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5.6 Reflections on the Concept of Coaching and the Roles of a Coach and Coachee

Annukka Huuskonen, Essi Ylistalo, Katariina Kunnas and Nina Smolander

The DigiCare project successfully developed and integrated the DigiCare Model and Learning Packages into the DigiCare Educational Program. These outputs underwent piloting in higher education institutions among our Asian project partners. Participant feedback played a crucial role in refining and improving the DigiCare Model and Learning Packages, with the aim of applying them in healthcare education settings wherever they are considered beneficial and relevant. This chapter focuses on the results collected from students' experiences of using coaching models, specifically the GROW model. The feedback form used in the DigiCare Project gathered demographic information, assessed the level of agreement with statements related to different phases of the GROW model, and included responses to open-ended questions.

The main goal of the DigiCare project was to enhance the digital and coaching skills of healthcare professionals, ultimately leading to the provision of high-quality care to patients in Asian partner countries. The project aimed to promote these competencies to ensure that future healthcare professionals possess the necessary skills to deliver patient-centered care that aligns with the evolving trends of digitalization in healthcare in Bangladesh (Ahmed et al., 2020) and Vietnam (Dang et al., 2021). By equipping healthcare professionals with responsive and up-to-date skills to effectively motivate (Rutten et al., 2014) and coach patients with chronic diseases such as diabetes (Komkova et al., 2019), cardiovascular diseases (Yousuf et al., 2018) or hypertension (Nguyen-Huynh et al., 2022) and improve their lifestyle choices for healthier behavior (Lindberg et al., 2017; Rise et al., 2013), the DigiCare project aimed to address the increasing healthcare demands of patients in partner countries, both in the present and future (Albis et al., 2019; Tran et al., 2016).

This undertaking necessitated a collaborative effort to improve and update the educational program, incorporating a novel competency area of patient coaching into healthcare education programs (Charli-Joseph et al., 2016). Coaching was an unfamiliar concept within the healthcare context of the partner countries, and its integration into educational programs necessitated a broader conceptualization of the phenomenon, as well as the development of plans for implementation, evaluation, and feedback (Dolansky et al., 2017). To address this, the DigiCare project developed the DigiCare Model (Read more in Chapter 3) and its corresponding learning packages (Read more in Chapter 4.1), which were subsequently put to the test in practical settings at Asian partner universities. Through this collaborative piloting process (Read more in Chapter 4.1) and the collection of valuable feedback, we were able to refine and tailor the educational program to align with the Asian context (Sánchez-Franco et al., 2021).



The Feedback Analysis



The DigiCare feedback form (Read more in Chapter 5.1) was utilized to collect student feedback after pilot cycles 3, 4, and 6 (Read more in Chapter 4.1). The feedback results presented in this chapter were collected after the completion of the final pilot cycle, which encompassed the comprehensive piloting of the entire DigiCare Model (Read more in Chapter 3) and its Learning Packages. This pilot cycle involved theoretical lessons conducted using the flipped learning method, coaching training with peers, and coaching sessions with either a patient or a student's relative (Read more in Chapter 4).

The questions in the feedback form were designed to find out the students' experiences with practicing the use of the GROW model. The aim was to gather feedback on how students perceived and experienced each phase of the GROW model (Table 12 and Table 13). Students were encouraged to reflect further on their experiences as a coach (Figure 29) and a coachee, and to share their perspectives

through open-ended questions. The feedback also included students' encounters with in-person and online coaching sessions, their experiences with the coach's interaction, focusing on professional communication, as suggested by local experts. Additionally, participants had the opportunity to provide feedback on their preparation for coaching training and their perceptions of the education provided.

As explained in more detail in chapter 5.1, the feedback form collected demographic information, information on the level of agreement with the statements and open-ended questions. The demographic information (Table 11) was analyzed using SPSS software.

Written feedback in the open-ended questions was collected in three languages: Vietnamese, Bangla, and English. Responses in Vietnamese and Bangla were translated into English and analyzed by grouping the content thematically. Four project members participated in the analysis of the feedback. The results of each analysis were compared with each other to ensure consistency.

Ethical Considerations

Each participating higher education institution applied for ethical approval individually if required by their university's statutes. Students who took part in providing feedback were provided with comprehensive information regarding the purpose of the feedback collection, the collection and processing procedures, as well as their rights as participants. Responding to the feedback form was voluntary, but students were informed that their response would be considered as informed consent to participate in the feedback collection process. Students were also informed of their right to withdraw from the study at any time without facing any consequences or being required to provide explanations.

All responses were collected digitally, and the raw data was accessible only to the Finnish project members who did not hold any teaching roles related to the respondents. This arrangement was implemented

to safeguard participants and alleviate any concerns regarding potential repercussions for providing honest feedback.

Participants

In the final pilot cycle of the DigiCare project, a total of 344 healthcare students from partner universities in Bangladesh and Vietnam participated. All participants were provided with a link to the feedback form, which was sent to them via email or WhatsApp. During the pilot orientation, participants were informed about their involvement in the pilot and the accompanying feedback questionnaire.

The respondents (N=137) were healthcare students studying nursing (n=84), and medicine (n=28) in three Bangladeshi universities (Universal College and Hospital, Khulna City Medical College and Hospital, City Medical College and Hospital), and two Vietnamese universities (Hanoi Medical College and Nam Dinh University of Nursing) (Table 11). The response rate was 39.8%.



Table 11. Demographic characteristics of healthcare student responders

Variable	Participants (N = 137)	
	n	%
Gender		
Female	102	96.2
Male	4	3.8
Age		
20 years or less	32	23.4
21–23	88	64.2
Over 23 years	11	8.0
Curriculum		
Medicine	28	20.4
Nursing	84	61.3
Level of study		
Undergraduate	132	96.4
Postgraduate	4	2.9
Form of study		
Full-time	69	50.4
Part-time	55	40.1
Field of study		
Medicine	11	8.0
Medicine and surgery	20	14.6
Community medicine	3	0.7
Pathology, Pharmacology and Microbiology	1	0.7
Health education	1	0.7
Midwifery	4	2.9
Nursing and midwifery	7	5.1
Nursing	78	56.9
Higher Education Institution		
City Medical College and Hospital (1)	32	23.4
Hanoi Medical University and Hospital (2)	7	5.1
Khulna City Medical College and Hospital (1)	12	8.8
Nam Dinh University of Nursing (2)	46	33.6
Universal Medical College and Hospital (1)	40	29.2

1 = Bangladeshi higher education Institution,
2 = Vietnamese higher education Institution

The majority (n=102; 96%) of participants were female students. The median age of the participants was 21.0 years (range: 18-25) and most of them were undergraduate students (n=132; 96%). Half of the respondents (n=69; 50%) were full-time students and more than half (n=78; 57%) were studying nursing. The distribution of participants by university was uneven with over half of respondents being students at two universities (Nam Dinh University of Nursing, n=46; 34% and Universal Medical College and Hospital, n=40; 29%).

Results

The level of preparation for the coaching pilot varied significantly among participants. On average, participants reported spending 16 hours preparing for the pilots, (range 5 minutes to 96 hours). It was particularly noteworthy that some participants described preparing for the pilot for an extensive period, even weeks in advance. Approximately half of the participants felt that the duration of the pilot was sufficient (n=37; 27%) or very sufficient (n=34; 24.8%). Moreover, more than two-thirds of respondents believed that the amount of theory training and self-study provided for the pilot was good (n=52; 38%) or excellent (26.3%; n=36).

In terms of ethical considerations, around two-thirds of respondents considered ethical aspects often (n=43; 31.4%) or very often (n=44; 32.1%). Data security was a topic of consideration for nearly 70% of respondents, with 36.5% (n=50) discussing it often and 32.1% (n=44) discussing it very often.

Using the GROW Coaching Model

Healthcare students' experiences of using the different phases of the GROW model as coaches were positive. More than half of the responses to the items (Table 12) indicated that the steps were implemented mostly or many times, accounting for approximately 60% of the total

responses for each item. However, it is important to note that some respondents did not ask any questions related to the coaching phases.

Table 12. The items on the feedback form that asked healthcare students about their experiences of being a coach (N=137) during coaching practice after the pilot cycle 6. Responses are in percentages.

Items	Not at all	Rarely	Few times	Often	Many times
Asked questions about your patient's health habits	2.9	13.1	18.2	32.8	32.8
Asked your patient to talk about any problems or their effects to patient's health	4.4	14.6	19.0	31.4	30.7
Asked your patient to talk about his/her goals in caring for health	2.9	8.8	20.4	35.0	32.8
Gave your patient choices about options to think about	2.2	10.2	29.2	29.2	29.2
Helped your patient to set specific goals to improve his/her health	3.6	9.5	26.3	29.9	30.7
Asked for patient's ideas when you made the health plan together	2.2	8.8	20.4	35.0	33.6
Helped your patient to make the health plan that patient could do in daily life	2.9	8.0	24.1	33.6	31.4
You were able to establish quality interaction with your patient during the coaching session	0.7	8.0	26.3	32.8	32.1
You received positive feedback of your coaching session	1.5	11.7	17.5	34.3	35.0

Similar to the feedback from students in the role of coach, students in the role of coachee also provided positive feedback regarding the effective use of the GROW model. For all but one item, more than half of the students indicated that they were mostly, or many times coached using a person-centered approach according to the phases of the GROW model (Table 13). However, there was a notable difference in responses regarding the item about the coach considering the coachee's own suggestions. Less than half of the students felt that the coach mostly (21.2%) or many times (22.6%) ignored coachee's own suggestions.

Table 13. The items on the feedback form that asked healthcare students about their experiences of being a coachee (N=137) during coaching practice after the pilot cycle 6. Responses are in percentages.

Items	Not at all	Rarely	Few times	Often	Many times
I was asked questions about my health habits	3.6	11.7	21.9	32.8	29.9
I felt accepted	3.6	7.3	18.2	36.5	34.3
I felt understood	4.4	10.2	20.4	30.7	34.3
I was told what to do regarding my health	2.2	5.8	21.9	35.8	34.3
I had an opportunity to share my thoughts about my health	2.9	13.1	21.9	27.0	35.0
I was encouraged to express my ideas related to my health	2.9	10.2	16.8	34.3	35.8
The coach ignored my suggestions	16.8	13.9	25.5	21.2	22.6
My ideas about my health were appreciated	1.5	6.6	24.8	35.0	32.1
I felt I was involved in my health plan	3.6	11.7	19.7	33.6	31.4

Students’ Experiences in the Role of a Coach

In the final pilot cycle of the DigiCare project, healthcare students had the opportunity to practice the role of a coach through various activities. Initially, they engaged in coaching sessions with their peers and received feedback from their peers regarding their coaching skills. Subsequently, they participated in coaching sessions with patients or their relatives (Read more in Chapter 4.1), focusing on lifestyle change topics.

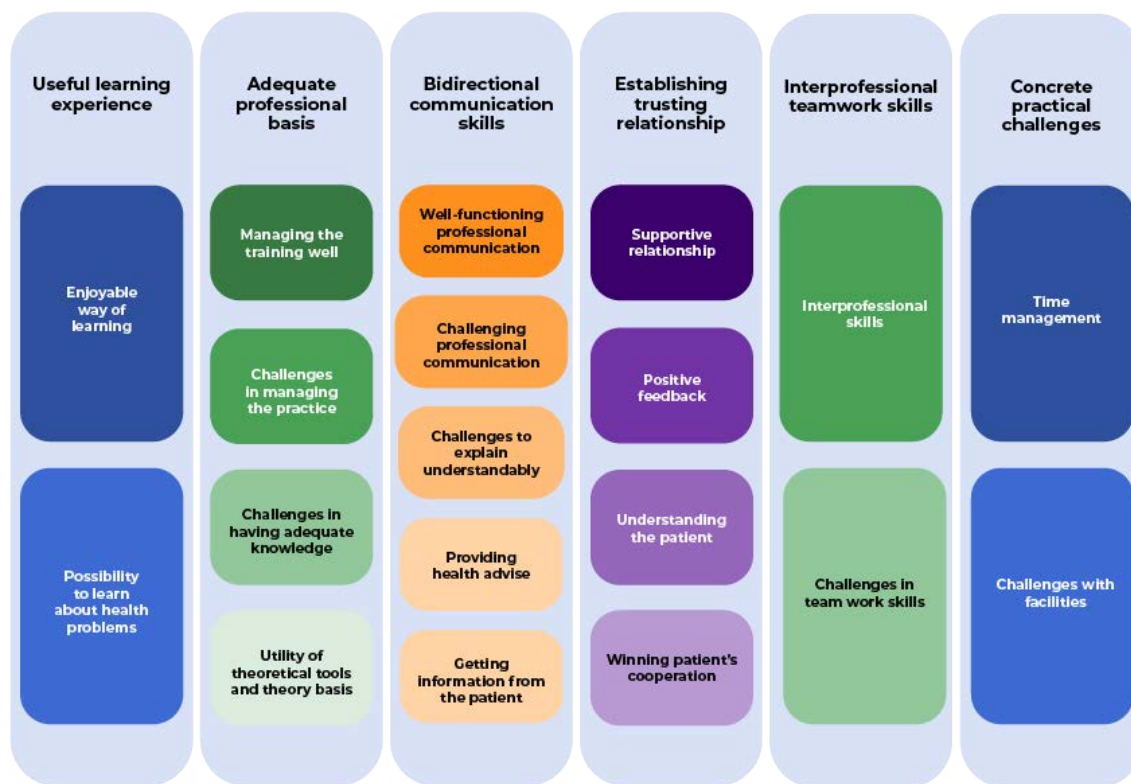


Figure 29. Students' experiences in the role of a coach



In the role of the coach, students described their learning experiences in terms of expressions that were categorized into two main categories: achievements and challenges. The figure 29 provides an overview of the sub-categories related to their experiences. Students reported the experience as useful for learning, but also identified practical challenges. The coaching exercise was perceived as a useful learning experience, an enjoyable way to learn and an opportunity to deepen their understanding of the management of chronic health problems.

Examples of phrases used by students to describe the coaching experience include:

“Enjoying every moment”

“Almost everything went well”

For the majority of students who participated in the pilot, coaching was a new concept. They reported significant learning and skill development for future use. However, students also expressed challenges related to their need for a strong professional knowledge base to effectively fulfill the role of a coach while also simultaneously applying professional communication skills. Based on the feedback received, students identified the importance of managing the coaching situation as a whole and guiding it in the desired direction in accordance with the coaching framework. This required a solid understanding of the GROW model and theoretical knowledge of the specific chronic disease to provide appropriate health advice. Despite these challenges associated with the role of the coach, students expressed confidence in their ability to counsel patients, provide information, and complete the coaching process successfully.



Students also emphasized the importance of establishing a trusting relationship with the coachee to perform effectively in the role of a coach. Building this trust was seen as crucial for obtaining relevant information from the coachee. It required the application of professional and interactive communication skills, including the ability to explain things clearly. However, students expressed challenges in managing the coaching situation. They mentioned the need for active listening, asking questions at the appropriate time, engaging in natural conversation with the patient, and overall, having a conversation with the patient in general as components of a well-managed scenario. Other challenging aspects included demonstrating understanding and empathy, being confident in the role of the coach, and providing positive feedback to the coachee. Furthermore, students recognized the importance of considering the patient's cultural background to establish a connection. However, they also acknowledged the difficulty of applying cultural knowledge within the coaching situation.

The practical challenges mentioned by students were related to time management and structural issues. The following terms were used to describe time management challenges:

“Not enough time”

“Limited time to explain theories to people.”

“Challenging to arrange tasks to complete them together”

The structural challenges identified by students encompassed various aspects such as infrastructure, organization, information technology and geographical distance. While students generally felt that inter-professional teamwork skills worked well, they did encounter some challenges. Interprofessional skills involved consultation, teamwork, and solidarity within the team. Challenges in teamwork skills were described in terms of task organization, collaborative completion, establishing connections, and mutual understanding.



Students' Experiences in the Role of a Coachee



The answers related to the role of the coachee were interpreted in relation to how the coachee experienced the coaching situation. The interaction between the coach and coachee was described in a positive light, with terms such as good, friendly, interactive, and safe being used.

One respondent expressed this in the following words:

“Our relationship with sir was very good this is new idea for us it is very necessary for us it will help us a lot to have good relationship with patient.”

Based on the responses, it can be concluded that the students recognized the significance of the interaction between the coach and the coachee. Several respondents emphasized desirable qualities related to this interaction. They expressed that the relationship should be social, understanding, intimate, and open.

Respondents felt that the coach was able to help them with their health problem. They reported that the coach encouraged their learning about the chronic illness, empowered them to take ownership of their health problems, and provided them with options, solutions, and encouragement.

The original quotes below illustrate this well:

“Stay informed about health issues and make a better self-care plan.”

“Know how to take better care of yourself, what to do and what not to do.”

The student responses regarding challenges during the coaching session varied, but some common patterns were identified. One recurring and relevant theme was the importance of knowledge about chronic illness, and the lack of knowledge was perceived as a challenge in the coaching relationship.

One respondent expressed this challenge in the following words:

“We lacked a bit of Knowledge about the disease, so it was a little difficult to talk to the patient as we know little about the disease.”

Similarly, the coachees emphasized the importance of the coach’s understanding of the coaching process, including its theoretical background, for the effective conduct of the coaching session. Furthermore, the coachees highlighted the significance of the coach’s ability to identify and address the coachee’s health issues, which was considered essential for the success of the coaching session. However, coachees noted that this task of identifying health issues was perceived as challenging. Effective communication skills were identified as a crucial competency in this context. Coachees observed that coaches sometimes struggled to ask relevant questions to extract the necessary information. Additionally, the ability to establish an appropriate relationship and motivate the coachee to take action was also identified as a challenge.

Other challenges that had an impact on the coaching session included difficulties in time management, network connectivity issues, and geographical distance. It is worth noting that the coaching sessions were conducted online, which added an additional layer of complexity to these challenges.

The Experiences of Online Coaching

The experience of online coaching was a novel concept for the participants. However, the majority of participants acknowledged the benefits of online coaching and provided positive feedback. On the other hand, there were also some respondents who expressed criticism regarding their experience with online coaching. Those respondents who had a positive experience with online coaching described it as an enjoyable and useful way of coaching.

It was also perceived as efficient and timesaving.

“Largely positive overall.”

“Will bring a lot of good for students/health care workers.”

Those who expressed a more critical perspective considered online activities to be secondary to face-to-face interactions. They perceived online coaching as less dynamic and more serious compared to in-person coaching.

More critical views included:

“Not appropriate as live coaching.”

“Not as... vivacious and fun as offline.”

Respondents highlighted various benefits of online coaching, including financial and time savings. Online coaching was perceived as convenient and flexible, as it eliminated the need for travel for both the healthcare professional and the patient. The online environment was

also seen as a platform for healthcare professionals to develop new skills while maintaining a good relationship with their patients.

Respondents recognized both the advantages and disadvantages associated with digital tools and applications for self-management. The advantages included time and cost savings, as well as increased efficiency in service delivery since online coaching is not constrained by location. The use of digital tools was also seen as beneficial in reducing the workload of health professionals while enabling them to provide continuous support to patients.

The following quotes are examples of responses relating to the benefits of digital tools and applications in supporting self-care:

“It will deliver medical services to remote areas.”

“Help you work more efficiently.”

← The disadvantages of using digital tools and applications to support self-management were identified as their limited applicability to all situations and the challenges associated with network problems and technology use in general. Some respondents expressed concerns about the efficiency of online communication. →

Examples of responses related to these drawbacks include:

“Since our country is not yet a developed country, there is no network system in all parts of the country.”

“Difficult to use with elderly and poor people.”

Limitations of the Feedback Analysis

There are several limitations to consider in the process of collecting student feedback, which may have influenced the results. Firstly, despite discussing the content and language requirements of the feedback form with all partners, the initial response rate for the first round of feedback was low. This could be attributed to the fact that the original feedback form only included questions in English and Vietnamese. Recognizing the potential language barrier for Bangladeshi students, the questions were subsequently translated into Bangla. Following this change, the response rate improved. Furthermore, it was observed that the response rate was low when the feedback form link was sent via email. However, based on the advice from our partners, sending the link via WhatsApp resulted in an improved response rate.

Secondly, the feedback form consisted of many questions that were closely related, which made it difficult for some students to differentiate between them. This could have led to confusion and affected the accuracy of their responses. Thirdly, the inclusion of several open-ended questions posed challenges, particularly for students in Vietnam and Bangladesh who were not accustomed to providing individual feedback. As a result, many responses to the open questions were brief, which limited the depth of information obtained and made it challenging to draw meaningful conclusions.

Fourthly, we observed instances of identical responses in the same language, suggesting possible group responses or sharing of answers among students. This introduced bias into the results and compromised the individuality of the feedback. Finally, we were informed by our partners that students have a cultural tendency to please, which may have influenced their responses to provide positive feedback. This cultural practice may have influenced the authenticity and accuracy of their responses.

Conclusion

The DigiCare pilots proved to be instrumental in gathering valuable information and feedback regarding the quality of the project outputs. This feedback was crucial in refining and further developing the Digi-Care Model, Learning Packages, and Educational Program to achieve the desired project outcomes.



Integrating a new competence into a curriculum requires support from the organization and decision-makers, sufficient time for change, and continuous program development and evaluation.



When implementing a new educational program in healthcare education that introduces a new competency, it is important to consider the specific characteristics of the piloting process. Special attention should be given to the clarity and comprehensibility of the feedback collection questions, ensuring that the process facilitates individual, honest, and constructive feedback. Additionally, piloting helps to create an educational program that meets the needs of the educational institution and the demands of the workforce.

It is worth noting that integrating a new competence into a curriculum requires support from the organization and decision-makers, sufficient time for change, and continuous program development and evaluation. These elements are vital for the successful implementation and sustainability of the new educational program.

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