CHANGEMEDED®

Coaching in Graduate Medical Education

A faculty handbook

Maya M. Hammoud, MD, MBA
Abigail Ford Winkel, MD, MHPE
Margaret Wolff, MD, MHPE
John S. Andrews, MD

Contributor list

Maja K. Artandi, MD
Stanford University
Palo Alto, Calif.
Chapter 3

Indira Bhavsar-Burke, MD, MHPE
University of Texas Southwestern Medical Center
Dallas, Texas
Chapter 3

Rebecca Blankenburg, MD, MPH
Stanford University
Palo Alto, Calif.
Chapter 7

Jeremy Branzetti, MD, MHPE
Yale University School of Medicine
New Haven, Conn.
Chapter 4

William B. Cutrer, MD, MEd
Vanderbilt University School of Medicine
Nashville, Tenn.
Chapter 3

Christen K. Dilly, MD, MEHP
Indiana University School of Medicine
Richard L. Roudebush VA Medical Center
Indianapolis, Ind.
Chapter 3

Elaine A. Donoghue, MD
University of Florida College of Medicine
Gainesville, Fla.
Chapter 2

Tyra Fainstad, MD
University of Colorado School of Medicine
Aurora, Colo.
Chapter 1

Maria Volkova Feddeck, PhD
Case Western Reserve University
Cleveland, Ohio
Chapter 1

Justin Forsyth, MB, BCh, BAO
University of Texas Rio Grande Valley
Harlingen, Texas
Chapter 2

Cloe Le Gall-Scoville, PhD
University of California, Davis
Sacramento, Calif.
Chapter 5

Michael Greenwald, MD
Emory University
Atlanta, Ga.
Chapter 7

Shwetha Iyer, MD
Albert Einstein College of Medicine/Montefiore Medical Center
Bronx, N.Y.
Chapter 2

Priya G. Jain, MD, MEd
Northwestern University Feinberg School of Medicine & Ann & Robert H Lurie Children's Hospital of Chicago
Chicago, Ill.
Chapter 6

Jean E. Klig, MD
Massachusetts General Hospital
Harvard Medical School
Boston, Mass.
Chapter 3

Amalia M. Landa-Galindez, MD
Florida International University Herbert Wertheim College of Medicine
Miami, Fla.
Chapter 4

Ronda Mourad, MD
Louis Stokes Cleveland Veterans Affairs Medical Center
Case Western Reserve University School of Medicine
Cleveland, Ohio
Chapter 5

Nicola Orlov, MD, MPH
University of Chicago Pritzker School of Medicine
Chicago, Ill.
Chapter 1

Nell Maloney Patel, MD
Rutgers Health Robert Wood Johnson Medical School
New Brunswick, N.J.
Chapter 6

Tracey Pickard, MSEd
Association of American Medical Colleges (AAMC)
Washington, D.C.
Chapter 4

Barbara Porter, MD, MPH
New York University Grossman School of Medicine
New York, N.Y.
Chapter 7

Jeffrey Ratliff, MD
Thomas Jefferson University
Philadelphia, Pa.
Chapter 7

Stephany Sanchez, MD
University of California, Davis
Sacramento, Calif.
Chapter 5

Sally A. Santen, MD, PhD
University of Cincinnati College of Medicine
Virginia Commonwealth School of Medicine
Cincinnati, Ohio
Chapter 2

Magdalena R. Scheer, MD
NYU Grossman School of Medicine
New York, N.Y.
Chapter 5

Kevin R. Scott, MD, MSEd
Perelman School of Medicine at the University of Pennsylvania
Philadelphia, Pa.
Chapter 4

Simran Singh, MD
Case Western University
Cleveland, Ohio
Chapter 6

Deborah L. Virant-Young, PharmD
Carle Illinois College of Medicine
Champaign, Ill.
Chapter 1

Sarah R. Williams, MD, MHPE
Stanford University
Palo Alto, Calif.
Chapter 6

Foreword

The American Medical Association's ChangeMedEd® initiative catalyzes innovations in pursuit of its mission to improve the health of the nation through medical education. Our supported projects have produced significant changes that are being adopted across the medical education continuum, including coaching.

"Coaching in Graduate Medical Education" is the third in the AMA's series of books focused on coaching and presents the work of experts inside and outside of ChangeMedEd who have implemented coaching programs in graduate medical education. As the field of academic coaching continues to grow, I hope you find this book a valuable resource as you initiate or grow an already existing coaching program.

Sanjay V. Desai, MD, MACP
Chief academic officer
AMA

Preface

This handbook was inspired by a need for a repository of best practices and recommendations for creating coaching programs in the graduate medical education (GME) setting. Coaching is an increasingly common component of medical education, but existing resources are mostly focused on undergraduate medical education. We hope this handbook will prove to be a valuable resource for educators implementing coaching programs in GME. From envisioning goals for a new program, planning logistics, and preparing faculty and learners, the authors of this handbook's chapters have used their own coaching program expertise and understanding of the literature to create a practical resource that is generalizable to the broader community. We feel strongly that academic coaching has the power to transform residents and fellows into self-actualized, adaptive learners and look forward to this handbook stimulating the implementation and improvement of coaching programs in GME.

Maya M. Hammoud, MD, MBA
Abigail Ford Winkel, MD, MHPE
Margaret Wolff, MD, MHPE
John S. Andrews, MD

Acknowledgements

The editors and authors of this book would like to thank Sarah Ayala of the AMA for her project management. Without her, this book would not exist. We'd also like to thank Amanda Moutrage, Emily Harding, and Olivia Westerbeck, also of the AMA, for their scheduling skills and project assistance. We'd like to thank Victoria Stagg Elliott, AMA, for her copyediting and catching our misspellings and misused words. The AMA's creative team including Lindsey Glosniak, Joseph Thompson, Christian Racoma, and Max Kalef get our gratitude for editing and designing this book.

We give additional thanks to the members of the AMA ChangeMedEd initiative who contributed to this book's creation and a special thanks to Sanjay Desai, MD, MACP, the AMA's chief academic officer. Without his leadership, this book would not have been possible.

Table of contents

Chapter 1: Why coaching? The meaning and purpose of coaching in graduate medical education....1

Chapter 2: How to establish a coaching program....8

Chapter 3: Coaching for performance improvement....16

Chapter 4: Professional and career development coaching....23

Chapter 5: Coaching to promote well-being....34

Chapter 6: Coaching the resident with concerns about unprofessional behavior....46

Chapter 7: Trainee considerations....58

Chapter 1: Why coaching? The meaning and purpose of coaching in graduate medical education

Tyra Fainstad, MD; Nicola Orlov, MD, MPH; Deborah L. Virant-Young, PharmD; and Maria Volkova Feddeck, PhD

Chapter summary

Professional coaching is a tool to guide learners toward the best versions of themselves through deep inquiry, metacognition, and psychological safety. Coaching is a growing, scalable, evidence-based method to improve both well-being and professionalism for graduate medical education trainees. Coaches help learners with both professional goals (clinical observation and feedback, performance review, reflective self-monitoring) and with personal well-being (burnout, imposter phenomenon, perfectionism). The purpose of this book is to introduce, define, and offer implementation strategies for integrating coaching into the graduate medical education environment.

Vignette

MA is a 2nd year resident who transfers programs for geographic reasons. Some challenges were identified at their previous institution, including poor medical knowledge and a lack of efficiency in documentation. The program director at the new program is considering reaching out to a professional coach to help MA reflect, set goals, and define success for the coming year.

Thought questions:

1. How might a conversation with a coach differ from a conversation with a mentor?
2. What is unique about the coaching approach that may result in growth for this resident?
3. How might one integrate coaching into the graduate medical education curriculum and for whom?

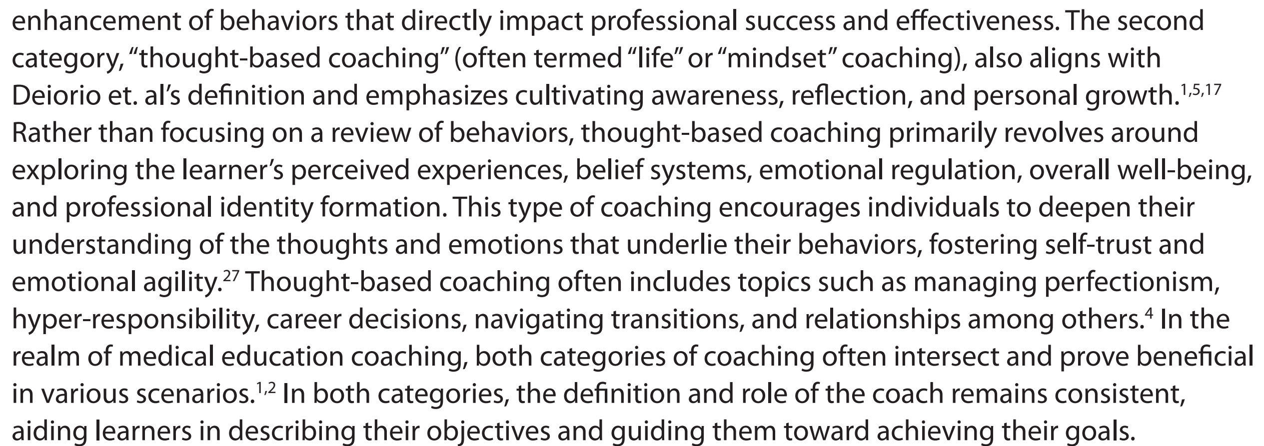
Professional coaching is a promising method to improve the personal and professional experience and outcomes of graduate medical education (GME) trainees.[1–7] Coaching has been variably defined, but its definition in medical education is widely accepted as a tool to help learners achieve their fullest potential by highlighting insights into their own assumptions, perceptions, and behaviors.[1,8] A coach may or may not have expertise in the realm of the identified learner need but instead is skilled at guiding self-reflection, needs-identification for growth, and insight into desired outcomes.[9] With inquiry and reframing, coaching is a learner-centered, future-focused process investigating beliefs and facilitating actions to align with an individual's values and progress toward personal and professional fulfillment.[1,10,11] Coaching, unlike therapy, does not diagnose or treat, but instead uses deep, non-judgmental questioning and metacognition ("thinking about one's thinking") to guide self-progress.[1] Coaching literature is growing within medical education, especially within GME, and generally supports a reduction in burnout and improvement in well-being and career success.[6,7,12-17] Studies generally suggest coaching has high potential for impact on GME trainees because of its scalability and ability to improve both domains of well-being and distress (burnout, moral injury, imposter syndrome).[5,6,12,17–19] Coaching may be particularly powerful in this population since it typically has higher access rates and less stigma than other mental health resources.[20,21]

The role of a coach is distinct from other medical educator roles including those of a mentor, adviser, and teacher (Table 1-1). The coach offers personalized guidance as well as the foundation of a psychologically safe space to help medical learners navigate challenges extending beyond gaining medical knowledge.[1] Coaches can provide growth toward a professional identity, skill development to empower learners, and foster a healthy personal-professional life continuum.[22] Coaching in medical education generally rests on the cornerstones of: 1) encouraging a growth mindset,[23–25] 2) appreciative inquiry toward reflection and metacognition,[1,17] and 3) creation of a non-judgmental, neutral, safe space.[4]

Table 1-1: Medical educator role responses to a struggling learner ("MA" in vignette)

Role	Mentor	Adviser	Teacher	Coach
Goal	To give the resident support and advice on how to improve; to be a trusted counsel.	To provide specific solutions and advice based on expert knowledge.	To provide information, direct, instruct, correct, and assess.	To support the resident in a developmental process whereby they define success for themselves. To guide them toward that goal by managing existing and potential challenges to reach their highest potential.
Tools	Establish a longitudinal relationship, share personal experiences, use wisdom and insight. Intentionally transfer knowledge and skills to guide the learner's activities.	Personal expertise, insider advice, making specific recommendations.	Direct observation of a skill followed by assessment and feedback conversation.	Learner-driven and centered inquiry, cognitive reframing, metacognition ("thinking about one's thinking"), encouraging self-reflection and development of personal values.
Example	"In my experience, improving clinical reasoning can be challenging. The trick I used was to listen really carefully on rounds to what everyone was saying and take a small note on each case as a learning opportunity. Hold yourself accountable to reading to your patients every day."	"This is not uncommon. We can have our chief residents meet with you weekly to talk through cases. They will focus specifically on your clinical reasoning. We'll get you through this, but it will take intensive and regular meetings."	(After observing a patient encounter): "How do you feel about that?" "I had trouble following your presentation since so much of the objective data was given to me in the HPI. Next time, I'd like you to finish the whole HPI before you tell me about any of the exam or labs."	"What is going well here?" "What does success look like, specifically for you here? How will you know when you have achieved that?" "What has worked for you in the past?" "What do you need from us as a program?" "How do you think you can best develop this skill?"

While we define an academic coach as "a person assigned to facilitate learners achieving their fullest potential,"[1] we recognize the various available classifications available within this definition. In the context of medical education, we offer two distinct outcome-based categories to delineate coaching types, within Deiorio et al's definition: coaching with a focus on behavioral/performance outcomes or a focus on cognitive/thought outcomes.[26] The first category, "behavior-based coaching" (often referred to as "executive" or "career" coaching), centers on habits, skills, and professional advancement. In this category, coaches often work with learners by evaluating performance via review of objective assessments of clinical competencies, improving time management and communication skills, or addressing examination failures by assisting the learner to identify needs and create a plan utilizing thorough self-monitoring and reflection for accountability.[1,26] This category emphasizes the



enhancement of behaviors that directly impact professional success and effectiveness. The second category, "thought-based coaching" (often termed "life" or "mindset" coaching), also aligns with Deiorio et. al's definition and emphasizes cultivating awareness, reflection, and personal growth.[1,5,17] Rather than focusing on a review of behaviors, thought-based coaching primarily revolves around exploring the learner's perceived experiences, belief systems, emotional regulation, overall well-being, and professional identity formation. This type of coaching encourages individuals to deepen their understanding of the thoughts and emotions that underlie their behaviors, fostering self-trust and emotional agility.[27] Thought-based coaching often includes topics such as managing perfectionism, hyper-responsibility, career decisions, navigating transitions, and relationships among others.[4] In the realm of medical education coaching, both categories of coaching often intersect and prove beneficial in various scenarios.[1,2] In both categories, the definition and role of the coach remains consistent, aiding learners in describing their objectives and guiding them toward achieving their goals.

Coaching can also be categorized temporaneously, with "coaching over time" (CoT) occurring in a longitudinal relationship and "coaching in the moment" (CiM) occurring in a one-time coaching conversation.[28] CoT involves regular meetings that foster trust, allow for deeper exploration, and can explore both performance-based discussions guided by clinical observations, synthesized data, and executive-based conversations as well as being guided by personal and professional success metrics set by the learner. CiM involves a one-time coaching session, either in a clinical (example: direct observation of an encounter and probing questions to identify behavior-based coaching toward actionable steps for improvement) or non-clinical setting (example: a one-time coaching meeting around a specific issue brought by the learner). Establishing psychological safety for the coachee is paramount in both CoT and CiM relationships to ensure open and honest conversations about strengths, weaknesses, and self-reflection.[29]

Given the wide range of outcomes that can be enhanced with different coaching strategies, the focus and structure of an academic coaching program should be tailored to meet the needs of the program and learners. In advance of developing a coaching program, particularly one with a longitudinal component, a few important components should be considered. The first components are time and resources. In an ideal world, a longitudinal coaching program would provide the implementation team, coaches, and learners with supported time for development and execution of coaching to ensure reliability among coaches and the consistency of attention they need to achieve their goals. An important initial decision is whether to utilize formalized certified coaches or to provide faculty training to hold coaching conversations. External coaches may be costly, particularly if they are paid for individual sessions which can add up quickly. When external certified coaches are employed, alignment meetings can ensure collective agreement on vision for the coaching program. Having uncertified faculty act as coaches also requires extra time and resources to train them appropriately and requires them to be away from clinical or other duties for coaching and training sessions.[30] Formal certification of faculty coaches is expensive, ranging up to tens of thousands of dollars depending on the program selected. Another decision contributing to resource allocation is whether to offer individual (1:1) coaching or group coaching. Individual coaching meetings are more traditional and well established in the literature,[7,12,31] though group coaching methods are growing in the literature base and offer scalability, low-cost, and feasibility (especially if digital) and can therefore democratize coaching.[4,5,17,32] Another benefit of group coaching is the development of community and the benefit of learners having their own challenges normalized by peers.[4,14,17] Finally, it is important to consider the sustainability of a coaching program, not only for long term financial viability but also to ensure the program fits the context in order to retain participant and coach engagement.

The second components to consider are the role of a coach and identity of the learner being coached in the greater medical education environment. Ideally, the coach should not have an assessment role for their coachee-learners to ensure safe, honest conversations about strengths and weaknesses, self-reflection, and vulnerability.[24,28,4,17] This is likely a more significant conflict within the undergraduate medical education environment where learners are still receiving grades, but it should be considered when designing a GME program and when assigning coaches. Coaching may be used across the learner continuum with potential benefit for all medical learners, regardless of their level of proficiency or where they are in the trajectory of their career.[33] In addition to benefiting the struggling learner in the domains mentioned above, coaching has been shown to increase domains of well-being in those already flourishing,[17] to help high-achieving learners reach even greater heights of success,[34] and to decrease burnout in the coachee.[6,10,17,23] Coaching has positive effects on the coach as well, including an increased sense of belonging and deepened professional identity.[3]

The third and final component is the context that coaching takes place in, which is important to consider. Coaching is a professional development opportunity and ideally not used solely to remediate bad behavior, though there are notable overlaps in these contexts.[35] When creating goals for a coaching program it is important to understand the integration of a culture of clinical performance[36] and a culture of personal development,[37] remembering that, ultimately, the goal of an academic coaching program is to encourage the mission and vision of each educational program while helping learners achieve their fullest potential.

Many insights into the meaning and considerations of coaching are offered in this book. The purpose of this book is to introduce, define, and offer implementation strategies for integrating coaching into the medical education environment. Chapters 2 through 6 give an overview of the content here and the subtypes of coaching as outlined in **Table 1-2**.

Table 1-2

Chapter	Chapter overview
Chapter 2: Establishing a coaching program	Introduces the basics of establishing a coaching program focusing on who can coach, where and when to use coaching, and how to integrate coaching into existing programmatic infrastructure.
Chapter 3: Performance coaching	Discusses how coaching can enhance clinical skills, time management, and overall competence in medical practice. Includes challenges and resources in domains of both academic and clinical coaching.
Chapter 4: Career coaching	Focuses on benefits of longitudinal career coaching during medical education. Showcases how coaching can aid in career decision-making and planning. Touches on academic promotion and aligning personal values with professional goals for long term career development.
Chapter 5: Well-being coaching	Gives a deeper dive into thought-based coaching to support medical learners' well-being and mitigate burnout. Discusses the role of coaching in promoting work-life integration. Includes tips for coaching around dimensions of distress (burnout, moral injury, and imposter syndrome) as well as dimensions of well-being (flourishing, self-compassion).
Chapter 6: Professionalism coaching	Explores how coaching can be utilized to address challenges and concerns related to professionalism and remediation. Offers coaching strategies to effectively work with struggling medical learners including direct remediation, discussion of awareness of limits, ethics and boundaries with patients, fitness for duty, and tricky situations of substance abuse and mental health diagnoses.

In the chapters that follow, we provide both a theoretical background and a practical framework for how to design and implement a coaching program in GME. This book is written for anyone interested

in coaching in GME. We reiterate the transformative potential of coaching for medical learners. Integration of coaching into training programs has already demonstrated effect and feasibility and holds great promise;[3-7,17] however, widespread adoption and long-term sustainability will depend on institutional and societal investment in physician well-being. Coaching is an essential, scalable, and accessible resource for all medical learners in their journey of personal growth and professional development.

Take-home points

1. Professional coaching is a well-established, evidence-based tool to improve both personal experience and professional outcomes in graduate medical education.
2. Coaching differs from other medical educator hats in that it uses inquiry rather than advice to guide toward success as defined by the learner. Coaching utilizes core concepts of growth mindset, appreciative inquiry, and metacognition.
3. Academic coaching is defined as facilitating learners to achieve their fullest potential and can be categorized by an outcome focus (behavior-based or thought-based).
4. Coaching can be effective for all learners, whether struggling or excelling. This book will cover implementation strategy as well as the various types of coaching in graduate medical education.

References

1. Deiorio NM, Carney PA, Kahl LE, Bonura EM, Juve AM. Coaching: a new model for academic and career achievement. *Med Educ Online*. 2016;21:33480. Published 2016 Dec 1. doi:10.3402/meo.v21.33480
2. Deiorio NM, Foster KW, Santen SA. Coaching a learner in medical education. *Acad Med*. 2021;96(12):1758. doi:10.1097/ACM.0000000000004168
3. Selling SK, Rooholamini SN, Grow HM, et al. The effects of coaching pediatric residents on faculty coaches' relationships, learning, and professional identity formation. *Acad Med.* 2023;98(3):376. doi:10.1097/ACM.0000000000005011
4. Mann A, Fainstad T, Shah P, et al. "We're all going through it": impact of an online group coaching program for medical trainees: a qualitative analysis. *BMC Med Educ.* 2022;22(1):675. Published 2022 Sep 13. doi:10.1186/s12909-022-03729-5
5. Fainstad T, Mann A, Suresh K, et al. Effect of a novel online group-coaching program to reduce burnout in female resident physicians: A randomized clinical trial. *JAMA Netw Open*. 2022;5(5):e2210752. Published 2022 May 2. doi:10.1001/jamanetworkopen.2022.10752
6. Palamara K, McKinley SK, Chu JT, et al. Impact of a virtual professional development coaching program on the professional fulfillment and well-being of women surgery residents: A randomized controlled trial. *Ann Surg*. 2023;277(2):188-195. doi:10.1097/SLA.0000000000005562
7. Palamara K, Kauffman C, Chang Y, et al. Professional development coaching for residents: Results of a 3-year positive psychology coaching intervention. *J Gen Intern Med*. 2018;33(11):1842-1844. doi:10.1007/s11606-018-4589-1
8. Cummings TG, Worley CG. Coaching and mentoring. In: Cummings TG, Worley CG, eds. *Organizational development and change*. Cengage Learning; 2009.

9. Deiorio NM, Skye E, Sheu L. Introduction and definition of academic coaching. In: Deiorio NM, Hammoud MM, eds. *Coaching in Medical Education A Faculty Handbook*. American Medical Association; 2017.

10. Gazelle G, Liebschutz JM, Riess H. Physician burnout: coaching a way out. *J Gen Intern Med*. 2015;30(4):508-513. doi:10.1007/s11606-014-3144-y

11. Lovell B. What do we know about coaching in medical education? A literature review. *Med Educ*. 2018;52(4):376-390. doi:10.1111/medu.13482

12. Dyrbye LN, Shanafelt TD, Gill PR, Satele DV, West CP. Effect of a professional coaching intervention on the well-being and distress of physicians: A pilot randomized clinical trial. *JAMA Intern Med*. 2019;179(10):1406-1414. doi:10.1001/jamainternmed.2019.2425

13. Dyrbye LN, Gill PR, Satele DV, West CP. Professional coaching and surgeon well-being: A randomized controlled trial. *Ann Surg*. 2023;277(4):565-571. doi:10.1097/SLA.0000000000005678

14. de Lasson L, Just E, Stegeager N, Malling B. Professional identity formation in the transition from medical school to working life: a qualitative study of group-coaching courses for junior doctors. *BMC Med Educ*. 2016;16:165. Published 2016 Jun 24. doi:10.1186/s12909-016-0684-3

15. Malling B, de Lasson L, Just E, Stegeager N. How group coaching contributes to organisational understanding among newly graduated doctors. *BMC Med Educ*. 2020;20(1):193. Published 2020 Jun 16. doi:10.1186/s12909-020-02102-8

16. Guck AJ, Buck K. Reducing clinician inefficiency and restoring meaning in practice: A professional coaching approach for family medicine residents. *Int J Psychiatry Med*. 2021;56(5):319-326. doi:10.1177/00912174211034624

17. Mann A, Shah AN, Thibodeau PS, et al. Online well-being group coaching program for women physician trainees: A randomized clinical trial. *JAMA Netw Open*. 2023;6(10):e2335541. Published 2023 Oct 2. doi:10.1001/jamanetworkopen.2023.35541

18. Makowski MS, Palomo C, de Vries P, Shanafelt TD. Employer-provided professional coaching to improve self-compassion and burnout in physicians. *Mayo Clin Proc*. 2022;97(3):628-629. doi:10.1016/j.mayocp.2022.01.008

19. Grant AM, Curtayne L, Burton G. Executive coaching enhances goal attainment, resilience and workplace well-being: A randomised controlled study. *J Posit Psychol*. 2009;4(5):396-407. https://doi.org/10.1080/17439760902992456

20. Jordan M, Livingstone JB. Coaching vs psychotherapy in health and wellness: Overlap, dissimilarities, and the potential for collaboration. *Glob Adv Health Med*. 2013;2(4):20-27. doi:10.7453/gahmj.2013.036

21. Sen S. Is it burnout or depression? Expanding efforts to improve physician well-being. *N Engl J Med*. 2022;387(18):1629-1630. doi:10.1056/NEJMp2209540

22. Johnson KM, Slavin SJ, Takahashi TA. Excellent vs excessive: helping trainees balance performance and perfectionism. *J Grad Med Educ*. 2023;15(4):424-427. doi:10.4300/JGME-D-23-00003.1

23. Fainstad T, McClintock AA, Van der Ridder MJ, Johnston SS, Patton KK. Feedback can be less stressful: Medical trainee perceptions of using the prepare to ADAPT (Ask-Discuss-Ask-Plan Together) framework. *Cureus*. 2018;10(12):e3718. Published 2018 Dec 11. doi:10.7759/cureus.3718

24. Hauer KE, Chang A, van Schaik SM, Lucey C, Cowell T, Teherani A. "It's all about the trust and building a foundation:" evaluation of a longitudinal medical student coaching program. *Teach Learn Med*. 2023;35(5):550-564. doi:10.1080/10401334.2022.2111570
25. Solms L, van Vianen A, Koen J, et al. Turning the tide: a quasi-experimental study on a coaching intervention to reduce burn-out symptoms and foster personal resources among medical residents and specialists in the Netherlands. *BMJ Open*. 2021;11(1):e041708. Published 2021 Jan 25. doi:10.1136/bmjopen-2020-041708
26. Nicolau A, Candel OS, Constantin T, Kleingeld A. The effects of executive coaching on behaviors, attitudes, and personal characteristics: a meta-analysis of randomized control trial studies. *Front Psychol*. 2023;14:1089797. Published 2023 Jun 2. doi:10.3389/fpsyg.2023.1089797
27. David S. Emotional Agility: Get Unstuck, Embrace Change, and Thrive in Work and Life. Avery; 2016.
28. Landreville J, Cheung W, Frank J, Richardson D. A definition for coaching in medical education. *Can Med Educ J*. 2019;10(4):e109-e110. Published 2019 Nov 28.
29. McClintock AH, Fainstad TL, Jauregui J. Creating psychological safety in the learning environment: Straightforward answers to a longstanding challenge. *Acad Med*. 2021;96(11S):S208-S209. doi:10.1097/ACM.0000000000004319
30. Brooks JV, Istas K, Barth BE. Becoming a coach: experiences of faculty educators learning to coach medical students. *BMC Med Educ*. 2020;20(1):208. Published 2020 Jul 1. doi:10.1186/s12909-020-02119-z
31. Palamara K, Chu JT, Chang Y, et al. Who benefits most? A multisite study of coaching and resident well-being. *J Gen Intern Med*. June 2021. doi:10.1007/s11606-021-06903-5
32. Feddeck MF, Cola P, Quinn JF, Boyatzis RE, Passarelli, A. Coaching in medicine: The way forward. *Academy of Management Proceedings*. August 2023. doi:10.5465/AMPROC.2023.16639symposium
33. Parsons AS, Kon RH, Plews-Ogan M, Gusic ME. You can have both: Coaching to promote clinical competency and professional identity formation. *Perspect Med Educ*. 2021;10(1):57-63. doi:10.1007/s40037-020-00612-1
34. Ericsson KA, Prietula MJ, Cokely ET. The Making of an Expert. *Harvard Business Review*. Published online July 1, 2007. Accessed March 21, 2024. https://hbr.org/2007/07/the-making-of-an-expert
35. Fainstad T, Ebel B. Faculty remediation coaching: Invest time to build trust. *Med Educ*. 2020;54(5):478-479. doi:10.1111/medu.14089
36. Boyatzis R, Liu H, Smith A, Zwygart K, Quinn J. Competencies of coaches that predict client behavior change. *J Appl Behav Sci*. October 2023:00218863231204050.
37. Terekhin R, Feddeck M. *Why Workplace Peer Coaching Groups Are Vital for the Corporate Culture of the Future*. Springer Books. 2023:371-386.

Chapter 2: How to establish a coaching program

Shwetha Iyer, MD; Justin Forsyth, MB, BCh, BAO; Sally A. Santen, MD, PhD; and Elaine A. Donoghue, MD

Chapter summary

In this chapter, we cover key principles for establishing a coaching program. This starts with defining the goals and objectives of the coaching program, followed by engaging the stakeholders and recruiting the coaches and coachees while identifying sources of funding for the program. Defining faculty development including hands on training and evaluation of the program should also be included in the initial planning prior to implementation of the program. Finally, it is important to develop faculty resources for continuing training of the faculty and providing feedback for quality improvement.

Prior to starting any coaching program, it is integral to understand the program's aim. What gap is the coaching program trying to fill? A program may consider conducting a needs assessment to illuminate learner needs, ideally with engagement from leadership, faculty, and learners. Needs assessments can include focus groups, individual interviews, survey data, or knowledge assessments (i.e., in-service exams). From these groups, coaching program leadership can identify the primary direction of the program. Some examples of areas that a coaching program could focus on are in Table 2-1.

Vignette

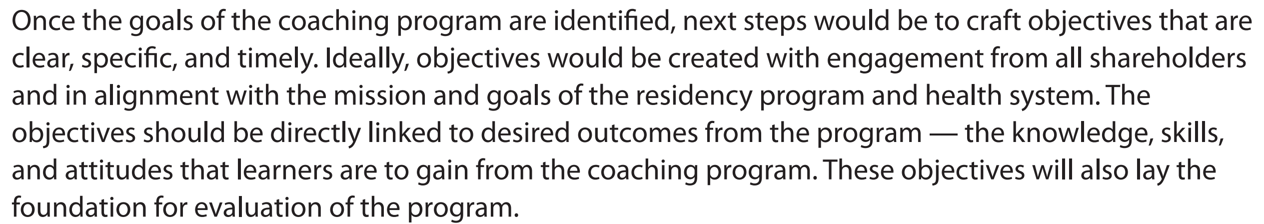
AB is a residency program director at an academic medical center who wants to implement a coaching program for the pediatric residents, so they will shift from being advised to being coached. AB would like to train all current advisers in coaching techniques.

Thought questions:

1. How will AB and the team clarify the goals of the coaching program?
2. What shareholders should AB enlist to help create and support the coaching program?
3. How will coaches be trained?
4. How will AB and the team assess the program and its effectiveness?

Table 2-1: Examples of coaching program goals

Category	Description / Examples
Learning	Acquisition of clinical skills (history taking, clinical reasoning), technical/procedural skills, research, and evidence-based medicine)
Remediation	Behavioral or academic problem identified by leadership or clinical competency committee
Professional development	Career goals, physician identity, self-reflective practice
Wellness	Burnout prevention, integration of personal and professional lives
Leadership skills	Understanding one's leadership style, managing a team (including conflict management), teaching and promoting growth in learners



Once the goals of the coaching program are identified, next steps would be to craft objectives that are clear, specific, and timely. Ideally, objectives would be created with engagement from all shareholders and in alignment with the mission and goals of the residency program and health system. The objectives should be directly linked to desired outcomes from the program — the knowledge, skills, and attitudes that learners are to gain from the coaching program. These objectives will also lay the foundation for evaluation of the program.

Types of coaching

After developing goals and objectives for the program, a next step would be to identify the type of coaching program that will be implemented. Programs should be clear on the differences between coaching, mentoring, and advising in the development of a coaching program to avoid overlap with other resources. Various types of coaching exist, including behavior-based and cognitive-based coaching as mentioned in Chapter 1. Current coaching programs include performance coaching (incorporating feedback from direct observation for improving critical skills in a trainee) and developmental coaching (the trainee constructs self-defined goals and bridges gaps in their trajectory).[1] A program will also have to decide if they are incorporating critical coaching skills (for example, active, deep listening; empathy; and positive psychology principles) in advising their trainees' professional growth — a coach approach model, a mixed coaching-and-advising model, or a pure coaching model. Lastly, programs need to consider whether trainees are getting coaching 1-on-1 with a trained or peer coach or in a group format. Clarifying the answers to these questions will lead to the identification of the appropriate tools and resources for development of the coaching program.

Engaging shareholders

For the success of coaching programs, it is important to engage your community, including learners, administration, faculty, and leadership at your institution and to consider their input at all stages. Not all shareholders need to be active participants, but they should be supporters with resources, ideas, or talents. Developing an advisory committee can be one way to obtain diverse input and expand support for the program. The role of the program leadership to the advisory committee should be clear. It can be helpful to engage those who might be resistant as well as early adopters. Clarify issues such as time commitment and needed resources up front and negotiate options.

Consider when to engage shareholders. Earlier engagement allows more input into the formation of the program, but less information is available about the planned structure. Later engagement allows for better explanation of the plans for the program, but substantial changes might be more difficult to make. Trainee input and involvement is important at all stages.

Coaching programs should have clear organization, regular review of the goals, and routine evaluation with improvement cycles, and these elements can be reviewed with the advisory committee for continuous quality improvement. Give thought to administrative support for the logistics of program implementation. Succession planning should start early.

Who can coach?

Coaching involves partnering with residents in a thought-provoking and creative process that inspires them to maximize their personal and professional potential. Despite the significant growth of coaching in medical education, there are no clear standards for who might be a coach. As discussed above, when developing a program, it is important to identify the goal of the program, such as well-being, academic performance, and procedures. This "North Star" will help guide program development, implementation, coach selection, and training.

A coach can be anyone but not anyone can be a coach. Depending on the program, they do not need to be physicians, since the role of the coach is to facilitate resident development and not to advise or teach. Faculty physicians can be costly and have limited time, so programs might pull from other members of the educational community, but it is important to ensure credibility, training, and knowledge about medical education. Two important coach skills are emotional intelligence (for the work of coaching) and a sense of responsibility (for follow-through with scheduling and training).

Coachees

Coaching has been shown to be effective for all levels of GME trainees.[2,3] Programs may wish to consider various methods for obtaining resident buy-in, such as:

Inclusion of residents in the process:

- Solicit resident input in establishing and regularly assessing/adjusting the program.
- Operate graduate medical education coaching programs distinct from medical student programs.

Education

- Reassure trainees that the program will avoid conflicts of interest — such as requiring coaches to recuse themselves from clinical competency committee discussions about the trainee.
- Reinforce confidentiality — and discuss any limits of confidentiality.
- Inform trainees about the rights and responsibilities of coaches and coachees.
- Provide information about (1) various forms of coaching; (2) the lifelong nature of coaching (that coachees include attending physicians, top-level executives, researchers, athletes, and other high achievers); and (3) how participation will likely help residents be more effective future coaches and/or coachees.
- Discuss research on coaching outcomes.

Protection of resident well-being

- Decide whether participation will be required or optional.
- Avoid penalizing residents if/when they decline to participate or engage.
- Protect time for trainees who choose to participate, such as by blocking a clinic hour for the resident.
- Avoid formal coaching during mealtimes, evenings, or weekends.
- Incentivize participation and build rapport; many residents respond well to good coffee or healthy food.

Recruitment

There are a number of options for recruiting coaches. The primary criteria is that it is important that they be willing to engage in coaching and training. Generally, residency programs recruit coaches from their faculty. If the program is large, there is the opportunity to bring faculty into the educational mission who may be less connected to the residents, such as faculty in affiliated community health care settings. Other programs choose to bring their core faculty in for coaching. Non-physician coaches are also an option, while setting clear expectations for both coaches and residents. These may be PhD educators, psychologists, social workers, or trained coaches. Additionally, sharing coaches across specialties is another consideration — such as anesthesia faculty coaching surgery residents

and surgery faculty coaching anesthesia residents. Finally, it is helpful to have a position description that sets expectations.

Funding for coaches

Funding for coaches can be challenging as faculty would like protected time or a monetary stipend for time spent coaching. This practice is variable depending on the program. Some programs use the mandatory Accreditation Council for Graduate Medical Education core faculty time to provide protected time for faculty. Other programs have administrative or educational time built into their compensation plan that is allotted to coaching. Additional options are to have "citizenship" requirements or track "educational value units" as part of an incentive or bonus plan that faculty can fulfill with coaching. While some programs offer a small compensation for coaching, many programs rely on faculty responsibility and commitment to education to coach without compensation. Some programs might start with initial grant or institutional funding.

Potential conflicts of interest

One caveat about coaches is that, ideally, they should not be in a position to perform important assessments or make advancement decisions for the trainee. They should not be able to make decisions about the future of the trainee — such as a program director or clinical competency committee member. This would create a conflict of interest that could hinder the coaching relationship if the trainee shared or exposed weaknesses. For some residency programs, members of the program leadership are coaches; in those settings, clarity around potential conflicts will be needed. It is sufficient for faculty who have contact with trainees to recuse themselves from assessments and decisions. When implementing coaching programs, setting expectations for the coach and coachee will be helpful. They need to recognize that the coach is not a career adviser, and that they do not need to have been through medical training. In small programs, avoiding these conflicts of interest can be especially problematic. Faculty need to pay attention to relationship management and to reassure the resident that conversations are confidential and will not be used for summative evaluative decisions. Then, the faculty coach needs to have the integrity to maintain those boundaries to separate coaching information and relationships from the data contributing to summative decisions and the decisions themselves. The ideal, however, is that the program avoids such conflicts of interest altogether.

Table 2-2: Coaching training resources

Resources
Initial training in coaching skills and different coaching styles[4] • Setting expectations • Managing the coaching meeting (structure, agenda setting, etc.)
Resources to refer residents to: • Counseling and mental health • Study and testing skills • Career advising
Ongoing training and feedback to improve skills
Regular coaching meetings with coaches for support and problem solving

Training

The type and length of training will depend on the program resources (Table 2-2), but there are certain foundational areas that should be covered (Table 2-3)

Table 2-3: Types of training

Type of training	Examples
Theory/Foundation of coaching	Difference between advising, mentoring, and coaching[5] Confidentiality and conflict of interest Coaching competencies[6] Program goals and objectives Scope of coaching Linking to complementary services (mental health, etc.) for issues out of coaching scope New approaches to coaching Working with diverse learners Addressing learner resistance Assessment tools
Practice/Skill building	Structured peer observation with feedback Case discussions Role play
Learning community	Peer-to-peer mentoring Group discussions Online discussion board
Resource repository	Website links Podcasts, training videos Papers, books Local contacts (mental health resources, tutors)

During training, having practice sessions using a rotating triad format of coach, coachee, and observer can be effective. Using real problems can give the practice more resonance. The coachee will state a coaching question, and the coach will ask coaching questions focusing on "What" and "How," rather than "Why." The observer will give feedback. Everyone then rotates positions until everyone has played all three roles. The experience of being coached can be very valuable in coach training.

Training can be internal if there is expertise, and experienced coaches can mentor new coaches. Outside trainers can also be utilized, and there are many coach training programs of varying lengths and specificity for medical education. Coaching training and certification can be[7] obtained through organizations like the International Coaching Federation for those who want more in-depth training. If any assessment tools such as DISC[8] or MBTI[9] are planned to highlight how different behavioral styles impact communication, coaches should be trained on the tool. Different coaching theories have been described.[5]

After the initial coach training, subsequent faculty development in a supportive environment is important. Formats may include: practice sessions to maintain and refine skills, teaching new approaches, community of practice building, and opportunities for coaches to get help from more experienced coaches and peers to manage the challenges that arise. Opportunities for synchronous and asynchronous training can keep coaches engaged in an environment of competing priorities. Ongoing assessment of coach challenges can help to focus training on the areas of greatest need.

Logistics

Good coaching requires relationship building, so the frequency and length of the sessions should be adequate to build a strong relationship. The number of coaching sessions might be set by the program structure, but flexibility and joint decision-making between the coach and coachee is helpful in deciding the optimal structure of the coaching engagement. Short coaching sessions can be very effective once a foundation is built, but longer sessions are often needed to tackle complex problems.[10] Coaches can build their skills to bridge prior themes into new coaching sessions and give the coachee time to reflect between sessions. More frequent coaching might be needed at inflection points like when coachees are considering future opportunities or facing challenging situations.

Matching coaches and coachees is important. Common interests and backgrounds can be helpful, but differing complementary characteristics can also be beneficial. Consider how coach/coachee mismatches will be addressed and how requested switches will be handled. Establishing policies and expectations ahead of time can set expectations and facilitate resolving these issues. Creative conflict can provide a learning opportunity for all, but unresolved conflict can undermine a program. Regular check-ins can make it more likely issues are addressed early.

Infrequent coaching sessions can disrupt continuity and relationship-building. Virtual coaching can be very effective but is not always optimal for reading non-verbal cues. Group coaching can be an effective option in some situations.[11,12] Regardless of the structure of the coaching engagement, scheduling is a perennial challenge. Self-scheduling through calendar apps can be an effective tool, and learning management systems can also help with tracking and organizing resources. Administrative support is also very helpful, and the scope should be established early in the process.

Potential session topics for faculty development

Coaches ideally will possess the skills to navigate any topic raised in coaching sessions — including the awareness to know when to refer the trainee to other resources. Nevertheless, faculty development can help prepare coaches for potentially common topics and give coaches a venue to practice responding. Consider including items like the following in faculty development sessions:[13]

- Academic: board study tips/techniques, milestone tracking, responding to and managing program feedback.
- Clinical: rotation study tips, identifying areas for improvement in clinical skills, navigating relationships with coworkers, conflict resolution.
- Career: considering career trajectory and fellowships, establishing professional identity.
- Well-being: physical and mental health, personal relationships, financial hardship, bereavement, spirituality.
- Other: accountability for resident-directed goals, time management, organizational skills, direction to additional resources.

Many topics may emerge in coaching sessions. Chapters 3, 4, and 5 of this book will review such topics in greater detail.

Challenges/Planning for barriers

When starting a coaching program, consider other logistical challenges including resources such as administration, identifying coaches, determining the scale of the program, and ensuring plans for sustainability. New programs may need to employ a change management model to engage the

community. In this case, communication throughout is critical. Once programs are launched planning for sustainability and leadership and coach transitions if needed will also be important.

Responsiveness to coach and coachee challenges may be necessary. For example, having back-up coaches or the ability to pivot to group or peer coaches may be needed.

Evaluation of programs

Given the resources and effort required for coaching, it is important to regularly evaluate the program. Evaluations are complicated, and further resources should be sought.[14,15] There are different evaluation approaches, including **process evaluations** and **goals/outcomes evaluations**.

A **process evaluation** explores if and how the activities are occurring. For example, the program may look into:

- Frequency of coaching meetings
- Whether goals are being set
- Management of faculty conflicts of interest
- Development of coaching relationships

These are process measures that can help assure the program is running effectively. Another type of evaluation is a **goals/outcomes evaluation**. For this type of evaluation, it is important to know what the goals of the program are and then measure those goals. These goals lead to outcomes which can be measured as well. To do so, a program may use Kirkpatrick's pyramid.[15] First, programs can measure coach and resident satisfaction with coaching. Second, programs can measure learning — such as whether the coaches are learning how to coach or when the program goal is aimed at a measurable resident learning goal. Is the coached resident learning? For example, if a program is aimed at improving in-service training scores, one may measure where residents have strengthened study skills. Third, a program may measure the behavior of the residents or coaches. Again, these should correspond with program goals. If the program goal is professionalism, one might measure the professionalism of the resident coachees. Finally, the highest level of evaluation would measure impact or results of the program. In this case, using the previous examples, a program may measure the in-service training scores or pass rates on national board examinations.

As noted, there is a lot of data that programs can collect and use for evaluation. It is important that data reflect the goals and to utilize, when possible, instruments with validity evidence. Finally, an evaluation is just the first step in process improvement. Once an evaluation is completed, sharing the findings with shareholders and planning for improvement are the next steps in continuous quality improvement.

Take-home points

1. Identify clear goals and objectives at the beginning.
2. Enlist help to develop the program to get investment from shareholders and input from varied sources.
3. Educate residents about coaching, reassure them about confidentiality, and utilize coaching to reduce — rather than contribute to — their own administrative burdens.
4. Think about evaluating your program effectiveness from the start.

References

1. Schulte EE, Sikon AL, Love L, Simonsen K, Berry A, Agarwal G. Enhancing physician wellness through coaching: An occupational psychiatry tool. *Psychiatr Ann*. 2019; 49(11):492-496.
2. Palamara K, Kauffman C, Chang Y. et al. Professional development coaching for residents: Results of a 3-Year positive psychology coaching intervention. *J Gen Intern Med*. 2018;33:1842-1844. https://doi.org/10.1007/s11606-018-4589-1
3. Fainstad T, Mann A, Suresh K, et al. Effect of a novel online group-coaching program to reduce burnout in female resident physicians: A randomized clinical trial. *JAMA Netw. Open*. 2022;5(5):e2210752. https://doi:10.1001/jamanetworkopen.2022.10752
4. Hammoud MM, Deiorio NM, Moore M, Wolff M. *Coaching in Medical Education*. Elsevier; 2023: Ch.3-p.18-32 and Ch. 5 p. 44-54.
5. Hammoud MM, Deiorio NM, Moore M, Wolff M. *Coaching in Medical Education*. Elsevier; 2023: Ch 1-p. 1-2
6. Hammoud MM, Deiorio NM, Moore M, Wolff M. *Coaching in Medical Education*. Elsevier; 2023. p 18-43.
7. The Gold Standard in Coaching | ICF - Find Education. International Coaching Federation. Accessed March 21, 2024. https://coachingfederation.org/credentials-and-standards/find-education
8. What is the DiSC assessment? Discprofile.com. Accessed March 21, 2024. https://www.discprofile.com/what-is-disc
9. Myers-Briggs Type Indicator® (MBTI®) | Official Myers Briggs Personality Test. Accessed March 21, 2024. https://www.themyersbriggs.com/en-US/Products-and-Services/Myers-Briggs
10. Lovell B. What do we know about coaching in medical education? A literature review. *Med Educ*. 2018;52(4):376-390. doi:10.1111/medu.13482
11. Régo P, Peterson R, Callaway L, Ward M, O'Brien C, Donald K. Using a structured clinical coaching programme to improve clinical skills training and assessment, as well as teachers' and students' satisfaction. *Med Teach*. 2009;31 (12): 586-e595. doi:10.3109/01421590903193588
12. de Lasson L, Just E, Stegeager N, Malling B. Professional identity formation in the transition from medical school to working life: a qualitative study of group-coaching courses for junior doctors. *BMC Med Educ*. 2016;16:165. Published 2016 Jun 24. doi:10.1186/s12909-016-0684-3
13. Patel K, Phillips R, Garcia A. Chapter 4: How can my coach help me? In: Wolff M, Jackson J, Hammoud M, eds. *It Takes Two: A Guide to Being a Good Coachee*. American Medical Association; 2019:19-24. Accessed March 21, 2024. http://cloud.e.ama-assn.org/20-1626-Coaching-H
14. Van Eck R, Myeloma E, Dubaybo B. Chapter 11: Coaching Assessment and Program Outcomes. In: Deiorio N, Hammoud M, eds. Coaching in Medical Education: A Faculty Handbook. American Medical Association; 2017.
15. Kirkpatrick DL, Kirkpatrick JD. *Evaluating training programs: The four levels*. Berrett-Koehler Publishers, Inc.; 2006.

Chapter 3: Coaching for performance improvement

Indira Bhavsar-Burke, MD, MHPE; Maja K. Artandi, MD; William B. Cutrer, MD, MEd; Christen K. Dilly, MD, MEHP; and Jean E. Klig, MD

Chapter summary

Coaching facilitates the individual development of trainees organically in the clinical learning environment. Performance improvement coaching allows trainees to build on their current abilities and maximize their potential by prioritizing self-regulation and positive, personal growth. In this chapter, we introduce the concept of coaching for performance improvement and review the importance of safe learning environments to achieve maximum success. We provide practical tips for approaching coaching conversations and identifying performance improvement goals in both clinical and procedural settings.

Coaching as a performance improvement tool

The development of expertise relies on accurate assessment and feedback. However, giving and receiving feedback that results in performance improvement is challenging and influenced by a myriad of different factors. Many learners approach performance assessments and feedback with anxiety, interpreting negative assessment as a representation of personal shortcomings rather than an opportunity for personal growth. Reasons for this are many, but central to them is a learner's focus on success and a fear of failure. This attitude of defining one's self-worth through feedback significantly undermines the learning process.

Vignette

Sarah, a 2nd-year neurology resident, is up for discussion in your clinical competency committee meeting. Her milestones ratings are consistently below what is expected for her level of training. Peers complain that she is rude and demeaning to them. One attending noted that she argued about a plan in front of a patient. As the group discusses her performance, they determine that she struggles with professionalism and communication with teams. You suggest coaching as the first step in addressing the problem. However, she is resistant because she believes her clinical skills are excellent.

Thought questions:

1. How might you gauge Sarah's readiness for performance improvement efforts?
2. What questions will steer your conversation toward her strengths rather than focusing on her struggles?
3. What techniques might you use to help Sarah set effective performance improvement goals?

Regimented progression through medical training and traditional approaches to learning make it difficult for trainees to evolve from a results-oriented (fixed) mindset to a process-oriented (growth) mindset. Performance assessments are often one-sided; trainees typically review feedback on their performance without an opportunity to actively participate in feedback conversations.[1] Coaching facilitates learners engaging in behaviors and reflections that help them achieve their greatest potential.[2]

Performance improvement coaching in graduate medical education (GME) is a form of individual development that focuses on a learner's current abilities with the goal to maximize potential through self-reflection and personal responsibility. Because GME-level trainees develop discrete skills and reach independent practice at varying rates, performance improvement coaching can be adapted

to the needs of individual learners at specific time points in their journey. Its adaptations include building confidence and overcoming imposter syndrome, remediating struggling learners, fine-tuning procedural skills, and fostering better communication.

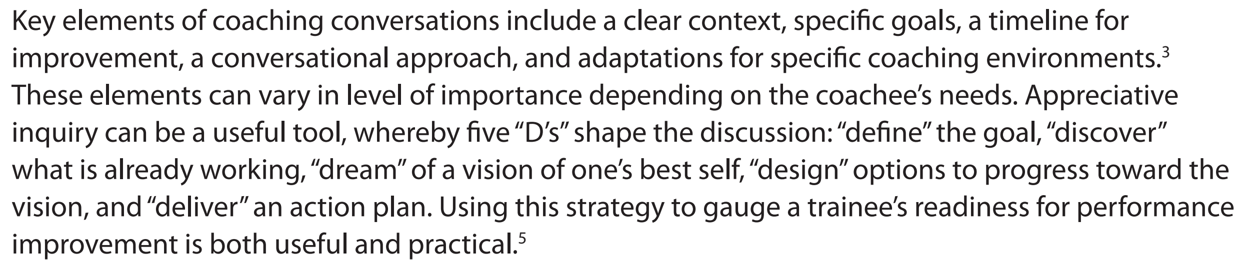
A crucial first step for successful performance coaching is creating a safe learning environment.[3] Trust is built by the coach's genuine concern for the learner's well-being and success. An essential aspect of building coaching relationships is the coach's understanding of what a learner values in their education and professional development. Frequently, a learner's awareness, motivation to learn, and personal responsibility are grounded in these values.[2] Identifying opportunities for improvement and capitalizing on a learner's intrinsic motivation are powerful tools for sustained and lifelong learning.[2,4]

Approaches to Coaching Conversations

The foundation of performance improvement coaching is deciding what approach will best address a coachee's needs. Coaching can occur during a single interaction or throughout several longitudinal sessions that are connected by goal setting and key takeaways. Regardless of subject matter or level of learner, the core coaching concept of appreciative inquiry, which prioritizes the generation of positive ideas (assets-based) over the identification of negative problems (deficits-based), forms the foundation for all coaching relationships.[4] This approach to "coaching conversations" allows the trainee to build on their strengths while co-creating new ideas for self-directed learning with their coach.[4] Examples of an assets- versus a deficits-based approach to performance improvement are shown in Table 3-1.

Table 3-1: Appreciative inquiry in performance improvement coaching. The top panel outlines appreciation-based versus deficits-based approaches to performance assessment. The bottom panel demonstrates a specific approach to appreciative inquiry.

Appreciative inquiry in performance improvement coaching	
Appreciation-based	**Deficits-based**
What is going well?	What are the problems?
How can we build on this?	How can we fix this?
What is present?	What is missing?
How can we empower you in the future?	How can we prevent this in the future?
How can we engage?	How can we intervene?
5 D's of appreciative inquiry	
"Define" the goal	"What do you want to focus on?"
"Discover" what is working	"What is going well (in the current situation)?"
"Dream" a vision	"What does success look like to you?"
"Design" options for progress	"What are potential next steps?"
"Deliver" an action plan	"What is the most useful first step?"



Key elements of coaching conversations include a clear context, specific goals, a timeline for improvement, a conversational approach, and adaptations for specific coaching environments.[3] These elements can vary in level of importance depending on the coachee's needs. Appreciative inquiry can be a useful tool, whereby five "D's" shape the discussion: "define" the goal, "discover" what is already working, "dream" of a vision of one's best self, "design" options to progress toward the vision, and "deliver" an action plan. Using this strategy to gauge a trainee's readiness for performance improvement is both useful and practical.[5]

Establishing a clear context of what will happen during the coaching process builds mutual trust and directs the conversation toward specific goals within a jointly agreed upon timeline. Often, this is achieved by establishing a coaching agreement or asking a coachee how to best remain accountable to each other during the coaching process. A conversational approach entails active listening by the coach, engaging with the coachee's strengths, and discussing ways to mobilize these strengths to achieve the necessary performance improvement. *Adaptations* of coaching conversations can vary, recognizing that the dynamic relationship between coach and coachee can be impacted by many factors, including busy clinical learning environments.[3] Taken together, these elements of coaching conversations create an opportunity for intentional, reflective performance improvement that is asset focused.

Identifying Performance Improvement Goals

Effective performance improvement coaching relies on the coachee's awareness that change is needed for ongoing improvement; this mindset must be established early on.[3,4] It is then possible to cultivate positive strategies for change that are essential products of each coaching conversation.

Identifying appropriate performance improvement goals is a joint endeavor shared by the coach and the trainee. In practice, this usually occurs after the coach has ensured the psychological safety of the learner.[3] Specific goal-setting techniques (e.g., WOOP or SMART) can be used to address discrete targets for performance improvement.[6] Coaches should help trainees with broader goals create plans that foster step-by-step progress. Progress toward goal-attainment builds a coachee's intrinsic motivation for improvement and creates an environment for coachees to develop a more nuanced understanding of their current performance and self-identify future areas of potential growth.[1]

When possible, the faculty coach should not be responsible for summative assessment of the coachee. This includes decisions regarding promotion or the need for formal performance improvement plans. If the coach is in a summative assessment role, the coachee may be hesitant to engage in open conversations with their coach for fear of judgement.[7] In the context of GME, however, this may be unavoidable as faculty often wear many hats. In these cases, coaching relationships benefit from strong communication and clear boundaries to ensure the psychological safety of the learner and limit any unintentional shift from a growth mindset to a performance mindset.

Coaching for clinical performance improvement

Coaching for clinical performance improvement often relies on the ability of the coach to discern the individual needs of the coachee, especially in early GME-level trainees. To this extent, content expertise is critical.

Learners may excel in medical decision-making, but struggle with communication or interpersonal skills. Other times, the opposite may be true. In some cases, trainees may have multiple domains that require targeted coaching, and determining the greatest immediate need is complicated. Alternatively,

trainees may be generally doing well and determining how to coach learners to fine-tune skills can be difficult.

Regardless of scenario, both clinical and procedural performance improvement coaching mirrors the Master Adaptive Learner (MAL) model, and approaches to performance improvement coaching should be learner centric. Identifying an area for growth occurs within the MAL's planning phase. Depending on the trainee's insight and awareness of their areas for growth, selection can range from a learner-directed and selected opportunity to an opportunity co-identified and selected with the coach to a coach-identified and selected area for focused improvement.

Often, trainees are referred for dedicated coaching due to perceived deficits in domains of clinical performance like medical knowledge. These perceived deficits can be further categorized into one of the following clinical reasoning categories: data collection, hypothesis generation, problem representation, knowledge organization, and/or assessment and treatment.[4] Opportunities for growth in these domains often present similarly among trainees at similar skill levels. Specific examples of commonly encountered trainee characteristics and targeted coaching techniques are described in Table 3-2.

Table 3-2: Examples of commonly encountered trainee characteristics and targeted coaching techniques, adapted from Bhavsar-Burke I, Reddy RM, Hammoud MM, Lomis KD. Chapter 7: Coaching for Performance Improvement. In: Hammoud MM, Deiorio NM, Moore M, Wolff M, eds. Coaching in Medical Education. Elsevier; 2023:66-74.

Reasoning domains and association with the Master Adaptive Learner model	Learner characteristics	Targeted coaching techniques
Data collection • Provides trainees opportunities for performance improvement in the context of their personal experience to address potential knowledge gaps.	Early: Disembodied interviewing; history not targeted to a differential. Late: Decreased efficiency or organization within the electronic health record; difficulties recognizing importance of nursing updates or when to call consults.	• Generate differentials prior to seeing the patient to organize questions. • Limit number of reported labs or imaging to no more than five relevant facts promotes organized data collection and an increased ability to recognize salient information.
Hypothesis generation • Helps learners readily identify when to reorder their priorities and adjust, either in the process of patient care or during one's career.	Early: Inability to generate differentials beyond typical presentations of common problems or inappropriate focus on uncommon causes of common problems. Late: Inability to effectively toggle between pattern and analytical thinking; often manifests as anchoring bias.	• Targeted "what if" questioning to focus a learner on how specific details of a case may change the diagnosis ("What if the patient had a fever? What if the patient had lower extremity edema?"). • Specific recommendations to slow down and reflect on each potential diagnosis to ensure problems are comprehensively evaluated.
Problem representation • Promotes consistent reevaluation of one's current performance with opportunities to focus on improving performance over time.	Early: Inability to synthesize important details in the context of those that are extraneous; "cannot see the forest for the trees." Late: Difficulty linking appropriately identified details to clinical syndromes.	• Frequent reframing scenarios; trainees are asked to reassess the clinical scenario each time new information becomes available. • Challenges to generate "one-liners" to summarize the patient case after new data becomes available.

Reasoning domains and association with the Master Adaptive Learner model	Learner characteristics	Targeted coaching techniques
Knowledge organization • Promotes goal setting by reinforcing skills needed to search for information and consider new opportunities in the context of one's current knowledge.	Early: Cannot describe more than a few diagnoses or illness scripts, usually due to lack of prior clinical exposure. Late: Often described as disorganized; "running around with their head cut off."	• Focus on symptomatology rather than diagnosis provides a scaffold for learners to organize their knowledge. • Promotes the evaluation of clinical scenarios in the context of presenting symptoms as opposed to potential diagnoses.
Assessment and treatment • Develops self-reflection and critical reasoning skills that are necessary to determine if a trainee is progressing appropriately toward a specific goal.	Early: Cannot arrive at the correct diagnosis; Learner hesitancy due to lack of confidence or imposter syndrome. Late: Difficulty recognizing severity of illness or inability to generate an evaluation plan beyond the initial work-up; learner hesitance due to lack of confidence or imposter syndrome.	• Practical "if, then" scenarios that allow trainees to think beyond their initial management plans. • Ensuring safe spaces and supportive learning environments so trainees can experiment with their treatment strategies safely. • Simulation exercises can improve self-confidence.

It is important to remember that almost 40% of "struggling" GME-level learners have mental health conditions contributing to clinical performance deficits. Improving clinical performance often requires a separate assessment by an expert who recognizes and manages mental well-being and substance use disorders.[4] When coaching for remediation, this additional assessment should include questions regarding current and/or previous history of anxiety, depression, psychosocial stressors, cognitive impairment, and substance use.[4] If a mental health condition is diagnosed and a trainee is then linked to and engaged in appropriate care, dedicated clinical performance coaching in the clinical learning environment is more likely to succeed.

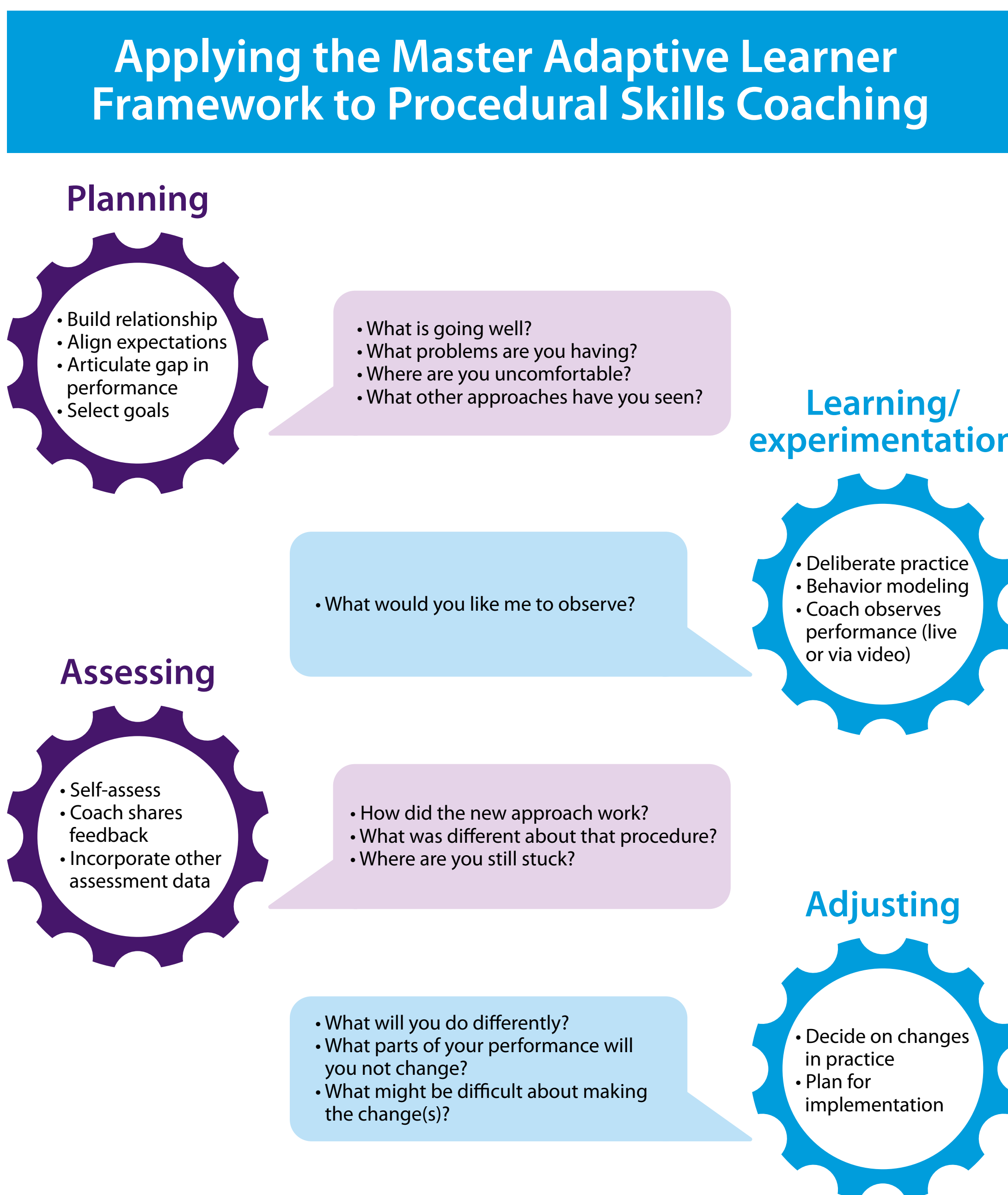
Coaching for procedural performance improvement

In many ways, coaching for procedural skill improvement is easier to conceptualize due to experience with sports, art, music, or similar pursuits. In procedural environments, coaching is composed of commitment by the learner to improve performance, goal setting, and feedback.[9] There is robust support for the benefits of this style of coaching on resident skill acquisition and retention.[9] This process of deconstructing tasks into steps, practicing these steps, and receiving targeted feedback works well for novice trainees. Following a period of direct observation, the coach then debriefs the procedure with the coachee, provides feedback on their performance, and sets goals for the next procedure. This deliberate practice style of coaching is also effective in improving non-technical domains, like periprocedural decision making, communication skills, and continuing professional development.[10]

As the coachee reaches a minimal amount of proficiency, coaching style can evolve to primarily facilitate the coachee's goal setting, reflection, and metacognition through questioning and supportive listening. Early in training, this is not feasible for either the coach or coachee. Novices must learn the basics of periprocedural tasks and steps of the procedure before they can set meaningful goals for improvement. Coaches must balance patient safety and efficiency with the coachee's needs for autonomy, so teaching is often more important than coaching early on. As a trainee's skills develop and they are granted progressive autonomy, coaching approaches should evolve from that of a "skills coach" to more of an "executive coach."[9]

As the coachee establishes foundational performance, they can reflect on aspects of their performance that they want to improve and ask for specific observation and feedback. At this point, coaching can be used to support the MAL model, like the steps outlined for coaching clinical performance (Figure 3-1).[11] During the planning step, the coach learns about the coachee and helps prioritize goals and strategies for improvement. The learning step for procedural skills might be better conceptualized as active experimentation or deliberate practice, where the coachee tries their planned approach; they may also observe experts performing the skill. In the assessing step, the coach guides reflection on the experience and shares feedback. This step is an ideal time for coaches and coachees to discuss other assessment data or performance evaluations if available. In the adjusting step, the coach asks questions to facilitate the coachee's plans for implementing change.

Figure 3-1: Master adaptive learning model in coaching for procedural skills improvement.



Coaching is a unique development tool designed to help trainees learn organically rather than being taught. Adopting these practices for performance improvement coaching will arm learners with the skills needed to become both independent and lifelong learners.

Take-home points

1. Performance improvement coaching is a form of development that focuses on an individual's ability to maximize their potential through self-reflection and personal responsibility.
2. Coaching to improve performance in graduate medical education often requires content expertise as trainees work to develop discrete skills in clinical and procedural domains.
3. Successful coaching conversations frame performance improvement as an opportunity for growth rather than a need for improvement.

References

1. Amabile T, Kramer S. *The progress principle: Using small wins to ignite joy, engagement, and creativity at work*. Harvard Business Press; 2011.
2. Bhavsar-Burke I, Dilly CK, Oxentenko AS. How to promote professional identity development and support fellows-in-training through teaching, coaching, mentorship, and sponsorship. *Clin Gastroenterol Hepatol*. 2022;20(10):2166-2169. doi:10.1016/j.cgh.2022.05.043
3. Klig JE, Stenson BA, Kivlehan SM, Jackson A, Berwick JR, Kosowsky JM. Twelve tips for practical clinical skills coaching. *Med Teach*. 2023;45(12):1357-1363. doi:10.1080/0142159X.2023.2220895
4. Hammoud MM, Deiorio NM, Moore M, Wolff M. *Coaching in Medical Education.* Elsevier; 2022.
5. Prochaska JO, DiClemente CC. Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*. 1982;19(3):276-288. doi:10.1037/h0088437
6. Eckhoff DO, Weiss J. Goal setting: A concept analysis. *Nurs Forum*. 2020;55(2):275-281. doi:10.1111/nuf.12426
7. Brooks JV, Istas K, Barth BE. Becoming a coach: experiences of faculty educators learning to coach medical students. *BMC Med Educ*. 2020;20(1):208. doi:10.1186/s12909-020-02119-z
8. Kalet A, Guerrasio J, Chou CL. Twelve tips for developing and maintaining a remediation program in medical education. *Med Teach*. 2016;38(8):787-92. doi:10.3109/0142159x.2016.1150983
9. Gagnon LH, Abbasi N. Systematic review of randomized controlled trials on the role of coaching in surgery to improve learner outcomes. *Am J Surg*. 2018;216(1):140-146. doi:10.1016/j.amjsurg.2017.05.003
10. Pradarelli JC, Pavuluri Quamme SR, Yee A, et al. Surgical coaching to achieve the ABMS vision for the future of continuing board certification. *Am J Surg*. 2021;221(1):4-10. doi:https://doi.org/10.1016/j.amjsurg.2020.06.014
11. Cutrer WB, Miller B, Pusic MV, et al. Fostering the development of master adaptive learners: A conceptual model to guide skill acquisition in medical education. *Acad Med*. 2017;92(1):70-75. doi:10.1097/acm.0000000000001323

Chapter 4: Professional and career development coaching

Jeremy Branzetti, MD, MHPE; Amalia M. Landa-Galindez, MD; Tracey Pickard, MSEd; and Kevin R. Scott, MD, MSEd

Chapter summary

Residency is the optimal time for professional development (PD) coaching, as it marks the transition from a highly structured, assessment-driven educational experience to the unstructured, self-monitored reality of an independent practicing physician. Coaching for PD differs from other forms of graduate medical education (GME) coaching (e.g., performance, well-being, or remediation) by its focus on cultivating both the long-term career goals and unique professional identity of the resident. When trainees identify their guiding values and purpose, they can set authentic personal and professional goals and identify concrete actions to achieve them. Done well, PD coaching allows trainees to make professional choices that align with personal values and professional identity. We recommend that PD coaches operate outside of the summative and hierarchical structures of the training program to ensure a psychologically safe environment for the growth-orientated PD coaching relationship.

Introduction to professional development coaching

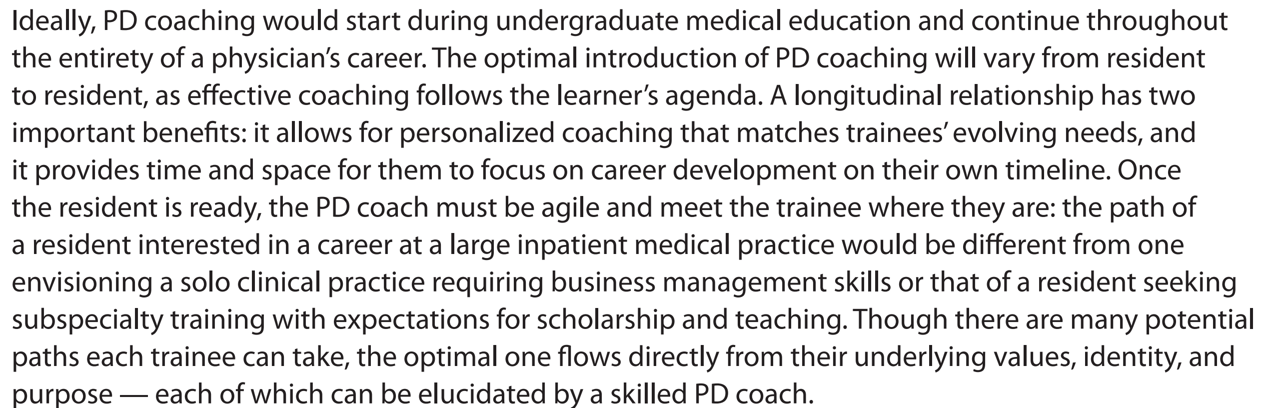
Professional development (PD) coaching is a nondirective partnership where the coach assists the trainee to align their purpose, personal goals, and values with their professional path. PD coaching can be instrumental in helping trainees develop an authentic professional identity. Initial work conceptualized professional identity development as the process wherein every medical student comes to "act as a physician."[1] Cruess et al. elaborated on how trainees internalized the characteristics, values, and norms expected of a physician.[2] Thus, effective learning and professional development require simultaneous construction of a unique and authentic professional identity. This identity does not develop in isolation, but rather in a dynamic manner through interaction with the learning environment, as described by Bandura's social cognitive theory.[3]

Vignette

Alumni feedback about a residency program consistently identified that many graduates left their first job after only one or two years. A coaching program was created to help empower residents to cultivate their own unique professional trajectories and identify opportunities that fit with their goals. Dr. Graves is core faculty, has been a clinical competency committee member for several years and has just volunteered to serve as a coach for the new program. They are meeting a new resident, Dr. Smith, for the first time. Dr. Graves has no formal coach training but has mentored a number of residents. Dr. Smith had early struggles related to clinical competency, but evaluations for the last six months suggest they have addressed their deficiencies. Dr. Smith has communicated concerns over the competitive nature of applying to fellowship, particularly because of their limited scholarly productivity and early clinical struggles. They request guidance with regards to next steps.

Thought questions:

1. Does Dr. Graves' prior mentorship experience sufficiently prepare them for coaching?
2. What principles can Dr. Graves use to guide a professional development coaching session for Dr. Smith?
3. How does Dr. Graves' experience on the residency clinical competency committee impact how they approach coaching this resident?



Ideally, PD coaching would start during undergraduate medical education and continue throughout the entirety of a physician's career. The optimal introduction of PD coaching will vary from resident to resident, as effective coaching follows the learner's agenda. A longitudinal relationship has two important benefits: it allows for personalized coaching that matches trainees' evolving needs, and it provides time and space for them to focus on career development on their own timeline. Once the resident is ready, the PD coach must be agile and meet the trainee where they are: the path of a resident interested in a career at a large inpatient medical practice would be different from one envisioning a solo clinical practice requiring business management skills or that of a resident seeking subspecialty training with expectations for scholarship and teaching. Though there are many potential paths each trainee can take, the optimal one flows directly from their underlying values, identity, and purpose — each of which can be elucidated by a skilled PD coach.

Relevance of professional development coaching to graduate medical education

Graduate medical education represents a significant transformation in the professional development of a young physician. Residents are leaving the highly organized medical school learning environment and entering a less-structured and at times chaotic workplace-based learning environment. Many will struggle with the adjustment to the daily demands of training, including long work hours, frequent rotation changes, unclear performance expectations, and increased responsibilities. There is often limited time or cognitive bandwidth for self-reflection and career planning; even high-functioning residents may struggle to address these important long-term strategic issues without a coach. Burnout rates during early residency can be greater than 80%.[4] Though coaching has excellent supportive evidence for mitigating burnout,[5] focusing only on at-risk trainees may neglect a significant percentage of those performing adequately but not to their full potential.[6]

PD coaching provides time and space for reflective discussions in a supportive environment. Residents often defer addressing deeper topics like personal values, career goals, or holistic growth and focus on the immediate need to develop clinical and technical skills. A longitudinal coaching experience can introduce trainees to important practices, such as reflective inquiry, curiosity, performance gap self-identification, and self-assessment, that will serve them throughout the arc of their professional career. Such activities can increase internal motivation, enhance trainee well-being, and may promote engagement at the program level. This dedicated time for reflection and planning may yield opportunities that may have otherwise been overlooked, increase communication, and foster relationships within the training environment. Coaching is also central to the development of master adaptive learners. The Master Adaptive Learner model includes informed self-assessment of personal strengths and weaknesses, adequately processing feedback, and formulating effective action plans for future success of the individual learner — all of which are intrinsic to professional development coaching.[7]

Key professional development coaching competencies and skills

The competencies and skills essential to PD coaching have significant overlap with those of performance-based coaching.[8] The process of PD coaching can be differentiated by a broader strategic approach (e.g., what is my professional identity?) rather than a specific tactical approach (e.g., skill acquisition or addressing a specific knowledge gap). The joint focus of both personal and career development highlights the broader lens required of PD coaching. A trainee who is able to cultivate self-awareness of their strengths, interests, and values and of their role within the health system is better able to identify opportunities for future roles, recognize barriers to continued growth, and plan for transitions. Another important distinction of PD coaching is that it is truly co-active. The coach

is not guiding or directing the trainee; the relationship is meant to be a partnership.[9] Therefore, the cultivation of coaching competencies and skills will yield a more effective coaching relationship, as coach and trainee work together to align values and passions with personal and career aspirations.

Principles and competencies for professional development coaching

We utilize the coaching domains as described by Wolff et al. as an organizational framework to better understand the competencies and skills required in PD coaching.[10]

Coaching structure and process

The purpose of PD coaching relationships needs to be clear to both coach and trainee. PD coaching meetings should be one-on-one, directed by the agentic trainee, and focus on personal growth that impacts the trainee's role and interaction within the greater professional context.[11] A trainee should drive the sessions while the coach should be responsible for maintaining the structure of the overall coaching process. Sessions should focus upon both personal and career development and build greater self-awareness of the trainee's core values and their alignment with current roles and future aspirations. The concept of Ikigai (Figure 4-1) may be a useful guide for coaches to use in these discussions. Ikigai encapsulates four domains: what you love, what the world needs, what you can get paid for, and what you are good at. Fulfillment in all four domains is optimal for professional fulfillment (Table 4-1).

Figure 4-1: The concept of Ikigai can be a useful method to help trainees discover their purpose. It encapsulates four domains (what you love, what the world needs, what you can get paid for, and what you're good at); fulfillment in all four domains is optimal for professional fulfillment.

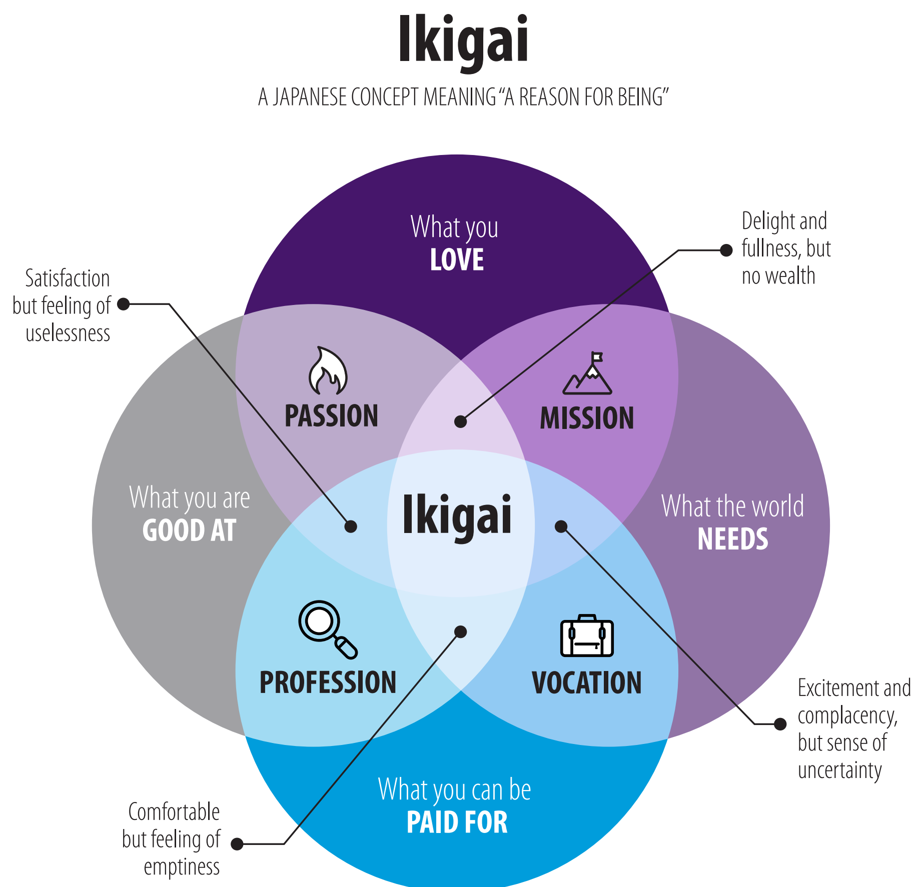


Table 4-1: Ikigai domains and relevant professional development questions for coaches

Coaching questions to help trainees discover their Ikigai. By working through these domains with a trainee, a coach can help them discover their *purpose*.	
Ikigai domain	**Relevant professional development questions**
What do you love?	• What kinds of tasks or activities energize you? • In what activities do you get completely immersed in and lose track of time? • If you could retire today, what would you do with your free time?
What are you good at?	• If you left your current job today, how would your colleagues, friends, and/or family praise you at your going-away party? • What skill or action do you approach with a lot of confidence? • What do people come to you for help with?
What does the world need?	• What one thing would you love to see improved in your community? • Who inspires you? Why? • What would the world be missing without you?
What can you get paid for?	• How important is salary to your future? • What does "making a good living" look like to you? • What major financial commitments (school loan, personal debt, family support, etc.) must you maintain for the foreseeable future?

Core competencies and skills

Extant coaching literature identifies core coaching competencies and relational skills necessary for fostering the meaningful, trust-based interaction at the center of a coaching relationship.[10,12] These competencies and skills should be the training focus of any PD coach (Table 4-2). Communication must be non-judgmental and nurturing of self-reflection, informed self-assessment, meaningful goal setting, and action/accountability plans in order for trainees to truly identify their unique personal trajectories.

Table 4-2. Essential competencies and skills for professional development coaching, adapted from: Kimsey-House H, Kimsey-House K, Sandahl P, Whitworth L. *Co-Active Coaching.* Fourth Edition. Quercus; 2018, and Wolff M, Deiorio N, Miller Juve A, Richardson J, et al. Beyond advising and mentoring: Competencies for coaching in medical education. *Med Teach.* 2021; 43(10): 1210-1213. doi:10.1080/0142159X.2021.1947479

Competency	Application	Example (Dr. Smith, trainee; Dr. Graves, coach)
Psychological safety	The coach should not have any supervisory or assessment capacity, so as to maintain a safe environment for discussion of current and future roles. Similarly, coaching discussions should be confidential.	Due to Dr Graves' explicit role as a career development coach for the trainees, they do not hold any trainee evaluation or assessment responsibilities. This ensures Dr. Smith is able to participate meaningfully in their coaching sessions without fear of disclosed information influencing their training program progress.

Competency	Application	Example (Dr. Smith, trainee; Dr. Graves, coach)
Accountability	Both parties are accountable to the processes and structure agreed upon at the outset. Coaches hold trainees accountable to progressing toward their desired goals. Stalled progress should alert the coach and trainee to examine the coaching relationship and if the original goals are still accurate.	Dr. Graves has noticed Dr. Smith is unprepared for coaching sessions and hasn't made much progress despite clear goals. Dr. Graves decides to begin their next coaching session by noting the stalled progress and revisiting the coaching agreement goals. Through open ended questioning and appreciative inquiry, Dr. Smith realizes their lack of preparedness stems from a personal barrier of fear of uncertainty and refines their goals to address and overcome this challenge.
Effective communication	Professional development coaching relies on a coach's ability to be attuned to verbal and nonverbal cues. Questioning should evoke awareness of the trainees' personal beliefs and values, how those fit into their current role within the broader context of an organization, profession, or society, and support them in creating actionable plans.	Dr. Smith struggles to self-identify tendencies that may impede growth within their medical career. Dr. Graves asks a powerful question: "What is an example of you feeling misunderstood by your colleagues or supervisors?" Through recounting a few examples, Dr Smith becomes aware of personal strengths and weaknesses affecting progress in their medical career.
Cultivates trust and safety through positive regard	The coach must hold the trainee in unconditional positive regard. They must feel secure and comfortable acknowledging perceived failures or shortcomings with the coach. This vulnerability is critical to deeper self-awareness and identifying desired future goals. The trainee should never be in the position of feeling the need to prove themselves worthy or conflate professional development coaching with summative assessment.	Dr Smith is not chosen to work on a project self-identified as very desirable for career advancement purposes. Dr. Graves praises Dr. Smith for taking a risk, causing Dr. Smith to feel comfortable sharing a personal performance deficit that likely contributed to this undesired outcome. Dr. Smith used the next coaching session to develop a plan to overcome this deficit in the future.
Empowerment	Empowerment is essential to any coaching relationship. Trainee empowerment yields the necessary self-efficacy and accountability to identify one's own values and, in turn, develop goals to work toward fulfilling them.	Dr. Graves observes that Dr. Smith is hesitant in setting clear goals related to their career development. Instead of offering guidance or suggestions, Dr. Graves focuses on questioning that allows Dr. Smith to develop insight into their goal-setting practices. As an added benefit, Dr. Smith applied this insight to refining other unmet goals and plans.

Skill	Application	Example
Powerful questions	Open-ended, neutral, short, non-leading questions prompt deeper responses. Aim for "What…" and "How…" questions (e.g., "What do you enjoy about doing research? How can you get a better understanding of a community practice job?); Avoid "Why" questions, as they often include an implied judgment that may prompt defensiveness (e.g., "Why haven't you tried…?")	Dr. Smith has an opportunity to participate in a highly desirable, but logistically challenging, elective clinical rotation with an underserved community. Dr. Graves asks, "how would this rotation help you honor your values?" Dr. Smith realizes the rotation resonates deeply with their core value of service and that regret from the missed opportunity would outweigh any time or effort needed to overcome the rotation's challenging logistics.
Self-managing	Coaches must manage the urge to advise trainees or "diagnose" their problems and avoid violating the trainee-driven focus of professional development coaching.	Dr. Smith relates a novel challenge to Dr. Graves, one that Dr. Graves quickly recognizes as familiar to their own early career experience. Dr. Graves avoids simply telling Dr. Smith how they had overcome the issue and instead focuses on asking open-ended questions to help Dr. Smith develop their own awareness and self-identified solution.
Reframing	Many instances of someone struggling to overcome a challenge in life come from failing to appreciate an alternative perspective on the issue. Helping a trainee develop a new perspective on a problem can lead to new insights and actions to overcome it.	Dr. Smith's family lives a considerable distance away. The demands of residency training have caused Dr. Smith to feel disconnected and question what drew them to a career in medicine. Dr. Graves utilizes powerful questioning allowing Dr. Smith to discover their ikigai (Table 4-1), which helps Dr. Smith reconnect to their core values and purpose in medicine.

Models

Models for PD coaching share common ground with positive psychology, which focuses on using an individual's strengths and character assets to build a satisfying life or career. A pilot study of PD coaching using positive psychology for internal medicine trainees resulted in increased time spent in personal reflection and decreased emotional exhaustion, a component of burnout.[6] Examples of other models that can be applied to PD coaching include GROW, Co-Active, appreciative inquiry, and SMART.[9,13,14,15] None are clearly superior; thus we recommend that a PD coach be familiar with any of these models. As the coach's ability expands, several models will be used interchangeably depending upon the needs of the trainee.

Coach development

The central purpose of PD coaching is to assist a trainee to achieve their unique personal and professional goals. As such, *experience in education or shared content expertise in a particular area of medicine is not required.*[16] Rather, the only requirement is the ability to use inquiry, curiosity, and effective listening to help the trainee reflect, develop new insights, and identify actionable goals. The bespoke nature of PD coaching makes assessment of the coaching experience a challenge, but a necessary one to inform continued growth as a coach. Indicators of PD coaching success may include improved quality and clarity of goals, ability of trainees to define their role within a

larger organizational context, and ability to identify and overcome barriers. It may also include improvements in any number of assessments of professionalism, goal attainment, and career satisfaction. Critical self-reflection, in addition to the trainees' perceived value in the coaching relationship, may help identify competencies and skills that require further development in order to obtain the greatest impact as a PD coach.

Professional development coaching in graduate medical education

As with all coaching, the optimal PD coaching session is brief, targeted, and future-focused. It starts with a specific topic, ends with a plan of action, and in between the coach uses powerful, open-ended questions to explore the topic and help the trainee develop meaningful insights. However, *there is no externally identified performance deficit or program requirement that the trainee must address;* it is entirely trainee-derived and driven. Thus, the range and application of PD coaching conversations are quite broad: choosing between employment offers, cultivating a specific niche over the next five years, an unending goal of "being the best doctor they can be," etc. (Table 4-3). What unites these disparate manifestations is that the trainee is driving the agenda, choosing the actions to be taken, and defining the markers of success.

Table 4-3: Prompts for common professional development coaching challenges

Potential challenges for residents	Prompts for further exploration
Fear that the path they want is unattainable, fear of failure	• What makes you think this is not possible? • Describe the ultimate, best outcome if there were no limitations. • Let's identify three small things you can attempt now. • Imagine you try this path, and it fails. What is the worst thing that would happen? What would you learn?
Rigid adherence to doing what they have always done	• What is a "moonshot" approach to this problem? • If you were to challenge yourself to try something new, what would you do? • Do you know someone who does this really well? What do you notice about what they do that is different from what you do?
Lack of honest self-awareness	• What are three of your strengths? • If you could wave a wand and instantly improve something about yourself, what would it be? • How do you think others perceive you? Do you agree with that perception? • How could you get more information about your performance?
Imposter syndrome	• Have you ever talked with anyone about feeling this way? • What objective feedback do you have about your performance? • Who could you trust to give you reliable and clear feedback? • What data could you collect to help you get an objective picture of your performance?
Lack of insight into performance	• How could you gain more insight into your performance? Could you record your performance live or in simulation? • Who could you anonymously survey for credible insight or feedback? • What feedback have you received that surprised or shocked you? Why?

Before the first session

The constructivist, values-driven journey of PD coaching starts by asking the trainee to identify a PD topic of their choosing prior to the session. This simple task prompts them to reflect upon what they want to get out of the session and reinforces their control, accountability, and agency in the PD coaching relationship. If they do not have a topic, consider rescheduling for another time when they do.

Though there are many important expectations for the coaching relationship (table 4-2), psychological safety deserves a specific focus. These sessions may arouse sensitive feelings, such as uncertainty that the trainee has chosen the right specialty or training program. They also may feel they don't deserve access to challenging career paths because of prior struggles in residency or other similar self-critical anecdotes. *We strongly recommend that PD coaches have no role in formally assessing the trainee or making summative decisions about their progress through the program.* If this is unavoidable, it is critical to be open and disclose this conflict of interest to the trainee at the outset.

During the session

Coaches should approach these relationships from a perspective that sees trainees as the foremost experts in their own lives. Coaches' roles are to be curious and explore through thoughtful questioning, metaphorically shining a light on a trainee's responses so they can be better seen, examined, and understood. Asking questions also demonstrates that the coach is fully present and listening. Nonverbal cues, such as the trainee's energy, vocal tone, or body language can provide valuable information. Energized speech about an interesting patient encounter or sinking into a chair when recalling a frustrating event may provide clues to a trainee's values. Silence is often important to allow time for reflection. Coaches' jobs are *to help trainees develop insights — not to provide answers, "diagnose" the problem, or find some objectively "right" solution.*

Between sessions

As with all other forms of coaching, the goal after a PD coaching session is for the trainee to address whatever action items they generated. Allow them space and time to process the coaching experience and work toward their goals. Residency challenges, such as time-intensive rotations, personal life struggles, or burnout can stall coaching progress. A good coach will maintain contact, champion trainee successes, stay patient with any setbacks, and be prepared to re-engage with the trainee when they are ready.

Barriers to professional development coaching

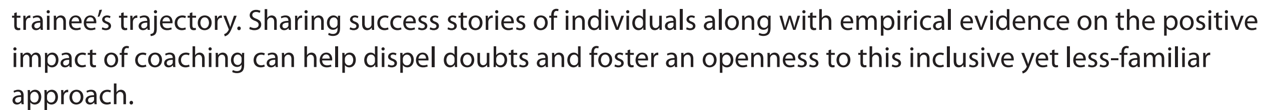
Several system-level factors threaten successful implementation of PD coaching. Addressing these barriers is crucial to unlock coaching's benefits. In addition, individual coaches sometimes struggle with initiating coaching conversations. Table 4-3 offers strategies to assist coaches in navigating these common coaching challenges.

Hierarchy and institutional culture

The hierarchical structure and prevailing institutional culture in medical training can discourage the vulnerability inherent to open engagement with coaching. In PD coaching, there are three particular barriers: the conflict of interest posed by coaching versus assessing a trainee, the common assumption that coaching is only for remediation, and the lack of acceptance of coaching as an essential part of trainee growth. One solution to address all three is: *Approach PD coaching with an ethos of coaching for compassion and growth and not for compliance.* This shift makes coaching interactions more comfortable, encourages psychological safety, and allows for genuine formative development discussions.

Resistance to change

Medical education often adheres to traditional teaching methods, leading to skepticism about novel approaches like coaching. Mentoring and advising are far more familiar and established, but those approaches rely on the expertise and opinions of the faculty, which might inappropriately influence a



trainee's trajectory. Sharing success stories of individuals along with empirical evidence on the positive impact of coaching can help dispel doubts and foster an openness to this inclusive yet less-familiar approach.

Lack of evaluation mechanisms

The lack of clear evaluation methods to determine returns on investment in coaching can deter health care professionals and institutions from embracing PD coaching. Furthermore, the longitudinal effect of PD coaching on career growth is difficult to capture in the short term, as tangible growth will continue years beyond the initial PD coaching engagement. Efforts are needed toward developing clear evaluation criteria aligned with desired coaching program outcomes. Individual programs could design comprehensive evaluations collaboratively, involving both coaches and participants at each institution. Such evaluation mechanisms can provide tangible evidence of coaching's benefits and encourage wider support.

Availability of professional development coaches

There is a scarcity of PD coaches who possess both clinical credibility and coaching skills. To address this, medical institutions should invest in comprehensive coach training programs for interested faculty who can in turn lead and champion the growth of coaching at their institution. Programs also may benefit from using coaches who are not clinicians. Coaches with diverse backgrounds encourage a wider lens and encourage thinking with a unique perspective without being beholden to dogmatic routines or biases within medicine. By nurturing a diverse pool of skilled PD coaches, the institution can ensure trainees receive tailored support that enhances their professional growth. Just as importantly, a coaching program does not always need to be a large, formal, stand-alone practice. Coaches can easily take advantage of already scheduled meeting opportunities to dedicate a few moments to coaching conversations. Integrating coaching into established workflows minimizes additional workload demands and builds a culture around coaching as the norm.

Conclusion

Professional development coaching empowers trainees to use their unique personal values, purpose, and skills to craft authentic professional goals and choose the necessary actions to achieve them. Residency training, which initiates the transition to specialty differentiation and independent practice, is the ideal time to initiate a PD coaching program. The optimal PD coaching relationship is psychologically secure, longitudinal, and empowering and exists outside of the formal assessment structures of the training program. PD coaching can be readily implemented into training programs and can lead to a cultural shift toward growth orientation within an institution.

Take-home points

1. There is no externally identified performance deficit or program requirement driving professional development coaching; its focus is entirely trainee-derived and driven.

2. Professional development coaching can help cultivate self-regulated learning, develop professional identity, build learner self-esteem, and mitigate burnout.

3. Undergirding all successful professional development coaching is an ethical, secure, and open coaching *relationship* that is complementary to, but outside of, the existing assessment mechanisms.

4. A PD coach should be present, curious, and focused on the trainee's relationship to their coaching topics, avoiding the urge to directly solve problems or provide personal opinions.

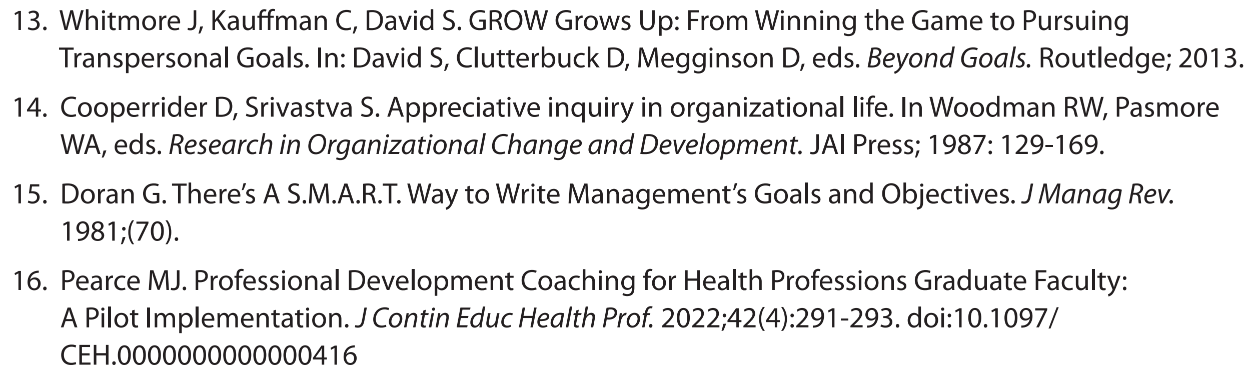
5. Effective coaching does not require experience in education or shared content expertise in a particular domain or specialty of medicine,

6. Approach PD coaching with an ethos of coaching for compassion and growth, and not for compliance.

7. Normalizing PD coaching within institutional culture is essential to sustainability and success.

References

1. Merton R, Reader G, Kendall P. The Student-Physician: *Introductory Studies in the Sociology of Medical Education.* Harvard University Press; 1957.
2. Cruess R, Cruess S, Boudreau J, Snell L, Steinert Y. Reframing medical education to support professional identity formation. *Acad Med*. 2014;89(11):1446-1451. doi:10.1097/ACM.0000000000000427
3. Bandura A. Social cognitive theory: An agentic perspective. *Annu Rev Psychol*. 2001;52:1-26. doi:10.1146/annurev.psych.52.1.1
4. Ripp J, Babyatsky M, Fallar R, et al. The incidence and predictors of job burnout in first-year internal medicine residents: a five-institution study. *Acad Med.* 2011;86(10):1301-10. doi:10.1097/ACM.0b013e31822c1236
5. Boet S, Etherington C, Dion PM, et al. Impact of coaching on physician wellness: A systematic review. *PLoS One.* 2023;18(2):e0281406. Published 2023 Feb 7. doi:10.1371/journal.pone.0281406
6. Palamara K, Kauffman C, Stone VE, Bazari H, Donelan K. Promoting success: A professional development coaching program for interns in medicine. *J Grad Med Educ.* 2015;7 (4): 630–637. doi:https://doi.org/10.4300/JGME-D-14-00791.1
7. Cutrer W, Miller B; Pusic M, et al. Fostering the development of master adaptive learners: A conceptual model to guide skill acquisition in medical education. *Acad Med*. 2017;92(1):p 70-75. doi:10.1097/ACM.0000000000001323
8. Love LM, Simonsen KA, Bowler C, Dallaghan GLB. Archetypes of coaching across the medical education continuum. *Acad Med.* 2021;96(12):1757. doi:10.1097/ACM.0000000000004169. PMID: 34010866
9. Kimsey-House H, Kimsey-House K, Sandahl P, Whitworth L. *Co-Active Coaching*. Fourth Edition. Quercus; 2018.
10. Wolff M, Deiorio N, Miller Juve A, et al. Beyond advising and mentoring: Competencies for coaching in medical education. *Med Teach.* 2021;43(10): 1210-1213. doi:10.1080/014215 9X.2021.1947479
11. Funck F. The Nuances of Coaching for Change vs. Coaching for Development. Center for Creative Leadership. Published September 16, 2020. Accessed March 21, 2024. https://www.ccl.org/articles/leading-effectively-articles/coaching-for-change-or-development/
12. The Gold Standard in Coaching | ICF - Core Competencies. International Coaching Federation. Accessed March 21, 2024. https://coachingfederation.org/credentials-and-standards/core-competencies



13. Whitmore J, Kauffman C, David S. GROW Grows Up: From Winning the Game to Pursuing Transpersonal Goals. In: David S, Clutterbuck D, Megginson D, eds. *Beyond Goals.* Routledge; 2013.
14. Cooperrider D, Srivastva S. Appreciative inquiry in organizational life. In Woodman RW, Pasmore WA, eds. *Research in Organizational Change and Development.* JAI Press; 1987: 129-169.
15. Doran G. There's A S.M.A.R.T. Way to Write Management's Goals and Objectives. *J Manag Rev.* 1981;(70).
16. Pearce MJ. Professional Development Coaching for Health Professions Graduate Faculty: A Pilot Implementation. *J Contin Educ Health Prof.* 2022;42(4):291-293. doi:10.1097/CEH.0000000000000416

Chapter 5: Coaching to promote well-being

Ronda Mourad, MD; Cloe Le Gall-Scoville, PhD; Magdalena R Scheer, MD; and Stephany Sanchez, MD

Chapter summary

This chapter discusses ways coaching can promote well-being in graduate medical education. Coaching empowers learners to focus on topics within their control when creating personalized health and well-being goals, including those related to work-life integration. We introduce a framework outlining multiple dimensions of well-being, as well as challenges commonly encountered during training that threaten well-being within each dimension. We explore specific examples of how coaching can enhance well-being, focusing on professional identity formation, time management, and mental well-being and resilience. Within each of these areas, we present coaching tools to address common challenges faced by trainees and discuss their practical applications to help learners reflect and solve their own problems.

Introduction

The Accreditation Council for Graduate Medical Education Common Program Requirements instruct training programs to commit to the well-being of all health care team members. Well-being is often discussed in the context of the absence or prevention of burnout or illness. However, well-being includes multiple facets within one's personal and professional life such as resilience, a sense of purpose, and cultivating meaningful relationships, among many others. By providing opportunities to reflect, explore possibilities, envision ideal outcomes, and grow in a judgment-free space, coaching can help residents achieve a variety of well-being goals because the trainee creates the agenda based on their individualized needs, desires, values, intrinsic motivators, and long-term vision.

Coaching has been shown to reduce emotional exhaustion and burnout symptoms as well as improve elements of well-being, quality of life, and resilience in physicians.[1-5] It also reduces symptoms of imposter syndrome and increases self-compassion in female residents.[6] A

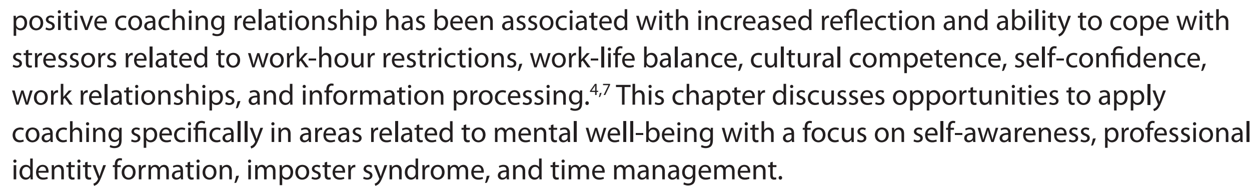
Vignette

Lisa is a first-year resident who meets regularly with her coach, Dr. Rizzo. Lisa has always considered herself a happy person, however since starting intern year she is rarely happy and cries often. She has not found joy in her clinical experiences, sometimes feels frustration toward her patients, and is profoundly saddened by her newfound exposure to death, violence, and human suffering.

The residency program is located in a new city, far from her home. In addition to clinical challenges, Lisa is adjusting to her new life as a resident, concerned about financial strain, and struggling with time constraints preventing her from doing the extracurriculars she used to enjoy. Most recently, Lisa is grappling with her role in an adverse patient outcome and begins crying during a lecture.

Thought questions:

1. What can Dr. Rizzo do to create a safe space for Lisa to work through her challenges?
2. What coaching tools can Dr. Rizzo use to help Lisa identify solutions to these challenges?
3. What are the limitations of coaching in this situation and when should Dr. Rizzo refer Lisa to mental health resources?



positive coaching relationship has been associated with increased reflection and ability to cope with stressors related to work-hour restrictions, work-life balance, cultural competence, self-confidence, work relationships, and information processing.[4,7] This chapter discusses opportunities to apply coaching specifically in areas related to mental well-being with a focus on self-awareness, professional identity formation, imposter syndrome, and time management.

A holistic approach to well-being

Occupational (e.g., work-home interference) or individual (e.g., coping styles) factors may be associated with physician burnout,[8-12] including a lack of autonomy (e.g., hierarchy in decision-making) or sense of control during training (e.g., non-negotiable income, schedule requirements). Examples of common challenges encountered during graduate medical education are included in Figure 5-1. While many challenges during training are outside of the learner's control (e.g., program requirements, duty hour regulations, adhering to hospital policies and insurance regulations), coaching empowers learners to reframe challenges, medical errors, or perceived failures with a growth mindset and self-compassion and helps them shift their focus toward goal-driven interventions that are within their control.

Some threats to well-being may be especially pertinent for trainees based on personal identity (e.g., gender identity, racial or ethnic background), including microaggressions, stereotype threat, and imposter syndrome. Coaching can be an effective resource to help learners manage any of these challenges because it is personalized, grounded in empathetic listening, avoids assumptions through open questions, fosters a judgment-free space for reflection, and prioritizes goals chosen by the trainee. For a deeper discussion of these topics, please refer to Chapter 7.

The eight dimensions of wellness adapted by the Substance Abuse and Mental Health Services Administration[13] (Figure 5-1) provide a useful framework to help learners consider a holistic approach to well-being. The trainee identifies and prioritizes these aspects of well-being based on their personal values and needs, which may change over time. Coaches can offer trainees reflection tools, such as worksheets,[14] to support this process.

Professional identity formation

A meaningful work and training experience is vital to professional well-being. Coaching to promote well-being is anchored in cultivating a sense of belonging and purpose and deliberate identity development.[15] Forming a professional identity, an internalized representation of oneself as a physician, is an iterative process that evolves over time.[16] Forming a resilient professional identity requires an understanding of oneself, the ability to reframe challenges, and the tools to counteract negative self-perceptions.

Figure 5-1: Common challenges to well-being dimensions during graduate medical education training

The components within each domain are unique to the individual and prioritization of components may change over time. Some items may affect multiple domains (e.g., financial debt may hinder one's ability to engage in certain social engagements and may contribute to emotional distress).

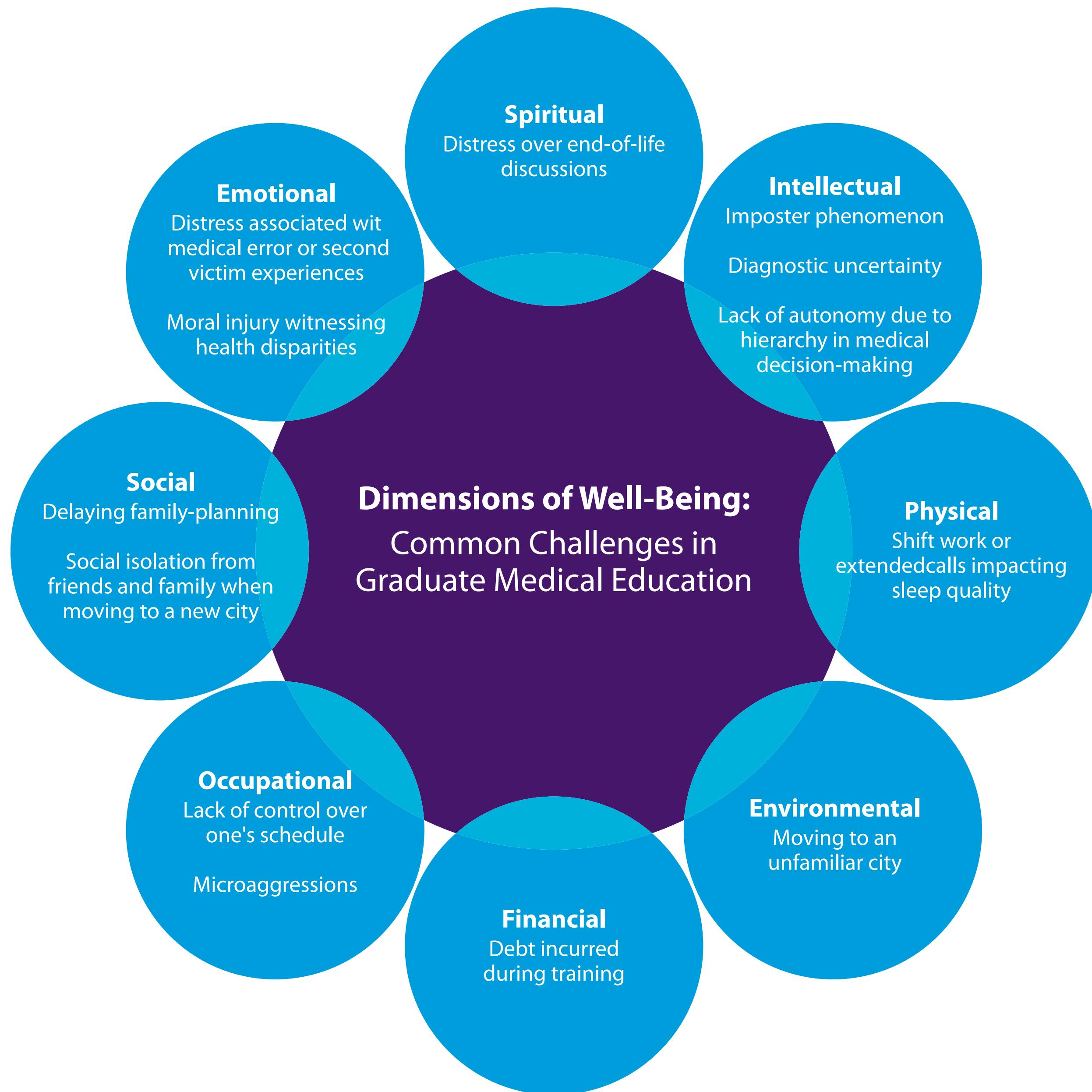


Figure adapted from Substance Abuse and Mental Health Services Administration. Creating a Healthier Life: A Step-by-Step Guide to Wellness. Published April 2016. Accessed March 21, 2024. https://store.samhsa.gov/product/Creating-a-Healthier-Life/SMA16-4958

Coaches can help trainees recognize how these principles actively shape the formation of a resilient professional identity. Two fundamental aspects of coaching for well-being involve cultivating a profound sense of belonging and an unwavering sense of purpose.[15] Actively encouraging self-reflection as a foundational step in identity formation helps trainees align their fundamental beliefs and values with a long-term vision. This ensures that their intrinsic motivators are engaged and that short-term goals align with broader aspirations.

Addressing challenges that undermine a sense of purpose or belonging, such as existential burnout and imposter syndrome, is important. Existential burnout, described as a loss of meaning in medicine and uncertainty in the professional role, can pose a significant threat to well-being during residency training. Reconnecting with one's professional identity formation can help trainees recover from or avoid recurrence of burnout.[17] A coaching approach supports trainees in navigating these complex emotions and finding ways to reconnect with their passion for medicine.

Imposter syndrome, sometimes called imposter phenomenon, is a common experience in residency training that can contribute to burnout.[18] Coaching to mitigate and address imposter syndrome focuses on offering positive self-perception tools to counteract self-doubt and a framework for reframing challenges. Table 5-1 presents illustrative scenarios in which residents may be experiencing existential burnout or imposter syndrome, tools coaches can consider using in each scenario, and examples of how to apply these tools in practice.

Narrative techniques, such as writing about a positive work experience, can enhance the process of professional identity formation in the context of well-being.[15] In our vignette, Dr. Rizzo could suggest this approach to Lisa to assist her in exploring the integration of her personal identity with her professional one. By nurturing self-awareness, reframing challenges, and offering tools and techniques as described in Table 5-1, coaching can help trainees form resilient professional identities that support well-being.

Table 5-1: Addressing threats to well-being in professional identity formation — examples, tools, and applications

Professional identity formation concern	Trainee experience example	Tool/technique	Example application
Existential burnout	A resident expresses that they don't think medicine is right for them, and they are thinking of quitting residency.	**Professional Identity Essay (PIE) (modified for use in medicine):** Encourages trainees to explore their understanding of professionalism at their current developmental stage and how that relates to shaping their professional identity Engages trainees in self-assessment, reflection, and goal setting	**Ask the resident to write a reflection on the following (excerpt of the 9 PIE prompts):** 1. What does being a member of the medical profession mean to you? How did you come to this understanding? 2. What do you expect of yourself as you work toward becoming a full-fledged physician? 3. What will the profession expect of you?

Professional identity formation concern	Trainee experience example	Tool/technique	Example application
Imposter syndrome	An early 2nd year resident transitioning to a senior role meets for a coaching check-in. She feels unprepared and nervous for this new role.	**Modified Values in Action (VIA) Inventory of Strengths:** An exercise to help trainees recognize, appreciate, and apply individual strengths and personal values	Remind the resident it is easy to identify their weaknesses but challenging to name their strengths. Using the VIA, ask them what they identify as their unique strengths. Encourage the trainee to think of examples of how they have applied their strengths in recent rotations. Ask them to describe a challenge and how they can use their strengths to create a new perspective on this challenge.
Imposter syndrome	An intern is struggling with organization of their oral presentations. They were given constructive feedback from the attending after rounds last week. The intern feels inadequate, out of place, and like they are a terrible doctor. This has led them to withdraw during rounds.	**CTFAR model:** A metacognitive model that proposes that thoughts about a circumstance produce feelings, which generate actions, and actions determine results Helps learners reframe their thoughts, therefore impacting their feelings, actions, and ultimately, their results **C**ircumstances (a neutral fact) **T**houghts (a malleable interpretation of the circumstance) **F**eelings (an emotional response to the thought) **A**ctions (the subsequent behavior) **R**esults (the outcome)	Ask the intern to reflect on each component of the CTFAR model to recognize what is and isn't in their control. First, ask them to identify the **circumstance** (receiving feedback), and their initial **thought** (I'm a terrible doctor). Emphasize that thoughts are malleable and are what lead to the **feeling** (inadequacy), which can influence the **action** (avoidance). The coach helps reframe the initial thought into "my presentations need more structure." This new thought can alter the prior feeling, generating a growth-oriented **action** (deliberate practice on oral presentations) and an improved **result** (organized presentations).

Table 5-1 references:

- **PIE:** Kalet A, Buckvar-Keltz L, Harnik V, et al. Measuring professional identity formation early in medical school. *Med Teach.* 2017;39(3):255-261. doi:10.1080/0142159X.2017.1270437
- **Modified VIA:** Palamara K, Kauffman C, Stone VE, Bazari H, Donelan K. Promoting Success: A professional development coaching program for interns in medicine. *J Grad Med Educ.* 2015;7(4):630-637. doi:10.4300/JGME-D-14-00791.1
- **CTFAR:** What is the get coached model? The Life Coach School. Accessed March 21, 2024. https://thelifecoachschool.com/self-coaching-model-guide/

Time management

Effective time management is central to physician well-being because it allows physicians to focus on meaningful aspects of work and ensures time for valued aspects of life outside of work. Ineffective time management can lead to burnout if residents stay late or take work home.[19] One of the challenges of residency that most impacts well-being is a lack of control over one's schedule. It is common for residents to give up habits and hobbies that they previously felt they had time and energy for, leading to a decrease in well-being. This leads to a natural grieving process that coaching can support, and coaches can use this opportunity to identify trainees' values and priorities. Additionally, the increased cognitive load experienced during residency can lead to decision fatigue and a lack of attention paid to self-care.[20]

Coaching for time management focuses on supporting trainees to develop individualized habits, routines, and systems that ultimately support their well-being. Coaching should focus on the core principles of time management and how trainees can adapt them to suit their specific circumstances. Establishing efficient routines and workflows during residency can make training a more positive experience overall and lay a foundation for a sustainable career.[20]

Coaching can help trainees clarify what items (including what portions of their schedule) are within their control and create actionable goals accordingly, rather than focusing on issues outside their control. For example, Dr. Rizzo from our vignette can help Lisa identify times when she might still be able to engage in extracurriculars, even if her engagement will be less or look different than it did previously. Additionally, coaches can encourage trainees to consider ways that they might optimize workflow and identify pockets of time at work and at home when they could be completing certain tasks. Through coaching, trainees can develop planning habits and have an accountability partner as they learn to manage their tasks and projects to completion with reduced stress and anxiety. Table 5-2 gives examples of time management challenges commonly faced by trainees, including prioritization, project management, task management, and procrastination, as well as tools to address these challenges.

Table 5-2: Addressing threats to well-being due to time management — examples, tools, and applications

Time management concern	Trainee experience example	Tool/technique	Example application
Prioritization	A trainee maintains a long to-do list but isn't sure where to start, leading to important tasks being neglected and poor self-care.	**Eisenhower Decision Matrix** (see Table 5-3)**:** A framework for prioritizing tasks and deciding what order to complete them in, if at all	Ask the trainee to map their to-do list onto the priority matrix. With practice, eventually the matrix can be deployed mentally.
Project management	A trainee is struggling with a research project and not making much progress.	**Project tracker:** A tool to manage projects, ranging from simple to more complex such as paper planners, digital calendars, or digital project management applications	Help the trainee break out the project into more manageable tasks and block time in their schedule to complete each task.

Time management concern	Trainee experience example	Tool/technique	Example application
Task management	A trainee is behind on their outpatient in-box during an in-patient rotation, leading to increased stress and avoidance.	**Schedule blocking:** A planning activity where time for a task is identified and put on a calendar	Ask the trainee to identify times in their schedule when it would make sense to look at the outpatient in-box. Ask about their in-box workflow and help them design a more efficient workflow (e.g., if a message takes five minutes or less to respond, do so immediately).
Procrastination	A trainee has a study plan but is having challenges doing practice questions when they planned to, leading to feelings of guilt and anxiety.	**Formula for focus activity:** An activity where the trainee reflects on what hinders and helps their ability to focus	Help the trainee identify times when they were successfully able to study and times when they weren't and plan how to enact their formula for focus in the upcoming weeks.

Table 5-3: Sample Eisenhower Decision Matrix for medical trainees

	Important/highly valuable	Less important
Urgent/time sensitive	**Do first:** • Finalize slides for tomorrow's grand rounds presentation • Review inpatient lab results • Write prescription for patient being discharged today • Complete operative report in medical record • Address water leak in kitchen	**Decide whether to do, schedule, or delegate:** • Reply to routine outpatient messages while on inpatient rotation (schedule) • Print handouts that are already available online for today's teaching session (don't do) • Arrange follow up appointment after a patient's discharge (delegate if possible) • Write jury duty excuse letter (delegate if possible) • Check today's routine emails (schedule)
Less urgent	**Schedule:** • Fellowship application due in three months • Conference proposal due in one month • Write abstract for journal submission • Complete question-bank for next year's board exam • Meet with mentor for routine feedback • Schedule routine dental cleaning	**Delay or consider not doing:** • Reply to certain personal emails • Volunteer work that does not add value or joy • Drop off donation box • Reorganize closet • Complete optional survey request that was sent to all residency programs

Table adapted from:

- Gordon CE, Borkan SC. Recapturing time: a practical approach to time management for physicians. *Postgrad Med J*. 2014;90(1063):267-72. doi:10.1136/postgradmedj-2013-132012
- Covey SR. *The Seven Habits of Highly Effective People.* Simon & Schuster; 1989.

Mental well-being and resilience

Some trainees may focus solely on academic performance and may be resistant to consider their mental well-being, even if such an approach is threatening their academic performance or putting them at risk of harm. This can occur for many reasons, including interpreting altruism to mean prioritizing all patient needs above their own at any cost. Furthermore, stigma around seeking help for mental illness exists among medical learners, with concerns that disclosure could impact one's career trajectory.[21,22]

One model of physician well-being comprises three domains: institutional wellness culture, efficiency in practice environments, and personal resilience.[23] While many well-being interventions focus solely on the physician's responsibility to improve their well-being or burnout risk, this model acknowledges a shared responsibility with health care systems and leadership to improve sources of burnout external to the individual physician. Although systems-level solutions are likely outside the scope of coaching, coaching can help trainees change what is within their control, including developing personal resilience or improving self-care practices.

Figure 5-2: Conceptual model of resilience in residents

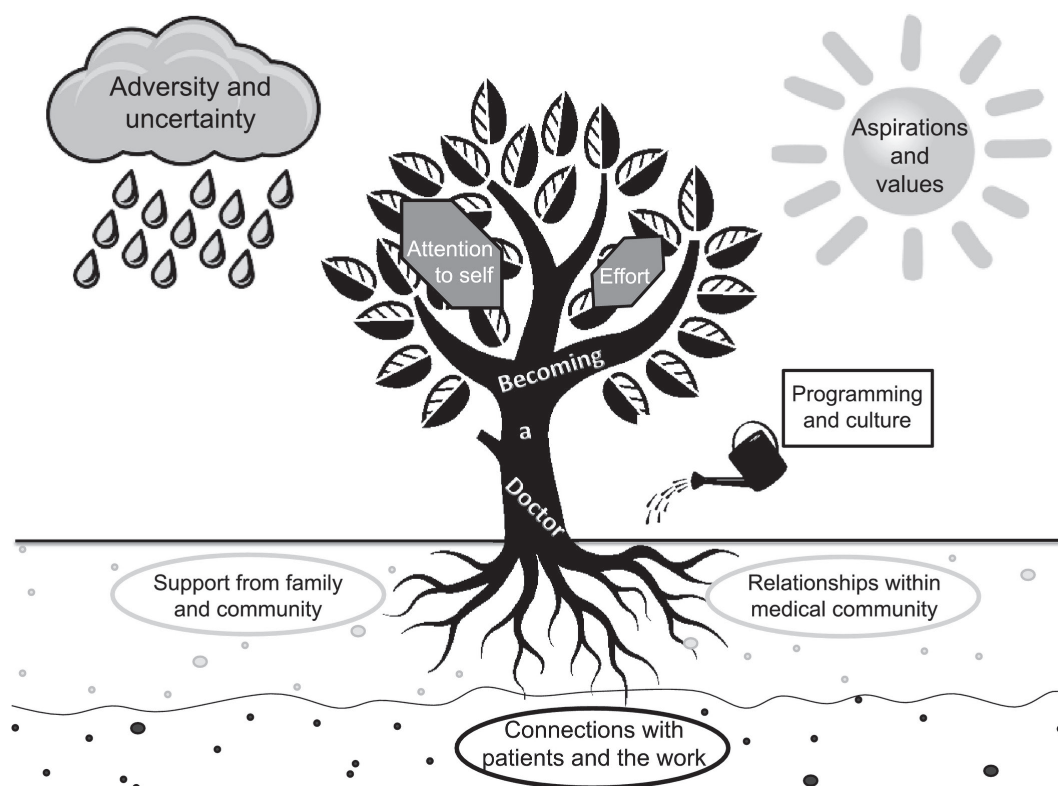


Image reprinted with permission from Winkel AF, Robinson A, Jones AA, Squires AP. Physician resilience: a grounded theory study of obstetrics and gynaecology residents. Med Educ. 2019;53(2):184-194. doi:10.1111/medu.13737

Resilience is considered by some to be a transformative process throughout residency, closely linked to professional identity formation and influenced by a trainee's engagement with their personal and professional context.[24] As such, strengthening one's resilience may be amenable to coaching via learning and deliberately practicing new skills. Coaches can also help trainees reframe setbacks

or obstacles with self-compassion and a growth-mindset. One conceptual model that has been successfully applied to decrease burnout in OBGYN residents nationally depicts resilience as a tree.[25] The tree weathers storms of adversity and uncertainty, with roots in family and community values and support systems and branches stretching toward aspirations (Figure 5-2).[24] While adversity and uncertainty create challenges, these challenges drive personal reflection and redirection, thereby cultivating resilience. Coaches can apply the model by encouraging trainees to create their own resilience trees, prompting self-reflection on their individual calling to medicine, support systems and role models, aspirations, coping mechanisms, and challenges.

Applying this model to our vignette, Dr. Rizzo could help Lisa ground herself by aligning her behaviors with her values (sun), develop or strengthen her connections in the medical community (roots), reconnect with her existing support systems (roots), and re-invigorate her previously developed self-care and coping mechanisms (leaves), such as physical exercise.

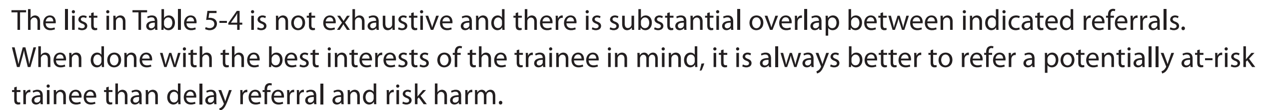
Screening and referrals

Inherent to coaching is the goal of empowering trainees to leverage their strengths to solve their own problems, rather than the coach advising or solving their problems. One of the coach's roles is to set and model appropriate boundaries for the coaching relationship. For example, a coach is not the trainee's friend, adviser, therapist, or doctor. Even if well-intended, stepping out of the coach role could stunt the trainee's growth and ability to achieve self-efficacy. Furthermore, a coach's failure to recognize a learner in need of referral to a third party for urgent medical or psychiatric evaluation could lead to serious harm for the trainee and/or others.

There are multiple scenarios when a coach should refer their trainee to other resources. These include suspicion of psychological distress, psychiatric illness, medical illness, or an undiagnosed learning disability (Table 5-4). For psychiatric or psychological concerns, coaches should be aware of their program's mental health resources, including urgent and emergent access to psychiatrists and access to affordable counseling. If a coach has a concern about risk of self-harm to the trainee or risk of harm to others (including patients), a coach should break confidentiality and escalate to program leadership or the emergency response system, depending on the urgency of the concern.

Table 5-4: Potential warning signs: When to refer for psychiatric, psychological, medical, or learning disability evaluation

- Feelings of hopelessness, depression, or anxiety; extreme mood swings
- Thoughts of harming self/others
- Expressing paranoid or delusional thoughts
- Social isolation
- Poor hygiene/disheveled appearance
- Repeated tardiness; not showing up for scheduled shifts
- Significant change in sleep patterns
- Illicit substance use/excessive use of recreational substances
- Excessive crying or inappropriate displays of anger
- Engaging in high-risk behaviors or legal trouble
- Abrupt behavioral or personality changes
- New medical symptoms such as (but not limited to) fevers, rapid weight fluctuation, palpitations, excessive sleep, insomnia
- Difficulty with organization or workflow (e.g., incohesive notes; staying excessively later than peers)
- Not completing required tasks



The list in Table 5-4 is not exhaustive and there is substantial overlap between indicated referrals. When done with the best interests of the trainee in mind, it is always better to refer a potentially at-risk trainee than delay referral and risk harm.

In our vignette, Dr. Rizzo should screen Lisa for mental health risks and consider referrals to counseling services and/or a psychiatrist for evaluation based on the screening results. Even if a referral becomes necessary, this need not sever the coaching relationship, so long as there is still a foundation of trust between the coach and trainee. Coaching continues to be important, as many challenges remain in the coach's purview, including helping Lisa identify important lessons from her patient's adverse outcome and reflect on her role in the patient's course.

Conclusion

Graduate medical education is accompanied by many changes and challenges, requiring successful trainees to be adaptable, resilient, and growth-oriented. Coaching offers trainees a judgment-free space to reflect, practice self-compassion, and design goals that are based on individualized strengths, motivators, and values. By engaging personal values and intrinsic motivators, trainees can learn to align their behaviors with their long-term vision. Through reflection exercises and coaching tools, trainees can reframe challenges into growth opportunities, develop resilient professional identities and strong support systems, discover joy and meaning in their work, and cultivate effective time management skills to improve their health and well-being for a successful and sustainable future in the medical profession.

Take-home points

1. Studies have shown that coaching can reduce burnout, increase well-being, improve coping, and promote quality of life for physicians. Learners can create goals pertaining to any dimension of well-being based on their individualized values, desired outcomes, and intrinsic motivators.

2. Reflection techniques can be pivotal in trainees' professional identity formation. Coaches can help residents identify meaningful aspects of their work and reframe their cognitive processes when their sense of belonging is threatened.

3. Effective coaching on time management can enhance learner well-being by improving work satisfaction. Better time management skills can help residents find time to recuperate from work-related stress and prioritize restorative or joyful experiences both inside and outside of work.

4. Coaching can help residents build resilience and coping skills through reflecting on their experiences, identifying growth opportunities during challenging times, and reconnecting with positive influences in their personal and professional environments.

5. Coaches should maintain professional boundaries, be prepared to screen for mental health concerns, and utilize suitable referral systems when needed.

References

1. McGonagle AK, Schwab L, Yahanda N, et al. Coaching for primary care physician well-being: A randomized trial and follow-up analysis. *J Occup Health Psychol.* 2020;25(5):297-314. doi:10.1037/ocp0000180
2. Dyrbye LN, Shanafelt TD, Gill PR, Satele DV, West CP. Effect of a professional coaching intervention on the well-being and distress of physicians: A pilot randomized clinical trial. *JAMA Intern Med.* 2019;179(10):1406-1414. doi:10.1001/jamainternmed.2019.2425
3. Dyrbye LN, Gill PR, Satele DV, West CP. Professional coaching and surgeon well-being: A randomized controlled trial. *Ann Surg.* 2023;277(4):565-571. doi:10.1097/SLA.0000000000005678
4. Palamara K, Chu JT, Chang Y, et al. Who benefits Most? A multisite study of coaching and resident well-being. *J Gen Intern Med.* 2022;37(3):539-547. doi:10.1007/s11606-021-06903-5
5. Palamara K, McKinley SK, Chu JT, et al. Impact of a virtual professional development coaching program on the professional fulfillment and well-being of women surgery residents: A randomized controlled trial. *Ann Surg.* 2023;277(2):188-195. doi:10.1097/SLA.0000000000005562
6. Fainstad T, Mann A, Suresh K, et al. Effect of a novel online group-coaching program to reduce burnout in female resident physicians: A randomized clinical trial [published correction appears in JAMA Netw Open. 2022 Jun 1;5(6):e2220348]. *JAMA Netw Open.* 2022;5(5):e2210752. Published 2022 May 2. doi:10.1001/jamanetworkopen.2022.10752
7. Palamara K, Kauffman C, Chang Y, et al. Professional development coaching for residents: Results of a 3-year positive psychology coaching intervention. *J Gen Intern Med.* 2018;33(11):1842-1844. doi:10.1007/s11606-018-4589-1
8. Dyrbye L, Shanafelt T. A narrative review on burnout experienced by medical students and residents. *Med Educ.* 2016;50(1):132-149. doi:10.1111/medu.12927
9. West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. *JAMA.* 2011;306(9):952-960. doi:10.1001/jama.2011.1247
10. Ishak WW, Lederer S, Mandili C, et al. Burnout during residency training: a literature review. *J Grad Med Educ.* 2009;1(2):236-242. doi:10.4300/JGME-D-09-00054.1
11. Prins JT, Gazendam-Donofrio SM, Tubben BJ, van der Heijden FM, van de Wiel HB, Hoekstra-Weebers JE. Burnout in medical residents: a review. *Med Educ.* 2007;41(8):788-800. doi:10.1111/j.1365-2923.2007.02797.x
12. Howlett M, Doody K, Murray J, LeBlanc-Duchin D, Fraser J, Atkinson PR. Burnout in emergency department healthcare professionals is associated with coping style: a cross-sectional survey. *Emerg Med J.* 2015;32(9):722-727. doi:10.1136/emermed-2014-203750
13. Substance Abuse and Mental Health Services Administration. Creating a Healthier Life: A Step-by-Step Guide to Wellness. Published April 2016. Accessed March 21, 2024. https://store.samhsa.gov/product/Creating-a-Healthier-Life/SMA16-4958.
14. Carepatron. 8 Dimensions of Wellness Worksheet. Published February 27, 2024. Accessed March 21, 2024. https://www.carepatron.com/templates/8-dimensions-of-wellness-worksheet
15. Toubassi D, Schenker C, Roberts M, Forte M. Professional identity formation: linking meaning to well-being. *Adv Health Sci Educ Theory Pract.* 2023;28(1):305-318. doi:10.1007/s10459-022-10146-2

16. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. Reframing medical education to support professional identity formation. *Acad Med.* 2014;89(11):1446-1451. doi:10.1097/ACM.0000000000000427
17. Abedini NC, Stack SW, Goodman JL, Steinberg KP. "It's not just time off": A framework for understanding factors promoting recovery from burnout among internal medicine residents. *J Grad Med Educ.* 2018;10(1):26-32. doi:10.4300/JGME-D-17-00440.1
18. Liu RQ, Davidson J, Van Hooren TA, Van Koughnett JAM, Jones S, Ott MC. Impostorism and anxiety contribute to burnout among resident physicians. *Med Teach.* 2022;44(7):758-764. doi:10.1080/0142159X.2022.2028751
19. Pitre C, Pettit K, Ladd L, Chisholm C, Welch JL. Physician time management. *MedEdPORTAL*. 2018;14:10681. Published 2018 Feb 14. doi:10.15766/mep_2374-8265.10681
20. Gordon CE, Borkan SC. Recapturing time: a practical approach to time management for physicians. *Postgrad Med J.* 2014;90(1063):267-272. doi:10.1136/postgradmedj-2013-132012
21. Dyrbye LN, Eacker A, Durning SJ, et al. The impact of stigma and personal experiences on the help-seeking behaviors of medical students with burnout. *Acad Med.* 2015;90(7):961-969. doi:10.1097/ACM.0000000000000655
22. Haque OS, Stein MA, Marvit A. Physician, heal thy double stigma - doctors with mental illness and structural barriers to disclosure. *N Engl J Med.* 2021;384(10):888-891. doi:10.1056/NEJMp2031013
23. Bohman B, Dyrbye L, Sinsky CA, et al. Physician well-being: The reciprocity of practice efficiency, culture of wellness, and personal resilience. *NEJM Catalyst.* 2017;3(4). doi:10.1056/CAT.17.0429
24. Winkel AF, Robinson A, Jones AA, Squires AP. Physician resilience: a grounded theory study of obstetrics and gynaecology residents. *Med Educ.* 2019;53(2):184-194. doi:10.1111/medu.13737
25. Winkel AF, Tristan SB, Dow M, et al. A National Curriculum to Address Professional Fulfillment and Burnout in OB-GYN Residents. *J Grad Med Educ.* 2020;12(4):461-468. doi:10.4300/JGME-D-19-00728.1

Chapter 6: Coaching the resident with concerns about unprofessional behavior

Sarah R. Williams, MD, MHPE; Priya G. Jain, MD, MEd; Simran Singh, MD; and Nell Maloney Patel, MD

Chapter summary

In this chapter, we tackle the complex topic of coaching at-risk residents with concerns of unprofessional behavior, as well as outline systems that should be in place to support trainees, coaches, and programs to be successful in this domain. We include a definition of professionalism, the importance of goal alignment, and the development of processes that help ensure trainees and faculty share a mental model of what success looks like. We also address common pitfalls in coaching for this specific purpose and how to avoid them. Lastly, we explore what may happen next if the process does not succeed.

Vignette

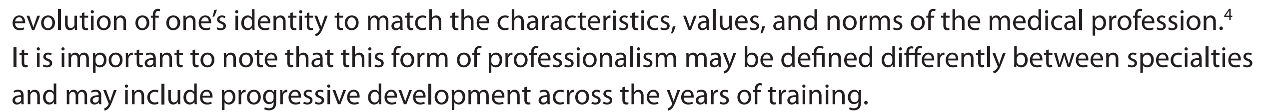
You have been asked to serve as a coach for a second-year resident who is dealing with "professionalism" and "insight" issues. The program leadership team is hoping that, with your help, this trainee can avoid being placed on a formal remediation plan. You are motivated to assist, and you recognize that this could be a complex scenario to navigate.

Thought questions:

1. How are "professionalism" and "insight" issues defined in this circumstance?
2. How will the resident demonstrate success throughout this process?
3. What is the shared understanding of the rationale for your involvement and the implications for the resident, the program, and you in this situation (bearing in mind the spectrum of actions that might result, from learning plans to informal remediation to formal remediation to probation and/or termination)?

Part 1: Professionalism in medical education—definition

Professionalism is based upon individual, environmental, and societal level factors, leading to the display of appropriate professional behaviors in specific situations. Epstein and Hundert have defined professional competence as the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.[1] In medical education, three dominant frameworks exist to describe professionalism: virtue-based professionalism, behavior-based professionalism, and professional identity formation.[2] Virtue-based professionalism focuses on humanism, moral values, moral reasoning, and character development where physicians put aside self-interest to act in the best interest of patients and apply ethical principles to their decisions and actions. In contrast, behavior-based professionalism focuses on competencies that can be defined, observed, and assessed. For example, in 1999, the Accreditation Council for Graduate Medical Education (ACGME) defined six Core Competencies, one of which is professionalism.[3] The key elements of this competency were defined as demonstrating respect, compassion, and dignity; being responsive to patient needs; and being accountable to patients, society, and the profession. A third framework, professional identity formation, focuses on the



evolution of one's identity to match the characteristics, values, and norms of the medical profession.[4] It is important to note that this form of professionalism may be defined differently between specialties and may include progressive development across the years of training.

Medical schools and residency training programs have focused on defining, promoting, and evaluating professionalism in an effort to reduce unprofessional conduct in learners. Coaching offers an adaptive approach to remediate perceived lapses in professionalism by helping trainees understand expectations and consequences for not reaching professionalism goals; improving the ability of learners to reflect on the relationship between the goals of professionalism and their own behavior, goals, and values; and assisting learners to identify and apply strategies to negotiate future challenges.[5-8] Importantly, coaching also allows this to be done in a process that is non-evaluative, where the coach does not directly participate in high-stakes evaluations or decide on promotion within the program. This gives the trainee the space to identify and reflect on their development in a safe space.

Part 2: The initial approach, alignment—ensuring trainees, faculty, coaches, and programs are on the same page

Trainees who demonstrate behaviors defined as unprofessional are often perceived as lacking insight and/or justifying their behaviors to achieve their goals. Problematic behaviors should be clearly identified to ensure trainees and supervising faculty have a shared understanding about what is considered acceptable versus unacceptable behavior within the training program. Unfortunately, this is often more easily said than done; we discuss this further in Part 3.

When unprofessional behaviors occur, and particularly if they become a pattern, the first step for the program is to identify this behavior and present compiled feedback to the trainee. From there, the trainee-coach partnership provides an opportunity for the trainee to explore perspectives that they may not appreciate without an opportunity to discuss and authentically reflect. These discussions may include considering how their behavior is being perceived by others as well as the impact of these behaviors on colleagues and/or patients. Potential disconnects between the trainees' intent versus their impact are crucial to explore.

If a trainee is truly unaware of the unprofessional nature of their behaviors and/or their impact, an open and honest discussion with the coach may be sufficient for growth to occur. On the other hand, if trainees are aware of their unprofessional behaviors or if the behaviors continue after initial discussion, it is important to explore both intrinsic and extrinsic contributing factors.

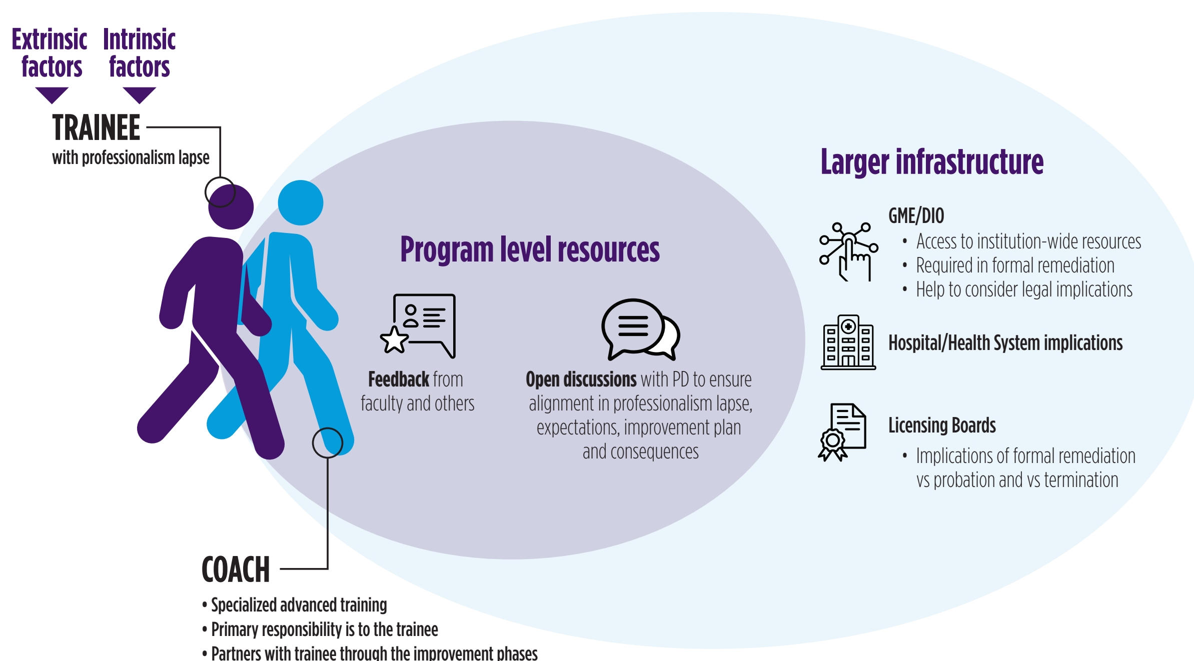
Extrinsic contributing factors may include burnout, fatigue, and/or a stressful environment at work, home, or both.[9] Intrinsic contributing factors may include lack of emotional intelligence, poor social skills, implicit or explicit biases, personality traits and disorders, psychiatric diagnoses (particularly anxiety and depression), and/or deficiencies in organizational or executive functioning.[10] Although it is not the most common cause of professional lapses, substance abuse must also be considered.[10] If these issues are identified in coaching conversations, additional resources or referrals are indicated as these domains are outside the purview of coaching.

While unprofessional behavior may be rooted in characteristics of the individual such as insecurity, immaturity or aggressiveness, these behaviors may also be learned, tolerated, and reinforced due to hospital or training program culture.[11] Also related to cultural influences, learned behaviors that were adaptive in a prior situation or program may be problematic within a new context, and coaching

conversations can help the trainee and coach explore perspectives, values, and strengths that may be more adaptive within the new system. Lastly, the increasing heterogeneity and diversity of medical teams may lead to certain behaviors of trainees, faculty, or both to be perceived as "unprofessional."[12-14] Coaching allows for an honest discussion of context, intent, and thoughtful development of new strategies that may be more adaptive.

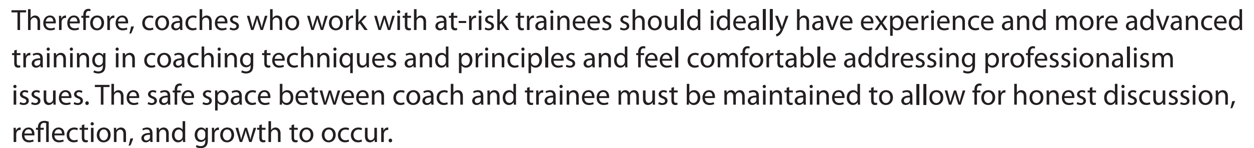
Once trainees have gained perspective around the impact of their behaviors, the importance of adapting these behaviors, as well as potential intrinsic and extrinsic contributing factors, the next step is the development of a plan to move forward. Depending on several factors such as the level of cooperation and engagement of the trainee, the degree of egregiousness of the behaviors and their impact, and program/institutional policies, action plans may range from thoughtful integration into an individualized learning plan to informal or formal remediation or probation. The precise definitions of these terms vary between institutions and states. It is critical that program directors and designated institutional officials have a clear understanding of the short- and long-term consequences of these actions and communicate them clearly with the trainee. This is covered in more detail in Part 4. It is imperative that there be alignment between the program's expectations, the trainee's responsibilities, and the coach's role in this process. We suggest a framework for conceptualizing the importance of the intersectionality of these factors in Figure 6-1.

Figure 6-1: Intersectionality of factors in coaching at-risk trainees



Part 3: Special considerations in coaching trainees with concerns for unprofessional behavior

Several models exist to attend to lapses in professionalism, and coaching plays an important role for this at-risk trainee group.[6,15] These situations may be quite complex to navigate. Faculty who have not received specific training have expressed feeling inadequately prepared to help trainees develop improved professionalism. Role-modeling is seen as the most influential teaching tool for professionalism. Unfortunately, many faculty are unsure about their own perceived lapses in professionalism and are uncomfortable addressing these with other physicians.[16]



Therefore, coaches who work with at-risk trainees should ideally have experience and more advanced training in coaching techniques and principles and feel comfortable addressing professionalism issues. The safe space between coach and trainee must be maintained to allow for honest discussion, reflection, and growth to occur.

Additional considerations and pitfalls, both internal and external to the trainee/coach partnership, must be considered to optimize outcomes of coaching for at-risk trainees.

1. Lack of actionable feedback

It is imperative that there be clarity among all parties around the perceived professionalism issue. However, reluctance of faculty and other stakeholders to have difficult or uncomfortable discussions with the trainee and/or an assumption that the trainee is already aware of the issue, contributes to a lack of actionable feedback. This can be further confounded by the drive to maintain the relationship, which often supersedes the desire to comment on what may be perceived as a minor issue or just having a "bad day." Similarly, faculty may be hesitant to put constructive/negative feedback in writing because they don't necessarily want it in the trainee's "permanent record."

Giving constructive feedback is difficult even when a trainee is receptive and insightful. If a trainee is considered defensive or otherwise "difficult" or if the topic of the feedback is complex or uncomfortable, the likelihood of the feedback being given drops further. Even if an attempt is made, it may be perceived as an "outlier" by the trainee as others may not have been willing to venture into these difficult topics in the past, resulting in even higher resistance on the part of the trainee. All these factors can lead to a scenario whereby a trainee perceived to have professionalism and/or insight issues may not have an accurate picture of the degree of concern and may even be surprised when a supervisor brings it up. Faculty may also be concerned about potential legal implications and protections for faculty; we touch on this further in Part 4.

To prepare, it is vital that there be a process in which specific examples of concerning behaviors can be collected so that a pattern can be identified and articulated. This way, the learning goal is about a theme rather than isolated events. The feedback also becomes less personal and more data-driven. Once these data are obtained, the coach can partner with the trainee to explore the content and navigate a path forward. A highly effective coaching technique known as R2C2 can help coaches facilitate this discussion (Figure 6-2).[17] The first "R" ("rapport" or "relationship") allows for trust to develop; the second "R" ("reaction/reflections") creates a safe space for the trainee to have their reaction to the feedback while also allowing the coach better insight into the trainee's perspective and assumptions; the first "C" ("content") connotes an invitation to explore the data for content that aligns with the trainee's goals/values; and the last "C" ("coaching/change") is the accountability step, coaching for change with the creation of a concrete action plan.17 We also discuss a model to specifically address coaching in remediation in Part 4.

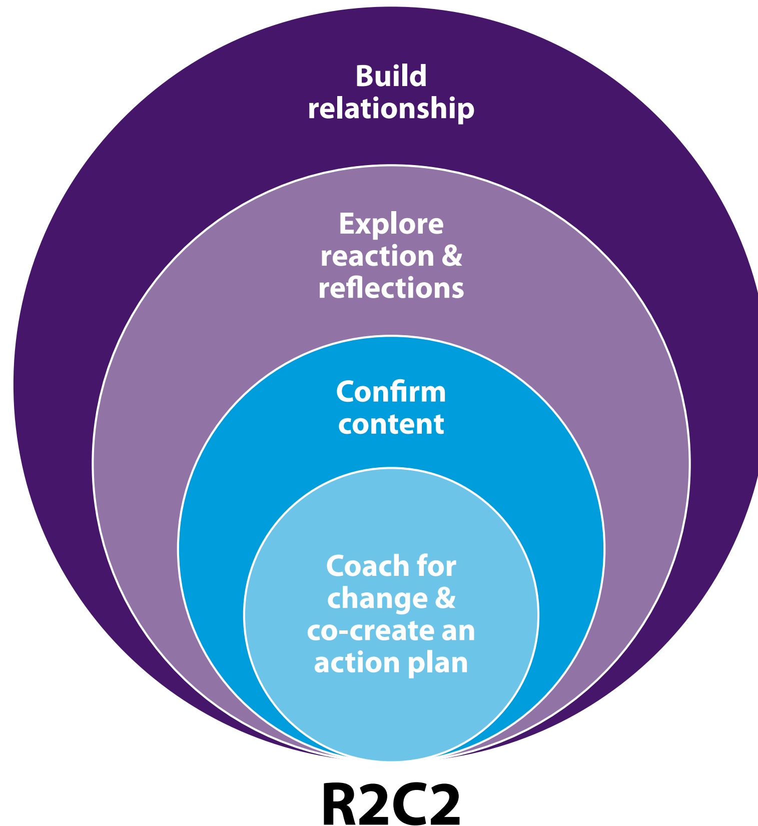


Figure 6-2: The R2C2 Model. Reprinted with permission from Sergeant J, Armson H, Driessen E, et al. Evidence-informed facilitated feedback: the R2C2 feedback model. *MedEdPORTAL.* 2016;12:1-387.

2. Accountability paired with a clear plan for how to demonstrate "success"

Feedback is hard to process and/or act upon when it is overly general. Vague feedback around professionalism can be even more difficult to navigate. For example, being told that one "lacks professionalism" or "lacks emotional intelligence" and needs to demonstrate "improvement" can be overwhelming. Where does one even start? It is important for the coach, trainee, and program to develop a set of specific demonstrable behaviors and expectations that are markers of progression, so that progress can be tracked and the process iterated accordingly.

3. Awareness of "halo/horn" effects and group think

Faculty need to remember the danger of cognitive anchoring in multiple domains, including the halo/horn effect in assessment. For example, if a trainee with a reputation of being a "rock star" shares a vulnerability or struggle, this may be interpreted as evidence that this trainee is committed to self-development and has a growth mindset. However, the same conversation with a trainee who is "struggling" can be seen as further evidence that they need an intervention. Group assessments and the resulting "group think" can further exacerbate this cognitive trap and make it very hard for a trainee to change how they are perceived, even if they fully engage in the process.

4. Need for safe spaces to talk and think across/through cultural and other identity differences

We wrote previously about the increasing heterogeneity of medical teams across many identities, cultures, and ethnicities. Professionalism, or the perceived lack thereof, can be heavily influenced by

implicit bias and other cultural blind spots. Coaching conversations, and the safe spaces they provide, can encourage exploration of challenges in how professionalism is defined in these contexts, elicit frank discussions around intent versus impact, and help co-develop action plans that are nuanced for the specific situation. Thoughtful incorporation of implicit bias training should also be considered where warranted.

5. Fight/flight/freeze response of the trainee/reluctance to ask questions

When an individual feels threatened, it is common to develop one of the following responses: fight, flight, or freeze. When this happens in a perceived high-stakes situation (for example, a meeting with a program director to discuss potential remediation), it can be very difficult for a trainee to be able to fully process next steps or even clearly hear what is being asked of them. Coaching allows for the trainee to have this reaction with a trusted partner, gain further clarity, explore their challenges and options with the coach, and make progress toward adaptive action.

6. Designing processes that help mitigate cognitive overload such as stereotype threat

Stereotype threat is a form of cognitive overload defined as a "socially premised psychological threat that arises when one is in a situation or doing something for which a negative stereotype about one's group applies."[18] An example is when a member of a historically marginalized group is asked to attend to a task that they have been conditioned to believe they will find difficult. In Steele and Aronson's original study, Black students underperformed white students when a test was described as being "diagnostic" of intellectual ability; however, this performance gap disappeared when the test was not described this way. Similar results have been shown around gender and math performance.[19] This suggests a powerful role of cognitive bandwidth and mindset on performance. Interventions that reduce the impact of stereotype threat (Figure 6-3) and enhance belongingness have been shown to close performance gaps.[20-21] Another more generalizable but related phenomenon occurs when someone feels "under the microscope"; only a portion of their focus is available for the task at hand.[22] Either or both may be factors for trainees who are placed on performance plans; coaches can be valuable partners in helping trainees navigate these challenges and co-create plans that address them.[23]

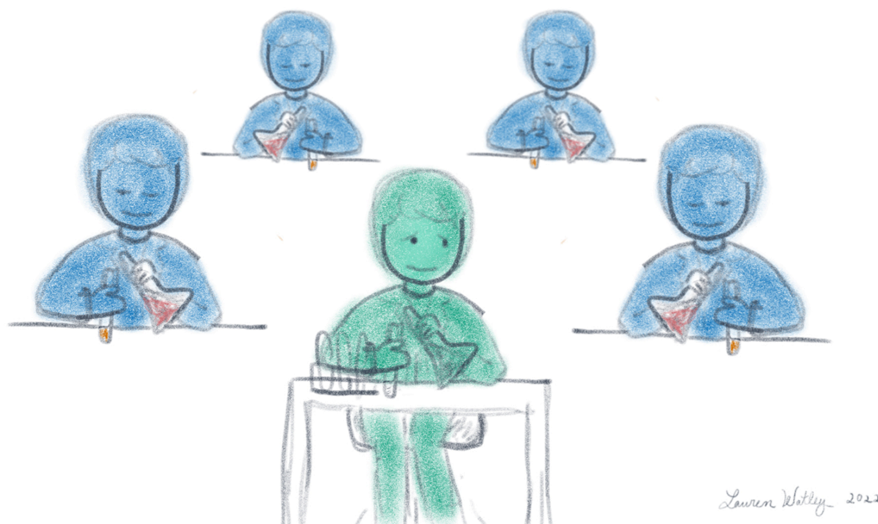


Figure 6-3: Impact of Stereotype Threat. Watley L, Whittemore J, Sanford R, Williams S. Impact of stereotype threat. Figure developed in support of Democratizing Quality Coaching in Medical Education, Basic Coaching Workshop, Stanford, CA 2022. Copyright Lauren Watley. Reprinted with permission.

7. Confidentiality

To preserve a psychologically safe space for coaching, discussions between the trainee and the coach need to be confidential. This applies to all coaching arrangements. The same applies to formal documentation from these meetings. Coaching programs often use structured worksheets to help clarify goals and guide (and celebrate) progress. With mutual consent of both the trainee and coach, these may be structured so that accountability goals and progress may be visible to the program, but the reflections that informed those goals remain confidential. Giving the trainee the last "edit" on such a document safeguards and supports their agency in the process.

8. Establishing a referral process for issues that are outside the purview of coaches

We have described several potential issues that may be identified in coaching conversations that should be referred, as they are outside the scope of coaching. These include but are not limited to burnout, personality traits and disorders, anxiety/depression, explicit bias, perceived learning or organizational disabilities, or substance abuse. It is important to have a referral process in place to ensure the right team is engaged in the process.

Part 4: Escalation beyond a "learning plan"; remediation, probation, and more

Issues around professionalism may require escalation beyond a standard learning plan. In these circumstances, more advanced coaching techniques may be necessary. It is also imperative that the escalation plan, along with its short- and long-term consequences, be transparent to all parties (trainee, coach, and program).

Coaching considerations

A 5-step model of appreciative coaching through remediation has been described by White and Barnett[24] and can be combined with other effective models such as GROW[25] and R2C2[17] described previously. This extremely helpful and practical resource describes an appreciative inquiry model of coaching, while adapting and expanding it to recognize the complexities of coaching a trainee through a remediation process. It recognizes both contextual and process components and is summarized in Table 6-1. We encourage your review of the full chapter as it includes multiple additional practical tools, approaches, and conceptual frameworks useful in remediation coaching. We also recommend that if coaches are involved in these higher-stakes discussions, that they in turn receive additional training and support at the program and/or institutional level.

A key take home message is that the coach can be instrumental in helping the trainee find congruence (Table 6-1) as well as tangible and actionable ways to see success in the remediation process as a path to achieving their intrinsically motivated larger goals. With this mindset, engagement is enhanced and success in the remediation process may be seen as just one step toward this ideal state.

Table 6-1: Summary: 5 step model of appreciative coaching: A positive model for remediation (adapted from Kalet A, Chou CL, editors. *Remediation in Medical Education: A Mid-Course Correction.* Springer; 2014.

Appreciative coaching in remediation: Context and process summary

Coaching context

1. Heightened emotions: the context of coaching is often strained at the outset in remediation situations, as most trainees come into a remediation with a humiliated, embarrassed, anxious, or otherwise emotionally-triggered and/or fearful mindset.
2. Relationship, trust, and a safe space are first and foremost and must be established for the trainee to see a path to success through the process and engage.
3. Development of coachee "congruence": most physicians carry a set of highly professional core beliefs and other deeply held values; "congruence" (described by Argyris and Schon[26]) is aligning these beliefs/values with our observable behaviors.
4. Coach self-awareness is vital to create a non-judgmental atmosphere. Depending on the situation, the coach may have strong initial reactions to the issues raised in the remediation and needs to come to terms with these to be effective as a coach.

Coaching process; helpful steps to promote success

1. Understanding the organizational context
2. A first meeting that begins rapport building and explores the coachee's understanding of the situation
3. Coaching using a strength-based and appreciative inquiry approach, including:
   a) Discovering and identifying trainee strengths (a variety of tools can help with this)
   b) Identifying what is fulfilling to the trainee about their chosen career path (their bigger picture "why")
   c) "Pivoting," defined by Orem et al.[27] as "the conscious act of turning attention from what the client does not want to what (the client) wants"
   d) Applying the reflective **5 D's** of appreciative inquiry: **Discovering** strengths ((a) above), **Dreaming** of the ideal future state, **Designing** a collaborative plan to achieve that future state (two helpful mnemonics here: SMART objectives [specific, motivating/measurable, achievable/aggressive, relevant, and timely]; and BEARS [barriers to change, evidence of behavior change, specific actions to achieve the goals, resources needed, and strengths that can be drawn upon]), **Developing** people/systems, and **Destiny** (evaluating outcomes/sustaining change).

Need for clarity and transparency around terminology, documentation, and consequences

Clarity around an escalation plan, and its potential short- and long-term implications to the trainee's career, is critical to discuss early in the process so that all parties (trainee, program, and coach) have a shared understanding about what is at stake and can make strategic decisions around next steps. Programs should define a process through individualized professional development plans, informal remediation, formal remediation, probation and, if necessary, dismissal. Having an established due process is an accreditation standard from the Liaison Committee on Medical Education (LCME) and the ACGME.[28] All residents (not just "struggling" or otherwise at-risk learners) should be working on professional development as an important part of lifelong learning and should develop an individual learning plan both for professional development and in compliance with ACGME guidelines.[29] Coaching provides both a thought and accountability partner for trainees through these plans.

The training program should be clear with both the trainee and coach about where on the learning/escalation pathway a trainee stands so there is alignment of goals and expectations. Success in this process should be the goal for all parties, both for value alignment and to mitigate negative consequences at various stages. And as a final step (and although rare in medical education) dismissal of a resident has a lasting impact on trainees, their faculty, and the program and therefore is not an action that should be taken lightly.[30] Regretfully, there remains a great deal of ambiguity around the definition and interpretation of these various escalation stages despite their high-stakes nature.

Another fear arises around potential legal consequences. An in-depth discussion of this topic is beyond the scope of this chapter. However, it is important to ensure that due process is observed and that there is clarity around processes across the remediation spectrum. If due process is in place, and if programs take action based on patient safety and educational standards, there is precedent for supporting programs and institutions.[31] We recommend you discuss these recommendations with your institution's designated institutional officer (DIO) and legal teams to design thoughtful processes that support trainees and programs alike.

Smith, Lypson, Silverberg et al. propose a helpful framework for remediation that addresses this ambiguity.[32] In this framework, formative individualized learning or development plans involve only the training program while formal remediation, probation, and termination involve the graduate medical education (GME) team as well. This framework also addresses disclosure of documentation, whereby documentation is not to be disclosed to parties outside the program if the trainee is successful in their remediation and that it be considered confidential. If unsuccessful, "probation" is activated, and documentation of the situation may be released to external parties including future employers.

We have adapted their framework and recommendations to emphasize the importance of normalizing learning plans for all trainees, not just those identified as struggling, and have suggested who may be best positioned to coach in each circumstance. This adapted model is summarized in Figure 6-4.

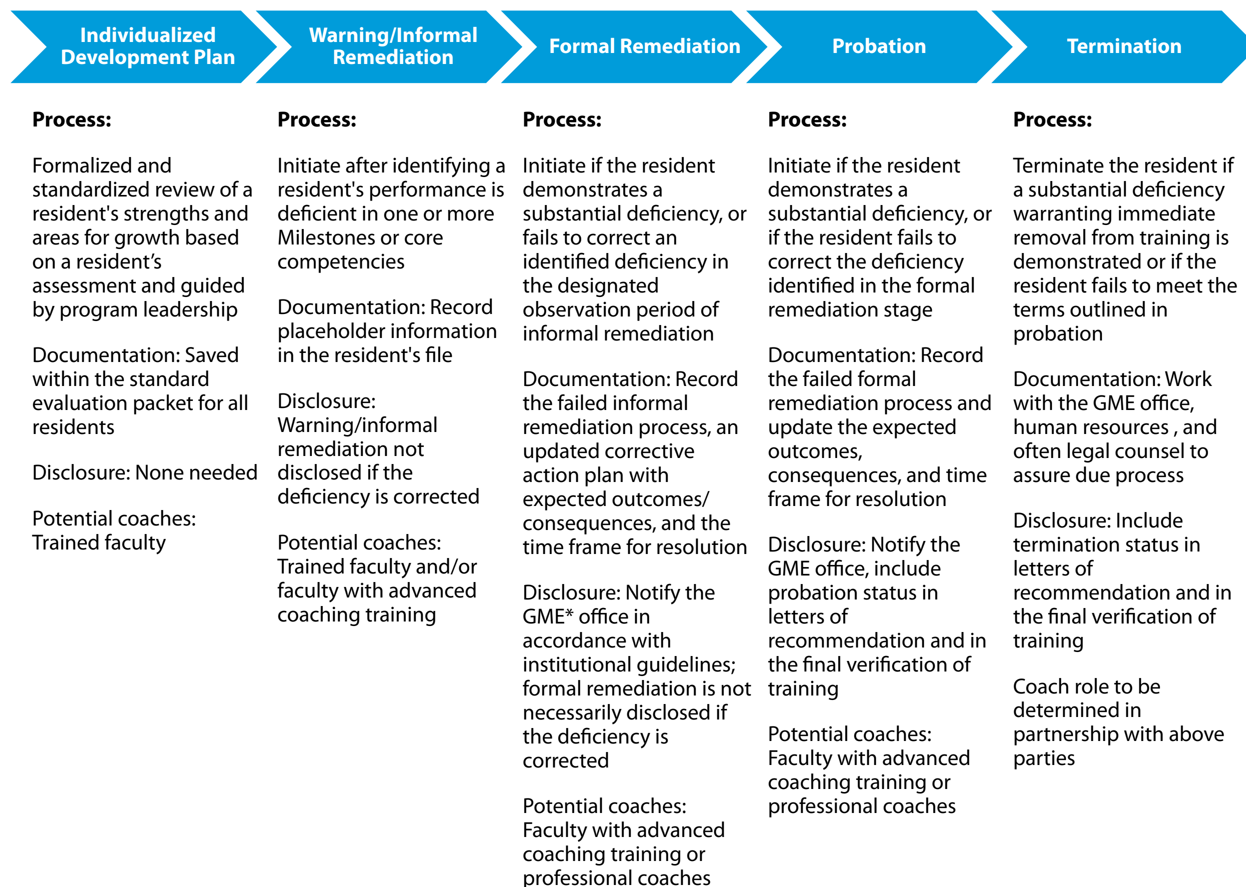
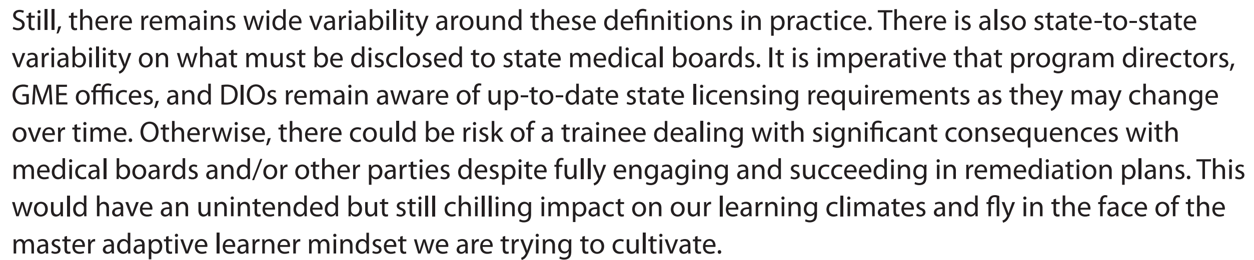


Figure 6-4: Model for normalization of learning plans and potential escalation. Adapted from Smith JL, Lypson M, Silverberg M, et al. Defining uniform processes for remediation, probation, and termination in residency training. *West J Emerg Med.* 2017 Jan;18(1):110-113. doi:10.5811/westjem.2016.10.31483



Still, there remains wide variability around these definitions in practice. There is also state-to-state variability on what must be disclosed to state medical boards. It is imperative that program directors, GME offices, and DIOs remain aware of up-to-date state licensing requirements as they may change over time. Otherwise, there could be risk of a trainee dealing with significant consequences with medical boards and/or other parties despite fully engaging and succeeding in remediation plans. This would have an unintended but still chilling impact on our learning climates and fly in the face of the master adaptive learner mindset we are trying to cultivate.

Conclusion

Coaching can be a powerful approach to support all trainees in achieving their full potential. Learners who are identified as "at-risk" due to perceived lapses in professionalism stand to benefit immensely from coaching and the safe space partnership that coaching provides for reflection, consideration of multiple perspectives, and co-development of action plans. However, this trainee-coach partnership is only one part of a broader strategy that should also consider underlying assumptions around how professionalism is being defined within the local culture, a shared mental model around metrics of success, as well as program and institutional expectations, resources, and due process. We support the ACGME's recommendation that all trainees should be on a learning plan. Within this context, professionalism is one of many skills our learners are developing. This chapter has provided practical steps to help trainees, coaches, programs, and institutions develop a multifaceted approach to enhance success for all parties in this complex domain.

Take-home points

1. Successful coaching in the complex milieu of perceived unprofessional behavior requires an alignment and plan around the importance of defining as well as understanding both the intent of the trainee and the impact of their behaviors on others. A shared mental model of how these behaviors are being perceived is critical.

2. Successful coaching in this situation also requires ensuring that the trainee not only recognizes but also understands the seriousness of the professionalism concerns as well as strategies they can implement to demonstrate improvement. The end goal should be not only success in this task but seeing this as another step toward achieving their larger goals.

3. Addressing perceived unprofessional behavior requires integrating coaching as a valuable resource to allow honest discussion, self-reflection, expectation-setting, co-creation, and progression on action plans and identification of potential additional resources that may be necessary for success.

4. These kinds of situations highlight the importance of aligning stakeholders, clear communication around roles and resources, and clarity around the potential escalation process.

5. All learners (and all faculty for that matter) in medicine are on a lifelong learning mission. We fully endorse the ACGME's recommendation that all learners be on an individualized learning plan to normalize and support this ongoing learning process and recognize the important role that coaching plays in fostering this master adaptive learner framework. Professionalism is one of many skills our trainees develop as they reach their full potential.

References

1. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA.* 2002;287(2):226.235. doi:10.1001/jama.287.2.226
2. Irby DM, Hamstra SJ. Parting the clouds: Three professionalism frameworks in medical education. *Acad Med.* 2016 Dec;91(12):1606-1611. doi:10.1097/ACM.0000000000001190
3. NEJM Knowledge+ Team. Exploring the ACGME Core Competencies: Professionalism and Quality Care (Part 7 of 7). NEJM Knowledge+. Published January 12, 2017. Accessed March 22, 2024. https://knowledgeplus.nejm.org/blog/acgme-core-competencies-professionalism/
4. Cooke M, Irby DM, O'Brien BC. *Educating Physicians: A call for reform of medical school and residency.* Jossey-Bass; 2010.
5. Bebeau MJ, Faber-Langendoen K. Remediating lapses in professionalism. In: Kalet A, Chou CL, eds. *Remediation in Medical Education: A Mid-Course Correction.* Springer; 2014. p103-127.
6. Mak-ven der Vossen MC, de la Croix A, Teherani A, van Mood WNKA, Croiset G, Krsurkar RA. A road map for attending to medical students' professional lapses. *Acad Med.* 2019 Apr;94(4):570-578. doi:10.1097/ACM.0000000000002537
7. Olive KD, Abercrombie CL. Developing a physician's professional identity through medical education. *Am J Med Sci.* 2017 Feb;353(2):101-108. doi:10.1016/j.amjms.2016.10.012
8. Lucey C, Souba W. Perspective: the problem with the problem of professionalism. *Acad Med.* 2010 Jun;85(6):1018-1024. doi:10.1097/ACM.0b013e3181dbe51f
9. Brown SD, Goske MJ, Johnson CM. Beyond substance abuse: stress, burnout, and depression as causes of physician impairment and disruptive behavior. *J Am Coll Radiol.* 2009;6(7):479-485. doi:10.1016/j.jacr.2008.11.029
10. John PR, Heitt MC. Disruptive physician behavior: the importance of recognition and intervention and its impact on patient safety. *J Hosp Med.* 2018;13(3):210-212. doi:10.12788/jhm.2945
11. Leape LL, Shore MF, Dienstag JL, et al. Perspective: a culture of respect, part 1. *Acad Med.* 2012 July;87(7):845-852. doi:10.1097/ACM.0b013e318258338d
12. Lee JH. The weaponization of medical professionalism. *Acad Med.* 2017 May;92(5):579-580. doi:10.1097/ACM.0000000000001647
13. Paul H, Pendergrast T, Baghoomian W, Barr A, Marino R, Anderson CTM. The weaponization of professionalism. KevinMD. Published August 2, 2020. Accessed March 22, 2024. https://www.kevinmd.com/2020/08/the-weaponization-of-professionalism.html.
14. Hill KA, Samuels EA, Gross CP, et al. Assessment of the prevalence of medical student mistreatment by sex, race/ethnicity and sexual orientation. *JAMA Intern Med.* 2020;180(5):653-665. doi:10.1001/jamainternmed.2020.0030
15. Papadakis MA, Paauw DS, Hafferty FW, Shapiro J, Byyny RL. Alpha Omega Alpha honor medical society think tank. Perspective: the education community must develop best practices informed by evidence-based research to remediate lapses in professionalism. *Acad Med.* 2023 Dec;87(12):1694-1698. doi:10.1097/ACM.0b013e318271bc0b
16. Bryden P, Ginsburg S, Kurabi B, Ahmed N. Professing professionalism: are we our own worst enemy? Faculty members' experiences of teaching and evaluating professionalism in medical education at one school. *Acad Med.* 2010 Jun;85(6):1025-1034. doi:10.1097/

ACM.0b013e3181ce64ae

17. Sergeant J, Armson H, Driessen E, et al. Evidence-informed facilitated feedback: the R2C2 feedback model. *MedEdPORTAL*. 2016;12:1-387.
18. Steele CM, Aronson J. Stereotype threat and the intellectual test performance of African Americans. *J Pers Soc Psychol.* 1995;69(5):797-811. doi:10.1037//0022-3514.69.5.797
19. Spencer SJ, Steele CM, Quinn DM. Stereotype threat and women's math performance. *J Exp Soc Psychol.* 1999;35(1):4-28. https://doi.org/10.1006/jesp.1998.1373
20. Ostrov JM, Long SM. Social class and belonging: implications for college adjustment. *Rev High Educ.* 2007;30(4):363-389.
21. Walton GM, Cohen GL. A question of belonging: race, social fit, and achievement. *J Pers Soc Psychol.* 2007;92(1):82-96. doi:10.1037/0022-3514.92.1.82
22. Watley L, Whittemore J, Sanford R, Williams S. Impact of stereotype threat. Figure developed in support of Democratizing Quality Coaching in Medical Education, Basic Coaching Workshop, Stanford, CA 2022.
23. Lyndon MP, Strom JM, Alyami HM, et al. The relationship between academic assessment and psychological distress among medical students: a systematic review. *Perspect Med Educ.* 2014 Dec;3(6):405-418. doi:10.1007/s40037-014-0148-6
24. Kalet A, Chou CL, editors. R*emediation in Medical Education: A Mid-Course Correction*. Springer; 2014.
25. Whitmore J. Coaching for performance: *The principles and practice of coaching and leadership.* 5th edition. Nicholas Brealey publishing; 2017.
26. Argyris C, Schon DA. *Theory in practice: increasing professional effectiveness.* Jossey-Bass; 1974.
27. Orem S, Binkert J, Clancy AL. *Appreciative coaching: a positive process for change.* Jossey-Bass/Wiley; 2007. p245.
28. Conran RM, Elzie CA, Knollmann-Ritschel BE, Domen RE, Powell SZ. Due process in medical education: legal considerations. *Acad Pathol.* 2018;5:2374289518807460. Published 2018 Nov 14. doi:10.1177/2374289518807460
29. ACGME Common Program Requirements. 2009. Accessed March 22, 2024. https://www.acgme.org/globalassets/pdfs/commonguide/iva5c_educationalprogram_acgmecompetencies_pbli_explanation.pdf
30. Schenarts PJ, Langenfeld S. The fundamentals of resident dismissal. *Am Surg.* 2017 Feb; 83(2):119-126.
31. Lefebvre C, Williamson K, Moffett P, et al. Legal considerations in the remediation and dismissal of graduate medical trainees. *J Grad Med Educ*. 2018;10(3):253-257. doi:10.4300/JGME-D-17-00813.1
32. Smith JL, Lypson M, Silverberg M, et al. Defining uniform processes for remediation, probation and termination in residency training. *West J Emerg Med.* 2017 Jan;18(1):110-113. doi:10.5811/westjem.2016.10.31483

Chapter 7: Trainee considerations

Rebecca Blankenburg, MD, MPH; Michael Greenwald, MD; Barbara Porter, MD, MPH; and Jeffrey Ratliff, MD

Chapter summary

In this chapter, we explore how to help trainees maximize their coaching relationships. We first share key considerations for matching trainees with coaches. We then share how to help trainees develop a trainee-centered agenda, key theories to share with trainees, and how to help trainees learn from feedback. We end with a discussion on navigating ineffective coaching pairings.

Vignette

CR is a high-achieving incoming resident who wants to get the most out of residency and pursue a highly competitive subspecialty. CR has never experienced coaching before and is skeptical about coaching.

Thought questions:

1. How would you help CR prepare for coaching?
2. How would you match CR with their coach?
3. What would you do if CR does not connect well with their coach?

Considerations in matching trainees with their coaches

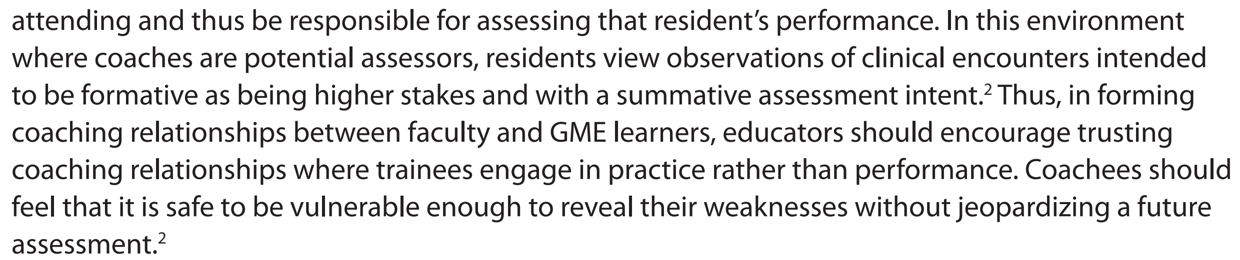
Considerations in choosing coaches

There are many considerations when pairing trainees with coaches including the number of trainees per coach, overlapping responsibilities of faculty members (e.g., do they serve in a summative role for the trainees?), and concordance of characteristics such as demographic background or specialty interest. Given the lack of evidence in this regard and the realities of faculty members having multiple roles in GME, the most important component is selecting and training individuals who can create a trusting relationship and facilitate self-reflection and goal setting.[1]

Matching based on subspecialty choice

One consideration is the specialty alignment of trainee and coach. When GME trainees have goals specific to their area of specialty training, the coach requires content expertise. In this coaching model, termed "performance-based coaching," coaches engage in direct observation of the trainee while they perform a clinical skill (history, exam, procedure, etc.). Specialty aligned coaches are best equipped to observe clinical encounters or discuss clinical experiences to guide the trainee in these domains. However, residents and fellows often have goals that are agnostic of their area of specialty training. For example, trainees may seek to develop skills or abilities in areas of well-being, professionalism, scholarly achievement, leadership, or efficiency. Here it becomes less critical that the coach relationship is aligned within their area of specialty training. Therefore, in forming coaching relationships, we must consider the goals of the trainee and how much specialty alignment is needed to maximize the outcomes of the coaching relationship.

While specialty alignment may be important for trainees meeting clinical goals, we must also consider the potential pitfalls in these relationships. When coaches are drawn from within a department, coaches are also potential assessors of a resident within the context of the training program's assessment program. Simply put, a coachee's assigned faculty coach may be their supervising



attending and thus be responsible for assessing that resident's performance. In this environment where coaches are potential assessors, residents view observations of clinical encounters intended to be formative as being higher stakes and with a summative assessment intent.[2] Thus, in forming coaching relationships between faculty and GME learners, educators should encourage trusting coaching relationships where trainees engage in practice rather than performance. Coachees should feel that it is safe to be vulnerable enough to reveal their weaknesses without jeopardizing a future assessment.[2]

Matching based on personality inventories

Another consideration is matching coaches based on personality inventories or other psychometric tests. In the psychological literature, studies have shown that while the psychometric profile of an individual in a coaching dyad may impact how they function in the coaching relationship, matching coach and coachee based on these metrics is not necessary.[3] Within medicine, a study of coaching relationships among practicing surgeons using the Myers-Briggs Type Indicator demonstrated that agreement of the Judgement-Perception domain within a coaching dyad was associated with higher coaching performance initially. However, this agreement disappeared as the coaching relationship evolved.[4]

Matching based on personal identities

Another consideration is creating coaching pairings based on personal identities including race, ethnicity, gender, sexual orientation, disabilities, religion, or other identities. Though there is minimal evidence in the coaching literature regarding this, evidence in the mentoring domain is equivocal. Those who are underrepresented in medicine identify that "fit" with their mentor is an important dimension, but it is unclear if matching improves that fit. In a study of family medicine department chairs, lack of "fit" caused dissatisfaction with mentorship relationships.[5] In terms of gender matching in mentorship, some feel having women mentor women is valuable due to shared experiences and a lack of women in academic leadership positions.[5] Yehia et al. showed that residents identify that having mentors from outside their identified gender or racial ethnic/group created barriers in the relationship.[6] Yehia et al. also found that residents from underrepresented racial and ethnic groups needed to explain circumstances and nuance to their mentor if they were not from the same racial and ethnic group. Outside of medicine, Bozer et al. found that coaching pairings based on "perceived similarities" in gender in executive business coaching had no significant improvement in self-awareness of strengths/weakness, career satisfaction, and job performance.[7]

Further research is needed to explore the role of identity matching in coaching pairings, particularly for those learners who are underrepresented in medicine or otherwise marginalized. Meanwhile, resources exist for coaching across identity differences. Osman et al. published a MedEdPortal workshop on mentoring across differences (Table 7-1).[8] Roth et al. provide recommendations for coaching across different cultures in business/executive coaching.[9]

Table 7-1. Learning pearls from mentoring across differences, MedEdPortal curriculum

Adapted from Osman N, Gottlieb B. Mentoring Across Differences. MedEdPORTAL. 2018; 14: 10743.
• Recognize and identify assumptions (about ethnicity, race, gender, age, etc.). • Learn to create an environment that invites and promotes open discussion about difference. • Mentors should take an active approach to creating new opportunities for mentees to explore a wide variety of roles, educational experiences, and experiments. • Develop a comprehensive definition of the roles and responsibilities of mentor to mentee, including providing psychosocial support, coaching, advocacy, and exposure to opportunities and networks. • Understand the pros and cons of same-identity mentoring relationships. • Cultivate developmental networks. • Seek to understand and appreciate generational differences. • Recognize and identify assumptions (about ethnicity, race, gender, age, etc.).

When divergence in matching is an advantage

One should consider when purposely not matching is advantageous to the coachee. Van Shaik showed that random assignment can still result in improved professional development and confidence.[1] In addition, purposely matching trainees with coaches from different specialties or subspecialties might allow the trainees to feel psychologically safer in the relationship and not worried that their performance will impact their later career interests.

How to help a coachee get the most out of their relationship with their coach

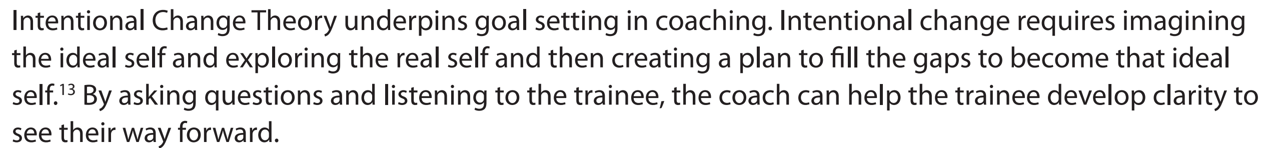
A trainee knowledgeable about the goals, benefits, and limitations of coaching will be able to maximize the benefits of a coaching relationship. A key part of this is to understand how coaching differs from a mentoring or advising relationship. While advising and mentoring is by nature more directive, the coaching relationship relies as much on the questions asked as the information shared.[10]

In a coaching relationship the agenda is set by the coachee who enters the relationship seeking help with personal or professional development. The coach's role is to help identify relevant personal characteristics and highlight feedback received to set goals for achieving this professional development. The coach helps the coachee in formulating the specific next steps to achieve their goals.

Theories coachees should know

Coachees can learn the education theories that underpin their work with a coach to help them prepare for coaching. The Master Adaptive Learner model posits that individuals who use a meta-cognitive approach to self-regulated learning can develop adaptive expertise.[11] Adaptive expertise is the result of becoming adept in the four phases of learning: planning (acknowledging and tracking knowledge gaps), learning (developing an active learning attitude), assessing (seeking opportunities for feedback), and adjusting (responding to feedback and making deliberate changes). A coach can help the trainee in all of the phases of the Master Adaptive Learner model, including integrating feedback to complete an accurate self-assessment, identifying resources for learning, reflecting on outcomes, and planning next steps.

Carol Dweck's Mindset Theory, described succinctly by Richardson et al, states that the person with a growth mindset believes attributes like intelligence and leadership are malleable and can be improved, while someone with the fixed mindset believes attributes are unchangeable and inherent to the person's self-worth.[12] The person with a growth-mindset is able to focus on improvement in the pursuit of mastery and welcome failure as a part of the learning process.



Intentional Change Theory underpins goal setting in coaching. Intentional change requires imagining the ideal self and exploring the real self and then creating a plan to fill the gaps to become that ideal self.[13] By asking questions and listening to the trainee, the coach can help the trainee develop clarity to see their way forward.

Engaging the trainee in setting the agenda

At the onset of a coaching relationship, it is helpful to have shared explicit expectations about the relationship. Some coaching relationships use a contract to codify the relationship; others accomplish expectation setting with a conversation. Reviewing the tenets of an effective coaching relationship — trust, boundaries, credibility, expectations, engagement, and interdependence — together can aid in developing a shared idea of how the relationship will proceed.[14]

A coaching relationship is unique in that the agenda is ideally driven by the coachee. At the initial meeting, the coach should be explicit about this aspect of the relationship, i.e., that the relationship thrives when the coachee drives the focus of the meeting. Ideally, the trainee should spend time prior to each meeting considering the goal they'd like to address, by reflecting on feedback, knowledge, performance gaps, or personal struggles. Goals can arise in topics such as academic performance, test preparation, clinical performance, managing professional relationships, career planning, professional identity formation, and well-being. As the coach explores the trainee's goal, there are several frameworks that can aid in identifying obstacles and developing specificity so that the trainee can move forward with clear next steps to achieving their goal. Regardless of the framework used, when the coach guides the trainee to be specific and to reflect on their current reality and potential obstacles, the groundwork is set for success in meeting any type of goal.

Helping trainees learn how to receive feedback

The focus on feedback has centered largely on how to give feedback. Like the relationship between a football quarterback and receiver, the feedback "giver" is (at most) half of the equation. Without feedback receiving skills the objective of helping identify, relay, and integrate the information will likely fail. We will address the what, why, and how of feedback with the perspective of the receiver or trainee.

What is expected when receiving feedback?

It is essential that both parties (giver and receiver) share expectations of what is covered in feedback. A commonly accepted definition of feedback is "the process by which a teacher compares learner performance to a standard and provides the learner with information about their performance for the purpose of improving their performance."[15] Process, standard, information, and performance are key words in this definition. Effective feedback:

- Is an on-going activity, rather than a one-time event
- Has consistency based on expectations for the group of learners
- Uses observations and data to support the message
- Addresses actions rather than assuming intent or character flaws

Why should trainees embrace feedback?

The most obvious value of effective feedback is that it is an opportunity for trainees to gain insights into aspects of their performance that are harder to quantify than simply a graded test, but there are other benefits beyond the immediate and specific issues addressed. Effective feedback is essential

to a growth mindset and is an essential part of a lifelong practice of learning. Furthermore, the act of receiving feedback can make future feedback sessions more effective as the practice builds familiarity and resilience to the stress of being evaluated. Finally, the regular practice of sharing feedback can create a "feedback culture" where sharing feedback is anticipated and expected. The receiver will feel more valued when convinced that the feedback provider is paying attention and concerned with their future performance and success in medicine.

Tips to share on receiving feedback:

Two sources provide guidance in processing feedback. In Thanks for the Feedback the authors describe three triggers that tend to block the reception of feedback: truth triggers, relationship triggers, and identity triggers.[16] Truth triggers refer to a reflexive negation of feedback validity. (Is there even some truth to the feedback?) Relationship triggers refer to negation of feedback because of the source. The message is invalid because of the receiver's perception of who provided the observation. Identity triggers refer to reactions based on the implications of the feedback on self-perception. (That's not who I am.) The authors conclude that the receiver can minimize the impact of the triggers by distinguishing the type of feedback, clarifying feedback details, and recognizing personal gaps when it comes to feedback. Furthermore, they counsel the reader not to switch-track (i.e., disentangle what from who) and to cultivate a growth identity (e.g., change "that's wrong" to "tell me more").

In *Feedback Mentality*, Shawnita Williams offers the SIFT model on how to approach feedback as a receiver.[17]

- Source: Is this coming from someone whose judgment you trust?
- Impact: Is the implication for change large or small?
- Frequency: How often have you received this feedback in the past?
- Trends: Are you getting this feedback more often?

When coaching is not working

Inevitably the coach-coachee relationship will face some challenges and in some cases seem to fail. What are the likely factors contributing to this failure? Let's look at the relationship from different perspectives to find likely solutions.

When coaching is not working: trainee considerations

When it feels like the relationship is less than ideal, it helps to diagnose the problem. Coaches offer unique communication styles and skills as well as tangible knowledge and experience. Perhaps the coach does not possess the skills or knowledge most needed for this particular trainee at this time. To determine this the trainee must have some insight into those needs. Is the issue how information is delivered or what information is provided? Does the coach seem to possess those needed traits (i.e., could adapt)? Could some supplemental coaching from someone else address those specific needs adequately or is the mismatch large enough to warrant seeking a different coach? Alternatively, is the issue one of trust? Does the trainee feel safe during vulnerable moments of self-reflection and analysis? If not, why? What could be said or done to gain confidence in trust?

When coaching is not working: coach considerations

When a coach recognizes that the trainee is not benefiting from the relationship, it is time for some self-reflection. Like any distinct role, there are teachable skills for coaches. What are my relative weaknesses as a coach? What resources are there to address these needs? Am I straying from the

role of a coach? Should I refer my coachee to others with a different skill set for some issues or is the challenge so pervasive that a different coach is needed? Are my needs as a coach not being met? Is my motivation waning and why? Are the coaching challenges more related to my overall job or life situation and how should I address that?

When coaching is not working: coaching program considerations

There are pros and cons to every aspect of a coaching program and sometimes unintended consequences of well-intentioned decisions. Often the limitations of a program are related to financial resources, but sometimes relatively low-cost changes can address common issues. How does the program incentivize participation? Are the expectations clear, measurable, and attainable (e.g., coaching contract)? Do we allocate enough support time for the needs of the participants? Are our participants adequately trained for their role? Are we effectively role-modeling best practices? Is the schedule practical? Are supplementary resources easily accessible? Is the program designed to foster trust between coach and coachee (e.g., confidentiality guidelines)? What processes are in place to address unsuccessful coach-coachee pairings? An effective coaching program will at the very least have a process implemented that seeks and responds to feedback on these issues. Ideally each program will have an evaluation system that includes process improvement.

Conclusion

Preparing residents and fellows to be coached will help them get the most out of their coaching experiences. It is helpful to consider if matching the trainee and coach will help them have a more effective coaching relationship. In addition, it is important to review key theories (including Master Adaptive Learner, Growth Mindset, and Intentional Change Theory) with them, teach them how to develop a coachee-centered agenda, and teach them how to receive feedback. Most of all, it will be helpful to give the coach and coachee tools to evaluate how their coaching relationship is progressing and how to further improve it.

Take-home points

1. It remains unclear if matching helps improve coaching outcomes. All coaches should be trained in how to coach across differences, to best meet the needs of our underrepresented in medicine and otherwise marginalized learners.

2. Coachee preparation will help them get the most out of their coaching experience. The coachee who comes with an agenda, has developed skills for self-reflection, and is open to processing feedback will have success from the coaching relationship.

3. Familiarity with Master Adaptive Learner, Growth Mindset, and Intentional Change Theory will help both the coach and coachee.

References

1. van Schaik S, Blankenburg R, Marmor A, Rassbach C. Chapter 10: Developing Coaches for Learners Across the Medical Education Continuum. In Hammoud MM, Deiorio N, Moore M, Wolff M, eds. *Coaching in Medical Education. Elsevier*; 2023:99–112.
2. Sawatsky AP, Huffman BM, Hafferty FW. Coaching versus competency to facilitate professional identity formation. *Acad Med.* 2020;95(10), 1511–1514. https://doi.org/10.1097/ACM.0000000000003144

3. de Haan E, Molyn J, Nilsson VO. New findings on the effectiveness of the coaching relationship: Time to think differently about active ingredients? *Consult Psychol J.* 2020;72(3):155-167. https://doi.org/10.1037/cpb0000175
4. Vande Walle KA, Pavuluri Quamme SR, Leverson GE. Association of personality and thinking style with effective surgical coaching. *JAMA Surg.* 2020;155(6):480-485. doi:10.1001/jamasurg.2020.0234
5. Koopman RJ, Thiedke CC. Views of family medicine department chairs about mentoring junior faculty. *Med Teach.* 2005;27(8):734–737. https://doi.org/10.1080/01421590500271209
6. Yehia BR, Cronholm PF, Wilson N, et al. Mentorship and pursuit of academic medicine careers: A mixed methods study of residents from diverse backgrounds. *BMC Med Educ.* 2014;14(1). https://doi.org/10.1186/1472-6920-14-26
7. Bozer G, Joo BK, Santora JC. Executive coaching: Does coach-coachee matching based on similarity really matter? *Consult Psychol J.* 2015;67(3):218–233. https://doi.org/10.1037/cpb0000044
8. Osman N, Gottlieb B. Mentoring Across Differences. *MedEdPORTAL.* 2018; 14: 10743.
9. Roth A. Coaching a client with a different cultural background-does it matter? *International Journal of Evidence Based Coaching and Mentoring.* 2017;SI11:30–44.
10. Wolff M, Jackson J, Hammoud M. It Takes Two: A Guide to Being a Good Coachee. American Medical Association. Published 2019. Accessed March 5, 2024. http://cloud.e.ama-assn.org/20-1626-Coaching-H
11. Cutrer WB, Miller B, Pusic MV, et al. Fostering the development of master adaptive learners: A conceptual model to guide skill acquisition in medical education. *Acad Med.* 2017;92(1):70-75. doi:10.1097/ACM.0000000000001323
12. Richardson D, Kinnear B, Hauer KE, et al. Growth mindset in competency-based medical education. *Med Teach.* 2021;43(7):751-757. doi:10.1080/0142159X.2021.1928036
13. Boyatzis R, Smith M, van Oosten E. Coaching for change. Harvard Business Review. Published November 30, 2020. Accessed March 22, 2024. https://hbr.org/2019/09/coaching-for-change
14. Deiorio NM, Carney PA, Kahl LE, Bonura EM, Miller Juve A. Coaching: a new model for academic and career achievement. *Med Educ Online.* 2016, 21:1. doi:10.3402/meo.v21.33480
15. van de Ridder JM. What is feedback in clinical education? *Med Educ.* 2008;42:189-197. doi:10.1111/j.1365-2923.2007.02973.x
16. Stone D, Heen S. *Thanks for the Feedback: The Science and Art of Receiving Feedback Well.* Penguin Books, 2014.
17. Williams, S. *Feedback Mentality: The key to unlocking and unleashing your full potential.* Bookbaby; 2020.
18. Fairley SG, Stout CE. *Getting started in personal and executive coaching how to create a thriving coaching practice.* John Wiley & Sons; 2003; p 30, figure 1.2.

© 2024 American Medical Association. All rights reserved. 24-1031265:04/24

CHANGEMEDED®