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Original Article

Peer Coaching as a Technique to Foster Professional Development in Clinical Ambulatory Settings

Leslie E. Sekerka, PhD, and Jason Chao, MD

Abstract

Introduction: Few studies have examined how peer coaching is an effective educational and development technique in contexts outside the classroom. This research focused on peer coaching as a platform to study the process of professional development for physicians. The purpose was to identify perceived benefits coaches received from a coaching encounter and how this relates to their own process of professional development.

Methods: Critical incident interviews with 13 physician coaches were conducted and tape recorded. Themes were identified using a thematic analysis technique.

Results: Themes emerged clustering around two distinct benefit orientations. Group 1, reflection and teaching coaches, tended to focus on others and discuss how positively they experienced the encounter. Group 2, personal learning and change coaches, expressed benefits along more personal lines.

Discussion: Peer coaching contributes to physicians’ professional development by encouraging reflection time and learning. Peer coaching affords positive impact to those who coach in addition to those who receive the coaching. The two clusters of benefits support the performance, learning, and development theory in that there are multiple modes to describe adult growth and development. Programs of this type should be considered in medical faculty development activities associated with medical education.

Key Words: Adult learning and development, ambulatory teaching, continuing medical education, faculty development, peer coaching, less thematic analysis

Introduction

For physicians, called to a profession to help others, it is important to understand what techniques are conducive to fostering their own learning, well-being, and growth as they give care. This research identifies peer coaching (PC) as a platform to studying this process. Coaching features an intense focus on learning that includes physicians working together to learn models of teaching or to address specific improvements.

Peer coaching has been described as a “structured process by which trained faculty voluntarily assist each other in enhancing their teaching repertoires within an atmosphere of collegial trust and candor.” Few studies have examined how this technique is an effective educational and development process in contexts outside the classroom. Prior research is descriptive, looking at PC in general and discussing outcomes in broad strokes. This study extends the current
literature not only by ascertaining how coaching helps the coach but also by examining PC in a clinical ambulatory setting, a nontraditional learning environment.

PC is important to continuing medical education as it builds on teachers’ knowledge and strengthens skills for teaching in a clinical environment. The technique was introduced to medical education in the early 1990s and is now highlighted as an important part of a comprehensive program for ongoing faculty development. It can be used in a variety of settings to empower educators as it bolsters learning for both physicians and students. The major functions of PC are to (1) provide companionship, (2) stimulate feedback, (3) promote analysis of applications to internalize tools, (4) foster adaptation, and (5) facilitate trial by providing support.

The present investigation looks at the role of professional development by interviewing physicians who have been peer coaches in a clinical ambulatory setting. The current literature suggests that PC relationships are mutually beneficial, fostering learning for both coach and coachee. Unexamined are what happens to the coach and how perceived benefits of the encounter relate to their own development. This research explores what positive outcomes occur when physicians coach other physicians by answering the following research questions: What perceived benefits do coaches receive from their PC experience? Does PC contribute to the coach’s professional development?

By featuring the benefits of PC, this research aims to foster interest in longitudinal approaches for preceptor development. This study attends to outcomes experienced by the coach and illustrates how PC may provide benefits that were previously unnoticed.

Background

Joyce and Showers articulated the framework for PC in the early 1980s, with the goal of edifying educator staff development. Education experts have underscored that coaching processes differ from other peer techniques. In educator PC, teachers learn about the theoretical foundation of a skill, observe it demonstrated, and then practice the skill with feedback. Coaching models vary and generally emphasize a technical, challenge, or collegial focus. The technical focus is designed to help master specific teaching methods. The challenge focus is directed toward resolving a problematic situation and helps pairs concentrate on individual areas in which they desire improvement. The collegial focus is relational and promotes shared reflection, leading to enhanced trust and communication.

Some researchers of professional development have hypothesized a sequential progression of skill attainment for effective physician development. Alternatively, building on the life-stage works of Piaget and Levinson, the Performance, Learning, and Development Theory postulates three nonsequential modes describing adult development. Individuals are predominantly in one mode during any one time in their life/career, and the current mode affects one’s process of growth. The three modes are performance, learning, and development, with no advanced orientation. Individuals have a dominant mode, but there is no sequential movement, and modes are expected to be revisited.

Since PC made its debut in the education arena, professional development programs emphasizing peer-centered options have emerged. One example is the Physician Peer Coaching Program (PPCP) at the Department of Family Medicine at the Case Western Reserve University (CWRU) School of Medicine. Since 1991, the mission of the PPCP was to improve the clinical teaching skills of faculty. PC was adopted because observations of clinical precepting revealed that physicians did not possess basic teaching skills such as asking questions, providing constructive feedback, and active listening. With over a decade of involvement, this program was ideal for examining physicians’ perceptions about their experiences as coaches.
Peer Coaching

PPCP trains preceptors as coaches so they can help other physicians with ambulatory teaching practices. It is a vehicle for improving instruction and enhancing clinicians' understanding and use of new teaching skills or improving existing competencies. This is learned by demonstration, practice, and nonevaluative feedback between coaching colleagues. Although it resembles a Kurthinian coaching model (i.e., collegial interaction rather than supervisory evaluation), PPCP blends various forms of coaching to generate maximum effectiveness. Fundamentals include voluntary participation, collaboration and parity of colleagues, shared identification of goals, focused observation of teaching with the provision of feedback analysis, and ongoing coach instructor support.

Methods

Participants were members of the CWRU, Department of Family Medicine, PPCP (N = 26). To become a coach, physicians agreed to participate in workshops in which small interactive cadres met to role-play coaching scenarios while being videotaped. Reviewing their tapes, coaches examined processes and shared reflections. Physicians were trained in two personal coaching sessions (i.e., observed and coached on teaching skills). Partnered with another physician, they began their coaching role in an ambulatory setting. Payment was $175 per session when attending a workshop or serving as coach.

An inductive qualitative method using grounded theory and thematic analysis was used to perform an in-depth analysis of coaches’ experiences. Coaches in the sample frame were contacted (two were not available). Critical incident interviews were conducted (i.e., an interviewing technique used in medical education research). Physicians were asked to think of a time when they assumed the role as coach (in a coaching session) and to respond to the following: "What are you getting out of being a coach?" "To what extent has this coaching experience affected your role as a physician preceptor?" and "What happens to you as a result of your coaching experience?" The tape-recorded interviews ran from 50 to 70 minutes and were transcribed verbatim.

The coach and physician he/she coached were asked to evaluate the session referenced in the interview. Twenty-four questions using a five-item Likert scale (1 = not applicable or not observed, 2 = poor, 3 = fair, 4 = good, 5 = excellent) were asked to evaluate the session as a whole and the coach's contribution and effectiveness in teaching. Items included questions about helping the coachee to learn and how effectively coaches asked questions, listened, used humor, and provided feedback.

Each coach's rating was averaged for an overall self-reported effectiveness score; similarly, coachee's ratings for an overall coachee-reported effectiveness score. Scores represented how effective each coach was in the encounter—from both viewpoints. Avoiding long-term memory bias, 11 coaches citing encounters from more than 2 years ago were dropped from the analysis (n = 13).

Through a compare-and-contrast method, the senior researcher identified manifest and latent themes from three randomly selected transcripts. Indicators for each benefit theme were found through an intensive iterative process, leading to the creation of a preliminary codebook. The codebook was used to identify the presence of themes in other transcripts, with frequency of indicators for each theme reflecting the strength of each benefit theme for each physician.

Once the draft codebook was complete, a research assistant was trained to learn the code. Three additional transcripts (randomly selected from the remaining 10) were independently coded by the researcher and the assistant. After adjusting several indicators, an interrater reliability of .87 was achieved. Percentage of agreement was calculated by the number of times both coders agreed divided by the number of times coding was possible. To test the validity of the codebook, the remaining seven transcripts were independently coded, and an interrater reliability of .91 was achieved.
Results

Twenty-four interviews were conducted with board-certified family physicians. Twenty-one were white, two were Asian, and one was black. The characteristics of participants are outlined in Table 1. Ten benefit themes were identified. Table 2 lists major themes and definitions with sample quotations. Benefits clustered around two general orientations: group 1 toward reflection and teaching and group 2 toward personal learning and change. Group 1 reflected a greater presence of themes 1 to 5 and group 2 themes 6 to 10. An independent-samples t test showed that the clustering of themes 1 to 5 (reflection and teaching) and 6 to 10 (personal learning and change) was significant at p < .05.

Seven coaches carried themes predominantly from group 1 and six coaches from group 2. Seventy-five percent of the female coaches fell into group 1, whereas males were distributed between the two groups. Group 1 considered benefits not as distinct but as integrated concepts. They processed the experience through a lens focused on others, putting collective orientations ahead of their own. Themes 1 to 5 exemplify centering on others, coupled with a conscious awareness of reflection time used to meet learners' needs. Group 1 embraced the "bigger picture" and often referenced ongoing learning. They viewed learning as a cycle, cognizant of multiple levels of the teaching-learning process. Group 1 linked comments with expressions of concern or empathy toward the student or preceptor. They framed outcomes around how to enhance their role as an educator. These coaches enjoyed the session and described how it contributed to their overall positive outlook.

Themes 6 to 10, predominantly associated with group 2, were along more personal lines. References were concrete learnings, tangible outcomes, and/or examples of direct benefit. In general, outcomes were related to personal change, with attention directed at their own learning or growth process. They enjoyed sharing the experience, especially when discovering that they made a contribution. This frequently included positive self-assessment and enthusiasm about seeing personal progress. They were pleased to be engaged in a process that facilitated their learning and offered self- affirmations in conjunction with notice of growth. This group expressed the importance of challenge and that coaching added something "new" to their practitioner experience, which served to keep things "interesting."

The mean coachee composite score was 4.2 (1- to 5-point scale; 5 = excellent), suggesting that merit was found in the experience (coaches rated themselves slightly lower; the mean self-reported coach composite score was 3.8). Comparing the groups, there was virtually no difference in the coaches' effectiveness scores. Coaches in group 1 (reflection and teaching), however, were rated slightly higher overall than those in group 2 (personal learning and change), 4.4 and 4.0, respectively.

Discussion

This study provided information about the perceived benefits of PC and insights on how coach-

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**Table 1 Characteristics of Coaches Interviewed**

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (n = 7)</th>
<th>Group 2 (n = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>3 female, 4 male</td>
<td>1 female, 5 male</td>
</tr>
<tr>
<td>Mean number of years as a teacher*</td>
<td>11.6 (SD 6.7)</td>
<td>11.7 (SD 6.8)</td>
</tr>
<tr>
<td>Mean age*</td>
<td>40.9 (SD 5.6)</td>
<td>45.0 (SD 7.1)</td>
</tr>
<tr>
<td>Academic rank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate clinical professor</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Assistant professor</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Assistant clinical professor</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Instructor</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clinical instructor</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

*No statistically significant difference between groups for coaches' time as a teacher or age.
### Peer Coaching

#### Table 2 Major Themes and Definitions with Representative Quotations

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 1: Reflection and Teaching</td>
<td>I get protected time for reflection. I think any time you step back and observe someone else’s teaching behavior you begin to reflect upon your own. And so it just puts you more into that reflective mode. I’ll mentally step back from time to time and think about which teaching skills I’m using and where; maybe certain parts of the teaching process have been covered and I need to focus on others.</td>
</tr>
<tr>
<td>1. Use of Reflection Skills</td>
<td>I just enjoy it…it’s pleasurable for me to have people feel more comfortable. I like the fact that if they have more knowledge, they’re going to feel more comfortable.</td>
</tr>
<tr>
<td>2. Sees the Bigger Picture</td>
<td>Many had positive feedback on the technique I offered. It has strengthened my belief that I have something to contribute.</td>
</tr>
<tr>
<td>3. Focus on the Learner</td>
<td>I feel like my purpose is in developing my career and still get me involved as my identity as a teacher…I guess paramount to that full identity is being someone who kind of really spirits…a positive influence…is an initiator and enabler. It’s like a cycle, and the more you feed into it, the better it becomes.</td>
</tr>
<tr>
<td>4. Enhances Well-being</td>
<td>I see things that I could possibly do when I’m precepting a student. I am able to try out some different styles.</td>
</tr>
<tr>
<td>5. Motivation to Teach</td>
<td>It helped me to make a lot of changes in myself.</td>
</tr>
<tr>
<td>Cluster 2: Personal Learning and Change</td>
<td>I enlightened myself, became more involved.</td>
</tr>
<tr>
<td>6. Notes Own Contribution</td>
<td>It is a growing experience for me…keeps it more interesting for me. This is a new challenge for me…this fits with my desire to look for something different and challenging and keeps what I do interesting.</td>
</tr>
<tr>
<td>7. Learns Something New</td>
<td></td>
</tr>
<tr>
<td>8. Experiences Change</td>
<td></td>
</tr>
<tr>
<td>9. Positive Self-Assessment</td>
<td></td>
</tr>
<tr>
<td>10. Seeks Challenge</td>
<td></td>
</tr>
</tbody>
</table>
Coaches perceived differentiated benefits centered around two orientations. Group 2 expressed more engagement in their own learning and personal change. With a greater focus on themselves, this introspective stance may have been used to facilitate the success of their learning process. Benefits seemed to be in service of the coach's own change, to give confirmation of proceeding in good form. By pointing out their contributions, they bolstered self-confidence and underscored personal mastery. Whereas coaches in group 2 demonstrated reciprocity, this mutuality was expressed quite differently in group 1. These coaches made little mention of engagement in new learning or change but referenced making improvements and sustaining ongoing learning. They focused on what their involvement could do to contribute to the learner's process or to advance teaching and were consciously engaging in reflective practices.

Because all of the coaches in this study were board-certified physicians, it is not clear if further development is linear. The two orientations found in this study may not necessarily be in stepwise progression. Using the performance, learning, and development theory, it is feasible that coaches' reference point contributed to the group differentials. The physicians may have started from different modes of growth when entering the PPCP. This explanation serves as a rationale for why the coaches perceived the benefits of their encounters so differently.

This inquiry illuminated the coaches' current mode vis-à-vis their benefit themes. Thirteen physicians of relatively equal status and experience were engaged in a partnered learning situation, yet they experienced it quite differently. We contend that this was an expression of the growth mode they were in at the commencement of their involvement. Specifically, coaches with benefit themes 1 to 5 (group 1) were likely to have started in the development mode, and coaches with benefit themes 6 to 10 (group 2) were likely to have started in the learning or performance mode. This would explain the emergence of very different benefit theme orientations. Worth noting is that both groups displayed effective coaching, regardless of orientation. This suggests that as long as the coach maintains a focus on the learner, coachees are likely to receive effective help.

The physicians engaged in the PPCP were willing to broach education and growth, which for some included experiences of personal change. As a result, preceptors received benefits contributing to both learning and development. Although it is important to consider expert and novice level of abilities in technical competencies, caution should be used in applying these terms to other areas of learning as the language implies hierarchy.

Limitations

A limitation of the study was a small sample size. Although all of the data were valuable, trying to associate memories was problematic for those referencing an encounter that occurred years ago. At the time of the interviews, those coaches citing earlier reference points were approximately 4 years older and had that same number of additional years of teaching experience over the subsample analyzed. Finally, with participation based on self-selection, we recognize a degree of bias. One cannot presume that individuals participating in PC will perceive the same benefits or that all potential benefits have been identified.

Future Research

Future research should assess development modes before and after participation in PC programs. This may help distinguish experiences and what types of helping behaviors warrant increased attention. By considering individual differences in professional development, those responsible for continuing education can create the most beneficial educational programs for physicians. In addition, the questions that guide the direction of future investigators are important because they will determine the extent to which special-
Peer Coaching

Lessons for Practice

- Peer coaching contributes to physicians' professional development by encouraging time for reflection and learning.
- Peer coaching can influence the physician coach as well as the physician who received the coaching.
- Physician peer coaches may benefit in their reflection and teaching or in their personal learning and development.

ized integrated programs can be used to enhance faculty education, especially for clinical teaching in ambulatory settings. As PC contributes to both coachee and coach, programs of this type should be considered in activities associated with medical education. We believe that this technique can be used in a variety of settings and has the potential to bolster learning at multiple levels.

The broader implications of this research are that PC serves as a vehicle for ongoing learning and personal and professional growth for medical educators, empowering physicians to excel as educators. This study exemplifies that even in the busiest of teaching environments, coaching offers an elegant framework for engendering cross-learning and support.

Acknowledgments

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