Coaching in Health Care: 
Focus on Physicians

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Coaching in Health Care: Focus on Physicians

Sandra Boeschen

The health care industry in the United States is highly complex, structurally and historically. The layered hierarchy of caregivers and regulations that affect direct care adds complexity. For example, the range of caregiver organizations includes insurers, hospitals, physician groups, pharmaceutical firms, biotechnology firms, and others. Health care reform has the potential to bring physicians into a prominent leadership role because many of the initiatives focus on cost reduction, as well as quality improvement and variation reduction in care practices. This article focuses on leadership coaching, particularly for emerging physician leaders. The change curve is steep – a good time for coaching.

There are many organizational settings in which physicians practice medicine in the United States. Some physician specialties have contracts with hospitals to provide services, for example, radiologists, pathologists, and hospitalists. Others, like surgeons, are individual practitioners who use the hospitals’ facilities. That’s why patients get bills from several different organizations when they have had surgery. The hospitals may be stand-alone or belong to a system. There may be separate out-patient clinics. As organizational structures vary, so do the ways in which hospitals and physicians are paid. This often leads to fragmentation in the system.

The concept of a health care medical home¹, emerging as part of health care reform, illustrates the increased awareness of building a communications and care bridge from one type of service to the next. This includes preventive and episodic care in the physician’s office, hospital care, home care, specialty care for acute and chronic conditions, palliative care, and hospice care. Patients have wondered why this connected care is so difficult to find.

As physicians transition to a leadership role, they learn how their organizational setting fits with related organizations and its performance demands. For example, a physician who has worked as Chief of Staff in a hospital has a different role and must demonstrate different competencies than when leading in a clinic setting.

Structure, funding, and leadership are essential for a more connected type of care to become commonplace. Physician leaders are needed in many current clinical settings. Physician leaders are well positioned to coordinate with other caregivers and administrative leaders to assure the patient’s needs don’t go unmet as they move from one type of care to another.

¹The goal of a health care medical home, also referred to as a patient-centered medical home, is to provide comprehensive primary care services from preventive care through end-of-life care. Individuals have access to a team of health care professionals to be sure their care is coordinated.
THE COACHING OPPORTUNITY

No matter which level or area of health care, there is a clear need for physician leaders who understand both the clinical and business structures of health care and have the abilities and skills to lead. This must occur not only in the exam room or hospital room but also in the administrative conference room.

Most physicians are not trained in leadership skills as part of their medical school training. They learn little about how to coach others to excellence. Fortunately, the high educational level of physicians makes them excellent candidates for coaching and training to learn those skills. Some physician leaders go on to get their MBA, MHA (Masters in Health Administration), or MPH (Masters in Public Health). Most hospital administrators have such a degree, the basic ticket of admission to the upper levels of health care administration. Physicians whose work remains largely clinical often choose to learn leadership basics without going back for a degree.

Coaching and leadership development

Physicians can access a wide variety of leadership courses, but coaching has an especially powerful impact because it is focused and personalized to the individual's needs. It's not necessary to be a physician to coach a physician. However, understanding the main components of the health care industry and the specific ways that health care professions function add significantly to a coach’s effectiveness and credibility. In addition, when a coach has some background in various health care settings, they are better able to discern what competencies would be most relevant to and important for the physician client.

It's probably most important for the coach to understand that physicians are trained in a specific way. Generally, they respond to evidence-based information, succinct discussion of key principles being taught, and an opportunity to practice and get feedback immediately.

Physicians may be reluctant initially to be in a multi-disciplinary session where leadership strengths and weaknesses are being discussed. This exclusivity has been changing somewhat over the past several years. There is anecdotal evidence that several categories of physicians are having an impact on how and with whom physicians want to learn: (1) hospitalists (who work closely with nurses on a shift basis), (2) female physicians (who are now more common in the workforce), and (3) younger physicians (who are used to a more egalitarian approach with partners and peers than was the previous generation of physicians).

It is a joy to coach physicians, given their quick and receptive reaction to well-prepared information and their desire to excel. Coaches provide a tutorial format for leadership skills as well as
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There is an intimidation factor that people often associate with physicians. Coaches need to let go of preconceptions about physicians as beings who stand apart from the rest of us. These are highly trained individuals who didn’t have an opportunity to take leadership classes and so are eager to fill in missing knowledge. Nearly all of the physician-coaching clients with whom we work want clear feedback. The irony is that physicians are often reluctant to give direct feedback to their peers. There is an ethic of collegial respect that influences interactions. In addition, there are complications that arise from consulting relationships where how an individual receiving the coaching services handles feedback may enhance or diminish referrals. Coaches need to be prepared to give direct feedback and to seek it.

Coaching physicians requires many of the same coach competencies needed for work with other kinds of leaders. The primary difference is the tutorial portion of coaching, where the coach is filling in information to improve leadership skills. Other leaders accessed this information via advanced education or classes offered by the organization. Why is there such a need for concise tutorials? Physicians in clinical practice already have demands on their time for continuing education in their clinical specialty. Unless the physician works in a full-time administrator role, time for other education is scarce. Self-employed coaches understand the conflict between taking time away from their practices to go to a class – in effect, they are not earning while expending money for the class. For physicians, there is a similar dilemma. Time away means a decrease in productivity, a strain on the rest of the group, and a lessening of income for the physician. Coaching can be an efficient and effective way to lessen this barrier to learning.

As with other types of leaders, physicians are willing to work on insight into self and adapting leadership style to a variety of settings. We see physicians as having an advantage – their values about improving patient care through their own actions are clear. Coaches can apply appreciative inquiry to cement the transferable skills from patient care to leadership. The question, “How do you do this in a patient care setting?” often surfaces skills from which leadership behaviors can be built. We jokingly tell physicians that they are bi-lingual (meaning fluent in “patient” and becoming fluent in “leader”). They can start where they are, work on areas for improvement, and bring their best care giving skills to the learning. However, the issue of expanding the repertoire beyond just the command style that was taught to many physicians continues to be challenging. Coaching can balance the appreciative with the
corrective, particularly when an informal or formal 360° feedback system is engaged.

“Dr. Sam”
Sam had taken a number of leadership courses but was still seen as domineering and impulsive. People around him felt squashed and unappreciated. He recognized that he needed specific help with behaviors that were getting in the way of leadership when his supervisor offered to promote him on the condition that he learn to control his impulsivity. He called me to ask for coaching.

Together, we deconstructed situations where he was likely to blurt out the answer rather than asking questions and listening to draw others in. A breakthrough came when he said testily “Stop talking about where I’m succeeding and tell me where I’m failing.” I told him about the importance of focusing on what works well to create new habits. Two weeks later, he grudgingly agreed that focusing on what works was creating new pathways and cementing behaviors. As he talked about the specifics of new actions, he learned—by rote, initially—ways of listening that changed how others interacted with him.

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PROMOTING THE COACHING CONCEPT WITH PHYSICIANS
Where members of a health care organization are familiar with coaching as an element of leadership development, connecting the physician leader with a coach is natural. The willingness to fund coaching varies. Fees can seem hefty, and return-on-investment metrics may seem unclear. It is frequently the coach’s responsibility to create an agreement that is educational as much as business-oriented. The conversations before coaching is implemented target the distilled way coaching can fill in gaps—areas that the individual needs to strengthen—and emphasize how coaching will accelerate integration of the physician into the organization’s leadership structure.

Because the individual is almost always part of a system of some kind, coaching takes a variety of forms. The coachee gets a more comprehensive service when he participates in a variety of these experiences. Here are some examples.

1. **One-to-one coaching:** This form of coaching is intended for physicians who are transitioning into new leadership roles. It focuses on bridging the divide between how physicians and non-physician leaders view each other. In particular, it involves increasing the physician’s awareness of the organization’s formal structure as well as appreciating the many informal structures of people and groups who influence what happens.

We jokingly tell physicians that they are bi-lingual (meaning fluent in “patient” and becoming fluent in “leader”).
For individual coaching, it’s not necessary to be a physician to coach one. In fact, what many new physician leaders want most is a coach who speaks “administrator-ese” and understands how to build coalitions and get things done in a large organization. In short, they want to work with someone who has lived in the world in which they’re seeking to function.

That said, there are times when it’s more effective to call in a physician who’s a coach. An example is a situation where the physician leader feels significantly distanced from others in the team and is in danger of being ruled out as a leader. (More on that below.)

Hospitalists (physicians who focus on inpatient care in hospitals) are an emerging cadre of leaders. Coaches can have a significant influence on how non-MD/MD communications can be improved and working relationships accelerated by concentrating on this group of leaders.

2. **Sounding board coaching**: Physicians who are in senior roles in medical centers, medical foundations, and other high level roles increasingly choose to meet with a coach as a sounding board. “I need someone who will tell me the truth, and someone I can ask about anything that’s on my mind” is the way more than one person has described this type of coaching. Sounding board coaching often continues over a period of time as trust and experience build between executive and coach. It’s most effective when some form of 360° feedback is included periodically. Without objective feedback, coaches can lose sight of how others are seeing the client.

3. **“Difficult physician” coaching**: At times a physician’s behavior triggers a negative reaction that requires attention before it reaches the disciplinary action stage. These are typically physicians who are highly competent clinicians, beloved by patients, but unable to “play well with others.” Coaches do end up educating clients who are new to coaching. The coach often should ask what the client’s expectations are with regard to the coaching of a “difficult physician.” A coach will often ask the potential organizational client a direct question about expectations: “Do you believe this person has a significant chance of success or have things gone too far?” More than one colleague coach has been caught off-guard when the coachee is fired and coaching is cited as “proof that we tried everything.”

Coaching with difficult physicians does not require a physician as coach, but it’s worth noting that a coach who is a physician can establish a special rapport.

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*Facilitated conversations with physicians in leadership roles provide a confidential setting to explore gaps in information and skills topics.*
The Board of Directors was impressed with their choice but also wanted her to be more of an administrator.

4. **Group coaching**: Facilitated conversations with physicians in leadership roles provide a confidential setting to explore gaps in information and skills topics. A traditional classroom training model still has its place. However, bringing physician colleagues together in small cohorts for a facilitated conversation is an effective way to orient them to leadership skills information.

Physician training involves learning a concept and skill based on known evidence, observing it, and then practicing it. In addition, time constraints, as noted earlier, are a significant factor in physicians’ lives, so a coach/facilitator needs to provide information and practice in a condensed period of time.

The following two examples illustrate group coaching/leadership skill building with physicians.

- Medical groups are increasingly investing in “clinic leads,” the physicians who are in a particular clinic setting on a day-to-day basis. These physicians are still practicing nearly full-time and have a small percentage of their time allocated to leadership of their peers and staff in the clinic. They typically have a non-physician counterpart, sometimes called a paired leader.

  One effective way to launch these physicians in their leadership role is to hold a day-long session, usually on a Saturday or at other non-clinic times, where a number of key leadership skills are taught in the context of the group’s work settings, the changes they are implementing, and the situations they face. This kind of session requires an adept facilitator who can help the participants reveal their thoughts about the role, in addition to being able to teach skills and lead the practice of those skills. The facilitator cannot come with a canned curriculum—a framework that allows for flexibility is the key.

  Typical topics are excelling at important interpersonal communications, exercising influence, facilitating team interactions, and leading change. The group’s leaders open the day, and an initial conversation about how the physicians are experiencing their site lead role is held. Groups are typically under 16 in number, unless their paired administrative leaders are included. In that case, the number can doubled, which, of course, changes the feel and dynamics of the group.

  The skills format consists of brief talks that cover the concept and skills. The facilitator asks participants...
to describe current situations so that the subsequent practice is useful and replicable back at the clinic. Then participants practice the skills with each other, followed by a debriefing of where the rough spots occurred. A second practice confirms for physicians how quickly initial mastery of skills grows and reinforces the important role played by planning and practice. Participants make a commitment to one of their co-participants, and both agree to check in with each other on how practice back at the clinic went.

- The second group coaching example is a leadership intensive called Physicians’ LeaderLab™. The session is a 2.5 day session where a cohort of 12-14 physicians explores the nature and dynamics of leadership. They work on goals for their leadership as well as behavioral aspects of their leadership style. Two in-depth assessments inform the physician participants as to how others perceive their leadership (in a way they’re unlikely to have experienced anywhere else). The participants develop goals and action plans, both with a peer coach and with one of the executive coaches who facilitates the session. They leave the session with a fully developed plan for their leadership work and another plan for their individual development. Several coaching sessions follow, including one with the participant’s sponsor to confirm the individual’s leadership goals and to offer specific support.

**CASE STUDIES**

The following case studies have been altered to protect the confidentiality of the individuals involved.

**Leader for a season**

A physician whose career experience was primarily in research was asked to lead an organization with a high public profile. She was exceptionally bright. She saw how different research streams could be brought together to create a unique and powerful research agenda with huge potential to improve survival rates of a serious disease. The potential for the organization to lead innovation internationally was within reach.

The Board of Directors was impressed with their choice but also wanted her to be more of an administrator. Board members were not research scientists, and the majority had been appointed through a political process. Their vision was limited regarding the science but fairly acute where visibility and “not rocking the boat” came into play. The Board, in other words, didn’t want the Executive Director to do anything “too risky.”

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2 Gene Scott, PhD, conducts Physicians’ LeaderLab™. For additional information, see Resources
They suggested that she acquire a coach to help her learn how to be an administrator. That suggestion came because they felt she was naïve about leading an organization, and that there was already some unrest among the employees.

The coach was familiar with research organizations. Hearing the Executive Director’s vision and her passion for it, she realized that the client was never going to be a typical administrator. While the Executive Director was fully capable of learning the skills of administration, including communicating vision, providing project direction, and showing appreciation, she also needed to become more strategic about managing her board. In particular, she needed to become more adept at working with the Board’s recruitment committee to assure addition of members who were more sophisticated about research. Though not on the coaching agenda the board had envisioned, it is an essential element in any CEO’s repertoire of skills.

As time went on, the coach interviewed the Executive Director’s direct reports and identified specific ways for her to improve her leadership. For example, the interviewees talked about great leaps in the Executive Director’s thinking, which made it difficult for them to understand and support her and the organization through their roles. Client and coach worked on the relatively simple skill of informing others. To the client it was a surprise that this type of communication was necessary—fellow research physicians had always understood her communication. But once she understood the importance of articulating in a sequential way what she was thinking and wanted of her direct reports, she immediately put the new skills into practice. Physicians are used to protocols and frameworks, so it is not difficult to apply them in the leadership realm, once spelled out.

The more strategic issues of Board selection and managing committees required some discussion about exercising political savvy. The client previously thought that the nine-person Board should oversee their own governance, thus her role, logically, was to inform them of the activities of the research arm. We talked about the impact of Board recruitment on her vision by applying elementary statistics to Board composition: “Three members who understand and support the vision replacing three with a limited local political agenda is a 33% swing in direction and statistically significant.”

An over-reliance on logic and reasonableness as influence skills was hampering the Executive Director. She assumed Board members would listen to the information she gave and understand the actions that information implied. She was frustrated with what she saw as their fuzzy logic. We talked through her MBTI assessment and applied it to the differing styles around her. She became more adept at adapting her approach to different styles but remained discouraged with the Board’s limited vision.

*It took some candid talk about what a waste of energy and coaching it was to focus on the boss rather than on what Armand could do himself to change the situation.*
Ultimately, the Executive Director felt she had done what she came to accomplish and wanted to move in a different direction. She left the position and moved into an entrepreneurial role in biotech. Given the client’s talent and passion, the rather plodding demands of the previous position were too limiting. Many of the things that motivate others—power and prestige of the position—didn’t mean anything in comparison to her research agenda.

**Over or out: Story of a non-physician leader**

The client in this case was a mature individual whose boss had recently assumed responsibilities for a larger division of the health care organization that encompassed clinics, hospitals, and physician organizations. Unfortunately, the boss kept his hand on both his new and previous roles. In other parts of the organization, the new division directors had already structured their part of the organization with a second-in-command person to lead the functional and site leaders for Finance. This client’s director stayed in the lead role, keeping the functional and site leaders in siloed roles. Working across several medical groups and hospitals, the siloed structure began to unravel. The client, Armand, arrived to coaching in a completely frustrated state.

Armand had strong competence in strategy and synthesis. His boss, the lead financial executive for the division, was great at tactics, and the CEO of the division relied on this ability to deliver on short-term items. Executing on a series of tasks was primarily what he wanted of Armand. The initial sessions with Armand understandably had a significant element of “venting.” No matter what coaching questions came up, Armand would revert to what his boss wasn’t doing right, the opportunities that were being missed, and the toll it was taking on the division’s effectiveness. It took some candid talk about what a waste of energy and coaching it was to focus on the boss rather than on what Armand could do himself to change the situation.

In a pivotal coaching session, the coach asked, “Based on what you’ve told me, what do you think is the potential for change with your boss and this situation?” Armand was still for a long moment. He said with a sigh and then a smile, “OK, I get it. I’m giving up my power and my energy trying to change another person. Complaining won’t change anything, though, I have to admit, venting does feel good.” With this awareness, he was able to move rapidly to an action plan for communications with his boss and design of several projects that would advance the Finance work across the region. Armand continued to talk with his boss about the strategic wisdom of restructuring the organization.

It would be nice to say that the boss listened and agreed that a different way of leading was required in the new structure. In fact, he was so focused on the tactical needs that he didn’t see any reason to change. Working with the team on a collaborative strategic vision wasn’t a priority.
Recognizing the need for independent action, Armand was able to carve out a somewhat satisfying role and expanded his experience through multi-disciplinary projects. As you often see in health care, there was a strong pull for Armand to be loyal to and protective of his colleagues who were less experienced. He wanted to change things and help the whole group move beyond the current situation to one where growth and closer collaboration would flourish.

We talked about situations where the most experienced person leaves and suddenly others in the group take on more responsibility. Armand was being courted for a larger role in a different health care system. He experimented with encouraging colleagues to step forward and have the conversation with the boss that they had been relying on Armand to have. To his satisfaction, his coaching was effective and the entire leadership team initiated a series of such sessions. Armand is moving on to the larger role elsewhere in the organization where his strategic abilities will be used fully.

From clinician to administrator
A hospital CEO was under pressure to add a physician leader to her senior team. She did so, spending a lot of energy getting the physician up-to-speed and somewhat integrated. The physician enjoyed the leadership exposure, which convinced him that his lifelong dream to go into international medicine was now within reach. He left for a leadership role in another country.

The CEO then recruited a physician who was in active practice and very familiar with the hospital. As an experienced leader, the CEO was very good at spotting raw talent and was now more seasoned with physician leaders. She decided her new physician candidate’s temperament was well suited to the leadership team, and that she could mentor him. With the CEO’s support, the physician engaged a coach to help with leadership skills he hadn’t had a chance to hone.

As with many physician leaders, a stipulation was that he would continue some clinical practice, though greatly reduced in time. This is common in physician leadership roles. There is a level of credibility with other physicians that is only achieved by continuing in clinical practice.

In a complex health care setting, focused help is needed to get oriented to and current with the leadership demands and culture.

In a complex health care setting, focused help is needed to get oriented to and current with the leadership demands and culture. Not having had leadership or organization development courses in medical school, physicians often don’t experience the need for agility in a large organization. Frequently, they don’t know how to utilize the broad array of resources available to an administrative leader versus a physician clinician.

This role required the ability to lead multi-disciplinary committees, working with non-physician senior leaders who were unused
to having a physician on the team. It also entailed influencing physician colleagues in paid, part-time roles to complete the work they had been asked to do.

The coach was familiar with the organization, and was able to quickly outline the coaching agenda with the client. The coaching incorporated the strategic goals of the role, an iterative process of six-month work plans and prioritization, and learning specific skills such as identifying good people connections and cultivating them, delegation, and facilitating meetings.

In addition, coach and coachee planned best ways to get additional mentoring, experience, and education. After three years in the role, the physician had grown in his leadership skills to the point where he could recognize where his leadership was accepted, and where the leadership team was still struggling to accept physician leadership. He was courageous about working through a number of these issues in sometimes painful conversations with the rest of the team.

In time, the physician’s close mentoring relationship with the CEO transformed into a collegial relationship. Currently, the physician is fully integrated into his role and trusted by teammates. He and the CEO have initiated a series of discussions about how to advance the physician’s education and experiences so that he can move into a higher-level leadership role, potentially a CEO position in the organization. The CEO is encouraging the physician’s participation in an MBA program and is finding colleagues in other parts of the organization to mentor the physician in projects, particularly those that connect quality and finance.

This was an instance where the CEO mentor had a central role in the individual’s development. The coach’s role was to offer a confidential, candid environment to work through challenges.

Conflict between the satisfaction of clinical work and a leadership role

Physicians joke that they were put in a leadership role because they “didn’t step back fast enough.” A physician attended a leadership workshop because the president of his group asked him to. When asked about his expectations at the beginning of the event, he said that he didn’t have any and wasn’t even sure he should be there. He assumed that all the other participants were far ahead of him on their leadership development path.

The session facilitators, experienced in working with physician leaders and coaching them, saw immediately why this physician’s medical group president had asked him to be part of the workshop. His talent in rallying other people was obvious. It was done in
a fresh, inclusive way that was straightforward while conveying respect for and interest in others.

As a result of this experience with other leaders, the physician realized that he had confused his image of a “leader” with his own innate leadership skills. The biggest barrier for him was concern about diminishing his clinical role. As a result of his experience exploring leadership, he returned to his home base with a keen interest in more learning. He requested that his continuing education funds be allocated for coaching and his group president agreed. The coach soon realized that this particular physician leader was capable of moving very rapidly. He was highly resourceful at locating mentors and making the best use of his coach. He was on fire to work on projects that would endear him to his group – and grieving what it would feel like to leave most of the care of his patients to his partners.

Where often a coach is focusing on leadership skills, in this case, it was most important to help the physician work out his conflicting feelings about loss of one role and excitement about another. The coach realized that this client was able to process his feelings rapidly and was not surprised when, two weeks later, the client declared his intention to apply for a significant new role in his organization. He had already thought through how to work with his colleagues to cover his patients, how to let his patients know about the change, and how to keep a meaningful clinical role.

The coach’s role evolved to helping the client pause and do a little extra research before plunging into new areas and projects. The coach also helped the physician see the complex interconnections of projects that affect a large group. The coach admires this client’s initiative, wants to avoid slowing him down unnecessarily, and provides just-in-time feedback on an irregular schedule that perfectly suits the client.

**COMMON THREADS**

Coaching in health care is similar to coaching any group of leaders. Depending on where they are in their experience curve, leaders need a combination of traits and abilities in their coach:

- Knowledge of the structure of health care organizations and how to navigate them. (While it can be argued that coaches from outside health care bring a fresh perspective, our experience is that health care background is preferable.)

- Ability to help the client clarify his goals in a new leadership role, in a role with increasing authority, or in a role he’s working to broaden.

- Self-understanding in which the client identifies strengths she brings to the leadership role, how to
Astute coaches focus in on the individual’s specific skill and behavioral growth, while staying tuned in to the changing American health care environment.

incorporate others with complementary strengths, and how to learn not only the content of the role but also self-governance in the role.

- Areas of focus for both coach and client, including mindset, insight, curiosity, and willingness to cross organizational borders.

For experienced coaches, these areas—mindset, insight, curiosity, and willingness to cross organization borders—are creative and interesting. Many sources on leadership point out that the most important work of top leaders is to be inspiring and strategic. For most physicians, there’s much to learn before achieving those competencies. Skills such as having a difficult conversation, influencing, building a multi-disciplinary team, and working systematically through change are at the top of the list.

**LEADERSHIP MORPhING**

Physician leaders face skepticism from non-physician leaders. As one hospital CFO said, “A physician’s planning horizon is the next day’s clinic appointments.” This is a harsh, but not atypical, point of view for non-physician leaders.

Historically in health care, there has been a gap between the physician and the non-physician leader (in hospitals). Hospital administrators are specially trained, usually in graduate degree programs in health care administration, and many have business degrees. Not based on studies, but on experience, there is a divide between physicians and those professional administrators who are accustomed to running multi-million dollar non-profits with sizable bureaucracies and a myriad of rules and accrediting bodies to which they are accountable. Physicians typically were trained to be clinicians, and most of them learned business skills later in their careers, if at all. There is a long-standing suspicion on the part of organizational administrator and the physician-clinician that the latter needs to protect the patient from the cost-cutting and regulatory incursions of the former. No wonder that when a physician “crosses over” into administration, her colleagues will literally say, “You’re one of them now.”

**CONCLUSIONS**

One of the most important things that both non-physician and physician leaders can do is walk in each other’s shoes. An administrator who spends a day a month in a clinic learns firsthand how the systems work, the dedication of the people who take care of patients who are not at their happiest, and where the barriers arise. Similarly, if a physician takes the time to understand the interrelated system issues that non-physician leaders of larger organizations face, they learn to slow down and collaborate with a wider group than usual. In coaching sessions, it is often very effective to bring the physician and non-physician together to discuss the physician’s leadership growth.
Electronic medical records, palliative care, hospitalists, intensivists, elements of health care reform, accountable care organizations and broader coverage for the population is healing the fragmented way in which health care has been delivered in the United States. Astute coaches focus in on the individual’s specific skill and behavioral growth, while staying tuned in to the changing American health care environment. The patient is at the center of this universe and benefits most from all the different actors in the system working well together. Physician leaders have a highly significant role to play. Coaching them is a challenge and one of the most satisfying forms of leadership development possible.

Note: The scenarios and other opinions here are derived from the experience of executive coaches who work mostly in health care and frequently with physicians. However, any errors of fact can be attributed solely to the author.

RESOURCES


Gene Scott’s LinkedIn site:
http://www.linkedin.com/profile/view?id=11685080&authType=name&authToken=AU5q

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