Key Questions for Training and Practice

Coaching in emergency medicine

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While finishing some paperwork before heading home from an evening shift, you briefly reflect on why the resident working with you this month is not excelling. You don't have any significant issues, except the fact that he seems satisfied with mediocrity. You tried to broach the topic, but felt rushed and (if you were to admit it to yourself) a little nervous about challenging him to move to the next milestone in his training. Maybe it's just your perception. He has successfully completed numerous previous rotations. You're not the program director, so this might not be your problem. But, the feeling catches you again. What should you do?

HOW DO I IMPROVE MY COACHING OF LEARNERS?: BEYOND "GOOD JOB" AND "READ MORE"

How do coaches motivate and train so effectively? Michael Phelps won 8 Olympic gold medals based on a training process that incorporated explicit, progressive, observation-based, real-time coaching. World-renowned cellist Yo-Yo Ma, no doubt, had similar coaching. We suspect that at no point did they hear "Good lap!" or "Nice tune" as a proxy for real feedback. Are we therefore missing something in emergency medicine (EM) education? The stakes in EM education are even higher than in music or athletics, yet similarly robust EM teaching techniques are infrequently used. In this article we describe a novel teaching framework — coaching — and its essential elements. The intent of this article is not to unpack the psychological framework for reframing feedback as coaching, but to illuminate the essential elements. After all, winning 8 gold medals is impressive, but the practice of EM saves lives.

HOW IS COACHING DIFFERENT FROM TRADITIONAL BEDSIDE TEACHING?

Coaching is not a semantic reframing of traditional bedside teaching. Whereas traditional bedside teaching can be a passive process for the learner and suffer from an (un)spoken power differential, coaching employs dynamic collaboration in working toward a common, specific goal (e.g., competent clinical care in a defined area). The educational agenda for a coach begins with the current level of knowledge, skills, attitudes or abilities of the learner, rather than the expectations, interests, expertise or whim of the traditional teacher. Coaching requires observation of true learner practice, role modelling of desired outcomes, and corrective and reinforcing feedback. A graduated and tailored educational "training schedule" requires longitudinal relationships between coaches and learners. Coaching is not a return to apprenticeship, for an EM curriculum would necessarily involve numerous coaching relationships over the course of training, thereby ensuring a deeper and richer educational experience beyond the perspective of a single teacher.

One framework[1] deconstructs coaching into the following components:

1. identify the performance gap against predetermined objectives,
2. explicitly describe the gap,
3. investigate the basis for the gap, and
4. target instruction to close the gap.

To successfully use a coaching framework in the emergency department (ED), we must observe actual performance, break the cycle of platitudes masquerading as feedback, strive for educational collaboration, establish a plan tailored to the learner and follow up

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on results. We have outlined a strategy using this framework for the EM environment in Box 1. This educational cultural shift will not be simple. Nonetheless, adoption of a coaching approach to bedside teaching does not require additional money or time. Further, we speculate that EM coaching will result in more effective (which in the long term is more efficient) teaching with the desired outcome of improved patient care.

WHY IS IT TOUGH TO COACH IN THE ED?

The 2 most significant challenges in EM coaching are clinical multitasking and learner diversity. Whereas traditional coaches often have the luxury of focused attention, EM physicians must simultaneously provide patient care. Emergency medicine coaches concurrently address patients' life-threatening conditions, manage ED flow and respond to incessant interruptions. In addition, we often coach several learners simultaneously, typically at different stages of training, and we may encounter a learner only once, thus inhibiting the formation of a coaching relationship.

To counter the first potential barrier, ED coaches must adopt a broader perspective of the coaching relationship. Discrete coaching moments must be deliberately sampled over the course of a shift, rather than employing (an impractical) consecutive and exclusive one-on-one coaching relationship for the entire duration of the shift. Second, not every learner will benefit from a coaching relationship. Coaching relationships should be appropriately targeted. (That is, a coaching relationship does not need to be employed for every learner on every shift. You cannot reasonably expect to coach a learner that you encounter for a single shift.) Finally, specific learner characteristics may influence coaching styles. The learning style (e.g., visual), personalities (e.g., defensive) and educational needs (e.g., communication skills) require coaching flexibility.

COACHING ELEMENT 1: DIRECT OBSERVATION

Observation of learner performance is the foundation of a coaching relationship. Learning occurs when new information is attached to pre-existing data. Encountering problems and acquiring new information challenges us to build on what we already know, particularly when the new information lies just outside our current data set. Learning is optimized when a learner is alert and feels some degree of performance anxiety. Without observing the true practice of a learner, it is difficult for a coach to accurately target the teaching moment.

Too frequently, EM physicians use surrogates of actual performance with a resulting impairment of their teaching. For example, a case presentation away from the bedside is not a substitute for observation of patient–learner interaction, and may inappropriately guide teaching of communication skills. Emergency medicine enjoys a unique clinical environment, unlike other medical specialties, that facilitates the observation of learners. Direct observation takes time, but will increase coaching effectiveness via high-yield, precise data.

Some educators have even advocated for "backstage

Box 1. Characteristics of effective coaching moments

1. Establish expectations early in the shift.
   "What should we focus our 'coaching' on today?"
2. Label the conversation as "coaching."
   "Let me coach you a bit on the discharge discussion you just had with that patient."
3. Elicit self-reflection (determine insight).
   "What did you think went well and what would you change?"
4. Provide feedback as immediately as possible after the event.
   Don't wait until the end of the shift but wait for a semiprivate opportunity.
5. Base the conversation on observed information and own it.
   "That … seemed difficult to me. What would you change another time?"
6. Discuss the behaviour, not the individual.
   "You need a chair to …" rather than "You're too short to …"
7. Provide corrective plan (if necessary).
   "How could you improve this?" "Have you considered …"
8. When identifying positive behaviour, provide an explicit description to assist with repetition.
   "Your approach to … was excellent, in particular the way you …"
9. Ask for comments and discuss that day's learning issues and plan.
   "Do you think this is a fair assessment of today's shift?"

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observation," in which teachers observe learners without their direct knowledge.[2] If explicitly stated at the outset, this practice is not only fair but may provide information we would not otherwise access. This practice mitigates the biasing Hawthorne effect.[3] Observation of some actual performance is essential to the provision of high-quality feedback and effective coaching.

The EM education literature describes several formal direct observation programs, in which coaching is done by a preceptor without any simultaneous patient care responsibilities.[4] However, the operational challenges (e.g., protected preceptor time) may limit the applicability of such programs to EM programs more broadly. We advocate for targeted sampling across a shift rather than constant observation with its attendant challenges.

COACHING ELEMENT 2: ROLE MODELLING

Studies of expert EM teachers[5] and learners[6,7] report that effective and efficient EM teachers actively role model their educational prescriptions. A good EM coach understands that their most powerful educational tool is not commentary but actual personal performance. However, role modelling is more than simply demonstrating competent clinical care in parallel with a learner. Emergency medicine coaches actively include learners as observers of their practice, provide necessary narration of their practice, role model (when necessary) the intermediate steps in complicated skills, and plan and intentionally role model important elements in the educational agenda (while understanding that all of their behaviour, intentional or unconscious, influences learning).

COACHING ELEMENT 3: FEEDBACK

Feedback is essential to most teaching models, including the only (to our knowledge) published EM-specific bedside teaching model: ED STAT (Emergency Department Strategies for Teaching Any Time).[8] The literature indicates that providing EM physicians with feedback on patient outcomes is essential to improved clinical care.[9] By extension, EM learners also benefit.[10] Effective feedback has also been demonstrated to foster reflective practice in learners, a necessary skill for lifelong learning. Feedback provides a learner with contextual commentary on personal performance that they may not be able to perceive because of lack of insight, knowledge or experience.[11] Box 2 describes essential elements of feedback or coaching moments.

At the outset of establishing a coaching relationship, it is important to set expectations and goals, including the anticipation of regular coaching moments. In fact, we advocate for labelling such feedback times as "coaching moments" to remind both learner and teacher of their collaborative educational relationship, and to put the learner at ease to receive constructive direction (using the psychology of enhanced acceptance via familiarity from previous exposure in sport, dance, music, etc.).

Effective coaching will be tailored to perceived gaps identified by the learner, as suggested by adult learning theory.[12] Balanced coaching must also address the observed gaps identified by EM teachers. However, such coaching moments must be distinguished from formal assessment to facilitate learning. Coaching is normative to the individual (and not to a peer group), meaning a performance gap is intentionally sought as a means of promoting excellence in the individual. In contrast, an assessment or summative evaluation will typically compare with a criterion (i.e., objective standard) to ensure academic advancement, having achieved a minimum level of competence.

Shared educational goals that evolve longitudinally during the coaching relationship may mitigate reservations from EM teachers that imprecise compliments to learners, rather than honest feedback, is the source of positive faculty evaluations.[13] If a true coaching relationship is established, "Good job" and "Read more" will neither be part of the coach's lexicon nor valued by the learner. Perhaps a key requirement for change is coaching the coaches.

Debate remains over the preferred feedback format. One approach is the agenda-led outcome-based analysis (ALOBA), in which coaches focus on key points

Box 2. Key elements of coaching moments

1. Explore
   Establish the learners' previous experience and current expectations. Inquire about knowledge, skills and attitudes.
2. Set common goals
   Decide on the coaching focus for the shift. (This does not need to exclude teaching on other topics during the shift.)
3. Target your observation
   Observe elements from the patient history, physical examination, case presentation, technical procedure, discharge instructions, interprofessional collaboration, charting, etc.
4. Identify the gaps
5. Provide tailored instruction
   Prescribe a learning plan to bridge the gap(s).
6. Role model
7. Follow up
   Return to the education prescription to assess its utility and the learner's progress.

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identified by the learner.[14] Another well-known practice is the "sandwich" technique, in which negative comments are sandwiched between 2 positive comments. This outmoded and formulaic approach devalues the shared educational agenda of EM coaching, as most learners have experienced this approach and wait for the negative, unable to assimilate the positives because of anxiety about what is to come. Some educators have suggested that eliciting feedback from learners on your own teaching can be effective. However, in our experience, the power differential between coach and learner often inhibits insightful and constructive feedback. Finally, neither written nor oral feedback have been demonstrated to be superior.[15] In some circumstances, written comments may be too generic or insufficiently prescriptive to effect change.[16] The foundational elements of high-quality feedback include observation, a detailed description of the encounter, and reflecting back to the learner good, adequate and inadequate aspects of their performance.

THE COACHING CYCLE

Both micro and macro cycles are important in EM coaching. The macro coaching cycle focuses on achieving the shared educational goal over the course of the rotation(s). It is more operationally significant to focus on the micro coaching cycle that occurs within shifts. Follow-up and adoption of practice ensures educational momentum, promotes accountability and requires learners to be active in their own educational development. What these cycles suggest is that coaching relationships, whether formal (i.e., officially labelled) or informal, must be intentional. (That is, both the teacher and the learner describe the relationship as a coaching relationship and commit to a large percentage of shared clinical time in a rotation, which allows greater facility for a coach to provide corrective and reinforcing feedback.)

WHAT TOOLS ARE AVAILABLE TO ASSIST ME AS A COACH?

An encounter card is an example of a "push" technique to facilitate coaching during every ED shift.[17] In wide use in many academic EDs, encounter cards require brief written documentation around select elements of EM care. Their value in promoting coaching is that they are a stimulus to a concluding coaching session at the end of a shift. On occasion, encounter cards may actually deter from coaching by removing any interaction until the completion of the shift.

Some teachers may have familiarity with multisource feedback or 360° feedback tools. In fact, these are assessment tools that are very different in design than the formative coaching described here. Similarity is in name only. Field notes capturing directly observed formative feedback have been used successfully in family medicine.[18]

Finally, specialty organizations (e.g., the Canadian Associate of Emergency Physicians, the American College of Emergency Physicians) and faculty development offices at most medical schools offer programs to equip clinical preceptors with the necessary skills to be effective coaches. Additionally, medical schools may offer formal teaching consultations focused on coaching skills.

CONCLUSION

The educational development of the next generation of EM clinicians requires an effective educational framework that matches the clinical environment of our specialty. Coaching promotes graduated and tailored learning based on direct observation of learner performance, role modelling of desired outcomes, and corrective and reinforcing feedback. We should have a very real and vested interest in our learners' progress; eventually, they will be our caregivers.

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