Serendipity, Flexibility, Calling and Commitment: How Clinicians Navigate the Path to Clinician-Coach

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Serendipity, Flexibility, Calling and Commitment: How Clinicians Navigate the Path to Clinician-Coach

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ABSTRACT

Objective: To explore the practice-related changes that occur as emergency physicians contemplate and navigate the path from clinician to clinician-coach.

Methods: Participants were interviewed about how they made sense of their coaching roles and coaching practice within the emergency department.

Results: A combination of inductive and deductive qualitative analytic approaches explored the initiation and evolution of the coaching practices of emergency medicine (EM) physicians as they navigated the path from clinician to clinician-coach. Enablers of and barriers to the initiation and development of coaching practices were identified, along with four overarching experiential qualities—serendipity, calling, flexibility, and commitment—that attend and support the process of becoming and being a clinician.

Conclusions: The stages of practice evolution and the notions of serendipity, calling, flexibility, and commitment offer a framework for understanding how EM physicians successfully embark on and navigate the path from clinician to clinician-coach.

1 | Introduction

In the high-pressure context of emergency medicine (EM), coaching—defined as 'partnering with clients in a thought-provoking and creative process that inspires them to maximise their personal and professional potential' [1]—is gaining recognition as a tool to enhance clinician well-being and resilience [2–4] and improve non-technical [5–7] and clinical/technical skills [8–10] and for trainee and practising doctors alike [11, 12]. However, to date, studies of coaching in EM have predominantly been *outcome* studies, which highlight the role of coaching in enhancing well-being, knowledge, ability and skill, rather than *process* studies, which provide insight into the psychosocial processes involved in the practice of coaching and the process through which clinicians become coaches [12].

Given this, it is a research priority to develop deeper insights into the process of coaching in EM, in general, and the processes through which physicians become coaches in the context of EM, in particular. However, despite the growing appreciation of the value and benefits of coaching in this context, research also suggests that EM physicians who are interested in incorporating

coaching into their professional practice face several obstacles to doing so, including lack of organisational buy-in and cultural resistance to coaching in EM and medicine in general [13].

The purpose of the current study, which is part of a wider program of Australasian EM coaching research by the authors, is to further illuminate the processes of and pathways to coaching in EM. To date, this emerging research program has illuminated the state of coaching in EM in Australia and around the world [12], the subjective value of coaching to clinician-coaches in Australasian EM [13], and the learning shifts of Australasian EM physicians who identify as clinician-coaches [14].

Although Rixon et al. [14], provided new insights into the learning shifts and mindset changes experienced by EM physicians who have become clinician-coaches, this work is silent on the behavioural and practice changes that emerge as EM physicians initiate the practice of coaching and navigate the path to becoming a clinician-coach. The present study addresses this omission, exploring the practice changes that occur as emergency physicians contemplate and navigate the path from clinician to clinician-coach, which we define as EM physicians who have incorporated coaching practices into their day-to-day clinical roles. In other words, we focus on what EM physicians 'do' (i.e., practice) rather than 'think' (i.e., perspective) on the path to becoming a clinician-coach, as well as what factors facilitate these behavioural changes in the context of EM.

2 | Method

2.1 | Study Design

This exploratory study employed the same qualitative research design as Rixon et al. [14], and draws on the same interview dataset. However, whereas Rixon et al. [14] used Braun and Clarke's [15] reflexive thematic analysis to explore the learning and mindset shifts of clinicians who become coaches, the present study used a different analytical method—namely, framework analysis [16]—to look for patterns in how clinicians begin their coaching journeys and evolve as clinician-coaches. We also drew on the transtheoretical model (TTM) of behaviour change, a well-established framework for understanding how individuals progress through different stages when adopting new behaviours, to aid interpretation of these patterns and pathways.

2.2 | Researcher Reflexivity

Our interdisciplinary team brought diverse perspectives to this study, shaping project formulation, methodological approach and data analysis. The lead researcher (A.R.), an experienced coach, and S.W., a professor of leadership, have studied EM physician leadership and coaching for several years. L.W., an EM physician with a PhD in leadership in EM, related personally to participants' coaching challenges and interpreted these challenges through the lens of an EM physician, while E.E., a PhD-qualified EM nurse researcher, contributed perspectives on the clinician environment. V.L., a healthcare management researcher and workplace coach, offered an 'insider-outside' perspective. As members of the broader academic and clinical community, we acknowledge our clinical, academic leadership and personal experiences influence our interaction with and the interpretation of the data collected.

2.3 | Participants and Data Collection

Twenty EM clinician-coaches participated in the research (see Table 1). Most self-identified as clinician-coaches (i.e., were not employed as clinician-coaches) and some used coaching techniques to inform their official work as supervisors, mentors and teachers. One-on-one semi-structured interviews were used to collect the data (see SI for the interview questions). Participants were recruited from the pool of emergency physicians who participated in an earlier qualitative study of clinician-coaches in EM [2]. This earlier study used an online Expression of Interest to invite emergency physicians to participate in a 'clinicians being and becoming coaches' project, which was distributed at the Australasian College for Emergency Medicine (ACEM) 2023 Annual Scientific Meeting, as well as snowballing through our professional networks. The study invitation described the project as exploring coaching as part of clinician roles. Emergency physicians were asked to self-identify whether they incorporated coaching into their clinical/and or leadership practice. Interested participants were directed to complete an online survey establishing if coaching is undertaken, either formally or informally, as part of their role. Using an interview guide developed by A.R., the interviews were conducted by V.L. between May and August 2024. The interviews enabled rich data collection while providing an in-depth understanding of how each participant made sense of their coaching roles within the E.D. The interviews were conducted online and recorded utilising Microsoft Teams. Transcriptions were cleaned and checked for accuracy by V.L. Participant privacy was protected following transcription by redacting potentially identifiable information from the raw data prior to data analysis.

2.4 | Data Analysis

The study followed the five stages of framework analysis [16]. The first stage was *familiarisation* in which transcripts were reviewed multiple times to build familiarity with the data and note initial observations. Early codes and reflections were recorded by individual team members. In the second stage, *identifying a thematic framework*, L.W. led the initial stage of coding and theme development, noting that clinicians' stories were often structured around 'helps' (enablers) and 'harms' (barriers) to coaching practice. From this, he inductively identified five thematic phases in participants' narratives: (i) foundations, (ii) motivation, (iii) mindset, (iv) practice and (v) maintenance. Recognising that clinician-coach is a multidimensional workplace identity, L.W. further categorised each enabler and barrier within these phases as personal (individual), interpersonal (relational) or organisational (systemic).

In the third stage, *indexing and refinement*, the research team determined that the TTM [17] offered a stronger fit for organising and interpreting the data owing to its affordance for analysing the cognitive and affective correlates of behaviour and facilitating behaviour change (see Table 2 for a summary of the

TABLE 1 | Participant demographics.

Participant	Gender	Age bracket	Work location	Coaching expertise	Years as a clinician within the ED environment	Years as clinician-coach in the ED?
P1	M	35–44	NSW	Intermediate	12 years	3 years
P2	F	45–54	NSW	Advanced	24 years	10 years
P3	F	25–34	QLD	Intermediate	8 years	5 years
P4	F	45–54	SA	Intermediate	17 years	3 years
P5	F	45–54	QLD	Intermediate	23 years	3 years
P6	F	45–54	QLD	Intermediate	25+ years	6 years
P7	F	45–54	TAS	Beginner	23 years	2 years
P8	M	35–44	TAS	Not reported	10 years	Not reported
P9	M	34–44	VIC	Intermediate	10 years	4 years
P10	F	45–54	WA	Advanced	25 years	10 years
P11	F	45–54	NSW	Advanced	25 years	4 years
P12	M	25–34	QLD	Beginner	10 years	< 1 year
P13	F	40–49	NZ	Intermediate	15 years	3 years
P14		30–39	QLD	Beginner	7 years	< 1 year
P15	M	45–54	NSW	Beginner	15 years	Not reported
P16	M	45–54	VIC	Intermediate	16 years	Not reported
P17	F	40–49	QLD	Intermediate	20 years	8 years
P18	F	40–49	QLD	Beginner	17 years	Not reported
P19	M	40–49	QLD	Intermediate	17 years	5 years
P20	M	50–59	NT	Intermediate	21 years	9 years

TABLE 2 | Stages of behavioural change adapted for the clinician-coaching context.

TTM stage	Meaning of this stage	Adapted meaning for the EM context
Precontemplation	The individual is not considering change and may be unaware of the need for change	The EM physician is unaware of, may not see the need for, or is not interested in coaching
Contemplation	The individual becomes aware of the problem and considers changing but has not yet committed	The EM physician is considering coaching, weighing up pros and cons, and beginning to see the potential benefits of coaching
Preparation	The individual intends to take action soon and may start making small changes	The EM physician intends to take action; starts to plan and gather resources; begins to develop a coaching identity
Action	The individual actively implements change by modifying their behaviour or environment	The physician is becoming a clinician-coach and actively modifies their behaviour and implements new skills and strategies
Maintenance	The individual sustains the new behaviour over time and works to prevent relapse	The EM physician is an established clinician-coach; practicing and developing; integrating coaching into professional identity

TTM). V.L. re-mapped the earlier sub-themes onto the five TTM stages: precontemplation, contemplation, preparation, action and maintenance. The previously identified enablers and barriers were then reinterpreted through the TTM framework.

In the fourth stage, *re-organising and reinterpreting*, the team engaged in iterative reinterpretation of the dataset, using the TTM stages as an organising structure. Through multiple rounds of coding and conceptual sorting, interview content was

synthesised into a final artefact, which categorises enablers and barriers by stage of change and personal/internal or organisational/external nature.

In the final stage, *mapping and interpretation*, which involved deeper interpretive work, V.L. identified four experiential qualities—serendipity, calling, flexibility and commitment—that appeared to characterise participants' transition from clinician to clinician-coach. These qualities were discussed and refined in collaboration with the research team. The collaborative nature of the analysis contributed to the rigour of the study, supported by iterative team dialogue, shared coding artefacts, and alignment of findings with participants' lived experiences.

2.5 | Findings

Emergency physicians' journeys from clinician to clinician-coach were shaped by a dynamic interplay of personal attributes, interpersonal relationships and organisational conditions. These experiences unfolded across five stages of behavioural change—precontemplation, contemplation, preparation, action and maintenance—that were adapted from the TMM [6] as described below (see Table 3).

2.5.1 | Stage 1: Precontemplation

In this stage, participants were typically unaware of coaching or had not considered it part of their role. Some described themselves as naturally suited to coaching—'the one people come to' (P4)—citing traits such as empathy and intuition.

For many, exposure to coaching came through chance encounters, such as hospital programs, leadership training, or the experience of being coached themselves. As one participant recalled, 'I just was a recipient of a coaching program that helped me develop insights and strategies for leadership. I really enjoyed it' (P11).

However, a lack of formal coaching culture was identified as a key barrier to even imagining coaching as a legitimate practice or as a possibility of professional practice. Some participants viewed their workplaces as sceptical, viewing coaching as 'soft', whereas others noted gaps in communication training and a lack of appreciation for reflective practice.

2.5.2 | Stage 2: Contemplation

Here, participants began to recognise the value of coaching, often influenced by personal experiences as coachees or by observing respected role models. 'Being on the receiving end really solidified it for me', one said. 'I thought, "This is powerful work"' (P7).

Many saw coaching as an extension of existing leadership or teaching responsibilities, especially in EDs where feedback and mentoring were part of daily routines. Others saw it as a way to contribute more meaningfully to junior staff.

Nonetheless, challenges included time pressures, training costs and uncertainty about coaching's viability in fast-paced ED settings. Some were hesitant about being coached by close colleagues, highlighting concerns around trust and psychological safety.

2.5.3 | Stage 3: Preparation

At this stage, participants actively pursued coaching, motivated by a drive for personal and professional development, a desire to support others, and a commitment to improving workplace culture. One described coaching as a bridge: 'It fills something that's missing in medicine—it's a way for both the coach and the coachee to grow' (P16).

Many undertook formal training, which provided structure and confidence. Peer encouragement was also important: 'A colleague pushed me to do it. He saw my potential before I did' (P6).

However, the same systemic issues persisted. Balancing coaching with clinical duties, limited funding, and minimal organisational endorsement created frustration; though many described this stage as a tipping point.

2.5.4 | Stage 4: Action

In this phase, coaching was integrated into daily clinical practice. Participants described using coaching in supervision, debriefs or 'corridor conversations'. As one said, 'It's embedded in how I interact' (P5).

Positive feedback, improved team dynamics and personal growth reinforced their efforts. Coaching helped some manage complexity, uncertainty and stress by reducing the pressure to always provide answers. Still, barriers remained. Fatigue, fragmented time and the emotional toll of coaching in high-pressure environments posed ongoing challenges. Some continued to conceal their coaching activities: 'I deliver coaching without calling it coaching—it's not accepted yet' (P17).

2.5.5 | Stage 5: Maintenance

This final stage involved consolidation of identity as a clinician-coach. Coaching became part of participants' professional self-concept. Greater confidence, peer validation and values alignment helped sustain their practice. 'I got validated. I saw myself differently, as someone who could really make a difference through coaching' (P6).

Some participants noted that supportive environments (e.g., formal programs, peer referrals and leadership backing) helped maintain their practice as clinician-coaches. Yet, the same systemic constraints—time scarcity, team turnover and undervaluation—remained, underscoring the fragility of sustained coaching practice.

TABLE 3 | Internal and external factors that enhance and impede the journey from physician to clinician-coach (stage, codes, and illustrative quotes).

	Enablers		Barriers	
Stage	**Internal to self**	**External to self**	**Internal to self**	**External to self**
Precontemplation *The EM physician is unaware of, may not see the need for, or is not interested in coaching*	**Coaching disposition** 'People, for some weird reason, they frequently seem to come to me when they've got an issue which could be in career direction, or they've had encounters with someone that they don't know how to handle. They seek me out and want to have a chat' (P4) **Intuition** 'I would always have a feeling about what was going on with the patient and people would say, "Well, why?". I'm like, "Well, I don't know. It's just what I feel"' (P2)	**Being coached** 'At the time, I didn't ever think about doing coaching myself. I just was a recipient of a coaching program that helped me through 360s and other things, develop insights and strategies for my leadership development. I really enjoyed it' (P11) **Supportive leadership** 'I was supported by being given the possibility shift-wise ... with respect to "Yes, you can choose to do this, and it's part of your professional development" ... [My leader] was fully on board with that' (P4)	**Perceptions of coaching** 'If you asked anyone in the department "Is there coaching in our emergency department?" they'd probably say no. It certainly wasn't and isn't embraced. A lot of the clinicians think they don't need that 'soft' stuff' (P17)	**Lack of communication skills development** 'Communication skills in general, being able to communicate with someone is important as a coach, and that's not formally taught, but it is taught quite heavily in med school' (P14)
Contemplation *The EM physician is considering coaching, weighing up pros and cons, and beginning to see the potential benefits of coaching*	**Communication skills** 'Some of the approaches and skills that you use in coaching are very overlapping with good leadership skills, and good questions, and good listening, and being a supportive leader anyway. I think a lot of people have these skills naturally. People we would call "good communicators" or whatever else. I think I did' (P11) **Transferable skills** 'Certainly, there's heaps of transferable skills that have crossover between coaching, mentoring, simulation [and] general educational conversations' (P12) **Self-improvement** 'One thing is to improve myself. There was obviously a self-motive of wanting to understand what I was lacking and climbing on facets that I did not know very well' (P16) **Role models** 'The best [clinician-coaches] are the ones who don't use the tick box ... They use [feedback meetings] as a coaching session, which I've seen once or twice' (P14)	**Being coached** 'I guess probably my own experience receiving coaching was the ultimate catalyst ... being on the receiving end of it really solidified for me like, "Oh, I really like this. I think it's incredibly powerful"' (P7) '[A turning point was] taking an interest to go and do this course [...] having no idea what coaching was' (P2) **Natural transition** 'I think that was a relatively natural process as you begin to take a leadership role within a department' (P18) **Congruence with ED work** 'I think more people do coaching or some sort of coaching than they realise in a clinical space, particularly in [the] ED, because of the way the department runs [...] You're always giving feedback to people and people coming up with questions and you're trying to encourage them to think for themselves' (P14) **Supportive environment** 'It's extremely important for me to work in an environment that supports learning and serves its patients in an equitable and honest way' (P16)	**Cost** 'One thing is the cost. I guess there's ways around that, but everyone in medicine [has] got such different capacities' (P15) 'For me, cost is a major barrier, and cost in terms of money and in terms of time, particularly time' (P15) **Overwork** 'There has to be this readiness for them to want to improve but if they're at the end of seven night shifts and their brain's on fire and it's been crazy and busy, then it might not be the right moment for coaching' (P3) 'It's difficult on the floor because it's so demanding' (P14) 'I think in health, it's very tricky because people are overworked often and they need something that is going to then be protective or helpful. It has [to not be] burdensome. The best way ... it has to be done in a way that works. All right. I'll be able to use my one hour and split it sometimes and [can do it as] I drive on the way to work. And it's not ideal, but then I see the benefit of continuity' (P15)	**Lack of structure/governance/ whole-of-hospital approach** 'This is a hospital-wide thing. It doesn't make sense for the emergency department to pay for my time. It has to come from somewhere. There's not really the structure and governance easily set up to allow for someone like me to do this, which is a bit of a shame' (P3) **ED is the wrong environment** 'It has a big role to be able to take it out of this space we work in because the environment is not for it [coaching] ... I think the deeper conversations need to be had outside of the clinical space' (P4) 'I think ED is probably not the first place to start this [coaching]' (P14) 'I think you'd need it [the coach] to be somebody outside of your ED. I don't think it would work ... It'd be just way too familiar ... I think a bit of distance, and so you can speak in confidence about things as well' (P20)

(Continues)

TABLE 3 | (Continued)

	Enablers		Barriers	
Stage	**Internal to self**	**External to self**	**Internal to self**	**External to self**
Preparation *The EM physician intends to take action; starts to plan and gather resources; begins to develop a coaching identity*	**Motivated to support others** 'I see coaching as helping someone to discover their own abilities and their own innate way of approaching something … helping them to solve the problem' (P10) '[I wanted to] be more approachable with my juniors and allowing them to have a space to recognise that they can grow as individual clinicians rather than being told what to do or being directed' (P14) **Professional development** 'What inspired me to get involved with that was the realisation that there's a pretty big gap between what most teams want their performance to be and what it is' (P3) 'For me, it was also professional development and to see if there was a way I could improve my leadership and communication skills to get better outcomes and empower my team and improve that overall' (P19) **Improve systems/culture** 'For me, the deep reason is actually to shift the culture of medicine to make it just a better place to work and the culture of the world. I want to take the world over with coaching and mentoring' (P10) **Filling gaps left by medicine** Though I could not crystallise my thoughts at that time, there was something that was missing in medicine. […] I look at coaching as a bridge to people attaining their fullest. In the process, I would also see that in terms of the coach's experience. It's also the coach who is learning through this process. I see it as a bridge for both the people' (P16)	**Formal training** 'The training was hugely supportive. It … extended and increased my repertoire of skills. It helped to integrate and coalesce those skills and to be able to apply them' (P6) **Opportunity** 'I did my coaching course, thankfully, through the initial phase of COVID, which meant I barely had any other non-clinical roles. I actually had time to do it over those six, seven months' (P4) **Conceptual freedom** 'I actually enjoyed that I went through training with a whole bunch of people who weren't doctors … I think that was quite refreshing because we could then take what we learned there and apply it to our context without anyone really dictating how it would work in a medical model' (P5) **Encouragement** 'I was externally pushed by a fabulous friend and one of my main mentors in clinical medicine to do it. He saw my value for other people but he saw also the value for me in doing the training so that I could build up. I informally coached without training and didn't value myself for doing it. He thought that with a qualification I would value myself better' (P6) **Space to focus** 'Being asked to work a lot from home enabled me to have the peace that you needed to get all this to settle in your mind, and not having lots of distractions going into the workplace nearly as much' (P4)	**Competing priorities** 'You can send out the group email [to coachees] but no one's going to check it because that's not what they have time or capacity to do. It always blows out. You think, "Oh, I'll get to that at the end of my shift." Then suddenly, you have to deal—like today—with some person who wants to threaten to discharge and they need to be in the hospital' (P15)	**Lack of funding** 'Who is actually going to pay me to do this—because I usually get paid by the emergency department—but are they really going to sacrifice 10 h of me, my time off the floor, to go help some cardiologists?' (P3) **Difficulty justifying coaching** 'Equally, if it's harder and less tangible to take it down the route of, say, patient safety and how coaching can help that, with culture, it's a little bit more difficult and less tangible (is my understanding at least) to connect those two in terms of how does coaching enhance culture; how does coaching improve patient safety?' (P8)

(Continues)

TABLE 3 | (Continued)

	Enablers		Barriers	
Stage	**Internal to self**	**External to self**	**Internal to self**	**External to self**
Action *The physician is becoming a clinician-coach and actively modifies their behaviour and implements new skills and strategies*	**Knowing coaching works** 'There's certainly more appetite from my point of view—building, helping to develop stronger people, both in a personal and a professional sense. There's certainly a lot of motivation on my behalf to work harder towards that' (P9) 'When you see that, when you get that light bulb moment in your coaching counterpart, that's a really good time [chuckles] because it works. That's really good, because you know that people are getting a lot of value out of it' (P20) '[Coaching] isn't just a side gig of 'Let's help people be happy'. This is integral to how they're going to function and perform at work' (P13) **Personal evolution** '[Coaching's] impacted every aspect of my life—my relationships, my parenting, the way that I show up at work as well' (P7) **Awareness raising** 'My approach has been, first of all, to raise awareness to try and talk about [coaching]' (P15)	**Role models** 'I find myself trying to copy the way that they [clinician-coaches] behaved and the things that they said and the way that they interacted with me as a trainee ... trying to understand why they do what they do' (P3) **Departmental commitment** 'There was some early adopters who did the training and then we started building coaching capacity within our workforce' (P5) **Increased opportunities** 'In terms of workplace stuff, just the role that I held as a director of training and having meetings with my trainees and setting up mentoring programs and things, being able to utilise it in those and get other people to use that' (P20) 'Finding opportunities to run workshops that have a coaching style. I've done this a couple of times in the well-being space where we've had people come and participate in a wellbeing workshop. You have to create that kind of safe space and it has to be a fairly small group' (P5) 'Then when I did my coaching course, thankfully, through the initial phase of COVID—which meant barely I had any other non-clinical roles—I actually had time to do it over those six, seven months. I became more and more interested in maybe taking that aspect outside of the clinical space and develop my own business, and then offering it to people who were not just trainees, but also the consultants that were burned out, my colleagues who had lost direction as to what they wanted to do, and do coaching outside of work' (P4)	**Physician mindset** 'I think just as a medical profession [...] wanting to improve, and seeking help to improve, has always been a barrier ... As a specialist, being the person that is meant to know everything, it's easy to hide that vulnerability. I think that's a big barrier from a medicine specific point of view, in terms of more broadly speaking with clinicians ... I think, from a coaching point of view, it's being an expert at being a coach, but not being the subject matter expert in terms of their journey into where they want to go necessarily' (P8) **Fatigue** 'Last year I just thought, oh, I'm just going to let the coaching drop. I'm tired and I just don't have the energy to add to it. There was this sadness with that because it actually gives me energy, but I just needed to coordinate and get the time management a bit better in my life' (P6) **Narrow coachee focus** 'You put on this beautiful curriculum for [the trainees] where they can learn and grow and experience, but they'll speak to the year above them and only turn up to the three sessions that they think the exam is based on' (P6) **Complex work** 'There's definitely been times where I don't know what to say or I don't know how to help somebody solve a problem, because it's often very complex. I think within the workplace they're really complex. There's a really complex relationship between clinical capacity, personal identity, performance of the department, and impact on patients' (P18)	**Lack of organisational support** 'It [coaching] was all done in non-clinical time or in our own time, so it was free for the hospital' (P20) 'Obviously, a lot of that [coaching] was done on goodwill and people's passion' (P19) 'I think that's my biggest challenge ... I'm really doing micro-coaching and opportunistic coaching rather than formal coaching in my work role, because I don't have any funding or time allocated to it in my role' (P5) 'Sometimes people who know me personally will refer people to me who are struggling but we don't have a formal coaching program' (P17)

(Continues)

TABLE 3 | (Continued)

	Enablers		Barriers	
Stage	**Internal to self**	**External to self**	**Internal to self**	**External to self**
Maintenance *The EM physician is an established clinician-coach; practicing and developing; integrating coaching into professional identity*	**Increased self-belief and value** 'I think I probably did value myself a bit better. I got a bit more validated on what I believed in. It certainly gave me a bit of oomph to identify myself as a coach' (P6)	**Workplace support** 'There's a coaching program that happens in the hospital, so that's very helpful because I don't have to go find a coachee for myself … It helps if I'm too busy and if I cannot. If I don't have the space, I would say no and that's OK. So it's quite flexible. So the environment that has been created for me to be a coach is pretty good' (P1)	**Clinical demands** 'There has to be this readiness for them [coachees] to want to improve but if they're at the end of seven-night shifts and their brain's on fire and it's been crazy and busy, then it might not be the right moment for coaching' (P3) 'We probably don't prioritise the non-clinical side of the job. There's obviously lots of clinical work to be done and there's responsibilities that come with that' (P9)	**Flexible teams** 'Another barrier is because we're such big department, we don't consistently work with the same team, so you may have a coaching conversation with a junior doctor on one day and then not see them again for three weeks' (P12) **Leadership and culture** 'I think the biggest speed bumps to practicing compassionate medicine, which is where I see clinician coaching, is on people's frames of reference. You'll live and die by the leadership and culture of a department' (P6) 'There would be some structural and organisational-level changes that could really facilitate coaching if we value that as a department and as an educational strategy. […] I would say there's not always a commitment to that' (P3) **Lack of professional accountability** 'There are some teams that are basically just on fire because of a few very destructive personalities that, in healthcare up to this point, we've not really sorted out a way to deal with. Without the human relations and leadership support from teams to really manage bad behaviour from individuals, it's very hard to help teams' (P3)

2.6 | Navigating the Path to Becoming a Clinician-Coach

Further inductive analysis of data and the results from the TTM-related analysis of the data suggested that participants' progression across the five stages of behavioural change appeared to be characterised by four experiential qualities (see Table 4). These qualities—serendipity, calling, flexibility and commitment—appeared to play an important role in enabling clinicians to initiate, evolve, sustain and consolidate their coaching practice and their identity as clinician-coaches in environments that lacked cultural or organisational support for coaching.

Serendipity frequently acted as the spark that ignited interest in coaching. Unplanned exposure—such as a workplace initiative, leadership course or an unexpected personal coaching experience—often led participants to discover coaching's potential. These chance encounters proved pivotal in altering clinicians' perspectives on how they might support colleagues and shape their professional practice.

Calling emerged as a deeply felt intrinsic motivation to support others and improve the clinical environment. Participants often described coaching as a way to 'give back', particularly to junior doctors navigating complex systems. This sense of purpose provided emotional fuel to push past inertia and institutional resistance. For many, calling was tied to a recognition that traditional models of leadership or supervision were insufficient to address the relational and developmental needs of colleagues in E.D. settings.

Flexibility enabled participants to adapt coaching practices to real-world clinical constraints. Rather than applying a rigid model, they developed a fluid, adaptive style—coaching in corridors, during debriefs, or opportunistically amidst other responsibilities. Notably, this flexibility was supported by a mindset shift: from expert problem-solver to curious facilitator. Their ability to blend coaching approaches with clinical roles, often in time-poor and unpredictable settings, helped sustain practice and build confidence.

Commitment was perhaps the most crucial attribute in sustaining coaching practice over time. Faced with ongoing challenges—lack of recognition, competing demands or absence of formal coaching structures—participants often relied on their personal commitment to continue coaching. They described self-funding training, using professional development time, and offering coaching informally, driven by belief in its value. For some, coaching became a vocation, pursued regardless of external validation.

Together, these four experiential qualities characterise the path from clinician to clinician-coach as an identity journey rather than a competency-based transition. They reveal how individuals actively navigate the intersection of personal development, professional purpose and systemic realities. Becoming a clinician-coach, in this sense, is less about acquiring a new set of tools and more about cultivating a way of being and working—resourceful, reflective and resilient—in complex contexts.

3 | Discussion

This study sheds new light on how EM physicians navigate the complex transition from clinician to clinician-coach in contexts that lack cultural or organisational support for coaching. By applying the TTM to map the evolution and progression of physicians' coaching practice and identifying four experiential qualities that characterise physicians' coaching journey we offer a novel, process-oriented understanding of coaching development in high-pressure clinical settings.

3.1 | The Experience of Navigating Change

The phenomenon or quality of *serendipity* was especially salient in the early stages. Many participants encountered coaching unexpectedly, suggesting that informal exposure or incidental experiences can play a powerful role in initiating interest. *Calling* emerged as a motivational force. This sense of purpose helped them persist even when coaching lacked institutional support. The finding echoes literature on identity work and intrinsic motivation, where meaningfulness is shown to enhance resilience in professional role change [18]. *Flexibility* enabled participants to blend coaching with existing clinical roles, embracing uncertainty and relinquishing the need to always be the expert, reflecting a learning shift from control to curiosity [14]. Finally, intrinsically motivated *commitment* was critical in sustaining coaching practice over time, suggesting that coaching is construed and experienced as a kind of identity project, pursued not because it is required, but because it aligns with deeply held values.

3.2 | From Mindset Shifts to Practice Evolution

Where previous research has focused on what changes (e.g., mindset shifts from expertise to humility), this study contributes by explaining how those changes unfold in context. The TTM framework allowed us to see clinician-coaching not as a binary state but as an evolving process shaped by readiness, context and identity.

Our findings suggest that internal motivation and personal values may be more critical than external supports in initiating coaching practice. Nevertheless, organisational recognition and structural support appear to play an important role in sustaining clinicians' coaching practice. Without such support, clinician-coaches may disengage from their coaching despite their commitment.

3.3 | Implications for Practice

Health organisations that seek to foster clinician well-being and resilience, as well as technical and nontechnical skills, may consider the role of creating and supporting coaching and coaching cultures in the teams and departments that comprise these organisations. Offering coaching 'tasters', building communities of practice, and legitimising coaching through leadership endorsement may accelerate movement through the TTM stages.

TABLE 4 | The experiential qualities that support becoming and being a clinician-coach.

Qualities	Meaning	TTM stage	Illustrative quotes
Serendipity *I discovered and embraced coaching because I saw—or experienced—what it can do*	Discovering coaching through unexpected encounters or personal experiences. Serendipity represents an openness to unexpected opportunities and a willingness to embrace new approaches. This receptiveness to new experiences is particularly valuable in the precontemplation and contemplation stages, planting the seed for later coaching practice	**Precontemplation** The EM physician is unaware of, may not see the need for, or is not interested in coaching **Contemplation** The EM physician is considering coaching, weighing up pros and cons, and beginning to see the potential benefits of coaching	'There was a coaching program that was offered by the hospital for us consultants because we're going through a hard time. So I was coached for about 6 to 8 months. And I actually liked it—it was a very [...] good, reflective time' (P1) 'None of us really understood what it was, but it just intrigued me, this idea of providing some support to juniors, and understanding what coaching was. I joined this pilot, which I think was probably maybe 8 or 10 consultants max. And then of course I just went on' (P2) '... my former boss came to me and said 'You need to do this'. It was the coaching qualification, and so I undertook that through the year' (P6) '... my own experience receiving coaching was the ultimate catalyst. I think that a lot of us find ourselves doing some coaching, albeit informally, and perhaps not even necessarily aware that that's what we're doing. And then being on the receiving end of it really solidified for me. Like, 'Oh, I really like this. I think it's incredibly powerful'. I think it's powerful work' (P7) 'I just was a recipient of a coaching program that helped me through 360 s and other things—develop insights and strategies for my leadership development. I really enjoyed it' (P11) 'I thought it was an interesting model and a unique way that we can get the best out of people that we're supervising or educating' (P14) 'Initially, I'd never had any exposure to it, and I actually got coaching during that thing, so it was quite good. There was a demonstration thing in front of everybody, and I just felt that it would be really, really useful for what I did' (P20)

(Continues)

TABLE 4 | (Continued)

Qualities	Meaning	TTM stage	Illustrative quotes
Calling *I coach others because I know navigating the challenges of clinical training and work—and work and life in general—is hard*	Recognising a strong internal motivation and sense of purpose in coaching. This intrinsic motivation serves as a powerful counterbalance to external barriers such as lack of recognition, time constraints or unsupportive cultures. Calling aligns with the contemplation and preparation stages as clinicians develop their motivation to coach	**Contemplation** The EM physician is considering coaching, weighing up pros and cons, and beginning to see the potential benefits of coaching. **Preparation** The EM physician intends to take action; starts to plan and gather resources; begins to develop a coaching identity	'What inspired me to get involved with that was just the realisation that there's a pretty big gap between what most teams want their performance to be and what it is. A lot of those gaps are related to issues that have to do with teamwork. It made more sense to me to think about those issues with teams rather than individuals' (P3) 'I think if coaching was something that everyone got offered it free—or that person it's Tuesday at 2:00, and for that person it's Wednesday at 4:00—couldn't that be powerful if there was actually something like that in the workplace? I think that would really help these trainees grow into much better clinicians and leaders if there was that aspect built into the program as well' (P4) 'That's where a lot of my interest in coaching has come along—in seeing people navigate stormy times and rough waters and not really have any life raft. I think a lot of my motivation for developing these skills was to try and help the next generation' (P5) 'I think it's a really great way to develop our people. It's impacted every aspect of my life; my relationships, my parenting, the way that I show up at work as well. [...] I think it's incredibly powerful' (P7) 'For me, the deep reason is actually to shift the culture of medicine to make it just a better place to work and the culture of the world. I want to take the world over with coaching and mentoring' (P10) '... it's a fabulous way to develop your people, to show that you value them, to provide better leadership. We know that better leadership provides better work environments. We know that good leaders have good teams, that they optimise their work, that they are highly performing. We know high-performing organisations have high-performing leaders' (P11) '[Coaching is] a different way of looking after people, I guess, as a doctor. Not looking after patients, but looking after my profession' (P11) 'I like what coaching brings to our arena. I think it's very powerful. [...] The power it has, like I said, is to help people raise self-awareness and also have a more solution-focused mindset—strength-based lenses to look at problems in people. [To] look at people's strength base is such a different thing. I think we can go from conflict into collaboration' (P15) 'When you see that, when you get that light bulb moment in your coaching counterpart, that's a really good time (chuckles) because it works. That's really good, because you know that people are getting a lot of value out of it' (P20)

(Continues)

TABLE 4 | (Continued)

Qualities	Meaning	TTM stage	Illustrative quotes
Flexibility *I can be a clinician-coach by applying my primarily clinical (technical) or my primarily coaching (intuitive) self to the task—or be somewhere in between*	This attribute is about adapting coaching practices to the clinical context and integrating them into clinical work—and vice versa. It also manifests as resourcefulness in finding opportunities to coach, adapting coaching techniques to suit the medical context and blending coaching with other clinical and educational activities. Flexibility is particularly important during the preparation and action stages	**Preparation** The EM physician intends to take action; starts to plan and gather resources; begins to develop a coaching identity **Action** The physician is becoming a clinician-coach and actively modifies their behaviour and implements new skills and strategies	'When I was a junior, it was all science. Now we are like, "Well actually, it is an art of medicine". Someone's gut intuition and experience as a clinician is better than an algorithm in terms of the PERC rule or Well's criteria or all these things, the heart score. If they have a gut worrying, then they're going to chase it no matter what heart score they are—we know it's not always right. But it is a combination of the two' (P2) '... the way I practice emergency medicine is probably not too far off from coaching. I'm coaching patients all the time—not even just learners—but often coaching patients through their healthcare journey as much as I am providing them with healthcare' (P3) 'A lot of the other aspects we're expected to have, such as being a good listener and looking at the strengths in the coachee so you can build on that future thinking—all of that is also in patient interactions' (P4) 'Every day I see the benefits of coaching conversations. I've not really got the opportunity to carve out big, long chunks of time in my role to actually do a more formalised coaching with individual employees. Even just the corridor coaching and the very brief coaching type conversations that we have, we have them in meetings, we have them in our performance reviews every six months—mine take on a very coach-like style. I found my ability to engage my team has improved considerably by using the skills I learnt during coaching' [P5] 'You can enjoy being humble, you can enjoy being vulnerable and being curious, and not being the expert' (P6) 'It doesn't feel uncomfortable. I'm not somebody who brings a shame in not having the answers. [...] That for me is where I feel like I always am—coaches are not experts' (P7) 'I think, as a coach, I get more comfortable with uncertainty. Whereas, as a physician, people feel like they have to have certainty. I don't think that's ever possible, really. Certainly not in emergency medicine. We deal with a lot of uncertainty. We make decisions in the face of limited information. Whereas you move to the wards or the ICU, they have much more information. They're making decisions with a lot more information available to them. Which may be why emergency's more open to coaching because we are used to uncertainty' (P17) 'I think there is a lot of overlap, I think both within coaching and within clinical care. Both of those things rely on early establishment of trust and psychological safety between either the patient family and clinician or between the coach and the person receiving the coaching' (P18) 'I think once you've taken on that coaching mindset and practice it, it's actually really empowering and almost a relief in some ways to know that you don't always need to know the answers' (P19) 'It's just that thing of being able to ask the good question so that they can sort out that muddle in their head and work out what is the best way forward, whatever it is they're trying to sort out' (P20)

(Continues)

TABLE 4 | (Continued)

Qualities	Meaning	TTM stage	Illustrative quotes
Commitment *Because I know coaching works and is important, I will coach whether I have the support of my workplace or not*	Dedicating time and effort to coaching despite job-related challenges and institutional constraints. Participants demonstrating commitment found ways to continue coaching even when faced with time restraints, lack of organisational support or indifferent colleagues. This is crucial during the action and maintenance stages when the initial enthusiasm may wane in the face of ongoing challenges	**Action** The physician is becoming a clinician-coach and actively modifies their behaviour and implements new skills and strategies **Maintenance** The EM physician is an established clinician-coach; practicing and developing; integrating coaching into professional identity	'We started doing it and then had a couple of case studies of how that went really well, and then made it so that they couldn't really say no. That's probably the best answer. We didn't ask anybody' (P3) 'I'm really doing micro-coaching and opportunistic coaching rather than formal coaching in my work role because I don't have any funding or time allocated to it in my role' (P5) 'The original group self-funded. Obviously, we have professional development allowances and things that we can access. I used professional development time to do my coaching diploma, but it was all self-funded' (P6) 'I think anything beyond the absolute necessities of our job are expected to be mopped up in personal time as opposed to having dedicated non-clinical time to achieve' (P9) 'I don't think anyone is formally calling it coaching. [...] In other words, no one identifies you as a clinician-coach in your workplace' (P12) 'There's always individual time to teach and coach on the [ED] floor because everyone's always coming up for advice. Using even a small coaching model to help them identify what they're doing, rather than telling them what to do, just can change things so much' (P14) 'I've made it aware that I'm happy to coach people who are struggling as well. Sometimes people who know me personally will refer people to me who are struggling but we don't have a formal coaching program' (P17) 'I have to say medicine is a funny ... [chuckles]. It's a funny world. Coaching can seem a little bit almost like homeopathy. It's a bit voodoo-y, non-scientific. I deliver coaching without calling it coaching. I don't label it as coaching, if that makes sense' (P17) 'Although, I did use PDL, Professional Development Leave, for [my coaching diploma]. In that sense, it was supported, but I paid for the diploma myself and did all of that off my own back' (P19) 'Once we'd done the coaching, one of my colleagues who did the diploma managed to get some funding to do a coaching conversations workshop, which we were able to then distribute broadly across HHS as an initial point. Obviously, a lot of that was done on goodwill and people's passion' (P19) 'Most people currently, they like to do that supportive thing and the people who are interested in it, they'll give that time up usually anyway. That happens a lot in medicine. People doing stuff on their own time or for free or whatever, and not expecting to be remunerated' (P20)

Embedding coaching into professional identity development programs could also increase uptake. Recognition—both symbolic and structural—can help clinician-coaches feel valued and reduce reliance on goodwill alone.

4 | Limitations and Future Directions

This exploratory study focused on a small sample of intrinsically motivated, self-identified clinician-coaches. Broader studies, including those resistant to coaching, may uncover further insights. Future research could also explore how coaching practice is sustained, adapted and embedded into team and organisational cultures over time. Moreover, given the benefits of coaching on EM physicians well-being and resilience, as well as technical and nontechnical skills, future studies could examine how to encourage those who would be good or great coaches but have not considered doing so, rather than on understanding and creating pathways for those who want to coach.

5 | Conclusion

The stages of practice evolution and the notions of serendipity, calling, flexibility and commitment offer a framework for understanding how EM physicians successfully navigate the journey from clinician to clinician-coach. By focusing on fostering and developing these qualities, rather than solely on overcoming specific barriers or searching for support that might not be forthcoming, clinicians and organisations can create more sustainable pathways to integrating coaching into healthcare practice.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** Supporting Information.