Coaching in GME: Lessons Learned From 3 Unique Coaching Programs

Magdalena Scheer, MD, MHPE
Kevin R. Scott, MD, MSEd
Zachary Schoppen, MD
Barbara Porter, MD
Holly A. Caretta-Weyer, MD, MHPE
Maya M. Hammoud, MD, MBA
Abigail Ford Winkel, MD, MHPE

In graduate medical education (GME), medical school graduates must develop into competent independent clinicians who can simultaneously care for patients, attend to their own well-being, and largely self-direct their professional growth.[1,2] Coaching has gained traction in medical education due to its personalized approach and ability to promote lifelong learning, and may be useful in helping navigate the transition to residency given the diversity of trainees' strengths, challenges, and goals.[3-7] However, there is variability in the design and implementation of coaching in GME, contributing to uncertainty about how programs might incorporate coaching into their unique contexts.[8-12]

Miller-Kuhlmann and colleagues' framework for coaching program development provides a theory-based starting point.[13] Here, we compare 3 different coaching programs in GME, developed within the American Medical Association (AMA) Reimagining Residency grant-funded initiative, to highlight real-world solutions to implementation challenges. These 3 projects explored coaching in GME with variable scope and focus over 5 years: the Emergency Medicine Residency Program Evaluation and Assessment Consortium (EMRC), the New York University Transition to Residency Advantage (TRA) program, and the Right Resident, Right Program, Ready Day One (RRR) project in Obstetrics and Gynecology (OB/GYN).

All 3 projects share a conceptual model of coaching wherein trainees set the agenda and coaches ask questions and provide tools to facilitate trainees identifying their own goals and solutions.[14,15] This common approach frames coaching interactions regardless of the specific goals of the programs. Coaching is essentially holistic, acknowledging both the surrounding context and trainees' values and priorities. Coaching provides a personalized approach that empowers residents to take ownership of their growth through guided reflection and strategic questioning to foster self-directed learning, resilience, and adaptability—key skills for navigating the complexities of residency and preparing for independent practice. By focusing on the individual needs of trainees, coaching supports their professional development and well-being—a key Accreditation Council for Graduate Medical Education requirement—in ways that traditional training structures may not.[16]

Three Coaching Programs

The EMRC program implemented a competency-based coaching model using specialty-specific entrustable professional activities to promote trainee progression toward competency.[17] Coaching sessions with faculty coaches, who varied across 6 sites and included EMRC associate program directors (APDs), non-EMRC institution-based coaches, and core faculty, were guided by individualized learning plans. Some sites separated coaches from formal assessors to ensure psychological safety, while others combined roles to better align coaching with competency committee processes.

The TRA program focused on optimizing clinical performance and facilitating the transition from undergraduate medical education (UME) to GME through a structured "warm handoff" from UME advisers to GME coaches across multiple specialties (internal medicine, OB/GYN, emergency medicine, pathology, and orthopedic surgery). Based on the existing structure of each residency, faculty held different primary roles as educators, including core faculty and program directors. Following a coaching development program, faculty coached trainees in semistructured meetings from the Match through the end of postgraduate year 1.

The OB/GYN RRR initiative targeted the transition to residency for incoming OB/GYN interns across 112 university programs and 59 community-based programs by offering faculty coaching training and aligning coaching efforts with a unified Readiness for Residency curriculum. Coaches in the RRR program included program directors, APDs, faculty, chief residents, and nonclinical program managers, with an emphasis on addressing professional development, well-being, and work-life integration to support the residency transition.[18]

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Comparing these 3 projects demonstrates that context must drive the design and implementation of coaching programs. We encourage those designing a coaching program to ask the following questions that emerged during discussions among the authors as they analyzed these programs: What are the program objectives? Which residents will be coached? Which faculty will do the coaching? What is the expected focus of coaching meetings? The TABLE outlines these considerations for the EMRC, TRA, and RRR coaching programs.

The varying aims, structures, and successes of these coaching programs affirm the potential that coaching offers to address a range of GME needs. Some of these successes include enhanced well-being and professional fulfillment, development of adaptive learning skills, and enhanced clinical competency. Even with the robust financial support from the AMA Reimagining Residency initiative and enthusiastic support from grant and institutional leaders, the obstacles encountered by these projects offer lessons to inform future efforts to integrate coaching into GME.

Lesson 1: Trainee Engagement Is Both an Input and an Outcome of a Successful Coaching Program

Transitioning from the structured learning of medical school to the autonomy of residency requires a shift in mindset—from relying on teachers for answers to developing self-directed, lifelong learning habits. By asking questions and providing the tools for trainees to identify their own solutions, coaches can help residents develop self-directed learning skills.[14,15] Effective coaching programs must balance structured guidance with learner autonomy, by considering factors such as learner readiness, program goals, and institutional support. Because coaching is coachee-driven, early trainee engagement is a critical input to its success. While voluntary participation in coaching may seem appealing, we found that engagement often develops through positive coaching experiences. Early coaching should be encouraged or possibly mandated for all new residents, with continued participation based on individual needs. When implemented effectively, coaching helps learners integrate performance-based data and feedback to guide their professional growth. Ultimately, continued elective engagement should be considered an outcome of a well-designed coaching relationship.[20]

Lesson 2: Selecting the Ideal Coach Is a Balance of Coaching Ability and Availability

Selecting the right coaches requires careful consideration of several factors, including accessibility, interest, skills, and additional roles in assessment and supervision. Accessibility involves both the logistical aspects of scheduling and the coach's existing relationships with residents. Whereas the TRA project did compensate coaches, the EMRC and RRR projects did not. Although many education-minded faculty at the institutions were willing to volunteer their time and expertise, lack of compensation is a barrier for busy faculty and makes sustainability of a coaching program difficult.

Given resource constraints, it is often impractical to hire dedicated coaches. One solution may be to repurpose funds (or faculty bandwidth) for existing mentorship programs. Mentors are often assigned by training programs to support residents, but true mentorship requires alignment of resident and faculty interests. Residents often begin training too undifferentiated to make effective use of formal mentorship programs.[21,22]

Alternatively, we can incorporate coaching by training existing education faculty in the coaching skills of active listening, thoughtful questioning, and constructive feedback. Faculty in leadership roles possess a deep understanding of residents' experiences and goals and are highly motivated to support their development. However, their involvement in assessment and program oversight may compromise the psychological safety needed for open and vulnerable coaching conversations.

Ultimately, the best coaching structure fosters consistent and meaningful engagement between residents and coaches. Programs should focus on optimizing these connections by aligning coaching assignments with the needs of both residents and faculty, recognizing that effective solutions will vary depending on the unique context of each training environment.

Practical constraints, such as demanding schedules, further influence the effectiveness of coaching. Trainees are unlikely to welcome a program intended to support their well-being that requires significant commitment outside of work hours, or that comes at the expense of other desirable educational or recreational activities. Explicit effort to structure coaching sessions at convenient times for trainees will increase the acceptability of these programs in GME.

Lesson 3: Coaching Inherently Requires Flexibility in Expected Program Focus and Outcomes

Assessing the impact of coaching programs presents challenges due to variability in program structures, institutional contexts, and learner needs. Measuring outcomes is complex, as coaching is inherently individualized—residents focus on different aspects of professional growth based on their personal and

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TABLE
Summary of Reimagining Residency Projects Using Coaching

	Emergency Medicine Residency Program Evaluation and Assessment Consortium	New York University Transition to Residency Advantage Program	Right Resident, Right Program, Ready Day One
Program goal	Promote trainee progression toward competency—as assessed by new specialty-specific, tiered entrustable professional activities—through coaching sessions that utilize an individualized learning plan	Maximize the use of educational data to improve clinical performance and perform a "warm handoff" from the robust academic advising structure of UME to trainee-driven coaching during internship	Promote professional development of incoming interns across the specialty of OB/GYN specifically supporting the residency transition
Residents	Emergency medicine residents of all years at 6 medical centers	NYU interns in internal medicine, OB/GYN, EM, pathology, and orthopedic surgery (later expanded to psychiatry, neurology, pediatrics, and general surgery)	Matched applicants and first-year OB/GYN residents across the United States (112 university programs, 59 community-based programs)
Faculty	Varied by site (6 US medical centers): ▪ EM APDs ▪ Non-EM institution-based coaches ▪ Core faculty	All faculty participated in a faculty development program on coaching. Varied by department: ▪ Core faculty without formal residency leadership role ▪ Faculty mentors ▪ Program APDs or PDs	All coaches participated in a faculty development program on coaching. Varied by site (eg, PDs, APDs, faculty, chief residents, nonclinical program managers)
Practical constraints	Some sites attempted to keep formal assessors (competency committee members) separate from coaches to allow for psychological safety in the coaching relationship. Others did not have the resources to keep them separate, and so coaches held a formal assessment role; however, many residents appreciated this as they and their coaches had a greater understanding of the competency committee process and could more easily connect the assessments to coaching conversations.	NYU has a robust educational data profile on learners and a significant number of graduates (approximately 40%) staying for residency, which may not be present at all sites to support the warm handoff. Subsequent coaching program success varied based on trainee and faculty engagement and structural support for the meetings from the program (eg, dedicated time).	Wide variations in program size, context, and resources exist throughout OB/GYN residency programs nationally. Some residents did not want to be coached by faculty from their specialty, so they were paired with trained faculty from another specialty.
Intended coaching focus	Clinical performance	▪ Clinical performance ▪ Professional development	▪ Professional development
Actual coaching focus[a]	Clinical performance and professional development	▪ Clinical performance ▪ Work-life integration ▪ Career planning ▪ Well-being	▪ Transition to residency ▪ Well-being ▪ Work-life integration
Outcomes	▪ Feedback suggests shift toward trainee-driven planning of learning and improved ability to self-assess. ▪ Feedback suggests increased trainee ability to address dissonance between internal and external assessments. ▪ Improved goal setting that aligns with accurate learning needs.	▪ Faculty found coaching training productive and acceptable.[4] ▪ Participants noted potential benefit in making explicit the pathway for professional growth and development. ▪ Potential to support individualized, self-directed learning.[15]	▪ At many programs, faculty volunteered for training, which demonstrates high interest. ▪ As programs used varying implementation models, overall outcome assessments are difficult.

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TABLE
Summary of Reimagining Residency Projects Using Coaching (continued)

	Emergency Medicine Residency Program Evaluation and Assessment Consortium	New York University Transition to Residency Advantage Program	Right Resident, Right Program, Ready Day One
	▪ For programs using professional development coaching (trainee rotation selection, project participation, and other academic involvement): improved alignment of long-term career goals with individual core values and interests.	▪ Residents reported improved professional fulfillment, with greater differences in those experiencing burnout.[19]	

[a] Intended vs actual because the programs evolved to meet the needs of the learner.
Abbreviations: UME, undergraduate medical education; OB/GYN, obstetrics and gynecology; NYU, New York University; EM, emergency medicine; APD, associate program director; PD, program director.

career goals. Confidentiality of coaching relationships fosters psychological safety and vulnerability, but it further complicates traditional assessment methods.

Despite these challenges, evaluation is essential and should be guided by the specific goals of the coaching program. Whether the primary aim is to enhance clinical competency, improve organization, support career development, or promote well-being, assessment strategies should align with those objectives. Additionally, surrounding context and culture play a key role, so demonstrating the impact on the learning environment, trainees, and faculty doing the coaching are important to support a case for coaching in busy training programs.

In all 3 of our programs, the intended and actual focus of coaching differed slightly, with greater-than-anticipated attention to professional development and work-life integration. A well-designed evaluation framework acknowledges the flexibility inherent in coaching while ensuring meaningful outcomes can be tracked at both the individual and programmatic levels. Rather than viewing variability as a limitation, it should be embraced as a strength—allowing coaching programs to adapt to the diverse needs of learners.

Conclusion

Developing a coaching program is complex and requires many different choices: which residents, which faculty, which structure, which program aims, which outcomes. Coaching is a flexible and adaptive approach to develop self-directed, motivated, fulfilled physicians who engage in lifelong learning. Effective coaching requires time, frequent contact, and psychological safety, all of which must be balanced with coaches' other GME responsibilities. Educators should lobby for the resources necessary to design and implement coaching in their unique contexts while maintaining flexibility, as the end product and impact may be broader than originally expected.

References

1. O'Brien BC. What to do about the transition to residency? Exploring problems and solutions from three perspectives. *Acad Med*. 2018;93(5):681-684. doi:10.1097/ACM.0000000000002150
2. Kassam A, Nickell L, Pethrick H, Mountjoy M, Topps M, Lorenzetti DL. Facilitating learner-centered transition to residency: a scoping review of programs aimed at intrinsic competencies. *Teach Learn Med*. 2020;33(1):10-20. doi:10.1080/10401334.2020.1789466
3. Chang LY, Eliasz KL, Cacciatore DT, Winkel AF. The transition from medical student to resident: a qualitative study of new residents' perspectives. *Acad Med*. 2020;95(9):1421-1427. doi:10.1097/ACM.0000000000003474
4. Winkel AF, Gillespie C, Park A, et al. Bridging the gap from student to doctor: developing coaches for the transition to residency. *Med Educ Online*. 2023;28(1):2145103. doi:10.1080/10872981.2022.2145103
5. Deiorio NM, Carney PA, Kahl LE, Bonura EM, Juve AM. Coaching: a new model for academic and career achievement. *Med Educ Online*. 2016;21(1):33480. doi:10.3402/meo.v21.33480
6. 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
7. Wolff M, Hammoud M, Santen S, Deiorio N, Fix M. Coaching in undergraduate medical education: a national survey. *Med Educ Online*. 2020;25(1):1699765. doi:10.1080/10872981.2019.1699765
8. Deiorio NM, Moore M, Santen SA, Gazelle G, Dalrymple JL, Hammoud M. Coaching models, theories, and structures: an overview for teaching faculty in the emergency department and educators in the offices. *AEM Educ Train*. 2022;6(5):e10801. doi:10.1002/aet2.10801
9. MacKenzie C, Chan TM, Mondoux S. Clinical improvement interventions for residents and practicing physicians: a scoping review of coaching and mentoring

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for practice improvement. *AEM Educ Train*. 2019;3(4):353-364. doi:10.1002/aet2.10345
10. Redman C, Chung CG, McFarlane D, Meara A, Ejaz A. Graduate medical education success coaching for residents and fellows: a single-institution real-world experience. *Med Educ Online*. 2024;29(1):2342102. doi:10.1080/10872981.2024.2342102
11. Awadallah NS, Jones TS, Christian N, et al. Proactive coaching in general surgery internship: incorporating well-being practices into resident professional life. *J Surg Educ*. 2023;80(2):177-184. doi:10.1016/j.jsurg.2022.09.021
12. Mann A, Fainstad T, Shah P, et al. "We're all going through it": impact of an online group coaching program for medical trainees: a qualitative analysis. *BMC Med Educ*. 2022;22(1):675. doi:10.1186/s12909-022-03729-5
13. Miller-Kuhlmann R, Sasnal M, Gold CA, et al. Tips for developing a coaching program in medical education. *Med Educ Online*. 2024;29(1):2289262. doi:10.1080/10872981.2023.2289262
14. Wolff M, Deiorio NM, Miller Juve A, et al. Beyond advising and mentoring: competencies for coaching in medical education. *Med Teach*. 2021;43(10):1210-1213. doi:10.1080/0142159X.2021.1947479
15. Park A, Gillespie C, Triola M, Buckvar-Keltz L, Greene RE, Winkel AF. Scaffolding the transition to residency: a qualitative study of coach and resident perspectives. *Acad Med*. 2024;99(1):91-97. doi:10.1097/ACM.0000000000005446
16. Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Clinical Pathology. Accessed April 23, 2024. https://www.acgme.org/globalassets/pfassets/programrequirements/300_pathology_2023.pdf
17. Caretta-Weyer HA, Sebok-Syer SS, Morris AM, et al. Better together: a multistakeholder approach to developing specialty-wide entrustable professional activities in emergency medicine. *AEM Educ Train*. 2024;8(2):e10974. doi:10.1002/aet2.10974
18. Strand EA, Worly BL, Morgan HK, et al. How we do it: student perspectives on changes to the obstetrics and gynecology residency application process. *J Surg Educ*. 2022;79(5):1093-1098. doi:10.1016/j.jsurg.2022.04.006
19. Winkel AF, Porter B, Scheer MR, et al. Evaluating the impact of coaching through the transition to residency. *J Gen Intern Med*. 2025;40(1):10-16. doi:10.1007/s11606-024-08865-w
20. Garibaldi BT, Hollon MM, Woodworth GE, Winkel AF, Desai SV. Navigating the landscape of precision education: insights from on-the-ground initiatives. *Acad Med*. 2024;99(4 suppl 1):71-76. doi:10.1097/ACM.0000000000005606
21. Joe MB, Cusano A, Leckie J, et al. Mentorship programs in residency: a scoping review. *J Grad Med Educ*. 2023;15(2):190-200. doi:10.4300/JGME-D-22-00415.1
22. Marcdante K, Simpson D. Choosing when to advise, coach, or mentor. *J Grad Med Educ*. 2018;10(2):227-228. doi:10.4300/JGME-D-18-00111.1

Magdalena Scheer, MD, MHPE, is an Assistant Professor of Emergency Medicine and Director of Integrated Clinical Skills, New York University (NYU) Grossman School of Medicine, New York, New York, USA; **Kevin R. Scott, MD, MSEd,** is an Associate Professor and Academic Chair of Emergency Medicine, Geisinger College of Health Sciences, Scranton, Pennsylvania, USA, and Residency Program Director, Geisinger Northeast Emergency Medicine, Geisinger Wyoming Valley Medical Center, Wilkes-Barre, Pennsylvania, USA; **Zachary Schoppen, MD,** is a Clinical Assistant Professor of Obstetrics and Gynecology, Corewell Health/Michigan State University School of Human Medicine, Grand Rapids, Michigan, USA; **Barbara Porter, MD,** is an Associate Professor of Medicine and Associate Director, Outpatient Experience, Internal Medicine Residency, NYU Grossman School of Medicine, New York, New York, USA; **Holly A. Caretta-Weyer, MD, MHPE,** is Clinical Associate Professor, Department of Emergency Medicine, and Associate Dean of Admissions and Assessment, Stanford University School of Medicine, Palo Alto, California, USA; **Maya M. Hammoud, MD, MBA,** is a Professor of Obstetrics and Gynecology and Learning Health Sciences, University of Michigan, Ann Arbor, Michigan, USA; and **Abigail Ford Winkel, MD, MHPE,** is a Professor and Vice Chair for Education, Department of Obstetrics and Gynecology, and Assistant Director, Institute for Innovations in Medical Education, New York University Grossman School of Medicine, New York, New York, USA.

Corresponding author: Zachary Schoppen, MD, Corewell Health/Michigan State University School of Human Medicine, Grand Rapids, Michigan, USA, zschop2@gmail.com

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