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Academic Paper

What Is Coaching in Cancer Care? An Exploratory Qualitative Study with Coaches and Healthcare Professionals

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Abstract

Cancer patients face multiple challenges, and coaching has emerged as a promising psychosocial support approach. This study explores how healthcare professionals and coaches view the definition, role, and integration of coaching within cancer care. Through thematic analysis of responses from 13 healthcare professionals and five coaches in French-speaking Belgium, findings show both groups see coaching as valuable psychosocial support but differ in their view of the role of coaching. Healthcare professionals view coaches as first-line providers, while coaches stress empowerment and post-treatment support. Addressing this discrepancy is essential for establishing a necessary foundation to guide both the implementation and evaluation of coaching in oncology care.

Keywords

coaching, cancer, qualitative, healthcare professionals, low-intensity psychosocial support, quality of life

Article history

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Introduction

Cancer is a life-threatening disease, with a rising prevalence of chronic forms. It poses several challenges to the patients and their relatives, including low quality of life, anxiety, depression, return to work, lasting fatigue, and fear of cancer recurrence (Lamore et al., 2019; Podina, Todea & Fodor, 2023; Ruiz-Casado et al., 2021; Wang et al., 2020). In that context, psychosocial support appears as a key component of supportive care for cancer patients (Scotté, Taylor and Davies, 2023), with various efficacy and efficiency (Guarino et al., 2020; Hulbert-Williams, Beatty and Dhillon, 2018). One rising form is the use of coaching-based approaches in cancer care, which are seen as briefer,

more solution-focused, and target subclinical mental health challenges, while not having the potentially dissuading label of "therapy" (Hulbert-Williams et al., 2018).

Coaching has gained interest since its onset in the corporate world, where it aims to increase performance and well-being at work (Redshaw, 2000). Its implementation has expanded to other fields and approaches, including chronic diseases and cancer (Kivelä, Kyngäs & Kääriäinen, 2014). Existing reviews within this domain have mainly focused on Health and Wellness Coaching (HWC), a form of coaching that aims at increasing health behaviours through goal setting, motivation work, and training (Barakat et al, 2018; Sforzo et al., 2018). Although this form of coaching appears to be important and with promising results, it may not reflect the entire spectrum of coaching. Several studies have relied on forms of coaching that do not only focus on health behaviours but are also related to education, decision-making, and self-management (e.g., Alders et al., 2017; Jull et al., 2021). A recent comprehensive review on coaching interventions in cancer confirmed the multifaceted nature of coaching, in that it addresses not only healthy behaviours, but also other key challenges, such as decision-making, self-management, or mental well-being (Gérain et al., 2025).

While these studies and reviews provide valuable insights into research made about intervention programmes, they pose two issues. First, they offer a limited understanding of the actual practice of coaching in cancer care, particularly in Western Europe. International societies have established definitions and frameworks for coaching practices (Greif et al., 2021), but these are guidelines that focus on general forms of coaching, not the specific applications for cancer patient support. Therefore, we need to better understand, beyond theoretical definitions, what coaching entails, what coaches do with cancer patients, and how it is seen as beneficial to the patient's well-being.

Second, that limited understanding also does not address the potential gap that might exist between what coaches do and how healthcare professionals perceive this role. Healthcare professionals may not be familiar with this broad spectrum of coaching techniques and approaches, potentially leading to a mismatch between their expectations and the role coaches are willing to take. If coaching is deemed relevant, this lack of clarity can hinder the integration of coaching into existing healthcare systems and limit its potential to improve patient care, as has been the case, for example, with licensed practical nurses (Martin & Weeres, 2016).

All this takes place in a context where exploring what coaching is, and how it is perceived, appears as a necessary avenue of research to better understand what the practice is, beyond academic books, theoretical definitions, and international societies' recommendations. It is acknowledged that the field often receives accusations of pseudoscience and could benefit from more empirical structure and support (Greif, 2021). Additionally, it remains essential to continue providing data in the exploration of the potential overlap between coaching and psychological care. This is particularly important given that such overlap can at least cause confusion and, in extreme cases, lead to harmful consequences (Palmer & Whybrow, 2018).

Goal of the present study

To address these gaps, the present study aims to explore how coaches and healthcare professionals consider coaching in cancer care. More specifically, it aims to better understand how healthcare professionals and coaches:

1. Define coaching within the context of cancer care (including their role, aims, and techniques)
2. Perceive the role of coaching within the healthcare system and the potential qualifications to perform coaching in that context.

The goal is to have a double perspective, based on the insights from healthcare professionals and coaches, and to identify potential gaps between the two. This understanding is essential to maximize the potential of coaching to improve the quality of support offered to cancer patients.

Methods

The present work uses the Journal Article Reporting Standards for Qualitative Research (JARS-Qual) as a framework (Levitt et al., 2018). The study received approval from the Institutional Medical Ethics Committee (ref: EC-2023-123).

Research design overview

The present study uses a qualitative exploratory survey to better understand how Belgian healthcare professionals and coaches define and situate coaching in supporting cancer patients. The qualitative exploratory design was used because of the current lack of an existing framework describing what coaching is and who the coaches are in cancer care, their actual roles, tools, and place in the healthcare system. As such, the present work aims to provide the basis for future works on the role and place of coaching in cancer care. The study was conducted through online written questionnaires to ensure that participants from different areas of the country could participate with no constraint of time or availability. This was also done because the initial goal was also to use this qualitative study as the first step of a Delphi study (McPherson, Reese and Wendler, 2018), which was later abandoned as the authors were convinced that the richness of the different inputs was more important than trying to reach a consensus.

Study participants

Description of the research team

The team consisted of four researchers, led by two main psychology researchers (i.e., the leading researcher (PG) and the principal investigator (EVH), supported by two interdisciplinary researchers (WJ, RT). This investigation was funded and launched based on a request from two non-profits in Belgium (Foundation against Cancer & Candras) who wanted an independent exploration of the role of coaching in cancer care. Before starting the study, the research team launched a scoping review of interventional coaching studies in oncology (Gérain et al., 2025) to gain an overview of the research in coaching and cancer. At the onset of the current research, the team's opinion was that coaching might be beneficial to patients, but that its role and place remained too unclear to assess its effectiveness.

Participants

Participants had to be coaches, healthcare professionals, or key stakeholders in oncological care. To be included, potential participants had to a) be healthcare professionals, public health administrators or researchers, or coaches, b) work with people confronted with cancer (no minimum experience required), c) work in French-speaking Belgium, and d) be French or English-speaking. The specific focus on French-speaking Belgium was due to different practices in Belgium's different regions. In Dutch-speaking Belgium, the term 'onco-coach' is one of the names given to coordinator nurses. Because of that specificity, a focus was preferred on the French-speaking part to allow for potential heterogeneity in views over coaching.

Healthcare professional participants were recruited by contacting scientific societies and academic centres. Coaches were recruited by contacting cancer walk-in centres and alumni of a nationwide cancer-focused training programme. Public health representatives and patient organisations were also contacted. In every instance, 'snowball' recruitment was used, where potential participants were asked to recommend other potential participants who might be relevant to the study.

The study relied on purposive sampling and therefore had an *a priori* ideal sample to ensure a plurality of views (Campbell et al., 2020), instead of relying on saturation (Hennink & Kaiser, 2022). As such, the aim was to have at least two individuals for each main profession/role: nurse,

oncologist, psychologist, and coach. Data were analysed after the data collection, as the emphasis was put on trying to generate plural views and not to be influenced by the content of the answers in that recruitment process.

A total of 13 healthcare professionals (including one public health expert) and five coaches participated in the study. Table 1 displays the characteristics of the participants in the study. Among healthcare professionals, seven were nurses, three psychologists, two oncologists, and one public health expert. Because the public health expert could be identified as being the sole person in that category, their personal information is not mentioned in detail.

Table 1: Participants in the study

Code	Job	Age	Gender	Years of work in oncology	Additional training
Nur35	Nurse	50	Male	30	Specialisation in onco-hematology Master in public health
Nur51	Nurse	30	Female	6	Specialisation in oncology
Nur59	Nurse (coordinator)	45	Female	20	Specialisation in oncology
Nur65	Nurse	37	Female	6	Specialisation in palliative care Communication training
Nur75	Nurse	39	Female	15	/
Nur77	Nurse	41	Female	17	Specialisation in oncology, haematology, and palliative care Hypnosis *Coaching Fréquentiel*
Nur86	Nurse	29	Female	6	/
Onco40	Oncologist	40	Female	13	PhD in oncology
Onco82	Oncologist	60	Female	10	Specialisation in oncology Training in supportive care
Psy7	Psychologist & researcher	29	Female	4	Certificate in psycho-oncology
Psy22	Psychologist	30	Female	5	Certificate in psycho-oncology
Psy33	Psychologist	32	Male	4	Certificate in psycho-oncology
PH52	Advisor in public health	38	Female	11	PhD in public health
Coa9	Coach	61	Female	1	Human resources bachelor Executive master in Business coaching Coaching training “Coaching & Cancer”
Coa20	Coach	42	Female	7	Bachelor in law Master in communication Certified coach Disability manager Certified NLP Master Practitioner Certified hypnosis practitioner Coaching training “Coaching & Cancer”
Coa29	Coach	51	Male	2	Engineer Certified coach (ICT) Coaching training “Coaching & Cancer”
Coa30	Coach	56	Female	6	Certified coach Certified NLP technician Coaching training “Coaching & Cancer” Former patient
Coa83	Coach	57	Female	6	Bachelor in Physics and pilot Certified NLP Master Practitioner

Note: The code assigned to each participant was based on their profession and their rank at the time they completed the survey.

Regarding the researcher-participant relationship, the first author knew some participating psychologists. Aside from that, the only contact with other participants was made for the participation in the study. The other members of the research team did not know nor interacted with any participants. Data were blinded when discussed within the team.

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Data collection and identification procedures

Data were collected through online questionnaires, using LimeSurvey from June to September 2023. Participants took between 9 and 110 minutes to fill out the questionnaires (Median = 18.50, M = 29.33, SD = 28.82).

The questionnaire addressed the different aspects of defining coaching, its role, the techniques used by coaches, the requirements to practice as a coach, and the place of coaching in cancer care. All questions were open-ended with free space for participants to answer without limit. The questionnaire was the same for every participant, whether they were considered healthcare professionals or coaches. Table 2 displays the different questions.

Table 2: Investigated Themes and Related Questions Asked To Participants

Investigated themes	Questions asked
Definition of coaching	A) How would you describe coaching in the case of a cancer patient?
Contributions	B) In your opinion, how can coaching contribute in this context?
Definitions of coaches	C) How would you define a coach in the context of oncology?
Specification of coaches	D) Who does or can do coaching?
Tasks & roles	E) What tasks and roles can coaches take on in oncology care?
Techniques	F) In your opinion, what techniques can an oncology coach apply to fulfil his or her duties and role?
Training/requirement	G) In your opinion, what certificates, training, and requirements are needed for a coach to work in the field of oncology?
Integration within the healthcare system	H) What is/should be the place of coaches and coaching in the healthcare system?
	I) Do you want to add anything?

Note: Two additional questions addressed what approaches and techniques from coaching could be used by healthcare professionals and which certifications/requirements would be required for them to do so. Because these two questions confused most participants, answers to them were not included.

Data analysis

Because of the goal of the study, the exploratory approach to the topic, and the nature of the data, a thematic analysis was favoured (Braun & Clarke, 2006). The six phases of thematic analysis were followed, first for data from healthcare professionals. The first phase included repeated reading of the data to immerse ourselves in its depth and detail. In the second phase, the data was systematically coded to highlight interesting aspects that could form the basis for repeated themes, using a predefined framework derived from the main topics covered in the questionnaire (Table 2). This ensured consistency between data collection and analysis while allowing flexibility for emergent themes. The third phase involved sorting different codes into potential themes and gathering all the related coded data extracts within them. As coding progressed, the framework was iteratively refined to incorporate emerging elements that were not initially anticipated, leading to the creation of new subcodes and adjustments to the thematic structure. During the fourth phase, themes were refined, ensuring they were internally coherent and distinct. The fifth phase led to the further refinement and specification of each theme, defining exactly what each theme was and what aspect of the data it captured. Finally, in the sixth phase, a coherent analysis was produced, weaving the analytic narrative with data extracts, and contextualising the analysis to existing literature and research questions. The process was then repeated for the data from coaches, using as a base the framework created during the six phases of thematic analysis of the data from the healthcare professionals.

All analyses were performed using NVivo. The initial coding and thematic analysis were performed by the first author and reviewed by the other authors at multiple stages to refine the coding and

ensure consistency. In the reporting of the results, the source of a thematic code was mentioned in brackets with the ID code of each participant. Table 3 shows a summary of the different themes.

Table 3: Summary of the Identified Themes

Theme	Subcode	Healthcare Professionals	Coaches
Coaching as a form of support		Coaching as a support function on multiple challenges Thin line with psycho-oncologists	Accompany patient to attain their self-defined goals Relation-focused support
Objectives of coaching		Support quality of life and wellbeing Prevention of aggravation	Based on the patient's needs and wills Support autonomy, change, and empowerment
	Supporting adaptation and change	Help the process of adaptation and acceptance of the changes caused by the disease Provide emotional and social support to patients	Support emotion and stress management The "Transition support" role is central from treatment back to normal life
	Goal-oriented change and empowerment	Designing and implementing immediate and long-term goals Help patients find their own resources (empowering)	Support empowerment in their treatments Support long-term changes and goal attainment Accompany return-to-work process
	Knowledge and education /Psycho-education	Providing information about the disease, treatments, and choices	/
	Coaches as intermediaries	Intermediary in the multidisciplinary team Coordination role Referral to adequate services (triage)	Helping patients in adequately communicating and managing complicated relationships with healthcare professionals
	Operational aspects of coaching	Solution-oriented Individualised practice Over the course of the disease	Active Based on questions to increase (self-)awareness
Techniques and implementation		Unclear about what coaches do Use of tools for evaluation, work on motivation and goal-setting Centrality of relational skills	Relationship as tool for change Questions to foster change Use of tools common in psychotherapy and specific to coaching
Requirement for coaches		Importance of certification Knowledge of the disease Relational skills Unclear if necessarily healthcare professionals	Necessity of certified coaching training Specialisation in cancer Relational skills Supervision & reflective practice
Place and integration within the healthcare system		Either adding tasks to existing roles or creating a new role of first-line providers in the multidisciplinary team	Complementary role to existing healthcare professionals, part of multidisciplinary team Emphasis on the transition after treatments

Results

Coaching as a form of support

The first component in trying to outline what is coaching in cancer can be boiled down to identify it as a support function, mainly toward the patients. Participants commonly described coaching as a "support" in oncological care, addressing both disease-related and other challenges (Nur51, 59, 75, 77, Onco34, 82, Psy7, 22, 33). The psychological aspect of coaching was particularly discussed (e.g., Onco34), drawing a thin line between the roles of the coaches and the psycho-oncologists. As such, the focus of coaching can relate to the disease and its treatment as well as the medical trajectory, but also other life domains (professional, familial, social, leisure) (Psy7). As one psychologist puts it, "a coach has the role to accompany patients to attain their own goals and develop their skills" (Psy33). This approach is seen as being close to the patient (Psy7) through multifaceted support (Nur77). This multifaceted support can also have specific focuses, such as

helping patients better communicate with healthcare professionals (PH52), as well as providing support to facilitate return to work (PH52). Coaching is seen mainly as an individual approach, which can also expand to group sessions, or even include informal caregivers and relatives (Nur65, Onco34).

The coaches were less about labelling their role than defining its goals. Coaching is about “accompany[ing] patients from where they are to where they want to go” (Coa20), highlighting the adaptability of the coaching approach to the needs of the patients (Coa83). Their emphasis was mainly on the relational aspect of coaching, including listening, providing support, and accompanying patients (Coa9). One coach also mentioned that such support can be defined as a “therapy” (Coa83), which blurs even more the distinction between coaching and (psycho)therapy.

Objectives of Coaching

Overall, the goal of coaching is to support quality of life (PH52) and well-being (psychological, physical, social, spiritual) (Nur77). One psychologist made the parallel between coaching and positive psychology, with the idea that coaching aims at aiding patients reach a “better being”, while not addressing intense psychological distress (Psy33). It echoes the view that coaching can help prevent the aggravation of certain problems or symptoms that may not yet be present (PH52).

The coaches also defined multiple goals but were more focused on the needs of the patients. This was notably done by aiming at supporting autonomy, decision-making, and taking necessary steps toward change (Coa30). Their emphasis was more on supporting empowerment (active role in what patients face) (Coa20, 29, 30), of “going from helplessness to taking back control of your life” (Coa20).

While both healthcare professionals and coaches define coaching as a way to improve patients’ well-being and quality of life, they emphasise different aspects. Healthcare professionals tend to describe coaching as a structured support to help patients face the challenges brought by cancer and its treatments, within the medical trajectory, often linking it to adherence, coping with treatment side effects, and adjustment to the disease. Coaches, however, highlight a broader and patient-driven process that prioritises autonomy and empowerment, decision-making, and long-term personal growth and adaptation beyond the immediate healthcare setting. This distinction is apparent in how each group approaches coaching in practice: healthcare professionals highlight adaptation to the disease, emotional and social support, and structured goal-setting during treatments, while coaches focus on fostering self-determination, supporting transitions (particularly after the curative phase), and helping patients make sense of their experience.

Supporting adaptation and change

In addition to these elements, healthcare professionals also provided more detailed roles in which coaching can take place: a) help the patient’s process of adaptation and acceptance to the disease and b) provide emotional and social support to the patient. When addressing adaptation and acceptance, healthcare professionals see that coaching must help patients adjust to the difficulties brought by the disease (Nur59), notably fears related to the disease and challenges in daily life (Nur65), as well as dealing with self/body image (Psy7). Most focused on the global adjustment to the disease in aiming at maintaining a form of well-being despite the occurrence of the disease (Psy33, Onco34, Nur37, 65, 59) but also growing from it (Psy33). This also encompasses the so-called ‘acceptation’ process of the disease (Nur77). The second aspect regards providing direct emotional and social support to the patients. As such, healthcare professionals mentioned that one of the main tasks was to provide “psychological support” (Nur35), moral and psychological support (Nur51), being attentive to patients (Nur59, Psy7), with empathy (Nur65). As such, coaches are seen as one additional potential psychosocial support for patients (Psy22).

In the same view, coaches highlighted the importance of emotion and stress management (Coa9, 20,30), particularly to deal with "the loneliness of the cured when all the treatments are finished, and the patients find themselves alone facing their recovery" (Coa30). Coaching is therefore seen as spanning during and after treatments (Coa20), as a "transition support" from medical and psychological care to a different form of support, to help the transition and "landing" from the intense phase of care to a new normality (Coa29). This "transition support" also aims at helping to deal with the changes in the body, the side effects, the fatigue (Coa30), as well as regain self-confidence and self-esteem (Coa30) and grieving what the disease has taken (Coa29).

Goal-oriented change and empowerment

Coaches are seen by healthcare professionals as providing other forms of support to cancer patients, notably goal-oriented change. This spans from concrete action-planning related to the treatment (better understanding of side effects of treatments and how to react to them – Nur51) to broader perspectives of accompanying patients in attaining their life goals (Psy33). This can be in daily life or the long term (Psy7), through elaborating and implementing new projects (Onco82) and planning over the long run (Nur59) to reach their aspiration (Psy33). As such, coaching can be seen as a way to support behaviour change, whether in the lifestyle to attain some personal goals (Onco82) or adjust to changes caused by the disease (Psy7).

Healthcare professionals also see coaches as supporting patients in "helping patients find their internal and external resources" (Nur59), as well as finding adequate social support (Nur59, PH52) and feeling supported and or appreciated (Onco34). It takes place in a context where these resources might be available, but not adequately put into use (Psy33). In other words, healthcare professionals see coaching as increasing agency and empowerment and encouraging patients to be actors in their treatments (Nur35), make their voice heard (Onco82) as well as "empower[ed]", through better use of their resources and strengths (Psy33, Onco82).

The coaches also had an important emphasis on change and empowerment, in two main forms. The first is to develop the "empowerment" of patients (Coa20), helping them have better treatment adherence, reduced mental health problems (depression, helplessness), and better quality of life (Coa20). To them, it includes action planning and implementation while respecting the rhythm of each patient (Coa9) and supporting behaviour change (Coa20), notably to help deal with the treatment's side effects (Coa30).

The second main aspect was to support long-term changes and goal attainment. Their objective is to identify a current (unsatisfactory) state and help patients attain a desired state, through obstacle identification and resource development (Coa83). The aim is to support the "evolution" of patients during and after the disease, by exploring their needs and motivations for the future (Coa30). This exploration often addresses more existential interrogations (e.g., "What will my life be made of from now on?", Coa29) and focuses on finding (or re-finding) meaning in life (Coa9, 29, 83) and working on the potential opportunities that the disease has created (Coa29, 30).

At the intersection of the two, the coaches highlighted how they can support the process of returning to work (Coa30). This support aims at accompanying patients during their return to work to help them find a balanced approach, step by step (Coa9, 30). The support to patients might therefore focus on finding new meaning in their work (Coa9) or living in adequation between their values and their life choices (including professional ones, Coa20) while ensuring they consider their mental and physical health during that process (Coa30).

Both groups see coaching as fostering goal-oriented (behaviour) change and agency, but they emphasise different aspects. Healthcare professionals describe coaching as a way to support patients in taking concrete steps (e.g., adjusting to lifestyle changes, planning for the future). They see it as helping patients mobilise internal and external resources to stay engaged in their care, manage their quality of life, and make informed decisions. Coaches highlight coaching as a

process of personal transformation, focusing on identifying obstacles, fostering self-determination, and guiding patients through broader life changes (e.g., returning to work or redefining their aspirations). While both perspectives acknowledge the role of coaching in strengthening patient agency, healthcare professionals emphasise structured support during care, whereas coaches position it as a support for long-term change beyond the disease.

Knowledge and education

Coaches are seen as also affording their support in the form of providing knowledge, information, and education. This first focuses on the knowledge of the disease, its treatment, and side effects (Nur35, 51, 59) but also checking that the patients have adequately understood the content of that information (Nur35). This covers also how they can support patients in performing adequate decisions based on that knowledge (Nur59). Such decision support can be more or less directive, from checking adequate understanding and implications of treatment choices (Nur59), to providing advice and opinions based on the patient's experience, although with a different look (Nur65). This is in line with the idea that coaches can be present to accompany the treatment adherence (Onco34), notably through working on the motivation to make sense of and maintain it, or, on the contrary, to decide to stop it (Nur75).

While most coaches repeated the importance of having a necessary knowledge of the disease, they did not highlight that they had any role in providing this knowledge. On the contrary, they showed how their intervention should be done in collaboration with other healthcare professionals with their knowledge (Coa29).

Coaches as intermediaries and case-managers

One of the most cited roles of coaching is being an "intermediary within the multidisciplinary team" (Nur35), where coaches take a coordination and intermediary role, having a global view over the patient's current state (PH52). This can take the form of organising the appointments and coordinating the different professionals (Nur51, 59), facilitating the care journey (Nur59), and making the link between the hospital and the patient's home (Nur59). Beyond that coordination, this can also take the form of administrative support and referral to adequate services (PH52). In that context of being involved in a sort of triage, the evaluation of need is central (Nur59, Onco82, Psy7, PH52), notably to refer to other healthcare professionals that could handle it more adequately (Onco82, Psy7), and follow-up on meeting these needs over time (PH52).

The coaches saw themselves less as coordinators or directly involved as intermediaries within the healthcare system, probably because they were all working outside the hospital. Instead, they see their role as helping the patients deal with these situations, notably in helping prepare questions for the oncologist (Coa20) or providing tools in sometimes-complicated relationships with them (Coa30). The direct involvement in these relationships or in the care itself is seen as rare (Coa9). Because coaches are close to the needs of patients, they are also seen as potential conduits for the patients to other necessary resources and actors within the care landscape (Coa30).

Operational aspects of coaching

When participants delved into how that support is operationalised, they often highlight how coaching is seen as either "solution-oriented" (Nur35), toward finding practical and concrete solutions (Psy7), often more practical and directive than what psychologists usually do (Psy33). As such, one of their goals is to provide tools to patients (Psy22), notably through finding and building solutions *with* (as opposed to *for*) patients (Psy7). As such, it is seen as a personalised and individualised practice (PH52, Psy7), close to the person (Psy7). Coaching support is also seen as spanning throughout the disease (Onco82), starting with the diagnosis phase (PH52) and continuing after the end of the treatments (Nur51). More than that, coaches are seen as having a

global vision of the patient’s journey (PH52), with the capacity to support patients throughout the journey.

Coaches see their interventions at the same time as active (Coa30) and based on asking questions to facilitate (self-)awareness (Coa9). “The coach will, through their questioning, help [patients] see more clearly in all of this and allow them to go through this transition without being alone.” (Coa30). One coach also mentioned that the fact they were dealing with cancer patients did not mean that they were providing coaching that was significantly different than if it was not with cancer patients (Coa83).

Techniques and implementation

Most healthcare professionals were not very clear about what coaching entails, notably because they found it was too vast to summarise (Nur77, Onco34) but also because they simply did not know (Psy7, Onco82). That being said, participants agreed that coaching relies on a series of different tools (Nur35) that can benefit the patients (Psy22) and help them face the challenges in their daily lives (Psy33). First, for the evaluation, coaches can rely on validated tests (e.g., to measure fatigue or well-being) (Nur35, 59), as well as tools to report possible incidents throughout the disease (Nur35), self-monitoring and action planning (PH52, Nur59). To work on motivation, they can rely on motivational interviewing (Nur65, Psy33) and tools to help in goal setting (Psy33). Regarding the implementation, coaches can use roleplay to help patients feel competent when facing the ‘real’ situation (e.g., in training to make an announcement, Psy33). Coaches are also seen as worth providing feedback to the patient's requests (Nur35). The most important aspect was the centrality of relational skills (Nur35,51,59), also highlighted as a basic requirement to be able to coach in the hospital.

The coaches were more specific as to what kind of techniques they used. They all highlight that the core element of coaching is to rely on the relationship to foster change in patients. This is done through open questioning, benevolence, non-judgment, confidentiality (Coa9, 20), as well as active and empathic listening (Coa9, 30, 83). Even though they agree that coaching might be more directive than other approaches, they also emphasised that coaches are not meant to give advice, but rather question patients so that they come up with their solutions (Coa9, 20, 30). In terms of specific tools and approaches, coaches appear to rely on a variety of them, sometimes close to tools that can be used in psychotherapy: Neuro-linguistic Programming (Coa20, 30, 83), hypnosis (Coa20, 83), mindfulness (Coa30), breathing exercises (Coa30), Cardiac coherence (Coa30), Transactional Analysis (Coa30), or Narrative approaches (Coa30). Typical coaching tools are also used (e.g., Robert Dilts’ Logical Levels, Moss’ Mandala of Being, *index de computation*) (Coa9). It is worth noting that coaches did not spontaneously mention some techniques that were deemed relevant by participant healthcare professionals, such as evaluation tools or roleplay.

Requirement for coaches

Regarding the “who” can be coaching, one participant commented that, in the current context, there is no regulation for who can be a coach (Psy33). As summarised by Nur75: “It looks like it’s everyone and anyone, there are coaches for everything”. She however completed her comment by stating that “everyone *can*, provided they have obtained a certificate”. The importance of having a certification was importantly supported by most healthcare professionals, whether through certified training in coaching (Nur65, Onco82, Psy7), in oncology (Nur35, 51, 65, 77, Psy22, Psy7), in relational aspects (Nur59, Psy22, Psy33), or a validation of the coach’s experience in the oncological domain (Nur35, 65). As pointed out by Psy33, this certification would “ensure that people have a clear understanding of their role, but also of the limits of their role, particularly in the face of distress and what is considered mental health care”. One participant mentioned that providing coaching does not require a specific certification (Onco34).

The participants pointed out that this certification would ensure two elements. First, the coaches must know the specific characteristics and implications of the disease and its treatment (Nur35, Nur 77, Onco 82, Psy7). This is to ensure that the coaching is “optimal and consistent with conventional treatments” (Nur77). This relates to those highlighting the necessity for coaches to have experience in the oncological domain, or in relation to cancer patients (Nur35, 59, 65, PH52). The second regards the support and relational skills of the coach, to ensure that they provide adequate support, without stepping out of their role. As such, coaches are expected to “well understand the psychology of patients and their relatives” (Nur35) and have relational, listening, and empathic skills (Nur35, 59, 65, 34, Onco34). One suggested that a form of certification for these skills would be to have ‘supervised field experience to check that attitudes are appropriate’ (Onco34).

In that context, there was a distinction between those who claimed that coaches should have a healthcare (e.g., nurses or psychologists) (Nur51, 59, 65, Onco34, Psy7, PH52) or a social work background (PH52), in opposition to those stating that being a healthcare professional was not a necessity in the first place, as “everyone” could, provided they can prove they have the required knowledge, experience, and adequate attitudes (Nur65, 75, 77), which includes former patients or peers (Psy33).

None of the coaches participating in the study were healthcare professionals. They all agreed that being a coach necessitates specific training in coaching recognised by national or international bodies (e.g., International Coaching Federation, European Mentoring and Coaching Council) (Coa9, 20, 29, 30, 83), with a specialisation in cancer coaching to have the necessary knowledge (e.g., treatments, side-effects, Coa20, 29, 30, 83). One added that his training and their role should be legitimised by an official national organisation (Coa9), notably through a minimum of 300 hours of supervised practice (Coa9). Aside from that, they also emphasised that coaches should have a keen interest or a personal experience to better understand patients and support them adequately (Coa30), in addition to adequate interpersonal skills (“how-be”, Coa30) and a need to be neutral and benevolent (Coa9). The importance of supervision and reflexive practice (‘metacognition’) was also highlighted (Coa9).

Place and integration within the current healthcare system

Regarding the place of coaching in the current oncological context, healthcare professionals pointed out that coaching is already present (Nur77), albeit without current regulation (Psy33). The view on the place of coaching importantly diverged, in two main approaches: a) adding tasks to existing healthcare professionals or b) a new complementary role. Regardless of its form, some participants pointed out that coaching should be recognised and publicly funded (Nur35), as well as ‘be recognised and valued by the social security system’ (PH52). Their role should be acknowledged as those of other healthcare professions (Onco82) and therefore be integrated within the nursing/care staff (Nur65).

A first approach is that coaching should be integrated into the tasks of existing healthcare professionals, notably in the training of nurses (Nur51), to provide them with more adequate tools to support and interact with patients, especially when they are in coordinating roles. This is supported by the observation that healthcare professionals (e.g., psychologists or nurses) might already been doing coaching in their current practice (Psy33). However, this suggestion is moderated by some participants who point out that coaching can be performed by professionals who are already present, such as nurses or psychologists, if we give them the necessary time (Nur75, Psy33). This is fuelled by the observation that, currently, the system is already under pressure, which does not allow that (PH52).

A second approach (which might not be opposed to the first), presents coaches as providing psychosocial support which can be complementary to what currently exists, notably provided by

(onco-)psychologists (Psy22, 33). In that view, coaches can be seen as first-line providers (Psy33), with more practical tools (Psy22), and the role of ensuring that the needs of the patient are met by the different providers (PH52). This role can be seen as preventive, in the sense that "not everyone needs to see a psychologist when facing the disease, but we can give people the tools they need to avoid having to see a psychologist afterwards." (Psy33). If coaches encounter intense psychological distress or psychopathology, they should refer to other professionals (Psy33). Whether in or outside the hospital, coaches might provide a form of psychosocial support that might be perceived as more accessible and less threatening than what the process of meeting with a psychologist can entail (Psy33).

The coaches themselves acknowledge that healthcare professionals may sometimes not know what coaches do and how they can benefit the patient (Coa20). None of them being healthcare professionals, they pointed out how coaches are professionals supporting patients but are complementary to existing care, such as physicians and psychologists (Coa29), as part of the multidisciplinary team (Coa29). One directly addressed the shared features of coaching and psychological support, by pointing out that coaching focuses on the "here, now, and tomorrow", while psychotherapy focuses on "delving into the causes of issues" (Coa30). As such, they see their work as a collaboration with psychologists to support the return to a normal life, including a return to work, often because the work of the psycho-oncologists is limited in time (Coa30). Coaching is therefore seen as having to be integrated into the global journey of patients (as with other professionals), with a strong emphasis on helping them return to life after the treatments (Coa30), "transition[ing] from being patient to being a survivor" (Coa29).

Discussion

The present study explored the definition, role, and place of coaching in cancer care through the lenses of healthcare professionals and coaches. While the findings highlight the potential of coaching as a complementary support function and that there was some common ground between the views of healthcare professionals and the views of coaches, they also reveal differences between these two groups.

Healthcare professionals generally view coaching as a supporting function that complements existing care. They see coaches as first-line providers who can address a range of patient needs, including providing low-intensity psychosocial interventions, care coordination, and triage. These perspectives align with the growing need for holistic and continuous support throughout the cancer journey (Scotté et al., 2023). However, healthcare professionals remain unaware of the specific activities that coaches perform. They see coaches as operating within the hospital setting, but the lines are blurred between the role of the coach and existing roles, including coordinating nurses. This lack of clarity highlights the need for a more precise description of coaching practices in that context.

Coaches, on the other hand, emphasise their role in facilitating patient empowerment and managing the transition back to a "normal" life after treatments. Their focus extends beyond the hospital walls, encompassing long-term support and attainment of self-defined goals after the end of curative treatments, which includes return to work (Cocchiara, et al., 2018). This perspective also aligns with the recommendations for supportive care, though with an emphasis on continuity beyond the "being cured" stage (Scotté et al., 2023). This perspective was not mentioned by the healthcare professionals in the present study, but both see coaching as one way to contribute to supportive care.

These complementary but contrasting viewpoints challenge the idea that both groups work with the same definition of what coaching truly entails in cancer care. While both groups agree on core principles – such as support, change management, goal setting, and a relation focus – the content

and context of coaching diverge. Healthcare professionals view coaching as part of multidisciplinary teams within the hospital, akin to a coordinating nurse providing information, first-line support, and coordination. Conversely, coaches emphasise an independent role focused on post-treatment transition, potentially outside the hospital. While indirectly confirming the importance of supportive care (Scotté et al., 2023), this discrepancy suggests that healthcare professionals and coaches may not be talking about the same thing, even though they use the same word.

The multidimensional ambiguity of coaching in cancer care calls for a potential clarification and better communication of their role, but also a necessary legal framework for coaching. Even though it seems that coaching fills necessary needs and definitions are set by some international societies (Greif et al., 2021), coaches are dealing with cancer patients, actual and former. As such, it cannot be excluded that coaching could be considered a form of healthcare and would therefore fall under the legal regulation in healthcare. Additionally, the tasks and techniques highlighted by the participants reinforce the blurred line with other healthcare practices, including psychotherapy. In the context of clarification and specification of what psychotherapy entails (Rief, 2021), the line must be drawn on where coaching ends and where psychotherapy/counselling begins to ensure that coaching practices respect the law (Bachkirova & Baker, 2018). For the training, both healthcare professionals and coaches call for a certification to practice as a coach. However, such certification cannot only be validated by (inter)national professional organisations without the legal acknowledgement of that certification. The regulation and clarification of practice should therefore be structured to acknowledge what would be the sufficient conditions for coaches to practice without overlapping with existing roles.

The presence of coaching in cancer care also reflects needs unaddressed by the existing setting and highlights promising avenues for improvement of supportive care provided to patients. These mainly relate to the need for low-intensity psychosocial interventions, case management, and support to transition outside of curative care. Whether it falls to coaches (as a “discipline”) or other professionals (with an additional “set of techniques” from the coaching field) to contribute to these improvements remains to be defined.

The first is the need for low-intensity psychosocial intervention for patients. A significant proportion of patients might not be willing to ask for help (Clover et al., 2015), but most of them would benefit from receiving tools to better handle their disease, change toward a set goal, or better manage their psychosocial challenges caused by the disease. In that sense, coaches could provide self-management and -regulation tools to help the patients in the challenges they face, akin to being first-line providers who could handle a vast array of challenges and be able to redirect if these challenges become too intense. The field of low-intensity interventions in cancer remains heterogeneous and lacks adequate evidence (Beatty et al., 2018). However, addressing it through the lens of health promotion by coaches appears to be a promising avenue of research, particularly in a context where pressure is already put on mental healthcare providers. As pointed out by one HP, clear guidelines should be drawn on where this type of support is appropriate, and the situations in which psychotherapy would be more appropriate (e.g., distinguish moderate distress with depressive symptoms).

That first-line support would also help in monitoring the needs of the patient by having someone whose role is to check the patient’s needs regularly and to triage them to the adequate provider, akin to case managers or patient navigators (Kelly, Doucet & Luke, 2019). In that, it joins the second need to increase continuity in the care of cancer patients. There is important evidence on how triage works in symptom management (Piazza & Drury, 2023), but that would also include psychosocial challenges. Doing so would also clarify that one follows a patient throughout their cancer journey and who would be their Single Point of Contact (SPOC). Therefore, it would help in addressing challenges in communication with healthcare professionals, answering most questions and leaving the more complex to meeting with the needed healthcare professional (e.g., the oncologist). In a context of constrained resources, allocating resources to having one coordinator

seems complex, but the potential benefit of doing so should be to consider how it could ease the patient's journey while better allocating the time of other healthcare professionals.

The third need identified is slightly distinct from the first two in that it focuses on the transition from the care environment to the outside of it. None of the healthcare professionals mentioned it, but it was present in almost all the contributions from the coaches, as it might be closer to their current practice. This need focuses on returning to a new “normal” life after the end of the treatments and easing this transition. This encompasses returning to work – which is a key issue in cancer survivorship (Cocchiara et al., 2018) – but goes beyond that by integrating the psychosocial adjustment to transitioning out of care (Stanton, 2012). This is fuelled by the observation that most psychological support ends at the end of the treatments when patients leave the hospital. Approaches in supportive cancer care recommend comparable support, where the care for patients does not end when they are considered “cured” physically but helps in the transition from being in treatment to being a survivor (Scotté et al., 2023). If that role is not already taken up by the (para-)medical team, coaches could fill that gap by providing this necessary support.

The present study has several limitations. First, the qualitative approach relied on written answers from participants. Even though it is related to the evolution of the study, which was based on a Delphi, it might have limited the depth of the insights provided. Second, the sample comprised coaches from comparable training and approaches. Even though it might reflect the current coaching landscape in French-speaking Belgium, it is also possible that other profiles were not included. The decision to focus on French-speaking Belgium was necessary due to large regional differences in terminology and practice (e.g., the use of “oncocoach” in some Flemish hospitals to describe specialised nurses), but this choice may have excluded perspectives from professionals working in different healthcare systems or with diverse training backgrounds. Comparative studies across linguistic or national contexts could help clarify how coaching is defined, regulated, and integrated into oncology care. Additionally, recruiting participants based on their professional roles within the oncological care system rather than their training or experience with coaching may have shaped how coaching was described, particularly by healthcare professionals, who often framed it in relation to existing medical structures. Future research could adopt a different sampling strategy, focusing on participants' direct experience with coaching rather than their job title, to validate findings and gain understanding of its perceived role and implementation from a different angle. This would also be an opportunity to clarify how coaching differentiates itself from psychological or other forms of support to unlock coaching's full potential and further contribute to the quality of care for cancer patients. Third, participants took between 9 and 110 minutes to complete the survey. The sources of the size of that range remain unknown.

In conclusion, while discrepancies exist between healthcare professionals and coaches regarding the definition and application of coaching in cancer care, both perspectives highlight supportive psychosocial care needs and the potential of coaching in that context. Coaching can address unmet psychosocial needs in areas like low-intensity interventions, care coordination, and post-treatment transition, but that would require a clarification of their role in the current landscape. By pointing that out, this work is especially relevant to healthcare professionals, coaches, and policymakers who aim to develop integrated and evidence-based supportive care. By bridging these differing views, clarifying the role of each professional, and including coaches in the process, this provides further avenues to address unmet psychosocial needs, enhance patient empowerment, and ultimately contribute to improved patient outcomes.

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