

## **CHAPTER 6:**

### **EXPLORING THE POTENTIAL OF PROFESSIONAL COACHING FOR THE GROWTH OF CLINICAL SUPERVISION IN PRACTICE**

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#### **CHAPTER CONTENTS BOX:**

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- The landscape of professional coaching as a clinical supervision continuum
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- Experimenting with a coaching framework in the clinical supervision situation
- Coaching possibilities in UK healthcare beyond clinical supervision
- Conclusion

#### **INTRODUCTION**

In this chapter we will examine what coaching is' and consider whether some of the core skills used in 'coaching a client' might also have some resonance with what clinical supervisors are trying to achieve in 'supervising a supervisee' . Just as important as what is trying to be achieved in coaching or clinical supervision, is the role of the 'client' and 'supervisee' in the two processes and the nature of the relationship itself. Much of the thinking behind this chapter is borne out from my own continuing development journey towards becoming an 'accredited coach' and being a recipient of the coaching process. Part of my agreement with Rachel (my coach), has been to personally experience coaching by using it as my own clinical supervision, as well as personally reflect on the potential of coaching by offering it as a form of clinical supervision in the healthcare setting.

In over a decade of the emergence of clinical supervision in UK healthcare there is some general agreement that the term 'supervision' is not an accurate description of the intentions behind the process and this in my view continues to act as a barrier in getting started in practice. The development of coaching is an unexplored frontier for clinical supervision and its application to the healthcare practice environment.

At the risk of 'muddying the water' which was a response a respected colleague of mine made to me at my notion of introducing elements of coaching into clinical supervision, I suggest that coaching and in particular development coaching has much to offer the clinical supervision encounter particularly for senior staff supervisees in terms of conversational structure, being more demonstrable in terms of outcomes, less 'problem' orientated and of a more equal relationship.

For health professionals new to the concept of clinical supervision, the term 'development coaching' might be more accurate for senior and experienced healthcare staff, reserving the term clinical 'supervision' for more individualised and performance related activities in practice with more junior staff. If this premise is accepted, the implications are enormous in healthcare in terms of developing coaches as well as supervisors and rethinking what already happens in clinical supervision. On the other hand, existing professional coaches and who undergo long training programmes to become accredited might feel their role is being usurped. My own view is that both coaching and nursing as professions has an established history of 'borrowing' knowledge from other related disciplines to inform their practices and just as importantly, in the knowledge development of clinical supervision activities which are evolving over time.

Although the chapter is not a broad examination of coaching as a profession per se, it seems sensible to question what happens in 'coaching' and in particular different interventions that might be suitable for use in the clinical supervision encounter. The different types of coaching and a popular coaching framework are outlined, in order to help make some tentative comparisons between the skills used in coaching and clinical supervision. For those of you already engaged in the process of clinical supervision whether as a supervisor, supervisee, or supporting the initiative as a healthcare manager, I would challenge you to consider experimenting with a coaching framework as a potential structure for one of your future clinical supervision sessions.

## **THE LANDSCAPE OF PROFESSIONAL COACHING AS A CLINICAL SUPERVISION CONTINUUM**

When one thinks of the term 'coaching' there is likely to be an association to competitive sports and winning (Kinlaw 1997:21, Peltier 2001:170, Starr 2003:5). For instance, how many times do you recall successful sportsmen and women when interviewed shortly after an achievement making direct reference to their coach as being instrumental to their success? Kelly Holmes, the UK double gold medallist in sprinting was a perfect example (I am writing this during the 2004 Olympics in Athens). A coaching model often used in competitive sports is the 'coach as 'expert' or 'personal trainer' i.e. in golf this might be helping a player towards winning a major tournament or simply remedying aspects of a players' game such as the grip used or swinging the club. In the UK as elsewhere in the world, successful sports team coaches are able to capture a nation's imagination and can even reach legendary status for example, the late Sir Alf Ramsey (England football World Cup winning coach in 1966), Sir Clive Woodward (England rugby World Cup winning coach in 2003) to name but a few. The reason for this acclaim is simple – successful results.

Effective coaching is not just confined to competitive sports and is evident in other areas demanding high performance. For instance, individualised coaching can enhance the performance of an opera singer and maximise the potential of musicians and those in the performing arts. You can probably think of many other instances in which coaching is cited as improving the abilities or the performance of individuals. Collectively, coaching a team or an individual to maximise their potential is likely to be based on some of the following coaching attributes;

- Being an expert or having a significant area of expertise
- Close observation and offering 'live' feedback on technique(s)
- Motivating towards winning ways
- Setting and increasing the levels of performance and endurance
- Being unpopular when necessary
- Developing a sense of self belief at 'being the best' or striving toward 'the best they can be'
- Giving of time and personal commitment and similar expectation for those being coached

If as a starting point we agree in principle that coaching (and in particular competitive coaching) is around nurturing potential, maximising individual or team performance and most importantly getting results, it is not surprising that coaching techniques and

processes have been applied to business and industrial sectors. However, Kinlaw (1997:21) rightly points out that a major difference between personal and professional development coaching and sports coaching is that competitive performances often last for a given period and players only need to be at their best for a defined period. In contrast, the work of businesses continues unceasingly (unless discontinued) with the consequence that employees are expected to be 'doing their best all of the time' and professional coaching in this situation is a much more complex activity to define.

Professional coaching is a newly emerging profession (ECI 2004, ICF 2003, UKCLC 2003) arising out of business consultancy. Although a new term, the idea of having a periodic one to one conversation with someone (usually a manager) at work about development needs has been around for decades. Jarvis (2004:8) rightly asserts that such conversations are largely based on 'knowing what you need to change' and is very different from then helping bring about those changes in a persons lifestyle or work habits which is the remit of professional coaching. The rapid expansion of professional coaching is due to a number of changes in the work environment (Box 8.1).

#### **BOX 6.1**

Key factors leading to the expansion of professional coaching in the workplace;

- Keeping pace and learning to adapt to increasing amounts of change
- Flatter organisational structures and broader management roles requiring individualised support
- Learning being considered lifelong and needing to take account of individual learning styles
- Targeted and responsive approach to individual development
- The cost of poor performers to the organisation
- Formalised support for those at the top who are often isolated or a significant distance from employees
- Employees having to take individual responsibility as they can no longer rely on employers to provide all their career development
- The cost effectiveness of work based learning schemes as opposed to just the training room of an educational provider
- Keeping up the momentum and support with published personal and professional development plans

- Flexible and individually tailored learning to increase an employee's performance

Adapted from Jarvis (2004:6)

This has in turn led to the surfacing of different areas of coaching expertise such as personal life coaching, executive coaching and corporate coaching to name but a few. More detailed accounts of the different types of coaching can be found in Hadikin (2004:15), Jarvis (2004:24) and Jay (2001). Interestingly, the term 'clinical supervision' was cited in the early 1980's as a method of coaching teachers for higher performance and transforming the work culture in North American schools (Snyder 1993:32). Despite such diversity, all professional coaching contains the development of a relationship between people and conversations that take place will have a different emphasis depending on the context and the needs of the person being coached. This is illustrated by Downey's (1999:15) broad definition of coaching that might also be a definition of clinical supervision in practice;

*Coaching (clinical supervision) is the art of facilitating the performance, learning and development of another*

West & Milan (2001) identify three specific types of coaching for leadership which help to further illustrate the different emphases in the coaching relationship;

- Skills coaching
- Performance coaching
- Development coaching

Skills coaching relates to developing specific skills and abilities in the client in which the coaching parameters and expected outcomes are clearly defined from the beginning e.g. improving presentation skills at meetings or delivering a conference paper. The relationship may involve directly instructing the client or offering advice and in essence 'training' the client. What distinguishes skills coaching from training is that it is delivered on a one to one basis rather than in a large group situation. Skills' coaching is a highly individualized and intensive relationship, focusing on the specific learning needs of the client and is usually short term. Although similar to mentoring, skills' coaching differs as a mentor either implicitly or explicitly assesses a person's

level of skill against organizational or professional competencies. A mentor relationship is typically an experienced senior staff member recruited from within the organisation that is expected to directly influence the way a more junior member of staff works or in other words, an apprentice/master relationship.

Performance coaching is wider in scope than skills coaching and intends to enhance a client's performance more generally in their role at work by helping the development of particular behaviours or, by raising the client's awareness of behaviours that limit performance. In this respect there is an expectation that coaching will produce results in a client's performance. More often than not the client's role and expected behaviours are defined by the organisation as performance objectives or job descriptors. Where these are not being met or, the client is under-performing, this can often become a source of referral for either internal (manager as coach) or, external coaching. Thorpe and Clifford (2003:34) emphasise the improvement of skills and performance as outcomes for the client and introduce the importance of reflective learning as being an important aspect of the process of coaching;

*.....the process of helping someone enhance or improve their performance through reflection on how they apply a specific skill and or / knowledge.*

Their definition aimed specifically at the coaching role of a trainer and manager in the workplace, is suggestive of facilitating reflection on established sets of competencies or preferred behaviours. The objectives in both skills and performance coaching are clearly defined in the shorter term i.e. over one year, in which results or outcomes can be followed up by the organisation in the form of an annual appraisal or personal development review.

Development coaching is usually considered a longer term investment on the parts of both the organization and the individual, for instance 12 to 18 months (but can last longer) and is a more evolving process than the specific task of Skills or Performance coaching. A similarity between clinical supervision and development coaching is that both are offered to senior or qualified practitioners and is highly individualized. The process begins by initially identifying the agenda and development goals, but more often than not the agenda alters depending on the changing circumstances and complexities of the client's or supervisee's world (West & Milan 2001:10). For instance, in my own development coaching in which my agenda was to discuss the

progress of a large clinical supervision project in prison healthcare, the session changed into ways of valuing what I do and putting a price on services that I offer. In turn this led to a complete re-think on managing my business finances which subconsciously I had been having concerns about. Timothy Gallwey a former tennis coach and a major influence on the origins of developmental coaching, based his Inner Game thesis (Gallwey 2000) on the realisation that a persons peak performance is often marred by their own 'self interference' . For example, this might take the form of self doubt and fear of failure in which an individual's potential, let alone peak performance is not able to be reached.

### **THINKING SPACE ICON:**

*Based on Gallwey's (2000) Inner Game thesis how many work colleagues can you think of that are generally more capable than their current performance suggests and in what ways might 'self interference' manifest itself?*

*Can you think of either a personal or professional example of how 'self interference' might be a factor in reducing your own potential or performance?*

Gallwey (2000:177) suggests that unlocking a client's potential is not so much a process of adding by the development coach (i.e new skills or behaviours) but subtracting or unlearning whatever is getting in the way of the client reaching that potential. In this respect, the task of the development coach is about facilitating the client's learning or to be more precise, enabling the 'un'learning of the client. Somers (2002:6) refers to this as 'drawing the client out' rather than 'putting in' and helping the client to draw on the huge reserves of talent and potential laying dormant in the person. A key element of development coaching and perhaps clinical supervision, places the client (or the supervisee), as the main problem solver through gaining an increased sense of self awareness during reflection on their personal or professional performance.

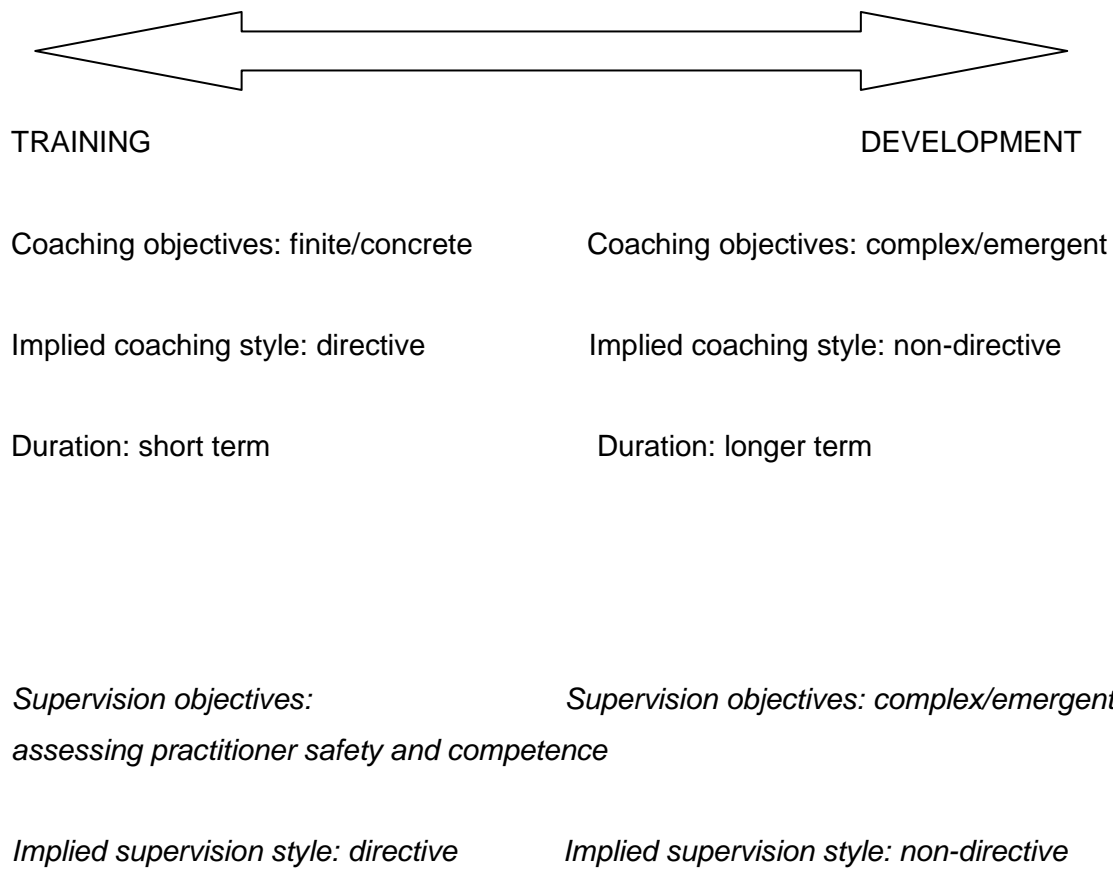
All three types of coaching outlined, whether skills, performance or developmental coaching present two basic coaching models that can be broadly categorised as either being directive in nature i.e 'showing and telling', or non directive, in that the client retains more control in the learning process. Whichever type of coaching is used all coaching remains outcomes orientated or performance focused and is a highly individualised and person-centred endeavour . The two extremes of directive

or non directive coaching activities can be seen as being on a coaching continuum depending on the clients experience and needs and has many similarities with the supervision continuum that already exists in UK healthcare. An adapted coaching / supervision continuum is outlined in Figure 8.1 based on the original work of West & Milan (2001:3).

**FIGURE 6:1**

An adapted continuum of coaching (Milan & West 2001:3) and its relationship to clinical supervision in UK healthcare (in italics)

SKILLS COACHING	PERFORMANCE COACHING	DEVELOPMENT COACHING
<i>SUPERVISED PRACTICE AND LEARNING</i>	<i>ORGANISATIONAL SUPERVISION</i>	<i>SUPPORTIVE SUPERVISION</i>



*Duration: short term*

*Duration: longer term (lifelong learning)  
and part of a practitioners' continuing  
professional development (CPD)*

**TIME OUT ICON (EXERCISE):**

*Consider the coaching continuum and the different types of coaching with the healthcare supervision continuum in Figure 8.1.*

- a) Where do you consider yourself to be on the supervision continuum as a healthcare practitioner today?*
- b) In what ways might the terms skills, performance or development coaching better describe what is currently happening in your own clinical supervision?*

In reality there is likely to be some overlap between the three types of coaching or supervision in practice. Most healthcare professionals have undergone lengthy training in which the work of the unqualified practitioner is duly assessed and supervised by a range of more senior qualified practitioners, mentors and trainers. But once qualified, immediate additional skills are then required by a practitioner in making the transition from unqualified to qualified professional. Clinical supervision for the newly qualified but junior healthcare professional will initially need to be more advisory and directive, focusing on the more specific skills of practice i.e. mentoring, and preceptoring. As the healthcare practitioner becomes more experienced and assumes a more senior role, he or she will then move towards the right of the coaching/supervision continuum. At this end of the continuum, roles at work become more complex or ambiguous, requiring the less directive skills of development coaching or developmental supervision.

Perhaps the term 'clinical supervision' might be reserved for when there is a need to more specifically learn *skills* or work to a minimum *performance* in practice? Might the terms *development coaching* or *developmental supervision* more accurately embrace the continuing professional development (CPD) needs or lifelong learning activities for more senior practitioners that require less direction but guided reflection on their practice? How many of you reading this feel trapped in a particular form of supervision that has an emphasis on skills or performance (more directive in nature), rather than developmental or less directive clinical supervision? In what ways might directive or non directive supervision be helpful or a hindrance in clinical practice?

## **HISTORY BOX:**

*In reality, I would suggest that we all probably have a tendency towards being either directive or less directive depending on our client's or supervisee's needs which are complex. In my past professional situation having been a senior practitioner in intensive care and a teacher in a university, I have often been looked upon to be an 'expert' with a resulting expectation from others that I be directive and guide. In some cases, being directive to others has been life saving in the clinical situation.*

*In contrast, now working as a full time externally employed change agent and as a independent consultant, I intend my role to be much less of an 'expert' and directive and more facilitative in nature. As this has not come naturally for me I am currently 'un'learning this in my own coaching/supervision. I have become much more consciously aware of my old tendencies towards retaining a degree of power and control through having some specific knowledge. My client's expectations are actively wanting me to remain as 'expert', provide answers and at the same time pay me for doing so. The contradiction is that I view my 'expert-ness' at its worst as being potentially counter-productive in fostering a sense of dependency on my services and one which will not be sustained after my contract expires, and at best, not really being facilitative at all. In other words, my being less directive will increase the ownership and subsequent autonomy to act of those that employ my services.*

## **COMPARING CORE COACHING SKILLS TO CLINICAL SUPERVISION**

The International Coach Federation (ICF) is a professional organisation for coaches based in the USA. Although not an officially recognised regulatory body it does offer some minimum standards and ethical guidelines for coaches and accredits the quality of coaching training programmes. The ICF (2004) describe the 'what' and 'how' of professional coaching as;

*.....a professional partnership between a qualified coach and an individual or team that supports the achievement of extraordinary results, based on goals set by the individual or team.....Through the process of coaching, individuals focus on the skills and actions needed to successfully produce their personally relevant results*

This definition explains what is expected of a coach working with a client and is helpful to begin to reflect on whether aspects of development coaching might be useful in the clinical supervision situation. The notions of professional partnership,

goal setting, getting results and being applicable in the one to one or group situation aligns to the principles and ideas underpinning clinical supervision.

As part of the standardisation of professional coaches the ICF (2002) identify four clusters underpinning a coaches' work and 11 associated core competencies that are individually examined before a coach can become an accredited member or professional coach (Box 8.2)

### **BOX 6.2**

The four clusters of coaching (ICF 2002) and 11 associated core competencies

#### *A) Setting the Foundation*

- 1 *Meeting Ethical Guidelines and Professional Standards* – Understanding of coaching ethics and standards and ability to apply them appropriately in all coaching situations
- 2 *Establishing the Coaching Agreement* – Ability to understand what is required in the specific coaching interaction and to come to agreement with the prospective and new client about the coaching process and relationship

#### *B) Co-creating the relationship*

- 3 *Establishing Trust and Intimacy with the Client* – Ability to create a safe, supportive environment that produces ongoing mutual respect and trust
- 4 *Coaching Presence* – Ability to be fully conscious and create spontaneous relationship with the client, employing a style that is open, flexible and confident

#### *C) Communicating effectively*

- 5 *Active Listening* – Ability to focus completely on what the client is saying and is not saying, to understand the meaning of what is said in the context of the client's desires and to support self – expression
- 6 *Powerful Questioning* – Ability to ask questions that reveal the information needed for maximum benefit to the coaching relationship and the client

7 *Direct Communication* – Ability to communicate effectively during coaching sessions, and to use language that has the greatest positive impact on the client

*D) Facilitating learning and results*

8 *Creating Awareness* – Ability to integrate and accurately evaluate multiple sources of information, and to make interpretations that help the client to gain awareness and thereby achieve agreed-upon results

9 *Designing Actions* – Ability to create with the client opportunities for ongoing learning, during coaching and in work/life situations, and for taking new actions that will most effectively lead to agreed-upon results

10 *Planning and Goal Setting* – Ability to develop and maintain an effective coaching plan with the client

11 *Managing Progress and Accountability* – Ability to hold attention on what is important for the client, and to leave responsibility with the client to take action

A similar initiative under the auspices of the European Coaching Institute (ECI) is also planned for the future to monitor the quality of coaching training programmes in Europe (ECI 2004a) and a *Code of Ethics* has recently been published by the European Mentoring and Coaching Council (EMCC 2004a) including *Guidelines on Supervision* for coaches (EMCC 2004b).

**TIME OUT ICON (EXERCISE):**

*Taking each of the descriptors of the 11 core competencies of coaching in Box 8.2;*

*a) Individually rate what you consider to be the appropriateness (or not) of each core competence for use in your clinical supervision situation i.e. Very Important, Important, Not Important. What is the rationale for the choices you made?*

*b) For those competencies you rated as Very Important or Important, download the behavioural descriptors from the ICF website and personally rate your current coaching abilities in clinical supervision. What might be the implications for you with this exercise?*

c) How useful might each of the 11 core competencies of coaching be in helping to set minimum clinical supervisor behaviours?

The four clusters may offer a useful content for any clinical supervisor training programme and the 11 core competencies a useful discussion point for the future evaluation and perhaps even regulation of clinical supervisor skills. A major difficulty facing existing clinical supervisors in UK healthcare practice is that there is an absence of literature and virtually no agreement on what the core competencies of a clinical supervisor are in practice. Training courses vary in length and content and in many cases, once having undergone such a programme, clinical supervisors are not then required to update or review their knowledge and skills whatever these might be. The current lack of regulation and minimum standards in healthcare clinical supervision therefore leaves the 'doing' of effective clinical supervision to individual interpretation and preference. Whilst it might be argued that adopting a less prescriptive stance for clinical supervision is its strength, there remain unanswered ethical questions about the effects of this on supervisees and what is happening within clinical supervision in organisations.

Using the four clusters of coaching as headings, a number of differences then emerge when comparing coaching to clinical supervision (Figure 8.2).

**FIGURE 6.2**

Some key differences between coaching and clinical supervision using the 4 key clusters of a coaches' competence (ICF 2002)

COACHING	CLINICAL SUPERVISION
<p><b>Setting the Foundation:</b> Incremental levels of coach training based on experiential learning and being coached</p>	<p>Often short and variable introductory training given in-house</p>
<p>Mutual contractual agreement made following detailed first interview matching methods and expertise</p>	<p>Mutual contractual agreement made based on practitioner experience and expectations</p>
<p>Coaches expected to have on-going supervision as a requirement of their Ethical Code (EMCC 2004)</p>	<p>Supervisors expected to have on-going supervision as best practice</p>

Coaching working towards becoming regulated that will include supervision as a professional requirement	No regulation of clinical supervisors although clinical practice regulated as a professional
Coaching as an emerging profession in its own right	Supervision viewed as an additional part of a qualified practitioner's role
Always an emphasis on client solutions and results for the immediate future	Often an emphasis on 'problems' and 'problem solving' occurring in practice
<b>Co-creating the relationship:</b> Client/coach agree terms and fees	Free at the point of delivery
Process mainly based on individual telephone conversations	Process mainly based on 'face to face' encounters either individually or as a group
Coach often external to the organisation	Supervisor often internal to the organisation
Short to medium term relationship	Medium to longer term relationship
Coaching viewed as adding value to the organisation in developing key staff	Clinical supervision aimed at all healthcare professionals particularly inexperienced staff
<b>Communicating effectively:</b> Tendency to be non-directive as a coach	Tendency to be more directive as a supervisor
The client is the expert in the conversation based on their situation	Tendency for the supervisor to be an expert in the conversation
Coach suspends experience and expertise unless client gives permission	Supervisor often uses professional experience and expertise in the session
Clarity with coaching role and expectations	Sometimes confusion with supervisory role and expectations
<b>Facilitating learning and results:</b> Always an emphasis on client responsibility during and after session	Often an emphasis on supervisee professional accountability during and after session
Emphasis on the persons performance and life as a client	Emphasis on supervisee professional performance at work
Coaching evaluated through outcomes and results made by the client	Difficulty in evaluating the effectiveness of supervision

A major difference is that clinical supervision is seen as an additional part of a practitioner's role following some introductory training. In other words, whilst the role may be expected in practice, this doesn't relieve you of your existing clinical responsibilities and often no additional time built in for the activity. In contrast, most coaches have undergone lengthy periods of experiential training to become accredited before practising as a paid professional. Whilst coaching is viewed as adding value to the organisation through the individualised development of staff, clinical supervision which has a similar philosophy is often viewed as an inconvenience in busy practice.

Both the coaching and clinical supervision literature distance themselves from being any form of therapy preferring instead to begin in the client's or supervisee's 'present' practices. As O'Donovan & Martin (2000:13) assert;

*Unlike therapies, coaching focuses on where you are now and where you want to get to, and the only place you can start from is where you are now.*

Whilst professional coaching has an established knowledge base from counseling, management consulting and psychology (Peltier 2001, Hadikin 2004, Starr 2003, West & Milan 2001), clinical supervision is only just beginning to explore different psychological frameworks as being relevant for clinical supervisors and is discussed in an earlier chapter. This might explain why clinical supervision still largely remains a 'problem' orientated intervention not dissimilar to a medical model in which problems (of practice) are sought, in order to help diagnose a condition (why such problems are occurring), before a treatment plan is prescribed (and if not followed through, creates even more problems). By contrast, professional coaching is a focused activity that adopts a more appreciative or positive approach concentrating on creating solutions and results with the client. Embracing a similar approach to the clinical supervision encounter could be transformational in creating a deeper self awareness in a supervisee's practice and focusing on improvement and change as an outcome. In turn, this will make the process more transparent and less challenging in evaluating the effectiveness of clinical supervision which is the subject of a later chapter.

Whilst it is not our suggestion that coaching replaces clinical supervision, some key elements of development coaching can quite easily be adapted for use in the clinical supervision situation, particularly with more senior healthcare practitioners (Driscoll &

Cooper 2005). However, this will mean re-negotiating the original clinical supervision intentions and expectations with the supervisee. Despite these obvious differences, coaching in my view shares more similarities than differences with clinical supervision;

- The terms coaching and supervision can evoke initial suspicion by the client/supervisee that they are underperforming
- Client/supervisee can exercise choice in who is their coach/supervisor
- Formal contract/agreement is made at the beginning of the process
- Expectation that the client/supervisee is in control of the process
- Senior managers can be coaches/supervisors
- Both processes are examples of formalised reflection on developing personal practice and improving performance
- Sessions begin with present practice and directed towards future actions
- Reflective questioning and active listening are key tools used by the coach/supervisor
- Both processes offer feedback to the client/supervisee
- Coaches/supervisors are expected to have on-going supervision as part of their continuing professional development (CPD)
- Both processes are intended to contribute to the personal and professional growth of the client/supervisee

Coaching is an eclectic discipline drawing on many differing sources of psychological literature. Some key areas that could be further developed in clinical supervision training based on the coaching experience is placing more emphasis on the use of powerful questions, active listening, designing actions with the supervisee during the session and a willingness to embrace a more holistic approach that takes account of the personal as well as the professional life of the person. It is interesting to consider how committed the supervisee and the supervisor are in clinical supervision which is 'given freely' in the NHS, compared to the client who pays for individual sessions or is sponsored by their organisation to engage in coaching to maximise their performance at work.

Finally, all coaching and clinical supervision is concerned with the personal or professional growth of the person. Before experimenting with the notion of coaching in clinical supervision, a powerful metaphor which comes to mind that for me explains

the complex nature of both coaching and clinical supervision is *The Rose* cited by Wright (1998:186);

### **CARTOON OF A ROSE (IN THE FOLLOWING TEXT):**

*When we plant a rose seed in the earth, we notice that it is small, but we do not criticize it as 'rootless' or 'stemless'. We treat it as a seed, giving it the water and nourishment required of a seed. When it first shoots out of the earth, we don't condemn it as 'immature' or 'underdeveloped', nor do we criticize the buds for not being open when they appear. We stand in wonder at the process taking place and give the plant the care that it needs at each stage of its growth. The rose is a rose from the time it is a seed to the time that it dies. Within it, at all times, it contains its whole potential. It seems to be constantly in the process of change, yet at each state, at each moment, it is perfectly alright as it is.*

### **EXPERIMENTING WITH A COACHING FRAMEWORK IN THE CLINICAL SUPERVISION SITUATION**

Clinical supervision like coaching relies on the sessions being productive for the supervisee. One way of achieving this is using a framework or structure to help navigate your way through a session as a clinical supervisor. Within the coaching literature there are many frameworks to choose from but the most widely used is the GROW model (West & Milan 2001:19). Originally developed by Graham Alexander in 1984 it was published by Sir John Whitmore in his seminal coaching text *Coaching for Performance* (Whitmore 1992). The importance of growth (of the client) is a critical element of coaching highlighted by the following definitions;

*.....a simple yet effective form of personal development where the client and coach create an alliance that promotes and sustains the clients personal growth and competence*

European Coaching Institute (2004b)

*Coaching is about performing at your best through the individual and private assistance of someone who will challenge, stimulate and guide you to keep growing*

(O'Donovan 2004)

The framework I have been using during my own coaching course and experimenting with in clinical supervision is the slightly adapted TGROW model (Downey 1999:29) diagrammatically represented in Figure 8.3.

**FIGURE 6.3**

**INSERT DIAGRAM HERE: A CONTINUOUS SPIRAL / CIRCLE containing the following and beginning with;**

**TOPIC**

**GOALS**

**REALITIES**

**OPTIONS**

**WAY FORWARD**

**NAIL DOWN**

As part of the initial clinical supervision agreement, as a clinical supervisor you are expected to control the structure and process of a session but, it is the supervisee who controls the content or TOPIC.

**HAZARD WARNING ICON:** If you are going to try out the TGROW framework in your next clinical supervision session you will need to seek permission to do so from your supervisee first!

The supervisee's TOPIC to be discussed in clinical supervision whilst seemingly obvious is critical to the overall outcome of the session. More often than not, the agenda set by the supervisee on further questioning can have several different layers and be difficult to isolate. This is where the supervisor is dependent on the supervisee to have carried out some written preparation beforehand contributing to the effectiveness of the session. Coaching is often carried out on a telephone and is dealt with in more detail in the next chapter. It is often helpful for the supervisee to have begun to reflect on what it is to be discussed and either e.mail or fax a preparation document to the clinical supervisor beforehand. The format for this can be discussed when the initial agreement is being negotiated and is helpful in giving the clinical supervisor some time to prepare for the session. Some trigger questions for the clinical supervisor for each of the elements of the TGROW framework is contained in BOX 8.3. Obviously it is easier to have questions in front of you using the telephone than in the face to face encounter, but it is surprising how quickly TGROW can be used once you are familiar with the different elements.

As already mentioned, the way that differentiates clinical supervision or coaching from therapy is by having a GOAL to aim for *before* getting into too much detail in examining the client/supervisee's actual realities. Setting goals based on the current reality of a situation can be difficult for the client/supervisee who may already be overwhelmed with their situation and can have a negative influence on a session. Often in clinical supervision a session is 'problem driven' instead of being more positive and solution focused that is the case in coaching. Goals that are formed by looking at the situation in the longer term and determining the steps needed to be taken to achieve that goal(s) are much more motivating and creative for the client/supervisee. In addition to this, setting goals not only provides focus but a way of being able to evaluate the effectiveness of the session based on goal outcomes.

To be able to successfully achieve client/supervisee goals it is important to do a REALITY check of the client/supervisee situation. I consider this a critical phase for the coach/supervisor to help the coach/supervisee assess the impact of those realities. Being a neutral or objective listener can help the client/supervisee reframe their situation or view it from a fresh perspective. Often I am questioned whether someone from outside a professional discipline can act as a clinical supervisor. My own experience is that it is much easier to be objective when you do not fully understand the supervisee's realities or situation and gives a license as a supervisor to ask 'silly questions' that get right to the heart of the matter (Sood & Driscoll 2004).

Another important element of helping the client/supervisee with their realities as a coach/supervisor is to remain 'in the present' with the intention of enabling movement forward on the topic using open ended questions. Sometimes I purposely structure questions to move the client/supervisee back into 'today' with a view to 'tomorrow' rather than remaining stuck in 'yesterday'! Although the 'past' might be useful to understand the context of a situation coaching/clinical supervision is not therapy and can sometimes be an unconscious ploy by the client/supervisee to avoid facing their present reality.

The OPTIONS phase helps to develop a sense of personal ownership of the issue and encourage choice, once a path has been cleared from the jungle of the client/supervisee's reality. If the previous phase has been rushed or inadequate time given for detailed questioning, it will reduce those choices and subsequent decision making by the client/supervisee. Sometimes in exploring options it becomes obvious

that more work needs to be done in the initial goal setting or gaining more clarity about the client/supervisee's reality. A key element of this stage is to develop a real sense of client/supervisee ownership by facilitating as many choices or options as possible to move forward, rather than being a phase in which the 'right' answer must be found. The more courses of action the client/supervisee generates, the more likely it is to be able to change their perspective on the situation and raise some positive energy for making progress with their topic. A critical success factor in clinical supervision and coaching is the development of a safe and confidential environment in which to explore ideas. The generation of options can be limited if the coach/supervisor pours cold water on ideas being produced due to having an in-depth knowledge of the client/supervisee situation i.e. working in the same environment, and once again being external is a big advantage that coaching offers clients, that clinical supervision often does not.

The WAY FORWARD is the final stage of the process that enables the client/supervisee convert their images and discussions with you into decisive actions. This means the client/supervisee making final choices and decisions about how to progress and I consider it to be a coach/supervisor responsibility to help summarise the session at this point in order for these to be made. This is where it can be of benefit (with permission), for the coach/supervisor to have taken some notes.

**HAZARD WARNING ICON:**

*Taking notes is more awkward in the face to face encounter where in doing so you may stand accused of not actively listening! On a telephone it is much easier, provided you have a headset in which you can listen as well as write.*

The final phase is where the client/supervisee needs to demonstrate a commitment to act or be response-able. The session ends with the client/supervisee agreeing the steps that will be taken, how these will be taken, and that they WILL be taken. I have been taught (and have been on the receiving end) to then NAIL DOWN the client at the end of each session by asking the client/supervisee to rate three questions on a score of 1 (definitely not) -10 (definitely will);

- How strong is your INTENTION to take that first step?
- How high is your ENTHUSIASM for taking that first step?
- How strong is your COMMITMENT to taking that first step?

Experience suggests that scoring 7 or less on each of these is likely to mean that little if no action will be taken following the session. The response or language used by the client/supervisee to the questions is often just as important as the verbal score. Low intention words such as 'perhaps', 'might', 'if' can also be indicators of intending to act or not after the session.

When I use the NAIL DOWN method I am always slightly apprehensive (as my own coach Rachel probably is), that scoring low equates to not having sufficiently helped the client/supervisee to clarify their situation, and be more confident in taking a step forward.....and then time has run out! Fortunately this has not happened to me yet, but if it did, the onus remains with the client/supervisee to answer a really powerful question..... 'what needs to happen to raise that score'?

Some ideas for questions a clinical supervisor might pose (although not all need to be used – you can probably think of others) using a TGROW framework in a clinical supervision session are contained in Box 6.3.

### **BOX 6.3**

#### **Questions using the TGROW framework a clinical supervisor might pose to a supervisee to aid structure and focus a clinical supervision session**

##### **TOPIC**

- What is it you would like to discuss today?
- What issue is uppermost in your mind from your preparation for the session?
- What is the topic or agenda for the session today?

##### **GOAL**

- By the time your hand hits the door-handle at the end of the session ....what would you like to have achieved?
- What would you like to be different when you leave the session today?
- If I could grant you wish for today's session, what would it be?

##### **REALITY**

- What is happening to you at the moment?
- How do know this to be accurate?
- Can you give me a worked example over the last week when this happens?
- What effect does this have on you?

- What seems to be preventing you from making progress?
- What have you tried so far?
- What support or resources might you be able to draw on with your situation?

### **OPTIONS**

- Can you write down six things that you could do right now (however improbable) to improve your situation?
- What resources do you have at your disposal to alter your situation?
- What might be some of the benefits and burdens of each of your ideas?
- Which idea would give you the most happiness in your situation?
- What are the possibilities for your future actions (do not all need to be realistic at this stage)
- Who might be able to help you with this?
- Would you like some suggestions from me (if client/supervisee stuck)?
- Could you rate from 0-5 the practicalities of each of your suggestions?

### **WAY FORWARD**

- What are you now going to do?
- What will your first step(s) be based on today's session?
- When will you begin?
- What might get in your way and how will you deal with this?
- How are you going to remember what you have agreed to do by the time we next meet?
- How will you get the support to move forward?
- Would you be agreeable to e.mail or telephone me about your progress before we next meet?

Whilst the TGROW framework is the most widely known and used in coaching there are other acronyms and models that you might wish to explore as an alternative framework for clinical supervision (Dembkowski & Eldridge 2003, Leibling & Prior 2003, Libri 2004, Mackintosh 2003, Martin 2001, Somers 2002). A limitation of the TGROW framework is where the stages are rushed, through lack of time and inexperience. For instance skipping through the stages, and not having a full understanding of the GOAL(S) representing the gap between the present situation and the desired outcomes or, when generating OPTIONS only a few 'tried and tested' choices are highlighted. Despite such limitations, in my experience TGROW does provide an excellent structure for those new to coaching but more importantly, it is enormously helpful in clinical supervision.

## **COACHING POSSIBILITIES IN UK HEALTHCARE BEYOND CLINICAL SUPERVISION**

According to *The Coaching Study* (Arnott & Sparrow 2004) involving over 100 UK organisations (including eight NHS organisations), a significant increase in the use of externally facilitated coaching is predicted in the near future. At present the majority of professional coaching is provided at executive/management levels and concerned with supporting both personal and professional development to improve organisational performance. With the emphasis on ensuring staff continuing professional development needs are met in Clinical Governance (McSherry & Pearce 2002, Swage 2003), the potential for coaching still remains relatively unexplored as a tool for developing health professional's practice.

Although coaching might be viewed as a tool for empowering individuals (Hughes 2003), great coaches know that individuals already have innate power and potential so therefore a coaches' task is to facilitate expression of it (Downey 1999:13). Whilst this chapter has concentrated on the use of coaching as a method for clinical supervision, Hadikin (2004) outlines a powerful case for developing a whole coaching culture in the NHS with a broader application to healthcare and in particular with patients;

*.....as we move as a society from a sickness/cure model towards a health/prevention model, we should look towards a profession which facilitates growth and change rather than a therapeutic model to 'cure' our 'illness'*

(Hadikin 2004:24)

Hughes (2003) suggests that in coaching where the client (or the supervisee) is promoted or be empowered to see themselves as being an expert in their own situation, the same can be applied with patients. Current government initiatives are doing just that, promoting the patient as an expert in their own experience of illness (DOH 2001). Imagine the vast resources that might be saved if healthcare staff were able to coach patients with chronic conditions to take more control over their lives than be dependent on a healthcare system that would seem to favour acute illness? Some evidence is already emerging that coaching can have a favourable effect on

patient outcomes (Brook et.al. 2003, Boyle, 2004, Horowitz et. al. 2002, Hughes 2003, Ream et.al. 2002, Vale et.al. 2003, Whittemore et.al. 2001, Whyte, 1997). Whilst a coaching potential for developing healthcare staff in clinical supervision is a distinct possibility, an even greater potential for developing a coaching culture generally in UK healthcare could emerge. Perhaps development coaching might even become the new clinical supervision?

## **CONCLUSION:**

The historical development of sporting coaching techniques and psychological processes has moved rapidly from the playing field to transforming the performances of individuals and organisations in corporate business. The seeds of professional coaching and the knowledge that coaches use is only now beginning to be realised in healthcare and like clinical supervision was, and perhaps still is, remains poorly understood.

Whilst not advocating development coaching as a replacement for clinical supervision or all clinical supervision to become development coaching, there would seem an enormous potential for the principles of professional coaching in clinical supervision as well as in the healthcare setting generally. The processes of both clinical supervision and development coaching seem to support the personal and professional growth of the 'client' or 'supervisee'. The way that this is achieved is through regular reflective but, action orientated conversations intended to increase future performance as a person and a practitioner. Unlike clinical supervision that undoubtedly has supervisee outcomes, development coaching is more transparent whilst remaining confidential. It is less 'problem' orientated than clinical supervision and has at its core demonstrable results following a structured conversation that increases professional performance making a positive contribution to the client's personal well-being. The key is in all parties developing an understanding about the intentions and expectations beforehand or when periodically re-negotiating the coaching or clinical supervision agreement or contract.

For those reading this chapter as professional coaches I extend an invitation and point out the potential 'co-alliance' that could exist between healthcare and the future of coaching. Perhaps some of the lessons and expertise of developing clinical supervision in UK healthcare over the last decade might offer the emerging profession of coaching a way forward as it comes to terms with its newly published

Code of Ethics (EMCC 2004), that requires a practising coach to also engage in 'regular' supervision as part of their continuing professional development (CPD) or might this be development coaching?

**ON REFLECTION BOX:**

- Professional coaching remains an unexplored frontier for the continued development of clinical supervision in healthcare
- The term 'development coaching' might be a more accurate description of clinical supervision for more senior healthcare practitioners
- Unlike professional coaching there is an absence of literature and virtually no agreement on what the core competencies of a clinical supervisor are
- Both clinical supervision and professional coaching has as its core the facilitation of a reflective conversation with another person to enhance their personal and professional growth
- Professional coaching frameworks are less 'problem' orientated and can offer structure for achieving demonstrable outcomes in clinical supervision

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## **SELECTED COACHING WEBSITE / RESOURCES**

<http://www.academyofexecutivecoaching.co.uk>

<http://www.associationforcoaching.com>

<http://www.coachfederation.org/>

<http://coachingfutures.com>

<http://www.coachinc.com>

<http://www.coachingandsupervision.com>

<http://www.coachingnetwork.org.uk>

<http://www.24-7coaching.com>

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