Health Care Professionals:
Learning a Different Conversation

Kathy Taberner

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Health care professionals are trained to focus on the health issue at hand, arrive at a solution, and prescribe (tell) or recommend a plan of treatment. This is the traditional systemic model of health care experienced in most countries in the world. Some health care professionals will argue they are more client-centered, meaning they look at the whole person instead of just the presenting issue. In this case, they are more likely to focus on the whole person and how the issue impacts them. Most patients still expect to be told what to do. This mindset of telling is prevalent in many societies around the world and is not restricted to health care. When telling, one conveys a message that one is correct and (seems to have) the best and only answer. The teller is the expert, the keeper of the knowledge.

In diagnosing a challenging health issue, as a patient I may welcome and find comfort in the professional having the ‘right’ answer. As Churchill (1952) once remarked, “I am always ready to learn, though I do not always like to be taught.” And yet, when health professionals collaborate with colleagues, how does this approach of the right/wrong dichotomy achieve the optimal result? In Conscious Business, Fred Kofman (2006, p. xxi) states, “The problem is not that people think differently, the problem is that somebody thinks that he is right, and anybody who does not think like him must be wrong.”

When one is told what to do or how to solve a problem, the implication is that the person does not know as much. Telling doesn’t support adult learning, though it may support compliant behavior. Galileo observed that “One cannot teach a man anything. One can only enable him to learn from within himself.” Depending on the tone used by the physician, any counter suggestion by the patient (listener) will not be well received because (by inference) it cannot be correct. The best answer has already been told to all who will listen.
What are the messages that telling send to us? If you are told often enough, learned helplessness (for example, see Peterson, Maier, & Seligman, 1995) can set in. Some messages I have experienced include “She knows and I don’t.”, “I cannot figure this out for myself. I must need help.”, and “I do as I am told.”

What is the impact on the leader or expert who is expected (by others or self) to constantly have the correct answer? As David Rock (2006, p. 40) notes,

> When we try to think for people it takes a lot of mental energy on our part. We think hard and still come up with the wrong answers for that person. They then fend off our ideas instead of generating their own thoughts. Then we start again and try another angle. All told, there’s a lot of wasted energy on both sides.

**THE PROGRAM**

I am a retired occupational therapist, a credentialed executive coach, and have worked for the past five years on a project in health care as an executive coach. I have been connected to programs with a goal of creating a learning culture with its focus on leadership. The goal has been to create a different conversation among leaders and preceptors that supports self-directed learning with the intention of creating a learning culture. My role has been to co-facilitate a one-day workshop that focused on the coaching communication skills and then to support coaching triads, comprised of participants in the program over the six-month program.

The program introduced the fundamental coaching communication processes and skills combined with content learning to support safety, learning, and leadership. “Questions open our minds, our eyes, and our hearts. With them, we learn, connect, and create. And with them, we can create better futures and better results” (Adams, 2009, p. 8).

One of the fundamental coaching skills addressed was openness and curiosity expressed by asking open (also known as open-ended) questions, instead of telling and jumping to solution. In my work in other industries, I have found participants pick up the notion of being curious and shifting to asking questions fairly quickly, adapting to communicating in a different way that supports learning for others.

My experience with health care leaders has been different, and perhaps this is because of the expectation of patients who need and want to be told what to do. For whatever reason, the learners struggled with the shift from telling to asking open questions. In the coach communication workshop, we demonstrated a conversation with a participant in which one of us told them what to do and the other asked questions so the participant could arrive at their

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own solution. Learners could pick up the difference in the two approaches and appreciated the difference in experience enjoyed by the participant.

In one of the dyad activities, they had a short conversation in which one attempted to ask the other open questions in response to a stated issue instead of solving it. They struggled. When debriefed, they all realized how much they tend to tell, providing solutions that they thought would work for the other person. Those who did experience open questions found they could arrive at their own solution with far more ownership than those whose solution was prescribed. They stated that they were given the message that they had the ability to figure out the answer themselves, which was much more encouraging.

We did many activities, some with no need to achieve depth in the questions, just to begin experiencing curiosity through open questions. Many struggled and eventually experienced a different way of being in a conversation. As we progressed through the six to eight hours of coaching, more began to be curious and ask open questions, rather than imposing their recommendation.

One of my favourite times of each meeting with a triad was our check-in when I asked them to provide feedback about conversations they had had and responses to intentions made at our last meeting. On numerous occasions, the stories that were shared involved that shift to being curious and the resulting experience. One participant shared a conversation he had with his 12-year-old son in which the son thanked him for taking the time to understand his point of view. Another indicated she now could better understand her spouse of many years. Many shared their relief in now not always having to know the answers, which they had found stressful. By asking open questions, they could support the others’ learning instead of having to know the answers themselves. With a focus on safety, some shared a different experience with an incident in which they explored what led up to it and focused on changes that could ensure a different outcome.

One shared the experience of becoming curious, asking open questions on a regular basis in this way: “Once you cross the line, you can never go back.” Others shared stories of conversations they had with colleagues where they were able to better understand the perspective of the other, producing a tangible difference in the tone of the relationship. Using open questions to test assumptions, they were invariably surprised by what the other was thinking and feeling. Their assumptions, once tested, were often off the mark. Most experienced that wonderful ‘aha’ moment when one savours achievement—the success realized when a behaviour has changed.

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**CHANGES TO THE CULTURE OF THE ORGANIZATION**

Based on feedback, observations, and discussions, I found eight broad themes.

**Shift from blame to no blame**

The focus of safety, which is of utmost importance in health care, shifted from blame to solution. Those involved in incidents and “near misses” participated in conversations where open questions were asked with a focus on moving forward. They left at the end of the conversation feeling they were part of the solution, not the problem. The learning involved in this process helped to ensure the same incident did not reoccur.

Typically, nurses spoke of the old-style meetings that followed a safety incident or near miss as experiences that added to their feeling inadequate and wrong. They said they left such meetings feeling awful and sometimes afraid. They had not learned anything during the meeting and had little understanding of what was needed to ensure the incident did not recur. Comments such as “I know you are a good nurse, so just make sure this does not happen again” were common endings to such meetings. The new approach explored the incident with much less tension and used the meeting as an opportunity to share and learn new ways to reduce the likelihood another incident would happen. As a result, nurses indicated they left the meeting feeling encouraged and committed, rather than blamed and disengaged. They learned new ways to change their behaviour. They could support others in making changes to minimize the risk that incident recurred.

**Increased support for continued learning**

A focus on the process of asking open questions where the learner could solve their own problems supports self-directed learning. Health care professionals shared that when they were asked a specific question about a procedure, protocol, or technical skill, they typically told the inquirer the answer. This was quick and met the need of the person asking the question. They also found this led to the same or similar question being asked a few days later, to which they again provided an answer. This process was quick, albeit repetitive.

The health care professionals found that when they asked an open question such as “What do you know about this procedure?”, “What do you think is the next step?”, or “How could you find out this information?”, then the other person (the inquirer) became part of the conversation. The situation shifted from one of a passive exchange of information to one where both parties were engaged. The person who was now being asked could think through the options and learn what to do.

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The health care professionals found that this process took the pressure off them; they no longer needed to have all the answers. When they were really listening, curious, and asked open questions, the person who needed the answer to the question was able to figure out their own answer or a way they could learn the answer for themselves. The health care professionals noticed that the inquirer did not return a few days later with a similar request or question. Even though this process took longer in the moment, over time, they spent far less time answering the same question, and the inquirer began to think for themselves.

Participants who were preceptors (mentors supporting their students' learning) talked of the shift in their approach to their preceptees (students). Instead of assuming they needed to provide all their knowledge, they began to ask the learner what their goals were for their placement. Once the goals were established, the preceptors found they were able to ask open questions and support the learner in developing their own solutions, thereby enhancing their learning and accountability for this learning.

**Increased collaboration in meetings**

The feedback from leaders at various levels of the health care hierarchy indicated they showed up in a different way at meetings. Typically, they would focus on solving the problem before it had been fully explored, because they felt they were too busy to do it any other way. This implied they were the brightest, the only expert. Once they shifted from telling and could better understand all the pieces of the issue, the group used a more collaborative approach. Their engagement level increased.

Many commented on how they began to sit back, ask open questions, and listen to what others had to say. They learned that such an approach provided everyone with an opportunity to share their ideas and feel they were heard. With the contribution of more ideas, they stated that there was an increase in collaboration.

**Building a learning culture**

The original intent of the initiative was to have this program build a learning culture and be run completely by internal staff. This has been realized. They are intentionally building the capacity for learning within the context of their cultures. Leaders at all levels, who have gone through the program, are asking more open questions and taking a more curious approach to solving problems. Others are still telling. Those who have become more curious find they can still ask questions of those who are telling and thus shift the focus to one of curiosity, collaboration, and learning for everyone. Health care professionals are becoming coaches and building the capacity for open, curious conversations throughout the organizations.
Understanding needs and concerns of patients and families

The participants are now more curious and open with patients and their families. Typically, upon discharge, families are provided with lists of procedures and other information which are relevant for them in supporting the continued recovery of the patient. Instead of telling a family what needs to be done at discharge, they are asking the family and patient to read the protocols to be followed at home. They then follow up by asking open questions to support the learning and comfort for family and patient prior to their discharge.

These instructions can at times be intimidating for the families. Even with a review of the instructions and provision of directions around what needs to be done, many families were leaving without a true understanding of what they were expected to do. As staff began to change their approach to discharge, they noticed a difference in how families felt when they left. They began to provide the families with the directions prior to discharge and then ask them open questions to further their understanding, for example, “What looks really doable for you”, “What will be most challenging for you?”, and “Who could be a resource or support for you as a caregiver?” The health care professionals shared how they found the families to be more communicative about their concerns. Families tended to indicate a greater level of comfort upon discharge when this approach was used.

Building relationships

When one looks at health care, there is a recognized hierarchy of services. When a physician tells one what to do, there often is a perceived power imbalance that non-physician health care professionals find challenging to deal with in a respectful manner. Now, when approaching a physician with a question or a request to understand a prescribed treatment, participants stated they are more curious and use open questions. They find they are able to communicate and understand the doctor’s rationale.

For example, it can be difficult for a nurse to challenge an opinion of a physician colleague. Some nurses found that when they became curious with a physician and asked questions instead of telling them how they disagreed, the physician would answer the questions, providing the nurse with a better understanding of the physician’s perspective. At other times, once the differing perspective was better understood and the tension had lowered, then the nurse could provide some context and ask an open question. The physician obtained a better understanding of her perspective and was able to adjust their recommendation in a collaborative way. For example, the nurse might say, “Given this situation, how will that procedure support the recovery of the patient?”

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**Increased emotional intelligence**

As participants became more comfortable asking open questions, they found they were able to stay open and curious, even when there was potential for emotions to come into play. By remaining objective and calm when asking open questions, the conversations could focus on developing an optimal solution. Marilee Adams considers this to be the first tool of *question thinking*. With it, you have the ability to “empower your observer.”

Participants shared stories of how they felt once they became aware of their own experience because of others telling them what to do, how to do it, and so forth. As they developed self-awareness around this, they realized how telling could trigger emotions for them, particularly when it touched one of their values. With an increased awareness around this, the participants were able to be proactive and respond with questions, instead of allowing their emotions to colour their thoughts and actions. They found that if they were self-aware, they were able to manage their own emotions, thereby building better working relationships.

**Better communication with family members**

This was a side benefit that was shared by some of the participants about their family life. As parents, we tend to tell our children what they should do based on our own experience as a child. We want our children to be safe, protected, and provided with every opportunity. We think that by telling them what to do, we are supporting this intention. The feedback shared by participants showed that when they (parents) really listened to their children and asked open, curious questions instead of prescribing what they should do, their children responded differently. Their children were better able to have a conversation with their parent when they thought they were being listening to and believed their parents were curious their perspective. Parents shared how powerful these conversations had been for them and how their children thanked them for really listening to them. Similarly, some spouses shared that they were finally able to understand their spouse, once they began to listen to what they were saying and were open and curious when speaking with them.

**SUMMARY**

Telling has long been and will remain one way of conveying our knowledge and expertise. For health care professionals, their knowledge, expertise, and judgement are of utmost importance to ensure safety and best practices. There are times when a different conversation can create optimal results, perhaps when supporting the learning of another, discussing an issue with a colleague, or empowering a patient and their family at discharge. Being flexible in one’s communication approach, with the ability to shift to curiosity, can create a different outcome. Although this shift can be a challenging set of skills for health care professionals to learn, once accomplished, it has the potential to build increased safety, respect, collaboration, and learning for patients and professionals alike.
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ABOUT THE AUTHOR

Kathy Taberner, MA, PCC

Phone: 604-351-0279
Email: kathy@coachingculture.ca
Website: www.coachingculture.ca

Kathy is a retired Occupational Therapist. She obtained a graduate degree in leadership and training, and focuses on leadership development. She has been an executive coach in health care for the past seven years and is completing a certification to specialize in coaching physicians.

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Themes for Issues 29-36 of IJCO™

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**Issue 29-32 themes**

**Issue 29, 8(1):** Organizational Coaching and Organizational Development/Organizational Effectiveness

**Issue 30, 8(2):** Organizational Coaching and Coaching Culture

**Issue 31, 8(3):** Organizational Coaching in Health Care

**Issue 32, 8(4):** Organizational Coaching and Change

**Issue 33-36 themes**

**Issue 33, 9(1):** Planning for the Future in Uncertain Times: Organizational Coaching and Strategic Planning

**Issue 34, 9(2):** Organizational Coaching in Non-profit Organizations

**Issue 35, 9(3):** Organizational Coaching and Psychometrics: The Role of Testing and Assessment in the Coaching Process

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