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Author: Sawatsky Adam P. MD, MS; Huffman Brandon M. MD; Hafferty Fred W. PhD

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Coaching Versus Competency to Facilitate Professional Identity Formation

Adam P. Sawatsky, MD, MS, Brandon M. Huffman, MD, and Fred W. Hafferty, PhD

A.P. Sawatsky is assistant professor of medicine, Division of General Internal Medicine, Mayo Clinic, Rochester, Minnesota; ORCID: <http://orcid.org/0000-0003-4050-7984>.

B.M. Huffman was associate consultant, Division of Hospital Internal Medicine, Mayo Clinic, Rochester, Minnesota, at the time of writing. He is now chief resident, Department of Medicine, Mayo Clinic, Rochester, Minnesota.

F.W. Hafferty is professor of medical education, Program in Professionalism and Values, Mayo Clinic, Rochester, Minnesota.

Correspondence should be addressed to Adam P. Sawatsky, Mayo Clinic, Division of General Internal Medicine, Gonda Building, 17th Floor, Rochester, MN 55905; telephone: (507) 284-8913; email: sawatsky.adam@mayo.edu; Twitter: @APSawatskyMD.

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Abstract

Professional identity formation, with its focus on the development of professional values, actions, and aspirations, is the ideal goal of medical education. Medicine is a community of practice, and medical education is a socialization process by which novice trainees become full community members. The authors believe coaching provides an ideal means for promoting this socialization process to develop a learner's identity as they engage in the community. Coaching involves an orientation toward growth and development, valuing reflection and nurturing continuous reflection, and embracing failure as an opportunity for learning. Competency-based medical education has provided clear outcomes (competencies) for medical education and programs of assessment around these competencies. Yet, there is a tension in medical training between professional identity formation (the process of socialization into the profession) and the formal assessment process. The ideal of multiple low-stakes assessments and written evaluations, intended as formative assessments, are perceived by residents as high-stakes evaluations with significant consequences for their future. The authors present a resident story that highlights this tension. They outline Goffman's theory of impression management, postulating that medicine's assessment system encourages residents to stage a performance for evaluators that displays their competence and conceals their perceived weaknesses. This performance hinders the formation of an appropriate professional identity. Coaching, the authors believe, provides a model that aligns assessment and professional identity formation. The authors propose several questions to contemplate when integrating coaching into medical education to facilitate the goal of professional identity formation.

“When failure is not an option we can forget about learning, creativity, and innovation.” — Brené Brown, *Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead*¹

I entered the resident work room on Match Day.* I was excited to see where the residents were headed for fellowship next year. The room, lined with computers, was abuzz as residents scanned patient charts and finished progress notes for the day. I tapped one of the senior residents on the back. She turned and looked crestfallen, bidding me with her eyes not to ask the question on the edge of my tongue. It was a question that she had painfully answered too many times already that day. I obliged, turned, and walked away. I found out later that she had not matched into a subspecialty fellowship.

I had worked with her regularly during residency. When presenting patients in resident continuity clinic, she regularly asked questions, readily admitted opportunities for growth, and genuinely engaged in learning. She presented thoughtful treatment plans for her patients while acknowledging and embracing uncertainty, rather than avoiding it in an attempt to exude confidence and decisiveness to her attending physicians. At one point, she stopped into my office to discuss a case where she had made an error that delayed care for a patient, seeking feedback for improvement and discussing the guilt she experienced that resulted from the situation. As she became a senior resident, she was willing to say “I don’t know” to questions from first-year residents and medical students and engage with them in finding the answers to their questions. While these qualities had undoubtedly facilitated her growth into the excellent doctor that she

* The story is told in the first person for effect. The story is not about a single resident, rather it represents a conglomeration of different residents that we have worked with during our time as medical educators. We chose to do this to illustrate a point and to protect the identity of any single resident.

was, I could not help but think that authentically presenting these same qualities may have hurt her in the fellowship match. I saw her as being caught between the development of her professional identity and a formal assessment system that had real consequences for her future career.

The many stories we have encountered like this implored us to reflect on the complexities of professional identity formation in medical education. In this Perspective, we will discuss the ideal process of professional identity formation in medical education, the challenge to implementing this ideal process within the current medical education environment, and potential steps forward.

Professional identity formation, with its focus on the development of professional values, actions, and aspirations, is the ideal goal of medical education.² Jarvis-Selinger and colleagues framed the discussion of professional identity formation in medical education by highlighting that it is “an adaptive, developmental process that happens simultaneously at two levels: (1) at the level of the individual, which involves the psychological development of the person and (2) at the collective level, which involves a socialization of the person into appropriate roles and forms of participation in the community’s work.”³ Cruess and colleagues, incorporating work from cognitive psychology (i.e., Kegan’s stages of personal identity formation⁴) and sociology (i.e., Wenger’s work on situated learning and communities of practice⁵), have proposed a model for the process of shaping a physician’s professional identity, wherein a lay person with an existing personal identity engages in experiences within the professional community through conscious reflection on and unconscious acquisition of the knowledge, skills, and attitudes needed to become a professional who “think[s], act[s], and feel[s] like a physician.”⁶ Cruess and colleagues have further advocated that the theory of communities of practice could serve as a

foundational framework for medical education, including curricular, instructional, and assessment practices, and the process of professional identity formation that details how an individual would move from legitimate peripheral participation to full membership in the profession.⁷ In this framework, by engaging in the activities of the profession, a novice is accepted and becomes part of the community, while taking on the shared ideals of community. Framing the approach to medical education and the process of professional identity formation in the theory of communities of practice has implications learners. For example, to become part of a community of practice, learners must first enter into a process called identification, which requires engaging in the activities of the community, imaging themselves as part of the community, and aligning with the values of the community.⁸ A learner's identity is shaped as they move through the community of practice, which often generates tensions between the learner's personal identity, professional identity, and professional community.⁸ In the story above, this tension was manifested in the learner's desire for personal and professional growth and the professional community's use of assessment for learner growth and development *and* as a means for choosing who to advance to the next level of training. Because of these tensions, the process of professional identity formation will often involve experiences of failure and intense emotions as learners navigate these tensions.⁸ We have seen this in our own work with residents who engaged in international health electives, in which they faced disorienting dilemmas, experienced strong emotional responses, and engaged in critical reflection and discussion, and thus, engaged in identity transformation.⁹ Within a community of practice, while the learner has agency to engage in the activities and with the ideals of the professional community, the learner is also shaped by the professional community.

So, how should professional identity formation be fostered in medical education? Coaching, we believe, provides an ideal means for promoting professional identity formation in medical education. Through their qualitative work on coaching, Watling and LaDonna conceptualized the core aspects of clinical coaching as several philosophies that are shared by the coach and the learner:

1. Mutual orientation toward growth and development, with the purpose of unlocking human potential,
2. Valuing reflection and nurturing continuous reflection in the learner to maintain growth, and
3. Embracing failure and endorsing the learning value of failure.¹⁰

Coaching provides the opportunity for learners to regularly engage with role models, mentors, experiences, and reflection, all factors that have a large impact on professional identity formation.^{6,11} Coaching carries a connotation of mutual engagement and partnership, of dedication to the growth of an individual, and of embracing vulnerability and teaching the learner to “fail well.”¹⁰ As such, it is well-suited for engaging learners in professional identity formation. Learners can embrace the tensions that they face between their personal identity, professional identity, and professional community, and process these tensions and the resulting emotions with their clinical coaches as they engage with experiences and learn the knowledge, skills, and attitudes that are required of them as a physician. While, we believe, coaching provides an ideal setting to foster professional identity formation in medical education, there are challenges to implementing coaching in medical education.

In order to create an environment that positively fosters professional identity formation, it is crucial that full members of the community clearly define the ideals of the profession, create a welcoming community for learners, engage learners in their journey to full participation, and “explicitly address the major factors influencing professional identity formation.”⁷ The medical community has sought to clearly define the professional ideals that underpin the process of professional identity formation. For example, the desired outcomes of medical education have been specified, most notably by the Accreditation Council for Graduate Medical Education (ACGME)¹² and CanMEDS¹³ physician competency frameworks.

These competency frameworks explicitly outline the goals of medical education, define what a professional should look like, and provide guidelines for curriculum development and learner assessment.¹⁴ The competencies the frameworks outline provide a structure for robust programs of assessment with multiple and regular assessments of learners as they progress through their training. For example, the ACGME instituted milestone assessments to provide transparent performance requirements for residents and fellows, provide a framework for resident and fellow assessments, and improve reporting to accrediting bodies and certification boards.¹⁵

How has this push for competency-based medical education (CBME), with increasing direct observation, formal assessment, and numerous written evaluations, affected trainees? The ideal of CBME is regular low-stakes programmatic assessments of learners that support professional growth.¹⁶ Nonetheless, residents tend to view all observation as assessment and suspect that any and all aspects of their performance have implications for “formal assessment, [their] permanent record, and even their training or career advancement.”¹⁷ As such, even low-stakes assessments, if coupled with permanent written evaluations, are often perceived by residents as high stakes and thus shape their interactions with faculty members.

While the communities of practice lens provides an overview of the process of socialization into the medical profession, it is inadequate to explain this conundrum. Alternatively, there are other theories that can provide a more telling lens for exploring how formal assessment influences professional identity formation. Goffman, in his work, *The Presentation of Self in Everyday Life*, presents his theory of impression management, which holds that when people enter into the presence of others, they seek to understand the situation and what is expected of them, and use that information to act in a manner that will get certain responses from the other people within the situation.¹⁸ He writes that “regardless of the particular objective which the individual has in mind and of his motive for having this objective, it will be in his interests to control the conduct of the others, especially their responsive treatment of him.”¹⁸ From this perspective, formal assessment sets up two teams—the learner as a performer and the faculty member as an audience to the learner’s performance.¹⁸ There are several examples of this performance in medical education. Residents across specialties at one institution regularly staged a performance when observed because that observation was graded and they thought that grade would have consequences for their career advancement.¹⁷ In surgical training, residents often put on a performance for their attending physicians, attempting to display confidence and decisiveness.¹⁹ By managing impressions, residents may hope to build a positive reputation, shape their supervisor’s evaluations, and attain more learning opportunities; residents may also recognize that impression management hinders their education and wellness, and ultimately may impact patient care.¹⁹ In our experience, based on our work in internal medicine, residents often stage a performance to portray confidence to gain greater autonomy in their practice.

Further, Goffman describes the frontstage where the performance occurs; in the front stage, “some aspects of the activity are expressively accentuated and other aspects, which might discredit the fostered impression, are suppressed.”¹⁸ There is also the backstage “where the suppressed facts make an appearance.”¹⁸ The backstage is where learners can work out their frontstage performances; it is a place where their uncertainty is often manifested and can remain hidden from the frontstage performance. An example of a frontstage performance is a resident’s formal case presentation to the attending on rounds, while in the backstage, the resident had talked through the case with a senior resident to work out the details of the case.

Given this theoretical framing, medical educators can see how formal assessment may shape the frontstage performance of residents when they present cases and discuss clinical decisions with their supervisors. Because of the ubiquitous nature of formal assessment, the stated goal of competence, and the perceived high-stakes nature of written evaluations, the goal of residents’ performances in front of faculty members is often to portray competence in all assessment domains and hide any weakness that might get them a lower evaluation score. Therefore, within the current CBME-driven medical education environment, community of practice gatekeepers unwittingly set up a system that may incentivize learners to hide their perceived weaknesses, negatively affecting their personal and professional identity formation, a system in which competency is no longer seen as the end goal of training but is the perceived goal of every observation encounter.

So where does this leave the medical education community? Within the countervailing tensions between assessment *of* learning and assessment *for* learning within CBME, do medical educators truly believe that “professional identity formation—the development of professional values, actions, and aspirations—should be a major focus of medical education”?² If so, then how then

can medical education shift the current assessment model to one that supports professional identity formation?

The coaching framework makes it acceptable for learners to reveal areas where they feel there is opportunity for growth and receive feedback on those areas. Under this model, impression management is viewed as dysfunctional. The coaching model supports vulnerability and authenticity, encouraging the learner to reveal their weaknesses as opportunities for growth. The goal of assessment within a coaching model is for the learner and coach to track progress and for the coach to provide feedback for growth. Nonetheless, the philosophies that underpin a coaching model may be particularly difficult to realize within medicine's current community of practice, given that the current culture is not comfortable with vulnerability and that the lines between coaching for professional growth and supervision for assessment of performance are regularly blurred.¹⁰ As a consequence, residents routinely act to "please the observer" because they rarely see the purpose of observation as coaching.¹⁷ If educators are to embrace coaching in medical education, there needs to be a culture change, which, among other things, will need to address how medical education structures formal assessment of competency.

CBME has provided clear outcomes for medical education and competency assessment allows training programs to prove to accrediting bodies and society at large that the physicians being graduated have the necessary competencies to practice medicine. While this function of formal assessment cannot be replaced, educators need to minimize the negative impact that it has on professional identity formation. Educators also need to realize that focusing on core competencies and performance early in training may make sense, but as a trainee progresses through training, there is "a gradual integration of competencies into a more holistic identity as a physician."³

Given the above, how does medical education shift the current assessment model to one that supports coaching as a model for facilitating professional identity formation? As coaching is well-suited for professional identity formation, educators need to make space within CBME for building coaching relationships. If educators want to make coaching a reality in medical education, they need to consider the following questions when integrating coaching into medical education:

1. How does medical education separate formative assessment and feedback from the formal assessment process, therefore, allowing space for coaching for professional identity formation?
2. How much formal assessment is actually necessary to ensure that the physicians graduating from residency training programs are competent?
3. How might formal assessment look different across the continuum of medical education; for example, how might the purpose of formal assessment move from the assessment of individual competencies to the coaching of a holistic identity that integrates all the competencies into the practice of medicine?

Lastly, apart from these questions is the larger question that medical education needs to address as a community of practice. Medical educators need to decide where the demonstration of weaknesses and opportunities for growth fit into the process of socializing physicians. Do educators want vulnerability to continue to be limited to the backstage, hidden from faculty members who hold power over learners' acceptance into the community and their future training and jobs, and, therefore, negatively impacting professional identity formation? Alternatively, do educators want to bring vulnerability into the frontstage performance, accepting it as part of the ideal of the profession, and allow it to shape the growth and development of a holistic

professional identity in trainees? To engage with coaching in medical education, educators either need to shift expectations and allow residents to safely reveal weakness as part of their frontstage performance or provide residents with adequate backstage space to reveal their weaknesses and seek feedback for growth. Medical educators can role model vulnerability through intellectual²⁰ and emotional²¹ candor, creating a learning environment that allows space for vulnerability, open discussion, coaching, and, ultimately, the professional identity formation that is closest to the ideal. This type of learning environment would provide space where residents can engage with their experiences openly, portraying their authentic self and receiving formative feedback through coaching, instead of putting on a performance of competence and hiding their weaknesses.

Returning to the resident I ran into that fellowship Match Day, I saw someone caught up in the realities of formal assessment and ultimately disadvantaged by her desired community of practice because she embraced vulnerability. She approached her faculty members as coaches but was unfortunately tied to an assessment model that was incongruous with coaching. I believe that she ultimately will do well because she embraces vulnerability as an opportunity for learning and growth. Nonetheless, I worry about how the current competency-based formal assessment system may continue to disadvantage learners like her who have the courage to embrace their weaknesses in the current learning environment as well as those learners who choose to hide their weaknesses from those that could help them grow.

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