Small Can Be Big: 
The Impact of Small Coaching Projects in Health Care Systems

Sue Drinnan with Brenda Olinek, Cathryn Lecorre, Trevor Maslyk and Connie MacKinnon, and Emma Sedgwick and Mike Roddis

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Small can be big, when the impact of a few hours transforms the way a person views themselves and their world. Very rarely, indeed, does one find a big change or improvement in any organization without small wins, built on steadily, one conversation at a time. Here are four reports from coaching practitioners who have led coaching initiatives.

- Ten-month coaching program to meet the needs of 45 health providers working with chronic disease clients. (Client-Centered Coaching for Health Professionals [CCCHP])
- Staff ranging from front-line workers to senior leaders and physicians from an outpatient care and surgery centre are offered nine training days over four months with group coaching follow-up. (A Leadership Development Program for the Jim Pattison Outpatient Care and Surgery Centre)
- Professional coaching to create greater leadership capacity offered to emergency medical services (EMS) mid- to senior-level leaders with five or more years’ experience in a leadership role practicing in large urban centres across Canada. (Advancing Emergency Medical Services Leadership Through Coaching)

Whether you use the term “coach” as a noun or a verb, even a small coaching initiative providing a positive impact on a professional health care system is a good thing. Coaching projects come in all sizes, each making a unique contribution and leaving its own fingerprint on the organizational culture. This article is not about the big million-dollar projects, but rather on the phenomena and impact that those myriad small- to medium-sized are have. In addition to the ripple effect that comes with powerful coaching, surely we must look at a significant cumulative contribution to health care. A second phenomenon is a common set of challenges that can get in the way of excellent smaller-sized projects growing into more widespread, credible, sustainable, or fully-funded programs. Each coaching project involves unique sponsors, risks, opportunities, and organizational acceptance. How does one leverage the features of your particular health care working culture and what is valued? What are the prized behaviors and beliefs, so that whatever is measured in the coaching evaluation captures their imagination? This article presents a compilation of health care coaching project models, and closes with some pointers to keep in mind when planning for future health care coaching projects.
The participants were able to identify the differences between the coaching philosophy and the traditional medical model of health care delivery.

**CLIENT-CENTERED COACHING FOR HEALTH PROFESSIONALS (CCCHP)**

Brenda Olinek

This experiential and interactive program was developed by Coach Brenda Olinek when Mount Royal College (now University) asked her to customize her coaching program to meet the needs of health providers working with chronic disease clients. Two program champions, Leanne Kiss of the Diabetes, Hypertension and Cholesterol Centre in Alberta, Canada, and Leslie Antymis, Program Manager, Endocrinology and Metabolism Program, Alberta Health Services in Calgary, offered the following observations regarding the impact of this coaching program.

A key shift that occurred for many of the participants in the CCCHP was to identify the importance of communication and the use of language as a tool to assist clients with self-management of their chronic condition. The coaching philosophy allowed the provider to meet the client ‘in that moment’ of the client/provider interaction and considers the client the ‘expert’ about their individual goals, priorities, and motivations, as well as with the challenges and barriers to achieving self-management and ongoing self-care. The participants were able to identify the differences between the coaching philosophy and the traditional medical model of health care delivery. They also could identify how the latter often promotes a compliance or adherence relationship between provider and client, and often is ineffective in assisting clients achieve self-care.

**Components of the program**

This ten-month program contains pre-workshop exercises and readings, a two-day coaching skills workshop, one-on-one coaching, and group coaching. It also contains a one-day “booster shot” workshop and a coaching skill evaluation. (See the Resource listing at the end of this article for a more detailed description of the program.)

The strength of CCCHP is combining theory with practice (follow-up and coaching), while participants integrate coaching skills into their daily client care. It also meets needs across professions such as social work, nursing, dietary, kinesiology, physiotherapists, education, and psychology. Participants gained an understanding of how work done by other disciplines impacts the same client base.
**Funding challenge**
Program champions Leanne Kiss and Leslie Antymis noted that external funding from the Patient Experience department provided an opportunity to move forward with a pilot initiative. Three professional coaches were contracted to deliver the program to 45 participants in the Calgary area. However, according to the champions,

> Following the pilot, funding to sustain the CCCHP was not attainable... only approximately one quarter of the clinical staff was able to participate.... Sustainability was the greatest challenge and it is unfortunate that many of the staff did not get to experience the CCCHP program. In addition, clerical staff did not participate in the program, but for future consideration, this group would highly benefit from this type of program. (L. Kiss and L. Antymis, personal communication, August 25, 2010)

**Program impact and measurement**
A questionnaire was completed by participants three times to measure their awareness, ability, and confidence using program content and coaching in a health care setting. Statistical analysis of a small pilot group supports the argument that CCCHP increases participants’ coaching skills. Six of eleven questions show statistical significance with movement in the positive direction in those questions. These results were presented at the 2007 International Conference on Chronic Disease Management (Kiss & Mierau, 2007).

In that session, the three main objectives of the CCCHP were identified as follows: (1) Integrate coaching principles into practice; (2) Improve the clients’ self-efficacy for managing their chronic condition; and (3) Increase capacity and access to service. When asked the impact of the program, Kiss stated, “I believe that the program achieved the first goal and... second goal.... Unfortunately, we were not able to measure the client impact directly.” Antymis added,

> Our capacity has almost doubled after we cross-trained staff. One of the underlying factors that impacted our ability to do so was that staff was structuring their appointments with clients according to the clients’ identified needs. This allowed us to provide more individualized scheduling. We were able to discuss the effectiveness of our program with clients and more readily discharge those who were ready to self-manage, thus increasing our capacity to provide services. (L. Antymis, personal communication, August 25, 2010)
CREATING LEARNING COMMUNITIES: 
A LEADERSHIP DEVELOPMENT PROGRAM 
FOR THE JIM PATTISON OUTPATIENT CARE AND 
SURGERY CENTRE, FRASER HEALTH, BRITISH 
COLUMBIA, CANADA 
Cathryn Lecorre

The goal of Creating Learning Communities is to enable all employees and physicians to create a learning culture at the Jim Pattison Outpatient Care and Surgery Centre (JPOCSC) in a way that builds personal awareness and responsibility; enhances engagement and ownership; and continuously improves the performance of the organization. As a result, the JPOCSC will be a leading facility in the delivery of outpatient services and quality care. The program targets all staff ranging from front-line workers to senior leaders and physicians. This includes up to 500 potential participants working there.

Vision
The vision for the JPOCSC is that it will be a leading facility in the delivery of outpatient services—a model of best practices and clinical integration—as well as a great workplace for physicians and employees. In order to deliver this vision, the leadership understood they needed to create a community of learning, where individual curiosity and creativity would be harnessed to deliver continuous improvement. This is the first facility of its kind for Fraser Health and within British Columbia. To be successful, the Centre seeks to contribute to the body of knowledge that defines best practice.

The specific request to Coaching Services came from Lisa Chu, Director of the JPOCSC. She is an advocate for coaching who believes that success for the project depends on creating a coaching culture (which includes asking great questions rather than telling others what to do). Lisa requested training and development that would create strong connections between (1) self-awareness and personal mastery; (2) the day-to-day behaviors necessary to deliver continuous learning; (3) learning processes and models; and (4) system performance, including health outcomes and economic sustainability.

Methodology
The program methodology was designed to integrate learning processes at individual, team, and system levels so that a learning culture delivering quality care was created. Creating Learning Communities was designed to integrate and apply the behaviours, accountabilities, and processes essential to creating a learning organization on behalf of the work that participants were currently doing. It seeks to tie learning, action, and outcomes together to promote innovation, integration, and collaboration.
The methodology included (1) three phases of workshops for a total of nine days over three to four months; (2) a cohort of participants ranging from front-line to senior leaders who develop a community of learning over time; (3) a combination of workshops with informal learning strategies such as mastermind groups and breakthrough projects; and (4) ongoing evaluation that included pre-, post-, and follow-up surveys and qualitative measures intended to assess participant satisfaction and impact.

Cathryn Lecorre, Lead for Coaching Services at Fraser Health, partnered with Alan Lund, Organization Development Consultant, to create and design the leadership development program. Coaching Services contracted Lori-Anne Demers, MCC, and the Demers Group to deliver the coach training and coordinated with several Fraser Health internal departments (Ethics and Diversity Services; Research and Evaluation Services; and the Strategic Team for Transformation). The design intention was to integrate the coach training with the organizational processes dedicated to continuously improving learning and performance.

**Resources and barriers**

Creating Learning Communities Leadership Development program was funded by the JPOCSC project. Funds were put aside specifically to enable cultural transformation.

Some of the barriers we needed to overcome involved time constraints: backfilling for the front-line employees participating in the program, and dealing with physicians’ limited participation due to schedule conflicts. The three three-day modules design did not facilitate their attendance.

**Program design**

**Module 1. Personal Power.** The main objectives are to provide participants with the experience and skills needed to raise their self-awareness and the ability to put their strengths to work. The process of remembering their core strengths and discovering what they love enhances their ability to be true to themselves in their role at work. The module focuses on discovering the power of being aligned with your strengths and vision in a way that generates energy, performance, and engagement in your patterns of interaction at work.

**Module 2. Core Alignment Coaching.** The main objectives focused on learning the fundamental principles of how to create an empowered and engaged team through an appreciative approach for leadership and communication. In a learning culture, all members of the community engage in candid, respectful, and generative conversations. The module focuses on coaching conversations that improve working relationships, inspire performance and engagement through powerful conversations, support others to achieve breakthrough performance, and generate innovative thinking.
Module 3. Aligning with Systems. The purpose of this module is to integrate leadership development and coaching with the organizational processes and models that foster performance and results at Fraser Health. This is a unique module, offered in partnership with four different departments in the organization. The module focuses on enhancing the ability of participants to learn at work while continuously improving organizational processes.

Ongoing: Learning partners and mastermind groups. Participation in small groups between modules enhances integration and accountability to implement new behaviours and actions in everyday work. With the support of a small group, participants deal with breakdowns, remember to align their life with their strengths, and get support to implement their breakthrough project.

Anecdotal outcomes
We solicited self-assessments that focused on the few spectacular shifts we saw with regard to difference in the participants from start to finish. One of the participants reported the following qualitative personal benefits of their participation in the Creating Learning Communities Program:

- [It’s] given me the confidence, tools and resources to take on projects that normally I would not have attempted.
- [I’m] more effective as a person and team member in engaging others and working with them to achieve the goals of opening a successful and unique health care centre.
- [I’ve] become a part of a vision and mission in community with others in a way that provides tools to be a better person, colleague, and caregiver at this site. I feel we will all be connected to each other in a more meaningful and deeper way.
- learned so much about how I communicate and can use my unique skills and gifts to create a great team and workplace to serve our clients.

Another participant declared these program benefits for their team:

- [We] function more effectively as an entity supporting the design, planning, and implementation of the programs for JPOCSC.
- Our team members now respect and acknowledge each other. This will allow us to be more present for our clients while providing care.
- [We] learned concrete methods for making decisions.
- [We are] learning together and building on each other’s strengths, creating a vision for our workplace.
Yet another participant offered these benefits:

- improved patient care and integration with other areas;
- improvements in our program;
- [now able to] work harmoniously and therefore more productively with each other, and perhaps have fun at the same time; and
- [able] to understand the vision for the entire project as well as the vision for our program.

Another participant offered this perspective: A hospital is only as good as the people in it. This kind of program supports the transformational change we want to achieve upon redesigning an innovative way of delivering care.

One of the participants in our first cohort was so inspired by the coaching conversations that she decided to take a coaching certification program and become certified. This participant became a co-facilitator for our largest cohort yet of 80 participants in our journey. She continues to be an on-site informal coach and mentor, reminding the community of who they are.

**ADVANCING EMERGENCY MEDICAL SERVICES LEADERSHIP THROUGH COACHING RESULTS OF AN ACTION RESEARCH STUDY**

Trevor Maslyk and Connie MacKinnon

We describe an action research study that examined the potential effectiveness of professional coaching relationships to create greater leadership capacity among emergency medical services (EMS) leaders in Canada. The EMS participants were mid- to senior-level leaders, selected by their respective Chiefs, with five or more years’ experience in a leadership role practicing in large urban centres across Canada. The coach participants were required to meet a number of criteria, including depth of experience in professional coaching within organizations and willingness to participate in the study *pro bono publico*.

Adhering to all relevant ethical considerations and standards, data were collected using both quantitative and qualitative action research techniques, including pre- and post-surveys and participant journaling.

The client participants were asked to focus on a single, tangible goal to be achieved within an eight-week time period. Throughout the coaching relationship, the EMS leader clients were required to actively document their experiences, thoughts, and feelings about the coaching experience in the study journal provided to them by the research team. At the conclusion of the coaching relationship, both the client and coach participants completed an online survey based upon the project’s research question and sub-questions.
Overwhelmingly, the qualitative data suggested that leadership coaching promotes self-awareness and self-discovery.

Organizational context
The EMS Chiefs of Canada was formed in 2002, with the mission “to advance and align EMS leadership in Canada” (EMSCC, 2010, p. 4). The vision of the EMS Chiefs of Canada (ibid., p. 3) states, “We are an organization that shares resources and provides services that support EMS leaders in developing a national direction for sustainable, progressive emergency medical services.” This research project was sponsored and endorsed by the president of the EMS Chiefs of Canada with the understanding that it would focus on the areas of strategic leadership and development in support of the organization’s vision and mission.

Findings
Based on the research findings, it was concluded that the EMS Chiefs of Canada influence the development of EMS leadership capacity by supporting leadership coaching as a developmental instrument. The study identified the critical factors necessary for successful coaching outcomes, recognized coaching as an underutilized and misunderstood leadership tool, and indicated that EMS leaders found value in coaching and coach-like leadership.

Anecdotal data from both the clients and the coaches supported the finding that the degree of client engagement was an important factor in determining the success of the coaching relationship. One client stated, “It comes down to being self-aware, wanting to learn, change and develop. I have to want to participate in the coaching relationship for it to be a success.”

It was also evident that trust and trustworthy relationships contributed to a successful coaching relationship. One journal entry indicated that “the relationship is very comfortable for me. I do not have a lot of reservations. I find it relaxing and somewhat refreshing after each session.”

Overwhelmingly, the qualitative data suggested that leadership coaching promotes self-awareness and self-discovery. At numerous points in their journaling, all clients indicated they valued the coaching relationship because it created an opportunity for them to self-reflect and self-evaluate. One client suggested that the coaching relationship stimulated not only his personal leadership development, but also his emotional intelligence as well. All clients reported significant progress toward their development goal, even given the short duration of the study.

Interpretations from the research
We drew four major conclusions from the research study’s findings:

- Successful coaching relationships are based upon trust, honesty, mutual success, and the desire to learn.
The doctor needs to acknowledge there is an issue and be willing enough to engage in a coaching relationship. Coaching doesn’t work with conscripts.

- The self-awareness created within the coaching relationship creates greater leadership capacity.
- Leadership coaching is a valuable way to develop EMS leaders though to date it is largely underutilized.
- EMS leaders can value coaching and the development of a culture that supports a coaching style of leadership.

**Recommendations and implementation challenges**

In May 2010 the findings of the study were presented to the EMS Chiefs of Canada Board of Directors. The following study recommendations, unanimously accepted, were brought forward to the EMS Chiefs of Canada Leadership Development Sub-Committee in the interest of creating implementation strategies for the EMS Chiefs of Canada general membership. The EMS Chiefs of Canada will

1. establish and support an executive coaching development grant;
2. host regular coaching development workshops, presentations, and seminars;
3. create a forum on the EMS Chiefs of Canada website that members can reference to seek out and engage the services of an external executive coach; and
4. establish a coaching community of practice that brings together EMS leaders with credentialed EMS leader coaches.

Implementation challenges do exist. Leadership development in EMS historically has been largely undervalued with greater emphasis placed upon continuing medical education. Funding for continuing leadership education is often difficult or impossible to secure, given the financial constraints facing EMS administrators. However, with a mandate to promote the development of EMS Leaders, the EMS Chiefs of Canada have committed to pursue and secure sources of funding within EMS Service Provider organizations to implement the study’s recommendations. Early efforts are cautiously optimistic.

**SUMMARY**

This research project presents a view of how the EMS Chiefs of Canada can utilize leadership coaching to advance EMS leadership development. The intention is to meet the significant and growing leadership challenges facing EMS service provider organizations, and indeed, all leaders in the health care continuum. Enhanced leadership capacity, improved patient care, and creative solutions to the many challenges facing the health care system in Canada and beyond would be the logical outcome.
WAYS OF WORKING: USING THE META-MIRROR, A TOOL TO ASSIST COMMUNICATION AND INSIGHT
Emma Sedgwick and Mike Roddis

Background
Neuro-linguistic programming (NLP) is an approach to organisational change based on a model of interpersonal communication. It is chiefly concerned with the relationship between successful patterns of behaviour and the subjective experiences (especially thought and information processing patterns) underlying them. Its proponents teach the distinctions to increase people’s self-awareness and effective communication, and to change their patterns of mental and emotional behaviour. The co-founders, Richard Bandler and linguist, John Grinder (Bandler & Grinder, 1975), coined the title to denote their belief in a connection between neurological processes (“neuro”), language (“linguistic”), and behavioral patterns that have been learned through experience (“programming”), and that can be organised to achieve specific goals in life.

The meta-mirror
Etymologically, “meta”, from ancient Greek, is an adjective with various meanings. One meaning is “behind” or “hidden”. It implies the part of something that is not immediately visible, is in the background, but which is there and has an effect. The meta-mirror is an NLP technique, developed by Robert Dilts (1990), and originates from Gestalt therapy.

The aim of the meta-mirror is to allow a person to experience a difficult interaction or relationship from different perspectives in order to gain insight into what is happening and how their behaviour influences the interaction. Ultimately, the aim is to change the person’s behaviour in order to improve future interactions and performance.

Reason for the intervention
When concerns emerge about a doctor’s communication style with patients, relatives and/or colleagues, it can be difficult to know how to assist the doctor to gain insight into these interactions and to improve their behaviour. The doctor needs to acknowledge there is an issue and be willing enough to engage in a coaching relationship. Coaching doesn’t work with conscripts. The coaching relationship is crucial and the doctor needs to feel safe enough to engage with the coach in order to carry out this process. Where the doctor is encouraged to receive behavioural coaching offered by their employer, we need to ensure that they are fully engaged in the process. This may take one or two initial sessions to allow the doctor to feel secure in the coaching relationship and to build rapport. The coach can ensure at the contracting stage with the doctor that the rules of engagement, including confidentiality, are clear and explicit.

Since conducting the meta-mirror, twelve months later, there have been no further complaints and the consultant describes increased confidence interacting, not only with relatives but with colleagues.
Each health care context will have unique beliefs, fears, values, or expectations that would need to be addressed directly for a coaching initiative to move to the next stage of viability.

The rationale for using this technique is that doctors are accustomed to intellectualising. Those who experience difficulties in communicating often lack the ability to talk objectively about their own behaviour. The great benefit of the meta-mirror is that it physically places the doctor in different positions so they are able to observe and talk about their thoughts and feelings from those different positions, in a way that is often impossible. It is important to stress the need for developing and maintaining rapport between the coach and doctor, as this can appear a novel and unusual way of approaching interpersonal difficulties.

**Intervention: The meta-mirror process**

The doctor and the coach jointly select an interaction from the doctor’s recent experience which resulted in a negative assessment of the doctor’s behaviours. To be most effective, the interaction selected should be remembered by the doctor.

Throughout the process, the coach accompanies the doctor and asks relevant questions to elucidate their thoughts, feelings, and bodily sensations in the different positions. A significant part of the process is to physically move the doctor into different positions around the room in order to experience the different perspectives.

The doctor describes to the coach how the interaction occurred. In particular, he or she will recall the positions adopted by both him/herself and the other person involved; who was standing, who sitting and where they were placed in relation to each other.

**Position 1.** The doctor now takes the position they were in during the interaction under analysis and imagines the interaction with the person in question. The doctor is encouraged to talk about their thoughts and feelings. Their body posture is noted, and they are specifically asked about what they might be experiencing in terms of bodily sensations, for example, butterflies in their stomach.

**Position 2.** The doctor now stands in the shoes of the other person. This will involve the doctor moving physically to a new place in the room. In this position, they talk as though they are this person, looking at themselves. The doctor is encouraged to describe their thoughts and feelings as though they were the other person and to give their impression of the doctor (themselves). By physically moving the doctor to this different position and asking the right questions, the doctor is able to imagine they are the other person and give comments about their own behaviour as seen through the eyes of the other person.

**Position 3.** This position is like being a “fly on the wall”. The doctor takes up a neutral position in the room where they can view the interaction between themselves and the other individual as an observer. This is often the “eureka” moment where the doctor appreciates the effect of their behaviour and what has been occurring. The doctor is then encouraged to describe what they need
in order to improve the interaction. It is not unusual for doctors to list resources external to them. The key is to get the doctor to think of what they need to do differently to influence the interaction.

**Position 4.** The doctor now goes back to their original position, both metaphorically and physically, and becomes themselves again, but with the benefit of having all the additional resources available to them. This position is often referred to as the “new, improved” doctor. The doctor describes their thoughts, feelings, and bodily sensations with the benefit of their insights.

The session closes with the doctor and the coach reviewing the experience and summarising in their own words what they have learned and how this will inform their behaviour in the future.

**Case study**
A consultant had received two complaints from patients’ relatives who alleged he had been rude and obstructive during conversations. Whilst the complaints were resolved locally, the Medical Director requested a series of coaching sessions to assist the consultant in his communication with relatives in the future.

One coaching session focused on one of the complaints and used the meta-mirror technique. The session started with a consideration of the reasons why the meeting with the relatives turned sour. On reflection, the consultant felt the catalyst for becoming angry was because the relative questioned his personal and professional integrity by calling him a liar. Honesty is a very important value for him and this incident got under his skin.

**Position 1.** We started with the consultant standing and imagining being opposite the relative in the patient’s room where the most difficult interaction had taken place. He talked about his feelings and thoughts. He described becoming angry, feeling hot and bothered, and losing control.

**Position 2.** Next, the consultant stepped into the relative’s shoes and talked about the relative’s perception of himself. As the relative, he could see that the consultant (himself) was under a lot of pressure and could see he was losing control, which he thought was unprofessional.

**Position 3.** The consultant then stood back and was an observer of the interaction between himself and the relative. He noticed that the situation was getting out of hand. He could see the relative had gotten under the doctor’s skin. He wondered if the relative had deliberately been trying to wind him up, for example, by pronouncing his name incorrectly. The consultant was then encouraged as this observer to state what he had needed at that time. He came up with the following list: junior doctor support; nurse support; and the knowledge that some relatives and patients may deliberately try to trigger his reactions.
Position 4. The consultant was then encouraged to step back into his own shoes in the interaction with the relative, but this time with all the additional knowledge and resources he needed to manage the interaction. With help he noticed a series of bodily sensations which were associated with the following thoughts: I feel calmer; I am in control; I am and can be professional; and I am more resourceful. I am able to think more clearly and (for example) offer the relative a second opinion of the patient’s condition.

Position 5. The consultant then stepped back into the relative’s shoes again to experience the interaction with a very different version of himself. As the relative, the consultant noticed the doctor was professional, in control, and was listening to him even though he might not agree.

Following the process, the consultant reported gaining some helpful insights. These included that it was interesting to step into someone else’s shoes, to see things from the relative’s perspective, and, as a result, try to understand what was driving their emotions. The consultant was encouraged to practise recreating the bodily feelings when he had been in position 4 of being calm, in control, and professional. In particular, he was to employ these before his interactions with relatives.

The changes
Since conducting the meta-mirror, twelve months later, there have been no further complaints and the consultant describes increased confidence interacting, not only with relatives but with colleagues. The meta-mirror is a specific NLP technique which allows individuals to experience what it is like to be in other people’s shoes. This allows them to gain insight into their own behaviour and to identify resources to change that behaviour.

SETTING YOUR COACHING PROGRAM UP FOR SUCCESS
Sue Drinnan

In engineering design, it is said that to excel, you can choose only two of three parameters: light, strong, or cheap. Coaching programs seem to have a less crisp but related set of limitations such as fast versus large, inexpensive versus attractive, accepted versus unproven, or consistent versus agile. For example, it is difficult to design or promote a program that is fast and has numerous participants, inexpensive and appealing to senior leaders, widely accepted without return on investment (ROI) evidence, or can prove quality consistency of messaging and results without parameters on coaching models. Ergo, understanding the needs of your true clients/sponsors and the organizational context is critical to the survival, sustainability, and impact of your program design. Below is a short list of five key components which, when defined and addressed, will increase the success and durability your efforts will have in the organization. Each health care context will have unique beliefs, fears, values, or
expectations that would need to be addressed directly for a coaching initiative to move to the next stage of viability.

1. Communication

Who needs to be informed? Is top management aware of your program? What elements are most of interest to them, and which should they be informed of beforehand? How does this project link to their mandate? To what media do you have access to ensure decision makers (at least) get the reassurances that will decrease their natural resistance (the need to protect themselves and the safety of the status quo from the dangers of the unknown)? What are the options for those who want coaching, but don’t have access to it?

2. Clarity

What assumptions and expectations do the stakeholders have? In every successful coaching engagement there is an explicit contracting process. The relationship of your coaching initiative to the health care organization needs nothing less and, many would say, deserves far more unambiguous positioning, with enough rigor to make it evidently adaptable to other departments (for example). Who needs to be educated about the expectations of coaching as a verb or competency (versus a profession)? How does the coaching initiative dovetail with existing leadership and management training programs? How is the coachee’s manager’s role positioned (as the eventual functional coach) versus your job as the short-term coach? Where do the coach’s loyalties lie when one party’s needs supersede those of the other (the health care organization’s needs versus the individual’s needs)? Are confidentiality borders crisp and understood for all involved?

3. Support

What does my program need to be successful? Are the leaders walking the coaching talk? What do they need to see (the “what’s in it for me?”) for them to make the change? There are innumerable noble coaching programs that are delivered pro-bono. It is difficult to sustain or expand without burning out that which drives the goodwill. What is needed to protect from frying your best talent? Do you have other coaches you can talk to and be mentored by? Track and celebrate successes? Acknowledgment? Formal recognition in their scorecard for succession management and retention?

On a different note, if booking and changing coaching appointments is taking a lot of time, then a strong case (with actual numbers) must be made for administrative support from the sponsors. Very senior leaders with executive assistants (EAs) tend to have to move appointments around more—especially if the organization has a culture of calling emergency meetings. Do you have the bandwidth or the technology to allow coachees to rearrange their own appointments?
4. Structure and procedures for measured results and viability

**What do others need to see?** What process is followed in the coaching method? Will the coaching generate a clear action plan with measurable outcomes? Often the sponsor wants to know that the coaching is tied to the development plan, possibly the result of a 360° feedback. Do you have pre- and post-program assessments (at a minimum)? What measures are you using to determine if the program was successful? What about measuring how effective you are? Even the most zealous supporter of your program cannot make a business case for future funding without quantitative proof that your program made a change in the things the health care organization cares about. What processes can you put in place early that will reassure them of the consistency and reliability of this program? Without solid data, the risk of your program becoming a “once and done” exercise is more likely.

5. Fresh perspectives

**What other resources can you tap into?** As your project grows, it will eventually impact other departments and disciplines. Different professionals (MDs, RNs, Administrators, RTs, OD and HR members, for example) perceive the organizational culture through their own lenses. How might they be stakeholders and do you understand what their values and perspectives are? How might you discover this information, especially early in the process (during audience, needs, and performance analysis)? How might your program align with what’s important to them so you garner their support in getting your project funded? Whose expertise can you draw on to make your project proposal more compelling to decision makers? Remember to offer them a sample of coaching to help them, so that they get a taste of what it is they would be supporting.

**CONCLUSIONS**

There are probably hundreds of smaller, unique, and possibly isolated coaching initiatives that cumulatively provide a benefit for health care organizations around the world. By inference, this means a lot of health care professionals may be getting support, becoming more effective, and delivering better care. If we had a better way of identifying and capturing the long-term impact on the organization or ROI of these small projects, we might discover that small really does add up to big. Here are three questions that can further this conversation: (1) Would you be willing and able to identify health care projects with a coaching component so that their coaching efforts can be captured and their results documented and standardized into a meta-analysis? (2) If you have a small health care coaching project, what steps can you take to design for and produce sustainable results? (3) If you have a health care coaching project, what could you do that increases the chances of growing that project into something more sustainable?
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RESOURCE

PathSeekers, Inc.: http://www.pathseekers.ca/coaching_skills_health_professionals.html

REFERENCES


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Connie MacKinnon is a Professional Certified Coach (PCC), former senior organizational leader, and experienced organizational consultant. She worked closely with the Alberta EMS Leaders to plan and execute change leadership strategies associated with a major organizational change. She also was Coach and Project Content Advisor to the research project described in this article.

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Emma Sedgwick qualified from medicine in the UK in the early nineties and was trained as a child adolescent psychiatrist before leaving to become a medico-legal adviser for the Medical Defence Union. She set up Healthcare Performance, Ltd. in 2008 with Dr. Mike Roddis. The company specialises in coaching, training, and consultancy within the health care sector.

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Mike Roddis, a pathologist, left clinical practice after becoming a National Health Service (NHS) medical director. He founded Healthcare Performance, Ltd. with Dr. Emma Sedgwick to work with doctors and other health care professionals with conduct and performance difficulties. In addition to coaching, mentoring, and working with dysfunctional teams, he helps employers in the investigation of poor performance in senior doctors and dentists, and provides management training, leadership development, and career and executive coaching for doctors and other professionals.

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Sue Drinnan received her Master of Science degree in neuroscience, is a Certified Executive Coach, and is a facilitator who works with global leaders and their teams to work even more effectively together. She was a national leader in health care research for nine years, and in 2003, she founded The Wisdom Consultancy, a management consulting firm specialising in workplace climate and leadership talent development. Sue speaks many languages, is a graduate from three universities, and uses emotional intelligence, conflict resolution, MBTI, and other tools in her work.
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