughout our institution.

Public Significance Statement
The patient–physician relationship depends on a foundation of effective communication skills by physicians. One-to-one coaching helps physicians recognize patterns in their communication style that can be enhanced to promote improved

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Susan H. McDaniel is responsible for the conceptualization of this coaching program and the methodology to evaluate this pilot. All authors contributed to the analysis of the results and the writing, review, and editing of this article. Susan H. McDaniel received support from URMC to develop the Communication Coaching Program and run this pilot study to test feasibility and acceptability. The authors have no other disclosures.

Thank you to Ronald Epstein, who provided helpful consultation regarding the development of the program, and to Sean Meldrum, the biostatistician who ran the statistics. We appreciate the feedback of those who participated with Susan H. McDaniel in the Executive Leadership Program for Women in Academic Medicine (ELAM), as well as from Tziporah Rosenberg and William Watson, who now function as part of the communication coaching team at URMC.

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patient–physician relationships, clinical outcomes, patient and family satisfaction, and physician well-being. A coaching framework developed at the University of Rochester Medical Center has been well received by physicians and supported by patients, such that it has expanded significantly.

Keywords: communication, coaching, patient satisfaction, patient−family-centered, physician–patient relationship

Skilled communication among physicians, patients, and families improves clinical outcomes and patient satisfaction and protects against medical errors (Duffy et al., 2004). Compassionate patient- and family-centered communication represents the moral center of the doctor−patient relationship (Stephens, 1991) and creates the phases of clinical encounters: establishing rapport, collaborative agenda setting, and acknowledging concerns of the patient and family (Levinson, 2011). Patients express more satisfaction when physicians actively listen and provide information with personal context in mind (Mauksch, Dugdale, Dodson, & Epstein, 2008; Stojan, Clay, & Lypson, 2016). Though its importance is well demonstrated, continuing medical education rarely focuses on communication skills. Nonetheless, physicians have been encouraged to develop these skills to improve efficiency (Duffy et al., 2004; Mauksch et al., 2008), and institutional attention increased significantly when reimbursement began to reflect patient satisfaction scores (Kennedy, Caselli, & Berry, 2011).

Because communication affects patient satisfaction, outcomes, and system reimbursement, approaches to ongoing support and development of these complex skills are important across the professional life span. Direct observation of clinical communication is optimal for teaching, learning, and practicing skills. It provides customized data (Kennedy et al., 2011), especially recognition of strengths, correction of common communication errors (Mauksch et al., 2008), and suggestions to improve skills associated with quality and satisfaction (Mauksch et al., 2008; Stojan et al., 2016). Coaching uses observation and targeted feedback to enhance skills. Communication coaching allows an expert to identify areas shown to improve patient satisfaction and quality and provide specific recommendations for improvement (O'Leary & Cyrus, 2015).

Coaching Structure and Approach

In 2011, in response to the Centers for Medicare and Medicaid Services reimbursement including Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) scores, the University of Rochester Medical Center (URMC) launched a patient- and family-centered care initiative, implementing training for all employees. Dean Mark Taubman asked Susan H. McDaniel to develop training that would be effective for faculty; this request was the genesis of the URMC Physician Communication Coaching Program. URMC is the home of biopsychosocial medicine (Engel, 1977) and family systems medicine (McDaniel, Campbell, Hepworth, & Lorenz, 2005). These approaches formed the foundation of the program, which was designed to activate a learning community of faculty to improve quality and safety outcomes, team communication, and physician wellness. This article reports the results of the pilot study undertaken to determine feasibility and value of a physician communication coaching program.

Method

Coding and Evaluating Physician–Patient Communication

Susan H. McDaniel conducted stakeholder input across 18 clinical departments; physician leaders identified 30 important communication behaviors and ultimately narrowed these to eight. These behaviors corresponded to items in the well-validated Calgary−Cambridge Observation Guide (CCOG) to the Medical Interview (Kurtz, Silverman, Benson, & Draper, 2003), a gold standard for patient-centered communica-

tion. Because of their demonstrated importance, we added items related to family (e.g., greeting family members and including them when eliciting concerns) and empathy (the CCOG+; Hojat & Gonnella, 2017).

The pilot focused on three communication behaviors associated with patient satisfaction and quality (Duffy et al., 2004; Levinson, 2011), using the easy-to-remember acronym ICU: *introduce* yourself and your role, check for *concerns,* and check for patient *understanding* (also referred to as "teach-back"). Susan H. McDaniel observed and coded physician–patient interactions using the core ICU and the CCOG+ checklist and wrote a detailed summary report about the physicians' performance.

Participants and Process

During the 6-month pilot, the URMC chief patient experience officer identified 12 physician participants, 6 with high and 6 with low HCAHPS scores, 6 from surgical and 6 from cognitive specialties.[1] All identified physicians agreed to participate in a study to help improve physician–patient communication. The group included four women and eight men. Patient satisfaction scores were not mentioned to the participants or revealed to the coach. The study was exempted from Institutional Review Board approval. Participants had Susan H. McDaniel observe 4 hr of clinical work; 75 patient interactions were observed and coded, and illustrative quotations by the physician and patient or family were captured. For every physician observed, the coach interviewed the last patient to gather the patient's perspective of the interaction.

Susan H. McDaniel provided each participant with a detailed written report, including quantitative data on all items with supporting quotes and qualitative descriptions, following the format of the CCOG+ (see Table 1).

Using the written report, Susan H. McDaniel provided each physician feedback highlighting their communication strengths, noting skills in need of improvement, and recommending next steps. For example, when a physician consistently said "hello" to a new patient but did not identify their role, the report noted this behavior and the evidence for why to do so. In a 1-hr debriefing, the coach discussed and modeled relevant skills; for example, active listening, setting an agenda, appropriate use of open-ended questions, and communicating warmth and compassion. Participants had the opportunity to ask questions, role-play skills, and outline new communication strategies.

Table 1
Behavioral Categories for Observation using the CCOG+

Initiate the visit (develop initial rapport)
Gather information (discover the patient and family's perspectives)
Build the relationship
Explain and plan (discuss diagnoses and treatment options)
Close the session

Note. CCOG+ = Calgary–Cambridge Observation Guide (CCOG) to the Medical Interview plus items related to family members and empathy.

Evaluation

Each ICU behavior included a frequency score (e.g., "You introduced yourself and your role in 4 of 9 interactions. You set an agenda 2 of 9 times."). Descriptive statistics portray frequency scores by behavior, comparing high HCAHPS scorers to low HCAHPS scorers, surgical to cognitive physicians, and male to female physicians. To evaluate the significant differences, we conducted independent *t* tests comparing the same groups noted above. Additionally, the length of each visit was timed, and average times were calculated. Physicians were scored on introducing themselves and their role only for new patient visits. Two weeks after debriefing with the coach, participants completed an anonymous survey assessing their overall experience—rating helpfulness on a scale from 1 (*Not at All*) to 5 (*Very Helpful*) and providing comments about the program.

Results

Participating physicians introduced themselves and their role in 29 of 36 new patient

[1] Surgeon participants were drawn from the Department of Surgery's multiple divisions plus one specialty surgery department; cognitive physician participants were drawn from the Departments of Pediatrics and Medicine and their multiple divisions. Each participant represented a different specialty or subspecialty.

visits. Cognitive ($p < .05$) and female ($p < .05$) physicians were significantly more likely to do so, introducing themselves 100% of the time (see Table 2). Seventy-two percent of the time physicians asked about patient concerns. Those with high HCAHPS scores did so significantly more than did those with low HCAHPS ($p = .001$); with high HCAHPS-scoring physicians being 10.6 times more likely to ask about patient concerns. Of the ICU behaviors, participating physicians were least likely to check for understanding, with a frequency of 23% overall. Female physicians ($p < .05$) and those with high HCAHPS scores ($p < .05$) were significantly more likely to do so. Female physicians were 6 times more likely to check for understanding than were their male counterparts.

The mean visit time was 16 min (range = 3–51). Physicians with higher HCAHPS scores spent more time with patients compared to those with lower scores. Surgeons and men tended to spend greater time with patients compared to their nonsurgeon and female counterparts.

Patient Perspectives

All 12 patients interviewed (one per physician) were told that the coach was present to help physicians across the institution improve their communication skills. All patients spoke positively about their physician. Patients commented their physicians had taken adequate time to answer questions, independent of the actual visit length. For example, "My doctor explained my problem clearly, and he took the time to answer my questions." All patients spontaneously expressed enthusiasm about the medical center sponsoring a communication coaching program. None complained about the observation.

Feasibility and Value to the Physicians

On a scale from 0 (*Not Useful at All*) to 4 (*Very Useful*), 60% of physicians rated the pilot *Very Useful* and 40% rated it as *Useful,* for an average rating of 3.7. Six participants provided written comments (see Table 3). A representative example: "I found your report to be very helpful and encouraging. The report was organized in a very usable way . . . I believe this type of experience is valuable since habits (good or bad) creep into communication . . . I would like to do this again."

Overall, the process was feasible, acceptable, and did not interfere with physician workflow. Participants universally appreciated the personalized recommendations, stating the process was more meaningful than expected because the reports captured the essence of them as physicians. One physician suggested all clinicians be coached to ensure systemic success in the initiative. Physician feedback also provided examples of improved workplace satisfaction and reduction of burnout as a result of coaching.

Table 2
Visit Type, Behaviors Observed, and Visit Length

	Physician type			Physician gender			HCAHPS			
	Surgical	Cognitive	*p*	Male	Female	*p*	Higher	Lower	*p*	Total
New patient (*n*)	24	12		24	12		19	17		36
Follow-up (*n*)	21	18		30	9		13	26		39
Total visits (*n*)	45	30		54	21		32	43		75
Introduce: % (*n*)	70.8 (17)	100 (12)	.03	70.8 (17)	100 (12)	.04	84.2 (16)	76.5 (13)	.91	80.6 (29)
Elicit concerns: % (*n*)	64.4 (45)	83.3 (30)	.07	70.3 (38)	76.2 (16)	0.31	93.8 (30)	58.5 (24)	.001	72.0 (54)
Check for understanding: % (*n*)	24.4 (11)	20 (6)	.31	13.0 (7)	47.6 (10)	.04	34.4 (11)	14.6 (6)	.037	22.7 (17)
Average visit length (min)	17.5	13.7		17.7	14.0		18.6	13.4		16.2
Visit range (min)										
Min.	3.0	6.0		3.0	6.0		3.0	4.8		3.0
Max.	50.7	33.8		50.7	36.0		50.7	37.4		50.7

Note. HCAHPS = Hospital Consumer Assessment of Health Care Providers and Systems; min. = minimum; max. = maximum.

Table 3
Physicians' Sample Comments Shared via Follow-Up Survey

Her comments were very objective and specific.
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 find the information very helpful—hearing what you think I did well and what you think I could do better. I will start to implement your suggestions with my next patient encounter.
I found your report to be very helpful and encouraging. The report was organized in a very usable way . . . 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.
Very helpful indeed even though it was truthful!
She made me realize that I did a lot of teaching, but did not always elicit patients' concerns.

Discussion

Limitations

We found significant results and strong endorsement by faculty physicians and patients. However, this pilot involves a small sample of teaching physicians and was contingent upon the successful communication of a single coach delivering feedback. The factors that contributed to the program's value and validity make it time-intensive, including 4 hr of direct physician–patient observation; a detailed, evidence-based report based on quantitative and qualitative data that describes the physician as clinician; and an hour-long individual debriefing to discuss the experience, the findings, and next steps.

Next Steps and Future Directions

Although our study establishes that targeted behaviors distinguish physicians with high versus low HCAHPS scores, future studies with repeated measures must establish that coaching is successful in improving physician communication behaviors. Larger scale studies are needed to discover all relevant outcomes (including patient outcomes), as well as the program's generalizability (including to nonteaching physicians) and the minimum effective "dose" of coaching required. In addition, interprofessional team communication has become increasingly important and deserving of attention and evaluation by communication coaches.

The results of this pilot led to further development of our program. Susan H. McDaniel coached all chairs of the URMC clinical departments so they know firsthand what coaching offers their faculty. Five clinician−educators are now coaching across departments, with several in training. We believe that improving clinician communication institutionally requires the development of a culture of feedback, with repeated sessions of observation and feedback in small doses over time.

Our pilot demonstrates that clinical communication coaching is a feasible and acceptable approach to improving physician communication. This approach deserves further study; it has promise in improving patient- and family-centered care and supporting physicians' experience and wellness over time.

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Received October 30, 2019
Revision received April 6, 2020
Accepted April 10, 2020 ■