*As the professional development of residents and its support is coming into focus … a more detailed comparison of coaching approaches might lead to fruitful insights.*

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## REFERENCES

1. Reitz R, Simmons PD, Runyan C, Hodgson J, Carter-Henry S. Multiple role relationships in healthcare education. *Fam Syst Health*. 2013;31(1):96-107. doi:10.1037/a0031862
2. Ferguson J, Wakeling J, Cunningham DE. General practice training in Scotland: the views of GP trainers and educators. *Education for Primary Care: An Official Publication of the Association of Course Organisers, National Association of GP Tutors, World Organisation of Family Doctors*. 2014;25(4):211-220. doi:10.1080/14739879.2014.11494279
3. Wearne S, Brown J. GP supervisors assessing GP registrars—theory and practice. *Aust Fam Physician*. 2014;43(12):887-891.
4. Hennel EK, Trachsel A, Subotic U, Lörwald AC, Harendza S, Huwendiek S. How does multisource feedback influence residency training? A qualitative case study. *Med Educ*. 2022;56(6):660-669. doi:10.1111/medu.14798
5. Lörwald AC, Lahner F-M, Mooser B, et al. Influences on the implementation of mini-CEX and DOPS for postgraduate medical trainees' learning: a grounded theory study. *Med Teach*. 2019;41(4):448-456. doi:10.1080/0142159X.2018.1497784
6. Telio S, Ajjawi R, Regehr G. The "educational alliance" as a framework for reconceptualizing feedback in medical education. *Acad Med*. 2015;90(5):609-614. doi:10.1097/ACM.0000000000000560
7. Telio S, Regehr G, Ajjawi R. Feedback and the educational alliance: examining credibility judgements and their consequences. *Med Educ*. 2016;50(9):933-942. doi:10.1111/medu.13063
8. Eva KW, Armson H, Holmboe E, et al. Factors influencing responsiveness to feedback: on the interplay between fear, confidence, and reasoning processes. *Adv Health Sci Educ Theory Pract*. 2012;17(1):15-26. doi:10.1007/s10459-011-9290-7
9. Sagasser M, Kramer AWM, Fluit CRMG, van Weel C, van der Vleuten CPM. Self-entrustment: how trainees' self-regulated learning supports participation in the workplace. *Advances in Health Sciences Education*. 2017;22(4):931-949. doi:10.1007/s10459-016-9723-4

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# Using fairness to reconcile tensions between coaching and assessment

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Coaching is dedicated to supporting learners' personal and professional development to assist them reach their potential.[1] In contrast, traditionally, assessment has been focused on achievement or selecting out the 'bad apples'. From this perspective,

coaching and assessment may seem as competing tensions but actually both are essential partners of each other. Coaching without assessment can be directionless, and closing the feedback loop often requires some form of assessment of whether goals have been attained. Assessment without coaching, on the other hand, means the only driver for learning is behaviourist and reductionist via grades.

But for coaching and assessment to be successful partners in learning, there needs to be mutual engagement, interaction, and partnership between coach and learner.[2] There are varied methods of coaching,[3] but a core component includes coach and learner collaborating on setting individual goals based on assessment and feedback.[4] The research study '*Goal co-construction and dialogue in an internal medicine longitudinal coaching program*', Farell et al. 2022 focuses on how goal developments unfolded between coach and learner.[5] This research followed eight coach-resident dyads over a 12-month period and noted that co-construction mainly occurred on how to meet goals, rather than prioritising of goals or co-constructing new goals. This appears to be a clash between an assessment ***of*** and an assessment ***for*** learning purpose in the coaching context. On the one hand, the coach seeks to support the learner, but in order to fulfil that role, they also have to form a judgement as to the learners' progress, and strengths and weaknesses. This judgement can easily be perceived as an assessment of learning which may hamper the uptake of the feedback.[6] Navigating this dilemma requires a coaching situation to be created in which both coach and learner see the process and judgement as fair. Without this perception of fairness, coaching is likely to be ineffective.

*On the one hand, the coach seeks to support the learner, but in order to fulfil that role, they also have to form a judgement as to the learners' progress, and strengths and weaknesses.*

Fairness is a fundamental quality of (health professions) education. It is often implied in assessment programmes but is not explicitly articulated as there is no simple definition.[7] Just as there is no set formula for coaching, there is no set formula which can be used for fairness. Previous research into fair judgements in assessment programmes showed that fairness has four key components: credibility, transparency, fitness for purpose and accountability,[8] and the relevance in the context of coaching is plausible. Credibility is related not only to the judgement itself but also to the person making the judgement[9]; learners are more receptive to feedback coming from sources they perceive as credible.[1] There is no recipe for a credible coach, but Lovell notes that coaches are expected to have expertise and experience within the relevant field.[4] Assessor engagement has also been noted to be important in the learner's credibility judgements.[7]

*Research into fair judgements in assessment programmes showed that fairness has four key components: credibility, transparency, fitness for purpose and accountability.*

Transparency in coaching relies on the provision of meaningful and useful feedback, enabling a shared understanding with the learner. Transparency can include a narrative which focuses on performance improvement[10] to ensure that learners do not continue to make the same mistakes.

Coaching allows for individualisation of learning goals. Learning in the workplace is produced by engagement with authentic clinical care and shaped by individual physical, social and organisational contexts.[11] Therefore, what is fit for purpose and fair to that individual must be determined by the coach and learner specifically to the individual contexts.

Finally, coaches have accountability to both learners and patients. Providing a culture within the coaching relationship which allows for learner agency and an opportunity to learn demonstrates accountability to learners. In addition, learners will become future health care professionals and need to meet the needs of the community. By ensuring that coaching focuses genuinely on developing the learner to be the best professional they can be, this accountability can work both ways.

These components of fairness are not simply a tick box list. At times, these components may appear to be in tension with one another. For example, a structured form forcing assessors to make judgements in a reductionist way may seem transparent but it is not credible or fit for purpose. It may actually diminish a learner's trust in the assessor and process.[12]

Like the clinical setting in which learning, assessment and coaching occur, fairness is a complex phenomenon. Using a complexity perspective is plausible and indeed encouraged within health professions education because clinical and learning environments are dynamic with numerous complex relationships and contexts.[13,14]

In the coaching situation, considering fair judgement as a complex adaptive system has strong explanatory power and can offer a better understanding of these tensions than linear or reductionist perspectives. Complexity holds that interactions and adaption of different components of the system are needed for an outcome to emerge.[15] Fairness is, therefore, created from the interactions between its

components[8] so there is no standard recipe to fairness, nor a one-size-fits-all solution. Expert and agile coaches have a repertoire of different strategies to support the interactions between credibility, transparency, fitness for purpose and accountability. In an assessment context, research demonstrated the types of strategies used by assessors to facilitate the interactions between the components of fairness including utilising narrative, aggregating evidence from multiple sources, procedural strategies, enabling a culture allowing for learner agency with a focus on their learning, articulating reasonable expectations of learners and ensuring a sound theoretic basis of assessment design.[8] These strategies may be different in the coaching scenario, and an extension of the aforementioned research study could be to review the existing 12 months of data to consider how fairness was created by the coaches in this study.

*Fairness is, therefore, created from the interactions between its components[8] so there is no standard recipe to fairness, nor a one-size-fits-all solution.*

Coaching and assessment are not irreconcilable but rather partners in a learning journey, with fair judgements being the essential linchpin necessary to ensure mutual engagement and interaction between coach and learner. Counterintuitively, overly strict regulatory frameworks and tick box approaches to managing this fairness may be appealing, but they would not do justice to the complexity of the real-world clinical and learning situation. Fairness can only be created through the interactions of its different components, facilitated by different strategies.

*Coaching and assessment are not irreconcilable but rather partners in a learning journey, with fair judgements being the essential linchpin necessary to ensure mutual engagement and interaction between coach and learner.*

Just as clinicians develop capability to handle the unknown, unpredictable and emergent; as coaches, learners and researchers, we need to do the same.[15] So while complexity thinking does not provide simple fixes, it does have implications for coach and learner training and the way coaching programmes are designed.

*Just as clinicians develop capability to handle the unknown, unpredictable and emergent; as coaches, learners and researchers we need to do the same.[15]*

## AUTHOR CONTRIBUTIONS

Both authors contributed to the design of the work, were involved in the writing of the paper, gave final approval for the version to be published and agree to be accountable for all aspects of the work.

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## REFERENCES

1. Atkinson A, Watling CJ, Brand PLP. Feedback and coaching. *Eur J Pediatr*. 2022;181(2):441-446. doi:10.1007/s00431-021-04118-8
2. Watling CJ, LaDonna KA. Where philosophy meets culture: exploring how coaches conceptualise their roles. *Med Educ*. 2019;53(5):467-476. doi:10.1111/medu.13799
3. Stoddard HA, Borges NJ. A typology of teaching roles and relationships for medical education. *Med Teach*. 2016;38(3):280-285. doi:10.3109/0142159X.2015.1045848
4. 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
5. Farrell L, Cuncic C, Hartford W, Hatala R, Ajjawi R. Goal co-construction and dialogue in an internal medicine longitudinal coaching programme. *Med Educ*. 2022;57(3):265-271. doi:10.1111/medu.14942
6. Harrison CJ, Könings KD, Dannefer EF, Schuwirth LWT, Wass V, Van der Vleuten CPM. Factors influencing students' receptivity to formative feedback emerging from different assessment cultures. *Perspect Med Educ*. 2016;5(5):276-284. doi:10.1007/s40037-016-0297-x
7. Valentine N, Durning S, Shanahan EM, Schuwirth L. Fairness in human judgement in assessment: a hermeneutic literature review and conceptual framework. *Adv Health Sci Educ Theory Pract*. 2021;26(2):713-738. doi:10.1007/s10459-020-10002-1
8. Valentine N, Shanahan M, Durning S, Schuwirth L. *Fairness in Assessment: Identifying a Complex Adaptive System. Manuscript Submitted for Publication*; 2022.

9. Chory RM. Enhancing student perceptions of fairness: the relationship between instructor credibility and classroom justice. *Commun Educ*. 2007;56(1):89-105. doi:10.1080/03634520600994300
10. Colbert CY, French JC, Herring ME, Dannefer EF. Fairness: the hidden challenge for competency-based postgraduate medical education programs. *Perspect Med Educ*. 2017;6(5):347-355. doi:10.1007/s40037-017-0359-8
11. Govaerts M, Van der Vleuten CP. Validity in work-based assessment: expanding our horizons. *Med Educ*. 2013;47(12):1164-1174. doi:10.1111/medu.12289
12. Watling CJ. Unfulfilled promise, untapped potential: feedback at the crossroads. *Med Teach*. 2014;36(8):692-697. doi:10.3109/0142159X.2014.889812
13. Mennin S. Self-organisation, integration and curriculum in the complex world of medical education. *Med Educ*. 2010;44(1):20-30. doi:10.1111/j.1365-2923.2009.03548.x
14. Fraser SW, Greenhalgh T. Coping with complexity: educating for capability. *BMJ*. 2001;323(7316):799-803. doi:10.1136/bmj.323.7316.799
15. Greenhalgh T, Papoutsi C. Studying complexity in health services research: desperately seeking an overdue paradigm shift. *BMC Med*. 2018;16(1):95. doi:10.1186/s12916-018-1089-4

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# Digital wellbeing: Are educational institutions paying enough attention?

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Digital medical education has expanded dramatically over the last decade: a quick search through the literature for terms associated with online education will reveal a roughly six-fold increase in publications over this period with hundreds of educational institutions describing their experiences of using technology to enhance learning. Examples include online learning to more recently, augmented, and virtual reality-based learning.[1–3] The COVID-19 pandemic created a further seismic shift towards digital teaching, learning and assessment as providers of medical education rushed to adapt to lockdowns, patient vulnerabilities, and reduced clinical placements. Technology-enhanced learning remains the current mainstay whereas institutions progressively attempt to find a new normal and adjust to the unpredictable pandemic era by returning to regular practice.[4] At a time where digitalisation is at the forefront of education provision, we recognise that very few articles are discussing the consequences of digital teaching methods on learner and educator wellbeing. Combining our initial scoping search of terms associated with digital medical education with the term 'wellbeing' revealed less than half a dozen articles that discussed or researched the consequences of digital teaching methods on the wellbeing of clinical learners or teachers.

Digital wellbeing looks at the impact of technologies and digital services on people's mental, physical, and emotional health. Today, learners and educators may be immersed in technology for most of their social, personal, learning and working needs. Younger students, in particular, may have a very active online presence from early childhood. Some may even have conducted most of their social and personal lives through online applications, social media, and gaming. Small and colleagues describe the impacts of technology use on brain health and development. The authors found that frequent use was associated with attention-deficit symptoms, addictive behaviours, lower emotional and social intelligence, and greater social isolation.[5] Rathakrishnan and colleagues found that electronic device addiction increased the risk of poor