

Medical Careers and Coaching – an Exploratory Study

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Abstract

Recent changes to medical career pathways have resulted in the introduction of a range of career support activities by medical education organisations. This doctoral research took a case study approach to consider how coaching can support doctors to make career choices. Data was collected through interviews with 18 participants. The findings have been combined into a career coaching framework for working with doctors. Coaches and doctors identified three groupings of metaphors which either: i) conceptualised a career in medicine, ii) described how doctors gain insights through coaching or iii) were specific to career coaching for doctors.

Keywords: career coaching, career choice, medical career, doctor.

Introduction

Within the UK, medical postgraduate deaneries are responsible for the education of doctors in training once they leave medical school. I joined the Kent, Surrey and Sussex (KSS) deanery as a careers adviser and coach in 2006 to develop a career support service for doctors in the foundation training programme which is the first stage in postgraduate training for doctors. The career structure for doctors was in the process of being changed as a result of the Modernising Medical Careers (MMC) Programme (Department of Health, 2004) which has as a principle that “rigorous counselling and career advice should be available through training”. Since 2006 there has been an independent review into the MMC (Tooke, 2007), which has led to an increasing emphasis on doctors’ training (Darzi, 2008) and further changes to the medical career structure.

The medical career structure comprises medical school (either as an undergraduate or postgraduate) followed by a two year foundation programme where, newly qualified doctors work within National Health Service (NHS) hospital trusts, whilst continuing their education. All doctors in the UK are given their license to practise by the General Medical Council (GMC) and are expected to follow the guidelines in *Good Medical Practice* (GMC, 2006). Newly qualified doctors are granted provisional registration with the GMC at the start of their first foundation year and gain full registration provided they successfully complete this year.

During their second foundation year doctors can choose to apply for further training in a specific speciality. There are over 60 specialities, for example, hospital medicine, anaesthetics, surgery, psychiatry and general practice (GP). During their training doctors are both in education and work and balancing these two goals can be challenging. Completing a specialty training programme provides the doctor with a certificate of completion of training (CCT) and with this they can then apply for consultant/GP principal posts.

As a coach I have worked with a wide range of clients. When I started coaching doctors I entered a new work context and needed to amend my own practice to take account of the regulatory

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environment provided by the GMC and the deanery who quality assure the training of doctors who could potentially become my clients.

My own view of coaching aligns with the definition from Bachkirova *et al.* (2010, p1):

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.

The aim of my research was to explore medical careers and coaching and my research question was “How does coaching support doctors to make career choices?” In the next section I will briefly outline the literature I reviewed for my research. This is followed by a description of my methodology and the results of my research. I end this article with a discussion and conclusion.

Literature review

The literature review considered three areas: medical career choice and medical career management, how career decision theory seems to support specialty career choice for doctors and where coaching has been used with doctors. Much of the research in the UK on medical career choice and medical career management has been quantitative studies. The Oxford Medical Careers Group, British Medical Association (BMA) and the Department of Clinical, Education and Health Psychology at University College London, all carry out a wide range of research on medical careers. With regards to career choice within medicine Goldacre *et al.* (2010) highlighted the importance of managing the expectations of medical students and doctors with regards to the career opportunities available in the medical specialties. The supply of posts for them to take up is seen as an important aspect of whether or not they are able to follow a career in the medical specialty of their choice. In addition, Goldacre *et al.* (2010) suggested that a qualitative exploration of the factors which affect specialty choice could complement their own findings.

With regards to medical career management, the need to plan careers advice into postgraduate training was proposed by Lambert and Goldacre (2007). The review of the foundation programme by Collins (2010) also supported the need to provide careers advice and went onto suggest that the lack of careers advice may have hampered foundation doctors’ career decision making. In addition, the BMA (2010) reported that more than one third of the BMA’s research cohort (of doctors who qualified in 2006) indicated that their experience of the foundation programme had not allowed them to make informed choices about their speciality (BMA, 2010).

Research into medical specialty career choice which takes into consideration how career decision making theory can help explain doctors’ choice of specialty has mostly focused on the work of Holland’s (1973) theory of person-environment fit (for example, Borges *et al.*, 2004 and Petrides and McManus, 2004) and Super’s (1955) developmental career theory (for example, Savickas, 2003). In addition, Savickas (2003) has considered narrative approaches to careers within medical specialty career choice. One form of narrative constructivist career counselling (McMahon, 2006) involves careers advisers using stories with clients to help them write their own career narratives. Reid (2005) proposes that “the turn to narrative approaches reflects a 21st century pre-occupation with meaning in contrast to a 20th century focus on facts”. The use of narrative approaches in clinical practice is supported by the work of Greenhalgh (1999).

Increasing dissatisfaction with a career in medicine in the United States has also been the subject of research by Gibson and Borges (2009) who report that the source of this is the difference between expectations and the actual practice of medicine as a career. No similar research has been carried out in the UK but Landon *et al.* (2006, p. 234) warn that “dissatisfied physicians are two to three times more likely to leave medicine than satisfied physicians”.

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Finally, there is limited empirical research into career coaching for doctors, although a number of commentators have written about it, for example, Houghton, 2006, Shelly, 2007 and Bhatti and Viney, 2010. Gowan (2010) in her work on coaching clinicians for leadership, suggests that coaching can help support doctors to survive their tough career and coaching has been recognised as a learning strategy to support doctors' personal and professional development by Conference of Post Graduate Medical Deaneries (COPMeD, 2009).

Many of the research papers identified here *do* identify the importance of providing information and advice to doctors with regards to their career choices and decision making. However, they do not examine *how* that career support should be provided. This is the gap in the literature that became the focus of my research.

Methodology

The overall research question for this study was how coaching supports doctors to make career choices. Alongside it I developed a number of sub-questions 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?

The research strategy chosen for this research is a 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.

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. Flyvbjerg (2006, p.194) also argues that "case studies produce context dependent knowledge which is essential to the development of a field or discipline" and this study is the first to consider medical careers and coaching. 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. The study aimed 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 provided important flexibility for the researcher.

The aim of the research was to produce a career coaching framework that is applicable to a particular context: the medical career pathway; one that has been subject to significant change. The selection of a case study approach provides opportunity to consider a number of different perspectives within the case itself.

Research participants and data collection methods

With regards to the research participants for this study, the aim was to ensure that a range of voices was represented. In total, 18 participants took part in the study – 13 were providers of career support and five were doctors I have coached. Further information on the providers of career support which includes the organisation they work for and their main client group, are included in table 1.

Organisation	Main client group	No of participants in the study
University careers service	Work with undergraduate medical students and postgraduate doctors	2
Deanery based careers provision	Work with postgraduate doctors	6
Freelance coaches	Work with a range of clients including doctors	5

Table 1: Characteristics of the career support participants who took part in the study

All participants took part in free association narrative based interviews (Clarke and Hoggett, 2009). This form of interviewing 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. The question I used for each interview was “What career support and/or coaching do you provide?” in relation to coaching doctors. At the end of each interview I referred back to my original research question and sub-questions (see Table 2) to check I had covered all aspects.

With regards to the doctors who had been coached, I approached everyone who had received more than one coaching session from me, and asked them to take part in either an interview and/or a qualitative questionnaire. Five doctors took part in the study. I started the interviews with the question “What issues led you to seek career support?”. How the research questions map onto the data collection methods is shown in Table 2.

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
What aspects of coaching contribute to specific career choices made by doctors?	Interviews with coaches and providers of career support Interviews/questionnaires with clients
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

Table 2: Research questions mapped to data collection methods

Data analysis

All the interviews were audio-recorded and transcribed. They were read a number of times and then analysed using a thematic approach (Braun and Clarke, 2006) which was chosen as it is

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accessible and flexible. Themes were identified in the data with the intention that it would inform the development of a career coaching framework. The software programme NVIVO was invaluable in tracking the coding and enabling the adoption of a recursive process which resulted in 15 overarching themes which were then combined into four overarching categories which are described in the results section.

Care was taken to ensure that participants gave their informed consent to the study and their identities remain confidential. Any comments which are used in this paper are anonymised and either attributed to a coach or a doctor who had been coached.

Results

The results are presented using the four overarching categories which have been combined into a career coaching framework: what doctors bring to coaching, what coaches need in order to work with doctors, the coaches' approach to their coaching practice and the coaching conversation.

What doctors bring to coaching

Doctors who come to coaching bring with them a range of career issues and dilemmas, have a set of specific characteristics as clients and may be looking for a diagnosis (of their career issue/dilemma); solution and answers (see Figure 1).

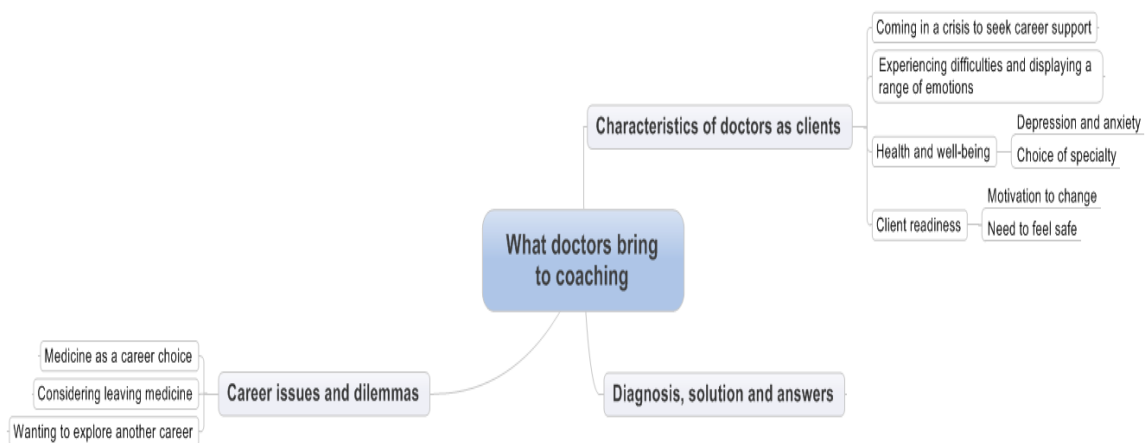


Figure 1: What doctors bring to coaching

Career issues and dilemmas

The most common reason doctors seek coaching is that they are experiencing difficulties relating to their choice of medicine as a career. For example, they may not know which direction to take next with their career and/or they may have health and well-being issues which are affecting their career choice.

Both coaches and doctors indicated that not all doctors remain committed to medicine and that in some instances doctors come to coaching because they are considering leaving medicine. In these cases they may want to explore another career and this can be challenging for them. One coach suggested that doctors may find it difficult to change their occupation as this can be seen as a failure if they leave the profession.

Characteristics of doctors as clients

Doctors seem to have a number of characteristics as clients. They may come in a crisis to seek career support. One coach said that her clients were:

... 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.' (Coach D)

The data suggests there are two aspects which seem to underpin doctors concern about fear and failure with regards to their medical career: they may not be able to achieve a goal they have set for themselves and/or they might find it difficult to identify a goal for their career. Additionally, doctors can find it difficult to assess their own abilities and one said 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. (Doctor B)

Coaches suggested that the work of a doctor can be high risk and that the impact of any mistakes they make can have a significant impact on their patients. Doctors who come to coaching can be experiencing a range of emotions and may be distressed. For example, doctors can be motivated and confused, have issues related to their confidence and/or be in a vulnerable position. Coaches who work with doctors may need to spend some time understanding their issues before supporting them in identifying their career goals. Grant (2007, p.255) indicates that goals can be motivated by a complex combination of internal and external factors and that goal content and goal motivation make significant contributions to psychological well-being or lack of it.

In some instances doctors come to coaching with health and well-being issues. For example, nearly half of the coaches interviewed mentioned that they had worked with people who had been depressed and one doctor agreed that they themselves had "sometimes been depressed". Well-being issues like exhaustion, stress and a lack of coping strategies were also raised with a coach commenting that: "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".

Coach participants in this study thought that doctors could come to coaching motivated to change and with the internal motivation to move their career issues forward. However, doctors do not always take action and may cancel sessions with one coach saying: "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".

Doctors as clients may have limited or no experience of being coached and may not have previously sought careers advice. The value of career coaching to doctors was seen by one coach as:

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, ... everybody benefits. (Coach M)

Diagnosis, solutions and answers

Doctors as clients may have a clear idea about the help they want. This can be influenced by their own experience of the working environment where patients see doctors for health issues and are looking for answers and a treatment plan. One coach said that "clinicians are used to finite issues" and another said that the "culture of the client group is to diagnose and have a solution".

Doctors who seek coaching are often looking for answers, what one doctor described as “to get to the crunch of what I could do”. Coaches might wish to consider McIlveen and Patton’s (2006, p.24) view that the “counsellor should not be privileged as the expert dispenser of truth”.

What coaches need in order to work with doctors

Three key areas of what coaches need in order to work with doctors emerged from the data: understanding the medical career pathway, an understanding of career theory and how coaching is organised (see figure 2).

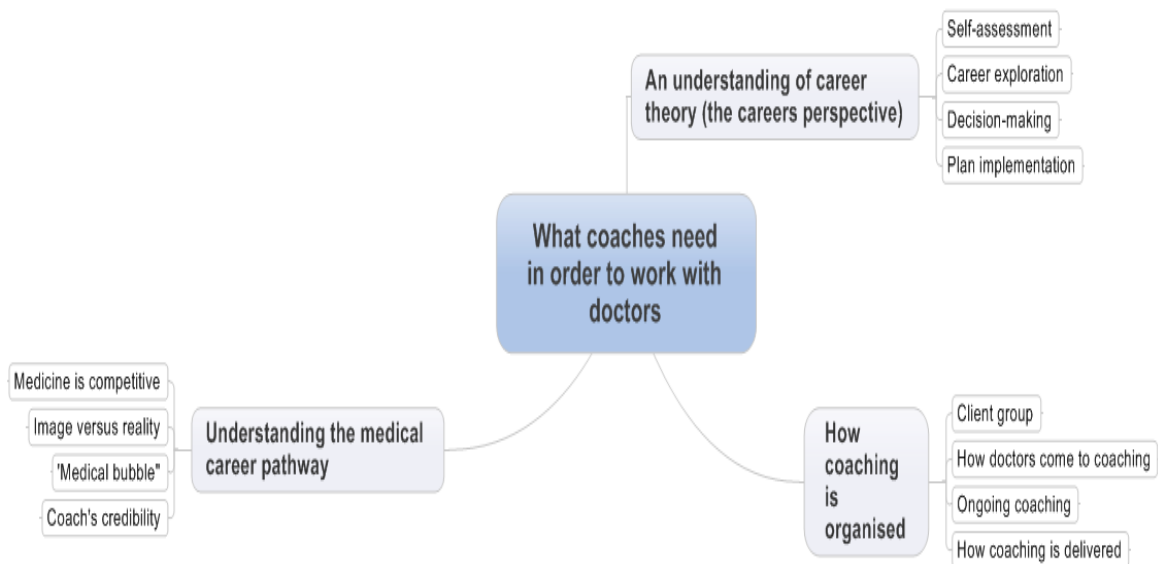


Figure 2: What coaches need in order to work with doctors

Understanding the medical career pathway

Coaches raised concerns that the medical career pathway continues to change and this presents challenges when providing career support to doctors. Medicine is seen as competitive and as one doctor said about being competitive “that’s not exactly me”.

The image of medicine versus the reality of it was also raised by participants as well as the transition from medical student to doctor. One doctor recognised there was a change in status: “you are not a student anymore, you are seen as a doctor”.

A number of participants described medicine as a bounded, almost isolated career and one coach 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. (Coach D)

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. This echoes Gowan (2010, p.67) who proposed that medical training takes place in a “training bubble”.

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

Coaches thought it was important that they had an understanding of their own capabilities and boundaries as a coach. 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 one coach indicating:

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. (Coach B)

However, being an outsider providing help and being non-judgemental was valued by doctors. In addition, coaches who work with doctors do need to be aware that they might be seen as the expert and someone who is there to give advice, rather than to support the client make career choices.

An understanding of career theory

Both coaches and doctors identified a number of key aspects of the coaching they received which have been categorised using a four stage career planning process which I use in my work as a coach (Elton and Reid, 2010); it comprises: self-assessment, career exploration, decision making and plan implementation.

Coaches discussed a number of reasons for encouraging doctors to carry out self-assessment with one coach summing it up as: "all these [career theory] models are just a means to an end really ... to get people to think". Doctors also recognised that self-assessment can be helpful with one saying "we did a series of exercises that helped me to fully understand who I am, what my interests and talents were and what I wanted from a career".

With regards to self-assessment, coaches and doctors identified a wide range of exercises, tools and techniques, including values, interests, skills, work environment and psychometric tests, primarily the Myers Briggs Type Inventory and specialty choice tests.

As far as career exploration is concerned, this can be an area of career planning that doctors need help with, as they may be unclear about the path they wish to take in medicine (or outside it). One coach thought that generating ideas together with a doctor meant 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". Another coach also helped with career exploration by effecting an introduction to a clinician working in the specialty that the doctor was interested in.

The next stage in the career planning process is decision making. 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. Fewer coaches use more intuitive exercises like Dilt's logical levels (Grimley, 2010, pp.195-196). Coaches had also developed their own exercises to support the decision making process, for example, one coach asks doctors to put their decisions on paper and carries a range of resources with her to help that process.

Coaches also thought that doctors can find it difficult to make a career decisions and may be hostile or wary and under pressure to make decisions. This pressure can come from wider social influences with one doctor suggesting:

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. (Doctor D)

The need for a plan B was also raised, as medicine is a competitive profession, and a doctor may not secure their first choice of medical specialty.

The final stage in the career planning process – plan implementation – has much in common with action planning in coaching. In addition, it is often focused on more specific job search activities like application forms, CVs and interviews. Interview skills were seen as a particular challenge and one coach described how a doctors' problem with interviews had led them to re-assess their career choice and start the process again.

How coaching is organised

Coaches structure their coaching in a wide variety of ways depending on the type of organisation they work for and how the doctor comes to coaching. For example, deaneries often provide coaching to doctors who are referred to them while freelance coaches may either work through an organisation or directly with a doctor. Coaches also make choices on how the coaching is delivered, for example, face-to-face coaching, by telephone or via email. Coaches may need to tailor how they provide coaching depending on how the doctor comes to coaching and other potential constraints.

Coaches' approach to their coaching practice

Six key areas of the coaches' approach to their coaching practice emerged from the data: coaching skills and knowledge, the models and processes which underpin practice, values, supervision and continuous professional development, the researcher as a coach and trainers and supervisors (see Figure 3).

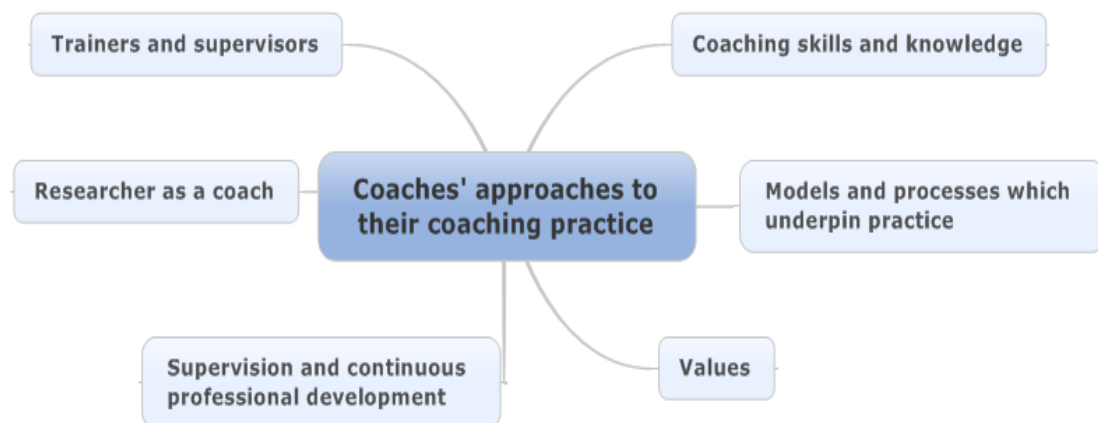


Figure 3: Coaches' approach to coaching

Coaching skills and knowledge

Coaches mentioned a range of skills which they use when working with doctors. Listening, questioning and challenging were discussed the most, together with the need to be more guiding, present, impartial, neutral, open-minded and non-judgemental. Many of the skills are similar to those in the Ali and Graham (1996) model of career counselling skills as well as most coaching models.

The need to deal with doctors' emotions was also raised. One coach thought that: "one of the most important bits about coaching is being present with the other person and giving them undivided attention". Doctors don't always articulate their emotions and one coach 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 to their coaching skills, the majority of coaches identified the need 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. One coach called it "knowing the edge".

Models and processes which underpin practice

When discussing their work with doctors, coaches mentioned a wide range of models and processes from the careers, coaching and mentoring and management literature, which inform their practice. The data suggests this breadth of approaches is linked to how each person in this study developed as a coach. Five of the career providers trained initially as career counsellors. 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 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 one coach:

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. (Coach B)

In this study the providers of career support had their own way of working with clients, informed by models and processes which were a combination of those found in the career, coaching/mentoring and management literature.

Values

One of the subsidiary research questions sought to find out how coaches 'operate' when coaching doctors and while I was coding the data I was struck by the number of times coaches mentioned 'value' in relation to their work.

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.

Supervision and continuous professional development

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 recognised by the majority of coaches. One coach explained that she had “had times where I’ve thought “what on earth is going on here? ... then that’s really helpful to have somebody else to help you look at it from a different angle”. The importance of supervision is recognised by Fillery-Travis and Lane (2006).

The researcher as a coach

My own 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, 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. A particular challenge relating to my work is when to coach and when to 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 and this is the type of issue I take to my own coach-supervisor.

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.

This research indicates that postgraduate doctors in training programmes can inhabit the “medical bubble”, which means that they do not look beyond trainers and supervisors for advice and support. Although the research by the BMA (2010) proposes that trainers and supervisors should be the ones to provide careers advice, this study 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

Coaching conversation

Three areas related specifically to the coaching conversation: the coaching process, metaphors and outcomes from coaching (see Figure 4).

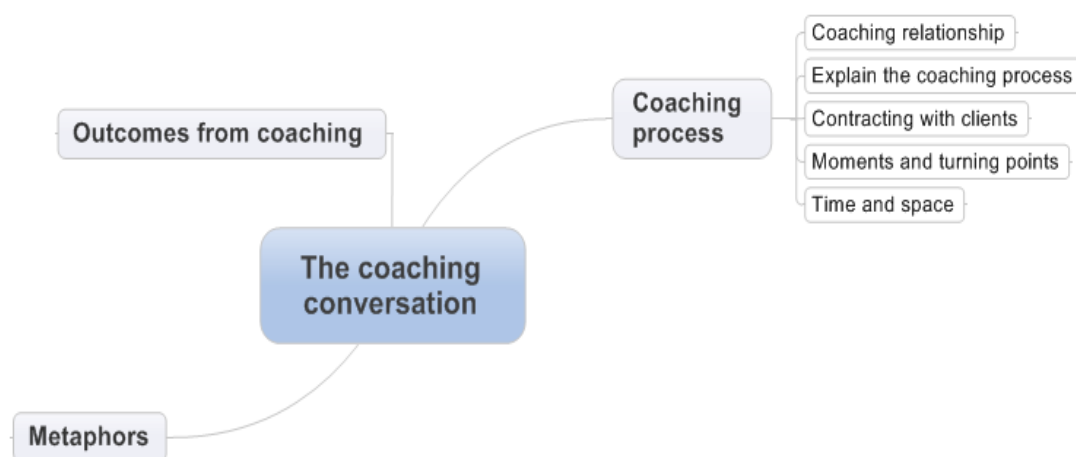


Figure 4: The coaching conversation

Coaching process

The coaching relationship was described by most coaches as important with one coach saying: “I am a great believer that the relationship is at the absolute centre of the coaching ... without it the coaching doesn’t work”. In addition, coaches recognised the importance of building trust and rapport with doctors and the need to agree how they will work with doctors. One explained that it was worthwhile spending time on “how you are going to work together”.

Managing doctors’ expectations of coaching was also seen as an important part of the coaching process with coaches seeing themselves having an overall facilitation role and ensuring that the agenda is owned by the doctor. One described her role as having “a meta-view of where that client is going in their career”.

Building “the contract” was discussed by a number of coaches and one coach described her intake session as:

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?”(Coach M)

During the coaching itself coaches described a number of moments 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 doctor made a discovery or gained an insight, which then impacted on the way the coaching progressed. One coach described one of these as experienced by her client as:

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”(Coach C)

De Haan’s (2008) research into moments and incidents in coaching practice proposes that they are present in the coaching relationship and pivotal in the learning and development of the client. De Haan (2008, p102) 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 the study accord with that view.

In addition, seven of the coaches discussed the importance of coaching providing time and space for doctors to consider their career issues. Doctors also agreed that this was an important part of coaching with one of them 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).

Coaching was also seen as providing space for doctors with it being described in a number of ways: a “facilitating space”, “safe space”, “third space” and “objective space”. One coach said that 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”.

Metaphors

As the research progressed I noticed that participants used a number of metaphors in their interviews. Both coaches and doctors used metaphors which described: (i) how a medical career is conceptualised; (ii) how using metaphors can help clients gain new insights; and (iii) other metaphors relating to coaching doctors (see Table 3).

How doctors conceptualise their medical careers seemed to be along the lines of the positioning and journeying metaphors discussed by Law and Stanbury (2009). Battles and races was one of the most frequently mentioned metaphors and being at a career crossroads was also discussed. 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’.

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

Table 3: Metaphors in relation to working with doctors

Using metaphors to help doctors gain insights and move forward was mentioned by a number of coaches including the need to “make things real” for their clients. Coaches explained that part of their work involved “holding/showing a mirror” to doctors. 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, one coach 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.

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. One coach 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”.

Coaches used metaphors to describe how they coached doctors. One coach introduced the idea of a Gordian knot; in her work she wanted to understand the tangled sub-plots to “understand more about the unconscious stuff that people bring to a learning situation, and learning how to sort of crack into that”. Stevens (1996, p.170) describes the use of metaphor as an important means to extend our understanding; the “way to make sense of any aspect of our experience is to find an appropriate metaphor” (p. 173).

Using 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. This view is supported by McMahon (2006, p23) who indicates that metaphor can be used as a tool through which meaning is constructed.

Outcomes from coaching

Coaches and doctors described a range of outcomes that doctors achieved through coaching. Three of these were linked to themselves as individuals, and the fourth involved them taking an action of some kind (see Table 4).

Self-change	Self-development	Self-reflection	Takes action
Face the present with confidence	Build my own respect	Articulate their fears	Be proactive
Focus on things good at	Develops career management skills	Go away and think it through	Changing tack
Making conscious choices	Get clarity	Got my head straight now	Client takes action
Making own decision	Good feedback at work	Life purpose	Come up with the answers themselves
Re-adjusted my focus	Improved communication skills	Start reflecting	Find solutions
Taking ownership	Learn something		Go and find out
	Process of self-discovery		Have a plan
	Set up own network		Improving health and well-being
			Managing workload
			Some sort of resolution

Table 4: Outcomes from coaching

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), which includes a focus on a “desirable and sustainable change for the benefit of the client”.

Doctors also took specific actions as a result of the coaching they received. This ranged from changing career direction through to improving how they managed their workload. One doctor said that coaching: “encourages you to find your own answers” and that having a plan “made me feel better”. It supported the doctor to establish what Nelson-Jones (2006, p5) identifies as “what is really important”.

Discussion and conclusion

The aim of this research was to consider how coaching supports doctors to make career choices and to develop a career coaching framework for working with doctors. The research methodology was a case study and data was collected through interviews with coaches and doctors who have been coached. Their narratives provided important insights (Flyvbjerg, 2006) into how coaching supports career choices. Four key areas have been identified and discussed in the above results section and combined into a framework (see Figure 5), which considers two key aspects: medical careers and coaching; and how coaches and doctors engage with the coaching. Each part of the framework can be used by coaches who currently work with doctors, as well as by coaches who are considering doctors as a client group, to review their coaching practice.

The framework encompasses a holistic view of career coaching for doctors, and takes into account process, content and outcomes. There are four key areas for coaches to consider:

- (i) what doctors bring to coaching – coaches will benefit from an understanding of what doctors as clients bring to coaching;
- (ii) what coaches need in order to work with doctors - coaches may benefit from having medical domain-specific knowledge;
- (iii) coaches’ approach to their coaching practice - coaches should consider understanding their own boundaries and limitations;
- (iv) 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.

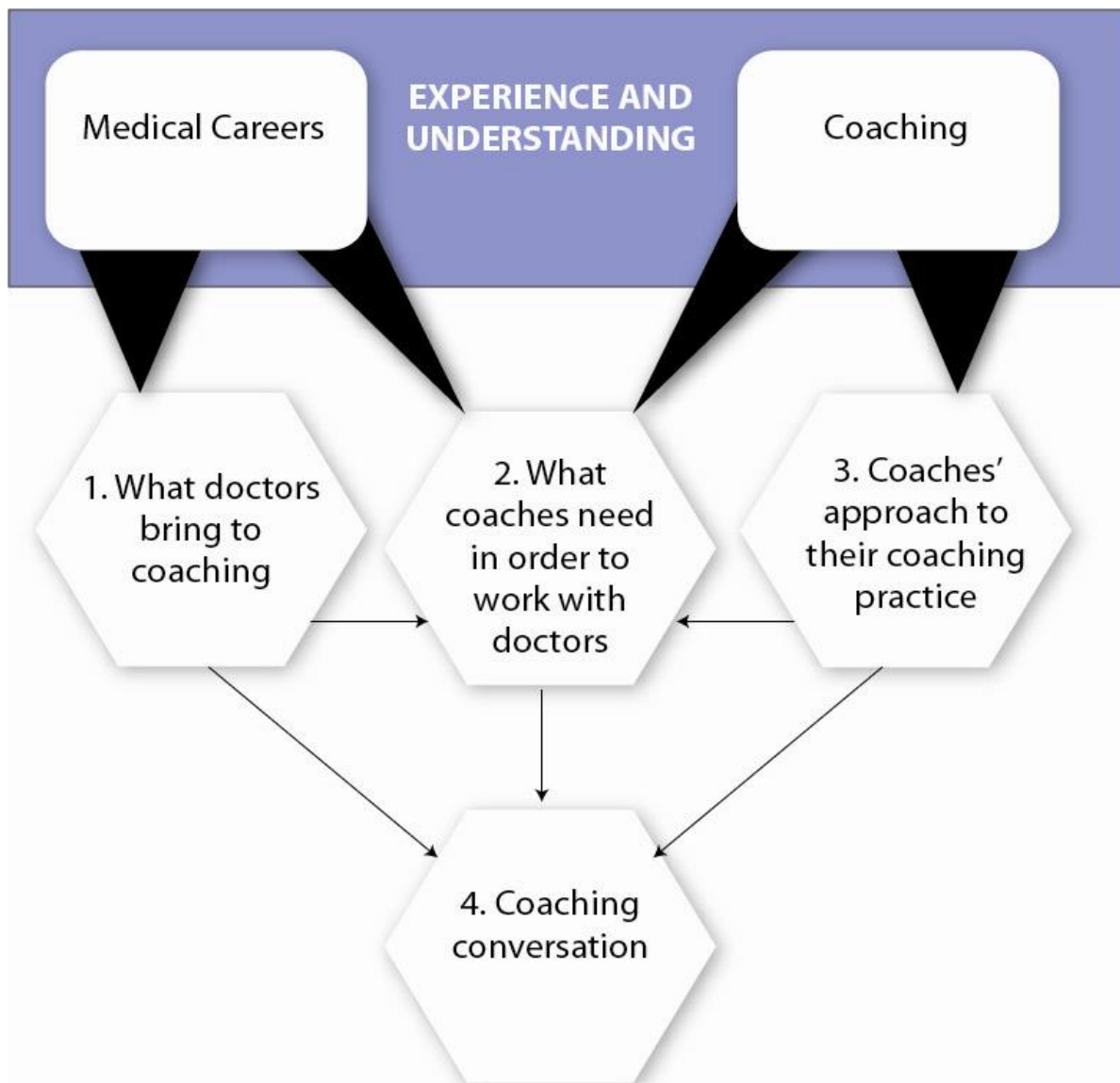


Figure 5: Career coaching framework for working with doctors.

The framework also 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 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.

As previously discussed, 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 for working 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 also benefit from having an understanding of medical career pathways. Doctors value “competence to practice” medicine (BMA, 2008) and this value 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, p. xix) has as a primary building block that “clients have the answers or they can find the answers” (p.4) and that “the coach’s job is to be curious, not to be the expert” (p.4). This research suggests that with doctors as clients there is a need to have an understanding of the medical career pathway and the careers literature to be credible as a coach to them.

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 framework 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.

In addition to the framework this study also makes the following contributions to professional knowledge and practice:

- Personal impact of coaching on doctors – this is shown in Table 4 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). Coaching provides emergent learning opportunities, which would suggest that emerging theories of career decision like narrative (Reid, 2005) and happenstance (Shottin, 2010) may be more appropriate than those of ‘fit’ (e.g. Holland, 1973).
- In relation to career theory, it seems that there are 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.
- 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.

The research was developed within 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 5) 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.

Finally, I would like to acknowledge the impact carrying out this research has had on my own practice as a coach and a provider of career support to doctors. The career support service we provide at the deanery has continued to develop as has my own practice; the continuation of the development of my understanding of my own capabilities and boundaries has been immensely helpful.

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