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# Commentary
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# Coaches in postgraduate training: a difficult choice

Providing feedback is a complex task. Predicting how feedback would be perceived and lead to goals, is even more complex. Can a closer look at the role of the coach provide important insights? In this issue of Medical Education, Dr Farrell and colleagues report their study on goal co-construction and dialogue during coaching sessions and question the role of faculty development here. The authors display their current practice and some of the general dilemmata of feedback, exploring how this unfolds in coaching relationships where the aim is to use residents' assessment feedback to co-develop learning plans. In this commentary, we focus on the role of the coach and the potential implications for those involved in postgraduate training.

The authors state that not much is known on goal-development in coaching conversations. We could not agree more. They investigated coaching conversations in resident-coach dyads by qualitatively analysing the conversations and interviewing participants. They found that the content of conversations focused on how to function as a resident rather than patient care and that the dyads co-constructed how to meet goals instead of prioritising or formulating goals. The authors argue that the conversations should provide not only academic coaching on professional identity formation (PIF) but also clinical coaching.

We will point out three major ideas to comment on from our experiences and perspectives: the coaches´ multiple roles, the benefits of a division of roles, and the trainees´ needs.

The authors outline that "Longitudinal coaching in residency programs is becoming commonplace". However, in our settings (England, Germany and Switzerland) longitudinal coaching roles are not typically embedded in postgraduate training programs. In Switzerland, formative feedback takes place regularly during training, with clinical and academic coaching typically combined and provided by the same person. In England, trainees have the support of clinical and educational supervisors, who provide formative feedback and facilitate the setting of educational goals. However, these interactions are also regulated by professional bodies, and contribute to professional gatekeeping and monitoring functions. In Germany, only one feedback conversation per year is mandatory. Thus, feedback depends mainly on the practises of individual supervisors. Such international differences seem remarkable and we would like to stress the importance to keep such differences in mind when comparing international results.

**The coaches´ multiple roles**

The manuscript states that "coaching that is implemented by the program risks blurring with other roles such as advising and mentoring". Coaching staff in this setting were asked to give an 'impression' of the resident's progress to the competency committee. Although not directly involved in summative assessment, this illustrates the overlap of roles frequently observed in medical education which can at times lead to problems (1).

On the one hand, faculty closely linked to the training program and already involved in the formative assessment of residents (such as clinical supervisors) are the perfect choice for coaching, as they understand the clinical environment, the specialty and learning goals, and know the learner well.

On the other hand, they may also be perceived as assessors, putting an open feedback conversation at risk. **The clinical supervisor's assessment role can become a threat to their role in the provision of formative feedback**, pastoral support or professional development due to a reduction in trainee openness about their vulnerabilities or knowledge deficits. (2-5)

In a training program where the coach is simultaneously caught up in multiple roles of supervision, assessment, monitoring and support (such as we observe in our own settings), authenticity and engagement in resident development may be called into question. Such a lack of commitment or credibility can lead residents to discount feedback (6, 7).

**Should division of roles be the goal?**

When feedback is delivered by a coach, it is important to recognise that feedback recipients (residents) are making credibility judgements about the feedback given and its source, which will subsequently have a clear influence on its impact in goal-setting (6, 7). The authors outline some of the benefits of coaching relationships which are set apart from direct clinical observation and assessment, particularly with respect to goal-setting for resident development. In contrast to the multiple role relationships typically observed in our own settings, **a more remote approach to the coach's role, removed from day-to-day clinical pressures and assessment, may help** to facilitate their credibility, through commitment solely to resident development.

However, as alluded to by the authors, clinical discussions in these instances are likely to require efforts to recontextualise the decontextualised assessment data, relying on the resident's memory and interpretation of events. Furthermore, resident's perception of the credibility of the source of their feedback (in this case, the coach) has been suggested to rest on whether they had observed the resident, or could understand their role in that context (8). This suggests that **clinical discussions with clinically remote coaches could lead to problems for meaningful discussion.**

If the "external" coach is to be beneficial, some details seem to be important to us. A coach with more contact to the clinical setting, the profession and the resident is likely to have a greater understanding of the resident's role in their context, relying less on resident efforts to recontextualise clinical challenges or achievements. This kind of coach could also help to formulate meaningful learning goals closer to clinical practice. However, we recognise that, in the reality of resident training, **where faculty resources are limited, coaches** with the programmatic and clinical familiarity we describe **are unlikely to be truly 'external'** from the monitoring of residents in their workplace. We would suggest that efforts to 'divide' roles in these instances may benefit particularly from selecting coaches who are not directly involved in higher stakes assessment of the residents.

**The role of the learner**

We recognise that the discussion of coaching role offers only one facet of the complexity of professional and clinical development in resident training. Whilst efforts are made to provide particular roles or resources for resident support, education in this context is too complex to completely predict its outcomes. Learners intuitively make best use of relationships and make best use of the available resources through self-regulated learning (9). Their behaviour described in the manuscript, to follow their needs and use the opportunity to set goals related to their development (instead of focusing on clinical skills), is plausible to us.

We would like to add our experience that, even with clinical supervisors as coaches of surgical residents, professional identity formation was still discussed in workplace based assessment feedback, independent of the resident´s year of training (4). It seems to us that

residents have a need for guidance on this aspect of development, and will use available faculty resources to seek this out, regardless of their defined role within the organisation.

## Conclusion

In this commentary, we have considered some aspects of the role of coaches for feedback in postgraduate training. Firstly, we discussed if the combination of being an assessor and a coach would be feasible. In contrast, we also considered options where coaches were removed from assessment activity, particularly high stakes assessment related to resident progression. Thirdly, we highlighted the importance of considering the learners' need for guidance of their own professional development when exploring clinical coaching. Due to international, and even more local variability in culture and implementation, we cannot offer a simple strategy to set up the coaching role. To our understanding, the clinical coaches' knowledge of the trainee´s daily activities and clinical setting, provides a strong basis for the co-construction of clinical and academic goals and enhances credibility. However, the potential for role conflict, or perceived role conflict, of a clinical coach should also be considered in implementation of this source of support. We would suggest that each of these facets of the coaching role provides important areas for further study. **As the professional development of residents and its support is coming into focus**, and where local and international contexts vary in their implementation of coaching, **a more detailed comparison of coaching approaches might lead to fruitful insights.**


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