Developing an academic coaching program

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Abstract

Academic coaching is emerging as a new model in preparing medical students for competency-based learning and creating their professional identity as lifelong learners (Schumacher, Englander, & Carraccio, 2013). Based on our review of the literature and our own experiences creating a coaching program in undergraduate medical education, we offer recommendations for success in the hope this will aid programs seeking to create or improve coaching in their own medical schools or residencies. Much of the content is applicable to faculty coaching programs as well. In general, developers must consider aspects of clear definition of the program, faculty development, monetary and intangible support, and logistical details in order to be successful.

Keywords: coaching, advising, mentoring, education, medical, undergraduate, self-efficacy

Introduction

As medical education becomes more focused on competency attainment, the path to achieving competency becomes more variable. Additionally, the rapid expansion of medical knowledge a provider is responsible for over a career necessitates learners becoming trained in continual cycles of reflection and improvement in order to remain competent as practicing physicians (Schumacher et al., 2013). The addition of academic coaching to medical education is emerging as an intriguing solution to achieving and maintaining competency. A coach can help learners self-identify the best path to success, and hold learners accountable for continually identifying and closing gaps in their knowledge, attitudes, and skills. While a coaching relationship can ideally help a learner improve in initiating their own self-reflection and self-monitoring, it would also model the concept that anyone, no matter how far along in their career, can benefit from participating in a coaching relationship.

Academic coaching is not well-represented in the medical education literature and best practices are currently emerging (Yoon, El-Haddad, Durning, & Hu, 2016). Based on review of the medical, general education, and business coaching literature, as well as our own experiences with creating and implementing a robust medical student coaching program at our own institution, we present the following recommendations to promote success in
developing a coaching program. We have built this program based on the definitions and constructs of coaching we have created through prior work (Deiorio et al, 2016).

Recommendations

1. Clearly define academic coaching and the coaching relationship for learners and faculty. Academic coaching has not been decisively defined in the medical education literature. Based on the literature and our experience, we recommend coaching being defined in the following way.

"Coaching is a developmental process whereby an individual learner meets with a faculty coach on a regular basis to create goals, identify strategies to deal with existing and potential challenges, improve academic performance, and further professional identity development. An academic coach is a person assigned to facilitate a learner reaching his or her fullest potential. Coaches work with learners by providing guidance for the learner to objectively assess his or her performance via assessments, identify individual needs, create a plan to address those needs, and develop sustaining practices to hold themselves accountable. Coaches help learners improve their own self-assessment abilities while modeling the idea that coaching is necessary throughout one's career. In the coaching relationship, a trusted longitudinal bond is formed, likely through assignment rather than the learner seeking out a preferred coach. The coaching relationship should be built on respect though not on friendship or solely only positive feelings."

Coaching is distinct from:

Advising, a process in which a staff or faculty member gives insight or direction to a student through teaching, mentoring, disciplining, coaching, and/or counseling on academic, social or personal matters (Kuhn, 2008).

Mentoring, which implies a more intimate interpersonal relationship created willingly between both participants where the mentor provides guidance, support, and opportunities to the learner.

Teaching or tutoring, which necessitates content expertise on the part of the faculty.

All parties involved must be oriented to the coaching construct. The concept of coaching may be new to learners and faculty, who have had prior experience with advisors or mentors and whose behaviors may default into one of those relationships without proper framing at the outset. Reading articles in the non-medical press, such as Gawande (2011) Personal Best, can be a convenient way to introduce the program in an accessible way.

2. Select faculty for their skills, not their content expertise. Coaches do not need to be content experts but rather guides that help learners navigate their educational experience and learning. We suggest that coaches be chosen for their skill in delivering difficult feedback and their ability to both support and challenge learners (Yoon et al., 2016). It is easier to develop faculty members' knowledge around the curriculum, but harder to instill traits such as directness and motivational skill. While faculty with medical degrees may initially appear more credible to the learner, those with advanced degrees in the sciences, education, or psychology could likely be an effective coach and support the process of learning.
3. Develop learners to be coached. After ensuring the learners understand the definition of coaching, attention should be given to preparing them to be coached. Some learners may enter the relationship believing they do not need a coach. We have created a module on "how to be coachable" that our students work through in small groups, with their coach. Areas for discussion include honesty with oneself and one's coach, cultivating a growth mindset, and developing a trusted relationship. We have also created a formative assessment for our coaches to complete about their student, including assessing how coachable the student is.

4. Create a structure and protect time for coaching meetings. The deliberate practice and feedback literature suggest that regular, scheduled and structured encounters between learners and their faculty result in better uptake and we believe the same is true for coaching (Ramani & Krackov, 2012). Scheduling regular meetings that have a consistent and well-defined structure ensures that relevant and important topics are addressed at each meeting, and that learners and coaches avoid the temptation to miss a meeting if things seem to be generally going well. In our program, coaches and learners have protected time for coaching preparation and meetings. We suggest meetings be held in private, professional spaces—unlike advising or mentoring, where meeting over food or in a public space can cement bonds, the coaching relationship must stay professional and on track. Unlike Yoon et al, we believe coaching to be most successful when it is a required, formal part of the educational program.

5. Prepare coaches to help learners navigate the many barriers that can impede academic success. Coaches must be knowledgeable and prepared to help learners understand their academic progress as well as emotional and psychological needs. Learners who have academic deficits often struggle in other domains (Guerrasio, Garrity, & Aagaard, 2014). As coaches and learners build relationships, coaches may recognize that some learners need emotional or psychological support. It is important to develop coaches to understand how to coach learners who need such support, and how to maintain appropriate boundaries. Coaches who are also clinicians may be tempted to diagnose or provide clinical advice to their learner, and this inclination must be addressed and avoided.

6. Schedule regular faculty development. Provide regular faculty development sessions for your coaches and help keep them abreast of research-based best practices. Tools such as Gibbs' (1998) model of reflection, Learning and Study Strategies Inventory (Weinstein, Schulte, & Hoy, 1987), and Skip Downing's (2013) Wise Choice Process can help coaches develop evidence-based practices as opposed to drawing only from their own learner experiences (Roth, 2007). Institution- or curriculum-specific updates can be communicated in person or electronically, but it is necessary to designate time and provide faculty development. It is also important to provide robust feedback for coaches on their performance. At Oregon Health & Science University (OHSU), coaches receive verbal feedback from peers during mock coaching sessions and written feedback from learners about the coaching relationship. We developed an observed mock coaching interaction utilizing student actors and common or potentially difficult coaching scenarios to provide written feedback to coaches from non-physician educators.

7. Create a clear way to view all academic evidence. One unique aspect and benefit of coaching, as opposed to
traditional advising or mentoring, is that all assessment information about a learner can be fair game for discussion. We believe the academic coach should not have to rely solely upon the information the learner should choose to share with them. However, information that is relevant for coaching and goal-setting includes many pieces—medical knowledge assessments, free-text feedback, video recordings of Observed Structured Clinical Exams (OSCEs), 360 degree evaluations, competency or milestone data, etc. To make the best use of preparation and meeting time, it is essential that this information be clearly accessible and displayed in an electronic portfolio. In our experience, this was an initially unrecognized and under budgeted, yet critical, component of the program. Hall, Byszewski, Sutherland, and Stodel (2012) developed an electronic portfolio program, which can be an option, if an institution is willing and able to invest the time and money.

8. Clearly define the role, if any, coaches will play in assessment or advancement decisions. As Cavalcanti and Detsky (2011) describe, there is inherent danger in allowing coaches to be assessors. This dual role can create biases that negatively affect both the coaching relationship and the assessor relationship. While coaches are privy to the aggregate of the learner's performance, and can easily summarize the learner's portfolio and understand other non-academic contextual pieces, positioning coaches in either an assessment or advancement process creates a risk of conflict of interest. Additionally, in considering coaching in undergraduate medical education programs, schools must be aware of the Liaison Committee on Medical Education (2016) stipulation, standard 11.1, mandating that "A medical school has an effective system of academic advising in place for medical students that integrates the efforts of faculty members, course and clerkship directors, and student affairs staff with its counseling and tutorial services and ensures that medical students can obtain academic counseling from individuals who have no role in making assessment or promotion decisions about them". Maintaining this firewall can be more challenging in graduate medical education programs, where the pool of both learners and education faculty are smaller, decreasing the possible permutations available to separate coaches from assessors. In this circumstance, we recommend coaches be removed from significant advancement decisions, such as roles on their learner's Clinical Competency Committee, whereas allowing coaches to assess their learners occasionally in the clinical environment may need to be acceptable. The circumstances under which a coach-learner relationship would be terminated should be defined in advance.

9. Acknowledge and encourage your coaches through programmatic and institutional support. In our experience, while monetary and administrative support for scheduling meetings and other tasks is important, there is no more important type of support than the intangible reinforcement provided by a dean who believes in coaching. A supportive dean allows for backup when the traditional curricular and clinical elements of the program threaten to encroach on the time allotted for coaching. We have supported coaching efforts by providing monetary support for faculty time and also with public recognition through our institutional publications and coaching awards. Additionally, we provide a coaching faculty portfolio that can be submitted with promotion and tenure applications and includes documentation of faculty development, and coaching efforts and effectiveness.

10. Allow space for coaches to support and coach each other. Providing opportunities for coaches to participate in a community of practice is an important part of their personal and professional development and will benefit the program. A community or practice (CoP) is one in which a group of skilled practitioners interact regularly and learn from and with one another for the purpose of professional and personal development (Lave & Wenger, 1991; Wenger, 1998). Being a member of a CoP enables coaches to become more efficient and effective because they can share and talk through common struggles, share coaching tips and ask questions to help solve problem rather than
having to retrieve information from arduous online or literature searches (Ardichvili, Page, & Wentling, 2003; Davenport & Prusak, 2000). Our coaches meet together monthly as a group. Most of those meetings allow time for coaches to meet as small groups to talk about common coaching problems, provide advice and tips to peers, and support each other.

11. Seek information from, and network with, other coaching programs—in medical education, but also in higher education and the business coaching realms. Academic coaching has occurred in the non-medical education setting for years, as have the fields of business and life coaching. Relevant literature and consultants can be found in both of these domains, as well as the human resource and psychology databases. (Cummings & Worley, 2009; Gazelle, Liebschutz, & Riess, 2015; Gifford & Fall, 2014; Sargeant et al., 2015). In our experience, many education professionals have worked on similar programs in undergraduate campuses and can be invaluable for networking and ideas. Faculty may have participated in their own life or business coaching and can be approached for advice and materials. As coaches benefit from a community of practice, so do coaching program leaders, so seeking out medical educators forming or leading their own coaching programs can be an invaluable source of ideas and support.

12. Plan early for meaningful and robust program evaluation. A coaching program can be examined from many angles—the effectiveness of the coaching relationship, the feedback the learner gives the coach and vice-versa, the perceptions of the program from the coach and the learner, and structured observed performance of learner and coach in a coaching situation, to name a few. Ideally, evaluation of high-level outcomes will help demonstrate that coaching is occurring and has led to improved learner outcomes. However, as with many educational interventions, a pure effect on the learner can be difficult to demonstrate, and specific instruments to measure higher-level coaching outcomes are currently lacking in the literature.

Take Home Messages

The recent emergence of coaching in medical education creates exciting opportunities for schools to develop coaching programs for their own learners.

A successful plan should include clearly defined objectives, opportunities for faculty and learner development, infrastructure and support, and the assessment and evaluation of the constituents and program.

Notes On Contributors

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Appendices

Declaration of Interest

The author has declared that there are no conflicts of interest.