

EUROPEAN ORTHODONTIC TEACHERS' FORUM 2016

Teach the Teacher

Fostering Resident Autonomy by Adopting a Coaching Approach to Teaching

How do you know when a resident is ready to function autonomously? How do they know themselves? Especially in clinical practice, where errors might have very serious consequences, it is often quite difficult to trust a learner to do things by themselves for the first time. Dependency on a supervisor can occur quite easily, despite the fact that both parties involved eagerly strive toward autonomous functioning. In hierarchical situations, especially when a lot is at stake or when evaluation is imminent, communicating discomfort is not easy. Yet it can be a major factor in performance and thus patient safety. To this and many other challenges in clinical teaching, better communication through a coaching approach to teaching can provide an answer.

The importance of a supportive approach to teaching

In this part, a formula from the scientific field of small group decision making research is presented, showing the importance of a people-based approach to teaching, alongside an equally important task oriented approach to teaching.

Task- and support-oriented behaviour in a learning context

Research in social psychology has shown that human interaction in the working environment can be described according to two axes: task-oriented behaviour and support-oriented behaviour.

The former concerns every kind of behaviour directly affecting the task at hand, such as telling the resident what to do, showing him or her how things are done, performing all kinds of practical acts. The latter concerns behaviour directly affecting emotions, and thereby indirectly affecting performance as well, such as asking a resident how he or she is doing, what he or she thinks about the procedure you are showing, what he or she would like to learn.

Both of these axes are of equal importance and they mutually influence one another. Subjectively, a resident who does not feel confident might very well underperform, or might even avoid to perform certain acts. Objectively, a resident who does not perform well, might receive less appraisal and more criticism and therefore might feel less at ease.

Research shows that task-oriented and support-oriented behaviour can be depicted as two orthogonal axes: both can vary independently from one another (figure 1).

In a work environment where errors might have very serious consequences, a strong emphasis on quality often exists, stressing the importance of task-oriented behaviour. Doctors are often predominantly trained in hard skills, much more than they are in soft skills. However, they work with people all the time. A patient judging the quality of your work, will base much of their judgment on how you treated them, rather than on how you treated their illnesses. The importance of human factors in teaching can thus hardly be overestimated.

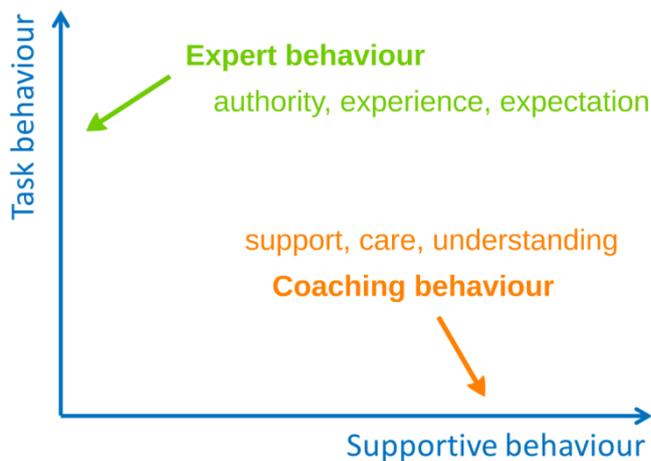


Figure 1: task-oriented and support-oriented behaviour

Task behaviour is strongly linked to the expert role, associated with authority, experience, expectation, etc. Supporting behaviour in a teaching context can also be described as coaching behaviour, such as showing care and understanding, in order to facilitate growth.

Some insight into a coaching approach to teaching is provided by research into small group behaviour. Scholars in this field have come up with the following formula:



Figure 2: decision effectiveness (E) as a function of quality (Q) and acceptance (A) (adapted from Mayer, N.R.F. and Hoffman, L.R. (1965) Acceptance and quality of solutions as related to leaders' attitudes towards disagreement in group problem-solving. *Journal of Applied Behavioral Science*, 1, 373-386.)

Shared decision effectiveness thus relies on the quality of the decision, as well as the degree of acceptance of the parties involved. In a learning context, the teacher can manipulate quality through his or her expertise, while acceptance is mostly out of

their control. The amount of acceptance is the extent to which learners agree with the procedure, the degree to which they understand what is expected from them, the degree to which they feel that a solution is their own and not someone else's, the degree to which they feel at ease with it.

Acceptance is very important. For instance, when acceptance of a certain procedure introduced by the supervisor is low, the learner is more likely to act otherwise as soon as the supervisor is absent. Therefore, it is key for good education to not only focus on quality, or task aspects, but also on the mental aspect of learning. This can be done, amongst other ways, by asking questions: what do residents think about the procedure, what questions do they have about it, what would they suggest themselves, what do they want to know, ... By asking questions, you can coach residents to more actively think about what they are doing, which will facilitate learning and in the long term foster autonomous functioning instead of dependency. It will contribute to independent, critical thinking.

Practical examples of a coaching approach to workplace learning

**A coaching approach
to learning technical skills**

- 1 silent run
- 2 Teacher explains while doing
- 3 resident explains what teacher will do
- 4 resident explains before he acts

Figure 3: Learning new skills in progressive phases: a coaching approach. (Peyton, J.W.R. (2003). Teaching and Learning in Medicine. London: Manticore.)

**Feedback:
Pendleton's approach**

What went well?

What could have been done better?

What will you remember from this?

Elaborate or correct where needed!

Figure 4: Pendleton et al.'s guidelines: a coaching approach to giving feedback. (Pendleton D, Schofield T, Tate P, Havelock P. (2004). The New Consultation. Developing doctor-patient communication. Oxford University Press.)

Key learning points

- Alongside task-oriented behaviour, coaching towards growth requires support-oriented behaviour.
- Acceptance of a solution is often equally important as it's quality. Expert advice is not always the best guarantee for behavioural change. Ask questions!
- Autonomy is the most important factor to get and keep people motivated. Promote it!

Situational Leadership

A teacher is usually responsible for the clinical acts of the resident. That is one of the ways in which a hierarchical relationship exists between them. We will now approach teaching practice by elaborating more on how to offer support from a leadership perspective.

Situational Leadership has a long tradition of research and practice and is one of a few leadership models on which there is quite some consensus. It is based on the above mentioned notion that professional behaviour can vary in the degree to which it is task- as well as support-oriented.

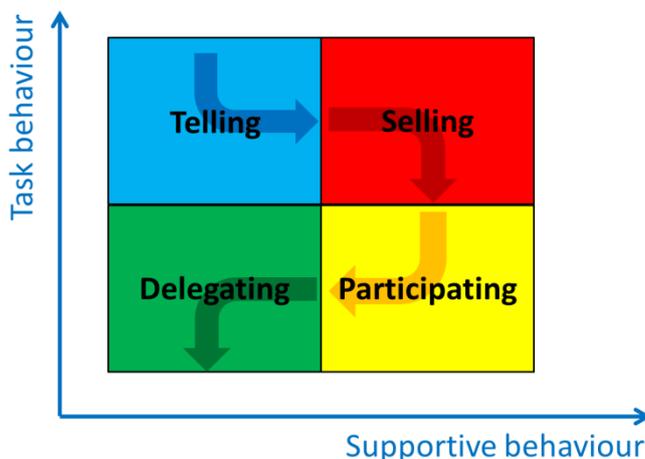


Figure 5: The Situational Leadership model
(adapted from Hersey, P. (1984). *The Situation Leader – The other 59 Minutes*. New York: Warner Books.)

Hersey and Blanchard, describe four leadership styles, each with their own characteristics:

- Telling: one-way communication: instructing, telling what, when, how, ...
- Selling: two-way communication: still providing direction, now providing socio-emotional support as well, convincing about what, when, how, ...

Participating: shared decision-making: little direction is given, cooperation where needed, discussing what, when, how, ...

Delegating: passing on most or all responsibility: resident works autonomously, being available for questions

Hersey and Blanchard's theory was one of the first leading models to stress behaviour as an important, trainable aspect of leadership, instead of the invariable traits of older leadership models. They also were the first to focus on the characteristics of the followers. Effective leadership was no longer defined by fixed traits, but rather by the context, hence the name of the model. Applying their theory in the context of clinical learning, the most effective teaching style depends on the maturity of a specific resident, in a specific situation.

Hersey and Blanchard define maturity in terms of competency for the task at hand and the follower's confidence in it or motivation to do it. Thus, they discriminate between four different profiles of followers:

- M1 followers lack the knowledge, skills and the confidence they need to be pushed: they mostly need instructions
- M2 followers lacking knowledge and skills often become demotivated besides instructions, they need to be supported and encouraged
- M3 followers become competent, but are not very confident yet they mostly need support and encouragement
- M4 followers are competent and confident they need your trust in order to work independently

The most appropriate leadership styles correspond to these levels of maturity in the following way:

M1: telling, M2: selling, M3, participating, M4: delegating

The situational aspect of this theory is also prevalent in the fact that a resident who is competent and confident in a certain task, can become unconfident under increasing stress or incompetent while doing another task, thus again requiring a different leadership or teaching style. This means that a good leader is one who adapts their style to the needs of the situation, the competence of the follower and the confidence or motivation of the follower. A good leader develops "the competence and commitment of their people so they are self-motivated rather than dependent on others for direction and guidance.

Exercise

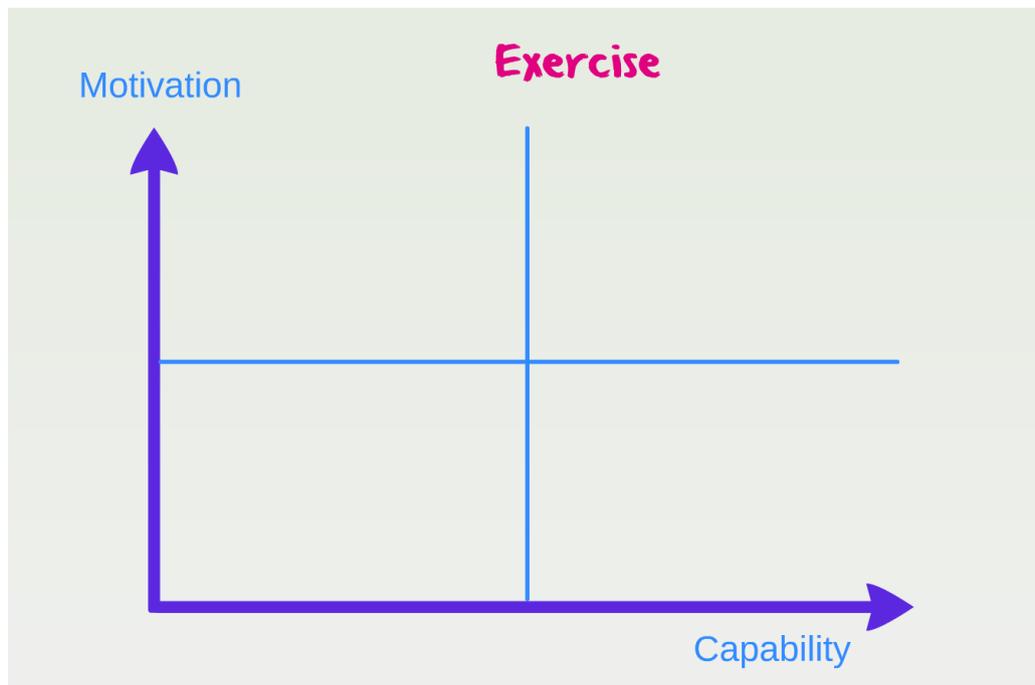


Figure 6: Exercise. Try to match the leadership styles with the corresponding maturity levels described in the coordinate system.

telling, selling, participating, delegating

Key learning points

- The best leadership style depends on:
 - the situation
 - the competence level of the resident
 - the motivation or confidence of the resident
- Keeping the right balance between task- and support behaviour motivates residents to perform.
- Be aware of your own leadership style preference!

Interpersonal circumplex

Continuing the basic assumption to this lecture, we discuss a new model to further elaborate on the use of a task-oriented factor and a support-oriented factor to describe human behaviour. The interpersonal circumplex provides insight in how you can influence other people's behaviour. Implications include dealing with inappropriate or otherwise challenging behaviour and adopting a right interpersonal style to coach residents toward growth.

The circumplex model

In yet another field of research, scholars found two axes, similar to the ones we discussed earlier, describing human behaviour. These axes are dominance, ranging between initiating and following behaviour, and communion, ranging between 'together' and 'against behaviour'. By combining these two axes, a circumplex structure of human behaviour emerges, as is shown in figures 7 and 8.

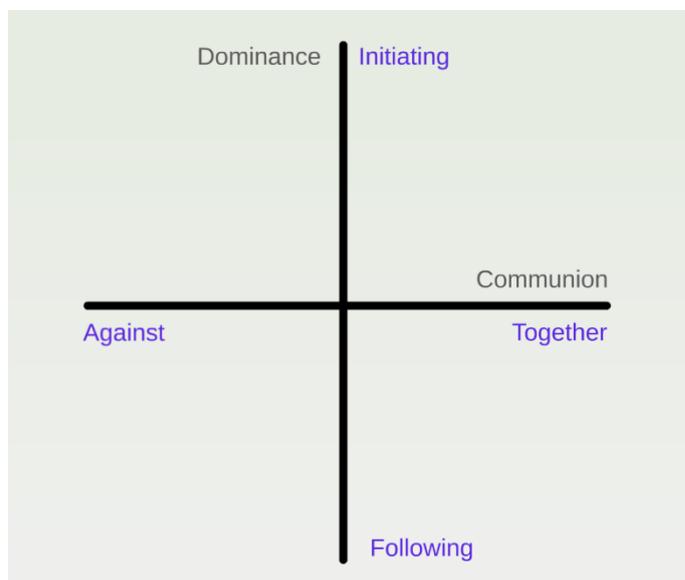


Figure 7: the axes defining the interpersonal circumplex

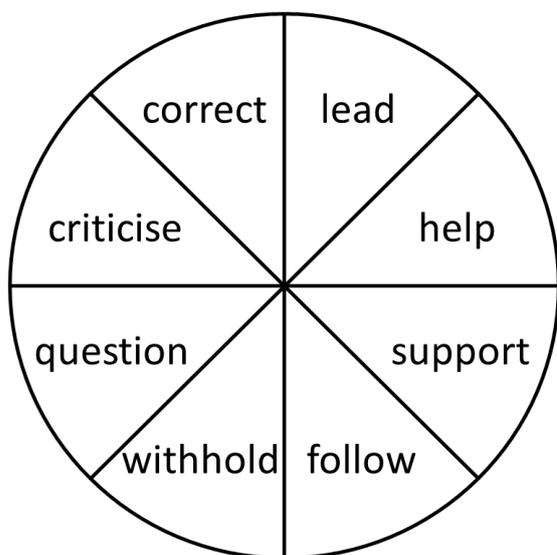


Figure 8: the interpersonal circumplex
(adapted from Wiggins, J. S. (1996). An informal history of the interpersonal circumplex tradition. *Journal of Personality Assessment*, 66,217-233)

Neighbouring style octants describe similar behaviour. Helping behaviour and leading behaviour, for example, both have initiating and together characteristics. Styles in juxtaposed octants describe contrary behaviour. All behaviour is positive, there are no negative styles in the circumplex above. A behavioural style becomes negative when it is not adapted to the specific context, when someone rigidly sticks to the

same style, or when someone exaggerates the use of one particular style. One of the characteristics of the circumplex is that the further a behaviour is situated from the center, scoring higher on one or both axes, the more extreme it is. Disturbing behaviour could thus be situated outside the circle.

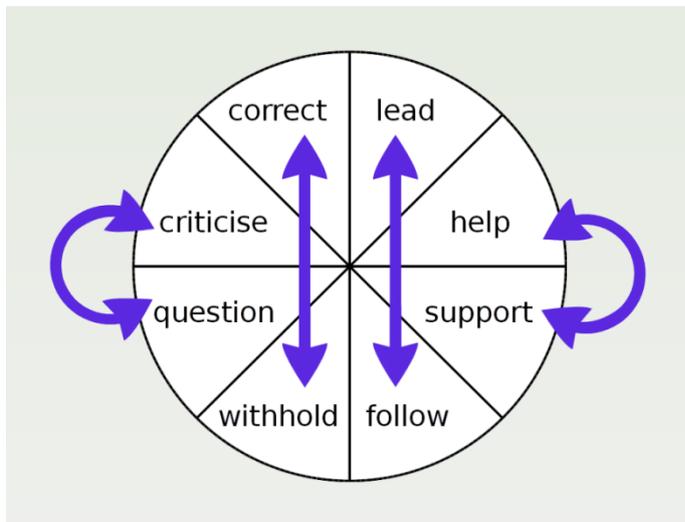


Figure 9: dynamics in interpersonal behaviour depicted in the circumplex

This circumplex enables one to better understand human interaction. Moreover, this theory will help you to influence people to interact in a more agreeable and constructive way, allowing you to tackle challenging resident behaviour and to broaden your spectrum of teaching styles. The dynamics explained by the model and thoroughly backed by research, are shown in the figure below.

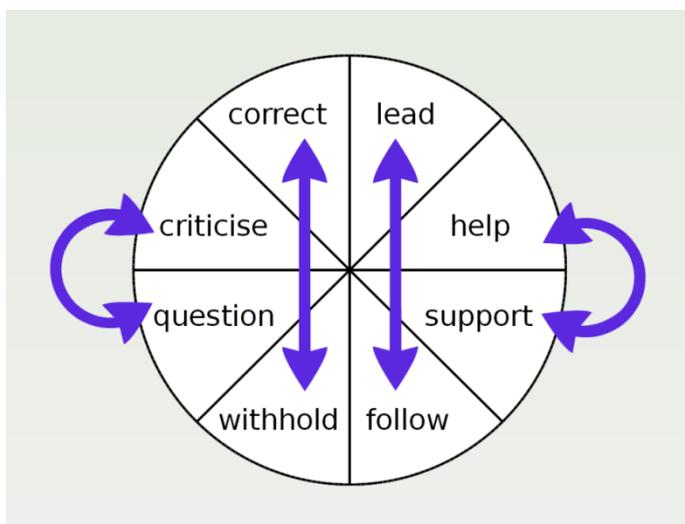


Figure 9: dynamics in interpersonal behaviour depicted in the circumplex

The circumplex theory describes how human behaviour is interrelated. Each kind of behaviour invites for a reciprocal kind of behaviour in others. Vertical arrows indicate complementarity: dominant behaviour elicits submissive behaviour. Round arrows illustrate symmetrical behaviour: together behaviour invites for together behaviour, against behaviour calls for against behaviour.

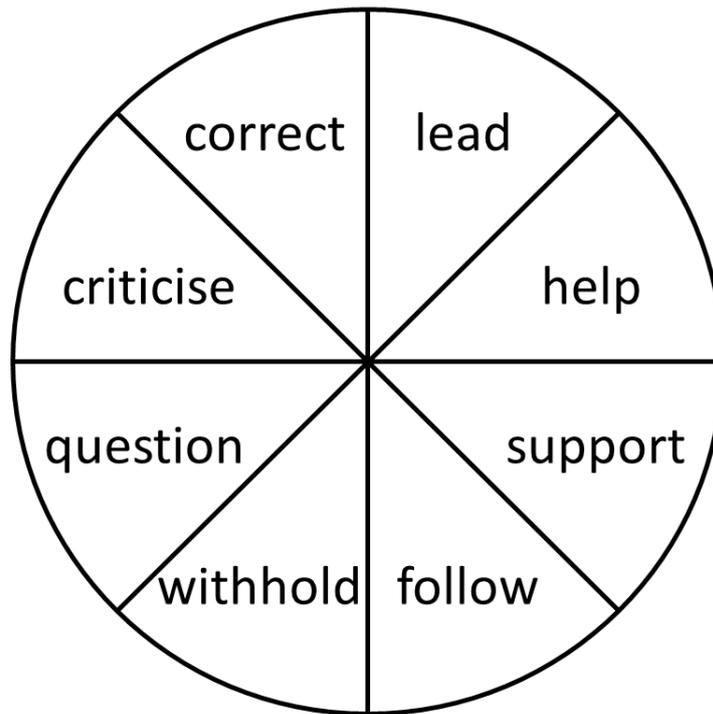


Figure 10: Exercise: Add the pitfalls and the implicit message of each behaviour to the respective octants.

Conclusions

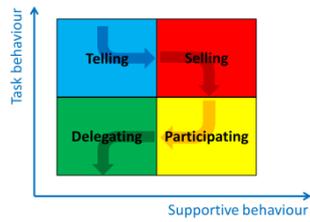
- An effective leader or teacher varies interaction styles according to the situation. All styles are potentially good, only exaggeration or rigidity is dysfunctional.
- A coaching approach helps preventing conflicts, or dealing with them.
- In order to influence people's behaviour, assess your own behaviour first.

General conclusions



A teaching approach, as opposed to a directive approach, fosters autonomy and motivates residents.

When teaching, change your style according to situation, skills level and motivation.



To influence other people's behaviour: understand your own behaviour and use it.

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