A Culture of Coaching: Achieving Peak Performance of Individuals and Teams in Academic Health Centers

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Ensuring that individuals receive opportunities to develop to their full potential in academic health centers is *anything* but common; rather, available opportunities focus exclusively on developing cognitive "thinking" or "doing" aspects of the individual or on meeting the needs of particular groups in health care or society. A sampling of the academic medicine agenda includes the following: educating learners on disease diagnosis, treatment and prevention, and health maintenance; practicing cost-conscious, quality-focused, team-based, patient-centered care; developing faculty niches; encouraging career choices aligned with societal needs; and managing student debt and conflicts of interest in continuing medical education. Indeed, academic medicine rarely, if ever, addresses the "being" aspect of the individual—including core values, sense of purpose, beliefs, self-awareness and trust, relational awareness, emotion and habits, character strengths, orientation to failure, learning preferences, motivation, lived experience, and goals—all of which are essential components in crafting a pathway to individual peak performance.

Providing members of the academic medicine community with opportunities to develop to their full potential is not only an uncommon goal but also an uncommon subject of research.

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Specifically, researchers have not determined whether there is value congruency between the culture of academic medicine and the goal of developing each individual to his or her full potential. Taylor,[1] reflecting from the perspective of medical anthropology, suggested that medicine is a "culture of no culture," defined by static and uncontested beliefs and timeless "truths," which have subordinated clinicians' desires to understand the lived experiences of their patients. Anecdotal accounts from students and residents are familiar: long hours, one-size-fits-all training, disjointed basic science education and clinical teaching, depression and burnout, subjective evaluations, and advising practices grounded in the belief that intelligence is a fixed entity.

Recently, researchers have described the culture from the perspective of medical faculty by examining the quality of their relationships to one another, to learners, and to patients.[2] While some faculty reported positive aspects of their relationships with regard to teaching and patient care, negative relational perceptions prevailed. Faculty reported disconnection, competitive individualism, the undervaluing of humanism, and a lack of trust in relationships with colleagues. Given these findings, it is reasonable to expect that a cultural shift will be necessary to support the goal of peak performance. Of concern are cultural norms that may not fully account for the importance of noncognitive knowledge and skill domains, the unique stories of individuals, and positive relational perceptions—all of which are necessary components if peak performance is to occur in AHCs.

Integration of professional coaches and the subsequent development of coachlike behaviors in faculty is one effective, if unrecognized, strategy for cultural change in academic medicine. Although the corporate world has widely recognized the value of executive leadership coaching, physician coaching is a more recent development.[3]

A brief summary about professional coaching as it applies to this essay is in order. Professional coaching—distinct from therapy, consulting, mentoring, training, and athletic development—requires unique academic and practicum training, credentialing, continuing education, and adherence to a professional code of ethics. Professional coaching does the following:

- draws on the philosophy of positive psychology and cognitive behavioral sciences to increase self-awareness, choice, and self-trust;
- supports personal and professional development;
- focuses on the future and the creation of the highest potential self;
- highlights a nonhierarchical partnership;
- relies on the creativity and resourcefulness of individuals to generate their own intention and solutions, with the coach supplying nonjudgmental, inquiry-based approaches and principles;
- precludes a reliance on a linear learning path or established curriculum;
- focuses on identifying opportunities for strengths-based development; and
- results in quantifiable outcomes.

Within our residency training program, a professional coach (P.M.T.) helped to develop coachlike behaviors (e.g., asking powerful questions, challenging beliefs, establishing trust, and being authentic) among faculty during the last academic year. Faculty have now partnered with one another to create a medical knowledge coaching program focused on clinical and board-tested concepts, an interdisciplinary ward team program that addresses communication between care team members and patients, and a well-being and career transitions curriculum for residents centered around balancing their personal and professional lives and preparing for life after residency. The anecdotally reported outcomes of the medical knowledge coaching program

are particularly noteworthy; they include a significant enhancement in board pass rates, an increase in both faculty and resident perceptions of residents' lifelong learning ability, and a discernable confidence in resident mindsets. As is often the case when uncommon goals are pursued, some unexpected discoveries have been made. Faculty report both enhanced trust in collegial relationships and that they have been surprised by the positive change in their attitudes about resident intelligence, compassion, reflection, and curiosity.

Integrating the principles and practices of professional coaching across the continuum and within the entire academic medicine community could gradually, but inexorably, shift the culture to be dynamic and relational: one in which talented individuals can and do apply their peak performance to all aspects of their work.

References

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