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Revised 27.10.23

**Can coaching advance medical leadership development?**

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**Introduction**

The United Nations’ Sustainable Development Goals for population health and wellbeing (1) will require effective clinical leadership to improve both population health outcomes and the quality of clinical services (2–5). Within the UK, investigations into failures in the NHS have highlighted the positive impact of clinical leaders who can continuously improve services and create compassionate environments (6).

Globally, there is a growing consensus that leaders are ‘made not born’ (7,8), and there is considerable interest to try and understand how best to activate doctors to become medical leaders that have team, organisational and system level impact.

Historically, there has been a lack of high quality research in the field of medical leadership development, combined with continued concerns that leadership training does not always translate into advanced leadership effectiveness (9).

Four recent systematic reviews exploring the impact of medical leadership development interventions on improving skills development and/ or technical and conceptual knowledge demonstrated a benefit at individual, clinical, and organisational levels (4,9–11). A range of interventions were assessed, ranging from large group didactic lectures, interactive plenary seminars through to individual (one-on-one) coaching and mentoring. Their findings suggested greater efficacy for interventions addressing individual learning needs compared with a generic approach. The positive impact was amplified when multiple interventions were used in combination; interactive small group sessions including action learning groups; individual or group project work; coaching; mentoring; experiential learning; peer, community and organisational support; use of reflective instruments and 360’ feedback; role play and/ or simulation; and discussion and reflections(5,10–12).

There is growing interest in leadership coaching across multiple industries, including healthcare. This commentary analytically lays out the role of coaching vis a vis other similar interventions, and then in addition (a) lays out different types of coaching interventions, and (b) presents some evidence on the effectiveness of coaching interventions.

**Definitions of coaching**

The practice of coaching has been established over a century as a model for training, education and skills development (13), with the earliest recorded use of the term in 1849 as a form of ‘tutoring’ (14). In the early days coaching was known for a a less directive, more facilitative approach with an emphasis on ‘client generated solutions’ (14). Over time, with the increasing evidence on the impact of coaching, there is now a greater emphasis on the academic grounding of coaching, and the interplay of psychological, behavioural and developmental science at its core (15).

Several defintions for coaching co-exist. At its core it is ‘*a dyadic, egalitarian relationship between a client and a professional coach, which involves a systematic process that focuses on collaborative goal setting, constructing solutions, and fostering clients’ self-directed learning and personal growth’* (16). All coaching interventions are based on the client’s unique and specific growth and development needs.

Coaching is one of many ‘helpful’, behaviour and response orientated interventions including: counselling, therapy, mentoring, cohort-based training, and management consulting. These all have several features in common and as ‘hybrids’ start to develop, with other therapeutic approaches integrating coaching methodologies, differentiating between these approaches is becoming increasingly difficult and also increasingly important when attempting to scientifically investigate the value of coaching, and to ensure that the most appropriate intervention is used to meet the client’s needs.

Passmore & Lai (17) have developed a set of criteria to help differentiate between these different interventions, adapted with permission, and summarised in in Table 1.

**Table 1: Key differences between coaching and similar ‘helpful interventions’** (17,18)

|  |  |  |
| --- | --- | --- |
|  | **Key features** | **Differences from coaching** |
| Mentoring | The mentor is usually a senior professional supporting a ‘protégé/ mentee’ to improve in their specific job, role, vocation or organisation/context.  Mentors usually draw on their own experience and observations.  Mentors may include passing on technical skills.  Usually a less formal relationship which may directly benefit the mentor as well as the protégé.  Relationship is usually hierarchical between a more senior mentor and the protégé.  Clarity around confidentiality may be less explicit at the outset. | Coaching emphasises greater ‘use of self’ in terms of the practitioner’s own self-awareness; uses more psychological models, tools and assessments; knows and uses the evidence base for professional development; works within formal, contracted, equal relationships with explicit agreements and assurances around confidentiality and ethical practice. |
| Management Consulting /Organisational ’Change Agent’ | The primary focus is on the effectiveness of the organisation rather than its individual members.  The origins of the coaching industry were frequently commercial variations of this approach to coaching. | The primary focus is on the individual client, may include 3-way contracting with the employer. |
| Personal counselling and psychological therapy | Focuses on problems in the present often relating to past trauma and early life experiences, includes clinical care.  May use a ‘coaching approach’ to support individuals with clinical or therapeutic needs to focus on the future. | Solution-focused in order to enhance the future, uses formal objective setting. |
| Cohort-based leadership training | Generally focuses on the transfer of declarative knowledge, is not tailored to individual needs, may not translate into real-world action, and may be passive. | Coaching is initiated for a variety of reasons including leadership development, skills development, wellbeing, and navigating professional transitions. |

**Subspecialisations within coaching**

There are now different subspecialisations within coaching practice, including ‘workplace leadership coaching’, as well as emergent hydrid forms of coaching.

‘Health coaching’ is an effective form of intervention used by health professionals to enhance patient’s future health and behavioural outcomes through goal setting and supporting the patient’s autonomy (17). This may also be called ‘clinical coaching’ or ‘therapeutic coaching’ particularly in the mental health treatment contexts.

‘Career coaching’ is a form of careers guidance, also called ‘career counselling’ to enhance career satisfaction. Meta-analyses have found strong evidence of effectiveness (19).

‘Life coaching/ personal wellbeing coaching’ is a more informal and less researched method of helping non-clinical populations set and reach their personal goals (20).

‘Team coaching’ (21), is a behaviour which a team leader can adopt to improve their teams’ overall effectiveness, through a mixture of interventions. External team coaches are now commonplace however a recent systematic review assessing the approaches and effectiveness of team coaching concluded that improving the coaching behaviours of leaders may be a more useful intervention than externally provided team coaching (22).

‘Group coaching’ is a hybrid of training and individual coaching to maximise the benefits of a coaching approach with knowledge delivery and learning from peers (23). Goals are set by individuals within the group. In contrast to team coaching, there is no ‘collective endeavour’.

‘Coaching Psychology’, coaching practiced by psychologists in non-clinical settings, originally described in 2001 by Grant (24) is now recognised as a distinct discipline within the field of psychology internationally. The use of psychology in coaching dates back over a century, the use of psychology in workplace coaching started more recently with the intention to increase the rigour of the underpinning science of psychology to positively effect outcomes (7,25). The British Psychological Society (BPS)’s Division of Coaching Psychology defines Coaching Psychology as '*the scientific study and application of behaviour, cognition and emotion to deepen our understanding of individuals’ and groups’ performance, achievement and wellbeing, and to enhance practice within coaching'* (26). A doctoral-level award was created by the BPS, enabling UK specialists in this field to become ‘Chartered Psychologists in Coaching Psychology’ in 2022 (27).

‘Leader-as-coach’ is the conscious use of coaching behaviours by leaders and managers in the context of their vocational roles, i.e. their ‘day jobs’. It is sufficiently different from workplace leadership coaching provided by an internal or external coach to merit being referred to as a subspecialisation of coaching (28,29).

**Workplace leadership coaching**

Coaching in the workplace was initially used in the private sector as a way to develop executive level leaders and high performers (30). By 2015, three-quarters of organisations surveyed by the Chartered Institute of Personnel and Development were offering coaching or mentoring, who projected a continued rise in the use of coaching (31).

Executive coaching is targeted at helping executives develop and maintain positive change in their personal development and leadership behaviour’(32). The terms ‘leadership coaching’, ‘workplace coaching’, and ‘business coaching’ are often used synonymously with ‘executive coaching’ to describe workplace coaching interventions with leaders and managers at all levels to support their professional development.

Leadership coaching involves two-way contracting between the client and coach, or three-way contracting between the client, coach and sponsoring organisation, setting coaching objectives that link back and are subordinated to wider organisational objectives (33).

**The professionalisation of coaching**

Nearly 20 years ago, Grant and Cavanagh (34) argued that only with a rigorous approach to ethics and a commitment to evidence-led coach training based on the ‘scientist-practitioner’ model, can coaching become a legitimate profession.

However, coaching remains an unregulated industry where anyone can call themselves a ‘coach’: not all coaches have received certified training in coaching, though others have worked towards higher coaching qualifications at diploma, master or doctoral level.

Three main international coaching professional bodies have now emerged (European Mentoring and Coaching Council, EMCC; International Coaching Federation, ICF; and the Association for Coaching, AfC). These are membership organisations providing services for coaches and in recent years they have also sought to collaborate, for example sharing common Global Code of Ethics (35).

All three offer ‘Independent Accreditation’ processes which are similar in principle to medical licensing and medical revalidation, as part of the professionalisation of coaching. An increasing proportion of coaches have ‘accredited’ with established Coaching Professional Bodies.There is no mandatory process to ensure that all coaches are ‘Independently Accredited’, nor for coaches (nor counsellors or non-practitioner psychologists), to be included on the Health and Care Professions Council Register.

Passmore & Woodward report that more than 50 percent of the over 1,800 coaches who responded to a survey run by NYU and Coaching.com, held an ICF (International Coaching Federation) credential (36). Nearly 15% reported holding no credential; and only 16% reported holding a Master’s degree in a coaching related field. The authors point out that this is low in comparison with other professional fields, where post graduate qualifications are essential, such as psychology, counselling and accounting.

The BPS has its own ethical codes which Coaching Psychologists must adhere to (37). The award of ‘Chartered Psychologist in Coaching Psychology’ is a legally protected title for psychologist coaches, which demands a high level of scientific research training, knowledge and experience. This is the closest to formal regulation of the coaching industry but only applies to coaching psychologists who have Chartered Psychologist status.

Independent Accreditation processes are increasingly seen as a vital aspect of ensuring the quality of coaching provision. All the professional bodies accredit coaches at different levels of skill development (similar to postgraduate awards), and this is starting to be reflected in the research literature, for example only coaches who have met specific independent accreditation criteria being included in research studies or reviews. In order for accreditation to have impact, the purchaser or commissioner of coaching services needs to be both aware that such processes exist and to choose how to use them in practice.

**Does leadership coaching work?**

The scientific interest in coaching is growing, resulting in an expanding number of quantitative and qualitative studies and meta-analyses exploring themes ranging from the impact of coaching to deeper dives into the determinants of the coaching relationship that result in greater effectiveness. As a recurring theme the effectiveness of workplace coaching (specifically, coaching in organisational context, business/ leadership/ workplace/ organisational coaching) is consistently positive across a number of variables at multiple levels, as outlined below.

Nine international systematic reviews and/ or meta-analyses on workplace coaching have been published since 2010 (30,33,38–44). An analysis of 39 coaching randomised controlled studies, with a total sample size of 52,528, yielded a statistically significant effect of workplace coaching across all leadership and personal outcomes (44). The ability of coach and coachee to respond flexibly and constructively to new events explicitly processing and addressing new information in the present moment was an important factor in the size of the effect.

Additional summaries of effectiveness include: Graf & Dionne on the impact of general coaching (45,46); de Hann on the value of executive coaching (47), and Lai and Palmer at el (48) who summarise the impact of Coaching Psychology research (psychologically-informed coaching by a coach with an academic background in psychology ‘Coaching Psychologists’) in the context of executive coaching.

A recent review (49) conducted for the 2022 NICE Guideline ‘Mental wellbeing at work’ (50) found that ‘preventative coaching’ in the workplace for individuals resulted in improved quality of life, reduced job stress, and reduced mental illness symptoms. The subsequent Guideline recommended that individual approaches for employees with or at risk of poor mental health be offered cognitive behaviour therapy sessions, mindfulness training, or stress management training.

At an organisational level, coaching of leaders and/ or managers is found to result in greater: satisfaction in their direct reports’; and others’ work engagement, organisational commitment, psychological empowerment, reduced occupational strain, and reduced turnover intentions. Improved self-efficacy in leaders has also been shown to directly improve the attitudes and motivation of followers (51). Psychologically-informed coaching specifically has been found to have a positive impact on the leader or manager’s objectively measured work performance by others (38).

Most research has focused on individual outcomes, and whilst this could be dismissed as internal bias from motivated participants, improved self-perception has been found to be an antecedent of substantial changes in the longer term which are then also noticed by others (52). At an individual level, coaching is now scientifically established to result in strong positive effects for the leader or manager being coached:

* **Improved cognitive outcomes including**: goal setting (ability and quality of); self-awareness; sense of responsibility to one’s own learning; goal achievement; goal-directed self-regulation; self-control; adaptability and flexibility.
* **Improved meta-cognitive outcomes including:** the processing and organisation of information; the planning, monitoring and revising of goal-orientated behaviours; internal self-regulation and cognition stimulating purposeful mental (internal) and behavioural (external) changes such as goal-attainment through a continuous cognitive process.
* **Improved affective (emotional) outcomes including:** satisfaction with coaching achievements; satisfaction with work, career and private life; wellbeing; coping; personal as well as work attitudes; motivation to apply new knowledge in the work environment; reduced stress; higher commitment to the organisation; self-worth; motivation; initiative; social integration; core self-evaluations (self-efficacy, self-confidence, and self-esteem; internal locus of control; reduced neuroticism).
* **Improved skills outcomes including:** improved performance and skills at work including strategic thinking, decision making, communication, interpersonal skills; improved transformational leadership; improved 360’ leadership ratings (self/others); improved resource management eg time.

**Does leadership coaching last and is there a ‘latency effect’?**

McInerney et al (2021)(53) undertook a systematic review of the enduring effects of coaching on professionals ranging from managers to executives, and found positive evidence of enduring effects from executive coaching, which were not seen immediately, consistent with a ‘latency effect’ of coaching. Many authors have attributed this to a gradual shift in internal sense making and cognitive processing.

The longer term effects from executive coaching were in two dimensions: ‘leader identity development’ (the process of resolving ambiguities relating to performing leadership roles, through forming and refining one’s sense of identity as a leader involving increased intrinsic motivation, identity creation and the reframing of one’s relationships with subordinates) and ‘psychological resourcing’ (the process of motivating oneself through psychological self-regulation, which requires both goal setting and alignment with values, coupled with learning feedback cycles, in order to build confidence and internalise the learning).

**Unintended consequences from coaching**

Unintended negative effects, real or perceived, are described in all helping professions and close dyadic complex partnerships, from medicine to mentoring, supervision, and coaching (54–58). This is of particular concern in particular when coaches may be working with mentally ill clients, whether the coach or client realises this or not.

Grant (59) identified the need for coach certification processes to include a compulsory understanding of mood disorders and associaterd referral procedures in 2007. Despite this,the three main coaching professional bodies have not implemented this, rather theystate that to ensure ethical practice as a coach, practitioners need to consider the limits of their competence and the potential need to refer on to another professional, as well as to undertake regular professional supervision (35). Only the BPS explicitly requires their Chartered Coaching Psychologists to have training in mental health issues..

**What factors drive leadership coaching outcomes?**

Through a meta-analysis of 117 empirical studies (qualitative and quantitative), Bozer & Jones (2018)(41) identified seven ‘promising factors’ determining workplace coaching effectiveness, several of which overlap: self-efficacy; coaching motivation; goal orientation; trust; interpersonal attraction; feedback intervention; and supervisory support.

Jones et al (60)’s survey of 161 individuals who had received workplace coaching found that affective outcomes were higher when coaching was provided by external coaches compared to internal coaches, and postulated that this is likely to relate to the level of sharing of sensitive information which a client may feel confident to share due to the greater confidentiality and impartiality from an external coach. In addition, positive outcomes were greater higher when coaching was provided by external coaches for those working in the most complex job roles.

Blended approaches to coaching which combine face-to-face (virtual, in person, or by phone) with remote contact from the coach in between sessions has been found to be more effective for affective outcomes (60). This is thought to due to the additional support provided, as well as a more responsive, flexible approach to supporting the client.

There does not seem to be a specific ‘dose-response’ effect from the number of sessions (44): effect sizes appear stable between 4 to 8 interventions, though self-reported measures was correlated with more sessions, and the coach and client appear to match the number of sessions to the client’s goals.

Wang et al’s recent meta-analysis of 20 studies of psychologically-informed coaching provided by external coaches found an overall positive impact on a number of outcomes (38). Significant positive effects were seen for individuals’ cognitive outcomes (general perceived efficacy and goal attainment); objective work performance improvement (rated by others); and individual’s psychological well-being. Affective outcomes (work attitudes, organisational commitment and job satisfaction) improved but the effect was not statistically significant. The meta-analysis (38) concluded that psychologically informed coaching provides a more holistic intervention to clients’ wider psychological needs, and that external leadership coaches with a background in psychology generate better coaching outcomes (38,48).

**Leadership coaching in healthcare and medicine**

Coaching in healthcare can serve multiple purposes, including the advancement of technical skills; leadership development and effectiveness; revisiting careers and transitions; and wellbeing. A scoping review on on coaching for surgeons (61) was published recently, and a scoping review of coaching for doctors is currently underway (62),

Atul Gawande anecdotally describes the impact of coaching in maintaining and advancing his technical surgical skills (63). Coaching as an intervention is being increasingly deployed within the leadership sector of healthcare, and the evidence base for coaching on the leadership of healthcare managers is currently being synthesised through a systematic review (64).

The Faculty of Medical Leadership & Management (FMLM) note an increasing demand for clinical leadership programmes designs that contain experience-based, reflective, coaching practices as they have a positive impact on expanding leaders’ thinking and perspectives, help translate new ideas and insights into practice; and support leaders to define newer, refined practices that improve leadership effectiveness(65). There is also a growing demand for individual and team coaching with an aspiration to improve personal and team effectiveness.

The four systematic reviews assessing the determinants of improving medical leadership described in the Introduction identified 15 studies which included coaching as at least one of the methods of intervention (5,10–12). Lyons et al’s systematic review (10) found that improved organisational level outcomes were more likely to include project work, mentoring, coaching, and the use of reflective instruments (10). Frich et al noted that while self-awareness is fundamental to leadership capacity, few medical leadership development programmes address personal growth, self-awareness, ways of ‘being’, or emotional intelligence (12): these are aspects of leadership development which coaching, and specifically psychologically-informed coaching, is likely to be highly effective at addressing.

**Conclusion**

There is a growing body of evidence that supports the utilisation of coaching for advancing leadership development across a wide range of cognitive, meta-cognitive, affective and skills outcomes that is superior to more traditional group-based approaches such as training and mentoring. Further research is needed to create a sufficient body of evidence within the context of leadership coaching within healthcare and within medicine.

Customisation of the coaching approach to the client’s needs and requirement adds greater value to clients and their sponsoring organisations. Subspecialisations within coaching appear to be on the rise and are akin to the evolution within medicine from generalist to specialist and subspecialist practice, and hold great promise within leadership development. Coaching Psychology forms a bridge between two specialties (coaching and psychology) and appears to have greater efficacy at addressing specific mental wellbeing needs, and increasingly important pillar within the increasingly complex context of healthcare leadership.

Coaching as a profession is now coming of age, with increasing professionalisation through voluntary ‘Independent Accreditation’ via the three main professional bodies, and the new legally protected title of ‘Chartered Psychologist in Coaching Psychology’.

Coaching is rapidly establishing credibility within healthcare systems, organisations and individuals to advance growth and development across a range of outcomes. By supporting and challenging clinical leaders to continuously strive to become ever better versions of themselves, coaching can make a positive contribution to the United Nation’s goals of healthy lives and wellbeing for all, at all ages.

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