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Medical Careers and Coaching

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Abstract

Research in the medical careers field in the UK tends to concentrate on career destinations for doctors and is used as an input into workforce planning by the Department of Health. Changes to medical career pathways, introduced by the Modernising Medical Careers programme, have brought into focus the need for medical schools and postgraduate deaneries to provide career support to medical students and postgraduate doctors. This study considers the practical aspects of how coaching can support these doctors to make career choices.

The research is a qualitative case study that considers medical careers within a medical education context. Interviews were carried out with 13 coaches; five clients were either interviewed or asked to complete a qualitative questionnaire, and I kept my own reflexive diary. Thematic analysis was used to develop the findings from the research.

Four key areas were identified in the data: what doctors bring to coaching, what coaches need to work with doctors, the coaches' approaches to coaching, and the coaching conversation. They have been combined into a framework that can be used by coaches, and also by trainers and supervisors who work with postgraduate doctors.

From a wider perspective, career coaching seems to encompass the aims of career support as well as go beyond it into other aspects of doctor's lives, such as work–life balance. Additionally, coaches used stories and metaphors in their work: one metaphor described doctors as being surrounded by the 'medical bubble'. The issues of the coaches' expertise and self-disclosure in coaching are discussed. Trainers and supervisors who provide career support may wish to consider their own development needs.

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Chapter One – Introduction

Changes to the career pathways open to doctors, introduced as part of the Modernising Medical Careers (MMC) programme, made the news headlines in 2008 when they suggested that jobs for doctors were in short supply. Since the introduction of the MMC programme and the single entry date for medical recruitment, there has been an increase in public awareness and statements from postgraduate doctors expressing concerns about the need to make career choices earlier than required by the 'old system'. Prior to these changes, doctors could explore a number of career options before selecting a specialty training pathway.

The British Medical Association's (BMA) report *Signposting Medical Careers for Doctors* (BMA, 2003, p.2) makes eight key recommendations, one of which is that 'further research is needed to test the effectiveness of the various methods of delivering careers advice'. Since this report, the cohort studies into career choice and career progression carried out by the Oxford Medical Careers group and the BMA have become the main source of information on doctors' careers in the UK. Many of these studies have been epidemiologically based and quantitatively researched, based on survey data (Taylor *et al.*, 2008). Specifically, the BMA has followed up two cohorts of doctors – Cohort One of 545 doctors who graduated from medical school in 1995, and Cohort Two of 435 doctors who graduated from medical school in 2006.

Goldacre *et al.* (2010, p.8) identify that the 'issue of career intentions and the degree to which they accurately anticipate later career outcomes should be of interest to medical educators and doctors themselves'. There are a number of reasons why this issue matters. The cost of training doctors in the UK is significant, and proposed changes to undergraduate education (Browne, 2010) and tuition fees will further impact on these costs. Goldacre *et al.* (2010) indicate that there are a number of unanswered questions regarding career choice; their paper is based on an analysis of specialty choice and career destinations, but does not explore the motivation behind any change. It goes on to propose further in-depth qualitative research with doctors who have changed career direction.

Providing career support to medical students and postgraduate doctors continues to be of concern to medical schools and deaneries alike (Goodyear *et al.*, 2007). A variety of models to provide this support have been implemented, although only one so far has incorporated coaching (Shelly, 2007). There are a range of people involved in the provision of career support, from university careers services, deaneries, employer

bodies and human resource departments, to external services like the BMA and coaching organisations. There is no current empirical research that considers how career support should be provided to doctors when they are faced with career choices.

The overall aim of this study is to explore how coaching supports doctors to make career choices; the sub-questions are as follows:

- What is the personal impact of coaching on doctors (as clients)?
- What aspects of coaching contribute to specific career choices made by doctors?
- Who are the main providers of coaching to doctors and how do they operate (the coaching process)?
- Within medical education what are the key components of a career management system for doctors?

Included in this chapter is an introduction to medical career pathways, the context for this research, a review of coaching, definitions related to careers, the philosophy underpinning the research and the research design.

Medical career pathways

Career pathways for doctors have been subject to a number of reforms since 1990. In order to practise as a doctor in the UK, an individual needs to hold full registration with the General Medical Council (GMC), which gives them a licence to practise as a doctor in the UK. The GMC itself publishes guides for medical students (GMC, 2009) and doctors (GMC, 2006) outlining the role and remit of a doctor.

The most recent changes to career pathways for doctors came about with the introduction of the MMC programme. It was initiated with the aim of improving patient care by delivering a modernised and focused career structure for doctors through an extensive reform of postgraduate medical education. The reforms introduced a new career pathway, which included the foundation programme and a range of specialty training programmes (Department of Health, 2004). The Department of Health (2003) also recognised that doctors in the foundation programme would need access to high quality assistance with planning their careers. One of the 18 key principles that underpin the MMC programme states that: 'Rigorous counselling and career advice should be available throughout training'.

Deaneries initially set up career support services for postgraduate doctors in 2006. The first major challenge they faced was the implementation of a new recruitment and selection process coupled with the introduction of new specialty training programmes. This was accompanied by a new web-based computer system called MTAS (Medical Training Application Service). Its introduction and operation did not go smoothly and there was a significant outcry against it in the press and media, leading to the formation of new pressure groups concerned about the impact of this system on medical training. This continuing public interest in the MMC programme led to the Department of Health commissioning an independent inquiry into these MMC reforms. The inquiry was led by Professor Sir John Tooke and culminated in the Tooke (2008) report. Recommendation 17 in the report recognises the importance of accurate data on career aspirations and choices, and advises that medical schools should play a greater role in providing careers advice. Research by Lambert and Goldacre (2007) also proposes that careers advice needs to be planned into postgraduate work and training.

The career structure for doctors has continued to change since the introduction of the MMC programme and currently a 'mixed economy' model exists (see Figure 1.1). The first stage of the career pathway is the foundation programme, which replaced the first two years of clinical practice for doctors who had completed their medical degree (previously this was the Pre-Registration House Officer year and then their first year as a Senior House Officer). Medical graduates are required by the GMC to complete at least their first year of the foundation programme within two years of graduating in order to be able to apply to be fully registered as a doctor with the GMC, otherwise they cannot practise medicine in the UK. Specialty training is designed to follow on from foundation training, and there are over 60 medical specialties. Some of these offer 'run-through' training and others offer 'uncoupled' training. Run-through training – for example, paediatrics and General Practice – provides structured training, which, subject to satisfactory progression, leads to the award of a Certificate of Completion of Training (CCT) and the opportunity to join the GMC's specialist register to apply for consultants' positions. Uncoupled training – for example, medicine, psychiatry and surgery – means that the first stage is to apply for a core training programme, which is usually either two or three years, and the next stage is to apply through a competitive process to higher specialty training – for example, medical specialties like geriatric medicine and endocrinology – which then, subject to satisfactory progression, leads to a CCT.

Figure 1.1 – Medical career pathway

Source: Adapted from Elton and Reid (2010, p.36)

The Department of Health's (NHS) Next Stage Review led to the Darzi (2008) report entitled *High Quality Care for All*. It identifies the need for 'a clear focus on improving the quality of NHS education and training' (p.14). The provision of careers information, advice and guidance to doctors and particularly to postgraduate doctors will continue to be challenged by changes to medical career pathways as the recommendations from both the Tooke (2008) and Darzi (2008) reports are implemented.

Context for the research

As a career coach I provide career support to doctors, and am Head of Careers for the Kent, Surrey and Sussex (KSS) postgraduate deanery. One of the tenets of the MMC programme is the availability of careers guidance to postgraduate doctors to help manage expectations. Within the KSS deanery a career support model for postgraduate doctors in training in the foundation programme (see Figure 1.2) has been implemented (Elton, 2006). Deaneries are responsible for overseeing medical education for doctors in a particular geographic area of the country, and 'contract' for that education to be provided locally by NHS hospital trusts in their region. The first level of career support in KSS is based in hospital trusts. Each trust-based team

comprises educational supervisors, a faculty careers lead and a medical education team, all located within the postgraduate medical education centre in the hospital; in many cases they run career support workshops for foundation doctors, and see them on an individual basis to discuss their careers. The trust faculty careers lead within each trust is usually a senior educational supervisor and/or a foundation programme training director. Trusts are supported by the deanery foundation school careers team, who provide them with copies of a career support guide called ROADS (Elton and Reid, 2010), run a number of career websites, offer faculty development in the form of workshops, and see postgraduate doctors who require additional career support – if, for example, they are experiencing difficulties making a career choice – on a referral basis.

Figure 1.2 – KSS career support model

Source: http://kssdeanery.org/education/about-us/about-careers/careers-support-model

Deaneries and the BMA both provide career support services. Many university careers services also provide support to medical students, although this is not universal throughout the UK.   Much of this is focused on key transitions and decisions required during the medical career pathway (see Figure 1.1). University careers services tend to provide assistance with medical students' applications into the foundation programme, and deaneries assist with their selection into specialty training programmes.

Coaching

Coaching is a relatively new learning and development intervention (CIPD, 2008, 2009), and there is a wide range of definitions of coaching. Within the coaching literature a number of writers have tried to establish a typology of coaching (Jackson, 2005; Ives, 2008). One of the most recent definitions of coaching from Bachkirova *et al.*

(2010, p.1) is: 'a human development process that involves structured, focused interaction and the use of appropriate strategies, tools and techniques to promote desirable and sustainable change for the benefit of the client and potentially for other stakeholders'. They go on to say that: 'coaching is an applied field of practice that has its intellectual roots in a range of disciplines: social psychology; learning theory; theories of human and organisational development; and existential and phenomenological philosophy, to name just a few'. I would agree that coach training is informed by a wide range of models and processes, and that coaches similarly come from a variety of backgrounds; I, for example, have a business background, while others who work in deaneries are psychologists.

There is an ongoing debate in the literature on the definitions of coaching and mentoring; Connor and Pokora's (2007, p6) definition is that: 'coaching and mentoring are learning relationships which help people to take charge of their own development, to release their potential and to achieve results which they value'. They see coaching and mentoring as being different but complementary; some of those differences are related to the length of the relationship, the formality or informality of the meetings, and who has more experience in the relationship. They argue that mentoring is more about developing the mentee professionally whereas coaching is aimed more at specific development issues. While I agree with this to some extent, my own overall definition of coaching is that it is a learning and development opportunity for clients to focus on the career issues that are important to them within a time frame that is mutually discussed and agreed. Within medicine, mentors can be seen as experts in the medical field (French, 2007), but this approach is not appropriate to me as I am not medically trained, and prefer to work with the client's agenda, not one informed by my own knowledge as a coach.

My interest in coaching developed in the late 1990s, when I attended an event that included a session from a sports coach and decided to find out more about how coaching could support learning and development. An early experience of coach training exposed me to a model of coaching and an understanding of some of the skills required for being a coach: for example, listening, questioning, challenging and immediacy. Further coach training with the Coach Training Institute (Whitworth *et al.*, 2007), which is more of a life coaching approach, moved me from a more explicit model for coaching to one that is underpinned by what the client wants; this differs from the Chartered Institute of Personnel Development (CIPD, 2009) view that coaching is a personal development tool used within organisations. In my coaching work, my concern is towards balancing the needs of the individual with the needs of the organisation, as

the people who refer doctors to me may be keen to ensure that they do not leave the NHS or medicine in the UK.

My work as a coach has been influenced by a number of coaching definitions and my personal values, specifically those of honesty, integrity, the importance of supporting others, and making a contribution through the work I do. I recognise that I am at the acceptor stage of development as a coach (Bachkirova and Cox, 2007), and I use high levels of empathy when working with individuals. I explore the role and personality match for the client, and use a wide variety of models and structures depending on what the client needs. The essence of my coaching approach is that the client's agenda is the prime focus for the coaching intervention (Hawkins, 2008) and, as Ives (2008) indicates, that the role of the coach is to support the client to identify their goals and the actions that will move the client forward through whatever issue, change, challenge or transition they are facing. Generally speaking, the relationship I have with clients is short-term and limited to between one and six sessions. The focus is with clients around issues relating to developing overall career management skills, rather than career development within a specific medical specialty.

With doctors as clients I need to be aware of different cultures. Doctors have professional careers (Inkson, 2007) and may be more comfortable with logic and positivism (Greenhalgh, 1999), reflecting their scientific training and evidence-based profession. My first degree was in agricultural botany, and since then my own personal and professional development has been in the fields of business, psychology and the social sciences. I work with a wide variety of clients in my private career coaching work and I see myself as a coach who is interested in both the psychological (e.g. Egan, 2007; Rogers, 1961; Savickas, 2005) and sociological aspects (e.g. Law, 2006) of career decision-making. My model of career coaching incorporates a range of these influences. It is primarily based on the four-stage career process (later shown in Figure 1.3), with a wide range of other models, tools and techniques from both my professional development in career support and coaching.

Career decision-making for doctors does need to be distinguished from decision-making in the context of their professional practice (Gladwell, 2005, p.39). It is also important that there is a clear understanding of what success means to doctors in this context. Megginson and Clutterbuck's view (2005, p.40) is that success means achieving what you value. This research aims to explore what career choices and decisions are valued by its participants.

The one-to-one work I do with doctors indicates the importance of enabling them to construct their own careers (Inkson, 2007, p.82), set realistic goals (Ives, 2008), take action, and develop career management skills – which they can use to assist further career choices – whilst recognising that the ongoing nature of change means that career decision-making is a lifelong process (Amundson, 2006). This way of working with junior doctors can be in contrast to their experience of developing within the medical education context, where their professional and personal development is influenced by the requirements of their occupation; doctors may seek expert advice rather than a more developmental approach (Inkson, 2007, p.133). My own definition of coaching, as previously stated, is that it is a client-focused learning and development opportunity, supported by theories of coaching and career decision-making, with an agenda and time frame that is negotiated between the coach and the client. This research aims to explore the current gap in our knowledge regarding how career support is provided to doctors and how coaching supports doctors' career decision-making.

Definitions of career

For this research, a number of definitions related to careers need to be explored. Hall (1976) uses the concept of 'career' to mean career as advancement, profession, a lifelong sequence of jobs and a sequence of role-related experiences. Baruch and Rosenstein (1992, p.478) look at a career as 'a process of development of the employee along a path of experience and jobs in one or more organisations'. Arnold's (1997, p.16) definition is that: 'a career is the sequence of employment-related positions, roles, activities and experiences encountered by a person'. Within the medical profession, the career pathway as set out by the MMC programme contains sequences as described by Arnold; however, this pathway is seen by medical students and doctors to be a rigid structure with little opportunity for flexibility – Arnold's definition is a broader and more flexible description of a career, and this is the definition I will adopt as I do my research.

Doctors continually develop their knowledge and skills within a specific medical specialty, and are encouraged to discuss cases they have dealt with, both with their educational supervisors and their colleagues, to aid the development of expertise through a case-based discussion. Also central to a professional career is the development of knowledge and expertise, which, in the case of doctors, is developed in clinical practice. Doctors learn on the job, which Eraut (1994, p.10) describes as entailing 'engagement in a succession of cases … which they have to learn about'.

Progression through a doctor's career carries with it the expectation that they will continue to develop and gain professional qualifications in the form of Royal College exams, which are a key part of specialty training programmes without which doctors cannot complete their programme, gain their CCT and thus apply for consultant jobs. These professional qualifications are a form of forced development, as they do not lead to an explicit postgraduate qualification (for example, a master's degree), unless one is taken alongside the Royal College exams. Doctors do sometimes take postgraduate qualifications to help demonstrate their commitment to a particular specialty: for example, master's degrees in subjects like cardiology.

Career support is described in a number of ways. It can be called 'career counselling', 'information, advice and guidance', and is increasingly being referred to as 'career coaching'. It can also be provided in educational settings such as university careers services, and within organisations where it is commonly referred to as 'career development' (Cedefop, 2008). Providers of career support may also be referred to in a number of ways, which include, for example, career professionals, career counsellors, guidance workers, personal advisers and career coaches. I use the term 'career professional' when referring to people who work in educational settings such as university careers services and deaneries.

Medical students are primarily supported by university careers services, and doctors by deaneries, although some deaneries subcontract work with doctors to university careers services. Within educational settings, the following definitions are in use (DENI, 2009, p.4):

Career Information: 'This is the general data you can gather about how to access learning and work opportunities'.
Career Advice: 'If you need more help to understand the information available, then you need advice. Advice is provided by an individual either face to face, or by phone or online, for example, to help you decide what course to do or which training provider to choose'.
Career Guidance: 'You turn to guidance when you need more in-depth help, either on your own or in a group, from a trained guidance worker. This will help you explore your options, relate information to your own needs and circumstances and make decisions about your career'.

Within organisations the focus of career support tends to be in the areas of career development, planning and management (Cedefop, 2008), with the aim of benefiting

both the individual and the organisation. Research by Hirsh *et al.* (2001) identifies that the provision of career support from within the organisation is seen as beneficial by those who received it, even though it is provided by someone employed by the organisation. Postgraduate doctors are both in education and employed by an organisation: they are selected into specialty training programmes managed by a postgraduate deanery, and they are employed by a hospital trust that provides training on behalf of the deanery. The KSS deanery careers service aims to provide support to postgraduate doctors that is impartial and benefits the individual, while bearing in mind the organisational context within which it works. The model for career support shown in Figure 1.2 is underpinned by a four-stage model of career support (see Figure 1.3).

Figure 1.3 – Four-stage career planning process

Source: http://www.medicalcareers.nhs.uk

Hirsh *et al.* (2001) recognise the importance of a shared framework for career support, and this four-stage process is shared across all parts of the career support model for the deanery (see Figure 1.2); it provides a basic process for providers and recipients of career support to help determine what help recipients require. For example, a doctor who was unsure of their likely career direction could be encouraged by the provider of career support to think about what they wanted from a career by first exploring their values, interests and skills through self-assessment.

Philosophy underpinning the research

My approach to the development of knowledge is that people place many different interpretations on the situations they find themselves in, and these are likely to affect their actions and the nature of their social interactions with others. My interest in people and careers has exposed me to the social sciences and an interest in social constructivism (McMahon and Patton, 2006). Understanding the self and particularly the use of psychometrics in coaching and careers work has led me to consider the psychological perspective (Wilber, 2000).

With this study I explore the use of coaching with doctors and their career decision-making. This is an area of interest for me that aligns with the working role I carry out as Head of Careers for the KSS deanery. It was selected to address concerns about how career support is provided to doctors and how coaching as an approach can be used with this client group. The context for the research is medical careers. In Chapter Six I outline my own background and coaching approach, which includes the importance of values and supporting others. McNiff (2008, p.352) discusses the importance of values in research and says that 'knowledge is generated by a knowing subject, from within a social context, and this is best communicated through narrativised accounts, that tell the story of one's learning'. McNiff (2008, p.355) goes on to say that the 'ontological, epistemological and pedagogical values form the bedrock of our identity and work' as researchers. Although McNiff is referring here to action research, this view is also pertinent to this case study.

The research question influenced the choice of methodology, as did a number of other aspects: my world view, my epistemological stance, my own interests, the topic itself, the context, and my role as a researcher within an organisation. Developing and understanding my own world view has been a significant challenge for me. My first degree was in a scientific subject, but my own career to date has been within IT project management, people management, career development, learning and teaching, and coaching. My own personal development strategy has focused on developing skills, knowledge and expertise in the management sciences, including my interest in social constructivist narrative approaches to careers (McMahon and Patton, 2006) and psychological approaches (e.g. Jung's theory of type as described in Kidd, 2006).

Research design

The subject of this research is how coaching can support doctors' to make career choices; an area which has not been explored to date. The overall methodological approach to the research is a case study, with the level of the case being careers within a medical education context. The aim is to contribute to professional knowledge about career coaching with a client group of doctors.

An interpretive perspective (Robson, 2002; Willig, 2008; Mason, 2002) provides an interesting challenge for the context of this research: medical careers. Within the field of medical research there is a key interest in evidence-based medicine and quantitative research, and many previous studies into medical careers have been mostly quantitative (for example, BMA cohort studies). Some writers, though, have considered

the use of narrative within the medical field, including Greenhalgh (1999, p.323), who identifies that doctors do not rely solely on objective evidence when reviewing patients' symptoms, and that 'clinical judgement and proficiency is an art as well as a science'. Greenhalgh (1999, p.324) goes on to say that 'genuine evidence based practice actually presupposes an interpretive paradigm' and reports on the use of stories within clinical practice.

This study is concerned with the impact of coaching on doctors, and with those who coach doctors, and aims to explore how coaching can support junior doctors with their career choices. It involves three stages of data collection: free association narrative interviews with 13 coaches/providers of career support; a qualitative questionnaire completed by three doctors (clients); and free association narrative interviews with three doctors (clients). Finally, I kept my own reflexive diary to enable me to reflect on the progress of the study, and my own multiple roles, and to identify any areas of potential role conflict. Thematic analysis is the approach used to categorise the data and thence develop the findings.

Guide to the chapters in the thesis

Chapter Two – Literature review
In the literature review I outline the key literature and why it is important. Three main areas are considered: (i) medical careers, and what is known about career choice in medicine; (ii) the general literature on career decision-making; and (iii) the literature on coaching and personal and professional development, with doctors as the client group.

Chapter Three – Methodology
There has been limited research into key transitions within the medical career pathway, the decision-making process, and the factors that influence decisions. This research takes a case study approach, and the data collection methods include interviews with coaches involved in providing career support, and clients who have been coached, together with my own reflexive diary. Thematic analysis will be used to analyse them and develop the findings.

Chapter Four – What doctors bring to coaching
The career issues and dilemmas related to medicine as a career choice that doctors bring to coaching are outlined. The chapter starts with a discussion of these issues and then goes on to identify some of the key characteristics of doctors as clients, including their health and well-being. A key area for coaches is that doctors are accustomed to

consulting experts, so may be looking for a diagnosis, a solution and an immediate answer from coaching.

Chapter Five – What coaches need to work with doctors

The issues that coaches who work with doctors identify are discussed. They include: having an understanding of medical career pathways, medicine being seen as a competitive career, the image of being a doctor sometimes being different to the reality, and the metaphor of a medical career as a 'medical bubble'. The credibility of the coach is considered important, as is their understanding of career theory.

Chapter Six – Coaches' approaches to coaching

The coaches' approaches to coaching are outlined together with the role of trainers and supervisors in providing career support, as well as the researcher's role as a coach. The chapter starts with a discussion of the models and processes that underpin the coaches' own practice; their values and coaching skills and knowledge are then explored. Two key challenges are identified: power in the relationship and the need for the coach to engage in supervision and continuous professional development.

Chapter Seven – The coaching conversation

The coaching conversation is covered in this chapter, starting with the coaching relationship and then the coaching process. Three key aspects of coaching are considered: (i) contracting with clients; (ii) the moments and turning points in coaching; and (iii) the provision of doctors with time and space. The outcomes from coaching for doctors are outlined. Metaphors for medical careers and how they can support coaching are discussed. They provide a way of understanding a doctor's view of their own career and are also used in coaching to help clients understand their career issues and gain new perspectives.

Chapter Eight – Conclusion

In the final chapter the implications for coaching practice are discussed, and four key areas are presented in a framework for coaches who work with doctors: (i) what doctors bring to coaching; (ii) what coaches need to work with doctors; (iii) the coaches' main approaches; and (iv) the coaching conversation. The wider considerations for career management in medical education are also considered. Some ideas for further research are proposed together with a summary.

Chapter Two – Literature review

The aim of this study is to explore how coaching can support doctors to make career choices. In order to review what is already known on this topic, a number of searches were carried out and three areas emerged: (i) medical career choice and medical career management; (ii) the theories of career decision-making; and (iii) coaching with doctors as the client group. The keywords used for these searches were: medical career choice, decision-making, career, coaching, health-care professional, doctor and physician. Much of the literature on doctors is found in specific databases, for example, Biomedcentral, EBSCO, Wiley/Blackwell and PubMed Central, and careers literature in databases like PSYCHInfo, Sage Premier and Business Source Premier. The coaching literature is mainly found on academic coaching websites.

Providing career support to postgraduate doctors has gained in significance as medical career pathways have changed (as discussed in Chapter One); there is extensive literature on medical careers and career choice, some of which focuses on issues relating to personality. The wider literature on personality, however, has not been included, as this case study is considering a specific client group: doctors. Research into career choice and decision-making is wide-ranging across client groups (for example, students and people in work) and this is used rather than the broader literature on decision-making. There is limited research on the provision of coaching for doctors, and more specifically, career coaching for doctors. In this review I critically examine the literature relating to medical career choice and career management, current theories of career decision-making, and coaching and doctors, as shown in Figure 2.1.

Figure 2.1 – Overview of the literature included in the review
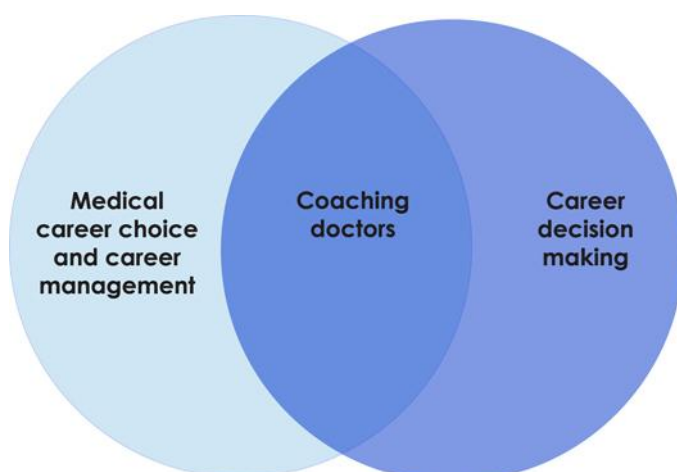
Medical career choice and career management

There are a number of organisations that carry out research on medical career choice in the UK. The most notable of these are the Oxford Medical Careers Group, the BMA (BMA cohort studies) and the Department of Clinical, Education and Health Psychology at University College London. This research into medical career choice in the UK is discussed, and then the situation in other health-care settings outside the UK is considered.

Medicine as a career comprises an initial degree in medicine taken at undergraduate level (between four and six years of study depending on the entry point to medicine) followed by postgraduate training while working as a doctor (see Figure 1.1). The cost of providing this training is significant, and the Collins report (2010) raises concerns about doctors making costly wrong career decisions, and about the timing of career support. Goldacre *et al.* (2010) recognise the importance of managing the expectations of medical students and young doctors regarding the career opportunities that are available in different medical specialties. They identify that a doctor's eventual career destination is more likely to match with the specialty chosen three years after graduation than that chosen within one year of graduation, and that this period, between year one and year three (after graduation), is a key one in the formation of a young doctor's career plans.

The tenth report of the BMA's cohort study of 1995 medical graduates (BMA, 2005) proposes that appropriate measures should be put in place to ensure that medical education includes the necessary subject material and processes to prepare doctors for a career in modern medicine. It also proposes that a mentoring scheme might be introduced at medical school and followed throughout a doctor's career, particularly in the early stages, to provide career guidance. The report is based on a ten-year longitudinal study of 545 doctors who graduated in 1995, and who represent about 15–20% of the total medical graduates in 1995. Since these doctors graduated, the medical education system in the UK has changed. However, the Collins report (2010, p.74) on the evaluation of the UK foundation programme for doctors recognises that progress has been made in the provision of information and advice on the careers open to doctors, although it does suggest that the quality of advice 'may be lacking' and that for some postgraduate doctors 'the lack of careers advice had hampered their decision making'. Lambert and Goldacre (2007, p.460) identify the need to plan careers advice into postgraduate work and training.

The fourth report of the BMA's cohort study of 2006 medical graduates (BMA, 2010) reports that two thirds of the cohort doctors are undertaking hospital-based specialty training and one third are in GP (General Practice) training posts. The doctors surveyed had completed the foundation programme and three quarters of cohort doctors took the first specialty training post they were offered. More than one third indicated that their experience of the foundation programme had not allowed them to make an informed choice about their specialty; however, 83% were of the view that the foundation programme equipped them with the generic skills needed in their specialty. A total of 16% of the cohort had not begun specialty training during the academic year 2008/09. Two thirds of the cohort reported that careers advice was available to help them achieve their career goals, and the main sources of advice included senior colleagues, educational supervisors, GP trainers, deaneries, Royal Colleges and the BMA. What is not clear from these studies is how the support was provided. Unmet career development needs for more senior doctors are also reported by the UK Medical Careers Research Group (Taylor *et al*., 2010) in their work with the 1988 cohort of UK medical graduates. This survey is based on a response rate of 69% of all medical graduates in that year and indicates there is a need for career development support at a later stage in a doctor's career.

Much of the research into medical careers in the UK considers medical specialty choice and career destinations for doctors. An area of particular concern is the number of doctors considering leaving medicine. Moss *et al.* (2004) in their questionnaire study of doctors indicate that 79% of those who replied to the questionnaire would stay in medicine but not necessarily in the UK. Of the 279 doctors considering leaving medicine, 72% gave reasons related to UK working conditions, 23% reasons associated with lifestyle choices, and 9% positive interests in a different career. However, this study did not examine the career support or decision-making process employed. Turner *et al.* (2005) identify that junior doctors assess quality of life issues and long-term career prospects when making long-term career decisions. Goldacre *et al.* (2009a) indicate that doctors have concerns about choosing hospital specialties and that it might be more difficult for them to change their specialty after the first two or three years of postgraduate training. In a more recent study, Goldacre *et al.* (2010) focused specifically on the career destinations of the doctors they surveyed and the timing of their choice of medical specialty. They assert (2010, p.7) that 'in any UK generation studied so far, appreciable percentages of doctors have to change career direction or take advantage of opportunities'. The supply of posts is proposed as a determinant of the likelihood or not of whether a doctor achieves a career in their chosen specialty.

Medicine as a career is described as tough by Gowan (2010) and difficult to navigate as a result of a range of initiatives that have made changes to the medical career pathway. The most recent change is the MMC programme, which has, since it was introduced, been the subject of a number of reviews, including the Tooke report (2008) and the Collins report (2010), with its focus on the foundation programme (see Figure 1.1).

Current research into medical career pathways in the UK supports the view that trainers and supervisors should be the ones to provide career advice (BMA, 2010; Miller *et al.*, 2010). Consultants in the UK who provide clinical and/or educational supervision come from all specialties and are generally from a different generation to postgraduate doctors. However, Fabian (2011, p.58) argues that 'younger doctors have adopted the view that a stark difference exists between work life and personal life' and that 'generational differences have framed this life–balance issue'. They are seen to have a different work ethic to their consultant supervisors, and this may go some way to explain how current doctors view their medical career and the way it is structured.

There is a wider issue as regards patient safety and doctors' own health and well-being. A recent Department of Health report (2010), *Invisible Patients*, indicates that ill health in doctors could lead to possible adverse effects on the quality of care provided to patients, and doctors' fitness to practice. Doctors are expected to be responsible for their own health as part of their registration with the GMC. The Department of Health report (2010, p.7) goes on to say that 'there is evidence for the impact of depression on doctors' performance, and working under the influence of drugs or alcohol increases the chance that health-care workers will make mistakes and communicate poorly with colleagues and patients'. The report also explains that 'sickness absence costs the NHS £1.7 billion each year and presenteeism – coming to work and performing at less than full capacity as a result of ill health – has been estimated to cost one and a half times this amount'.

In other health care systems the picture is different. For example, in the US system, medicine is studied as a postgraduate subject once an individual has completed their first degree. Their medical degree is usually four years and the American Medical Colleges have developed an extensive careers programme (http://www.aamc.org/careersinmedicine) to aid trainees in their fourth year at medical school to choose their specialty.

With regards to medical students, Reed *et al.* (2001) propose that there should be a focus on developing strategies with the aim of improving specialty decision-making in three areas: (i) the knowledge of the specific factors associated with specialty choice should be explored and confirmed; (ii) the concept of specialty choice decision-making as a developmental process should be recognised and made explicit; and (iii) the improvement strategies should recognise the need to track students longitudinally. Research in the United States has focused particularly on specialty choice (Leong *et al.* 2005; Hartung *et al.* 2005; Borges and Gibson, 2005). Borges and Gibson's (2005) research into personality patterns related to medical specialty choice indicates that the decision to specialise in a particular area of medicine is influenced by a variety of factors. These include: experience as a medical student, level of performance in a specialty, gender, values, and interests. Personality is also considered as a variable that affects specialty choice (Stratton *et al.*, 2005). The key issues relating to medical career choice are: the timing of the decision, difficulties relating to workforce planning and what career opportunities are available to doctors, who provides career support to postgraduate doctors, and a recognition that ill health in doctors can have an impact on their career choice and potentially patient safety. Additionally, there seems to be little research into the areas of specialty decision-making as a developmental process, and how it is supported.

In the Netherlands, research by Soethout (2007) focused on the career choices of medical students and recent graduates. This study's aim was to identify the factors associated with the choice of specialty. In his findings, Soethout (2007) proposes the need for more regular longitudinal research to further understand the career preference process. Further afield in Australia, Laurence and Elliott (2007) consider how junior doctors make their career choices. A key finding of this study is that the two crucial components of the career decision-making process are experience and role models. This view is also supported by the work of Sobral (2001) in Brazil. However, some care needs to be taken with research from other countries, as the medical career system is different to that of the UK. It is interesting, though, that research into medical career choice in both the UK and abroad aims to understand the reasons and factors that impact on career choice, and to aid the development of specific tools and techniques to support that choice, rather than to look at the developmental process underpinning career decision-making.

The number of women doctors in medicine is increasing. Deech (2009, p.2) reports that 'the number of women entering medical school has increased significantly – from 492 (24.4% of the total admissions) in 1960/61 to 4,583 (56.2% of the total admissions) in

2008/09'. The implication of gender in career decision-making has been studied by Lawrence *et al.* (2003), who identified four key factors affecting career choice by female doctors: interest, flexibility, women friendliness and job security. The Elston (2009) report on women in medicine recognises the importance of ensuring women doctors are incorporated into the workforce for the benefit of patients. They also considered the approximately 60 UK medical specialties from two perspectives – whether or not they are people-oriented or technically-oriented and whether they are more 'plannable' or more unpredictable – and indicate that 'women on average prefer more people-oriented, plannable specialties' (p.6). However, this concern for the increase in women medical students and its potential impact on the workforce is not supported by Goldacre *et al.* (2009b), who argue that more medically qualified women will not reduce the percentage of doctors available to work in the NHS. Rather, they argue, it is the likelihood that women will want to train part-time, and this would need to be factored into work planning; this view is supported by Taylor *et al.* (2009), who indicate that women's career progression in medicine may be indirectly affected by more flexible working patterns like part-time working. Tregoning *et al.* (2009) propose the need for more longitudinal research in the UK to consider the implications of family-friendly medical careers.

Most of the studies into career and specialty choice discussed so far have been quantitative. In Canada, Mihalynuk *et al.*'s (2006) mostly qualitative study looks at the free choice of clerkship electives, which medical students undertake during medical training as a way of experiencing a particular specialty. This free choice is seen as beneficial, and the clerkship as an important landmark in career decision-making.

There has been some development of career resources for postgraduate doctors in the UK, for example Elton and Reid (2007, 2010), Sci59 (originally Sci45) – a specialty choice inventory developed by the Open University (Gale and Grant, 2002; Stern, 2005) – and the NHS medical careers website (http://www.medicalcareers.nhs.uk), which has been reviewed by Mellors-Bourne (2010). Tools and resources to aid specialty choice are the subject of an extensive literature review carried out by Borges and Savickas (2002). Their findings indicate that the Myers Briggs Type Indicator (MBTI) was the most frequently used psychometric instrument to support medical specialty choice. However, MBTI represents just one of a wider range of resources that are available to people who work in careers and in coaching (Carr *et al.*, 2008).

To summarise, research into the medical career pathway identifies the importance of providing information and advice to doctors to assist them in making career choices,

with the general premise that career support should be provided by supervisors (i.e. clinicians). It also suggests that as far as career destinations for doctors are concerned, the supply of posts is a determinant in career choice for doctors; the cost of training doctors is significant; and doctors do consider alternative career paths, including leaving medicine. Some of the key issues are: the timing of a doctor's career choice; the career opportunities available to them; and how there is limited consistency in how career support is provided to postgraduate doctors. Existing research does not take account of a more developmental approach to the provision of career support or examine how it should be provided.

Career decision-making

There is a wide range of overarching theories of career decision-making, as well as models, processes, tools and techniques to assist with making a specific decision. One of the most well-known overarching theories is Holland's theory of interests (Holland, 1973), which is an example of a person–environment fit model. Kidd (2006, p.15) indicates that:

'... the most important tenets of the theory are that: people and occupational choice can be categorised into six interest types: realistic, investigative, artistic, social, enterprising and conventional; occupational choice is the result of attempts to achieve congruence between interests and environments; congruence results in job satisfaction and stability.'

Within medicine, a number of studies have considered how this potentially attractive model can be used to understand and support career choice (e.g. Petrides and McManus, 2004; Borges *et al.*, 2004). Borges *et al.* (2004) argue that medical students could fit into several different medical specialties, and that Holland's model could be used 'to explore how well their personalities can be expressed in different specialties and practice environments' (p.188). Earlier research by Furnham (2001) suggests, though, that Holland's model, which is based on the notion of person–environment fit, implies a level of stability both in terms of jobs and people. The medical profession is changing in response to a wide range of factors including sociological and technological change, and there is a perception that there is a level of uncertainty within a medical career, so Holland's model may not be appropriate to medicine.

The work of Super (1955) considers career decision-making from a developmental perspective and argues that individuals may need to make a series of decisions during their careers. His developmental theory proposes there are a number of stages a person goes through: exploration, establishment, maintenance and disengagement. The exploration stage is an important part of career choice (Inkson, 2007, p.67), and

there are particular implications for medical careers as there may be limited opportunities to explore potential career choices depending on the subjects studied and experienced in UK medical and foundation schools.

Reid (2005) discusses the use of narrative-based approaches and how they can help people manage the changing world of careers; an approach that is also supported by the work of Savickas *et al.* (2009, p.239), who argue that the 'new approaches are needed to meet the needs of 21st century clients'. McIlveen (2007, p.296) says that Savickas' theory of career construction 'addresses the subjectivity of career' and that 'career is generated through conversations'. Bimrose (2006, p.6) also supports the use of narrative approaches with clients, as her view is that these approaches place more value on 'the softer outcomes of the career guidance process, like the development of career decision-making skills or helping the client to achieve a higher level of personal self-awareness'. Bimrose (2006) goes on to suggest that there are important questions related to why practitioners do not use these newer approaches. Giving clients the opportunity to tell their stories can help develop their understanding of the concept of a career and what is possible for them. A narrative approach with an emphasis on 'meaning' provides the opportunity to place the clients' goals in context, which leads to realistic plans.

Much of the current research into medical careers is either quantitatively based or utilises a small number of career decision-making theories: for example, Holland's model (Petrides and McManus, 2004) and narrative approaches (Savickas, 2003). Law (2006, p.4), though, proposes that 'to tell a story is not to provide hard evidence'. However, the work of a career coach involves listening and helping clients understand their stories so they can understand what they want from their career. Narrative approaches in clinical practice are supported by Greenhalgh (1999).

Writers have also presented the notion of a career using a range of metaphors: for example, careers as 'roles' or positioning, where a person occupies a variety of roles within their occupation (Inkson, 2007); or as 'journeys', where the career is defined by a professional occupation (Inkson, 2007, p.133). Understanding how doctors see their careers in these terms is not discussed in the literature on medical careers. The majority of research on career decision-making for doctors has been informed by the work of Holland, for example, rather than a developmental approach that is more akin to coaching.

Ibarra (2002), in her work with people considering mid-career transitions, raises concerns about the 'test and tell' approach to career support, and proposes that 'we are many selves' (p.43). She introduces the notion of work identity, which includes the sense of our own self in our professional role, how we live our working lives, and the stories we tell about what we do and how we arrived at where we are (Ibarra, 2002). Ibarra (2002) also proposes that working identity is a process of experimenting, testing and learning about our possible selves. This work is interesting, as it suggests it takes time to make a career change, and that this change should start with action and then bring in reflection.

Work identity is also seen as central to job performance (Patton and McIlveen, 2009). The notion of a work identity does have relevance to medical students and doctors, as they may find their early career choices about where, for example, to apply for their foundation programme, difficult to navigate (Thomas, 2008). They can also be unclear about the expectation and demands of the working environment in a hospital or general practice and the roles they will inhabit as a doctor. Difficulties in securing their medical career choice can have a significant impact on work identity for medical students and doctors, and may lead them to reassess their career choice. In some cases, doctors feel they are imprisoned in their work and that they have invested their own time and resources in pursuing it (Inkson, 2007, p.33). Medicine as a university subject is very competitive and generally attracts people with high academic achievement. Medical students can experience difficulties when applying for the foundation programme, and find themselves in a foundation school that was not their first choice. It may be the first time they have 'failed' to pass something they see as important, and this can lead to them needing to redefine their own view of success. Many medical school curricula are limited in their scope to cover key career development constructs like career self-efficacy, an individual's personality, and career decision-making (Sugarman, 2001).

In summary, researchers considering medical career choice have utilised person–environment fit theories like Holland's (e.g. Petrides and McManus, 2004; Borges *et al*., 2004); however, less use is made of developmental and narrative-based theories. Considering the use of narrative in medicine is supported by the work of Greenhalgh (1999). A narrative approach to careers and a more developmental approach supported through coaching is the main focus for this study.

Two further aspects in the literature are considered next.

1. Models, processes, tools and techniques to support specific decisions

In their professional work, doctors are expected to diagnose and treat patients as a key part of their role. Medical decision-making is therefore an important competence for doctors to develop, and much is written about it (e.g. Harries and Ayton, 2007; Whitney *et al.*, 2008). When it comes, though, to making career decisions, there is a separate range of career literature proposing models, processes, tools and techniques. Some writers propose that a rational approach to career decision-making is possible (Inkson, 2007, pp.119-120), and others identify styles of decision-making like Harren's (1979) three styles: rational, intuitive and dependent. Whereas Egan (2007, p.237) recognises the messiness of career decisions and that there are no perfect career decisions, he does, though, offer a balance sheet approach to decision-making. Lawson and Hoban (2003) review a number of career decision-making theories in medicine, and Broscio and Scherer (2003) propose a more rational approach based on a prescriptive six-step framework. More recently, Krieshok *et al.* (2009) argue that the scientific approach to decision-making has been called into question, and that both rational and intuitive approaches are essential to vocational decision-making.

Outside medicine, decision-making models that take account of both rational and intuitive approaches to decision-making have been developed. Snowden and Boone (2007) describe a framework that considers the unpredictability of the business world and its impact on leaders' decision-making; in contrast, Megginson and Clutterbuck (2005, p.71) offer a more intuitive exercise that uses values in a decision-making matrix. However, within the vocational decision-making careers literature, recent work by Krieshok *et al.* (2009) discusses the ongoing move from matching processes to ones that are more about adapting to change, which is relevant to doctors as they are likely to make a series of choices throughout their career. In order to make those choices, Bubany *et al.* (2008) argue that approaches to decision-making that include interdependence, experience, intuition and emotion are more appropriate in a changing environment than the rational approaches that seem to dominate the career decision-making literature. Within the medical careers literature, an example of an intuitive approach to decision-making is offered by Elton and Reid (2010, p.53) with their ROADS checklist, which is based on a series of values that recur in the medical career choice literature and is quoted as follows:

- Realistic – are you being realistic about yourself AND the demands of the job?
- Opportunities – have you given serious consideration to all the opportunities available?
- Anchors – have you built in the things which give you support in your life?

- Development – do your choices fully develop your potential?
- Stress – have you considered those aspects of your work that create particular stresses for you?

Krieshok *et al.* (2009) assert that vocational adaptability has its antecedents in the work of Super (1955) and his construct of career maturity, which is all about a person's readiness to make educational and vocational choices. This construct is particularly relevant to a career in medicine. A student's decision to study medicine at university can start with their A level choices at the age of 16, and then with their choice of where to take their undergraduate degree. Individuals develop and mature through their late teens and early twenties (Sugarman, 2001), and when faced with further decisions such as where to complete their foundation programme and which specialty programme to apply for, the approaches used to support their earlier educational choices do not always translate into making further vocational choices. Krieshok *et al.* (2009) offer a decision-making model that is trilateral, incorporating intuition, reason and occupational engagement. They make the case for occupational engagement as a mechanism to enable adaptive career decisions, and provide occupational engagement scales for students and workers. This occupational engagement can be difficult for postgraduate doctors to engage in if the doctor is not allocated to a foundation programme that contains a work placement in the specialty they intend to be their future career. Foundation programmes are allocated on a competitive basis, and allocation to a programme currently depends on the students' academic score and completed application form. This can lead to difficulties with making career choices. The UK foundation programme promotes the use of 'tasters', where a doctor spends up to a week in a specialty they are interested in, and this aspect was specifically discussed in the Collins report (2010), including a recommendation on how to improve this aspect of career development.

Another concept relevant to medical career choice is Super and Knasel's (1981) concept of career adaptability. Advances in medical research and technology together with patient demographics mean that specialties are not static, and the work that a hospital consultant undertakes today may not be what will be expected of a consultant in 5–10 years' time. Doctors choosing hospital specialties are likely to be able to apply for consultants' posts in the next 10 years and so be able to adapt to changes in the work of the specialty and to changes in what the role demands to be important. Bimrose and Barnes (2007, p.43) recognise that 'the centrality of career decision making to career advancement is widely acknowledged', and within medical careers that choice is made to take a particular training pathway that leads eventually to a

consultant post. That pathway can be difficult to change once a doctor is developing along it.

The recent changes to the medical career pathway discussed in the introduction generated a certain amount of anger and sadness in medical students and junior doctors. Supervisors have found it difficult to navigate their way through the new pathways and advise accordingly. Lerner and Tiedens (2006, p.125) in their research recognised the impact of anger on judgement and decision-making, and suggested that 'people are particularly sensitive to emotional stimuli that reflect their own emotional states'. While this view is of interest, raised emotions linked to the introduction of the medical training application system in 2007 resulted in policy changes within the MMC programme. One change involved the removal of run-through training in some specialties (for example, surgery), which have now become uncoupled. Entry into core training and subsequent entry into higher specialist training are both competitive processes, and there are no guarantees a doctor can progress smoothly from core into higher training. Run-through did provide this certainty, provided a doctor was progressing satisfactorily. Additionally, concerns are still being raised about the information needed to support career choice in medicine (Collins, 2010) and how best to support the process.

2. Supporting career decision-making

The value of providing support with career decision-making has been the subject of recent research by Bimrose and Barnes (2007), who have been tracking 50 individuals (not doctors) who received guidance interviews over a five-year period. They propose that 'the process of using information about options to increase aspirations and progress careers is central to career decision making, which in turn is a central feature of the guidance process' (Bimrose and Barnes, 2007, p.21). In their research, Bimrose and Barnes (2007) identify a number of career competencies: researching employment and/or course requirements, seeking employment, education and/or training opportunities, understanding labour market conditions, writing a CV and/or job applications, interviewing skills, reflecting upon options and decisions (with others), demonstrating confidence in career decisions, and using effective networking and communication skills. The study also identifies insights into changes to occupational and personal roles, skills and competence development, and influences on progression. Guidance was regarded as useful when it challenged ideas and understanding, inspired self-confidence, increased self-awareness, gave direction, provided access to information, and structured opportunities to talk to a professional. The research identifies a fourfold typology of career decision-making – the styles

identified are: strategic, evaluative, aspirational and opportunistic. The people taking part in the study are seen to have career resilience and the ability to proactively take charge of their careers by managing challenging and difficult circumstances. In contrast, these areas have not been explored specifically with doctors, as much of the medical careers literature is focused on specialty and career choice rather than how career management is supported in medical education.

Baruch (2004) recognises the change in career systems from the more hierarchical, linear approach to multi-directional career systems with consequential changes to how employees view their psychological contract (Patton and McIveen, 2009). Ng and Feldman (2008) in their longitudinal study of organisational commitment identify age, work experience and stage as important variables with regards to the relationship individuals have with their employers. Baruch (2004, p.60) argues that organisational structures, cultures and processes are essential inputs to career systems and that 'new models of career systems are required, that will better fit these changes in both organisations and the wider environment'. The research indicates that the academic careers model is one to consider for employees of organisations. This model is 'built around professional challenge, the learning environment and professional, rather than institutional commitment' (Baruch, 2004, p.68). It does seem to offer a possible way forward for medical careers, although one aspect – institutional commitment – would need careful consideration: doctors provide a key service to the NHS and are bound by an ethical code determined by the GMC (GMC, 2006), so their 'institutional commitment' is both to their NHS employer and the GMC from which they gain their licence to practise.

Bimrose (2006) argues that our occupational identity is built through work, informs how we relate to work organisations and how we develop skills and knowledge. In times of significant change, Bimrose (2006) indicates that occupational identity can be developed through communities of practice (Lave and Wenger, 1991) and they can help individuals cope with the pressures and stresses of work. In addition, Eraut (2005) has considered professional learning in relation to the new surgical curriculum, and Playdon and Tavabie (2011) discuss the development of communities of practice in medical education literature, and consider it an important aspect of medical education.

Doctors are seen as having professional careers (Inkson, 2007, p.133), and their career path encourages the development of expertise and eventually sub-specialisation. The BMA report (2008, p.4) on professional values identifies that 'competence to practise medicine' is the most important core value for doctors from

their two cohort studies (1995 and 2006 cohorts). The BMA report (2008, p.6) goes on to say that: 'Professionalism expresses a profession's culture and it should epitomise good practice' and that: 'The doctor–patient relationship must be the keystone of professionalism'. Part of a doctor's work identity relates to their view of professionalism and values, and key to their career decision-making is developing an understanding of how their values influence career choice.

Coaching doctors

A literature search found no empirical studies relating to career coaching and doctors, although there are commentators who have written about career coaching doctors using the GROW model (Shelly, 2007), and those providing career coaching (Chambers *et al.*, 2006); coaches who use the MBTI (Houghton, 2005b, 2006), run coaching and mentoring schemes for doctors (Bhatti and Viney, 2010), and those who use neurolinguistic programming (Kersley, 2006). A number of writers discuss the use of life coaching (e.g. Kersley, 2005; Chambers, 2005; Gooneratne, 2007), leadership coaching (Gowan, 2010) and executive coaching with doctors (Sauerberg and Prunty, 1999). Manek (2004, p.1) describes coaching for doctors as a 'road to salvation'. Katz and Morahan (2006) propose that accomplishments can be dissected with a career compass, and that career coaching can help determine the paths and processes that can help a doctor arrive at their desired career destination.

Sauerberg and Prunty (1999), in their review of the use of executive coaching with physicians in the United States, recognise the value of coaching in physicians' personal development. More recently, Gowan (2010), in her work on coaching clinicians for leadership, proposes the value of coaching to support survival in a tough career. This study concludes that coaching is a vital component of leadership development for doctors. It also identifies the importance of a safe space to explore the impact of their career choices. The value of coaching as a learning strategy to support doctors' personal and professional development is recognised by COPMeD (2009), and the Deech report (2009) includes recommendations to improve access to mentoring and careers advice by future commissioners of medical education seeking to identify those doctors with skills in this area. Despite all these suggestions for adopting coaching as a way of supporting doctors' development, there do not seem to have been any empirical studies investigating whether or not coaching would be an appropriate way of supporting doctors' career decision-making.

Providing career support and coaching are relatively new areas within the medical profession, and there are few published articles on the subject. Commentators like

Shelly (2007), provide a range of career coaching resources to support trainers and supervisors working with doctors applying for specialty training, utilising the GROW model (Whitmore, 2002), and include an outline of the skills and responsibilities of the coach. Chambers *et al.* (2006) also propose a framework for a coaching session. What neither of these commentators do is base their work on both coaching and career decision-making theory.

In contrast, coaching and career coaching within the nursing profession is more widely established. Alleyne and Jumaa (2007) propose that their executive co-coaching programme with primary care nurses contributes to improvements in the management of change, and that it has a positive impact on the provision of district nursing services. The Center for American Nurses (2007) emphasises that career coaching can help nurses set goals for their career and that working with a qualified coach can help both novice and expert nurses. Donner and Wheeler (2005) in their work with nurses support the view that the client is the expert and the one that makes change happen as a result of coaching. They say that the coaching conversation is all about possibilities and action, and that career coaching can assist individuals with a broad range of career planning and development areas. Donner and Wheeler (2005) view coaching as a conversation built on mutual trust, and that the coach must be someone whose expertise and approach the client values and trusts. Chin (2008) supports the view that coaching and mentoring are learning and development interventions that help people stop and reflect on situations they are in to help them find pragmatic ways to transform them. These studies in career coaching for nurses indicate that it can have a positive impact on the provision of patient services and care, an endeavour that is equally important to doctors. However, they are largely US studies, operating in a different health care system to the one in the UK.

Mentoring is an approach that has been used more widely than coaching with doctors and other health-care professionals (e.g. Redfern, 2004; Donner and Wheeler, 2007). French (2007) says that in 2007 over 50 mentoring schemes for doctors were being developed in the UK. His view is that the power of mentoring lies in its use as a way of developing opportunities as well as solving problems. French's view (2007) is that medicine, with its changes to the medical career pathway, is moving away from the sponsorship model of mentoring linked to the medical apprenticeship approach, towards the need for mentees to take ownership of their own goals and solutions. French (2007) indicates that the mentoring approach is likely to challenge doctors' skills development to ensure that those who are acting as mentors avoid jumping to solutions when working with doctors. Steven *et al.* (2008, p.552) say that it is: 'probable

that organisations would be strengthened by doctors who feel more satisfied and confident in their professional roles as a result of participation in mentoring'. However, the definition of mentoring used in medicine can align more to sponsorship mentoring and patronage, where the mentor is an experienced senior doctor in the specialty the mentee is interested in, rather than the more developmental approaches (Megginson and Clutterbuck, 2005).

Taylor *et al.* (2010, p.189) identified that the need for careers advice does not just apply to postgraduate doctors. A total of 31.5% of NHS doctors report having unmet needs for advice about planning their future, and low job satisfaction and low levels of satisfaction with their leisure time were associated with these unmet needs. Approximately a third of those who reported unmet needs wished to develop or change their career in medicine. This survey of more senior doctors highlighted the need for career development on a lifelong career basis as well as access to counselling and mentoring, and called for 'some sort of continuing informal mentoring' (Taylor *et al.*, 2010, p.189). Concerns, though, were raised by participants about its availability, the time it might take, impartiality and confidentiality. There was also some support for peer mentoring, an approach that Le Cornu (2005) proposes challenges the traditional assumption that the mentor knows best.

There are no studies so far, though, into the use of either coaching or mentoring to support doctors' career choices. What has not been considered is the use of aspects of coaching like goal setting, underpinning models, essential processes, and the roles of the coach and client. Additionally, the medical career literature has not considered some of the emerging career theories like narrative (Reid, 2009) and happenstance (Shottin, 2010). As a practising coach, my interest is in using coaching with doctors, and the focus for this study is on how coaching can support doctors to make career choices. This study will give an opportunity to research coaching within a medical professional setting.

Summary

Providing support to medical students and postgraduate doctors continues to be of interest in the medical education literature, albeit with little research into how it should be provided. What much of the research into medical career pathways in the UK has in common (Goldacre *et al.*, 2010; Lambert and Goldacre, 2007; Deech, 2009; BMA, 2010; Collins, 2010) is that these studies raise the importance of providing career information and advice to doctors to assist them in making career choices, and in the case of Collins (2010), to avoid making costly wrong decisions. They identify the need

for career support and that it is important for medical education, but do not explore how it should be provided. The general premise is that career support is provided by senior colleagues, clinical and educational supervisors (also called trainers), and medical education organisations – for example, Royal Colleges, deaneries and the BMA – within a clear structure (BMA, 2010; Miller *et al.*, 2010). This also reflects the approach taken by my own organisation (see Figure 1.3), where access to the careers team is on a referral-only basis.

Doctors in postgraduate training programmes are both in education and employment, usually within the NHS. For example, the UK foundation programme has both an operational framework and a curriculum that is supported by the foundation programme portfolio, which every foundation doctor is expected to use to record their educational achievements and the results of their assessments. A section of the portfolio is available to record thoughts on career choices that are being considered. Changes to the operational framework and curriculum to encourage the development of career choice and decision-making have been included in the recent update to these documents. Progress has been made to provide resources to help support medical students and doctors in the foundation programme to make career choices. However, career development in work programmes (Cedefop, 2008, p.33) can lack clear objectives and have difficult to implement self-help strategies, and employees can be suspicious of employers' motives. The requirement to include career management in medical education is recognised by a number of reports (e.g. Tooke, 2008; Collins, 2010). The needs of both the individual and the organisation should be considered, and Cedefop (2008) recognises the importance of individuals being able to acquire the skills necessary for successful career management, and that there is a major trend in guidance provision towards self-help strategies, although much remains to be done to provide career development to people in organisations; this is a situation that is certainly a concern for medical careers in the UK, where the focus is on the structure of career support rather than on a consideration of how it is delivered on a one-to-one basis.

While mentoring has been mentioned by a number of writers as being a potential way forward to support junior doctors' career development (BMA, 2003; Straus *et al.*, 2006; French, 2007), it can be seen by doctors as a remedial approach with a longer time frame than coaching. There is also considerable debate in the literature on what the difference is between mentoring and coaching (Macafee and Garvey, 2010). The value of coaching as part of career management is recognised in nursing (Hadikin, 2004, Redfern, 2004; Donner and Wheeler, 2007).

Currently part of the work I do as an internal coach is to coach individual doctors who have been referred to me for career support. My work with doctors in postgraduate training programmes and their consultant supervisors means that I am particularly conscious of the way the profession operates with its keen interest in evidence based medicine and quantitative research. Doctors often make referrals to other health professionals to seek an expert opinion, together with the requirement for a report, to assist with a patient diagnosis.

One of the challenges I face as an internal coach is to be cognisant of the needs of the individual and of the organisation particularly when a doctor is considering leaving medicine. Issues around confidentiality need to be carefully negotiated (St John-Brookes, 2010) and the limitations explained to doctors I coach. A further challenge is related to when I coach and when I refer on. Recent work by Maxwell (2009) has considered the boundary between coaching and therapy. One feature of the work I do with doctors is that they may have health issues which are impacting on their career choice and potentially on their work as a doctor. I do need to consider confidentiality (Maxwell, 2009) particularly with regards to the doctors own safety and that of their patients. Doctors are bound by the GMC's code of practice.

I regularly draw on a wide range of literature and sources when I develop materials for my work; both the sociological and psychological aspects of career theory (Kidd, 206) are relevant to medical careers. Medicine as a profession can be seen as a bounded system with a defined career structure and doctors are particularly interested in diagnostics and testing. Deaneries that utilise a career coaching approach (Shelly, 2007) to support doctors making career choices are in the minority. Research is urgently needed to explore how coaching can support doctors to make career choices, and this is the focus of my study.

In Chapter Three I explain the research design for this study.

Chapter Three – Methodology

The aim of this study is to explore how coaching can support doctors to make career choices. It was developed through the reading of the literature, and the following sub-questions are explored:

- What is the personal impact of coaching on doctors (as clients)?
- What aspects of coaching contribute to specific career choices made by doctors?
- Who are the main providers of coaching to doctors and how do they operate (the coaching process)?
- Within medical education what are the key components of a career management system for doctors?

In this chapter I discuss the chosen paradigmatic and methodological approaches and explain how the research subjects were selected. Then I describe data collection methods, and explain the data analysis framework and how the data is presented. Finally, I discuss validity, reflexivity and ethical issues.

Paradigmatic and methodological approaches

One of the key reasons for doing this research is to enhance our knowledge of coaching with doctors and to inform professional practice. Central to my own practice is social constructivism, as there is an emphasis on 'the proactive nature of human knowing, acknowledging that individuals actively participate in the construction of their own meaning' (McMahon and Patton, 2006, p.4). Also of importance is a consideration of the notion of truth, and whose truth it is (Riessman, 2008). My own epistemological position is that knowledge is assumed to be experiential, personal and subjective, and socially constructed. The chosen methodology and methods for this research therefore focus on engaging in talking and exploring people's experiences.

As a researcher working in the field of medical careers I wanted to understand how the methodology conceptualises what Willig (2008) refers to as the role of the researcher in the research process. My own relativist ontology suggests that, as the researcher, I will be a central figure in the research process and will 'construct' the findings. A key principle of constructivism is the notion that knowledge is created rather than discovered. As a coach and a researcher I am a social constructivist (believing that an individual creates knowledge in a particular context – the 'I' perspective) and a constructionist (believing that the group creates knowledge in a context – the 'we'

perspective). This study takes a qualitative approach and will involve participants who coach and those who have been coached.

In developing the methodological approach, a number of approaches were actively considered: action research, grounded theory, the narrative approach and case study.

The initial research proposal considered the use of action research (McNiff and Whitehead, 2009) to help develop a coaching framework through a number of action research cycles using coaching clients. This was a particularly attractive approach, as the research could be planned and managed more closely through the research cycle, and there was the possibility of developing a forward momentum for the research. As a well-established and practised project manager, this also appealed to my own personal skills, abilities and knowledge. The people I coach are doctors, and many of them are referred to me by their educational supervisors and/or training programme directors because it is felt that they would benefit from more in-depth career support. Furthermore, the issues they bring to the coaching vary widely, and in many instances there are some elements relating to career choice, not all of which are directly identified by the clients. The nature of the work I do with them is confidential and it is important that this be maintained. I do have a responsibility to my clients to maintain that confidentiality, and also to the wider context of their own work, where confidentiality and patient safety are both important.

In developing an action research methodology, one area that was a particular concern was how I would recruit participants to the research. The pattern of referrals for career support of doctors on either foundation or specialty training programmes is unpredictable. I could not be sure I would have enough people to work with for each action research cycle, and the majority of clients are referred, which brings into question the nature of the relationship I could develop with them. The referral is carried out through a training programme for which the deanery has overall responsibility through the Head of School for that particular programme. There is a potential power relationship here and a conflict with my own value of providing support to an individual (McNiff and Whitehead, 2009, p.111), which aims to meet their needs first and foremost. I did not wish to be in a situation where a condition of being referred for career support was that the person would also be asked to take part in the research in order that I had sufficient people to meet the requirements of an action research cycle. The needs of the individual for career support must take precedence, and so action research was discounted as a research methodology for practical and ethical reasons.

A key part of my research is the development of a framework for providing coaching to doctors, and grounded theory was investigated. The intent of a grounded theory study is to generate or discover a theory (Strauss and Corbin, 1998) through working with a number of participants: the theory is grounded in the data. Charmaz (2006, p.130) has argued for a constructivist grounded theory that 'sees both data and analysis as created from shared experiences and relationships with participants and other forms of data'. In my work at the deanery I inhabit a number of different roles that influence my thinking on careers and career theory. As a coach, I have developed a way of working with my clients over a number of years, including my own framework for coaching individuals. I am also an educator and run postgraduate programmes in managing medical careers. Developing a coaching framework for doctors that is grounded in the data from my research is attractive; however, I am likely to bring my own pre-conceived ideas and assumptions into the research, as well as my own values (Charmaz, 2006, p.131). What I already know is a challenge for this approach (Madill *et al.*, 2000) and for this reason I did not selected grounded theory as my overall methodological approach.

Another approach I considered was narrative enquiry. The use of stories in career support has grown as a method of helping to support clients (Savickas, 2005). Coaching clients do bring stories into their sessions, and we use these to help them understand their own career history and illustrate some of the difficulties and challenges they face, and how they might see how they can get to where they want to be. In order to develop a coaching framework, I am interested in the stories clients tell me, as well as the perspectives of those who provide career support, including my own story. Narrative enquiry is used to capture detailed stories or life histories (Creswell and Plano Clark, 2007, p.55); however, such depth is not appropriate for this research, as I am looking for short rather than 'life' stories to illustrate a coaching framework. There are also similar issues with regard to confidentiality, as there were in action research. However, there is a link in the literature to the use of narratives in providing career support (Savickas, 2005), so narrative interviewing forms an important part of the data collection methods chosen for this research.

After careful consideration, the methodological approach that has been chosen for this research is case study. Yin (2009, p.4) indicates that case studies are appropriate for explaining a present circumstance: for example, how a social phenomenon works. This research seeks to explore how coaching can support doctors to make career choices. It is within a 'bounded system' (Stake, 1995, p.2), that is: careers within a medical education context. The level of the case is coaching with doctors, and it is contextually

based as it is situated within the NHS medical profession. Simons (2009) also suggests that there is a tradition in using case studies in medicine and for education evaluation projects, both aspects of which are represented to some extent in this research.

Yin (2009, p.8) proposes three conditions to consider when deciding on a research strategy: (i) the type of research question posed; (ii) the extent of control the investigator has over actual behavioural events; and (iii) the degree of focus on contemporary as opposed to historical events. The research question under investigation is a 'how' question; it does not require there to be any control of behavioural events, and there is a focus on contemporary events. This would indicate that a case study approach is appropriate for the research question under consideration.

In addition, Simons (2009) recognises a number of key strengths in the use of case studies for qualitative research. Important amongst these is the opportunity to study a project in depth, and for it to be interpreted in the context in which it is enacted. Case studies can explore the processes and dynamics of change in a particular context, which is crucial for this research, as the medical career pathway has recently been impacted by a significant change: the MMC programme. This study aims to document multiple perspectives, and Stake (1995) proposes that case studies can vary depending on how they honour multiple realities. Another key feature for case studies is flexibility and that they are not constrained by time period or method (Simons, 2009). This link to method provides important flexibility for the researcher.

The selection of a case study approach also provides an opportunity to consider a number of different perspectives within the case itself, and data analysis will be carried out using thematic analysis (Braun and Clarke, 2006) to develop themes (Willig, 2008, p.44) that will inform the coaching framework. The research question, with its focus on doctors and their career choices, carries an implication within it about the use of stories. The move to evidence-based medicine is a relatively recent change in the last 20 years or so, and teaching and learning in medicine has been based on stories for much longer (Greenhalgh, 1999). The use of stories gathered through interviews with participants within this study will complement the case study research and enable the representation of participants' perspectives through the use of their actual descriptions (Madill *et al.*, 2000).

Selection of research subjects

In relation to the choice of research subjects, the aim was to include a range of participants and ensure their voices were represented. The potential research subjects for this study fell into two main groups: (i) providers of career support and (ii) people who have been coached. Within the medical field a range of people provide career support to medical students and doctors; they include medical careers advisers, doctors (educational supervisors, clinical supervisors and associate deans) and other external bodies like the BMA and private coaches. The credibility (Bosley *et al.*, 2006) of the person providing career support, or the helper in this research, is an important aspect of the relationship. Bosley *et al.* (2006) indicate that this concept of credibility reflects the key features of the career helper that the recipient of their help experiences as relevant and useful.

The providers of career support all have a postgraduate qualification in careers and/or training in coaching (see Table 3.1). This is a limited number of people within the UK, so all 13 interviewees came from two of my networks: the National Education Advisers Forum (NEAF) careers group and the Medical Careers Advisers Network (MCAN). In addition, I used the snowball approach to sampling (Robson, 2002, p.266) and followed up people who were suggested to me. This proved an effective method of recruiting research participants. The providers of career support fell into one of the following categories: career counsellors in deaneries, associate deans (doctors) in deaneries with responsibility for careers, career counsellors from university careers services, and freelance career coaches, most of whom had trained and practised as doctors. The majority of coaches interviewed were women, and this is similar to the findings of Sultana and Watts (2005, p.69), whose research into career guidance provision in Europe found that the majority of career guidance staff tended to be women.

Table 3.1 – Demographics of the coaches who were interviewed for this study

Organisation	Male	Female	Medically qualified	Non-medically qualified	Total	Coach identifiers
University careers service, working with undergraduates and postgraduates	0	2	0	2	2	C1 and C2
Deanery-based, working with postgraduate doctors	1	5	3	3	6	C4–C9
Freelance coaches	1	4	4	1	5	C3 and C10–C13

The coaches interviewed for this research have a variety of backgrounds and training pathways, as outlined in Table 3.2.

Table 3.2 – Coaches' backgrounds and training

Organisation	No. of coaches	Background and training
University careers service	2	Both are qualified careers practitioners and one has a master's in occupational psychology
Deanery-based coaches	6	Most are qualified careers practitioners with additional specific qualifications: • Chartered occupational psychologist • Human resources with special interest in learning and development • Master's in mentoring and coaching in an organisational context • MBA with a dissertation on mentoring • Postgraduate foundation certificate in psychotherapy and counselling Trained in MBTI Egan-trained mentor
Freelance coaches	5	More than half with a psychotherapy background One with a wider consulting background Range of coaching courses and accreditation: including behavioural, leadership, life, NLP and solution-focused coaching Trained in MBTI

In order to select doctors who had been coached, I took a non-probability approach to sampling (Robson, 2002, p.264) and approached all the people I coached who I had met at least twice. This was done to ensure that there had been at least one follow-up session after the initial meeting to see if there had been some change and/or follow-through, and to give some idea of the effectiveness of the coaching. One concern was the likely success rate of inviting people to be interviewed, as many of them are no longer in the region. The expectation was that the majority of these interviews would need to take place over the telephone. For this reason, participants were given the option to complete a simple qualitative-based questionnaire as an alternative to an interview. Data was collected from five doctors in total. Three completed questionnaires (all female and either in the foundation programme or early in their specialty training); three were interviewed (two males and one female who came to coaching to review their career choice); and one female doctor completed the questionnaire and took part in a follow-up interview. Further information on the characteristics of the client respondents is included in Table 3.3. Their reasons for seeking career support initially were either that they were finding it difficult to make a career decision, they were

considering leaving medicine, were unhappy with their specialty choice and/or wanting to identify alternative careers. In all cases they could be said to be in transition between what Super (in Kidd, 2006, p42) describes as the career exploration and establishment phases.

Table 3.3 – Characteristics of client respondents

	Reason(s) for seeking career support			
	Finding it difficult to make a career decision	**Considering leaving medicine**	**Unhappy with their specialty choice**	**Wanting to identify alternative careers**
Working as a foundation doctor	D4 D6	D4 D6		D4
Working in a specialty	D1 D2/D5 D3		D1 D2/D5	D1 D2/D5 D3

An area of concern was that the postgraduate doctors might be thought to have been in a dependent relationship with me as the researcher (Simons, 2009), and the option of a qualitative questionnaire enabled the doctors to choose how they would like to participate in the research.

Choice of data collection methods

I identified a number of different research subjects and used interviews as the prime method of data collection (Kvale, 2007), together with my reflexive diary. How the research questions map to the data collection methods is shown in Table 3.4.

Table 3.4 – Research questions mapped to data collection methods

Research question	Data collection point
What is the personal impact of coaching on doctors (as clients)?	Interviews with coaches and providers of career support Interviews/questionnaires with clients Own reflexive diary
What aspects of coaching contribute to specific career choices made by doctors?	Interviews with coaches and providers of career support Interviews/questionnaires with clients Own reflexive diary
Who are the main providers of coaching to doctors and how do they operate (the coaching process)?	Interviews with coaches and providers of career support
Within medical education what are the key components of a career management system for doctors?	Interviews with coaches and providers of career support

An overview of the data collection process is shown in Figure 3.1 and each process is then described in turn**.**

Figure 3.1 – Data collection process
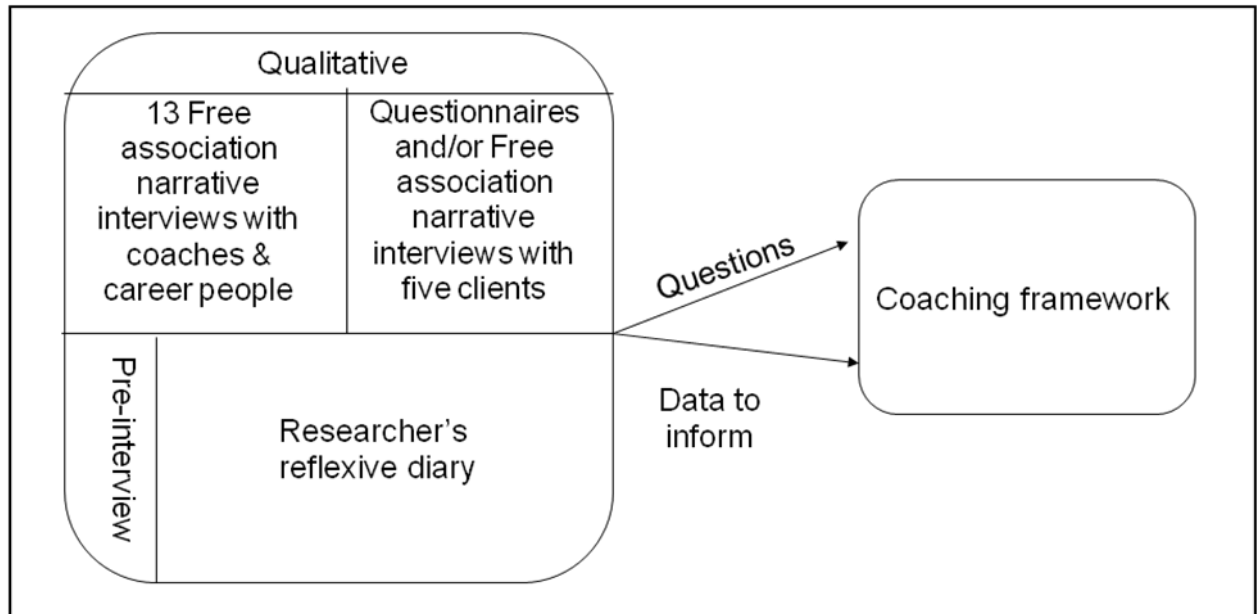
1. Interviews with coaches and providers of career support

The first phase of data collection comprised 13 interviews with providers of career support. The initial plan for the interviews was to use a semi-structured approach (Robson, 2002), with a few broad open-ended questions aimed at being non-judgemental, (Charmaz, 2006) as follows:

- What career support and/or coaching do you provide? How is it organised?
- What are your thoughts about coaching, mentoring and counselling?
- What kinds of career issues are brought to sessions with you?
- What kind of outcomes come from your coaching?
- Do you have any examples of critical incidents, turning points (De Haan *et al.*, 2010) and 'aha' moments experienced by your clients during coaching?
- How might coaching be used to support others?

Coaching, by its very nature, can involve interviews of varying duration that take place either face-to-face or over the telephone; there are also coaches who coach using email and other internet-based methods. The interviews that were set up with providers of career support were a mixture of face-to-face (nine interviews) and over the telephone (four interviews). It was important to ensure that participants did much of the

talking (Charmaz, 2006). All the interviews were recorded and transcribed verbatim (Braun and Clarke, 2006).

When I reviewed the transcript from the first completed interview, I realised that once I had asked the first question 'What career support and/or coaching do you provide?' that I had not asked the remaining questions in the order I set out on the interview schedule. What I tended to do was follow the flow of the conversation and pick up on aspects and issues about their interactions with clients. When we reached the natural end of the conversation I cast my eyes over the questions I had planned to ask and saw that I had asked them all, although not in the order I had planned. I was concerned about my approach to the research process so I decided to return to the literature to see what changes I might need to make for my next interview. Clarke and Hoggett (2009) propose a research interview approach that seemed to have some similarities to what I had just done. They describe a technique called free association narrative interviewing (FANI), which involves asking an open question to start the conversation and then letting the topics and areas to explore be identified through the conversation, and followed up in no specific order. I decided to use this approach with future interviews and started them all by asking 'What career support and/or coaching do you provide?' The main topics I wanted to cover were only referred to at the end of the interview. It seemed that this approach would ensure a more flowing interview, allowing the voice of the participant to come through.

This research is about the process of coaching, and it was important that the experiences of the people involved in it were used to inform the outcomes from it. During the first data collection phase the providers of career support did not just discuss their work with individual doctors, but also mentioned their values and aspects of their own practice.

Interviewing other coaches also gave me insights into their practice and my own. During the interviews I started to notice that interviewees would tell me stories and vignettes about particular situations and clients, and preferred to construct the stories about their own practice in their own particular way. This gave me insights into how they operated as providers of career support, and the values they expressed. I also found myself thinking about my own multiple roles of researcher and coach, and decided that I would include these thoughts in my research diary.

2. Interviews and questionnaires with clients

The second phase of data collection was with clients, and two methods were used to collect data from doctors who had been coached: (i) a qualitative questionnaire and/or (ii) an interview. The questionnaire was initially piloted with a coach and a client who provided very different responses to the initial set of questions. The coach thought it was fine and would give me some useful data, while the client was not clear about some of the questions and found it difficult to complete. This feedback was used to update the questionnaire, and a series of questions were included with text boxes for the responses. The following questions were included in the questionnaire:

- What was the initial issue you took to your first coaching session? Was it careers-related?
- Were there any turning points and/or moments during the coaching when you became clearer about your issue? Could you illustrate what happened with a specific story? What did the coach do to help facilitate your discovery?
- What was the outcome of the coaching for you? Did you make any specific choices? Were you able to set yourself goals to help you resolve your issue?
- How would you describe the process of the coaching you received? How many sessions did you have? Were they face-to-face, over the telephone or a mixture of both?
- Did your coach ask you to complete any exercises and/or undertake activities between sessions? What were they?
- Taking the coaching as a whole, what worked well for you?
- And finally, what would you have liked the coach to do differently?

The qualitative questionnaire was sent to doctors who had been coached, with a request that they complete it and give consideration to taking part in a follow-up interview. Three doctors completed the questionnaire and three doctors agreed to be interviewed over the telephone. One doctor completed a questionnaire and was interviewed. Of the three interviews, one was recorded and transcribed verbatim, while the researcher took notes for the other two.

In the interviews, a similar approach to that taken with the providers of career support was followed. Once again, Clarke and Hoggett's (2009) free association narrative interviewing was employed. Where interviewees had provided a questionnaire, the first question asked was 'Is there anything you included in your questionnaire that you would like to comment on first?' Where the participant had not provided a questionnaire, the first question asked was 'What career issue led you to seek career

support?' This open question was used to start the conversation, and the topics and areas to explore were identified through the conversation.

3. Researcher's reflexive diary

Simons (2009, p.4) stresses that it is important to monitor the impact of the self on the research project, and specifically the need to carry out a 'rigorous exploration of how your values and action shape the data gathering and interpretation and how people and events in the field impact on you'. In order to monitor myself during the research process I kept a reflexive diary and asked a colleague to interview me at the start of the data collection phase. The pre-interview was used to review my approach to the research.

Including myself in the data collection phase meant designing an appropriate method. I was keen to keep a diary to collect my own thoughts on the research study, as well as at the data collection phase. McMahon and Patton (2006) recommend that 'career counsellors connect with their own career stories in order to coalesce theory and practice'. Initially, I thought I might use elements of the morning pages approach (Cameron, 2006) for the diary, where I would write something every day. However, this proved not to be practical for me because my work pattern is difficult to predict, so I adopted a more flexible approach. The diary was aimed primarily at being reflexive, as I used my thoughts and ideas to inform the data collection phase and modify my approach when needed: for example, adding in the option of a qualitative questionnaire with the doctors I had coached came about as a result of a diary entry linked to the decision on how best to approach potential interviewees. The diary also enabled me to reflect on the roles I inhabit and to act on any concerns I had about role conflict, thus enabling me to give consideration to epistemological and personal reflexivity (Willig, 2008).

I was concerned the diary might not include all my thoughts about the data collection phase of my research. One way of addressing this issue was to combine the diary with an interview before the main data collection phase. A colleague carried out a largely unstructured interview with me, and I did find this professional conversation about myself and my research both challenging and thought-provoking.

There are a number of current debates about reflective accounts and reflexivity in both coaching and research. Jackson (2004) discusses the importance of reflexive practice in coaching, and proposes a simple four-cornered framework of reflection in coaching that comprises balance, objectivity, perspective and capability. Clarke and Hoggett

(2009) emphasise researcher reflexivity and the influence of the researcher's life history on their approach to research. Alvesson *et al.* (2008, p.494) indicate that reflexive practices enable a researcher to think about what they are doing to encourage insights into the nature of social science. Additionally, they indicate that there are ways in which a researcher can foreground other participants' voices and introduce 'r-reflexivity', proposing that it enables reconstruction, reframing and multi-perspectives, and encourages the consideration of alternative views. Alvesson *et al.* (2008, p.497) also say they 'prefer a pragmatic rather than idealist engagement with reflexivity', and Simons (2009, p.89) sets down a number of ways that subjectivity, for example, can be explored in the process of research. These views influenced my decision to keep a reflexive rather than reflective diary.

Data analysis strategy

The approach taken to data analysis acknowledges my social constructivist/constructionist perspective, the case study methodology and data collection methods used. This research is a case study on coaching doctors, and the data analysis uses thematic analysis (Braun and Clarke, 2006) to inform a coaching framework.

Thematic analysis was chosen for the data analysis; Braun and Clarke (2006, p.77) describe it as an accessible and flexible approach and define thematic analysis (p.79) as 'a method for identifying, analysing and reporting patterns (themes) within data'. It is also appropriate within a case study approach that is not 'wedded to any pre-existing theoretical framework' (Braun and Clarke, 2006, p.81).

Using thematic analysis requires a number of decisions be taken (Braun and Clarke, 2006) regarding what is a theme, whether or not the analysis is inductive versus theoretical, and how that relates to the researcher's own epistemology. In order to identify themes within this research, I concentrated on identifying themes in the data that captured something important with regards to the overall research question. Carrying out the thematic coding was challenging, and I found it difficult to move quickly through the data (Bazeley, 2007). The software program NVIVO was used to track the coding as it was done, and this was helpful. As coding progressed, overarching patterns in the data (Boyatzis, 1998, p.7) began to emerge, and NVIVO was invaluable in tracking the coding, and enabling the adoption of a recursive process, which resulted in 15 overarching themes, each with their own sub-categories. These themes were reviewed and refined to ensure they were clearly understood, including how they fitted together. Table 3.5 provides an indication of the themes and

sub-themes which were identified in the data and the number of statements attributed to each. A further breakdown is included at Appendix B.

Table 3.5 – Key themes

Themes	Sub-themes	No of statements
What doctors bring to coaching	Career issues and dilemmas	87
	Characteristics of doctors as clients	142
	Diagnosis, solution and answers	27
What coaches need to work with doctors	Understanding the medical career pathway	46
	An understanding of career theory (the careers perspective)	208
	How coaching is organised	120
Coaches' approach to coaching	Coaching skills and knowledge	71
	Models and which processes underpin practice	51
	Values	336
	Supervision and continuous professional development	11
	Trainers and supervisors (as providers of career support)	37
	Researcher as a coach	305
The coaching conversation	The coaching process	191
	Metaphors	27
	Outcomes from coaching	66

With the analysis I was interested in how coaching supported doctors to make career choices. The themes that emerged from the coding process were informed by my own specific research interests and background as a coach, but were rooted in the data. While I tried to limit my engagement with the literature in the early stages of the analysis, this was difficult with regard to the careers literature. Some aspects of my own practice and this literature were used to develop some of the themes: for example, the four-stage approach to careers (see Figure 1.3) helps to develop an understanding of why doctors seek career support, and the range of issues and problems they bring to coaching.

Once I had a range of themes, I moved to interpret them in relation to my overall research question, as well as the subsidiary questions described in Table 3.4. The aim of the interpretation is to identify latent themes in the data so as to examine the underlying ideas and assumptions within it. This is particularly important with the interview data to ensure that it could be examined from a constructionist perspective so as to seek to understand the context and conditions within which career support is provided to doctors. Additionally, I identified a number of short stories that enabled me to acknowledge the different voices of the research participants, and these have been used to illustrate the research findings. This plays to my own personal values as a

researcher and coach: giving people the opportunity to voice their stories, and listening to them.

Ethical issues

This study involves the use of human participants, and there are three important procedural areas that need to be considered: (i) gaining access to participants; (ii) informed consent; and (iii) confidentiality. Contact with all potential participants was via email, and they were given the option of taking part in the study or not. For people who had been coached, an alternative method of collecting data was devised that allowed them to write their own data (Charmaz, 2006). A participant information sheet (see Appendix A) and consent form were designed and used to obtain informed consent from all research participants. The consent form assured participants that their identities would remain confidential and that any comments used in this thesis would be anonymised.

Simons (2009, p.106) argues that anonymity and confidentiality need to be decoupled. She proposes that researchers need to honour confidentiality throughout the research process and be alert to issues that participants would prefer to keep private. Anonymity, on the other hand, is supported by Simons in research reports (2009, p.107), as participants may not fully understand the repercussions of being named, and there is a possibility of legal challenge. All participants in this research study have been anonymised.

There are also two further practical ethical issues that affect this study: (i) my role as Head of Careers within the deanery and its potential impact on the research participants; and (ii) the notion of being an insider researcher. Charmaz (2006) proposes that the dynamics of power and professional status may affect the direction and content of interviews. For the doctors who had been coached, the data collection methods were designed to take this issue into account: a qualitative questionnaire was offered as an alternative to an interview, and where these were completed the questionnaire provided the opportunity for participants to write the data themselves (Charmaz, 2006).

The notion of being an insider researcher and the associated knowledge from my role in the deanery and as a coach requires consideration. McCulloch (2008, p.59) argues there are a number of challenges for researchers undertaking research into their own institution, and that 'ethical issues can loom large' if the researchers are intending to develop a critical interpretation of their organisation. The level of the case study chosen

for this study is broader than my own institution, as it is career support within a medical education context. With regards to the selection of participants from my own organisation, the Postgraduate Dean provided overall deanery permission for the interview process. The coaches who participated in this study came from a number of different organisations involved in medical education, including people who coach on a freelance basis; none of them were relying on the deanery to provide future work. The involvement of coaches from a number of organisations ensured the development of a critical interpretation at the level of the case study, rather than one based on my own institution.

Validity and reflexivity issues

Simons (2009, p.127) says that validity is 'concerned with how you establish the warrant for your work'. Yin (2009, pp.14-16) identifies three potential limitations of a case study approach: (i) the potential lack of rigour, (ii) generalisability, and (iii) case studies can take too long.

The potential lack of rigour in this study is addressed through the use of multiple methods of collecting data from a range of participants and software (NVIVO) to manage the process of data analysis. A form of triangulation has been adopted, by using these different data sources to gain an understanding of the issues, and explore different perspectives within the context of medical careers. From a credibility perspective, Riessman (2008, p.193) says that 'following a methodological path, documenting claims, and practising reflexivity strengthens the case for validity'.

Reflexivity is recognised as a concept that can be employed in qualitative research as a concept equivalent to the holy trinity of validity, reliability and generalisability to demonstrate rigour in quantitative research. This section now aims to discuss the connection between rigour and reflexivity in relation to the analysis of the data that has been collected, and specifically to consider the identification and management of potential areas of bias. These are key challenges I face as a researching professional in order to ensure the research contributes to the coaching discipline.

Currently, I inhabit a number of roles at work: I manage a career support service and the NHS medical careers website, act as course leader for a postgraduate master's in managing medical careers, and coach individual doctors. The deanery as an institution oversees medical education for postgraduate doctors in one region of England. My interest in careers and coaching means that I regularly draw on a wide range of literature and sources when I develop materials for my work.

Reflexivity and the discipline I work with are relevant to the challenges I face in ensuring that this research project is able to demonstrate rigour. In considering reflexivity and the discipline, I have articulated my interest in the research question and have included a range of literature and frameworks in the earlier chapters of this thesis. In particular, I am familiar with the concepts of objectivity and subjectivity in relation to the careers work I do. I spend time with clients helping them understand what a career means for them, and considering careers from the subjective perspective of meaning. Taking care with my own subjectivity during the research process is a key concern, and Simons (2009, p.84) suggests that 'Seeking out your subjectivity is more than a rational process. It is sensing when your emotions and feelings are engaged'.

As a researcher, I have considered my own approach to this study and taken up Simons' (2009, p.88) suggestion that researchers identify their subjective 'I's, as 'they are not independent, have a common value system, and raise different angles which the researcher needs to be aware of when conducting a research project'. Taking my own values (as later described in Table 6.4) and my own background and interests, I identified three subjective 'I's. They were: the 'practical I', the 'curious I' and the 'community I'. The 'practical I's concerns were largely related to getting the research done and ensuring time and space were allocated to the research project, very much reflecting my background as a project manager. The 'curious I' was particularly concerned with people as individuals, exploring their career choices through coaching, and ensuring they were able to have the career they want regardless of pressures they experienced from external entities like the organisation they worked for. The 'community I' was concerned about the wider community and the health care system, and wanted to ensure that people made appropriate choices, as a medical career does have links to the community, and the results of a doctor's inappropriate choices could impact on patient safety. Identifying these subjective selves particularly benefited the data analysis and writing up phases of the research project: for example, using NVIVO to manage the data ensured my 'practical I' did not feel I was wasting time on reviewing the data inappropriately.

With regards to the trustworthiness of case-based research, the following arguments from Flyvbjerg (2006, p.194) are relevant to this study:

- Case studies produce context dependent knowledge which is essential to the development of a field or discipline.

- Case studies can 'close in' on everyday situations and test how something occurs in social life.
- Case studies focus attention on narrative detail and important insights can unfold from the stories of actors in the field.

From the perspective of generalisability, Simons (2009) indicates there are a number of ways inferences can be made from case studies to other contexts, including process generalisation (Simons, 2009, p.166). In this research, the aim is to produce a coaching framework that is applicable to a particular context: the medical career pathway; one that has been subject to significant change.

Simons (2009, p.162) proposes that a limitation of case studies is that they cannot be used to generate theory. This study is contextually specific, and the findings from it will not be used to generate a theory; rather, the aim is to develop a framework for coaches who work with doctors as their client group. It will not be applicable to other contexts without further research. Simons (2009, p.162) argues that case studies can be 'too subjective', indicating that subjectivity cannot always be avoided and that case study can be only an appropriate approach in certain contexts. This research has acknowledged the potential for subjectivity in its selection of data collection methods, and in its employment of a reflexive stance, through the use of a diary, in the methodological approach.

Summary

To summarise, this research is a qualitative case study of careers in a medical educational context, which takes a social constructivism perspective. Data was collected through the use of interviews with coaches, and a combination of interviews and questionnaires with doctors who have been coached. I also kept a reflexive diary. The data was analysed and interpreted using thematic analysis, and a range of ethical, validity and reliability issues were addressed.

The data analysis provided a vehicle to organise the findings from this study. As it progressed, four overarching themes emerged from the data: (i) the role of the coach, (ii) doctors as clients, (iii) the medical career issues that doctors brought to coaching, and (iv) the coaching itself. These four aspects have been developed into the following chapters: Chapter Four considers what doctors bring to coaching, and Chapter Five what coaches need to work with doctors as clients; Chapter Six outlines the coaches' approach to coaching, and Chapter Seven the coaching conversation. The four aspects are then presented together in an overall framework in Chapter Eight.

Chapter Four – What doctors bring to coaching

In this chapter I outline the findings from the analysis of the qualitative interviews and my own reflexive diary to outline what doctors bring to coaching. The chapter is divided into four sections: (i) doctors' career issues and dilemmas, (ii) the characteristics of doctors as clients, (iii) doctors wanting a diagnosis, solution and answers, and (iv) a final summary. Figure 4.1 provides an overview of the key themes discussed in this chapter.

Figure 4.1 – Overview of what doctors bring to coaching
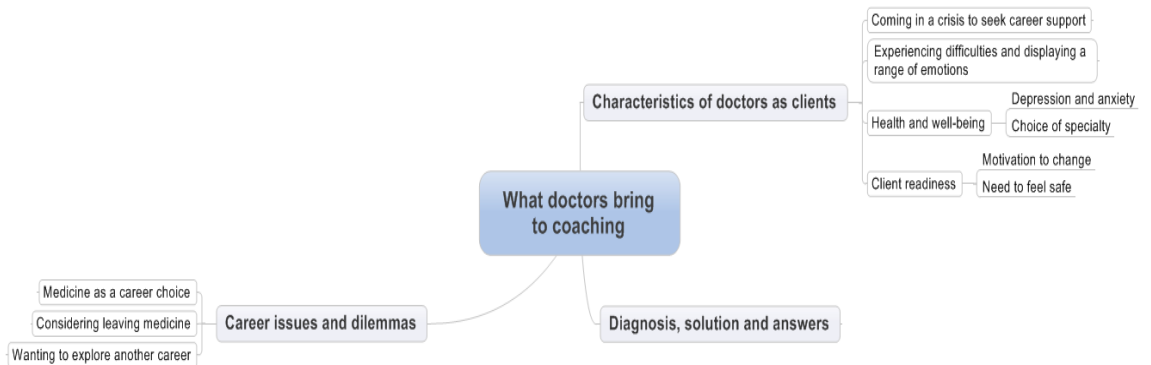
The coaches who were interviewed for this research fall into two main groups (see Table 3.1): coaches who are career/coach professionals (C1–6) and those who qualified as doctors, some of whom are still in current clinical practice (C7–13). The chapter includes data provided by coaches about their clients as well as information from doctors (D1–6) in order to develop the findings from this research.

Career issues and dilemmas

There are three overarching themes from the data for the problems or issues that doctors brought to coaching: (i) medicine as a career choice, (ii) considering leaving medicine, and (iii) wanting to explore another career.

1. Medicine as a career choice

The most common reason for seeking coaching given by respondents is the doctor's choice of medicine as a career; this data was classified into six sub-themes: (i) decision difficulties, (ii) career progression, (iii) their career choice not working, (iv) career goals, (v) issues with job satisfaction, and (vi) losing confidence. The most common decision difficulties experienced by doctors included not knowing which direction to take, and accepting a job offer out of guilt when a colleague or friend had not received any. Problems passing Royal College exams had hindered a number of doctors' career

progression. Clients and coaches alike described situations where the doctor's career choice had not been working, including where doctors were finding it difficult to handle the stress in their chosen job, or were feeling they had made a mess of their career; or that their career path had been chosen by others (sometimes family members) or their career choice had been made too early. All the doctors who took part in this study were unclear about their career goals and wanted to do something different, although they were not sure what area to work in. Coaches described situations where their clients had issues with their job satisfaction, including doctors who had been high fliers who were finding it difficult to deal with disappointments, and those who were not sure that medicine was the right career for them. Coaches also discussed doctors who had lost their confidence and were concerned that they were 'useless', and that this might impact on patient safety.

The majority of coaches said that they felt they needed to know about the overall medical career pathway structure, and be able to work with doctors who might have health and well-being issues, including concerns about their own competence. Coach C5 likened the issues being presented to a 'Gordian knot', and said that part of her work involved: 'the teasing apart of that knot: let's get all this information and rational thinking a little bit unravelled and see, you know, loosening that a little'. C6 supported this view that doctors can need help to understand their underlying issues, which can be complex, before looking at ways in which they can be addressed.

2. Considering leaving medicine

Coaches and clients alike indicated that not all doctors remain committed to medicine throughout their career. A specific reason for doctors to seek career support is that they are considering leaving medicine, and this study identified the following reasons they do this: (i) health issues affecting their medical career; (ii) being dissatisfied with medicine as a career; and (iii) the doctor not having achieved the necessary competence to practice as a doctor. C12 described how she discussed her own reasons for leaving medicine with a doctor, and this helped the doctor realise that leaving medicine would not necessarily be the end of the world.

Coaches described a number of health issues affecting medicine as a career choice, from specific illnesses that meant that a doctor could no longer continue in clinical practice, to mental and physical health problems that were impacting on their actual practice. These clients' coaches identified that being dissatisfied with medicine as a career meant that the doctors had either lost their enthusiasm for medicine, felt trapped in medicine, did not enjoy working with patients or were not sure that medicine 'fitted'

them as a person. Those who needed an alternative career were doctors who could not continue in their medical training programme, as they had not been successfully 'signed off' by their consultant supervisors.

Coaches reported that providing support to doctors who are leaving medicine because they are unable to complete their foundation programme was particularly challenging. Their trainers and supervisors live in the 'medical bubble' as well, and may not be aware of opportunities outside it. Coaches need to be aware of the membrane around the bubble, and encourage doctors to look outside it at a broader range of career options. There are resources to help them (for example, http://www.medicalcareers.nhs.uk, http://beyondclinical.thecareersgroup.co.uk and http://www.prospects.ac.uk), and in my experience the challenge is to encourage doctors to review the resources available. This can be difficult for them because they need to be ready and motivated to consider a change.

Increasing dissatisfaction with a career in medicine in the United States has been the subject of research by Gibson and Borges (2009), who report that the source of this is the difference between their expectations and the actual practice of medicine as a career. No similar research has been carried out in the UK. Gibson and Borges (2009, p.346) say that a key theme from their research is that a number of participants were considering switching specialties or quitting medicine, and this was linked to role stressors as well as 'the lack of fit between what an individual wants from work and what the environment provides him or her'.

3. Wanting to explore another career

However, the coaches thought that exploring another career – either within medicine by considering another specialty, or one outside medicine – could be challenging to doctors. Doctors may think they are too far down the training pathway to change specialty, or may find it difficult to change occupation, as this can be seen as a failure if they leave the profession (C12). Furthermore, doctors do not know what other opportunities there are because, as one coach (C2) described one of her clients: 'he'd been in a world, all his friends were doctors, his girlfriend was a doctor, etc., etc. He didn't know what happened, as he put it, outside that bubble'.

Characteristics of doctors as clients

The literature on doctors as clients for career coaching is limited, and the existing coaching literature for doctors tends to focus on leadership development and executive coaching (Gowan, 2010). A number of themes are identified in this research, including:

being close to burnout, stressful working conditions and uncertainty about career choice. Four aspects of doctors as clients are identified from the data: (i) coming in a crisis to seek support; (ii) experiencing difficulties and displaying a range of emotions; (iii) health and well-being; and (iv) client readiness.

1. Coming in a crisis to seek support

Participants indicate that often doctors do not readily seek support, with C13 expressing the view that 'doctors, as I'm sure you know, are really bad at getting support … with those sorts of worries that they don't dare to speak to anybody else, because there's so much piled on top of that decision to do medicine: friends, family, spouses, and so on'. In my experience, doctors can find it difficult to discuss their concerns with colleagues and family, and this may then impact on their mental health.

Participants explained that the coaching doctors received included a number of key features: an opportunity for doctors to reflect on their career concerns and set the agenda for the session, goal setting and action planning, and the provision of a facilitating space. Coaches expressed more clearly than clients, doctors' fears about achieving their goals and/or not being able to identify a goal. C7 related the view of one of his clients: 'if I don't get the top job, the way doctors are, I'm a failure'; and with regard to not being able to identify a goal, C4 said that one of her clients was:

'... in a real dilemma as to which way to go and what to do next, and they're being influenced by so many different forces, I'm not surprised they're just feeling really out of control and not knowing where to turn.'

The data suggests that two aspects seem to underpin these themes of fear and failure: (i) a doctor might not always be able to achieve a goal they have set themselves, and (ii) they might find it difficult to identify a goal for their career. I have worked with a number of doctors who can no longer continue in their training programmes and have found it difficult to identify career goals. In a diary entry (7/3/11) I wrote about a client who could no longer work as a doctor; her current priority was to find a job, and she had a number of ideas to follow up, although I wondered if she had the energy and motivation for doing the investigative work required. Grant (2007, p.255) indicates that goals can be motivated by a complex combination of internal and external factors, and that goals that a client perceives to be autonomous and aligned with their own values are likely to be engaging and lead to greater goal attainment, satisfaction, and well-being; and that goal content and goal motivation make significant contributions to psychological well-being or lack of it. Grant's (2007) theory about goals needs to be considered from the perspective of the client's motivation, and the goal defined within that context.

Doctors can express preferences with regard to who provides support and coaching. For example, C11 indicates that: 'some doctors maybe wouldn't want to go to another doctor, even a retired doctor', and in some instances they 'don't really like going to coaches'. In the case of C8, she said: 'I think the people I see I probably actually need to continue to see because … me and the resources I have access to are the last resort for them'.

Doctors can present a façade, indicating all is going well. Doctor D1 thought that this was 'instilled in you from day one of medical school where you start to learn to put up barriers and fronts; it seems that's something you get better at in medicine'. In this client's case he describes how he started to 'imagine thoughts in your head and I went round and round in circles into a downward spiral and my thoughts became destructive'.

Another explained their difficulties in assessing their own abilities. 'The outcome for me so far is that, despite knowing that there are more career possibilities than just medicine, because of my difficulty with objectively assessing my abilities, I continue to think that I would not be a strong enough candidate for any of the positions' (D4). Doctors can get lost in their search for their own fulfilment (C10) and may find that their needs as clients can be 'expressed and immediate or they're unexpressed and emerging' (C3).

2. Experiencing difficulties and a range of emotions

In this study one coach (C1) described doctors as bright and skilled and said that she: 'found it very, very stimulating work' and that 'there's still lots of opportunity for you to work alongside them, to unearth some of the sort of deeper guidance issues'. However, three overall themes about clients were discussed by coaches: (i) the difficulties they were experiencing, (ii) issues around confidence, and (iii) they were coming to coaching with a range of emotions.

Coaches suggested that the work as a doctor can be high-risk, and that those who come to coaching experience a range of difficulties relating to their role at work, including, for example, being 'motivated and confused' (C2), as well as 'having things going on outside of work' (C6). Coaches who work with doctors may need to spend time understanding their issues before supporting them in identifying their career goals.

Issues around confidence were identified by the coaches and one of the clients as a key area for a doctor seeking coaching, although these issues may not be immediately apparent. C10 suggested doctors may have 'limiting beliefs', and D1 had concerns 'about failing'. This research indicates that coaches may need to work with doctors on areas related to confidence and their own capabilities. This is a view supported by Gowan (2010, p.72), who studied doctors in their final year of postgraduate training, and reported that doctors raised, in their coaching programme, issues of loneliness due to their long working hours and living alone, and that 'the culture of training dented their self confidence on a regular basis'. Gowan's (2010) coaching programme encouraged doctors to build on and develop their strengths.

Coaches reported that doctors who come to coaching can express a range of emotions. They may be 'hostile or wary' (C2), 'vulnerable' (C12) or be experiencing isolation, loss and betrayal. This links into issues around confidence, and doctors may be concerned that they are failing in their career and that it is impacting on patients and themselves. Coaches need to be prepared for doctors to express a range of emotions from sadness and loss through to anger. Doctors' suicide rates are higher than in other groups of health professionals (White, 2010). The possibility of suicide is not mentioned explicitly by participants in this study, although I am aware of two recent suicides of doctors in training programmes in one region of England. White (2010, p.2) argues that 'what research repeatedly shows is that doctors are particularly reluctant to admit to health problems: unable or unwilling to seek help', although the reasons for this are not explored. Coaches may find some doctors who come to coaching need referral to another service, and this is covered in the next section on health and well-being.

3. Health and well-being

In this study, coaches who work with doctors as clients identify health, stress and well-being as common themes from two perspectives: (i) the doctor's own state of mind when they seek career support, and (ii) the career issue/choice the doctor is facing can be related to these areas. For example, C11 thought that some doctors who come to coaching have 'mental health or physical health problems'. Nearly half the coaches interviewed mentioned that they had worked with people who had been depressed, and one coach (C13) said that she had routinely done an anxiety and depression score with new clients. C6 also said that: 'when a trainee's very depressed or very anxious they don't even know they're very depressed or anxious'. A client (D1) also said 'I have sometimes been depressed'. In a diary note (15/3/11) I reflected on two of my current clients who are doctors, both unable to complete their foundation programmes, and in each case seeing therapists for support with their mental health.

Depression, though, was not the only area of concern when doctors sought career support. Emotional issues, exhaustion, stress and a lack of coping strategies were also raised, as illustrated by the following comments:

'Generally speaking, if somebody comes to me there are emotional issues' (C13).

'I felt exhausted, disillusioned after my experience and did not feel ready to approach the challenges of F2 after I felt that I had done a year of administration' (D6).

'So I think we put a lot of stress on … very young people, some of whom will be equipped to cope with it, and others won't' (C2).

Research by McManus *et al.* (2004) describes the modern medical workplace as a complex environment that doctors respond to differently; a view supported by Gilmore (2010). McManus *et al.* (2004, p.8) explain that a 'high perceived workload and poor support are therefore determined as much by the doctors themselves as … specific working conditions'. Gibson and Borges (2009, p.340) also identify the issue of stress in relation to the practice of medicine. Twenge (2009, p.400) indicates that the self-confidence of the current generation has not led to better mental health, and that anxiety, symptoms of depression and general psychopathology have all risen sharply over the generations. White (2010) identifies that the stakes are high for doctors, and the environment they work in is high stress, and goes on to suggest that health professionals have higher rates of depression, anxiety and substance misuse than other groups of workers. Doherty and Nugent (2011, p.132) investigate the link between personality and vulnerability to stress in medical students, and identify conscientiousness as a significant predictor of performance at medical school.

Coaches had also worked with doctors with health issues that had affected the doctor's choice of specialty. One coach (C4) raised the issue of a client with long-term health problems whose future was uncertain: 'they'd had a huge amount of ill health and actually, we don't know what the future holds for them because they still have big periods of time off sick and so on, and maybe a medical career isn't actually for them'. This is one example of where experiencing a career crossroads can act as a trigger for a doctor to seek career support and/or coaching.

Doctors are expected to look after their own health and be cognisant of the impact of any problems they might have on the work that they do. The BMA report on professional values (2008, p.4) includes 'the view that doctors are responsible for their own actions and also those of their medical colleagues' and that this view is 'held by an increasingly higher proportion of doctors'. Initiatives to improve the health of health

professionals described in the *Invisible Patients* report (Department of Health, 2010, p.7) are largely structural, and the report proposes: 'a range of measures which should help to prevent ill health and assist with early identification and effective management'.

4. Client readiness

Working as a coach with doctors can present a number of challenges. Lack of insight was cited by C7 and C4, though doctors either found it difficult to engage with coaching or knew what they needed to do but were not able to do it. C4 said about one of her clients:

'This person was a psychiatrist, so a lot of the work she was doing with her own clients and patients … she actually probably knew what she needed to do herself, but it's really hard when you're in that place.'

Taking this a stage further, C6 related a story about a client who had painful knowledge relating to the career she was considering:

'I saw a trainee … whose child has been diagnosed as profoundly autistic and she's working in community paediatrics and there's an issue about will she be bringing something to bear by her deeply painful knowledge of having this desperately handicapped child? Or will it be unbearable for her to be practising?'

Participants in this study thought that doctors could come to coaching motivated to change (C2), with the internal motivation to move their career issues forward and to find the time for coaching (D1). This finding accords with Beven's (2009, p.18) view that a client's motivation to change is important, and that coaches need to engage with their clients' readiness for change.

Doctors as clients can take on new ideas (C2) and be self-directed (C3). However, there are some doctors who do not take action, and C2's view is that:

'if that keeps happening … there's an issue there, is the client putting up the barrier or is there a genuine reason why … coaching is not the right approach?'

In addition, clients cancel sessions, as C12 relates:

'I've seen people do all the interesting things that psychotherapists talk about … cancel sessions at the last minute, with all sorts of amazing excuses and … amazing things that have happened'.

In the literature, Kretzschmar's (2010) exploration of clients' readiness for coaching identified six themes, three of which are relevant to the findings from this study: (i) commitment to change, (ii) psychological interpretations, and (iii) feeling safe. Clients need to be ready in themselves to benefit from coaching.

Coaches also indicated that doctors could find it difficult to talk to other doctors about aspects affecting their work, with C1 saying that 'they can't even say it to their spouse because their spouse might be a doctor'. Two non-medically qualified coaches thought that doctors who were experiencing career issues valued the 'safe space' they could provide, as they are bound by different codes of practice and confidentiality compared to coaches who are also medically trained. Doctors have a responsibility for their own health (GMC, 2006) and, for example, are expected to seek treatment for health issues that affect their practice as a doctor. If they discuss health issues with a spouse or partner who is a doctor, then that spouse or partner has a responsibility (GMC, 2006) to report their concerns initially to the doctor's employer if the doctor does not do it themselves.

The findings from this research indicate that doctors come to coaching because they are experiencing career difficulties that are sometimes related to issues of health and well-being. Doctors' careers can be stressful. Coaches may wish to clarify if there are any limits to confidentiality with their clients, particularly if the coach initially trained as a doctor.

Diagnosis, solution and answers

The findings from this study propose that doctors may not have an experience of coaching and/or seeking career support, and may find it difficult to seek support; and that when they do approach a coach they are looking for ways to resolve a problem or issue and potentially change their occupation. All the doctors interviewed for this study had faced a career choice, and were varied in their reasons for seeking help with their career. A number of the coaches also described reasons for doctors seeking career support and how they expected to be coached.

With regards to coaching, one coach (C12) said: 'it's not unusual that when people come to you in the first place they don't have any experience of being coached at all'. A counter view to this was made by C8, who has a key role in medical education and said 'I think doctors are coached a lot more than they recognise', which aligns with the COPMeD (2009) report, indicating that coaching is an appropriate approach to support doctors' learning.

As far as doctors seeking career support is concerned, C2 thought that for some doctors it might be the first time they had sought any sort of careers advice; a reluctance to seek career support is reported in other studies: for example, Vogel and

Armstrong (2010). Clients may also tell you that 'I could never say this to any of my doctor friends' (C2). C13 thought it was not self-indulgent to get help because:

'The happier you are and the more confident you are, and if you're in a job where you feel valued and that you're good at it … you benefit, your colleagues benefit, your patients benefit, your organisation benefits, your friends and family benefit; everybody benefits.'

Additionally, C1 thought that 'it's perfectly okay for them to come … and get careers advice when they don't want to change their career – it's about maximising the career they're already in as well'.

However, doctors as clients may have a clear idea about the help they want and how they would like it to be provided when they seek coaching. Four coaches said that doctors who came to coaching were looking for a diagnosis and solution; a practice which mirrors their own experience of the working environment where patients see doctors for health issues and are looking for answers and a treatment plan. C1 said that 'clinicians are used to finite issues' and C5 that the 'culture of the client group is to diagnose and have a solution'.

When doctors seek career support in a crisis they are looking for an immediate answer and preferably for the coach to fix their issue for them. D1 described it as needing 'to get to the crunch on what I could do'. C1 sees doctors as outcome-based and that they like to 'cut to the chase'. However, not all clients want to take immediate action. C2 describes what coaching provided to a client:

'He said … "I'm going to take at least three, maybe six months to decide on this" … he'd been in medicine for so long, and surely … six months was not going to matter in the wider scheme of things.'

In this instance, coaching empowered the doctor to take a measured approach to the change he needed to make to his career, and this situation is mirrored with the work I have done with some of my clients who have decided not to move straight from the foundation programme into specialty training. In my diary (2/9/10) I made a note of what a doctor said about the coaching she was experiencing with me: that she did not expect me to know all the answers, but that she nevertheless felt empowered by the coaching to make her own choices, and that it was fine for her to take her time exploring possible career options before she needed to apply for jobs later in the year.

Summary

The findings from this study suggest that doctors come to coaching when they are experiencing a variety of career and related dilemmas; they exhibit a range of

characteristics as clients, and are looking for a diagnosis and a solution as well as an 'answer now'. Doctors bring a wide range of career and career-related issues to coaching, from needing help with a specific job application, to considering leaving medicine and perhaps needing an alternative career. Their issues generally fall into three areas: (i) medicine as a career choice; (ii) considering leaving medicine; and (iii) wanting to explore an alternative career either within or outside medicine.

Doctors can find it difficult to seek support and may seek help with a career issue at a crisis point. Coaches need to be aware that doctors may need coaching to clarify their career goals, and may present a face that all is going well when it is not. Doctors may also lack confidence and find it difficult to assess their own abilities. In some instances they may have underlying health issues. Grant (2007, p.258) describes clients with high goal-striving and high mental illness as 'distressed but functional' and indicates they may present a significant challenge to coaches who do not have clinical counselling training. One client said that doctors develop a façade, a process that starts at medical school.

It is important that coaches who work with doctors recognise that as the coach, they need to decide if and how to work with these clients (Grant, 2007, p.260). This research indicates there may be a tension between a doctor seeking or not seeking support for their career issue, and their health and well-being. A lack of well-being can lead to a delay in seeking career support through coaching. The coaching itself can help doctors set themselves career goals and lead to an improvement in well-being. However, the coach may need access to other sources of support, such as a referral to a counselling service or occupational health, if the doctor's mental or physical health requires an immediate diagnosis.

Doctors may be experiencing issues related to self-confidence, be concerned about failing and exhibit a range of emotions. In some cases doctors could have undiagnosed or diagnosed depression and other mental and physical health issues that are affecting their choice of career. A coach working with doctors should consider their own competence and the boundaries of their experience, and how 'deep' to work with doctors as clients. This is what one coach described as 'knowing the edge', and an important aspect is that coaches need to know when to propose a referral to another coach or service. Coaches may need access to confidential sources of help for doctors.

In their clinical work, doctors regularly consult experts for an opinion. They can come to coaching looking for a diagnosis and a solution and may want the answers

immediately. Coaches might wish to consider McIlveen and Patton's (2006, p.24) view that the 'counsellor should not be privileged as expert dispenser of truth'. The coaches and doctors alike discussed the importance of developing the doctor's own capacity for making career decisions. Coaches appear to need to appreciate that doctors may be seeking a diagnosis and a solution and want 'answers now' for their career issues. They can also experience difficulties identifying their career goals and may have difficulties motivating themselves to achieve them.

In Chapter Five, what coaches need in order to work with doctors as clients is discussed further.

Chapter Five – What coaches need to work with doctors

In this chapter I outline the findings from the analysis of the qualitative interviews and my own reflexive diary to outline what coaches need to work with doctors. The chapter is divided into four sections: (i) understanding the medical career pathway; (ii) understanding career theory; (iii) how coaching is organised; and (iv) a final summary. Figure 5.1 provides an overview of the key themes discussed in this chapter.

Figure 5.1 – Overview of what coaches need to work with doctors
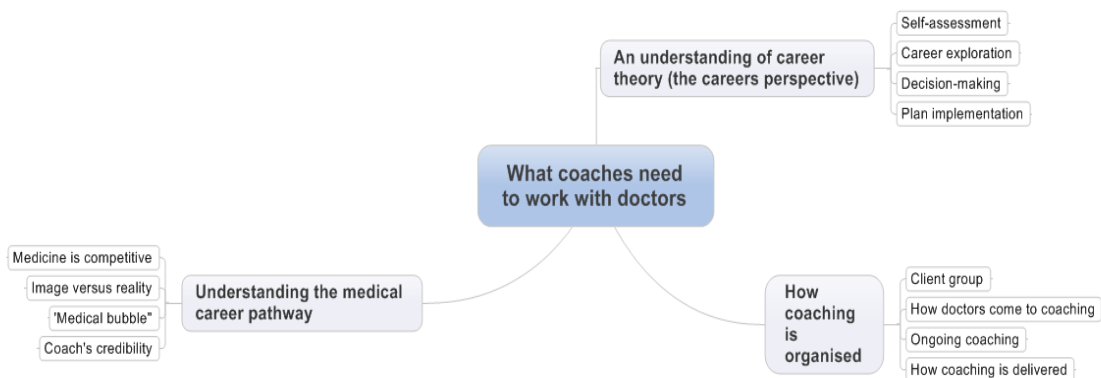
Understanding the medical career pathway

The findings from this study indicate that coaches have a number of perceptions relating to understanding the medical career pathway: medicine is seen as a competitive career, and there are issues relating to the image versus the reality of medicine as a career, and the notion of the 'medical bubble'.

Coaches raised concerns that the medical career pathway was continuing to change, and this presented challenges when providing career support to doctors. One of the coaches who had initially trained as a doctor suggested that when they were newly qualified it seemed that any specialty was open to them, and that the current system 'seems harder to change track if you start training in one specialty and then want to change to train in another one' (C11). However, one coach (C13) said doctors do not need to follow the traditional path and that 'very often in jobs you can choose what you do, particularly the higher you go'.

A number of career coaches who were not medically qualified, raised concerns about the medical career pathway and how doctors see their careers. One coach (C2) likened it to 'one of those moving walkways you get in airports', indicating the need to keep

going in one career direction, and she felt that many of the doctors who sought careers advice 'have not really thought through where they're at and what they do'.

1. Medicine is competitive

There was also recognition that medicine is a competitive profession, and that as one coach (C12) put it 'it doesn't suit everyone', or as D3 said 'that's not exactly me'. There was also a suggestion from C12 that 'however well you plan and think about it, sometimes you can't know that until you get there'.

This study indicates that recent changes to medical career pathways seem to have led to the impression that there are more restrictions on what doctors can do, with less flexibility, and that the backup options that are available are limited. As one coach (C11) put it, people used to say 'oh if you're going for a specialty, if that doesn't work you can always do general practice'.

Medicine is a profession, and C13 described medicine as:

'In the UK, yes it's a profession, and by profession I mean self-directed – they're responsible for their own career, they're responsible to their professional body or bodies … in the UK this must be the most mapped out profession I can think of … There's a lot of structure compared to other professions.'

Two coaches suggested that a challenge for those who work with doctors is the level of knowledge and understanding of the medical profession you need as a coach to work with them. In addition, C2 thought providers of career support would lose credibility if they did not understand the way the medical profession is structured.

The BMA (2008, p.6) report on professional values, which is based on their cohort studies, identifies that 'professionalism expresses a professional culture and should epitomise good practice', and that the GMC's code of practice, *Good Medical Practice*, 'is the formal expression of professionalism for the medical professions'. In the report (p.4) the 'competence to practise medicine' is seen as the most important core value for doctors. This has implications for working with doctors. Doctors in the UK primarily work in NHS hospital trusts (BMA, 2010), and as an organisation, the NHS is rarely out of the news. The medical profession is therefore seen at work by patients and the general public on a regular basis. The BMA report (2008, p.6) indicates that 'medicine as a profession has held an implicit social contract with society … as professional self-interest has been seen to predominate over altruism, society has sought to redefine and make more explicit the contract'.

Entry in medical school requires high scores at A level, and this focus on academic ability and scoring highly continues throughout medical school and entry into work. Applicants to the foundation programme (see Figure 1.1) currently receive an academic ranking from their medical school, and complete an application form, which is scored. The popular foundation schools in London and the South East are frequently oversubscribed. Entry into specialty training, the next step after foundation, is also a competitive process. In the following quote, coach C2 discusses the need for doctors to develop strategies to deal with career issues:

'The medical profession is quite a competitive one … I think perhaps that young people who are going into it, they'll get to a certain pitch, either as an undergraduate or … their specialty training and they'll think "actually there are a lot of people here better than me", and if that only happens to you in your early or mid twenties … that's quite a shock, whereas probably if it happens to you when you're 12 then it's maybe easier to deal with, or you develop strategies to cope with that.'

In my experience, these competitive selection processes into foundation and specialty training can cause anxiety for doctors if they do not get their first choice programme. They may be unable to deal with these setbacks and may become stressed or angry about the process and their own abilities.

Coaches who work with doctors need to have an understanding of medical career pathways and medicine as a profession. Medical career pathways continue to change, and both coaches and clients perceive there is lack of flexibility to change training pathways. Not all coaches agree with this view, with one seeing medicine as a fantastically diverse industry (C1), and another (C13) suggesting there are possibilities to change career direction.

2. Image versus reality

With medicine as a career, C10 saw an image versus reality gap between how a 16/17 year old sees medicine when they apply to medical school, and the reality of working as a doctor. He thought that when you are: 'sixteen, seventeen it's very glamorous or very trendy … to believe that you are going to be a hero somehow, so it pleases your ego, but without knowing what it is pragmatically'. C10 went on to say that doctors' academic education impacts on their creativity, and that there were specific reasons for this related to their work: as doctors 'you don't sell potato crisps or cars, you know, if you add a zero to a milligram it can kill your patient'. Once a doctor enters the medical career pathway it is seen as single track, with C12 indicating that: 'medicine is so blinkered, and there's this expectation that once you've got on the treadmill at day one in medical school that you will continue all the way through'.

The transition from medical student to doctor is also seen as problematic because there is a change in status which D3 describes as 'you are not a student anymore, you are seen as a doctor … but then you need to prove things also because you have other responsibilities'. White (2010) argues that the transition from medical student to practising doctor is important, and this is the subject of a review by the Medical Schools Council and the General Medical Council.

3. 'Medical bubble'

Medicine as a bounded, almost isolated career was mentioned by a number of interviewees. C4 thought one of her clients was:

'In the medical bubble where all her colleagues are doctors and it's all they ever talk about and I think that added to her anxiety and perception of herself that she was never quite as good as her peers.'

Using 'bubble' as a metaphor in this instance suggests there is a boundary around doctors that encloses them within medicine, and that their own world view is likely to be constrained by this boundary. The strength of the bubble membrane might also be variable so that in some instances doctors can 'break through it' to see what is on the other side, and in some instances they cannot, leading to a view of their career from a single perspective, and being unable to seek other views and assistance. This in itself is likely to lead to anxiety and stress and impact on work–life balance. Gowan (2010, p.67) proposes medical training takes place in a 'training bubble'.

Four coaches had also discussed work–life balance with doctors. For example, C5 said they brought to coaching 'a work–life balance issue where there's a need to re-evaluate ways of working, ways of career thinking because something else has changed in the wider scheme of things.' In addition, C11 thought that 'there's still that dilemma about childcare and maybe not wanting to have those sorts of full-time commitments that for instance hospital training still seems to involve'.

Work–life balance is discussed in the BMA report (2008, p.11), with around three in five doctors having the view that 'a career in medicine should also include some consideration of acceptable work–life balance'. This view is supported by Gibson and Borges (2009, p.339), whose research with physicians in the United States identifies the balancing of personal and family life with medicine as being a key issue relating to physicians' satisfaction. The BMA report (2008, p.11) also says that 'doctors have different expectations of their careers compared with previous generations; they expect a more balanced approach to their professional lives, while remaining committed to medicine'.

4. Coaches' credibility

Coaches reported the need to have an understanding of the provision of career support for doctors and the dilemmas they face, as well as an understanding of their own capabilities and boundaries as a coach.

In contrast, the view that coaches need to know a lot about the medical profession in order to work with doctors is challenged by C12, who said that to be an effective career coach there is a need to have 'real confidence in your expertise and realising that the minutiae of every single specialty isn't really what these people need or want'. The medical career structure does have a degree of complexity to it, and C2's view is that people who come from a non-guidance context need training in the career structure, and that those who have not been immersed in the culture of the client group will be perceived as outsiders; a perception that has its drawbacks and advantages. C6 supports the view that the practitioner needs experience and skills, and in the following quote, C1 relates an experience where she needed to 'raise her game':

'This psychiatrist was absolutely fascinating because he kept pre-empting what I was going to say next, quite literally, and I remember thinking if I had been a less experienced careers advisor I would have found that very intimidating, because you could have read it as someone who … [was] making your presence immaterial … but [he was] actually [doing] quite the opposite, and I really felt I had to … raise my game.'

This story indicates that doctors as clients can be challenging, and coaches need to be clear about their role in the coaching conversation. Doctors can also present challenges to the coach, as they may see the coach in a number of different ways: as an outsider, expert, friend and someone who gives advice. Of particular concern is when the client sees the coach as the expert, with C2 indicating:

'Yes, because I think there might be a tendency, not just with doctors but with clients in general, to see the coach as … the expert and what he or she says is right, and they are perhaps a little bit like an authoritarian figure … I don't think that's a good coaching relationship.'

Another potential challenge is if the client sees the coach as a friend; something which C12 has experienced:

'Somebody once said to me … "Aren't you like a friend?" And I said: "No, I don't think I am, because I don't have all that other baggage – however good and bad that baggage might be for your friend, that bit doesn't get in the way".'

However, being an outsider providing help and being non-judgemental was valued by D5. C1, a non-medic, also thought not being a clinician would be a problem; however, she discovered that:

'I've realised it's one of my sort of greatest aspects of what I can offer them is the fact I'm not a clinician and I'm not in that system – they … appreciate being able to articulate what they can do and their skills to someone who can then interpret them back and say "well, you know, those qualities are really valued in loads of other industries and professions, not just in medicine".'

Coaches who work with doctors do need to be aware of these potential challenges, and that they might be seen as the expert and someone who is there to give advice, rather than as someone to support the client to make career choices within a learning environment. Patton and McIlveen (2009) argue that it is important to synthesise the context of the practitioner and the client.

An understanding of career theory

A particular challenge in developing the findings of this study is my own personal engagement with the careers literature, and consequently, how best to display the findings in this chapter. I have made a positive decision to utilise that literature in a proactive way to help categorise the career perspective.

A well-known process used to support clients with career issues is DOTS: decision learning, opportunity awareness, transition awareness and self-awareness – although it is used in the following sequence: SODT. Kidd's (2006, p.82) view is that DOTS represents 'the four aims of guidance' and 'therefore the kinds of outcomes that should be evaluated'. DOTS and modified versions of it are used in medicine (e.g. Watmough *et al.*, 2009; Elton and Reid, 2010). The themes that emerged from the data have been categorised utilising the four career planning stages (shown in Figure 1.3) developed by Elton and Reid (2010).

1. Self-assessment

Self-assessment is aimed at encouraging clients to develop their own knowledge about specific career-related attributes, to help support them to make career choices. Coaches discussed a number of reasons for encouraging clients to carry out some form of self-assessment, with C11 summing them up as: 'all these models are just a means to an end really … to get people to think'. Doctors recognise that self-assessment can be helpful, with D6 saying 'we did a series of exercises that helped me to firstly understand who I am, what my interests and talents were and what I wanted from a career'.

Coaches and doctors alike describe a range of the most frequently used exercises, tools and techniques in coaching, which focus on the following areas: interests,

psychometric tests (including MBTI and specialty choice tests), skills (including those that are transferable), strengths, talents, values, and the work environment.

The most widely mentioned exercises were those related to values (Nathan and Hill, 2005), with C7 suggesting doctors experience difficulties when they are in 'an environment which does not fit their values' and C12 saying that the work values exercise helps doctors gain an insight 'which helps them make decisions'. D4 also suggested that: 'the coaching sessions helped me explore my interests, my values and my likely preference of work environment, type of work, workplace configuration, etc.'

Doctors are familiar with the use of tests and checklists in clinical medicine (Frank, 2006), and found the use of psychometric tests helpful:

'I find the psychometric tests very insightful into who I am as an individual as this was where I felt that my career confusion lay' (D6).

'I thought the personality one was particularly helpful as it provided suggestions of things to consider from a work perspective … it helped me understand my personality and the implications as far as my career is concerned. I liked that it was an on-line exercise' (D5).

Coaches also had views about the use of tests, with C3 suggesting that:

'I'm really interested in decision-making, so a fundamental step … is personality typology and Myers Briggs … they might unlock a bit of self awareness … that's great … some of the suggested career directions might inform that … that's a fundamental basis.'

This research indicates that coaches use a wide range of self-assessment exercises, tools and techniques, with the aim of developing a doctor's own self-awareness to help them develop their career thinking. However, not all tests have been found to be helpful, as research by Borges *et al.* (2009, p.571) into the use of emotional intelligence (EI) has found, arguing that EI 'is not an effective predictor of specialty choice'. A recent study by Taber *et al.* (2011, p.207) into the influence of personality traits and values suggests that 'personality differences exert some influence on medical specialty choice' and that 'values influence how an individual practices an occupational choice' (p.208). However, Furnham (2008, p.350) identifies the notion of fit between a personality and an organisation, and says that 'the essential assumption is that if there is a congruence of fit between an individual's personality-based preferences and behaviours, he or she will be more happy, healthy and productive at work'.

Coaches and doctors alike discussed the importance of understanding the skills a doctor has, and what skills are transferable either to other specialties or other occupations. D4 described how coaching helped her 'realise what skills … apply as a project manager', and C11 thought that the skills gained from working in medicine could be used in other occupations. C3 also said:

'I'm a great believer that nothing is ever a waste, so okay, you might feel as though you've gone a rather circuitous route, but all of that process will have stood you in good stead … there are loads of transferable skills, you just don't appreciate them at the time.'

Clients felt that coaching enabled them to give less consideration to what the specialty required of them, with D5 describing: 'anaesthetics was something which I had started to think about – I realised I needed to consider more what I wanted from a career, and less about what the specialty required of me'.

Asking career clients to increase their own self-awareness through self-assessment is a key part of career coaching. Eva and Regehr (2005, p.S52) indicate that education within the health professions has 'emphasized the importance of being able to self-assess one's ability as the critical foundation on which to build self-directed/life-long learning skills and preserve the self-regulating nature of the professions', and that safe practice for health professionals on a day-to-day basis 'requires an awareness of when one lacks the specific knowledge or skills to make a good decision regarding a particular patient'.

2. Career exploration

As discussed in Chapter Four, doctors who come for coaching may be unclear about the path they wish to take within medicine, and if they are considering leaving medicine, or thinking about pursuing another career outside medicine, they can require help to explore other careers. With regards to career exploration, the four main themes identified in the data are: (i) exploring, (ii) generating ideas, (iii) identifying opportunities, and (iv) considering options.

Exploring career options was seen as valuable by D4, as it provided an opportunity to find out about job responsibilities. C13 thought that one of the benefits of MBTI was that it provided 'a kind of template for looking at future possibilities based on their type'.

C1 thought that generating ideas needed to be done together with the doctor so that: 'It's not just me saying these are some of the typical … specialties that you might want

to think about, or these are some of the typical roles outside medicine that you want to do'; the exploration is 'being very much led by them'.

C6's view was that there was a need to identify 'some specialties that they could happily inhabit post-foundation if they'd made a mistake'.

In terms of considering career options, C13 encourages doctors to 'start mapping the territory', and then takes them through a process of option appraisal that:

'Can range from going into public health, especially if they're very anxious about the clinical work … or they might be thinking about something completely non-medical, you know I had somebody wanting to open a bakery. I suppose people tell you their secret dream.'

D4 said that it can 'be difficult to relate the information about myself to possible career options', and this is where the link between self-assessment and career exploration comes in, with the need to understand the self and what is important from a career perspective, and relate that to the careers which are being explored. Learning, which Kolb (1984, p.38) describes as 'the process whereby knowledge is created through the transformation of experience', is important in the careers field. C4 described doctors realising when they were in the wrong specialty going on to identify what additional skills they might need.

Coaches do sometimes assist doctors with their career exploration, for example to effect an introduction to another clinician to set up a taster in a specialty of interest. A taster is a way of finding out about a specialty and what the work entails before a doctor makes a career choice. In the United States, medical students tend to construct their own potential career paths, and Savickas (2003, p.2) argues that 'the problem of making a commitment to a specific specialty can be resolved by activity in the real world'. Tasters in the UK are one way of finding out more about a specific specialty as part of exploring potential career choices. The following quote, from a deanery-based coach (C6), who sees doctors from the foundation programme who want to explore a specialty that is not part of their current training programme, explains how she helps to facilitate tasters:

'I will email the head of school or somebody I know in that specialty … "Can this person come and talk to you or could you arrange a taster?" If they say "yes", I then give their details to the trainee and leave them to do it … I think it's too brutal for this very vulnerable population of trainees to be trying to work their way through the maze and hitting brick walls.'

3. Decision-making

Doctors may come to coaching looking for ways to resolve an issue and/or make a decision quickly. Research participants mentioned a wide variety of exercises, processes, tools and techniques that coaches use with doctors to support career decision-making. Some of these indicate a more 'rational' approach to decision-making: for example, asking a doctor to identify the pros and cons of a particular career choice; and others are a more 'intuitive' approach: for example, reflecting on some of the blocks relating to the decision.

Three 'rational' approaches to decision-making (Nathan and Hill, 2005) were frequently mentioned: (i) pros and cons, (ii) ranking, and (iii) weighting and scoring exercises.

'So we began with a very simple kind of pros and cons, "okay so what are the pros for going for this course? What are the cons?" and we looked at some of those' (C4).

'I find it works quite well with clinicians because of this sort of almost quantitative bias. I do the old ranking 1 to 10 … I'll say "okay so how keen are you actually on paediatrics on a scale of 0 to 10?" and then they'll say "well I'm about a 6", and then what I'll do is say "okay, why is it 6 rather than an 8?" or "why is it a 6 rather than a 4?"' (C1).

Fewer coaches use more intuitive approaches: for example, C11 uses Dilt's logical levels, which are a series of questions to explore with a client (Grimley, 2010, pp.195-196); and C4 challenges assumptions and reflects on some of the blocks to the decision, saying that the coaching:

'Helped her to … reflect on some of the blocks that she felt she had … when she did look at age she scored it really low, whereas in her head it had been one of the biggest things that was stopping her … it was about challenging some of those assumptions' (C4).

Coaches also use other ways of making the decision real for doctors. C11 told the following story about using a coin exercise to help bring a subconscious decision to the surface:

'I asked her to take a coin and said "offer A is heads, offer B is tails", and I said "I suspect here there's a decision you've already made, but we just need to get it to surface, because I think if it surfaces everything else will be clear". So my instructions were "here's the offer on one side, here's the offer on the other, toss the coin, hold it, don't reveal it, and before you reveal it think this to yourself: statistically there's a 50:50 chance it could go either way, if I really don't mind what this decision is it will make no difference whatsoever what I see when I reveal my hand. If actually it matters one way or the other, those feelings will come up now". So I said "... Just concentrate on what you feel about what comes up and see if that clarifies anything". And at ten past nine the following morning … I had an email saying "I did the coin thing … you were right, I knew all along. I've made my choice … thanks".'

The coaches had developed their own exercises: for example, C4 asks doctors to put their decision on paper, and always has paper and pens with her to support this activity. This approach is supported in the literature by Nelson-Jones (2006, p.6), who indicates that 'visual images can be alerting, calming, coaching and affirming'.

Additionally, coaches raised concerns relating to making the career decision itself. Doctors can vary as regards decisiveness, and C2 thought that they could procrastinate and find it difficult to make a decision. This could be partially explained by the view from C1 that 'there's probably more angst for young junior doctors in decision-making because they are not used to having to make those decisions on their own without the benefit of input from other people'. One of my own clients (diary note, 02/06/11) would have benefited from both information and experience in the specialties she was considering, as her career difficulties were exacerbated by a lack of work experience in one of the options she was considering.

C2 suggests doctors may need to consider the consequences of the decision before they make it. The need for a realistic time frame is also recognised by C13, who said she tends to 'get them to set a realistic timescale for the decision, three to six months, and then set them a programme of how to get there, where they're taking little steps on a regular basis'. Stibel *et al.* (2009, p.149) say that 'judgement and choice do not always go together'.

Coaches thought that doctors could be hostile or wary, and under pressure to make decisions. The pressure can come from the wider social influence, with D1 suggesting that:

'I think the NHS wants to get doctors trained, working and providing a service. I feel this is coming through from a business perspective and it puts the pressure on them to make career decisions … It means people are making difficult decisions at an early stage.'

C9's view is that doctors need to have a plan B, as medicine is a competitive profession, and a doctor may not secure their first choice. C6 also thought that doctors should be open to unexpected opportunities, and Shottin (2010, p.62) develops this further by arguing that there is a need to be 'proactive in order to capitalise on unforeseen events'.

4. Plan implementation

Plan implementation has much in common with action planning in coaching. One coach (C6) describes it as the mechanics of what doctors want from career support, and a number of coaches recognise that action planning is key to the work they do; C8 said:

'... one of the things I really got from coaching (training) was the last bit, the sort of the planning element to it, and really being focused and really getting commitment to action at the end.'

The most frequently mentioned activities link directly to job hunting and the recruitment and selection process: application forms, CVs and interview skills. D4 valued coaching support with the application process and developing her CV; she found it helpful to find out how she could improve her application. C3 said that:

'There are all sorts of online application forms these days, and that's part of it as well, so there's that structured sense of … "what have you got that you need? What's in place already and what do you need to work on?"'

Preparing for an interview and interview skills are areas of concern for doctors; C3 said:

'Things like interview skills, and we do a lot of rehearsing, asking them questions, and sometimes they'll have thought about the questions. One particular client … visited the hospital, which was great … Brownie points with the interview panel … it settled them, it gave them confidence that they knew what they were talking about.'

If doctors experience problems with interviews, it can lead to them reassessing their career choice and needing to start the process again with self-assessment. For example, one of C9's clients came to coaching to discuss career options because they 'didn't do well in the interviews for core medical training'.

How coaching is organised

Coaches who work in university careers services and deaneries generally operate on a referral basis, with more prescribed methods of working with doctors. Coaches who work with doctors on a freelance basis have a range of mechanisms for working with individual doctors. Two coaches explained how they have set up career support structures in their own deaneries. C8 thought that her master's in mentoring and coaching in an organisational context had enabled her to set up a career coaching structure in her deanery, and that the course had given her 'a lot more confidence in carrying out some of the things that I put in place'. C7 utilised his own experience as a medical student, where he had experienced problems, to underpin the work he had

done setting up a mentoring programme in his deanery. Table 5.1 shows how coaches work with doctors.

Table 5.1 – How coaches work with doctors

	University and deanery careers services	**Freelance coaches**
Client group	Consultants Postgraduate doctors Medical students	Individual doctors Trusts who refer doctors
How clients come to coaching	Mainly referral basis	As individuals Referral basis
What coaching is offered	Different models of consultation, from brief surgeries to a number of sessions Never one size fits all	Either book sessions in blocks or one at a time Preference for short-term clients Number of sessions varies
Ongoing coaching	Confirmed follow-up date and session Time between sessions varies	Can be no follow-up Time between sessions varies
How coaching is delivered	Email coaching Face-to-face coaching Telephone coaching	Email coaching Face-to-face coaching Telephone coaching

The majority of the deanery-based coaches see people on a referral basis, and those based in universities on a referral and a drop-in basis. They use a range of ways of working with clients: for example, C6 (a deanery-based coach) offers different models of consultation depending on what support is required, and reviews all the cases that come to the deanery. She usually sees those doctors, who have a range of complex issues and are likely to need a number of sessions, and refers to a university careers service those who have more specific needs: for example, assistance with the recruitment and selection process into higher specialties.

Freelance coaches are usually contracted either to provide coaching directly to an individual doctor or to a hospital trust, which then refers a doctor to the coach for coaching. A freelance coach (C12) explains that: 'doctors come to me through two different routes: they either come to me of their own volition and they are then paying the bill themselves, or … via their employer, most commonly the Trust'. Another deanery-based coach (C9) recognises the value of having access to an external coach for some doctors, and that in her deanery: 'some people self-fund and some people the deanery will refer them, and that's a very good resource'.

Both groups of coaches work to specific guidelines on what coaching doctors are offered, although those who work with individual doctors directly have more freedom to tailor coaching to the individual. For example, one deanery-based coach (C5) usually

only sees a doctor once for coaching, as the doctors who might require support work are in a very geographically dispersed area, and it can be difficult for them to get the time to travel to see her. C6 is a deanery-based coach, who generally sees doctors with more complex career issues, while D4 reported her coaching (from me, a deanery-based coach) took place over 'between five and seven sessions, each of which was approximately 1–1.5 hours long'. C2 primarily works for a university careers service where there are more prescribed ways of working with clients, who are usually limited to two sessions, and her view is that the 'client should be able to move on him or herself, and if you give them two, possibly three hours then that's probably enough'.

Freelance coach C12 explained she had different guidelines for each group. If the trust is paying, she said: 'they usually want a set number of sessions … I usually recommend six'. If the doctor is paying for the coaching themselves, then she says to the individual that:

'It's likely that we're going to need a certain number of sessions to tackle the issue that you want to tackle, but I'm going to leave it completely open for you about how many sessions you think that is, and we will review it along the way together, but you are in the driving seat.'

Freelance coaches rely on their websites, word of mouth and other methods to attract clients, and then develop an individual programme for each client depending on their needs. Liljenstrad and Nebeker (2008, p.58), in their study of coaching services, argue that technology, and particularly the Internet, is 'helping to spread coaching too by providing coaches with greater access to clients both domestically and internationally'.

Meeting face-to-face for coaching was valued by clients (D2, D4 and D6). Telephone coaching is also used by some coaches, although one coach (C7) is not keen on this method. C11 says that telephone coaching does have the advantage of providing her with anonymity. Clients D2 and D6 say that they benefited from telephone coaching. Furthermore, the issue of a widespread geographical area – for deanery-based coached particularly – could be overcome to some extent with the provision of telephone coaching.

Clients come to career coaching either by being referred to a coach, or by approaching a coach directly, with C12 suggesting:

'Some people particularly come to me because it's on the website about me leaving medicine … people will often say … "you've had an interesting career", and I usually laugh and say "well yes, and most of it has been unplanned".'

C12 also identifies the importance of being clear with clients in an initial conversation, about what they think coaching is, and to establish that the client believes the coach is the right person for them; and if not, then C12 would suggest an alternative coach. C10 thought that sometimes you have to say to people 'well I think this is not the right time for you to do coaching, come back later on', and C6 identifies mental health issues as a reason for referral to another service. This view is supported by C8, who suggested that: 'there are some people … if they're seriously in difficulty for health reasons or whatever else … need funnelling off into somewhere else'.

Coaches also varied in their approaches to how ongoing coaching is managed. C2, though, emphasised the importance of setting a date to follow up on a session to review the actions agreed in the coaching.

Summary

This chapter has outlined three key findings linked to what coaches need to work with doctors as clients: (i) an understanding of the medical pathway; (ii) an understanding of career theory; and (iii) the ability to articulate how they organise coaching with clients.

Coaches raised concerns about changing medical career pathways, and there were also a variety of views of how knowledgeable the coach needed to be about medicine as a career. What participants thought was important was for coaches to be experienced and skilled. Doctors value a coach who is non-judgmental and an 'outsider'. The recent changes to medical career pathways have left many doctors confused about the options open to them, and this study suggests that coaches who work with doctors need an understanding of medical career pathways as a way of demonstrating their credibility as a coach.

Medicine as a career is competitive, with the suggestion that it does not suit everyone. The image versus the reality of a medical career was discussed, as well as the transition from medical student to working as a doctor. The metaphor of the 'medical bubble' was introduced, and its significance considered.

A four-stage process from the careers literature was utilised to support the categorisation of findings linked to the careers aspects of coaching. This process is used by just under half the coaches and was experienced by all the doctors. Coaches discussed the use of a wide range of self-assessment activities, including psychometric assessments, with the aim of developing their clients' own understanding of

themselves in relation to their career plans. Doctors found the exercises helped them develop their career thinking.

Exploring career options was seen as a valuable activity for doctors, and particularly those who were facing difficult career choices. One coach described this activity as 'mapping the territory'. For doctors in the foundation programme, tasters are a way of experiencing a specialty they are interested in but unlikely to work in, before they apply for a specialty training programme. One deanery-based coach saw setting up tasters as part of her role. This was not mentioned by other coaches. There is a fine line here to tread between encouraging doctors to carry out their career exploration and the doctor relying on the coach to do it for them. It can be helpful for coaches to have a working understanding of career theory and practice, and access to a range of tools and techniques in their 'toolbox'. Doctors find exercises involving areas like values and skills, as well as psychometric tests, beneficial; this is a view supported by Allworth and Passmore (2008, p.23), who argue that psychometric tests 'can be useful tools for coaches to support their clients in building awareness through self-exploration and understanding'. One client thought that more frequent and shorter exercises during the coaching would have helped her career thinking.

Exploring career options for alternative careers was seen as valuable by doctors, although they could find it difficult to relate career options to themselves as individuals. Coaching can help support this activity, and coaches need to consider how much help they provide to doctors with regards to career exploration.

The findings propose that coaches be clear about what they can and cannot do for their clients. One of the clients interviewed for this research would have found it helpful to have access to clinicians in the deanery who could provide information about their specialty; and this is an area deaneries could consider as part of their career management activities.

Decision-making forms an important part of career coaching. Doctors can be nervous about making decisions that they think will be difficult to change. Participants in this research used a wide range of strategies, exercises and tools. The most frequently mentioned rational exercises were pros and cons, ranking and weighting approaches, and scaling exercises. Reflecting on previous decisions and NLP techniques were discussed, as well as using visual ways of supporting decision-making, like getting the decision on paper. Coaches use inventive ways of supporting doctors' career decision-making.

The final stage focuses on the 'mechanics' of careers work and job-hunting, such as application forms and interview skills. The majority of coaches had substantial experience in this area, although about a third of them preferred not to do this work: what one coach described as the 'nuts and bolts'. Goal setting is seen as an important part of coaching doctors.

The findings indicate that coaches structure coaching for their clients in a wide variety of ways, which seem to be dependent on the organisation they work for and how the doctor comes to coaching. Technology and geography are additional factors for coaches when deciding on the coaching they provide, and coaches also make choices on how coaching is delivered: for example, face-to-face or telephone coaching. This research indicates that coaches who work with doctors need to be clear about the practical aspects of how coaching is organised with clients, as well as what their expectations are of clients.

In Chapter Six, the coaches' approaches to coaching are considered, together with the role of trainers and supervisors in the provision of career support, and the researcher as a coach.

Chapter Six – Coaches' approaches to coaching

In this chapter I outline the findings from the analysis of the qualitative interviews and my own reflexive diary to consider the coaches' approaches to coaching. The chapter is divided into six sections, as shown in Figure 6.1, together with an overall summary at the end.

Figure 6.1 – Overview of the themes relating to the coaches' approaches to coaching
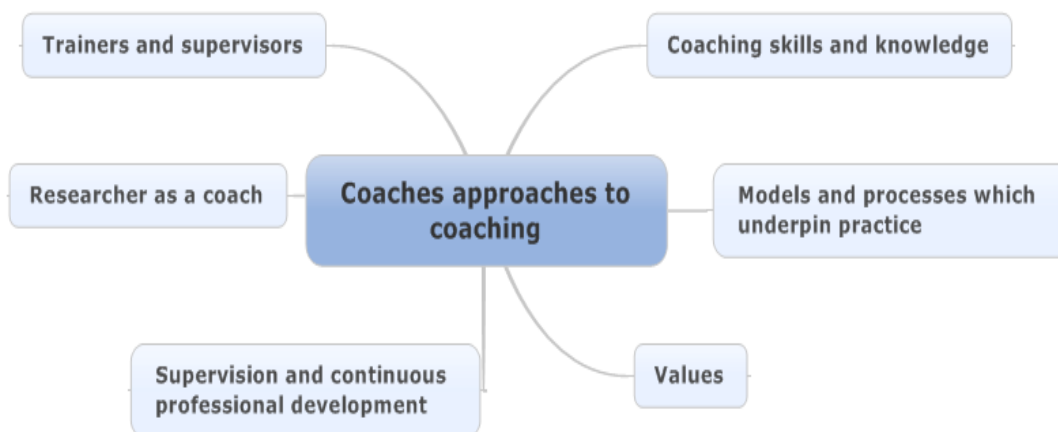
This study identifies that coaches seem to have a number of key aspects that relate to them as coaches: their own personal characteristics, their knowledge and experience, their values and models, and the processes and skills that underpin their practice. All the coaches mentioned a range of personal attributes they drew on when coaching doctors, including being able to appreciate people's perspectives, having a desire to help, being flexible, and having language skills, patience and visual skills. One coach (C5) said 'I guess we all bring our own styles of approach and practice to what we do' and C12 'I'm so lucky. I love my job'. The notion of being a coach is related to what Van Nieuwerburgh (2011) describes as a 'way of being' in coaching.

Coaching skills and knowledge

In the analysis of the interviews, having coaching skills was identified as a theme, with C6 recognising the 'experience and skills of the practitioner' in careers work. Coaches mentioned a wide range of skills they used when working with doctors. Listening, questioning and challenging were discussed the most, together with a number of other skills. Table 6.1 shows how these coaching skills have been compared with the Ali and Graham (1996) model of career counselling skills. In addition, a number of other coaching skills were mentioned, which do not directly correlate with the Ali and Graham (1996) model. Coaches described how they needed to be more guiding, present,

impartial, neutral, open-minded and non-judgemental when coaching doctors, as well as when dealing with a doctor's emotions. For example, C8 thought that: 'one of the most important bits about coaching is being present with the other person and giving them undivided attention'. C5 also recognised the importance of: 'keeping your own emotions under wraps as well, trying to be neutral', and being completely impartial was recognised as important by C4. The additional skills coaches described were: giving feedback, using their intuition, listening to the story and to the client, and understanding what people don't say. The importance of providing feedback to doctors was raised by two coaches, with C3 indicating that, for clients, 'one of the expectations and agreements is about feedback, how they take feedback and what level of challenge somebody wants'. Stober and Grant (2006, p.321) also recognise the importance of feedback from the coach.

Table 6.1 – Comparing the Ali and Graham model of career counselling skills with coaching skills

Ali and Graham model of career counselling skills	Coaching skills
Active listening skills:	
Observing the client's behaviour	Body language
Listening to the client's words	Listening to the client's story
Listening to the adviser's feelings	Listening to the coach
Listening to silence	Silence
When to break a silence	
Listening – what the client hears	
Understanding skills:	
Restating	
Paraphrasing	Testing understanding
Summarising	Summarising
Questioning	Asking questions
Interpretative skills:	
Challenging	Challenging
Being specific	
Self-disclosure	Self-disclosure
Immediacy	Immediacy
Effective provision of information	

With regards to understanding what doctors don't say, C10 said that: 'You come to a point in coaching where … you have perhaps enough experience … it's not only what they say or what they don't say, it's what they can't say, because words are limiting'.

In addition, dealing with doctors' emotions during coaching was widely raised by coaches. C6 thought they could have an impact on both the coach and the doctor: 'I think that these are people who are very distressed … as a practitioner one needs to

be able to contain that level of distress and not let it overwhelm the trainee or yourself'. C2 said about one of her clients:

'He had to go out and find a job. He wasn't sure how he would do that, and so we dug under that and it turned out he'd never really had to do anything like that ever before in his life, so he was quite frightened of that, even though he was a very self-assured, very marketable young man.'

Emotions can impact on career actions, which is a view supported by McIlveen and Patton, (2007).

Listening as a key skill for coaching was mentioned by all coaches. C8 said that: 'in terms of what would make the biggest difference to trainees it would be the open-minded listening'. The value of listening to a client is that it helps clients articulate to themselves what they are really saying (C1), and that: 'sometimes they see it as an enormous relief to have a completely external person who is prepared to come along and … listen to their story from beginning to end' (C12). The importance of listening as a key skill for coaches with regard to the potential for successful outcomes for clients, is discussed in the coaching literature (e.g. Wasylyshyn, 2003; O'Broin and Palmer, 2006).

The value of linking listening to asking questions was recognised by C5:

'And I tend to find, by listening to stories, picking up themes, influences from past decisions, it helps to frame a good set of critical questions about "what's real now? Does this factor matter now? How important is this now compared to how important this was when you made that decision? ... that would be the kind of flow through into the line of dialogue I'd be looking at.'

In particular, the ability to ask open questions is a key coaching skill, and C6's view is that there is a need to have some sort of process, a set of skills, and that this needs to be explained to trainees in the sessions she has with them. Research by Newsom and Dent (2011, p.1) into the work behaviours of coaches indicates that open questions are one of the three most frequent coaching behaviours for coaches; with the other two being 'establishing trust, honesty and respect and clarifying and understanding client concerns and challenges'.

Challenging was also seen as an important coaching skill by coaches. C4 described how she challenged a client 'quite toughly', and with another client how she tried to 'challenge her a little bit on some of the assumptions that she's had about herself because she hasn't actually had any evidence that she's not performing, but her perception is that she's always failing'. In contrast, doctors as clients can be seen as

challenging. C10 described it as 'the doctor plays the role of [having a] very directive way of speaking … very commanding … in terms of leadership'. A coach providing career support to doctors needs to be aware of the medical career structure and culture when working with doctors (see Chapter Five).

Most coaches were clear that their role was to support clients to solve their own problems and to take care when giving advice. However, the need to avoid providing solutions to people's problems is described as a challenge by C12:

'Yes, and one of the things from my own development … is that as a coach, to get over this need to do things and the need to make it right … I suppose having also trained as a doctor myself, that we are taught to give advice and solve people's problems, and so there was always this great desire to rescue people … I'm not sure whether that desire will ever go away but with time I've tried to sit on it.'

C12 also raised the issue of self-disclosure. She suggested that it could benefit her clients, although another medically qualified coach (C11) recounted how she felt it necessary to: 'hold back' and be clear with the doctor that it was their agenda that was important. However, some doctors may come to coaching looking for answers (C7). CIPD (2009, p.17) indicates that where the coach wants the client to solve their problems themselves, it is a sign of mature coaching, and the coaches interviewed for this research have considerable experience in coaching.

These coaching skills, together with what the coach does in the coaching conversation, seem to link into the coach being a facilitator within the coaching relationship (see Chapter Seven). There also appears to be a link to the coaches' values when reviewing the data on what the coach does to facilitate the coaching for the client: creating space, developing people, helping to construct their thinking and helping to see something better. However, there is no published research on coaches' values, so this link can only be inferred from this research. C3's view is that 'the role of the coach is to create space for intellectual work or emotional work or practical planning for the future kind of work', and C10 suggests that coaching is more about developing people. A number of coaches described their work as holding up a mirror to their clients. 'Making it real' was mentioned by C4, and all the coaches stressed the importance of the coaching being client-led in order to build capacity and sustainability in the client.

In addition to the coaching skills that have been discussed, the majority of coaches identified that they needed to know their own boundaries, especially if coaching a particular client would be outside their individual competence. Six coaches specifically mentioned that having knowledge of counselling was beneficial to their work. C10

called it 'knowing the edge'. How deeply a coach works with a client was described as 'the depth of the exploration' by C6, and C13 related an instance of a doctor who did not engage her as a coach, as the initial coaching brought some deep emotional issues to the surface, which the client did not want to explore further. Grant (2007, p.250) indicates that 'coaching focuses both on facilitating goal attainment and enhancing well-being'. His research findings 'underscore the importance of coaches having a sophisticated understanding of the issues relating to coaching and mental health'.

With regard to their own responsibilities and personal preferences, the coach participants in this study raised a number of issues. Freelance coaches had more of an opportunity to express their own personal preferences for the coaching they provided to doctors, with C13 explaining that she was now 'less willing to do the nuts and bolts', by which she meant supporting people to apply for specific jobs. The situation for deanery-based coaches can be somewhat different. C8 is the associate dean for careers, and sees trainees who are experiencing significant career issues. She sees herself as 'the last resort' for a doctor as regards their career. C6, as a deanery-based coach, thinks she has some responsibility for the outcome of the coaching she provides. McIlveen and Patton (2006, p.23) indicate that career counsellors should be critically self-aware, and should self-confess their power in the relationship with the client and be 'fully conversant with the theories and discourses they are practising'. The CIPD report (2009) on line managers as coaches recognises the importance of power and the need for the line manager to consistently be a role model of coaching characteristics. In some instances deanery-based coaches have multiple responsibilities to their organisation, which need to be explained to their clients. Beven (2009, p.13) also says that the perceived power relationship can influence a client's state of readiness to take action, which he defines as motivation.

The findings here indicate that coaches who work with doctors need to be aware of the boundaries of their own competence. Respondents raised the importance of understanding when counselling might be more appropriate than coaching. Doctors as clients can be challenging, and coaches need to be clear about their role and preferences for the type of coaching offered to clients. Supervision is potentially a way for coaches to explore these issues.

Models and processes that underpin practice

When discussing their work with clients, coaches mentioned a wide range of models and processes from the careers, coaching and mentoring, and management literature, which inform their own practice (see Table 6.2).

Table 6.2 – Models and processes

Career counselling
• Ali and Graham (1996) model
• Myers Briggs Type Inventory (MBTI)
• Books by Houghton (2005a, 2005b)
• Narrative approach to careers
• Exercises from Nathan and Hill (2005)
• The ROADS to success (Elton and Reid, 2010)
• Windmills careers programme (Hawkins, 1999)
Coaching and mentoring
• Egan model (Egan, 2007)
• Emotional intelligence
• Goal-oriented models
• GROW – Goal, Reality, Options and What will you do (Whitmore, 2002)
• Neurolinguistic Programming (NLP) coaching techniques
• Time to think (Kline, 1999)
Management literature
• Gallup thinking on strengths-based leadership and the strengthfinder questionnaire
• Maslow's (1970) hierarchy of needs
• Understanding motivation

The data suggests this breadth of approaches is linked to how each person in this study developed as a coach. Five coaches trained initially as career counsellors, where they were introduced to a wide range of career theories and models as part of their postgraduate courses, and seem to have adopted those that meet the needs of their client group. The medically qualified coaches (seven people) took a range of coaching and mentoring courses, with two of them completing postgraduate courses. One freelance coach has a background in organisational consulting and now runs a coaching company. The most commonly cited models were: NLP (Grimley, 2010) (four coaches), ROADS (Elton and Reid, 2010) (four coaches), MBTI (three coaches), GROW (Whitmore, 2002; Shelly, 2007) (three coaches) and Egan (2007) (two coaches). Overall, having a 'kitbag' is seen as beneficial by coaches, however the need to try out different models and processes with doctors is identified by C2:

'The whole concept of providing career support to doctors in training is relatively new … we've got all sorts of good models and good structures, but it is a very specialised field and they do come with certain issues or baggage that might differ from the mainstream careers climb … I do think we have to try out different things, we have to feel our way, we have to see how different trainees, different doctors, different undergrads react to different models of career planning, and different ways of helping them to help themselves, which is what we're here for.'

Coaches mentioned two particular aspects of NLP: modelling excellence (C11) and using NLP to moderate their own work as a coach. Those who made use of NLP initially trained as life coaches, and then found their clients brought career-related and

career development issues to coaching. Interestingly, this accords with Grimley's (2010) view that NLP coaching is a flexible approach that can be used in a wide range of coaching contexts.

The ROADS book (Elton and Reid, 2010) offers a career management approach for medical students and postgraduate doctors. C2 explained how one of her clients used it:

'He was very motivated but he was very confused and during the interview I mentioned to him the book called "ROADS" … it'd be just a good idea if he could dip into this and have a think about how it applied to him, and he returned … he'd read the entire book and he'd acted on it … and he'd found it stunningly helpful.'

This career resource book was developed by a colleague and myself, after an extensive review (Elton, 2006) of what was needed to support doctors with their career management. It is interesting that in this case, the doctor had utilised the content after one session with a coach.

MBTI was mentioned by a number of coaches, all of whom are trained practitioners. C4 has found it helpful to: 'be aware of the cues … as to how I might modify how I work with somebody'. C7 is a trained MBTI practitioner, and thought for some of her clients it can be 'a light bulb moment' and be used to 'question those drivers' that are part of their career issue. Using MBTI in coaching is supported by Carr *et al.* (2008, pp.54-57), who propose ways of working with clients related to their dominant type preference. Additionally, Borges and Savickas (2002), in their literature review of medical specialty choice and personality MBTI type in the United States, argue that there is more variation in personality type within each medical speciality than between different medical specialties. Gibson and Borges's (2009, p.349) more recent research indicates the need to work with individuals to 'help them understand their needs and wants with regards to work, to form realistic expectations of their work life as a physician, and to incorporate salient life roles into career planning', which involves considering a range of ways of working with doctors rather than relying on one aspect, such as personality.

Coaches who are also medically trained mentioned specific models, for example, GROW (see Table 6.2) and Egan (2007), which they modify to suit their own particular coaching practice. How the GROW model (Whitmore, 2002) – with its focus on identifying a goal for the session, exploring the client's reality, identifying options, and on the clients deciding what they will do – is used by C8, is described in the following story:

'If I can have some email interaction with them to start with, find out what they want to get from the thing, so get the sort of the 'G' out of the way beforehand basically, and even some of the 'R' by … getting them to come with something that can at least précis where they're up to, and so that we can sort of focus the interview on something more. Of course if either of those two are where their main emphasis is then I would clearly focus there, but that would also come out on how they were prepared to engage in it beforehand.'

Egan's skilled helper model (2007) is focused on getting clients to tell their stories. C7 finds that when working with doctors using Egan they can 'let go of that bundle and off they go', and that 'the brainstorming bit … they can see the light … that bit of the model I've found very, very useful'. C5 also has an interest in the narrative traditions:

'It means that I'm predisposed … to think in terms of story and themes, themes and concepts. I tend to pick up on the language that someone is using and find a common theme in that, and from that you can often pick out a metaphor that's linking to their career issues. Battles and races are quite common.'

Savickas (2003, p.1), in his conference paper on exploring medical specialties, identifies that 'career is a biographical reflexivity with which individuals interpret their work lives'. Law and Stanbury (2009, p.18) argue that narrative and learning are historically entwined, and that 'fables, myths and parables are our longest standing teaching and learning methods'. This view is supported by Beven (2009, p.12), who says that the aim is 'to help clients engage with their stories in a constructive fashion', and by Rehfuss (2009, p.82), who indicates that understanding and enhancing the power of an individual's story is the role of the career supporter. A growing interest into the role a client's narratives play in career and personal development has been identified by Nathan and Hill (2005) and Beven (2009).

In this study, it appeared that coaches who were not medically trained used a wider range of models and processes from both the careers and coaching and mentoring disciplines. What they all had in common was their own way of working with clients, informed by models and processes that were a combination of those found in the career, coaching and management literature (see Table 6.2). Those who were medically trained had come to coaching in order to develop their own career, and their coaching training was primarily from a number of different theoretical approaches – for example, person-centred coaching and the NLP approach to coaching – and utilised a number of models, such as GROW. Those who were not medically trained had either career counselling/guidance training supported by coaching skills, or utilised a particular genre of coaching, such as leadership coaching.

Values

During the coding of the data, I was struck by the number of times coaches mentioned 'values' in relation to their work. In Table 6.3, values mentioned five times or more have been classified using the Hopson and Scally (2009, p.48) approach to work values. This asks an individual to identify their key values into three broad areas of what they would they like in their work: being, having and doing. Some values were outside this classification and are shown separately in the other column.

Table 6.3 – Coaches' values

Being	Having	Doing	Other
Challenge	Clarity	Achieving	Expectation
Creativity	Experience	Developing	Honour their values
Learning	Knowledge	Exploring	Relationship
Practicality	Responsibility	Facilitating	Trust
Reflection	Structure	Hearing the client	
Understanding		Helping	
		Interesting	
		Supporting	

McCann (2008, p.66) says that values are 'fundamental concepts or beliefs that people use to guide their behaviour in the workplace'. In the careers literature, Nathan and Hill (2005, p.57) describe work values as:

'The degree to which a person regards his or her work as worthwhile. This "worthwhileness" includes the amount of power, autonomy, creativity, learning, altruism, security, status and money which are sought in work.'

One of the subsidiary research questions seeks to find out how coaches 'operate' when coaching doctors. The BMA (2008) report into professional values for doctors identifies that 'competence to practice' medicine is their most important value, followed by caring, compassion, commitment, responsibility and integrity. Responsibility seems to be important to coaches and doctors alike. Having knowledge and experience were identified as values for coaches, and this has similarities to the notion of competence for doctors. 'Support and helping' for coaches seem to be along the same lines as 'caring and compassion' for doctors. Coaches also bring in the importance of trust and a more specific focus on learning and creativity.

Later in this chapter I compare these values of participant coaches with my own values as a researcher and coach.

Supervision and continuous professional development

Two key aspects for a coach – knowing who I am and 'knowing the edge' for coaching – were mentioned by C10 in the section on coaching skills and knowledge. Three coaches mentioned the importance of knowing their MBTI profile, and C10 indicated that coaches needed to have some kind of background or training in counselling to know where their limit was:

'It's important to know the differences so that you can really say "oh this is the edge", this is where I can say "well now this is not coaching anymore" … I would find for me very difficult to do the two at the same time.'

As previously discussed, in order to work with doctors as clients there seems to be a need for coaches to understand their own boundaries and limitations, as well as their own specific areas of expertise. In addition, coaches recognise the importance of continuing to learn and support themselves when working with clients. The benefit of supervision was described by C12 as 'I've had times where I've thought "what on earth is going on here?" And then that's really helpful to have somebody else to help you look at it from a different angle'. C4 also describes how she has formal supervision in her role:

'I go once a month to look at cases … the work that I do, and again that really helps me to perhaps see a different perspective if I've really struggled with something or feel that there's a block or that I'm stuck with something, to explore that with somebody who's been trained and may be able to bring some of that back into the work that I'm doing with that particular individual.'

The importance of supervision (Fillery-Travis and Lane, 2006) and its link to continuing professional and personal development is a view supported by Hawkins (2010, p.383), who argues that coaching supervision should assist the coach in developing their own expertise as a coach, mentor the coach's own development, and provide 'an external perspective to ensure quality of practice'.

Trainers and supervisors

Doctors in foundation and specialty training programmes have their work overseen by educational and clinical supervisors (collectively known as trainers and supervisors) who are senior clinicians. The role of trainers and supervisors in the provision of career support was discussed by coaches and doctors alike. C1 suggested that she could provide an 'agenda free, professional objective relationship', which she thought was 'incredibly powerful for people'. This was thought to be in contrast to what doctors might experience in their day-to-day work. Those in training have both a clinical and an educational supervisor, many of whom are senior hospital consultants. Educational

supervisors are expected to meet their trainees regularly to discuss their progress within the training programme (foundation or specialty) and, where necessary, their career aspirations and plans. Clinical supervisors also offer careers advice to postgraduate doctors.

At work, doctors are 'seen' by their supervisors, peers, patients and the general public. Within the clinical environment there is a structure that was described by one doctor (D3) as follows: 'the trouble is that the hierarchy is so vertical and so important, so massive … and then the politics'. Furthermore, doctors are concerned about 'not rocking the boat' (C3). D2 suggested that supervisors were: 'not the best people to provide career support', and C2 said: 'I think most of those people were extremely well meaning … but they may not necessarily have been doing it to the benefit of many of their younger peers'.

This view was also supported by C6, who suggested that clinicians expected doctors to experience a specialty – in this case, anaesthetics – as they themselves had:

'I have spent 10 years doing clinical observations of clinical teaching, so I've been on ward rounds and operating theatres … I've always been the observer rather than a participant, which I think is helpful … I think I don't make that mistake that clinicians can make that their experience of anaesthetics is how everybody would experience it.'

There are also other challenges when seeking support from people a doctor works with. C13 identified it as: 'they're working with a group of people that they just don't get on with, or who are not at all supportive'. C13 then went on to say that people in powerful educational positions can 'wreak havoc for other people, because people who are insecure in positions of power cause an awful lot of problems'. A number of coaches expressed their concerns about people in senior positions having negative opinions of the medical career structure, and the impact this could have on medical students and doctors; C1 indicated her concerns as follows:

'What worries me is a lot of the more experienced doctors who went through a different system where they were able to be an SHO [Senior House Officer] for many more years to discover their sort of natural preference, these are now the consultants of today, and a lot of the medical students I work with say "oh God, a lot of the registrars and the consultants in my firm say, 'oh, you know, poor sod, you've … got to decide really quickly haven't you? That's a real shame, we didn't have to do that'". So the students are often being given this message that they have been disempowered and they're at the sort of mercy of this system and I do think that's sometimes perpetuated by some of the comments of the more experienced medics.'

In addition, C8 thought that one approach would be to get away from doctors giving advice, and D2 stressed the importance of educating the medical profession, as

'educational supervisors are not always knowledgeable about specialties other than their own, or career options which might be possible'. C2 suggested that:

'The people who usually help doctors, particularly if they are at points of transition or they needed to make important decisions, are not usually trained in any form of careers work, coaching, guidance, counselling or whatever … I think all we can do is what you're doing, educate more senior doctors, educate MEMS [Medical Education Managers], get them thinking about the careers process, because they tend to come to us, when all else has failed.'

Participants did, though, recognise that doctors do seek support from their colleagues and supervisors to help them with their career choices, as well as coming to coaching. In the medical field, doctors frequently consult an expert in another specialty if a patient presents a number of health issues. Also, medical students and junior doctors seek help from consultants, as they are seen as experts in their field, and their skills and influence is valued (Bosley *et al.*, 2006). However, this is not always a successful strategy when seeking information and advice about careers, as consultants are not always familiar with the new medical career pathways and may not be familiar with specialties other than their own. Consultants may not recognise the value of their own networks (Bosley *et al.*, 2006) to the student or doctor seeking help.

Furthermore, trainers can also experience difficulties when providing career support. C1 indicates that more senior doctors can find it frustrating that 'junior doctors and medical students … can't accept that systems won't necessarily bend around to fit them'.

Postgraduate doctors in training programmes are in both education and work in the NHS. This research indicates they can inhabit the 'medical bubble', which means that they do not look beyond clinicians for advice and support; their source is usually trainers and supervisors. Educational supervisors are one group of people widely consulted for career support (Goodyear *et al.*, 2007, p.214). Although the research by Hirsh *et al.* (2001) and the BMA (2010) proposes that trainers and supervisors should be the ones to provide careers advice, this research indicates that they may not be best placed to provide career support unless they have an understanding of medical career pathways and are able to provide support rather than direct advice.

The researcher as a coach

In this section, I use the data from my interview with a colleague and my reflexive diary to consider my interest in careers and coaching doctors, and my own values in relation to those of the coaches interviewed for this research. In the pre-interview I discussed some of the key points in my own career history, which, looking back, are significant as

far as developing my own interests in careers and coaching are concerned. In this section I am utilising an idea from Simons (2009, p.93): writing about 'self' in relation to my study.

My coaching style and approach have been influenced by the professional development paths I have taken, as discussed in Chapter One. Understanding my own values and how they inform my practice is an area I revisit as part of my own personal development. I considered these values in relation to how they influenced my choice of topic, and compared them to those that seem to have been important to those coaches who were interviewed for this research. Table 6.4 compares my own values with those of the coaches who took part in this research.

Table 6.4 – The researcher's and coach participants' values

Researcher's values	Shared values	Coaches' values
Flexibility	Challenge	Creativity
Individuality	Developing people	Experience
Intellectually stimulating	Helping	Exploring
Expertise	Interest	Relationship
Professional	Learning	Responsibility
	Practicality	
	Supporting	

My values relate to both my work as a coach and those I bring to the research (Simons, 2009, p.93). There are some interesting similarities and differences between my values and those of the coaches I interviewed for this study. For example, there are seven shared values and five that are not shared. Values relating to our practice vary significantly, with the coaches citing creativity, experience, exploring, relationship and responsibility, and myself citing flexibility, individuality, intellectually stimulating, expertise and professional. The coaches who participated in this study come from a wide range of backgrounds, which might go some way to explaining the similarities and differences in our values.

How I work with each client is determined according to their needs, and I utilise a range of models, processes, tools, techniques and skills from the careers, management, and coaching and mentoring literature. Working with doctors as clients can involve supporting their career decision-making and using both rational and intuitive approaches. In addition, my coaching approach is primarily goal-oriented, and the work I do with clients can be goal-focused and concerned with their personal and adult development (Ives, 2008). Chung and Gfroerer's view (2003, p.141) is that career coaching 'combines the concepts of career counselling, organisational consulting and employee development' and that there is an overlap between career coaching and career counselling, which seems to be indicated by this research. The length of the

coaching engagement with each client usually lasts between one and six months. Doctors are frequently referred to me when they are having difficulty making specialty choices. The time frames for the associated recruitment and selection periods are short, and this means that the amount of time available to coach them is limited (Ives, 2008).

A further challenge concerns when I coach and when I refer on. One feature of the work I do with doctors is that they may have mental health issues that are impacting on their career choice. Recent work by Maxwell (2009) has considered the boundary between coaching and therapy, and the bounds of confidentiality I have with doctors are such that I do need to consider patients and their safety, as doctors are required to adhere to the GMC's code of practice.

As a practising coach, I have my own coach-supervisor with whom I raise issues relating to my own practice, and I carry out self-coaching from the perspective of being a researcher by asking questions of myself and my place in this research. Writing my thoughts down in my reflexive diary has been helpful, and an entry for 22/10/10 helped me understand an aspect of myself as a coach, which I was not attending to. When coaching, I ask questions and gain insights, which I share with my clients, but which I cannot easily explain from a logical perspective. I find the concept of the 'third eye' (sometimes called the mind's eye, which is a way to 'see' things with the mind) helpful, and for me it signifies the use of space and time when coaching individuals.

Summary

This chapter has presented six overarching themes linked to the coaches' approach to coaching: (i) coaching skills and knowledge; (ii) the models and frameworks that underpin practice; (iii) values; (iv) supervision and continuous professional development; (v) the role of trainers and supervisors in the provision of career support; and (vi) the researcher as a coach. The coaches vary demographically (see Table 3.1) and come from a variety of backgrounds (see Table 3.2).

Coaches saw their role as a facilitator for the coaching (Stober, 2006, p.20), and what the coach does when they are coaching doctors was seen as important. Coaches may find that some doctors express a range of emotions, and need to be attuned to when this distress is a possible indication that there are other mental health issues that are outside the competence of the coach. A range of coaching skills was described: for example, being present, listening, challenging, and asking questions, as well as being aware of what they do as coaches. Eraut (2000, p.14) argues that skills are part of

personal knowledge, and represent 'the cognitive resource which a person brings to a situation that enables them to think and perform'. The coaching skills mentioned most frequently were: being present, listening and challenging, plus the use of appropriate tools and techniques. Coaches described their role as having an important part to play in building the relationship with the doctor as client, helping them see something better, supporting their development and building their capacity. A number of coaches described what they did as 'holding a mirror' to the doctor to help them see themselves and 'make it real'. One coach described their role as acting as a thinking partner. Coaches who work with doctors are encouraged to review their own practice and be clear about their skills and their coaching approach with doctors. Furthermore, being a coach to doctors means there is a need to facilitate learning and development for the doctor, make choices about the level of challenge to use, and if and when to self-disclose about their own career path; this is particularly relevant to those coaches who are medically trained.

In addition, the coaches who were interviewed utilise a wide range of models and frameworks in their practice. The models and processes that underpin their practice are from three main academic disciplines: (i) careers; (ii) coaching and mentoring; and (iii) the management literature. The most common of the coaching ones were: NLP techniques (Grimley, 2010), GROW (Whitmore, 2002) and Egan (2007). From a careers perspective, the work of Ali and Graham (1996) and ROADS (Elton and Reid, 2010) were frequently mentioned. Each coach's practice is underpinned by a number of models and processes, which vary depending on their initial training. All the coaches see the value of expertise they can call on in their practice.

Professional values (BMA, 2008, p.4), and particularly the 'competence to practise medicine', are important to doctors' own practice as clinicians. Coaches' own values were identified in their interviews, and (in Table 6.4) I compared their values with my own, which revealed some interesting similarities and differences. For example, we share the values of challenge, developing, helping, interesting, practicality and supporting and learning/intellectually stimulating. Coaches who work with doctors may wish to be aware of doctors' own views about professional values, particularly as regards competence, and also be cognisant of the values that underpin their own practice as a coach.

The need for supervision and continuous professional development was identified as important for coaches who work with doctors. A number of coaches had a range of other skills and experiences, including therapeutic counselling training. Coaches should

be aware of the limits and boundaries of their own competence, and be able to access supervision to discuss issues that are raised during coaching. This need for supervision was supported by the majority of coaches.

Previous research has suggested that clinical trainers and supervisors should provide careers advice and support. However, the participants in the research raised concerns about this approach, as their view was that it was important for providers of support to have an understanding of medical career pathways, and for the doctor seeking support to be the 'expert' in their own career. This might present a challenge to trainers and supervisors, as they are used to being consulted as experts in their own field.

In Chapter Seven I focus on the coaching conversation as a means of exploring in-depth the relationship between coach and client.

Chapter Seven – The coaching conversation

Doctors seek career support for a range of issues as identified in the previous chapter. In this chapter, data from the qualitative interviews and my reflexive diary is used to consider three aspects of the coaching conversation: (i) the coaching process, (ii) metaphors, and (iii) the outcomes from coaching. Figure 7.1 provides an overview of the key themes. The chapter concludes with a section summarising the key findings.

Figure 7.1 – Overview of the key themes relating to the coaching conversation
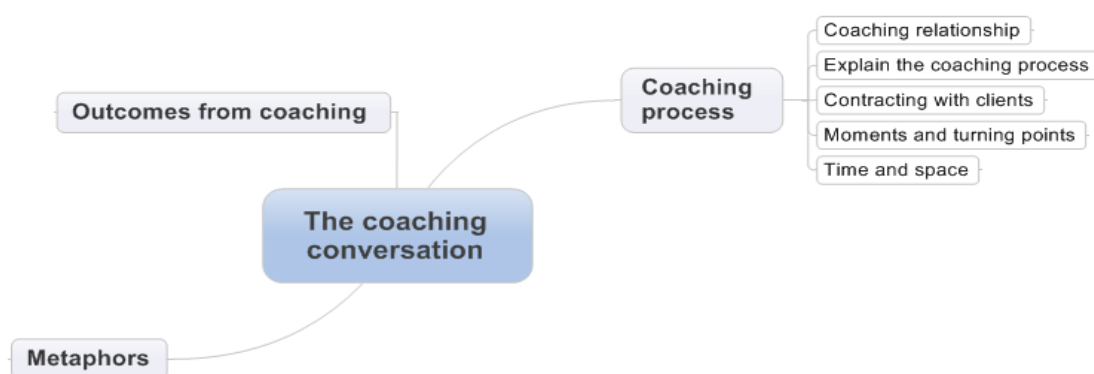
The coaching process

Five areas relating to the coaching process were seen as important by participants: (i) the coaching relationship, (ii) the need to explain the coaching process, (iii) contracting with clients, (iv) moments and turning points, and (v) providing time and space for doctors.

1. Coaching relationship

A coaching conversation involves a coach and a client, and can be carried out face-to-face, over the telephone or via email. Doctors bring a range of issues to coaching, which may change as the coaching progresses; C6 describes one of her clients:

'Although it started as a conversation on the sort of mechanics of CVs and application forms and interviews … over … a number of sessions it became about psychologically accommodating ... [him] into his new view of himself as a sort of a doctor who's about to assume consultant responsibilities.'

In Chapter Six, the role of the coach in the coaching of doctors is described as a facilitator, and most coaches thought that the relationship with the client was important; C12's view was that 'I am a great believer that the relationship is at the absolute centre of the coaching … without it the coaching doesn't work'.

Coaches recognised the importance of building trust and rapport in order to develop

the relationship. C8 said 'I do think that you probably do need one face-to-face interaction to kick off and to get to know each other and to really form a rapport'; C10 recognised the importance of building trust with the client, and C12 thought that the client should feel they were able to trust the coach. This view is supported by Day *et al.* (2008, pp.207-208), who indicate that 'the relationship between the practitioner and client is one of the most critical factors in both therapy and executive coaching', and that 'both client and therapist are seen to be active participants in the relationship'.

C4 works with some doctors over an extended period, and maintains an ongoing relationship with them:

'Through either the telephone or email … often they're having to go out and do stuff themselves and then they may be coming back in to review, to reflect, to regroup, to see where they might go next or what they might need to do next.'

2. Explain the coaching process

Coaches thought the coaching process needed to be explained and negotiated with doctors. C2 thought it was worthwhile spending time on 'how you are going to work together', as well as 'introducing clients to different ideas'; she thought that it can be 'trial and error to find what is best for your client'. Managing clients' expectations is important (C1). C3 said that one area of expectations and agreements is about feedback, how they take feedback and what level of challenge somebody wants, which links back to the coaching skills discussed in Chapter Six.

Coaches recognised the need to agree how the coach would work with the doctor, and what the coaching required of them. They identified the importance of being clear with doctors about what the coaching sessions would entail, and a key aspect was the issue of confidentiality. C5 ensures the boundaries of confidentiality are discussed, and C3 stresses that 'I believe that coaches should be working within a strong competent and ethical framework … I should know what I'm doing and know what my limitations are'. C11 makes it clear to her clients that she is providing coaching, not counselling.

Additionally, coaches discuss with doctors what their expectations are of them during the coaching process. They may ask doctors to bring something to the first session, develop goals for the coaching, and stress the importance of the doctor taking action. Coaches do, though, see the coaching as being client-led, and that it 'might be a first step in giving themself permission to make their own choices' (C3).

Within the coaching process, coaches saw themselves as having an overall facilitation role, which involved helping doctors identify where they wanted to get to, finding out

what motivated them and ensuring the agenda was owned by the client. C13 said that one of the important things about coaching was that doctors 'get clarity about what the problem is and what they're trying to achieve by changing'. C3 described her role as having 'a meta-view of where that client is going in their career'.

One feature of coaching is that it involves some form of structured conversation, starting with goal setting and culminating in action planning and the setting of deadlines. Coaches recognised the importance of goal setting for their clients and their role, with C4 saying that 'sometimes … people … need a bit of help and handholding to help them to feel more empowered … [and] start to make some initial kind of choices and actions for themselves'. With regard to goal setting, D2 said about coaching:

'I decided to change specialty and successfully achieved this. Coaching helped me to set goals to help achieve this, such as attending courses and speaking to colleagues in the specialty I wished to join for further guidance.'

Moving the doctor forward was seen as important by three of the coaches, with C7 indicating 'it is about moving them forward, but they're the ones that have to make the decisions about where they're going to go'. C3 also recognises the importance of reviewing progress:

'The step when we meet again is the review, and that review may be there just to go okay, tick off a bunch of things, or it may be an in-depth review, some reviews can take half a coaching session because of something they learned.'

In addition, facilitating the conversation involves the coach controlling the flow and helping the doctor understand themselves and untangle their career thinking, what their drivers are and what motivates them. D6 said that the value of coaching is that 'I had contemplated leaving my job altogether but it helped me to get back into my job'.

3. Contracting with clients

Once a client has agreed to work with a coach, then coaches thought it was important to 'build the contract' with them. C12 describes what she calls her 'intake session':

'I get them to fill out some sort of paperwork and we have an intake session, which is very much about our relationship, because I'm a big believer that that's really important … confidentiality and all those sort of bits and pieces get covered, but it's also a "where are they? And where are they hoping to end up? What are their goals?"'

The need for clear contracting with a client is supported in the careers literature by Ali and Graham (1996, p.49) and in career coaching (Hazen and Steckler, 2010, pp.314-315), where the coach needs to decide with the client the destination the client is aiming for, and the methods to be used to get there.

4. Moments and turning points

Coaches described a number of moments when coaching doctors, which they variously called 'aha moments', 'light bulb moments' and 'turning points'. What they all had in common was that they were times during a coaching session when a client made a discovery or gained an insight, which then impacted on the way the coaching progressed. Two quotes illustrate this:

'"If you could write your perfect job description what would it look like?" And I could just see coming over him … it was a lovely moment, he said, "oh, well I'd never thought of it that way before", and it was almost like the world had opened up for him, in that he had been working in this little box … suddenly it had occurred to him that he might be able to choose' (C13).

'The breakthrough moment was "do you know what? I'm not the same person that I was before as after, and therefore I can give myself permission to do things differently"' (C3).

De Haan's (2008) research into moments and incidents in coaching practice proposes they are present in the coaching relationship, and pivotal in the learning and development of the client. De Haan (2008, p.102) goes on to describe some of these moments as breakthroughs, and that they are 'moments in which deeper layers and ways of viewing and assessing things differently are found'. The research findings from this study accord with that view.

C13, reflecting on a critical moment when a doctor decided not to continue with her as a coach (which De Haan *et al.* (2010) would characterise as a rupture in the relationship), recognises that she has learnt what she prefers to do, and said to her client that:

'"I totally understand, I'm really sorry if I took you somewhere you didn't want to go" … I explained to her that I can do the practical stuff, but through experience I've noticed that it actually doesn't serve the client to do that when there are underlying problems ... I felt quite congruent about that, quite clear about what I will and won't do.'

5. Time and space

Seven of the coaches mentioned that an important part of coaching was that it provided time and space for doctors to consider their career issues, with C8 suggesting:

'One of the most important bits about coaching is … giving them undivided attention … that creates the space in which magic can occur … it's very simple to explain but it's not simple to do.'

Coaches explained that doctors as clients may have issues with time management. C11 has coached doctors with time management and work–life balance issues that

have been impacting on their career. C2 recognises that doctors as clients may be 'pushed for time'; in one instance, a doctor came to coaching with the request that the coach should tell them what to do in the 20 minutes available for the coaching session.

Doctors thought coaching provided them time to think, with D5 describing it as giving: 'me an opportunity to reflect on my career choice and consider other possibilities; it gave me the time to do that'. Coaching provides time for doctors to think; a view supported by Laske (1999).

Research participants also said that coaching created space for doctors. They described it in a number of ways, calling it a 'facilitating space', a 'safe space', a 'third space' (one which is co-created between the coach and the client) and an 'objective space'. C5 (a non-medically trained deanery-based coach) said she explained to doctors that: 'we can offer … [a] clear and objective space for you to explore current issues and future plans … we're quite explicit about "it's a space".'

Coaching as a 'third' space was mentioned by one coach. The counselling literature offers an interesting perspective from Froggett (2008, p.100), who explains that: 'Benjamin distinguishes between the energetic, symbolic and moral thirds', and that these 'thirds' arise in non-verbal inter-subjective exchange.

Metaphors

Participants in this research used a number of metaphors that seem to fall into three groups: (i) how a medical career is conceptualised (using the positioning and journeying approach from Law and Stanbury, 2009); (ii) how using metaphors can help clients gain new insights; and (iii) other metaphors relating to coaching doctors (see Table 7.1).

Table 7.1 – Metaphors in relation to working with doctors

Positioning and journeying	Helping doctors gain insights	Other metaphors
Arch between the two Battles and races Climbing Mount Everest Crossroads Journey Mapping the territory Pilgrim's progress	Glass half full Holding/showing a mirror Making it real Let go of that bundle We will find a way Wood for the trees	Cooking is very creative Doctor as hero Gordian knot, tease the knot apart and re-wrap the threads Medical bubble Medical career as a travelator Stately home metaphor

Participants used both positioning and journeying metaphors to describe how medicine is conceptualised as a career. C5 thought a medical career could be described as battles and races. Law and Stanbury (2009, pp.1-4) argue that metaphors are used to speak of inner meaning, purpose and significance, and that 'the metaphors for careers are ways-of-seeing career management: as if people are positioning themselves in a race and as if they are travelling on a journey'.

Coaches mentioned the need for them to help doctors gain new insights in order to identify possible ways forward. A range of metaphors were discussed, including the need to 'make things real' for their clients. Coaches also described how they 'hold/show a mirror' to their clients as a way of helping the client see themselves. McMahon (2006, p23) indicates that metaphor can be used as a tool through which meaning is constructed and Jinks (2006, p.96) suggests that metaphors offer opportunities to work in different ways with clients to transform their experience, and that potentially, clients may be able to take control of reality.

A range of other metaphors were discussed by participants. For example, C1 introduced the stately home metaphor to represent medicine as a career with lots of rooms to explore and things to see and experience. This metaphor also conveys some of the notion of tradition and hierarchy, both of which are currently part of the medical career pathway and are aspects mentioned by coaches and clients alike.

As mentioned previously, a number of coaches thought doctors may be in a 'medical bubble' and find it difficult to see beyond it to look for ways in which they could solve the issues they bring to coaching. C10 indicated that medicine can kill creativity, and the use of metaphors with doctors can help bring a more creative and flexible approach; a view supported by Jinks (2006, p.96) who says that 'metaphors offer an opportunity for communication that is less concrete, more creative and flexible'.

Participants also used metaphors to describe how they coached doctors. C5 introduced the idea of a Gordian knot, and that in her work she wanted to understand the tangled sub-plots and to: 'understand more about the unconscious stuff that people bring to a learning situation, and learning how to sort of crack into that'. One coach (C6) described her work as 'cooking', and is considering writing a 'recipe book for medical careers'. Stevens (1996, p.170) describes metaphor as an important means to extend our understanding, and that (p.173) the 'way to make sense of any aspect of our experience is to find an appropriate metaphor'.

Metaphors do seem to have a number of benefits when coaching doctors, as they help them understand how they conceptualise their career, develop a shared understanding of the career issues they face, develop new perspectives and move them forward. Metaphors also contribute to the coaching relationship (McMahon, 2007, p.286). McMahon (2006, p.21) indicates they can be used as a 'vehicle for moving away from the conscious mind and prior meaning structures into uncharted territory where new meaning may be created and stories of possibility co-constructed'.

The use of metaphors with coaching clients is recognised as a way of exploring a situation from a number of dimensions, and to enrich clients' understanding of the issues relating to it (Megginson and Clutterbuck, 2005, p.5). Career counsellors like McMahon (2006, p.21) say that 'the use of a metaphor provides visual clues and a bridge towards deeper understanding of a situation'. Metaphor is also used by therapists; Jinks (2006, p.96) indicates that 'therapists use metaphorical communication themselves to communicate their understanding, share a new perspective, or convey a message to their clients'.

Outcomes from coaching

In Chapter Four, the main reasons doctors seek career coaching were outlined. Participants in this study indicate that doctors who come to coaching experience a number of career issues: feeling stuck in their job, they had hit the buffers, were finding it difficult to pass exams, were unsatisfied with their job, and could not find what they were suited to. Some of the decisions they faced were whether or not they should continue to train in medicine, find an alternative job, re-evaluate their options, take a gap year and/or sabbatical, or consider training on a less than full-time basis.

Issues relating to the clients as individuals were also discussed in the coaching sessions. Doctors indicated that it was difficult to admit to a weakness, and that there were things they could not deal with, which included: changing career, leading to a possible loss of face; issues linked to their self-esteem; and difficulties dealing with change. Some came to coaching with the thought that there might be 'hope for me in an objective way' (D5).

Doctors' expectations of coaching vary. D1 said 'I didn't have the naïve thought that I was just going to be told what the right thing was to do', and 'I had the hope that maybe I would get some answers from myself with expert help.' This aligns with McKenna and Davis (2009) view that an 'active ingredient' of coaching is placebo or hope.

Coaches and doctors alike discussed how coaching supported doctors to achieve their goals. Frequently mentioned career goals were: changing specialty, making decisions about what career path to, and resolving issues relating to satisfaction at work.

Participants described a range of outcomes that doctors achieved through coaching. Three of these were linked to themselves as individuals, and the fourth involved doctors taking an action of some kind (see Table 7.2).

Table 7.2 – Outcomes from coaching

Self-change	Self-development	Self-reflection	Taking action
Face the present with confidence	Build my own respect	Articulate my fears	Be proactive
Focus on things good at	Develop career management skills	Go away and think it through	Change tack
Make conscious choices	Get clarity	Got my head straight now	I take action
Made my own decision	Received good feedback at work	Considered my life purpose	Came up with the answers myself
Re-adjusted my focus	Improved my communication skills	Started reflecting	Found solutions
Took ownership	Learnt something		Went and found out
	Process of self discovery		Have a plan
	Set up my own network		Improved my health and well-being
			Managed my workload
			Found some sort of resolution

The coaching doctors received seems to have included a significant amount of personal learning and development, which accords with one of the key underlying principles for this research from the definition of coaching from Bachkirova *et al.* (2010, p.1), with its focus on a 'desirable and sustainable change for the benefit of the client'.

Doctors take specific actions as a result of the coaching they received, ranging from changing tack in their career through to improving how they managed their workload. Coaching also encouraged doctors to come up with the answers themselves and find their own solutions. D1 said of coaching: 'it encourages you to find your own answer' and that having a plan 'made me feel better'.

Confidence was an issue raised by a number of coaches and doctors. D4 thought that 'due to my extreme lack of confidence I have not made much progress with this part of the coaching process but I believe that after a few more sessions this may change'; and C13's view was that coaching helped clients 'get their confidence back'. C4

describes working with a particular doctor with issues around confidence, who thought she was not performing well: the work they did together about expectations and standards meant that the doctor has gained in confidence and has been able to make changes to improve her own workload. In this instance, coaching supported the doctor to establish what Nelson-Jones (2006, p.5) identifies as 'what is really important to me?'

Coaching enabled doctors to develop career management skills (C2) and to learn something, with D4 indicating that 'coaching helped me explore what career might suit me', and D6 saying that coaching helped by 'identifying who I was again'. D5 thought that coaching gave an opportunity to reflect on career choice, which was 'difficult to do in a busy job'. Grief (2007, p.223) says that 'coaching aims at improving the attainment of self-congruent goals on conscious self-change and self-development', and that 'an experienced coach is able to facilitate the result oriented self-reflection of his or her clients'. This study indicates that coaching can provide an opportunity for doctors to self-reflect.

C13 thought coaching could have wider outcomes:

'It's helping people to understand that it isn't self indulgent to get help, because the happier you are and the more confident you are, and if you're in a job where you feel valued and that you're good at it, everybody benefits; you benefit, your colleagues benefit, your patients benefit, your organisation benefits, your friends and family benefit.'

Doctors as clients made a number of suggestions of what else they would have liked from coaching, ranging from 'something early on which gives positive feelings' (D1) to the opinion that 'more exercises' would be useful, and that it would be helpful if the deanery provided access to people to talk about specific specialties (D5).

Summary

The findings in this chapter indicate there are three key areas relating to the coaching conversation: (i) the coaching process, (ii) metaphors, and (iii) the outcomes for doctors from coaching.

With regard to the coaching process, the coach's responsibility for creating the coaching relationship was identified by the majority of coaches and seen as central to the coaching; a view Stober (2006) supports. The importance of building trust and rapport with doctors was acknowledged as an important part of building the relationship.

Coaches discussed the need to agree how they would work with doctors as clients, and what coaching would require of the doctor. Confidentiality should be discussed within the context of a clear contracting process. Those who trained as doctors, as well as non-medically qualified coaches who work for deaneries, may need to be clear about their own responsibilities to the medical profession as regards confidentiality and patient safety, and be explicit about this with the doctors they coach. Coaches who are freelance might like to consider confidentiality within the ethical principles of organisations to which they are affiliated.

The findings also suggest that coaches have a key role to play in managing the coaching conversation and developing a meta-view of where a doctor is going in their career and how the coaching is progressing. The coaching conversation can be structured depending on the coach's own underpinning models and processes. What they all have in common is the identification of a goal, the notion of moving the client forward and that the coach will control the flow of the conversation.

Moments and turning points within the coaching itself were described in a number of ways. What they all had in common was that they were points in the coaching where doctors gained insights and understanding relating to the issues they brought to coaching; this then resulted in them identifying a way forward, which might be that they had a choice to make and/or were able to give themselves permission to do something differently. Moments and turning points within the coaching conversation seem to be a way of assisting doctors to develop their understanding of their career issues and identify ways to solve them. They can also impact on coaches and provide them with an opportunity to learn something about their own coaching practice.

The study shows that the coaching conversation provides time and space for doctors to reflect on what they brought to coaching. Coaching was described as a 'safe space'. Doctors are not always able to talk to other doctors about their career difficulties, as doctors have a responsibility for safe clinical practice and might have concerns relating to confidentiality regarding their own situation. In addition, doctors work within a busy working environment and experience a range of issues relating to time and time management. On occasion, these issues are brought to coaching. Time pressures, coupled with their need for answers quickly, means that coaches may need to create an environment within which coaching sessions can be seen as a productive use of a doctor's time. This environment was described as providing both time and space for the coaching to take place. The space itself was described as: facilitating, safe, objective

and a 'third space'; as well as one where solutions can be found, and 'within which magic can occur'. Coaches may need to be aware of the time challenges facing doctors and that for coaching to be effective, the environment within which the coaching takes place needs to be seen as 'safe' – within the bounds of confidentiality.

Participants discussed a range of metaphors when talking about their work with doctors as clients. These can be linked to the career literature to conceptualise how a medical career is seen, and can be used to help doctors develop their own understanding of their situation (for example, being shown a mirror), as well as for the work relating to coaching doctors (for example, the medical bubble). Doctors may come to coaching in a crisis or because they are at a crossroads (a positioning metaphor), and medical careers may be described as battles and races (journeying metaphors). This study suggests that metaphors can be helpful to this client group, as they can help them understand how they conceptualise their career; they can develop a shared understanding of the career issues they face; and they can develop new perspectives and move these perspectives forward. Stevens (1996) identifies that metaphors can help extend our understanding, and Megginson and Clutterbuck (2005) argue that they can help clients explore a situation from a number of perspectives. Metaphors also contribute to the coaching relationship, and Kemp (2006, p.287) proposes that 'metaphors … are the key to learning transfer through coaching'. New metaphors were discussed: for example, the Gordian knot, the medical bubble and the stately home. The Gordian knot was used by one coach to describe her work with doctors, as she helped them untangle their career thinking.

As discussed in Chapter Four, doctors bring a range of issues to coaching, which can relate to their dissatisfaction with their existing job, or to them considering leaving medicine; their expectations of coaching vary. The outcomes doctors gain from coaching range from identifying actions they can take to progress their career issue, to ways in which they can develop themselves; these include three areas related to the self: (i) change, (ii) development, and (iii) reflection.

In the final chapter I discuss the implications for practice and how this research contributes to the coaching literature.

Chapter Eight – Conclusion

Changes to medical career pathways for doctors were introduced as part of the MMC programme, and resulted in the need to provide more structured career support to doctors. Medical postgraduate deaneries have approached this requirement in a number of different ways, and as Head of Careers for my own deanery (KSS), the work I do is informed by a coaching approach. The overall aim of this study was to explore how coaching can support doctors to make career choices. Additionally, it considered: (i) the personal impact of coaching on doctors; (ii) what aspects of career coaching contribute to specific career choices made by doctors; (iii) who coaches doctors, and (iv) what are the implications of the framework for career management in medicine.

Chapter Two outlined three areas of relevant literature: (i) medical career choice; (ii) theories of career decision-making; and (iii) the coaching and mentoring literature as it relates to doctors. Previous studies into medical career choice in the UK have been primarily quantitatively based, using data from surveys, with some qualitative data collection. They are mainly cohort studies, which are focused on the details of the choices and decisions doctors have made at specific points in time after qualification, and their career destinations. Some studies in other countries have considered medical career choice from the perspective of theories of career decision-making, and in particular, the notion of 'fit'. The literature on coaching and mentoring with doctors takes as its prime focus leadership and executive coaching, and is limited in extent.

This study contributes to the gap in knowledge about how doctors are supported in making career choices, by utilising a case study methodology. Free assocation narrative interviews were carried out with 13 coaches, and interviews and qualitative questionnaires with five clients. I kept a reflexive diary, which I used to capture issues relating to the research. Chapter Three outlined the methodological approach taken in the research, and detailed the data collection methods that were employed.

From a thematic analysis of the interview data and diary entries, I presented the findings from the study in four chapters. In Chapter Four I considered what doctors bring to coaching, and in Chapter Five, how coaches work with doctors as clients. Chapter Six considered the coaches' approach to coaching, and discussed the role of trainers and supervisors in providing career support, as well as the researcher as a coach. In Chapter Seven a number of aspects relating to the coaching conversation were discussed.

This concluding chapter starts by considering the overall research question in the light of the coaching framework that has been developed from the findings, and then consideration is given to the four objectives outlined in Chapter One and described above. The contribution to professional knowledge and practice is discussed, limitations of the study are outlined, and ideas for further research are suggested.

The coaching framework

The study findings indicate that coaching may be used to support doctors with their career choices, and that there are four areas that could be combined into a coaching framework for coaches who work with doctors. They are: (i) what the doctor as a client brings to coaching; (ii) what the coach needs to work with doctors; (iii) the coach's own approach to coaching; and (iv) the coaching conversation itself.

1. What doctors bring to coaching

Doctors who seek help with their career may come to coaching with a range of career issues and dilemmas, which include: their choice of medicine as a career, that they are considering leaving medicine, and that they are seeking an alternative career either within or outside medicine. They may come in a crisis and be experiencing a wide range of emotions and health and well-being issues. In some cases they may be what Grant (2007, p.258) describes as 'distressed but functional' and need access to other services. As discussed in Chapter Four, it can be helpful for coaches to have access to a range of confidential services for when a referral is appropriate.

Doctors are used to consulting experts for an opinion in their day-to-day work, so they can come to coaching seeking a diagnosis, solution and immediate answers. This study indicates that the issue of expertise needs to be carefully navigated between coach and doctor as client. This is a view supported by Cavanagh (2006, p.33), who says that coaches' 'domain-specific knowledge is constantly in play but never overpowering the client'. Stober's view (2006, p.20) is that the coach is the expert in the coaching process, and the client is the expert in the content. Doctors may see the coach as an expert in medical careers; coaches might wish to be aware of the need to build capacity in their clients to help them become experts in their own career choices and career management.

2. What coaches need to work with doctors

Coaches recognised that medicine is a competitive career and that there can be a disconnect between the image of working as a doctor and the reality. A metaphor that describes the work of a doctor as being within a medical 'bubble' that surrounds them

was described, together with the implication of this with regard to providing career support. Coaches could consider developing an understanding of medical career pathways in order to help establish their credibility as a coach to doctors.

Coaches also proposed that there was a need for them to understand the theories that underpin career decision-making, and many of them discussed a wide range of tools and techniques they used to support doctors to make career choices. This information was presented using a four-stage career planning process, which aligns to Kidd's (2006) view that these four stages relate to what clients seek as career support outcomes.

Coaches described a wide variety of ways they worked with doctors, which included aspects like the number of sessions they had with clients and how ongoing support was organised. No one single approach stood out, although those who worked as freelance coaches were more likely to have a series of sessions with a doctor, whereas coaches who worked for universities and deaneries generally were more limited on what they could provide.

3. The coaches' approaches to coaching

The coaches who participated in this study discussed a range of models and processes from the careers, coaching and mentoring, and management literature that they consider underpin their practice. Those who initially trained as career counsellors were more likely to utilise a broader range of models and processes in their work compared to those who first trained as doctors. These differences in the coaches' backgrounds were also reflected in their values.

The study also suggests that the coaching skills that coaches possess seem to share many similarities with the career counselling skills described by Ali and Graham (1996). There are, though, some differences, including: being present, the use of intuition by the coach, and giving feedback to clients.

The need for coaches to understand their own boundaries and limitations was identified. One coach called it 'knowing the edge'. A number of coaches raised the importance of supervision as a way of helping them to review and continue to develop their own practice. Linking supervision to continuous professional development was seen as beneficial.

The role of clinical trainers and supervisors as providers of careers advice to doctors was discussed by coaches and doctors alike. Trainers and supervisors have a responsibility for ensuring doctors in training receive appropriate postgraduate education as well as career support. Most coaches were keen to stress that the agenda for coaching should come from the doctor and that the coaching should be client-led. They also thought that doctors, including trainers and supervisors, should not give careers advice. Doctors thought that trainers and supervisors needed educating in the changes to medical career pathways.

4. The coaching conversation

Most coaches recognised the importance of the coaching relationship and the need to build trust and rapport with their clients. Within the coaching conversation itself, an important aspect is confidentiality and the need to 'contract' at the start of each coaching session with a doctor, as well as agreeing what level of 'challenge' is appropriate. Coaches may need to consider 'how deeply' they will work with doctors, and when to self-disclose and when not to. This can be particularly relevant to those who initially trained as doctors.

Additionally, the findings from this study indicate that coaching provides time and space for doctors to explore their career issues and make choices and decisions. The 'space' created between a coach and a client has been described in a number of ways, including a 'safe space' and a 'third space'. Doctors valued the opportunity to reflect on their career issues in the time and space that coaching provided.

The aim of coaching is to facilitate learning, and this study indicates that doctors who have received coaching, experience a wide range of outcomes: from taking specific actions to move their careers forward, to continuing to learn and develop. Chapter One described that the definition of coaching chosen to underpin this study is from Bachkirova *et al.* (2010), and has learning and development as its focus. Eraut (2000, p.114) says that 'learning is defined as the process where knowledge is acquired'. However, doctors are used to acquiring learning in more formal settings through the use of curricula and in lectures and seminars, from eminent doctors and professors who are considered experts in their field. In contrast, coaching encourages learning in less formal settings and can prepare doctors to take advantage of what Eraut calls (2000, p.115) 'planned and emergent learning opportunities' to aid their career decision-making. Emergent learning opportunities are, by their nature, uncertain. Coaching enables doctors to set goals for their career and recognise opportunities as they come along, which links to the happenstance theory of career decision-making

(Shottin, 2010), rather than other career theories, such as the notion of 'fit' (Holland, 1973). Coaches thought that they needed an awareness of the changes to medical career pathways. Doctors, through the work they do, need to be able to deal with and manage uncertainty in their clinical practice, and coaching appears to offer the opportunity for learning in a wider range of contexts.

Coaches used a range of metaphors to describe their work with doctors as clients, as well as how a medical career is conceptualised. Both positioning (for example, career crossroads) and journeying metaphors (for example, medicine as a travelator) were used. Metaphors were also mentioned with regard to how coaching can help doctors gain new insights into their situation (for example, by holding or showing them a mirror), and to describe their career dilemmas (for example, the notion of a Gordian knot that needs to be untangled to better understand the career issues a doctor is faced with).

5. The framework

The four areas described in the above paragraphs have been combined into a framework (see Figure 8.1), which considers two key aspects: (i) medical careers and coaching; and (ii) how coaches and doctors engage with the coaching. Part One is concerned with the medical career issues a doctor brings to coaching. Parts Two and Three relate to coaches: Two is what coaches need to know about medical careers and coaching in order to work with doctors as clients, and Three is about the coaches' approaches to coaching in a medical career context. Part Four considers the coaching conversation between the coach and the doctor.

Each part of the framework may be used by coaches who currently work with doctors, as well as coaches who are considering doctors as a client group, to review their coaching practice. With regard to what doctors bring to coaching, coaches may need to navigate the issue of expertise with their clients, and consider developing an understanding of medical career pathways in order to help establish their credibility as a coach. In addition, coaches who wish to move into career coaching may consider developing their understanding of the theories of career decision-making. How a coach approaches coaching with a doctor is also included in the framework, and coaches may wish to consider when to coach a doctor and when to suggest a referral to, for example, a counselling service. Metaphors were utilised by both coaches and doctors within the coaching conversation, and coaches may find it helpful to consider how they use metaphors in their coaching.

Figure 8.1 – Career coaching framework for working with doctors
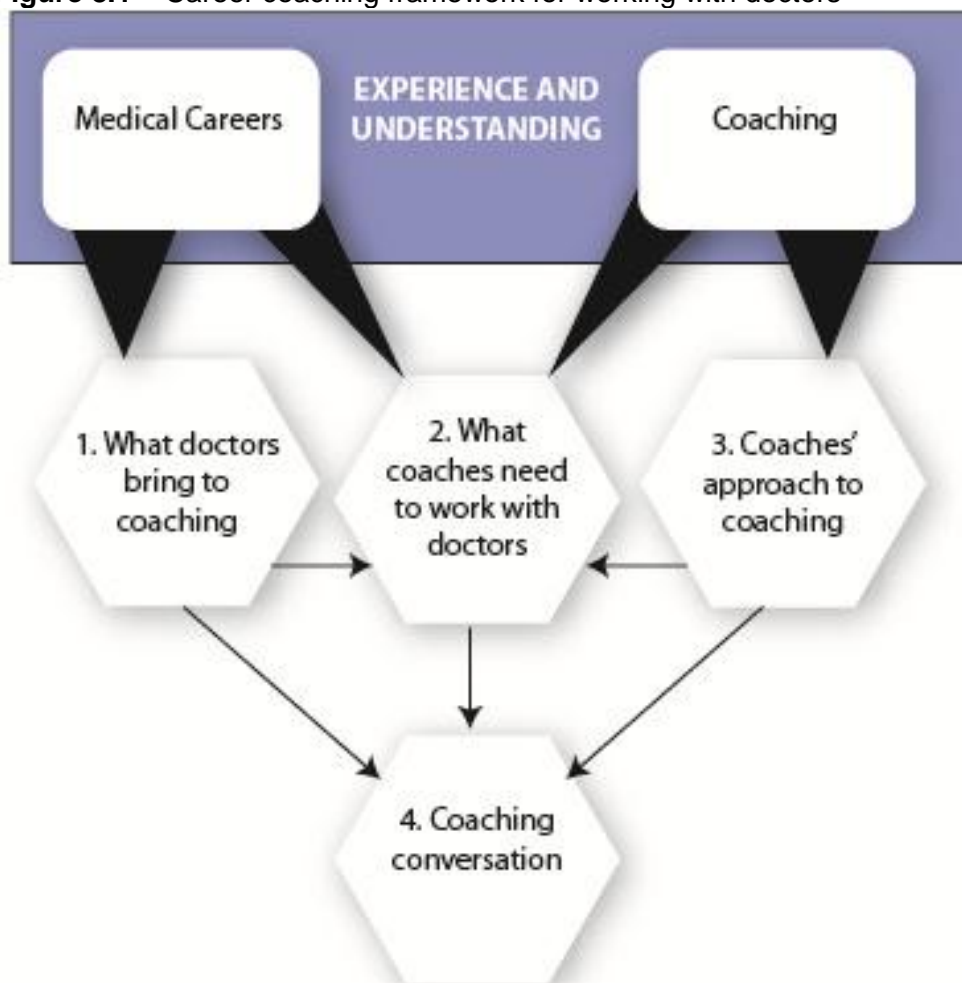
To summarise, the framework encompasses a holistic view of coaching for doctors, and takes into account process, content and outcomes. It can be used by coaches who wish to work with doctors, and provides four key areas for coaches to consider: (i) an understanding of what doctors as clients bring to coaching; (ii) that coaches seem to benefit from having medical domain-specific knowledge; (iii) that coaches may need to understand their own boundaries and limitations; (iv) and that the coaching conversation provides doctors with an opportunity to achieve a potential range of outcomes from coaching. In addition, the framework has the benefit that it has been developed by considering how doctors and coaches interact within medical careers and coaching perspectives.

This study has taken as its focus a specific client group, and has considered all aspects of coaching as opposed to other coaching research, which has focused on one specific aspect: for example, moments in coaching (De Haan *et al.*, 2010). The framework has some similarities and differences to the suggestion by Grief (2007, p.227) that there are four predictors of success for coaching: (i) the quality of the relationship; (ii) the

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individual analysis and diagnosis of the strengths and weaknesses of the client; (iii) the adaptation of the coaching to the individual client; and (iv) the clarity of goals and expectations at the beginning of the coaching.

Research question, objectives and limitations

The overall research question was how coaching can support doctors to make career choices, and four objectives were explored. The coaching framework (described in Figure 8.1) was developed from the findings of this research. It is based on the aspects of career coaching that contribute to specific career choices by doctors (Objective ii), and includes the personal impact of coaching on doctors (Objective i) within the coaching conversation part of the framework.

With regard to the coaches, the main providers of career coaching to doctors (Objective iii) came from one of three backgrounds: they were either from a university careers service, or were deanery-based coaches or freelance coaches. What coaches need to work with doctors was described in Part Two of the framework, and Part Three covers the coaches' approaches to coaching. Both these aspects are areas coaches might like to consider with regard to their work with doctors, to identify if they have any professional development needs.

The study has some limitations. It took as its focus a specific context – careers within medical education – and utilised a case study approach. Simons (2009, p.162) discusses two limitations for case studies: (i) they cannot be used to generate theory, and (ii) they can also be considered too subjective. The development of a coaching framework (see Figure 8.1) for coaches who work with doctors is applicable in the context within which it was developed. Doctors are considered professionals, and their careers are developed through postgraduate medical education. The framework may not be transferable to other professional career contexts – for example, the legal profession – without further research to determine if it is appropriate in a different setting.

In consideration of what is meant by the issue that case studies are 'too subjective', Simons (2009) attests that subjectivity is not something that can be avoided, and that in certain contexts it is the most appropriate approach. Simons (2009, p.163) proposes that subjectivity should be acknowledged, and that a researcher should 'concentrate on demonstrating how values, predispositions and feelings impact on the research', with the aim of not trying to erase subjectivity, but to recognise when 'it contributes to insight and understanding and when it might become a potential bias' (p.163). Employing a

reflexive approach through the use of a diary has been an important part of my methodological approach, as has including the voices of the participants in this research.

A further limitation of the study relates to the recruitment of doctors who had been coached by me. Doctors who come for coaching can, as a result of it, make career choices that mean they change postgraduate training programmes and move to different parts of the country. Difficulties were experienced in contacting people whom I had coached, to ask them if they would be prepared to take part in this study. Some of them did not respond to requests from me and it is possible I did not have up-to-date contact information for them, as they are not required to provide this information if they move to a different deanery. However, a number of coaches from different backgrounds took part in this study and discussed the reasons doctors sought coaching from them, and also provided insights into their own work as coaches.

Contributions to professional knowledge, practice and implications

This study utilised conventional research instruments – interviews and a reflexive diary – in a new field where previous studies have been primarily quantitative. The findings from this research have provided four contributions to professional knowledge and practice, the main one of which is the career coaching with doctors framework (see Figure 8.1). It provides a contribution to the coaching literature, as it offers a way of working with a particular client group (doctors) within the specific context of medical education.

Doctors can come to coaching with a range of career issues and dilemmas, and many coaching models, for example, NLP coaching Grimley, 2010), GROW (Whitmore, 2002) and co-active coaching (Whitworth *et al.*, 2007), share similarities with the career coaching with doctors framework developed here. These models all recognise that clients come to coaching with issues and dilemmas they want to work on, that the coach needs to be skilled in managing the coaching conversation and that the decisions people make are linked to other aspects of a client's life.

Coaches who work with doctors may benefit from having an understanding of medical career pathways, as doctors value 'competence to practice' medicine (BMA, 2008), as discussed in Chapter Six. This value around the competence of the practitioner links into the knowledge and credibility of the coach which is an area where this career coaching with doctors framework differs from other coaching models like GROW

(Whitmore, 2002) and co-active coaching (Whitworth *et al.*, 2007). The co-active coaching model (Whitworth *et al.*, 2007, pxix) 'involves the active and collaborative participation of both the coach and the client' and that a primary building block is that 'clients have the answers or they can find the answers' (p4) and that 'the coach's job is to be curious, not to be the expert' (p4). This research suggests that with this client group there is a need to have an understanding of the medical career pathway and the careers literature to be credible as a coach to doctors. Coaches may wish to consider their own development needs with regard to this group. The framework developed from this research suggests that doctors as clients often come to coaching in a crisis and can find it difficult to resolve these issues without help from a competent practitioner.

While this framework has been developed primarily for those coaches who work with doctors the issue of competence and being a competent coach has wider implications. This framework shares a view with NLP coaching (Grimley, 2010, p185) where 'the goal … is to maximize client's resourcefulness and increase the choice they have in a given context'. In this research the context is the medical profession. The framework could be explored in other professional contexts where the profession itself values competence and competent practitioners, for example, the legal profession.

Understanding the medical career pathway could help coaches develop what NLP coaching (Grimley, 2010) considers as a shared language to help the client move towards understanding their own 'maps of the world' (p188). NLP coaching also recognises the use of metaphor to help clients 'bypass the analytical mind and be accepted by the holistic mind of the unconscious' (p195). The coaching framework developed through this research also recognises the importance of metaphor.

The coaches involved in this study came from diverse backgrounds, and utilised models and processes from the career, coaching and mentoring, and management literature. They also had a variety of ways of working with doctors as clients. Coaches recognised that confidentiality should be explicitly discussed with the doctor, and any limits explained. In addition, coaches who originally trained as doctors might like to consider the potential impact of self-disclosure during coaching.

Doctors experienced a range of outcomes from coaching, and valued the time and space it provided for them to consider their career issues. The career coaching with doctors framework which has been developed recognises the importance of self-assessment and self-awareness which are both included in coaching models like co-active coaching (Whitworth *et al.*, 2007) and NLP coaching (Grimley, 2010. It also

incorporates a mentoring model as it does take more account of the context than many pure coaching models'. Additionally, coaches who work with doctors may benefit from access to other confidential services.

The findings from this research also provided the following additional contributions to professional knowledge and practice:

1. The personal impact of coaching on doctors was outlined in Table 7.2 under four broad headings: (i) self-change, (ii) self-development, (iii) self-reflection and (iv) taking action. The outcomes that doctors gained from coaching went beyond the four aims of guidance discussed by Kidd (2006), which are encapsulated in the four-stage process shown in Figure 1.3. Some of the outcomes for doctors indicate that coaching played a part in their learning and development, and this accords with the initial definition of coaching that I offered in Chapter One. Coaching provides emergent learning opportunities, which would suggest that emerging theories of career decision may be more appropriate than those of 'fit' (e.g. Holland, 1973). Coaches, in their interviews, did not explicitly discuss career theories like narrative (Reid, 2005) or happenstance (Shottin, 2010), although a number of them did seem to be encouraging doctors to understand what they wanted from a career, and to explore career options for themselves.

2. In relation to career theory, it seems that some coaches encourage their clients to relate stories as part of their work, and that the use of metaphors in coaching serves a number of purposes. They can help doctors conceptualise their medical career and gain new insights into their own situations. Metaphors are also used by coaches to describe their work. In addition, this research proposes that there are also similarities and differences between the career counselling skills identified by Ali and Graham (1996) and those discussed by coaches. Potentially, providers of career support could benefit from an understanding of both the careers and coaching literature, concerning the skills that can be used with clients.

3. Previous research into medical careers has indicated that there is a role for trainers and supervisors to play in the provision of career support (Collins, 2010). From a career support and coaching practice perspective, trainers and supervisors may wish to review their role as providers of career support, and

consider what professional development they require that might help them in their work with postgraduate doctors.

From an overall medical education and career management perspective, there are two main implications for policy and practice. These relate to (i) the role of clinical trainers and supervisors with regard to career support, and (ii) what is provided at deanery level.

Recent reports into postgraduate medical education (Tooke, 2008; Collins, 2010) have suggested there is a role for trainers and supervisors to provide career support to doctors. This study suggests that the coaching framework that has been developed might form the basis of a career management approach in medical education. However, one of the doctors interviewed for this research thought that trainers and supervisors might not be best placed to provide career coaching, as they may not understand the recent changes to medical career pathways and do not have an understanding of career decision-making theories. This is in contrast to Henochowicz and Hetherington (2006, p.186), who propose that physicians have an important role as coaches to other medics. The findings from this study recognise the need for coaches who work with doctors to have appropriate skills, and for their practice to be underpinned by a coaching framework.

Participants also proposed that an area that deaneries could consider is the provision of senior doctors who could impart information on specific medical specialties to assist with career exploration. Clinical trainers and supervisors might also be well placed to assist with this activity.

Areas for further research

An unexpected finding from this research is the use of metaphor in coaching. It is an area for potential further research, and a particular area of interest is the notion that coaching provides a 'third space', one that is co-created by the coach and the client. This could be investigated by considering the content of actual coaching sessions to explore how this 'third space' is developed and used.

A further potential area of research relates to the coaches themselves. There seems to be limited research into coaches' values and their backgrounds, and how these relate to their coaching practice. Liljenstrand and Nebeker (2008, p.59) indicate that 'it is not clear which educational background is best suited for providing coaching services'. The coaches involved in this research came from a variety of backgrounds and used a wide

range of models and processes from the career, coaching and mentoring, and management literature. An area to explore in more depth would be their own personal life histories about how they became a coach, and what influenced them as they developed a new career path as a coach. An understanding of coaches' career development pathways and whether these impact on the genre of their coaching practice would be an interesting area of research.

Two potential areas for research in the careers field are: (i) to consider the role of new emerging career theories with doctors as clients, and (ii) to explore if coaching is the new guidance. For example, it would be interesting to know more about the role of happenstance and how it can contribute to a doctor's career opportunities and choices. This is particularly important within the changing context of the NHS, where there are significant external influences on the organisation with regard to workforce planning, which impact on the work that is available to newly qualified doctors.

An increasing number of women are entering the medical profession, and concerns have been raised by the Royal College of Physicians on the impact that this will have for the medical profession (Elston, 2009). This study did not focus on issues of gender, and there has been limited research considering women doctors' career development needs and whether coaching is an appropriate way of providing career support. This is an area for research, perhaps contrasting it with the coaching framework developed in this study.

Summary

This study has impacted on both my work as coach and how I continue to develop the career support services the deanery provides to doctors. While I have been carrying out the research for this doctorate the way the careers team provides career support to doctors has continued to change and develop. Regular one-to-one drop in career sessions for doctors, which we provide at hospital trusts in the region, have become a key part of the work of the two careers advisers in my team. Most of the doctors I have personally coached have been referred to me through the trainee support group rather than via the hospital trust medical education team. This has been a challenge for me as I have needed to develop my own practice with regards to confidentiality and the referral paths which are available to me. Previously I would have primarily discussed confidentiality with the doctor seeking career support. With more of the work with individuals coming through the trainee support group there has been more of a need to explicitly discuss confidentiality with the person who referred the doctor to me. This has led me to improve the information on career support which is included in the deaneries

trainee support guide thus ensuring that as an internal coach what I can and cannot provide are clearly stated in the guide.

In addition, I have been working on providing further information on sources of support for doctors which can also be used by members of the trainee support group. The research I have carried out for this thesis, and in my own practice, indicates that there may be other reasons why a doctor is experiencing career difficulties. From time to time I see a doctor for career support who would benefit from a referral to another service, for example, a counselling service. Initially, this information sheet on source of support started life as a spread-sheet which included services like counselling, dyslexia support and educational psychology amongst others. It has now developed into a range of sources of support which takes the form of a discrete credit card size foldout card which can be given to doctors and their trainers and supervisors.

Another part of my role at the deanery is to continue to develop the career support services we provide and our postgraduate programme Managing Medical Careers. This study has increased my own awareness of the impact of doctors with health and wellbeing issues on their work. Alongside this we developed the diploma year of our postgraduate programme to include a health and wellbeing module. This was well received by our course participants who, all have senior roles in medical education, and provide career support to a wide variety of doctors. One of the course participants is also a member of the deanery trainee support group and a member of my team is working with him to develop a health and wellbeing workshop which will be offered as a pilot to specialty trainees in February 2012.

The study has also offered a number of contributions to professional knowledge and practice. Coaches who work with doctors may benefit from reviewing the coaching framework that has been developed, and in particular, the need to be familiar with medical career pathways and have an understanding of career decision making theory. Coaching provides time and space for doctors to consider their career concerns – something that is not always available to them in their busy lives.

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Appendix A – Participant information sheet

Participant Information Sheet

December 2009

Project title: An exploration of how coaching can help doctors with their career decision-making

Thank you for expressing an interest in this research project. Your experience is particularly relevant to this study and I would like to explain why this research is being carried out and what it involves. Please take time to read the following information carefully.

This research investigates how coaching can support doctors with their career decision-making. Recent changes to medical career pathways have resulted in doctors in training needing to make career decisions earlier than in the previous system, and Deaneries have implemented career support for doctors in a variety of ways. I was recruited by the Kent, Surrey and Sussex Deanery to provide a career support to doctors. My approach is based on my experience of career support, coaching and decision-making gained through my own career choices, and this research aims to explore how coaching can support doctors with their career decision-making.

I am initially selecting people who either coach or have been coached to take part in this study, and am then using a snowball approach to identify further participants. If you decide to take part, I will set up an individual interview with you that will last approximately one hour. This will be either face-to-face or over the telephone, depending on what is most convenient for you. Discussions will be audiotaped to alleviate the need for note-taking. Insights from the interviews will be used to develop a repertory grid exercise to support career decision-making.

All information collected during the course of this research will be kept strictly confidential, within the limitations of the law. Paper records will be kept in a secure location and electronic files will be protected by the use of passwords. In accordance with Oxford Brookes University's policy on Academic Integrity, the data generated will be kept securely in electronic form for a period of five years after the completion of the research project. Immediately following the collection, all data will be de-identified to ensure anonymity: i.e. codes will be used to identify research participants in place of their names. Findings from this research will be used within Joan Reid's doctoral thesis and may form the basis of articles submitted for publication in appropriate medical education and coaching journals. Participants would be referred to by pseudonym in any publication arising from this research. Naturally, copies of any article(s) accepted for publication will be made available to you, should you wish to receive them.

It is entirely up to you to decide whether or not you wish to take part in this research. If you do decide to participate, and therefore contribute to our further understanding of this research topic, you will be given

this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

This study is being conducted by myself, Joan Reid, (a doctoral student in the Coaching and Mentoring department of the Business School at Oxford Brookes University) as part of my doctoral research programme, and it has been approved by the University Research Ethics Committee at the University. My supervisors are Dr Elaine Cox (ecox@brookes.ac.uk) and visiting Professor David Clutterbuck (dclutterbuck@brookes.ac.uk), and they are both senior researchers within the department. The research programme, which began in December 2009, will run for approximately two years.

Should you require any further information, please do not hesitate to contact me at the Business School, Oxford Brookes University, Wheatley Campus, Wheatley, Oxford OX33 1HX or via email at jreid@brookes.ac.uk, or by telephone on 07885 417055. If you have any concerns about the way in which the study is being conducted, please contact the Chair of the University Research Ethics Committee at ethics@brookes.ac.uk.

Thank you for taking the time to read this information sheet.

Appendix B – Key themes in the data

Themes	Sub-themes	Number of statements
What doctors bring to coaching (Chapter Four)		
Career issues and dilemmas	Medicine as a career choice	45
	Considering leaving medicine	17
	Wanting to explore another career	25
Characteristics of doctors as clients	Coming in a crisis to seek support	26
	Experiencing difficulties and displaying a range of emotions	44
	Health and wellbeing – depression and anxiety	26
	Health and wellbeing – choice of specialty	29
	Client readiness – motivation to change	11
	Client readiness – need to feel safe	6
Diagnosis, solution and answers	Seeking support Diagnosis and answer	8 19
What coaches need to work with doctors (Chapter Five)		
Understanding the medical career pathway	Medicine is competitive	6
	Image versus reality	19
	"Medical bubble"	7
	Coaches' credibility	14
An understanding of career theory (the careers perspective)	Self-assessment	86
	Career exploration	32
	Decision making	69
	Plan implementation	21
How coaching is organised	Client group	19
	How doctors come to coaching	13
	What coaching is offered	41
	On-going coaching	10
	How coaching is delivered	37
Coaches' approach to coaching (Chapter Six)		
Coaching skills and knowledge	Listening Questioning Challenging	23 32 16
Models and processes	Career counselling	15

which underpin practice	Coaching and mentoring	26
	Management literature	10
Values	Being	100
	Having	48
	Doing	156
	Other	32
Supervision and continuous professional development	Supervision	6
	Professional development	5
Trainers and supervisors (as providers of career support)	Positive aspects	8
	Negative aspects	29
Researcher as a coach	Researchers values	5
	Shared values	198
	Coaches' values	102
The coaching conversation (Chapter Seven)		
The coaching process	Coaching relationship	25
	Explain the coaching process	74
	Contracting with clients	12
	Moments and turning points	37
	Time and space	43
Metaphors	Positioning and journeying	7
	Helping doctors gain insights	8
	Other metaphors	12
Outcomes from coaching	Self-change	14
	Self-development	15
	Self –reflection	12
	Takes action	25