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Competencies for Those Who Coach Physicians: A Modified Delphi Study

Angela M. Passarelli, PhD; Gail Gazelle, MD; Leslie E. Schwab, MD; Robert F. Kramer, PCC; Margaret A. Moore, BSc, MBA, NBC-HWC; Raja G. Subhiyah, PhD; Nicole M. Deiorio, MD; Mamta Gautam, MD, MBA, FRCPC; Priscilla Gill, EdD, PCC; Sharon K. Hull, MD, MPH, PCC; Cara R. King, DO, MS; and Andrea Sikon, MD, BCC, PCC

Abstract

The rapidly evolving coaching profession has permeated the health care industry and is gaining ground as a viable solution for addressing physician burnout, turnover, and leadership crises that plague the industry. Although various coach credentialing bodies are established, the profession has no standardized competencies for physician coaching as a specialty practice area, creating a market of aspiring coaches with varying degrees of expertise. To address this gap, we employed a modified Delphi approach to arrive at expert consensus on competencies necessary for coaching physicians and physician leaders. Informed by the National Board of Medical Examiners' practice of rapid blueprinting, a group of 11 expert physician coaches generated an initial list of key thematic areas and specific competencies within them. The competency document was then distributed for agreement rating and comment to over 100 stakeholders involved in physician coaching. Our consensus threshold was defined at 70% agreement, and actual responses ranged from 80.5% to 95.6% agreement. Comments were discussed and addressed by 3 members of the original group, resulting in a final model of 129 specific competencies in the following areas: (1) physician-specific coaching, (2) understanding physician and health care context, culture, and career span, (3) coaching theory and science, (4) diversity, equity, inclusion, and other social dynamics, (5) well-being and burnout, and (6) physician leadership. This consensus on physician coaching competencies represents a critical step toward establishing standards that inform coach education, training, and certification programs, as well as guide the selection of coaches and evaluation of coaching in health care settings.

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From the Institute of Coaching, McLean Hospital, Belmont, MA (A.M.P., M.A.M.); Fuqua School of Business, Duke University (A.M.P.); Division of General Internal Medicine and Primary Care, Harvard Medical School, Boston, MA (G.G.);

Affiliations continued at the end of this article.

These are particularly difficult and unsettling times for the medical profession. Although being a physician has always been a demanding vocation, disruptive trends in the industry, now compounded by the COVID-19 pandemic and its aftermath, have brought severe pressure to bear on physicians and their organizations, and some are breaking under the strain.[1,2] Physician burnout is now at the highest level ever reported, and health care organizations struggle with retention, engagement, and lagging morale in the entire health care workforce.

Although data revealing high levels of burnout abound, data on solutions remains scant. Coaching is a strengths-based method of facilitating growth and change rooted in self-determination, autonomous motivation, and a trusting relationship. Science-based physician coaching provides a powerful ally and support, leading to greater self-efficacy, something particularly important in the setting of reduced external autonomy. Coaching for executives and managers in leadership development in other industries and coaching for workforce health and well-being are well established.[3-5] Although

research on coaching for physicians is in its infancy, a number of studies support it as a modality to reduce burnout.[6,7]

Currently, there are no standards for those who coach physicians and no single certification pathway required to enter the coaching profession. Hence, physicians and leaders lack a clear way of assessing the expertise of those claiming to be physician coaches. If coaching is to honor its responsibility to medicine, it will be attuned to the medical profession's context, circumstances, and needs, and coaching practitioners need to deliver services of high quality. This situation calls for identification of a set of competencies—those widely shared in coaching and needing special emphasis, as well as some freshly formulated for their particular relevance and utility—specific to the subspecialty of physician coaching.

We describe the results of a modified Delphi study orchestrated by the Institute of Coaching at McLean Hospital to establish expert consensus on core competencies for physician coaching. The intention of this study was to build upon existing models of coaching competencies, standards, and credentials and not to replace or substitute for established standards and credentials for professional coaches.

PHYSICIAN COACHING

Coaching is a relational process intended to facilitate self-directed, positive change and growth on the part of the "coachee." Coaching addresses both personal (eg, reduced burnout, enhanced work-life integration or well-being) and professional (eg, enhanced leadership skills, job satisfaction, or performance) development objectives of the physician being coached.[6,8] Coaching of physicians has been introduced in various formats. The first format, traditional coaching, involves a certified professional coach working one-on-one with a physician. Such coaches are often, but not always, external to the health care system or practice at which the physician is employed. We refer to coaches who work with physicians as "physician coaches," noting that physician coaches need not be physicians themselves.

To reduce costs associated with one-on-one coaching by an external coach, group coaching and faculty/peer coaching formats have emerged. In the group coaching format, one professional coach meets with a group of physicians simultaneously.[3,9] Participants in group coaching may benefit from learning from the experiences of others, supporting each other, and building social connections. Personalization of group coaching is achieved through individual efforts between sessions (eg, reflective exercises, goal setting, and deliberate practice with new behaviors). Finally, faculty or peer coaching is similar to the previous 2 formats, but rather than utilizing certified professional coaches, physicians are trained in coaching fundamentals and perform this service for peers or students, not in their direct reporting path, as a component of their job responsibilities.[10]

As a helping relationship, coaching is occasionally conflated with psychotherapy. Although coaching and psychotherapy share some features, they are distinct interventions. Both coaching and psychotherapy are dialogic in nature, rely on a high-quality relationship, involve asking questions that enable the client to explore subjective experiences, and foster behavior change. However, the aim and approach of the 2 interventions are different. Whereas psychotherapy aims to alleviate distress and restore functioning, physician coaching aims to address physicians' career development needs.[11,12] Thus, coaching takes a present- and future-focused approach to extracting learning from life's challenges that can be applied to the pursuit of a desired future state. Psychotherapy is more likely to delve into the past to understand and resolve current challenges. Moreover, physician coaching presupposes mental health. Although physicians may come to coaching with high levels of stress, depression, or anxiety, coaches do not diagnose or treat mental health disorders, nor utilize medication as part of a treatment plan. A coach can work with a physician on visible, observable behaviors as well as topics that may be less evident, such as the physician's orientation, goals, assumptions, and values.[13] As Brazeau

et al[12] point out, individual psychotherapy is more appropriate than coaching when "distress is severe, persistent, or generalized across professional and personal life domains." It becomes the therapist's role to address root causes, such as personality disorders, childhood traumas, and unprocessed life experiences.[13] Physician coaches should be trained to recognize signs of psychological distress and know how to refer a client to an appropriate mental health care provider.

These complexities raise the imperative that physician coaches pursue credentialing and continuing education and adhere to a common code of ethics. Regardless of the format of coaching and the background of the coach, we propose that the preparation of physician coaches be guided by a standardized set of competencies.

EVOLUTION OF STANDARDIZED COACHING COMPETENCIES

The emerging subspecialty of physician coaching rests on the conventions of the broader coaching industry. However, general competency models, credentialing processes, and ethical standards insufficiently address the unique needs of medicine. In order to support the subspecialty of physician coaching, domain-specific competencies must be articulated and agreed upon. As the field matures, the initial competencies will be refined based on empirical evidence so that education, credentialing, and possibly licensure rest on a valid set of knowledge, skill, and ability areas.[14]

We summarize 3 coaching standards and credentials established by nonprofit organizations in the United States since the mid-1990s. The majority of coaching professionals in the United States seek, hold, and maintain a coaching credential from one or more of these organizations. Each of these organizations assembled coaching stakeholders and large groups of coaches to define coaching competencies and deliver standardized credentials, deploying various best practice processes.

In 1998, the International Coach Federation was the first to complete a coaching practice analysis and release its core competency model and standards, along with 3 levels of coach credentials now completed by 30,000 coaches worldwide (Associate Certified Coach, Professional Certified Coach, and Master Certified Coach). The core competencies were substantially updated in 2019 to 63 coaching competencies in 8 domains (ethics, coaching agreements, coaching mindset, presence, trust and safety, active listening, evoking awareness, and cultivating learning and growth).[15]

In 2022, the National Board for Certified Counselors' Center for Credentialing and Education launched the Board Certified Coach credential, completed by 3900 coaches, based on 154 competencies in 4 domains (ethics, coaching knowledge and applications, assessment, practice management).[16]

In 2015, the National Board for Health and Wellness Coaching (NBHWC; a controlled, nonprofit affiliate of the National Board of Medical Examiners [NBME]) launched the National Board Certification for Health and Wellness Coaches, based on 128 competencies in 4 domains: coaching structure, coaching process, health and wellness, ethics and legal.[17] The NBHWC/NBME process articulated the scientific theories and literature that were translated into their coaching competencies, which informed the coaching theory and science section of the physician coaching competencies described subsequently. There were 9000 National Board Certified Health and Wellness Coaches as of June 2023.

STUDY METHODS

Despite the existence of general coaching competency models adopted by various accrediting bodies, no set of competencies exists to guide a subspecialty of physician coaching. Given the absence of existing empirical data and lack of agreement in the field, we employed a Delphi technique. The Delphi is a common approach to establishing competencies in medicine[18-22] via a structured process to collate diverse opinions and experiences into a convergent framework.[23]

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Specifically, we employed a modified Delphi approach, informed by the practice of rapid blueprinting. Rapid blueprinting is a method by which the NBME works with subject experts to efficiently and rigorously develop content for medical credentialing and evaluation examinations.[24] Our process consisted of 2 phases—the development phase and the confirmation phase. In the development phase, we drew on practices of rapid blueprinting to generate an initial set of competencies. A group of 11 experts from various stakeholder groups determined a list of key thematic areas and specific competencies within them. In the confirmation phase, a larger stakeholder group was invited to rate agreement with and comment on the initial competency document via an electronic survey, consistent with a traditional Delphi approach.

Development Phase

Expert Panel. Rigor in the Delphi technique relies on the involvement of a representative group of expert stakeholders. However, there are no universally agreed upon criteria for the selection of experts, nor is there minimum or maximum number of experts on a panel.[23,25] Guided by existing studies, we defined experts as informed individuals who are knowledgeable about and have a stake in effective physician coaching from diverse vantage points (eg, as a coach, physician being coached, purchaser of coaching).[19,23,26]

In the development phase, an expert panel of 11 physician coaches from the United States and Canada was purposively selected to draft the initial competency document. This group included expert physician coaches representing a diverse array of practice areas within physician coaching (eg, coaching of physician leaders, medical residents, and surgical residents). Physician and nonphysician coaches were represented, as well as key organizations in the industry, including the American Medical Association, Canadian Medical Association, Institute of Coaching, and International Coaching Federation. Attention was also paid to ensuring that both community hospitals and academic medical centers were represented. Among our 11 panel experts, 8 (72.7%) identified as female and 7 (63.6%) had doctoral-level training in medicine.

Data collection. Traditionally, the first round of a Delphi process involves qualitative idea generation via an open-ended survey. To expedite this round, we utilized the rapid blueprinting approach of orchestrating 2 virtual half-day meetings of the 11-person panel. In the first virtual meeting, the panel identified key areas or "categories" of competencies based on the following 2 questions: (1) In what general fields of knowledge should a physician coach be proficient to realize successful performance? (2) In what general areas must the coach have skills? This process yielded 6 key areas. The panel then broke into subcommittees to write specific competencies in each area as interim work. These competencies were compiled into one document that was reviewed by the entire working group in the second half-day meeting. The steering committee then integrated the feedback from the virtual meeting into final changes to the competencies document.

Confirmation Phase

Study Participants. Institutional review board approval was received for the confirmation phase. Participants were identified by both self and peer nomination. An open call for participants invitation was posted on several social media sites and distributed in snowball fashion by members of the expert panel. Inclusion criteria for expert stakeholders included those who had knowledge and practical experience with successful coaching of physicians or physician leaders within the preceding 3 years as either (1) the coach, (2) the individual being coached, (3) the sponsor of coaching—eg, chief medical officer or practice manager who hires coaches, (4) a physician educator who uses coaching, or (5) an educator/trainer of those who coach physicians and who were employed in the health care context in the United States or Canada. This recruitment process allowed us to monitor representation across stakeholder groups in the sample. This step yielded a

group of 176 individuals to whom the survey was emailed. The email addresses failed for 8 stakeholders, leaving 168 who presumably received the email. More than 100 stakeholders started the survey, but some did not continue after entering their demographic data and therefore are not included in the final sample; 97 stakeholders completed the survey in full, resulting in a 57.7% response rate. Demographic information is presented in Table 1.

TABLE 1. Demographic Characteristics of the 97 Study Participants in the Confirmation Phase

Variable	No. (%) of participants
Sex	
Male	22 (22.7)
Female	74 (76.3)
Nonbinary	1 (1.0)
Age (y)	
25-34	1 (1.0)
35-44	23 (23.7)
45-54	30 (30.9)
55-64	21 (21.6)
65-74	20 (20.6)
75-84	2 (2.1)
Stakeholder category[a]	
Coach	73 (75.3)
Individual coached	20 (20.6)
Sponsor of coaching	4 (4.1)
Physician educator	16 (16.5)
Coach educator/trainer	12 (12.4)
Coach credential	
Yes	70 (72.2)
No	27 (27.8)
Years of coaching experience	
<1	9 (9.3)
1-3	33 (34.0)
4-6	20 (20.6)
7-10	16 (16.5)
>10	19 (19.6)
Work in academic medical environment	
Yes	50 (51.5)
No	47 (48.5)
Physician	
Yes	69 (71.1)
No	28 (28.9)

[a]Multiple responses could be selected for stakeholder category; hence, the total is greater than 100%.

Data Collection. The competency document finalized in the development phase was sent to this broad group of stakeholders for evaluation and comment. After providing consent to participate in the study, respondents completed a survey in which they could download the full competency document. In the survey, the full competency document was split into the 6 key areas, 4 of which were further divided resulting in 17 subsections. Respondents rated the extent to which they agreed with the competencies in each subsection using a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) and had an opportunity to elaborate on their scores with open commentary. Finally, survey respondents were asked to indicate the relative importance of each key area by distributing 100 percentage points across them such that a greater percentage indicated greater importance to effective coaching of physicians.

Agreement levels (analyzed as described subsequently) exceeded the predetermined 70% threshold, indicating only one survey round was necessary to establish consensus. That said, for completeness, 3 physician coaches from the phase 1 expert panel reviewed all comments and as a group, decided if and how to respond by editing the competencies. Their modifications to the original competencies did not introduce any substantive changes in meaning, further supporting the decision to conduct only one survey round.

Consensus Thresholds and Data Analysis

Rigor in the Delphi approach requires that a priori thresholds be set for establishing consensus.[27] Based on previous studies and best practice recommendations, we determined that 70% agreement would indicate consensus.[23,25] Agreement was determined at the subsection level by calculating the percentage of respondents who responded "agree" or "strongly agree." Average scores were also calculated. Qualitative comments were discussed and reconciled among 3 members of the steering committee. Finally, relative weighting was analyzed by calculating the average percentage assigned to each key area.

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RESULTS

The first (development) phase of the study yielded a competency document with 6 key areas: (1) physician-specific competencies, (2) understanding physician and health care context, (3) coaching theory and science, (4) diversity, equity, and inclusion (DEI), (5) well-being and burnout, and (6) physician leadership. These 6 areas were further divided into subareas containing 129 specific competencies. Core skills for all physician leaders, including team/unit leaders and senior leaders, were outlined in the physician leadership key area. These core skills differed from all other competencies in that they described skills that coaches might presumably develop in others, rather than competencies of coaches themselves. Despite this difference, the research team believed consensus was required if the skills were to appear in the final document, so they were included as a subarea in the confirmation phase of the study.

The second (confirmation) phase of the study provided overall confirmation of the competency model. Agreement scores ranged from 80.5% to 95.6% (Table 2). Although agreement scores for all subareas surpassed the 70% threshold for consensus, qualitative comments were also taken into consideration in determining whether to retain, modify, or delete competencies. Comments relating to assumptions about the core skills for physician leaders indicated a lack of consensus and possible confusion about that item set. Most convincingly, a clear theme in the comments suggested that these assumptions were neither necessary nor appropriate for a physician coaching competencies document. The steering committee opted to remove these core skills from the final competency document, resulting in agreement scores that ranged from 85.5% to 95.6%.

The steering committee modified the language in the competency document based on the comments. No substantive changes were made to the nature or number of competencies. The final document is available in the Supplement (available online at http://www.mayoclinicproceedings.org).

TABLE 2. Agreement Scores From Confirmation Phase Survey

Key area and subareas	No. of competencies	Average agreement score	Agreement (%)
(1) Physician-specific competencies			
Demonstrates ethical practice	12	4.68	94.3
Professional practice standards when working with sponsors and stakeholders	6	4.73	95.5
Addressing physician mindset	9	4.71	95.6
Evoking awareness and listening actively	8	4.61	92.2
(2) Understanding physician and health care context, culture, and career span			
Health care system and culture of medicine	17	4.57	89.2
Role management	8	4.63	92.8
Physician career paths	3	4.44	89.3
(3) Coaching theory and science	16	4.37	86.7
(4) Diversity, equity, inclusion, and other social dynamics	14	4.65	91.6
(5) Well-being and burnout			
Developmental tasks to support well-being	7	4.76	95.1
Self-care	4	4.76	92.7
Stress management, burnout, and resilience	7	4.68	91.4
Mindfulness	3	4.39	85.5
(6) Leadership			
Leadership mindset	6	4.60	92.5
Managing adversity	5	4.52	91.4
Communication skills	2	4.46	87.7
Organizational development	2	4.36	87.2

The assigned weighting provides guidance in terms of the relative importance of the key areas to effective physician coaching (Table 3). Weighting ranged from 21.1% (most) to 11.8% (least) for important key areas and did not correspond to the number of specific competencies within the area.

DISCUSSION

Coaching is an approach that has rapidly gained momentum in health care with an

TABLE 3. Key Area Weighting

Key area	Average weight
Coaching theory and science	21.1%
Understanding physician and health care context, culture, and career span	18.6%
Well-being and burnout	18.0%
Physician-specific coaching competencies	14.3%
Physician leadership	12.1%
Diversity, equity, inclusion, and other social dynamics	11.8%

increasing body of research substantiating its efficacy in mitigating burnout. There are no standards for those who coach physicians and no one certification pathway required to enter the profession. A modified Delphi technique, informed by the NBME's rapid blueprinting practices, was utilized to establish consensus among stakeholder groups in understanding what competencies are required when coaching the physician population. This step yielded competencies in 6 key areas.

Key Areas

Key Area 1: Physician-Specific Coaching Competencies. Physician-specific coaching competencies situate common coaching standards in the physician coaching context (eg, subarea 1.1, demonstrates ethical practice), and explicate new competencies specific to physician coaching (eg, subarea 1.3, addressing the physician mindset). These competencies call for coaches to demonstrate ethical practice and avoid assuming diagnostic or prescriptive roles, especially regarding mental health issues. Physicians' legitimate sensitivity around mental health and malpractice risks necessitates creating a particularly safe and private coaching environment. Vital for trust and rapport, coaches must respect the privacy of physicians and patients and maintain confidentiality in and beyond coaching sessions. When working with sponsors and stakeholders, coaches must remain unbiased, refrain from acting as intermediaries, and proactively manage boundaries among multiple roles and/or multiple clients in the same health care organization (eg, subarea 1.2).

Effectively coaching physicians requires an understanding of the unique factors that may shape their mindsets. Physician mindset, as used here, refers to a set of beliefs generated in part by various challenges faced at different career phases that shape physicians' self and world views. For example, medical education is intensely focused on cognitive training and inadequately addresses self-awareness and self-leadership, emotional and social intelligence, teamwork, leadership, and well-being skills.[28] The system of medical training creates a strict sense of hierarchy based on status, which inadvertently fosters harsh self-criticism (low self-valuation[29]), perfectionism, and imposter beliefs.[30]

Addressing the physician mindset requires understanding and validating common phenomena such as a particularly intense cognitive focus and dominant (even intimidating) expert, fixer, and perfectionist mindsets. Coaching can help physicians work through an excessive sense of responsibility, which may be trauma-based.[31] Coaches evoke awareness and self-compassion by validating the internal and external challenges physicians face and shining a compassionate light on harsh self-criticism.

Listening actively is crucial, with coaches holding space[32] and speaking succinctly and minimally in order to draw out a physician's experiences and perspectives, as well as clarity on growth opportunities. Coaching creates a safe and positive environment, conducive to rapid awareness and learning.

Coaching can help physicians develop a healthy receptivity toward feedback that is strengths-focused (eg, building on what's good, using strengths to overcome challenges) and deploy a growth mindset (eg, focus on getting better rather than looking good).[33] Coaches help physicians develop new resourcefulness (eg, efficacy, resilience, hope) for navigating their workplaces more effectively.[7] They cultivate physical body awareness (eg, noticing breathing patterns, muscle tension) and use science-based

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mindfulness tools to generate mental and emotional awareness, regulation, and calm.[34] Coaching helps physicians identify their cultural triggers and loosen their biases. Encouraging openness and vulnerability, while maintaining healthy boundaries, coaches help physicians notice their blind spots and use their strengths to turn their challenges into growth.

Key Area 2: Understanding Physician and Health Care Context, Culture, and Career Span. This set of competencies calls for coaches working with physicians to be aware of the various factors particular to health care that impact physicians. Medicine is a dynamic field with constant innovation and changes in knowledge, technology, administrative oversight, and regulations, requiring physicians to engage in lifelong learning and adaptability. Common stressors include electronic medical record systems, malpractice risk, and shifting performance targets and financial incentives, causing stress and even moral injury.[35] The corporatization of health care has compromised the physician autonomy, the foremost core psychological need established by self-determination theory, impacting their work conditions and focus on patient care.[36] Physicians face challenges in working with nonphysician administrators and are expected to be ever-competent experts while adapting to changing performance targets.

We suggest that coaches will be more effective if they understand the health care system's cultural dynamics, hierarchy, and the concept of moral injury.[37] This knowledge will allow them to help physicians recognize unrealistic expectations, address disempowerment, navigate ethical challenges, and develop adaptability. Coaches must also understand the emotional impact of productivity pressures, helping physicians optimize efficiency and balance administrative tasks with high-quality patient care.

Effective coaches help physicians manage their role within the health care system. In order to do this, coaches need an awareness of power dynamics, know how help physicians navigate resourcefully, and address the victim mentality for self and others. Coaching promotes collaboration, self-awareness, and critical conversations with peers and superiors. Coaches assist physicians in managing conflict and recognizing potentially disruptive behaviors that could lead to disciplinary actions. At critical junctures in physician career paths, coaches support identity formation and facilitate role transitions.

Key Area 3: Coaching Theory and Science. Effective physician coaches understand the scientific underpinnings of coaching techniques and processes, just as physicians understand the scientific underpinnings of medical procedures, interventions, and medicines. Coaches are well informed about evidence-based theories including physician well-being, mindfulness, emotional intelligence, self-determination theory, positive psychology, motivational interviewing, the transtheoretical model of behavior change, intentional change theory, growth mindset, adult development, goal-setting theory, design thinking, and coaching outcomes research.[32] Coaches apply the relevant scientific knowledge to support physicians more effectively in improving their well-being, leadership, and overall performance.

Key Area 4: Diversity, Equity, Inclusion, and Other Social Dynamics. This set of competencies represents an important advancement over existing competencies models, which have insufficiently addressed DEI issues to date. Long-standing patterns of societal, structural, and individual inequity in North American society have had considerable impact on health care, requiring coaches be attuned to these issues.[38,39] Diversity, equity, and inclusion comprises various domains such as sex, race, neurodiversity, sexual orientation, ethnicity, and more, as well as their intersections. This set of competencies calls for coaches to understand larger systemic structures at play, show genuine empathy, reduce biases, and be sensitive when coaching individuals who feel excluded or different.

Effective physician coaches recognize the unique nature of physician-patient relationships, starting with the moral imperative physicians honor in caring for all patients and being aware of biases patients may have against physicians or vice versa. Competencies in physician coaching related to DEI issues include understanding the presence and impact of bias and inequity in the medical setting, developing curiosity and cultural humility, adapting communication styles to accommodate identity-based needs, and managing emotions around equity and inclusion. The coach also validates the physician's experiences, creates opportunities for exploration and growth, and is aware of stereotypes and implicit bias that exist within various groups and power dynamics in medicine.

Key Area 5: Well-being and Burnout. Physicians face unique threats to their well-being, including high rates of burnout and mental health disorders.[35] The demanding nature of medical training and practice, combined with the pressure for perfection and limited time for self-care, contributes to these risks. Additionally, physicians may experience vicarious grief and other emotional pain from witnessing patients' suffering, losses, and societal burdens.[40]

Effective coaches are equipped to help physicians focus on aspects within their control to improve their sense of agency and well-being. This process includes connecting with their values, developing emotional intelligence and self-compassion, and accessing inner wisdom. Coaches can help physicians overcome socialized beliefs that hinder self-care and set appropriate boundaries. Stress management, burnout prevention, and resilience building are also vital components of coaching, with mindfulness techniques used to process and integrate unhelpful thoughts and fears contributing to burnout.

Key Area 6: Leadership. Physicians often take on leadership roles without formal training or support. They may face challenges integrating leadership responsibilities with their clinical work. Some physicians progress up the organizational ladder, requiring additional leadership skills.[41] Key areas for physician leaders to develop competence in include effective communication, conflict management, delegation, developing others, emotional intelligence, listening, adaptability, overcoming imposter syndrome, self-awareness, well-being and self-care, and workload management.

Coaching for physician leaders focuses on developing a leadership mindset (extending self-leadership to others), including self-awareness, self-regulation, empathy, and social skills. Coaches help physicians shift from individual contributors to team-oriented leaders and develop executive presence and inclusive leadership skills.[42] Coaching also involves managing adversity, supporting physicians in crisis management, critical conversations, and handling resistance to organizational mandates. Trauma-informed coaching is essential due to the prevalence of trauma in physicians and physician leaders.[31]

Furthermore, coaching addresses communication skills, including aligning unit goals with the organization's mission and strengthening listening and verbal communication skills. Finally, coaches assist physician leaders in organizational development by recognizing the importance of developing current and future leaders and guiding them in strategic planning, board alignment, navigating the health care environment, and managing external stakeholders and media relations.

Implications for Practice

This study addresses the specific coaching competencies required for those who provide coaching to physicians. The results of this study can be useful in at least 4 ways. First, those who coach physicians are often not physicians themselves and may have an incomplete understanding of the rigors of training, the current health care industry context, professional culture, and issues facing physicians over their career span. Moreover, when physicians coach other physicians it is essential to put aside the

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lenses of expert, mentor, or teacher in the service of the coaching role. These competencies provide guidance in both situations.

Second, physicians and health care institutions seeking coaches have not previously had a way to analyze and gauge an individual coach's competence. This study's results provide concrete standards that can effectively guide coach selection and evaluation.

Third, while widely accepted, coaching competencies such as those from the International Coach Federation utilized in general coaching training programs lack a focus on coaching theory and science, DEI, and well-being and burnout—topics essential for effective physician coaching. Thus, the competencies established here may have broader application to general coaching competencies.

Fourth, these competencies provide a road map for training physician coaches in the future. Importantly, the weighting suggests that (1) coaching theory and science, (2) understanding physician and health care context, culture, and career span, and (3) well-being and burnout are of particular importance in coach education. This is a very timely issue as many such health care and physician-focused coach training programs are emerging and currently no standards exist for their curricula.

Limitations and Future Research

Although this study drew on an international sample of stakeholders, the generalizability of the findings is limited to physicians in the US and Canadian health care contexts. Because the focus was on physicians, the unique needs of nursing professionals, technicians, therapists, or other key professionals in the health care ecosystem are not represented. Additionally, the results may not be generalizable to physician coaching in other countries. Although the study sought to include a group of highly expert coaches to develop the initial competency document, we acknowledge that their selection was based on reputation rather than an objective measure of performance. Lastly, the results could be biased by the overrepresentation of women and underrepresentation of recipients of coaching in the confirmation sample. The percentage of respondents who identified as women (76.3% [74 of 97]) paralleled the number of women coaches more generally[43] (72%). To examine potential sex differences in our sample, 2-tailed independent samples t tests were conducted on all areas in Table 2. These analyses revealed that men and women differed significantly in agreement in only one area—key area 1, subarea 4: evoking awareness and listening actively (t_{75}=2.26; P=.027). Men (n=20; mean ± SD average agreement score, 4.85±0.37) agreed more strongly than women (n=69; mean ± SD average agreement score, 4.5±0.87) with these competencies. With regard to recipients of coaching, future research should examine the lived experiences of physicians who have been coached regarding what competencies would have been helpful to them. This factor could further validate or refine the current results.

Further, although the Delphi technique is considered an excellent method to obtain consensus,[23] it has been criticized as being less rigorous and scientific than such methods as a randomized controlled study.[44] Future research is needed to transform the competencies into behavioral constructs that can be reliably measured and tested against desired outcomes.

Despite the emergence of several competency models from professional coaching bodies, the term *competency* remains a contested issue in the coaching field. First, there has been debate about what constitutes a competency. Coach credentialing bodies define competencies as knowledge, skills, abilities, and personal characteristics important for coaching.[14,45,46] These competency models are typically developed through expert consensus building and/or job task analysis.[14,45] In the absence of evaluation vis-à-vis performance, this approach likely results in minimum thresholds for entry into professional practice rather than indicators that differentiate superior performance.

Competency definitions from professional coaching bodies stand in contrast to the definition of behavioral competencies

advanced by Boyatzis and McClelland,[47,48] who define a competency as *a capability or ability of a person, not a characteristic of a job, that results in effective performance of a role or job*. In this view, competencies are sets of behaviors intentionally enacted in a context that empirically distinguish effective performance. Boyatzis et al argue that consensus-based approaches to defining competencies may result in a list of job tasks, skills, and values that do not reflect behavior and intent, and hence, would not be considered competencies. Rather, the list may indicate 'threshold' knowledge or capabilities necessary for minimal or average performance, but likely will not empirically distinguish effective performance. [49]

Second, some argue that existing competency models do not adequately depict the complexity of what coaches do in coaching.[50] Moreover, having highly competent coaches does not guarantee that successful coaching will ensue. Outside influences such as characteristics, capacities, and motivation of the person being coached and the environment in which coaching takes place can have profound effects on the outcomes of coaching.[50]

Given these limitations, what is the value of this undertaking? We contend that this compendium of competencies establishes minimum expectations for ethical practice, provides structure for education and training programs, offers foci for supervision, and helps to clarify public understanding of the role and functions of physician coaches.[51] It also establishes a baseline from which further behavioral studies can be developed.

CONCLUSION

Coaching in health care settings is an important opportunity to improve the well-being, agency, and impact of the health care workforce. Although coaching standards have been developed for coaching patients in health care (NBME and NBHWC), standards for coaching health care professionals or health care leaders have not been established. We sought to establish a compendium of competencies as baseline standards for the emerging subspecialty of physician coaching. Our aim is for these competencies to inform the selection, education, certification, and evaluation of physician coaches as the field evolves.

POTENTIAL COMPETING INTERESTS

Ms Moore has received payment as CEO of and owns stock in Wellcoaches Corporation and the Institute of Coaching; Dr Gautam has received payment as CEO of PEAK MD Inc and has stocks in that business; Dr Hull is the owner of Metta Solutions, LLC, and has received payment for various coaching and consulting engagements, speaking engagements, and travel related to that business. Dr. Passarelli recieves payment for coaching and consulting services through AMindSet Learning and Development, LLC. Mr. Kramer recieves payments of co-founder of the Spiro Coaching Institute. The other authors report no competing interests.

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SUPPLEMENTAL ONLINE MATERIAL

Supplemental material can be found online at http://www.mayoclinicproceedings.org. Supplemental material attached to journal articles has not been edited, and the authors take responsibility for the accuracy of all data.

Affiliations (Continued from the first page of this article.): Atrius Health, Leslie Schwab, LLC: Physician Coaching Services, Newton, MA (L.E.S.); Spiro Coaching Institute, Greensboro, NC (R.F.K.); Wellcoaches Corporation, Wellesley, MA (M.A.M.); Department of Psychometrics and Data Analysis, National Board of Medical Examiners, Philadelphia, PA (R.G.S.); Department of Emergency Medicine, Virginia Commonwealth University School of Medicine, Richmond (N.M.D.); Department of Psychiatry, University of Ottawa, Ottawa, Ontario, Canada (M.G.); Health Care Administration, Mayo Clinic College of Medicine and Science, and Human Resources, Mayo Clinic, Jacksonville, FL (P.G.); Metta Solutions, LLC, Durham, NC, and Department of Family Medicine, University of North Carolina at Chapel Hill School of Medicine (S.K.H.); Obstetrics and Gynecology Institute, Cleveland Clinic, Cleveland, OH (C.R.K.); and Department of Internal Medicine and Geriatrics, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, Cleveland, OH (A.S.).

Correspondence: Address to Angela M. Passarelli, PhD, Management and Organizations, Fuqua School of Business, Duke University, 100 Fuqua Drive, Durham, NC 27708-0120 (angela.passarelli@duke.edu).

ORCID

Angela M. Passarelli: https://orcid.org/0000-0002-0998-0979

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