



## Twelve tips for designing and implementing an academic coaching program

Svetlana M. King, Shafeena Anas, Ricardo Carnicer Hijazo, Johanna Jordaan, Jean D. F. Potter & Naomi Low-Beer

To cite this article: Svetlana M. King, Shafeena Anas, Ricardo Carnicer Hijazo, Johanna Jordaan, Jean D. F. Potter & Naomi Low-Beer (2024) Twelve tips for designing and implementing an academic coaching program, Medical Teacher, 46:9, 1140-1146, DOI: [10.1080/0142159X.2024.2308058](https://doi.org/10.1080/0142159X.2024.2308058)

To link to this article: <https://doi.org/10.1080/0142159X.2024.2308058>



© 2024 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group



Published online: 31 Jan 2024.



Submit your article to this journal [↗](#)



Article views: 1710





View related articles [↗](#)



View Crossmark data [↗](#)

## Twelve tips for designing and implementing an academic coaching program

Svetlana M. King<sup>a</sup> , Shafeena Anas<sup>b</sup>, Ricardo Carnicer Hijazo<sup>b</sup> , Johanna Jordaan<sup>a</sup> ,  
Jean D. F. Potter<sup>b,c</sup>  and Naomi Low-Beer<sup>b</sup> 

<sup>a</sup>College of Medicine and Public Health, Flinders University, Adelaide, Australia; <sup>b</sup>Brunel Medical School, Brunel University London, UK;  
<sup>c</sup>The Hillingdon Hospital Pield Heath Road, Uxbridge Middlesex, UK

### ABSTRACT

Coaching has become increasingly popular as a mechanism to support learning across the health professions education (HPE) continuum. While there is a growing body of literature in this area, there is minimal guidance related to the design and implementation of academic coaching in health professional courses. This paper seeks to contribute to this literature by presenting guidance for academic developers who are considering introducing academic coaching into a health professional course. The 12 tips are based on the authors' collective experiences of designing and implementing academic coaching in university medical courses in Australia and the UK. Although focused on medical education, this paper is intended to have applicability across the health professions, and potentially across university and postgraduate training contexts. Together, the tips offer a strategic and operational framework to guide the design and implementation of academic coaching initiatives in health professions education.

### ARTICLE HISTORY

Received 24 July 2023  
Accepted 17 January 2024

### KEYWORDS

Academic coaching; health professions education; program development; learner support; faculty development

### Introduction

Coaching as a mechanism to support learning has gained popularity in health professions education (HPE) in recent times (Alfa-Wali 2013; Lovell 2018; Najibi et al. 2019). Much of the coaching literature originates from other disciplines (e.g. business, sport, the arts) (Stokes et al. 2021), requiring adaptation of concepts to the HPE context, which is inherently complex. In the HPE literature, coaching is described in two ways: coaching in clinical skills, and academic coaching (Wolff, Morgan, et al. 2020). It is the latter that forms the focus of this paper.

In this paper, we offer a definition of academic coaching, building on previous work by Deiorio et al. (2016), and incorporating self-regulated learning (Zimmerman 1990; Pintrich 2000), goal setting (Doran 1981; Lawlor and Hornyak 2012), and reflective practice (Wald and Reis 2010; Wass and Harrison 2014):

Academic coaching<sup>1</sup> is an interactive, longitudinal, relational, learner-centred process that focuses on continuous development and improvement. Learner support is provided by a coach who employs diverse strategies, such as active listening and powerful questioning, to enhance the learner's capacity for self-regulated learning and reflective practice. Coaching scaffolds and facilitates learner engagement with multiple forms and sources of evidence (e.g. results, feedback) to inform the development, monitoring, and review of learning goals that propel the learner towards a defined 'end point.'

Aspects of this definition warrant explanation. The learner/coach relationship is the bedrock of coaching and requires time and effort to build trust and respect. Evidence refers to any information that is accessible to the learner (e.g. assessment results, feedback, self-assessment)

that either prompts action, or aids evaluation of a strategy's effectiveness. The 'end point' is important, as the learner/coach relationship is typically finite (Cleary and Horsfall 2015). In the case of a health professional degree, for example, the end point is graduation. The *impact* of coaching, however, is potentially lifelong, as an intended outcome of coaching is that the learner continues to engage in reflective practice, self-regulation, and self-monitoring (Deiorio et al. 2016).

Coaching and mentoring are closely related. Indeed, the literature often uses the terms interchangeably (Landreville et al. 2019), contributing to definitional challenges (Lovell 2018). Mentoring and coaching both offer support and guidance (Ramani et al. 2023) to facilitate development (Wolff, Deiorio, et al. 2021), but differ in orientation, the nature of the relationship, time commitment, and expertise. Coaching is typically associated with a performance orientation, a formal time-bound relationship, and process-focused expertise (Stokes et al. 2021). In contrast, mentoring is characterised by a growth/development orientation, less formal relationships, reduced time pressure (Clutterbuck 2008), and expertise driven by prior knowledge (Stokes et al. 2021). In making such distinctions, it is important to recognise that both mentoring and coaching can positively impact learning and development.

While the HPE literature offers general guidance about coaching and requisite skills (e.g. Gawande 2011; Reynolds 2020), practical guidance about program-level design and implementation guidance is lacking. As coaching program development is time-consuming and complex (Donner and Wheeler 2009; King et al. 2022), the lack of appropriate guidance limits the capacity to adopt a systematic,

comprehensive approach. In this paper, we offer a framework in the form of 12 tips, to address this gap.

These tips are based on our collective experiences of designing and implementing coaching in two medical courses—one in Australia and the other in the UK—drawing on evidence from the coaching literature. While these experiences are grounded in university medical education, we have framed this paper with a broader HPE audience in mind.

## Tip 1

### ***Define the coaching program's purpose, philosophy, and strategy***

At the outset, establish the coaching program's intended purpose (Deiorio and Miller Juve 2016) and consider:

- The learners, their prior knowledge and skills, and their socio-cultural backgrounds.
- The course's intended learning outcomes, and how coaching can facilitate achievement of these outcomes.
- How coaching can support different dimensions of learning (e.g. knowledge, skills, professionalism, well-being) and assessment.
- Varied views on the purpose of the program (e.g. learners, educators, clinicians, patients).
- How coaching can support accreditation requirements.

Once the purpose is established, develop a program-level coaching philosophy, adapted from the sport literature (Van Mullem and Brunner 2013), aligning the principles and values underpinning the coaching program with organisational and/or professional goals (Donner and Wheeler 2009). A clearly articulated philosophy can enhance awareness of, and receptivity to coaching as a learning process, and facilitate recruitment of coaches (Tip 3). A coaching philosophy also serves as a compass point, informing decision-making to facilitate internal alignment between different aspects of the program.

Defining the purpose and philosophy of the coaching program is an iterative process involving key stakeholders (e.g. educators, coaches, learners, educational leaders). As organisational strategic plans evolve, the coaching philosophy should be regularly reviewed to ensure it remains contemporary. Culture will influence the philosophy of the coaching program. Factors that contribute to culture include societal norms and expectations, the nature of learning and teaching, and the organisational culture of the program.

## Tip 2

### ***Embed coaching within a structured learning and assessment program***

Related to Tip 1, embed coaching into the course's learning and assessment structure. In our respective medical courses, coaching is embedded in programmatic assessment, which prioritises assessment *for* learning (Schuwirth et al. 2017). This makes intuitive sense, as coaching supports learners to shift their focus from passing hurdle assessments towards using evidence (including assessment results) to drive learning. Indeed, several authors recognise the importance of coaching in courses with programmatic assessment and competency-based approaches (Sargeant

et al. 2018; Watling and LaDonna 2019). For a discussion on how coaching was integrated into the Flinders medical program, please see King et al. (2022).

It may be argued that coaching could exist as a stand-alone activity. We suggest, however, that because of the focus on performance and longitudinal monitoring of progress, coaching may have greater efficacy if it is integrated, forming part of course completion requirements. This is consistent with Deiorio and Miller Juve's (2016) recommendation. Where courses do not require learners to formally monitor their progress over time, the capacity for formal self-regulation and associated coaching may be limited. This could inhibit learners' ability to identify 'blind spots' and carry their learning forward into subsequent courses, promoting a 'modularised' approach to learning.

To embed coaching, consider the course structure and organisation of learning:

- How will coaching be integrated with learning modules and assessments across the course?
- What new/existing structures could facilitate learner and coach engagement in the program?
- Can course-level outcomes offer a framework for goal-setting and reflective practice?
- How will coaching support learners to integrate/consolidate their learning across the course?
- When and how often will coaching sessions occur in relation to other course activities and assessments?
- How will learners, coaches and other faculty be supported to understand coaching principles?
- (How) will learner engagement in coaching processes be assessed?
- Will coaching be mandatory or optional?

Consistent with other medical programs (e.g. Heeneman and de Grave 2017), our respective coaching programs are underpinned by an ePortfolio, providing a platform for learners and coaches to evaluate progress over time. Portfolio use is most effective when supported by a skilled mentor/coach (Murdoch-Eaton and Sandars 2014; Wass and Harrison 2014; Driessen 2017) and has been found to improve learners' self-awareness, goal-setting and insight (Buckley et al. 2009). In our respective programs, learners are supported to recognise the role of the ePortfolio in facilitating appraisal of transferable skills developed during the coaching process. Care should be taken to identify a fit-for-purpose tool, with capacity to adapt to meet course requirements, and ongoing technical support and training for learners and coaches. Related to Tip 1, ensure that all stakeholders understand the purpose of the ePortfolio.

## Tip 3

### ***Clarify the coach's role and requisite skills***

Aligned with the purpose of the coaching program (Tip 1), clarify the scope of the coach's role and extent of engagement. As outlined in Tip 1, the coach's role will be shaped by cultural norms and expectations surrounding teaching and learning, the organisational culture, and the socio-cultural background of the learner. What is the coach's role throughout the course in supporting learning (e.g. academic support, pastoral care) and assessment (Tip 2)? This is

important given the identified tensions between coaching, learner support, and assessment (Cavalcanti and Detsky 2011; Heeneman and de Grave 2017; Watling and LaDonna 2019). Distinguishing assessment from *progression* decisions can assist with this. In our programs, coaching is integrated into programmatic assessment, and coaches support learners' self-assessment of their development as self-regulated learners and reflective practitioners. These evaluations contribute to progression decisions, alongside other learning domains across our courses (e.g. knowledge, skills).

Next, clarify the requisite skills of the coach, and their alignment with the program's coaching philosophy. Several coaching skills are described in the literature including: powerful questioning (Tofade 2010); active listening (De Souza and Viney 2014); probing (Deiorio et al. 2021); prompting reflection (Wolff, Morgan, et al. 2020; Wolff, Ross, et al. 2021); facilitating problem-solving (Holt and Ladwa 2008; Bannister et al. 2018) and help-seeking (Brown-O'Hara 2013); and supporting learners to set (Cameron et al. 2019) and achieve goals (Alfa-Wali 2013) in response to feedback (Armson et al. 2019; Wolff, Stojan, et al. 2020). This is important, given that coaching is not necessarily intuitive (Sargeant et al. 2015; Armson et al. 2019) and often confused with mentoring (Manek 2004; Cleary and Horsfall 2015; Chopra et al. 2018).

Learners from racially, ethnically and socially under-represented groups may differ in their coaching needs. Coaches may not necessarily recognise these needs, which can impact on the coaching relationship and/or the coaching process (Najibi et al. 2019). Hence, coaches may require support to develop a suite of coaching approaches to cater to individual learners' needs (Tip 5).

Finally, identify those best placed to coach learners (Wolff, Morgan, et al. 2020). Although coaching in HPE is typically undertaken by clinicians, this need not be the case. Coach recruitment should prioritise interpersonal skills (Wolff, Morgan, et al. 2020) and the capacity to develop coaching skills (e.g. active listening) over content expertise (Deiorio and Miller Juve 2016). In our respective programs, we recruit coaches using multiple methods (e.g. word of mouth, electronic advertisements, presentations, and direct approaches). We deliberately recruit individuals with an interest in contributing to learners' development and the capacity to develop coaching skills. Additionally, we seek coaches with diverse professional backgrounds (e.g. health and social professions, education). This diversity is considered a strength.

For coaches who are also clinicians, Watling and LaDonna (2019) highlight the importance of distinguishing coaching from 'playing' (i.e. clinical work). Failure to delineate these roles (Marcdante and Simpson 2018) can compound difficulties in distinguishing coaching from mentoring. Similarly, it is important to differentiate coaching from other roles (e.g. clinician, lecturer, supervisor) and maintain appropriate boundaries (Deiorio and Miller Juve 2016). A clear coaching philosophy (Tip 1) can help articulate these distinctions.

#### Tip 4

##### **Recognise that context (including resourcing) informs coaching design decisions**

The context and culture of an organisation and broader societal norms (Tip 1) will influence how a coaching

program is operationalised, including infrastructure and resourcing. These factors will inform decision-making in relation to coaching program design and implementation. Decisions should consider sustainability, financial viability, and scalability; hence, ongoing commitment from senior management is essential. Considerations include:

- How many coaches are required, and what is the ideal learner-coach ratio, to ensure program sustainability?
- Will coaches support learners at different stages of the course, or will they work with a single cohort until completion of the course?
- What systems and software will underpin and support the coaching program? How user-friendly are these systems? How will coaches be trained (Tip 5) and supported to use these systems? Can systems and software facilitate data access for research and evaluation (Tips 11 and 12)?
- How will the program be funded, and how much annual funding is required?
- Will the program be managed by dedicated staff or integrated into existing roles? A dedicated team, including administrative support, is invaluable in managing program logistics, particularly where coaching is embedded in complex, multi-year courses (Donner and Wheeler 2009).
- Will coaches be remunerated? Remuneration provides formal recognition and validation (Sheu et al. 2020). Based on a survey of 32 US medical schools, most schools with coaching programs offer 5–25% full time equivalent remuneration to coaches (Wolff, Hammoud, et al. 2020). For non-remunerated coaching programs, the expectations of the 'voluntary' coaching workforce may influence logistical decisions (e.g. the frequency of coaching sessions). Alternative ways to validate and acknowledge coaches' contributions should be considered (e.g. academic status, certification towards professional registration).
- How will coach attrition be managed?
- How will interpersonal issues between learners and coaches be managed?
- Is there capacity to provide remedial coaching for learners experiencing difficulties beyond that which can be supported by the student's coach? If so, who will provide this coaching, and how will this be managed?

#### Tip 5

##### **Establish a faculty development program and foster a coaching community**

Given the complexities of the coaching role (Tip 3), faculty development is critical (Manek 2004; Cleary and Horsfall 2015; Cameron et al. 2019) and should involve initial induction training complemented by ongoing, longitudinal support (Armson et al. 2019; Sheu et al. 2020). This is important because as learners progress through the course, needs and expectations change, requiring different scaffolding by the coach. Ongoing faculty development is also essential in ensuring consistency in coaching approach and quality (Wolff, Morgan, et al. 2020). Our respective programs involve 'calibration' sessions prior to each coaching cycle. These sessions support coaches to moderate



expectations of students at different stages of the course and discuss observations, issues, and coaching approaches.

Establishing a community of coaches (Heeneman and de Grave 2017) facilitates informal social learning, access to support and peer learning (Deiorio and Miller Juve 2016), strengthening and validating coach identities, and enhancing job satisfaction (Sheu et al. 2020). Within this community, create and maintain a peer learning culture to foster collective sense-making, thus reinforcing coaching as a distinct educational role. Aim to establish a non-hierarchical structure, if appropriate in the context of the coaching program, to position coaches as equal learning partners, emphasising sharing of practice to build individual and collective coaching capacity. To achieve this, consider how best to facilitate discussions about coaching practices. Both our programs offer faculty development through deidentified case-based discussions that are grounded in authentic experience and mirror coaching processes used with learners, similar to published recommendations for faculty development of coaches (Deiorio and Miller Juve 2016; Orr and Sonnadara 2019). All coaches are encouraged to participate in these sessions.

As coaching is likely to be a novel concept for faculty, providing timely training just before it is required ('just-in-time' training) can distribute cognitive load and promote deeper engagement. This is particularly useful for coaching programs embedded within broader, complex course structures. Working backwards from time-sensitive coaching activities can facilitate just-in-time training.

## Tip 6

### *Scaffold learner support to apply coaching concepts*

Support learners to understand fundamental coaching concepts (e.g. self-regulated learning, reflective practice, goal setting, and feedback) (Deiorio and Miller Juve 2016). Introducing these concepts simultaneously at the commencement of a course is not ideal. Learners are likely to experience cognitive overload as they grapple with the complexities of the course, assessment, and transitioning to a health professional course. Scaffolding this learning and using a 'just-in-time' approach, similar to faculty development for coaches (Tip 5), is preferable.

Design teaching sessions and learning resources with different learners in mind (e.g. the disengaged learner, the learner struggling to understand expectations of the coaching program, the highly motivated, engaged learner) and consider the learners' socio-cultural backgrounds in the context of their academic achievement. This can be achieved by remaining attentive to questions and feedback from learners and coaches to develop a suite of learning approaches and resources. For example, in conjunction with a Flinders medical student, we developed a helpful analogy in which the portfolio is like a laboratory notebook, wherein goals (experiments) are outlined and learning plans (methods) are detailed and evaluated over time. Remaining attentive even in established programs can help ensure all learners' needs are met while modelling reflective practice.

Support learners to explore various learning approaches. For example, developing specific, measurable, achievable, relevant, and timely (SMART) learning goals (Doran 1981;

Lawlor and Hornyak 2012) is a complex skill requiring practice and support. Similarly, reflective practice and reflective writing can prove challenging, particularly for learners with limited experience. Provide varied writing and goal-setting frameworks, encouraging learners to determine what works for them (Murdoch-Eaton and Sandars 2014; Wass and Harrison 2014).

## Tip 7

### *Clearly communicate expectations to facilitate learner engagement*

After defining the purpose of the coaching program (Tip 1), consider how to communicate, socialise, and promote this to various stakeholders (e.g. organisational leaders/managers, governing and accreditation bodies, coaches, and learners). Different stakeholders often require unique narratives or 'elevator pitches'. Donner and Wheeler (2009) recommend using multiple communication methods for key stakeholders, including testimonials and research evidence. Develop these narratives with various stakeholders in mind (e.g. the reluctant learner, the dubious clinician), to anticipate and address potential concerns. Narrative construction is an iterative process (Tip 1); trial narratives with various stakeholders to elicit feedback and prompt further refinement.

Use open, clear communication with stakeholders to reduce anxieties associated with educational change. Be attentive and responsive to feedback posed as questions and/or reactions to proposed plans. During implementation, clarify expectations for both learners and coaches. This can be facilitated by developing criteria and/or rubrics, supported by illustrative examples.

## Tip 8

### *Partner with colleagues to share coaching practices*

Seek opportunities to discuss coaching approaches and practices with like-minded colleagues within and across institutions (Deiorio and Miller Juve 2016; Reynolds 2020). This extends on Tip 5 by moving the focus beyond the institution.

Partnering can be beneficial for all parties as it facilitates peer learning beyond the local context. Indeed, our collaboration has been symbiotic, contributing to educational development in both institutions. Our distinct organisational cultures (Hofstede Insights n.d.) and societal norms have enabled us to refine our understanding of coaching principles and broaden implementation ideas. Writing this paper formalises and evidences our peer learning, not only contributing to our individual and collective scholarship, but also providing an invaluable embedded faculty development (Kumar et al. 2023) opportunity.

## Tip 9

### *Identify coaching champion teams to promote the program*

Several authors (e.g. Deiorio and Miller Juve 2016; Orr and Sonnadara 2019) highlight the importance of seeking the

support of senior champions and leaders (e.g. deans) who believe in coaching, with a designated project lead overseeing implementation. We suggest extending this to identify multiple coaching champions with different roles (e.g. coaches, learners, clinicians, educators) across diverse contexts (e.g. within and across the institution, and within health services).

While important to identify coaching champions during the design and implementation phases, it is equally important to *maintain* these champions. They can support the program's sustainability (Tip 4) by promoting the program through their professional networks, facilitating coach recruitment. Champions located across contexts can be particularly valuable where learners remain dubious about coaching, particularly in transitioning to clinical placements and practice. Ensuring the coaching philosophy remains contemporary (Tip 1) and is clearly communicated using diverse narratives (Tip 7) can help foster a team of coaching champions.

## Tip 10

### ***Be adaptable, flexible and responsive to implementation***

Although a clear design and implementation approach is important, it should not be so rigid as to prevent adaptation in response to feedback and new insights. To facilitate adaptability, establish an implementation *framework* rather than an implementation *plan*.

Adopt a similar mindset to that used when embarking on a research project: engage in an iterative process informed by literature, collegial discussions, and peer review; and develop strong internal alignment between framework elements. Align your coaching philosophy to the organisation's vision and mission (Tip 1) and course structure (Tip 2). Acknowledge the role of context in defining the coach's role, coaching practices (Tip 4), and coach selection (Tip 3).

Be transparent with stakeholders about any changes (Tip 7) and provide a clear rationale and evidence to facilitate a culture of trust and continuous improvement (Tip 11). This will demonstrate to stakeholders that reflective practice and utilisation of evidence to inform progress are not just activities for learners, but are also embedded in program-level processes. The Flinders team deliberately adopted this approach in developing an improvement plan in 2023. The preceding two years were characterised by widespread consultation with stakeholders, incorporating ongoing feedback from learners and coaches. All stakeholders received access to the full proposal, which ultimately received unanimous support.

## Tip 11

### ***Establish a continuous quality improvement coaching culture***

Coaching is founded on continuous improvement. Hence, a coaching program that embeds continuous quality improvement strengthens internal alignment (Tip 10). Ideally, integrate an improvement focus across all aspects of the coaching program, incorporating multiple angles and perspectives (Deiorio and Miller Juve 2016). This can,

in part, be achieved by establishing and maintaining an ongoing evaluation process (Donner and Wheeler 2009). To achieve this:

- Establish and maintain a partnership with learners and coaches and meaningfully engage with all stakeholders towards a common improvement focus.
- Be transparent and explicit about the rationale and method for introducing changes, including processes undertaken to achieve this (Tips 7, 10).
- Explicitly and deliberately model reflective practice and self-regulated learning by obtaining evidence (e.g. from stakeholder feedback (Tip 6) and routinely collected program evaluation data) to identify strengths and weaknesses, determine areas for improvement, and establish goals and plans, underpinned by ongoing monitoring of progress (Tip 10).
- Regularly review alignment between the coaching program's philosophy (Tip 1) and its implementation.

Cultivate a continuous improvement mindset amongst coaches, providing feedback opportunities as part of their continuing professional development (Reynolds 2020). Each coaching interaction should solicit learner feedback and promote self-reflection to enable coaches to evaluate their coaching approaches and facilitate deliberate practice (Marcdante and Simpson 2018). Feedback can be elicited through the use of validated tools (see Deiorio et al. 2016). Flinders coaching sessions conclude with a meeting debrief, wherein learners provide verbal feedback to their coach. This is complemented by written feedback as part of students' end-of-semester assessment. This enables coaches to improve their practices while supporting learners to develop skills in providing feedback, but does require coaches to demonstrate intellectual candour (Molloy and Bearman 2019).

## Tip 12

### ***Develop a program of coaching research and scholarship***

Just as continuous improvement (Tip 11) is important, so too is establishing a program of coaching research and scholarship. This is particularly pertinent given the paucity of research into the effectiveness of coaching to support learner development (Lovell 2018). A program of research and scholarship will contribute to the international body of coaching literature in HPE, providing evidence to demonstrate the impact of coaching while informing discussions with stakeholders (Tips 7, 10). Furthermore, coaching research can deepen understanding of best practice, enhance coaching effectiveness, and strengthen the bidirectional relationship between educational research and practice.

## Conclusion

As coaching becomes more widely practised in HPE, and the critical role of coaches in preparing the future health workforce is recognised, the number of health professional courses that adopt coaching will likely increase. This paper

extends the existing literature by offering evidence-based, experience-informed considerations in designing and implementing an academic coaching program. By sharing our learning, we intend to support colleagues who are introducing coaching programs into their courses who, in turn, will contribute to individual and collective coaching capacity and scholarship in HPE.

## Note

1. Henceforth referred to as coaching.

## Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

## Funding

The author(s) reported there is no funding associated with the work featured in this article.

## Notes on contributors

**Svetlana King**, BEd(Sec)(Hons)/BA, PhD, FANZAHPE, is a Senior Lecturer in Health Professions Education and MD Portfolio and Learning Coach Coordinator at Flinders University.

**Shafeena Anas** is Senior Lecturer (Education) at Brunel Medical School and lead for the Academic Coaching programme. She is also Academic Head of Team-Based Learning and Lead for Equality, Diversity and Inclusion (EDI).

**Ricardo Carnicer Hijazo**, PhD, FHEA, is a Lecturer in Education, Team-Based Learning Facilitator, Module Lead and House Tutor at Brunel Medical School.

**Johanna Jordaan**, MBChB, Adv Cert (Couns), is an Academic Status Holder and previous MD Portfolio and Learning Coach Coordinator at Flinders University.

**Jean Potter**, PhD, FRCP, is an Honorary Clinical Senior Lecturer and Senior House Tutor at Brunel Medical School, and Palliative Care Consultant at The Hillingdon Hospital NHS Foundation Trust, London UK.

**Professor Naomi Low-Beer**, MBBS MD, is Founding Dean of Brunel Medical School.

## ORCID

Svetlana M. King  <http://orcid.org/0000-0002-3977-7269>  
 Ricardo Carnicer Hijazo  <http://orcid.org/0000-0002-7440-2964>  
 Johanna Jordaan  <http://orcid.org/0000-0001-9821-6421>  
 Jean D. F. Potter  <http://orcid.org/0009-0002-0740-0368>  
 Naomi Low-Beer  <http://orcid.org/0000-0002-6801-0091>

## References

- Alfa-Wali M. 2013. Surgical leadership through coaching. *J Surg Educ*. 70(5):680–682. doi:10.1016/j.surg.2013.02.003.
- Armson H, Lockyer JM, Zetkovic M, Könings KD, Sargeant J. 2019. Identifying coaching skills to improve feedback use in postgraduate medical education. *Med Educ*. 53(5):477–493. doi:10.1111/medu.13818.
- Bannister SL, Wu TF, Keegan DA. 2018. The clinical COACH: how to enable your learners to own their learning. *Pediatrics*. 142(5):1. doi:10.1542/peds.2018-2601.
- Brown-O'Hara P. 2013. The influence of academic coaching on: Baccalaureate nursing students' academic success, perceptions of the academic coaching relationship, perceived NCLEX-RN exam readiness and success on the NCLEX-RN exam. Widener University School of Nursing.
- Buckley S, Coleman J, Davison I, Khan KS, Zamora J, Malick S, Morley D, Pollard D, Ashcroft T, Popovic C, et al. 2009. The educational effects of portfolios on undergraduate student learning: a Best Evidence Medical Education (BEME) systematic review. *Med Teach*. 31(4):282–298. BEME Guide No. 11 doi:10.1080/01421590902889897.
- Cameron D, Dromerick LJ, Ahn J, Dromerick AW. 2019. Executive/life coaching for first year medical students: a prospective study. *BMC Med Educ*. 19(1):163. doi:10.1186/s12909-019-1564-4.
- Cavalcanti RB, Detsky AS. 2011. The education and training of future physicians: why coaches can't be judges. *J Am Med Assoc*. 306(9):993–994.
- Chopra V, Arora VM, Saint S. 2018. Will you be my mentor? – four archetypes to help mentees succeed in academic medicine. *JAMA Intern Med*. 178(2):175–176. doi:10.1001/jamainternmed.2017.6537.
- Cleary M, Horsfall J. 2015. Coaching: comparisons with mentoring. *Issues Ment Health Nurs*. 36(3):243–245. doi:10.3109/01612840.2015.1002344.
- Clutterbuck D. 2008. What's happening in coaching and mentoring? And what is the difference between them? *Develop Learn Organ*. 22(4):8–10. doi:10.1108/14777280810886364.
- De Souza B, Viney R. 2014. Coaching and mentoring skills: necessities for today's doctors. *BMJ*. 348:g4244. doi:10.1136/bmj.g4244.
- Deiorio NM, Carney PA, Kahl LE, Bonura EM, Juve AM. 2016. Coaching: a new model for academic and career achievement. *Med Educ Online*. 21(1):33480. doi:10.3402/meo.v21.33480.
- Deiorio NM, Foster KW, Santen SA. 2021. Coaching a learner in medical education. *Acad Med*. 96(12):1758–1758. doi:10.1097/ACM.0000000000004168.
- Deiorio NM, Miller Juve A. 2016. Developing an academic coaching program. *MedEdPublish*. 5:143. doi:10.15694/mep.2016.000143.
- Donner GJ, Wheeler MM. 2009. Coaching in nursing: an introduction. Indianapolis, USA: International Council of Nurses.
- Doran GT. 1981. There's a SMART way to write management's goals and objectives. *Manag Rev*. 70(11):35–36.
- Driessen E. 2017. Do portfolios have a future? *Adv Health Sci Educ Theory Pract*. 22(1):221–228. doi:10.1007/s10459-016-9679-4.
- Gawande A. 2011. Annals of Medicine: personal best. *The New Yorker*. 87(30):44.
- Heeneman S, de Grave W. 2017. Tensions in mentoring medical students toward self-directed and reflective learning in a longitudinal portfolio-based mentoring system—an activity theory analysis. *Med Teach*. 39(4):368–376. doi:10.1080/0142159X.2017.1286308.
- Hofstede Insights. n.d. Organisational culture: what you need to know.
- Holt VP, Ladwa R. 2008. Mentoring. A quality assurance tool for dentists. Part 1: the need for mentoring in dental practice. *Primary Dental Care*. 15(4):141–146.
- King SM, Schuwirth LW, Jordaan JH. 2022. Embedding a coaching culture into programmatic assessment. *Education Sciences*. 12(4):273. doi:10.3390/educsci12040273.
- Kumar K, King SM, Kette G. 2023. Reconceptualising faculty development for the future. *Focus Health Profess Educ*. 24(3):106–114.
- Landreville J, Cheung W, Frank J, Richardson D. 2019. A definition for coaching in medical education. *Can Med Ed J*. 10(4):e109–e110. doi:10.36834/cmej.68713.
- Lawlor and Hornyak. 2012. SMART goals: how the application of smart goals can contribute to achievement of student learning outcomes. Annual ABSEL conference.
- Lovell B. 2018. What do we know about coaching in medical education? A literature review. *Med Educ*. 52(4):376–390. doi:10.1111/medu.13482.
- Manek N. 2004. Developing coaching skills: a practical approach for education supervision. *The Clin Teach*. 1(2):74–76. doi:10.1111/j.1743-498X.2004.00036.x.
- Marcdante K, Simpson D. 2018. Choosing when to advise, coach, or mentor. *J Grad Med Educ*. 10(2):227–228. doi:10.4300/JGME-D-18-00111.1.
- Molloy E, Bearman M. 2019. Embracing the tension between vulnerability and credibility: 'Intellectual candour' in health professions education. *Med Educ*. 53(1):32–41. doi:10.1111/medu.13649.
- Murdoch-Eaton D, Sandars J. 2014. Reflection: moving from a mandatory ritual to meaningful professional development. *Arch Dis Child*. 99(3):279–283. doi:10.1136/archdischild-2013-303948.

- Najibi S, Carney PA, Thayer EK, Deiorio NM. 2019. Differences in coaching needs among underrepresented minority medical students. *Fam Med*. 51(6):516–522. doi:[10.22454/FamMed.2019.100305](https://doi.org/10.22454/FamMed.2019.100305).
- Orr CJ, Sonnadara RR. 2019. Coaching by design: exploring a new approach to faculty development in a competency-based medical education curriculum. *Adv Med Educ Pract*. 10:229–244. doi:[10.2147/AMEP.S191470](https://doi.org/10.2147/AMEP.S191470).
- Pintrich PR. 2000. Chapter 14 The role of goal orientation in self-regulated learning. In Boekaerts M, Pintrich PR, Zeidner M, editors. *Handbook of self-regulation*. New York: Academic Press; p. 451–529.
- Ramani S, Kusurkar RA, Lyon-Maris J, Pyörälä E, Rogers GD, Samarasekera DD, Taylor DC, Ten Cate O. 2023. Mentorship in health professions education – an AMEE guide for mentors and mentees: AMEE Guide No. 167. *Med Teach*. 2023:1–13. doi:[10.1080/0142159X.2023.2273217](https://doi.org/10.1080/0142159X.2023.2273217).
- Reynolds AK. 2020. Academic coaching for learners in medical education: twelve tips for the learning specialist. *Med Teach*. 42(6):616–621. doi:[10.1080/0142159X.2019.1607271](https://doi.org/10.1080/0142159X.2019.1607271).
- Sargeant J, Lockyer J, Mann K, Holmboe E, Silver I, Armson H, Driessen E, MacLeod T, Yen W, Ross K, et al. 2015. Facilitated reflective performance feedback: developing an evidence- and theory-based model that builds relationship, explores reactions and content, and coaches for performance change (R2C2). *Acad Med*. 90(12):1698–1706. doi:[10.1097/ACM.0000000000000809](https://doi.org/10.1097/ACM.0000000000000809).
- Sargeant J, Lockyer JM, Mann K, Armson H, Warren A, Zetkovic M, Soklaridis S, Könings KD, Ross K, Silver I, et al. 2018. The R2C2 model in residency education: how does it foster coaching and promote feedback use? *Acad Med*. 93(7):1055–1063. doi:[10.1097/ACM.0000000000002131](https://doi.org/10.1097/ACM.0000000000002131).
- Schuwirth L, van der Vleuten C, Durning SJ. 2017. What programmatic assessment in medical education can learn from healthcare. *Perspect Med Educ*. 6(4):211–215. doi:[10.1007/s40037-017-0345-1](https://doi.org/10.1007/s40037-017-0345-1).
- Sheu L, Hauer KE, Schreiner K, van Schaik SM, Chang A, O'Brien BC. 2020. “A friendly place to grow as an educator”: A qualitative study of community and relationships among medical student coaches. *Acad Med*. 95(2):293–300. doi:[10.1097/ACM.0000000000002900](https://doi.org/10.1097/ACM.0000000000002900).
- Stokes P, Fatien Diochon P, Otter K. 2021. “Two sides of the same coin?” Coaching and mentoring and the agentic role of context. *Ann NY Acad Sci*. 1483(1):142–152. doi:[10.1111/nyas.14316](https://doi.org/10.1111/nyas.14316).
- Tofade T. 2010. Coaching younger practitioners and students using components of the co-active coaching model. *Am J Pharm Educ*. 74(3):51. doi:[10.5688/aj740351](https://doi.org/10.5688/aj740351).
- Van Mullem P, Brunner D. 2013. Developing a successful coaching philosophy: a step-by-step approach. *Strategies*. 26(3):29–34. doi:[10.1080/08924562.2013.779873](https://doi.org/10.1080/08924562.2013.779873).
- Wald HS, Reis SP. 2010. Beyond the margins: reflective writing and development of reflective capacity in medical education. *J Gen Intern Med*. 25(7):746–749. doi:[10.1007/s11606-010-1347-4](https://doi.org/10.1007/s11606-010-1347-4).
- Wass V, Harrison C. 2014. Empowering the learner to reflect: Do we need another approach? *Med Educ*. 48(12):1146–1147. doi:[10.1111/medu.12612](https://doi.org/10.1111/medu.12612).
- Watling CJ, LaDonna KA. 2019. Where philosophy meets culture: exploring how coaches conceptualise their roles. *Med Educ*. 53(5):467–476. doi:[10.1111/medu.13799](https://doi.org/10.1111/medu.13799).
- Wolff M, Deiorio NM, Miller Juve A, Richardson J, Gazelle G, Moore M, Santen SA, Hammoud MM. 2021. Beyond advising and mentoring: competencies for coaching in medical education. *Med Teach*. 43(10):1210–1213. doi:[10.1080/0142159X.2021.1947479](https://doi.org/10.1080/0142159X.2021.1947479).
- Wolff M, Hammoud M, Santen S, Deiorio N, Fix M. 2020. Coaching in undergraduate medical education: a national survey. *Med Educ Online*. 25(1):1699765. doi:[10.1080/10872981.2019.1699765](https://doi.org/10.1080/10872981.2019.1699765).
- Wolff M, Morgan H, Jackson J, Skye E, Hammoud M, Ross PT. 2020. Academic coaching: insights from the medical student’s perspective. *Med Teach*. 42(2):172–177. doi:[10.1080/0142159X.2019.1670341](https://doi.org/10.1080/0142159X.2019.1670341).
- Wolff M, Ross P, Jackson J, Skye E, Gay T, Dobson M, Hughes DT, Morgan HK. 2021. Facilitated transitions: coaching to improve the medical school to residency continuum. *Med Educ Online*. 26(1):1856464. doi:[10.1080/10872981.2020.1856464](https://doi.org/10.1080/10872981.2020.1856464).
- Wolff M, Stojan J, Buckler S, Cranford J, Whitman L, Gruppen L, Santen S. 2020. Coaching to improve self-directed learning. *Clin Teach*. 17(4):408–412. doi:[10.1111/tct.13109](https://doi.org/10.1111/tct.13109).
- Zimmerman BJ. 1990. Self-regulated learning and academic achievement: an overview. *Educ Psychol*. 25(1):3–17. doi:[10.1207/s15326985ep2501\\_2](https://doi.org/10.1207/s15326985ep2501_2).