McMaster Program for Faculty Development (MacPFD)

Spark Podcast

Official Transcript

Episode Number: 10
Title of Episode: Healthcare Leadership with Dr. Profetto | Coaching with Dr. Mackin
Producer: Nick Hoskin
Music by: Scott Holmes
Featured Guests: Dr. Jason Profetto and Dr. Robin Mackin
Interviewer: Dr. Teresa Chan
Date of original release: February 3, 2021

Dr. Teresa Chan (00:00):
And now, although we don't have any sponsors, we'd like to bring you some information about upcoming events or exciting news about MacPFD. First of all, mark your calendars for April 28th, 2020, that's a Wednesday. Because it is the 2021 women's symposium at the Faculty of Health Sciences. This is the first women symposium and is being co-sponsored by a number of really amazing powerful women, but most importantly, Dr. Sonia Anand, who is the Associate Chair of Equity Inclusion within the Department of Medicine. This is Sonia's brainchild, and she is doing a great job of being our conference chair. Definitely check out the calendar within the MacPFD website, so that's macpdf.ca/event-calendar, and you'll see it listed right up there in the primary events. Secondly, we'd like to announce that we are accepting abstracts for our own upcoming conference. It'll be the 14th annual day in faculty development. The title of the conference is going to be academia disrupted innovations and dilemmas prompted by the COVID-19 pandemic.

Dr. Teresa Chan (01:00):
So if you're someone who's done some really cool innovative stuff that has helped your faculty survive the pandemic, or rethink academia in light of the pandemic, definitely, we wanna hear from you. There are different kinds of abstracts that you can submit. So check out our info page, it's right off the event calendar, and you can check it out. We're gonna have short talks, long talks, updates, innovation reports, you name it. And definitely, just like last year, we're gonna have lots of workshops. So we'd love to have you come out and mark the calendar for the actual date itself, which is May 25th, 2021, it's a Tuesday or if you're ambitious and you want to share your own wears and tell people about what you've been up to, definitely check out the abstracts and the submission information. And those are due on February 28th, 2021 by midnight. So definitely, think about submitting something, if you've got something to share. We'd love to hear from you and we're really excited to have those two events coming up.

Dr. Teresa Chan (02:00):
Welcome to The MacPFD Spark podcast. This podcast is meant to inspire you to take the next step in your development journey as a faculty number. We're really excited to bring you all sorts of content from inspiring you to teach or supervise differently, to leading and managing your team, to thinking about new creative ways or humanistic ways to actually do your work, and finally, to up or game in your scholarly practice. Are you excited yet? I certainly am. So sit back, listen and enjoy this latest episode of the MacPFD Spark podcast.

Dr. Teresa Chan (02:36):
Hello everyone, and welcome back to another episode of MacPFD-Spark. It's episode 10. And I'm really excited to bring you two exciting speakers. The first, people have heard from before. His name is Dr. Jason Profetto, and he's been on the show before. Jason speaks in this episode a little bit about what leadership means to him as a physician and how he's pivoted to make sure that he is engaged in healthcare leadership, and how he thinks about that and why he gets engaged in that area. Another guest that we have later on in the podcast is Dr. Robin Mackin. Now, Robin was an academic fellow here in the Department of Peds, but she's since left us to become an assistant professor at Western universities, Department of Pediatrics. We're sad to hear that she's left us, but we're so excited that she's moved on to an amazing opportunity, just down the road and not too far. And she's gonna be speaking to us about coaching.

Dr. Teresa Chan (03:33):
Alright. Hello everyone. I'm here again with someone that's been on the podcast before, but maybe this is the first time you're tuning in. Dr. Jason Profetto is a family and academic physician who is also an assistant clinical professor here in McMaster School of Medicine. Thank you so much too Jason for jumping in this recording with me and having a chat.

Dr. Jason Profetto (03:55):
Thank you very much Teresa. Hi everybody, it's great to be back and to chat again on these topics. Thank you.

Dr. Teresa Chan (04:00):
Alright, so today I brought Jason back to chat with us a little bit about leadership and his role. And many academicians leadership maybe is the last thing that they wanted to in their day. People see it as administrative burden. But I think that there's probably a nice synergy between some of the stuff that we want to do as scientists or scholars or academicians, and the work that needs to be done at the various tables where things happen. I wanna talk a little bit about being a physician and an academician who's in the room where it happens sometimes to take a line out of the Hamilton, the musical, but the idea is that I think that some people shy away from being in those rooms. And I thought maybe, could you speak a little bit about your journey as a leader in your profession?

Dr. Jason Profetto (04:43):
Yeah. Thank you, Teresa. So one of the most important things that I think of right off the bat is that leadership or taking a leadership position, especially if there's a little bit of a political feel to it, depending where you're at can actually be really challenging. It can be quite onerous. It can be a thankless job at some of the best times. And I like to go back to Abraham Lincoln's saying where he says, the best way to predict the future is to create it. When you're a medical student, you know mentorship is important, you look around, you look for the leaders that you really wanna look up to and feel comfortable asking questions. And I think to myself, being at that point, being a student, you should strive at one point, strive to get into leadership to make a change, but not only that, to also help and mentor the people that are actually coming up within your institution or your circle. So my leadership positions, I've been fortunate to get into some medical political stuff, like the Ontario Medical Association, I sit as a district for a delegate. The Hamilton Academy of Medicine, which is a branch society of the Ontario Medical Association in Hamilton.

Dr. Jason Profetto (05:51):
I've been there for about four years, five years. I am currently the Vice President, and next year I will be the President of the association or the Academy, I should say. And then even within our actual clinical work, I am a family doctor, I work with other family doctors. Our group is called The Family Health Organization, and I'm quite actively involved in different leadership aspects there, and then even on a bit of a more micro level, running a practice and being a leader within the practice, and guiding and helping patients, staff and process. There's actually quite a bit of overlap in transcending themes throughout these positions.

Dr. Teresa Chan (06:33):
Alright, so it sounds like leadership's something that you're encouraging others to kinda take a role in and that you yourself has gravitated to sort some of these activities in the past. What do you think it takes to get started? What's your take on that? If someone is a junior faculty member and maybe hasn't taken a lot of leadership on, maybe you're someone who has always had leadership roles and maybe you're a little bit done with it, why would someone wanna get back in the game or why would someone wanna start?

Dr. Jason Profetto (07:00):
I love the question. And I love the question because I'm gonna give a somewhat paradoxical answer. So what I don't think it requires is a lot of anything in particular. I can't stress this enough. I think anyone in medicine would have great leadership potential, and there's nothing specific on your resume that needs to be checked before you can get into a leadership position. I would almost say this is something that requires more abstract skill sets, a bit of ambition, a bit of motivation, a bit of a willingness to make change in whatever community it is, and then just going after it. The nice thing about hearing that, for me anyway, is that it's a bit encouraging and also liberating. It doesn't mean that any one individual needs anything specific before they can get into leadership. And I would also say you'd be amazed at how much potential there is out there in both the academic and medical political world in terms of leadership opportunity.

Dr. Teresa Chan (07:56):
I think a lot of people shy away from leadership 'cause they haven't seen themselves yet as leaders. And what you're saying is that you shouldn't have to see yourself as a leader to aspire to go and do something, you should just go do the do thing that you think is right, and so it's like the next right step, the next right move. And some of that might be in the leadership position, might be in an advocacy position, maybe actually following someone along in their journey as a leader to support them. And so I think what you're saying is just roll up your sleeves and do the work, the heavy lifting that it takes to be a good person in the world. Some of that might require some leadership along the way. Alright. Well, that's pretty inspirational. And so as someone who's been on a bunch of leadership positions, and the last time you were on the podcast, we did talk a little bit about undergrad admissions and other kind of positions you've hold as a leader in the medical school. But do you have any insights for those people who are kind of ready for their next leadership role? What are some things that they could think of when they're looking to, well, those things and step forward?

Dr. Jason Profetto (09:00):
One of the most important things I think is if someone's actually starting to think about some leadership positions or pursuing something that would be more of a higher seniority type position, where you would actually have a lot of impact and influence and change is, I would really look

around and try to decide what interests you. Because these are not positions where you're gonna be thanked and praised at nausea, these are positions that can be somewhat challenging at the best of times. And if you're doing something that you're very passionate about it's something that you really enjoy, and it's not necessarily energy zapping to the point that it burns you out, these are things that will strengthen you as a person, a clinician, an academic, and you'd be amazed at how far you can go in terms of learning and just getting a sense of a new landscape and just... For an example, I'm involved more in academics, but I've ventured over the last four or five years into some political stuff with the Ontario Medical Association.

Dr. Jason Profetto (10:03):
I am amazed when you hear some of these doctors speak at the OMA councils, how much they know, their business sense, their legal sense, their policy sense. I learned so much from attending, but then as a result, when I report back to my family health organization and the constituents that I represent, I'm also very informed. And the amount as a result that I've learned is tremendous. And I just think it's an untapped potential for a lot of people.

Dr. Teresa Chan (10:31):
Yeah, I think that a lot of people in healthcare sometimes shy away from being at the tables that are political for various reasons. Sometimes some of us worry that if you take a political stance that maybe people won't like you as a doctor anymore, and that politics could get in the way of patient care. Or if you're another healthcare provider, it could just be that people might not go pick you as a physiotherapist or go to you as a nurse practitioner. Obviously, we have some of those things that as someone who has a longitudinal practice, people are unlikely, when they find out you voted this party or that party, to drop you. Because it's actually hard to get a family doctor right now, to be honest, in our catchment area. And so maybe it's less of an issue, but I think that some of us worry about that. Have you ever felt that way? Do you ever feel that sometimes by the things that you do that people might feel awkward around you as a clinician?

Dr. Jason Profetto (11:26):
Yeah, I think so. You made me think about something too, because it's really interesting what's happened in my experience. So I do a lot of clinical stuff, I do a lot of academic stuff, I have a lot of leadership position, but as a result with doing this... It's almost funny we're calling it... I would almost call it random sampling of different life experiences, but you also open up some unique possibilities. So what's happened to me, for example, is about 70% of my time is clinical and then the rest is academic and political. But as a result, that 30% has to be filled. So what do we do? We have an associate. I have an associate that works with me that I get to mentor. And as a result, my clinical practice is always covered. But now we have a couple of doctors that are doing it with me and they are also developing their unique sense of what it means to be a leader within the practice, and then branching off from there. So I think that dynamic is very interesting, I also think there's a lot of possibility in terms of what we can do in the future with having clinician leadership positions blended, and whether that means academic political or other, it can extend quite a bit.

Dr. Teresa Chan (12:35):
Yeah, I think there's an untapped potential. My partner is a lawyer, so in law school, they don't necessarily train you to be lawyers, they train you to think like lawyers. But a lot of people go to Law School and end up starting out companies, being involved in politics, they enter into Public Health, they enter into all sorts of domains, and we tend to enter into a specialty. So whether that's your profession, like you train in the physio, you usually end up being a physio unless you enter back into

academics and stuff like that. And same thing with residency, it kind of, I don't wanna say brain washes you, but you spend five years doing something, you're gonna do it for probably a good chunk of time after that. And so I think it's actually a harder barrier, there's some systemic things that we do in our training that make it so that in the health professions, we don't see ourselves as politicians or leaders or people who could make change in the world at a bigger level. And I think that what you're saying is that start off small, but learn as you go, and maybe you'll have more potential then to make bigger change. Because as a physician, you can probably take care of one patient at a time, but as someone who affects policy, you could affect millions of people at a time, your impact could growth.

Dr. Jason Profetto (13:45):
I also think there's a very synergistic relationship between the two. As a clinician, I am on the ground, I am seeing people every day, I am talking to the very people that I am trying to make change for. And then once you get into more academic political positions of leadership, you truly... And I can't emphasize this enough, but you truly have an understanding of what it's like on the ground. A good example for me is I do quite a bit of indigenous health in my practice, and we have many, many families that come from local reserves and certain areas that have higher indigenous populations. I interact with indigenous people on a regular basis in my practice. So when we talk about indigenous related equity issues and MV admissions, or when we talk about it at the level of the Ontario Medical Association, I have experience that's very close, I have experience that's very granular. And as a result, I really do think that I have a much greater appreciation for those details that need to come up.

Dr. Teresa Chan (14:46):
So I think that they probably feed each other, and I think they give you a lens to different systems level approaches when you're on the ground, and then a ground level perspective when you're at a boardroom table debating about the system. So I like that tension between those two things and how they can work together actually. So thanks for really opening it up for us today, Jason. I really appreciated your insights on that. I think that'll give a lot of people on pause for that, it's definitely given me pause for thought. So I'm really excited that you had the time to speak with me.

Dr. Jason Profetto (15:13):
My pleasure. Thank you so much, Teresa.

Dr. Teresa Chan (15:16):
Have you ever stared across the table at your mentor or your mentee and not know what to say? We've been there too. So within the divisions of emergency medicine across family medicine, medicine and pediatrics, we've been working on a really cool initiative called the Do-It-Yourself mentorship playbook, and we've just published our first volume. We've been hard at work to create this amazing work book for you to engage in mentorship. For those who are both academics and clinicians, this book aims to help you raise the bar in your mentorship by providing you worksheets and resources to be able to up your game.

Dr. Teresa Chan (15:49):
So if you're looking for some inspiration, whether you're a master chef of a mentor and just wanna get some new ideas, or if you are a starting out mentee and you're not really sure where you should go, this book can give you the playbook so that you and your mentor can have a plan and a little bit of a curriculum to explore the first couple of years of your career. You can check it out by going to

macpfd.ca, and it's in the what's new section, or you can search for us on the web at the McMaster campus book store. It's an e-pub, and so as soon as you pay your $35 plus tax, you'll be able to get a copy immediately and download it to your device of your choice. Happy reading everyone.

Dr. Teresa Chan (16:27):
Hello, my name is Teresa Chan, and I am the assistant for the program for faculty development here at McMaster's Faculty of Health Science. I am really excited to have Dr. Robin Mackin who is a pediatrician and a world class athlete, and on top of that, someone who is really keen, on nerding about coaching than helping our coaching team here at McMaster Program for Faculty Development. We think how we're gonna do all this stuff, both in the pre and the post COVID era. So I thank you so much, Robin for coming to agree to do this webinar with us. It's really exciting to have you share your wealth of knowledge in this area. And I won't take too much more away from your own thunder and you're gonna tell your story doing all this, but all this just to finish her academic fellowship here at McMaster Children's Hospital, and she'll be heading off into the world doing a whole bunch of really cool outreach work and welcoming... And just hitting our stride. And so I am really excited to welcome her to kinda give this guest lecture. I'm sure this will be the last time we have her as a guest at Master Program for Faculty Development, but we're excited to have her do this on the last day of her training. So we'll have everyone give her a round of applause at the end, but thank you so much for joining us, Dr. Mackin.

Dr. Robin Mackin (17:35):
Thanks for having me, Teresa. Basically, I'm gonna spend the next 30 minutes really trying to just review and try to take a deep dive into what are the principles of coaching and how do they apply to what we envision coaching to be in the health profession. I think if you're probably logging in at 5:00 PM on a Tuesday evening, then probably this is something that you're already otherwise engaged in, but I think the reality that we have to acknowledge is that coaching has become part of a lot of professions educational duties and with that comes a lot of what I would term sort of cautious skepticism, which I think is appropriate. Because any time we adopt something new, what we have to consider is what is fundamentally different about what we're asking people to do now versus what they were doing before.

Dr. Robin Mackin (18:16):
And so I wanna draw your attention a little bit to the background picture that I chose for the title slide. And the reason I picked it was that I think it actually depicts our trainees at different levels, recognizing that when they enter different levels of training that they probably are a bit staggered than when they're starting. And the question for us to explore over the next 30 minutes and with the panel is whether or not we still want them to all finish at the same finish line, or if we actually need to acknowledge the fact that there's probably staggered personal finish lines as well. And so I'll get you to think about that as we sort of jump into some of the literature and explore some of these definitions in a bit more detail. So as far as the objectives that I'm hoping to meet over the next 30 minutes, is to really look at what is the definition of a coach, and what are the principles of coaching as it applies to healthcare professionals?

Dr. Robin Mackin (19:00):
We're gonna look at the difference or maybe the similarities between feedback and coaching, and then we're gonna look at how coaching in medicine and coaching in sports might be different. Now, my background is in medicine, and so you'll hear me talking about that. But as I sort of speak about some of these examples, I hope you can draw some parallels from the different expertise that you

come from. And lastly, but probably most importantly, my goal is to inspire some enthusiasm, recognizing that coaching is a fairly new concept for a lot of the healthcare professionals. And in order for it to be successful and sustainable, it's important for lots of discussions with our trainees amongst our faculty to really describe how we want this to look and how we envision this as a group. And so we've already introduced ourselves together, but I wanted to sort of just show you how we're gonna use the poll throughout the session, so we can actually get some engagement from the audience. And so all of the answers are completely anonymous. So we'll do the first poll now, just to get a sense of who's in the audience with us today.

Dr. Robin Mackin (19:56):
Great. So we have sort of a spread of people from different schools, which is excellent. And so we'll be able to sort of draw on all these different expertise and perspectives as we get to the panel. So that's great. So before we start, I do have to disclose that I come into the topic of coaching with a bit of a biased lens. So I was an elite athlete prior to coming to medicine, I also was a coach, and I'm married to a basketball coach. So coaching, in the way that I understand it, is very much influenced by what coaching looks like in sports. And I often find that coaching can look very different in the different areas that we've seen it, and so keep in mind that my perspective is very much biased by the fact that I've experienced this in the realm of sports.

Dr. Robin Mackin (20:36):
So before we start, I wanted to share a story with you 'cause I think this really gives you a sense of what coaching could and should look like. And so I'm gonna take you back to Brazil in 2007. And this was the Pan-American Championships, and we had just been awarded the silver metal. We were coming back to the athletes village, and we were greeted by Marnie McBean, who was one of Canada's most decorated Olympians. And she said to us, "Congratulations on your silver medal. But one of the most important things I want you to know is that over the next 12 months, every country is gonna be training to be one year better, but your job is to figure out how to be one and a half years better." And so I looked around and some of my team mates went back to celebrating. And I sort of was struck by the fact that she had said something so simple but at the same time so complex.

Dr. Robin Mackin (21:25):
How was I supposed to get out a year and a half better with a chronological time of 12 months. And she was absolutely right. Everybody else would be training the exact same over the 12 month period. And so that's what set me out on this one-and-a-half year better plan, where I basically wrote out every aspect of my physical game, every aspect of my mental game. And what that would look like to be one and a half years better and how I was gonna do that. But in order for that to truly be successful, what I needed, was actually the help of my coaches. And so I sat down with all my different types of coaches and we thought about how do we redefine these? How do we reframe it? What are realistic expectations? And most importantly, how are they gonna hold me accountable?

Dr. Robin Mackin (22:04):
Because one of the hardest things being an athlete or being a learner is that you get really stuck in the present, in the short-term. So, although I knew I needed to get to the end of this plan and be a year and a half better in a year, I really didn't understand what that looked like, maybe six months in, when all of a sudden, I was fatigued and burnt out. And so what you need your coaches there for is to help remind you of what that end vision is. What is that vision that you want for your athlete?

What's the vision for the team that you're looking for? And so for those of you that are preceptors of learners, my question to you is, what is our educational vision for our learners?

Dr. Robin Mackin (22:40):
When competency-based medical education came, it initially was proposed to me that this is a new model where we're gonna ensure that trainees in different specialties are gonna graduate competent in all the areas that they needed to. But in fact, as I started to join more medical education communities, I realized that they were actually trying to individualize education so that we can make sure that learners were meeting their full potential. And so I wanna share a couple of quotes with you that come from an article where they talk to people in medicine who had careers as athletes and musicians before. And I thought some of these quotes really highlighted this idea of striving for personal best. So one musician says, "Clinicians often speak of competency. It has this connotation of adequacy. Whereas musicians speak of the even better performance and the constant need to push towards their personal best."

Dr. Robin Mackin (23:32):
And I like this quote because it suggests that there probably is a difference between competency and personal best. In a similar vein, another quote from that study talks about the fact that there's probably evident advantages in encouraging doctors to constantly improve, rather than to attain a predetermined level of generic competency. So that brings us to the question of, if we think that coaching is the way for us to help our learners meet their full potential, what exactly are we asking our faculty to do? What is a coach? And so I'd like to poll you guys on how clear is the definition of a coach to you. Perfect. So most people feel that they agree that it's a fairly clear definition to them. And then about 25% of people think that it's neutral. And so I think that if we look at the literature, I was able to pull some definitions. So in Sauter's article where they actually looked at all the different labels in medical education, they said a coach probably is someone that's trying to extract the highest level performance possible from the learner.

Dr. Robin Mackin (24:32):
So the outcome being the fact that we're actually gonna be able to achieve the highest level of performance. In Lovell's systematic review, he talks more about the process of coaching, which is this idea of timely and individualized feedback based off observed behaviors, and again, focusing on this outcome, which is that the learner is able to meet their full potential. The third definition, which comes from Watling's article, which I really thought resonated with me, was this idea that for coaching to be coaching, there's actually three main principles. The first one involves mutual engagement. There needs to be a clear and bilateral orientation towards learner, growth and development. Both the coach and the coachee need to engage in reflection. And that both of them need to acknowledge that failure is not only inevitable, but is actually invaluable for learner growth.

Dr. Robin Mackin (25:17):
So those are a few definitions. But what it really comes down to is this idea that we use these terms so interchangeably. A mentor versus a coach versus a teacher. And are these the same or are they a bit different? And Lovell, actually talks about it in his systematic review. This idea of conceptual attention. So he had a hard time sort of including and excluding studies based off the way they were labeled. Because a lot of the times, the way they actually described the process or the principles of that relationship, they may have actually mislabelled it. And so we often see these terms used interchangeably, but how do we actually define them and really characterize what each of them

means. So in Lovell's systematic review, he actually had this table where he looks at, what are the defining features of teaching, versus mentoring, versus coaching?

Dr. Robin Mackin (26:02):
So if we draw our attention over to coaching, you can see again that as far as the outcome or the purpose, it's very much focused on this idea of pushing a learner to hit and achieve their personal best. And the process by which they actually get there, focuses on the fact that you need to have observation, that there needs to be a reflection, and that it's through a collaborative model. And so use a non-healthcare sort of example as someone who was a pitcher and a pitching coach. If I wanted to teach about gaining more miles per hour, so to actually pitch faster, I could easily do a presentation in front of a bunch of pitchers and tell them, "Here are the mechanics and the important aspects of being able to throw faster." If I was actually mentoring. So a lot of people would come up to me and say, "Based off your expertise, I really wanna be able to throw faster. How can I do that?"

Dr. Robin Mackin (26:50):
And although I can't say what specifically might work for them, I can in fact give them lots of common things that they can work on that will probably help them throw faster. And also some drills and other things that they can do that will likely contribute to more miles per hour. But if I was coaching them, then I would actually watch them pitch multiple times, dissect their mechanics, figure out specifically for them, what is that actual thing that they need to do in their mechanics to be able to throw faster, and what are the drills or the things that I need them to work on to be able to get there?

Dr. Robin Mackin (27:26):
So I want you to take a second and think about something that would be applicable to the area that you practice in where you could sort of compare how you might teach it, how you might mentor it, and how you might coach it. So I'll give you a second to think about that. And then in this study, and this was the one that was done by Sauter, what they did was they said, "You know what? We have a lot of labels for our preceptors in medical education, can we somehow characterize them based off their educational purpose and whether or not they needed to in the profession or outside of the profession?" And if you look to see where the coach fell, they actually decided that the educational purpose was relationship building, and that the coach could actually be outside the profession. But what they acknowledge in the study is the fact that probably coaching could be put under each of these educational purposes, but the avenue by which you actually meet the outcome is so dependent on the relationship building that they said that in fact, this is the core to coaching.

Dr. Robin Mackin (28:24):
What I found most interesting is that they put it under extra professional. And I want you to think about that, 'cause we're gonna come back to that later. But whether or not our coaches can be outside of the profession that we're training in. So we talk a little bit about the role of the coach, and we talk about the different definitions of coaches versus mentors, versus teachers, but rarely, in fact, do we have any evidence to suggest that coaching interventions are actually successful in medicine. So if you look at Lovell's systematic review done in 2018, what's interesting is, is that there's actually no articles that predate 2008 that talk about coaching within the realm of medicine. So it's a fairly new concept. And his systematic review there was a total of 21 papers, and there was the three main themes. So there was coaching for doctor well being, there was coaching for non-technical skill acquisition, and there was coaching for technical skills. And that was predominantly surgical.

Dr. Robin Mackin (29:15):
And what they actually found in the results is that there's good data to suggest that coaching interventions can decrease surgical error, they can increase technical skill acquisition, they can improve exam scores, and they can identify students who might be struggling academically. He did allude to the fact that there actually hasn't been any coaching interventions or connections to how it may impact patient care. And my question is, is that although we know that these coaching interventions are successful, what exactly are the principles of coaching that are being employed that are leading to the success? So what exactly is coaching? So you can't talk about coaching without actually talking about coachings relationship with feedback. And so we're gonna transition to our next sort of concept.

Dr. Robin Mackin (30:00):
So is coaching equal to feedback? And so I'd like to actually get a sense of what the audience's thoughts are on this. So the difference between coaching and feedback is very clear to me. Do you strongly agree with that, agree, neutral, disagree, or strongly disagree? Great, so we have a nice split here. So some people disagree, some people agree, and some are neutral. So let's explore this a little bit more. So if we look at the Royal Colleges model for sub-specialties in medicine, they sort of divided it into coaching feedback. So if it wasn't confusing to you yet, they now said, "You know what? Let's actually put the two terms together." But thankfully, they actually gave us some definitions to work off. So they said that feedback is actually giving information about what was observed compared to an expected standard, while coaching feedback is feedback, but you're actually giving some actionable suggestions for improvement. So I struggled with this for a long time because I said, "I'm not really still sure what was so different about coaching and feedback." And when I would reflect on the fact that I was a coach before, I never had occurred to me to think about was I giving feedback, or was I coaching?

Dr. Robin Mackin (31:04):
And sometimes when I'd finish having a discussion with a learner about their performance, they would thank me for feedback, and they'd thank me for coaching. And I really wasn't sure if there was something inherently different about what I was doing. And so I went to a workshop recently. And again, as I told you earlier, I'm sometimes struck by a very simple statement. But thanks to Dr. Parveen Wasi, who really just said, "You know what? Coaching is just effective feedback." And that was my aha moment. So really what we've done, is some people were giving feedback that also had actionable items, but we've now standardized it to say that coaching feedback means that by a basic minimum, you're observing the interaction, you're giving feedback based off a standard, and then you're also giving actionable item.

Dr. Robin Mackin (31:48):
So my question was, "Well, we're all pretty versed in feedback, we all go to workshops, we've been told to sort of grow in the area of feedback, so why did we need this huge revamp in terminology to do something that we all supposedly were doing well before?" That brings us into discussion about feedback. So back in 1994, there was a study done by Irby, where they actually said feedback is an intractable problem in medicine. But that was back in 1994. Well, then there was a more recent study done by Watling, within the clinical environment. And even there medical students acknowledged the fact that feedback was important, but the quality of feedback was still lacking.

Dr. Robin Mackin (32:26):

And so what I wanna share with you is this study done in 2014 that was done by Watling, and colleagues. And what they did was they actually talked to people who were athletes and musicians prior to medicine, and got their reflections on the learning culture and feedback. So what did they have to say? Well, one interesting comment that came from a musician was that a lot of feedback people get is that, of course your knowledge is never as good as it can be. I think this is the equivalent to read around your cases. But that's a really vague thing. Because saying to the musician, "Well, that was pretty good, but you could play a little better." That's really the equivalent. And I think this concept is highlighted in this second quote, where one of the participants said, "You know, if they tell you that you need to improve, but they can't tell you how, then it's useless information." And another musician brought up a really interesting point, which is that she talked about the fact that feedback has a much smaller role in how medicine is taught.

Dr. Robin Mackin (33:19):
In music, in that culture feedback is vital. It's so vital, it's not even called feedback. And so I thought that was interesting 'cause that was sort of that reflection that I had when I was a coach previously. Was I giving feedback or was I coaching? And then if we think about the culture of feedback a little bit more, what was interesting that the participants pointed out was that coach disciplines actually normalized critical feedback in a way that most participants felt was missing from medical training. And as an elite athlete, I from a very young age, was ingrained to me that if the coach wasn't yelling at you or wasn't finding something wrong, or picking apart something that you were doing, that you actually needed to worry, because that means that they didn't see any more potential in you.

Dr. Robin Mackin (34:01):
And so as an athlete, although it was frustrating to always be told how you could do something better, you actually would be more concerned if they stopped finding ways to tell you to be better, because you'd be worried that they didn't think you had potential. And so another participant commented on the fact that learners in medicine seemed to accept the need to lower their expectations of teaching and feedback. And this was based off the fact that they recognize that a lot of the teachers play multiple roles at the same time, which is different than in the sporting and the music world, where their sole sort of job is that of a coach.

Dr. Robin Mackin (34:32):
And lastly, one of the participants pointed out that they recognize that feedback was central to their development in music or sport, but played a more marginal role in their medical training. And I found this one particularly interesting because although really successful athletes and successful musicians are important to society, if we feel that feedback is really important to learner growth, including learners within medicine, then if we have people who are graduating who are gonna go on to impact patient care and patient lives, then perhaps we really should be prioritizing our quality feedback within the realm of healthcare professions.

Dr. Robin Mackin (35:08):
And I wanted to share one last quote with you where one of the participants talked about this fact that you expect your coach to criticize everything you do, because if they're not, then that means they weren't watching. And I wanted to ask you guys, do you feel that our learners are looking for that same sort of critical feedback? Are our learners willing to be vulnerable, recognizing that it's in their best interest to grow? There was a survey done about feedback culture in the Department of Pediatrics, I think it was in 2019. And what I found really interesting was that only 50% of the time

residents had either said that they agreed or strongly agreed that the person giving them feedback had their best interest in mind.

Dr. Robin Mackin (35:48):
And to me, the core of being able to give critical feedback is for the person receiving the information to have no doubt that this is in their best interest. But we know that feedback is a two-way street. So let's try to understand a little bit about what makes feedback credible. And so I wanna share a study with you that was done with internal medicine residents. I guess I should do a poll first, just to see if you guys think that our learners are looking for critical feedback from their preceptors.

Dr. Robin Mackin (36:15):
Great. So actually majority of you feel that your learners are looking for critical feedback most of the time, and a few hardly. And so let's talk a little bit about what exactly makes feedback credible in the eyes of residents. So this was done with internal medicine residents back in the 1997. And they found three main themes of which I'm gonna focus on sender credibility. What makes the information credible from the sender. And so in terms of the senders characteristics, interestingly enough, if the clinician had a low level of knowledge, was inexperienced, or they didn't trust them, then the feedback wasn't taken credibly.

Dr. Robin Mackin (36:49):
In terms of senders behaviors, if they didn't observe them and they really didn't pay attention to them, then they didn't really care about the feedback that came from that person. In terms of the content of the feedback, if it was insignificant or it was inconsistent with something that they really felt strongly about themselves, then the feedback also wasn't gonna be seen as credible. And lastly, if the feedback was delivered in a group setting or was in any way perceived as being judgemental, then the feedback really wasn't credible to the learner.

Dr. Robin Mackin (37:19):
And in a study done by Watling in 2012 where they actually talked to learners about sort of cues and credibility judgments, they also suggested that respect had more to do the clinicians performance as a clinician rather than his or her style relating to the learner. And I find this interesting because conversely in a study done by Watling, where they actually talked to coaches, so there was no learners involved, they identified the fact that probably good coaches had more to do with their ability to bring out the best in the learners and less to do by their own knowledge and skill. And we know that in the sports world, this is very true. So most of the best coaches were never the super star athletes, and vice versa. Super star athletes are almost never the best coaches. And the reason being is even though you might naturally be athletic or gifted enough to be able to perform the action or perform at a certain level, it's very different to actually be able to watch somebody else and be able to pick apart and motivate them and communicate in a way that will allow them to grow and become better.

Dr. Robin Mackin (38:21):
So this brings me back to that question where Sauter had said, to be a coach means that you don't necessarily need to be within the profession. So I'll ask you, do you have to be an excellent clinician to be an excellent coach? Okay, interesting. So we have a very nice split here. So this is a conversation that I have with colleagues often. And I think it largely depends, is generally what the last answer is, but hopefully, we can talk a little bit about this in some of the discussion, because I think it actually brings up some really interesting perspectives.

Dr. Robin Mackin (38:50):
So moving on to our last concept. As we transition now, let's look at coaching in medicine versus coaching in sport. And are they similar and are they different? And this is very similar to the parallels that we draw between patient safety and the aviation industry. Recognizing that there's probably lots to learn, but that there's also some distinct cultural differences that we need to be aware of and acknowledge. So I wanna share the study that was done by Watling, where they actually had 21 participants in total, I think it was. But they took 10 participants who were coaches within medicine, but also had direct experiences as coaching outside of medicine. They had eight people who considered themselves coaching within medicine, but had no direct experience outside of that, and they had six participants who were sports university coaches, and they didn't have any role in medicine.

Dr. Robin Mackin (39:35):
And they basically did a qualitative study where they interviewed them for about 30 to 75 minutes about their role as a coach, what motivates them, had them trying to reflect on what makes them successful as coaches and to try to articulate the principles of coaching that makes them be able to do the job well. And so between there, we were able to come up with three shared philosophies that were similar between coaching and medicine and coaching and sports. That in either case, coaching involved this mutual orientation towards growth and development. So the outcome being that the learner was gonna get better. That there was an endorsement of reflection being imperative that the coachee was able to reflect on the process and that both of them had to embrace failures as a catalyst for learning. And despite these distinct sort of similarities, what they realized though, was that there was still some cultural differences that made coaching very different in the two different domains. The first one was this idea of engaging reflections as a coach. What they talk about in the study is that a lot of the coaches outside of medicine reflected on how they impacted the development, the success and failure of their athletes. But that there wasn't a similar emphasis on reflection in anyone that was a coach in medicine.

Dr. Robin Mackin (40:47):
Secondly, was this idea of comfort with vulnerability. They recognize the fact that it's probably hard for learners to be comfortable with being vulnerable, and that perhaps needing to be coached might be a sign of a weakness. This idea of blurred lines, recognizing that in sports, the coach can't just jump on the ice, can't jump on the court, but that in medicine, the coach can always be a player. And that part of their identity is very much attached to always being a player. And so that's very different between the two domains. And lastly, this idea of defining and developing coaches. So very clearly in sports, the growth of a coach, the career path of a coach is very different than its athletes or its players, but that in medicine, it's not as clear.

Dr. Robin Mackin (41:31):
Does being a good clinician or being a good teacher automatically mean you're gonna be a good coach? And is there a separate career path or development and growth that is specific to being a coach within medicine as it is in sports? So what now? So I think that we recognize that coaching is probably important for our learners because we recognize that coaching allows us to have good quality feedback and to help our learners meet their full potential. But how much experience do our faculty have with coaching? For me to be a good clinician and a good teacher, I very much had it modelled for me both in a positive way and ways that I maybe didn't wanna emulate. But those experiences really shaped the type of clinician and teacher that I wanted to be. For a lot of our

faculty, they haven't had the opportunity to actually be coached before or maybe even coached in any other realm. But now, we're asking them to coach our learners to success. And is that fair? Are they ready for that? And so I wanna poll you guys as well. So as of today, how ready do you feel to coach our learners to success?

Dr. Robin Mackin (42:30):
Okay. So again, probably biased by the fact that we have people who are interested in coaching in our audience today, but we have a lot of people who either agree, strongly agree, or feel neutral about being ready to coach their learners, which is great. And so I wanna just belabor this point of our experience and basically our credentials to coach with showing this picture of myself. Back in medical school, I lived in a basement apartment of a family. And so if I wanted to coach this six-year-old recreational coach pitch team on the weekends as a former Olympian in the sport, would I be allowed to coach her team?

Dr. Robin Mackin (43:02):
Well, to find out, I'd have to go on the coach.ca website. I'd pick softball and I'd picked community because it's not competitive. And what I'd actually learn is that for me to coach this six-year-olds team on the weekend, I'd actually have to complete two different courses. And if you open up these courses, they're actually not just one-time workshops. And I know the argument always is, is that you can go to a workshop and you can get a certificate, but that doesn't necessarily mean that you're gonna be good at whatever you do. But with coaching being so new and a lot of people not having much experience with it, it's probably really important for us to make sure that we're building a foundation and developing a language that allows everyone to grow from. And so that just talks about this idea of accountability. And a lot of the coaches within the university sport realm really emphasize this idea that as coaches, they're always growing.

Dr. Robin Mackin (43:47):
They're watching other coaches, how they do things, how they teach, how they run different systems, and they're learning and developing on a regular basis because they have accountability to that role. And I wanna just share this clip with you, and this comes from the coach.ca toolkit. This is the head coach of the women's soccer team. And he talks about this idea that coach education is a journey, it's not just a destination. So I'm gonna share this two-minute clip with you guys.

Jason deVos (44:09):
Hi, I'm Jason deVos the Director of Development with Canada Soccer. One of the best pieces of advice that I got when I first started doing coach education from one of my instructors was not to think of coach education as a destination, but rather to think of it as a journey. And what he meant by that was that getting a license or taking a course or gaining a qualification is just the beginning of your learning as a coach. And you really have to go into those courses with an open mind, knowing that the real work is going to come when you start putting that knowledge that you gain on the course into practice in a practical sense in the coaching world. So one of the other things that I really like to encourage coaches to do in soccer, because we have a tendency to be a little bit myopic in our sport when we only look at what's going on in the soccer world. But what I really like to do is to go to multi-sport conferences because I feel that you can gain a lot of knowledge from other sports and what's working and what's maybe not working in other sports, and then try to learn from that and apply it to your own sport.

Jason deVos (45:06):
So it's one of the things that I always try and encourage. So whether it's a coaching theme like empowering your players to take ownership of their own learning, or if it's an organizational or structural theme, maybe tracking the data that's relevant to the athletes in your sport, you can learn from some of the other sports and the successes that they've had... And the final piece I'd like to talk about is the importance of coach mentoring. All the qualifications in the world are great, but one of the things that I found really beneficial for me as a coach is to identify someone that you really respect in your sport, who's an outstanding coach, that's perhaps coaching at a very high level, who you could use as a mentor to bounce ideas off of and learn from. And kinda have them give you some practical guidance and feedback in your coaching. It's certainly something that's helped me in my coaching career, and I hope it'll help you in yours as well.

Dr. Robin Mackin (45:54):
So I thought that was nice in the sense that it sort of inspires us to... Even though he's an Olympic sort of soccer coach, he's still trying to learn from other people and grow as a coach. And so it enables us to feel comfortable actually seeking other opportunities and looking to our peers and people with other expertise to hopefully help us grow in the area of coaching as well. And so I just wanna leave you with one final thought, which is that let's not just coach to competency, let's actually coach our learners to personal best. And with that, thank you very much for joining me.

Dr. Teresa Chan (46:23):

Thank you so much for tuning in to the MacPFD Spark Podcast. Just so you know, this podcast has been brought to you by the McMaster Faculty of Health Sciences and specifically the Office of Continuing Professional Development and the Program for Faculty Development. If you're interested in finding out more about what we can offer for faculty development check out our website at www.macpfd.ca that's www.M-A-C-P-F-D.ca. Many of our events are actually web events that are free. Finally, I'd like to thank our sound engineer Mr. Nick Hoskin who has been an amazing asset to our team, thanks so much Nick for all that you do. And also thank you to Scott Holmes for supplying us the music that you've been listening to. All right. So until next time this is MacPFD Spark signing off.