#4N1 (2449) Feedback-seeking behaviors in residents: Perspective from program directors, program administrative assistants and resident leaders

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Background: On-going transitions to a competency based education system in medicine necessitates increased feedback from preceptors and feedback-seeking behaviors from residents. The purpose of this project was to gain insight from program directors (PDs), program administrative assistants (PAAs) and chief residents (CRs) on resident feedback-seeking behaviors.

Summary of work: 44 participants (9 PDs; 18 PAAs; 17 CRs) provided input on feedback-seeking behaviors, including the frequency, negative and positive perceptions, encouragement within the program, and the key competencies feedback is/should be sought out in. Both quantitative (ANOVA, descriptives) and qualitative (content analysis) methods were used in data analysis.

Summary of results: 79% indicated that residents seek additional feedback very infrequently. Negative perceptions associated with seeking additional feedback included being perceived as lacking confidence (15%), high maintenance (15%), aggressive and insecure, (24%), and a risk of being flagged (9%). CRs believed that residents sought less feedback in the medical expert domain.

Discussion: Negative perceptions associated with seeking additional feedback are not conducive to optimal learning. These have to be managed by faculty and learner development.

Conclusion: Feedback in medical education is an integral component to positive learner outcomes. These results highlight the need to promote a culture of feedback-seeking behaviors across programs, supervisors, administration and residents.

Take-home message: Seeking additional feedback is essential for acquiring competencies and efforts are required to ensure that this does not reflect negatively on the learner.

#4N2 (1186) Safety first: the way feedback is verbally and non-verbally transferred and received during upward feedback dialogues

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Background: Two factors important for effective feedback are feedback’s quality and a safe environment. In medical education literature these factors are predominantly studied in feedback from supervisors to residents. Little research exists how these factors come forward in upward feedback dialogues (UFD) between residents and supervisors about supervision quality.

Summary of work: A mixed-method study was conducted to study the verbal feedback-process and non-verbal behaviors during 12 UFD in which two residents gave feedback to their supervisor. UFD were observed for non-verbal behaviors with a structured observation scheme. Dialogues’ transcripts were analyzed by template-analyses, which contained i.a. feedback-level (self, task, process, self-regulation).

Summary of results: Results showed key themes about the verbal feedback-process like feedback-level, concretize, self-reflection, mitigating feedback, emotional reactions, formulation of action points and protection. The average occurrences over time of the following non-verbal behaviors were described for both residents and supervisors: appropriate touch, facial-expressions, body position, gestures, eye-contact and forward lean.

Discussion: The verbal feedback-process and the non-verbal behaviors both show that during UFD residents and supervisors strongly focus on maintaining a safe environment but less on the transfer of good quality feedback. It can therefore be questioned if feedback in this way is most effectively transferred and received.

Conclusion: Based on our results we conclude that there is a tension between creating a safe sphere and transferring and receiving good quality feedback during UFD between residents and supervisors. Future steps include more research about these two elements in UFD and suggestions how to reduce or handle with this tension.

Take-home message: Transferring good quality feedback and maintaining a safe environment doesn’t seems easy in UFD. However, the use of these dialogues seems promising because it’s a way to contribute to a medical work culture where providing and receiving feedback, both between as within hierarchical relations, is a common used professional activity.
#4N3 (716)
Exploring the Influence of Feedback about Implicit Bias on Health Professionals

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Background: Implicit bias can adversely impact clinical outcomes. The implicit association test (IAT) is an online metric of response time that informs an individual about their implicit bias. IAT results may stimulate reflection; however, feedback about implicit bias may also trigger emotions that reduce the effectiveness of feedback interventions.

Summary of work: We explored how health professionals perceive the influence of taking the IAT and receiving their results. We utilized a constructivist grounded theory approach and conducted semi-structured interviews with paediatric physicians and nurses (n=21) after they completed the mental illness IAT and received their result.

Summary of results: We identified 3 tensions that emerged when participants were confronted with feedback about their implicit bias. These tensions were: 1) acceptance vs justifiability, 2) actual vs ideal identity, and 3) desire for change vs acknowledgment of change as difficult.

Discussion: Our findings inform an improved understanding of the interplay between emotions and feedback, and may offer potential mediators to reconcile feedback that is inconsistent with self-perceptions. Consistent with previous research, guided reflection may mitigate the resistance to feedback about implicit bias that is inconsistent with self-perception.

Conclusion: Our study suggests that guided reflection informed by tensions related to personal and professional identity may hold unique potential for implicit bias recognition and management curricula. Navigating such tensions through facilitators who model vulnerability regarding their own biases may facilitate acceptance of bias related feedback.

Take-home message: To better understand how individuals process feedback inconsistent with self-perceptions we must explore how feedback and guided reflection influence personal and professional identities.

#4N4 (754)
Why do clinical teachers want to provide feedback in a busy emergency department?

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Background: Feedback is an effective pedagogical tool in clinical teaching and learning, but the actual perception of clinical feedback is often described as unsatisfactory. Little is known about what drives clinical teachers to provide feedback in busy clinical settings. We aimed to investigate motivation for feedback provision in an emergency department.

Summary of work: A qualitative secondary analysis of semi-structured interview data (conducted 2015-2016) with 18 attending physicians purposively sampled from a large teaching hospital ED in Taiwan. Data were analyzed inductively thematically. Intrinsic and extrinsic motivations for providing feedback were identified. Findings were categorized into autonomy, relatedness or competence according to Self-Determination Theory.

Summary of results: Both intrinsic and extrinsic motivations were found. Intrinsic motivations: (1) commitment to pass-down experiences as their teachers did; (2) seniors taking care of juniors (customary in Eastern working cultures). Extrinsic motivations: (1) teaching hospital faculty responsibility; (2) patient safety and quality of care; (3) developing competencies for future partners.

Discussion: Unlike assessment feedback, which often happens within protected time and space and is anticipated by both the teacher and learner, clinical feedback is often influenced by numerous clinical factors. Despite motivations provide driving forces for clinical feedback provision, feedback occurs only after considering clinical loading, learner-physician relationship, anticipated outcome and time.

Conclusion: Understanding motivations for providing feedback enables us to improve clinical learning environments, design courses, and reinforce drives in order to engage the clinical teachers with feedback provision.

Take-home message: Various intrinsic and extrinsic motivations drive clinical teachers to provide feedback in a busy clinical environment. Understanding these can facilitate a greater level of clinical feedback between educators and students/trainees for the betterment of patient care.
About Politeness, Face and Feedback: Exploring perceptions of residents and faculty regarding institutional culture factors affecting feedback

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Background: Feedback is a complex social interaction situated within an institutional culture, perceived lack of credibility or a shared mental model could result in rejection of the information. In this study, we explored resident and faculty perspectives of the influence of institutional cultural factors on the quality and impact of feedback.

Summary of work: Using constructivist grounded theory approach, we explored residents’ and faculty perspectives on the institutional feedback culture, impact of politeness on feedback quality and bidirectional feedback. We conducted 8 focus group discussions and 8 interviews. Discussions were audiotaped and transcribed. Thematic analysis was performed through the lens of institutional culture.

Summary of results: Institutional culture was described as: the culture of politeness with avoidance of language potentially damaging to self-esteem, and culture of excellence where the ‘pedigree’ of the institution and trainees inhibited constructive feedback. The hierarchical environment and lack of faculty feedback seeking were reported to be major obstacles to bidirectional feedback.

Discussion: Within the institutional context, we identified three key themes related to participant perceptions of feedback conversations: (1) Facilitating constructive feedback exchanges, (2) Encouraging feedback seeking and receptivity, and (3) Enhancing bidirectional feedback. Participants described barriers and facilitators under each of these themes, and provided suggestions for culture change.

Conclusion: The institutional culture of excellence and politeness was perceived to be a significant barrier to honest, meaningful feedback and may impact feedback seeking, receptivity and bidirectional feedback.

Take-home message: Understanding assumptions and values that constitute an institutional culture, recognizing the barriers to change, aligning proposed new behaviours with the existing mission and showcasing their benefits, are essential to guide successful culture change.

Multi Source feedback for educational leaders in clinical departments – a bridge to change of practice and consolidation of managerial support

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Background: Educational obligations, responsibilities and plans for development are not necessarily discussed between educational leaders (EL) and Heads of Departments (HOD). A Multi source feedback process designed for ELs might provide the documentation on educational practice and challenges in the clinical department needed to incorporate educational issues in appraisal meetings.

Summary of work: The MSF process involved personal feedback to the EL from a consultant combined with a mandatory appraisal meeting based on MSF data with the HOD, who had been prepared for the meeting by a coach. Semi-structured interviews with 33 ELs and HODs on the outcome from the process were performed.

Summary of results: The MSF process enabled HODs to provide ELs with tailored support on educational matters based on the feedback from both trainees and trainers. The majority of ELs welcomed the opportunity to discuss important educational matters and the support incorporated in designing a common future plan for education with the HOD.

Discussion: MSF displays HODs’, trainees’ and trainers’ perception of the department’s education. Positive appraisal, recognition, clarification of roles and dialogue with HOD based on documentation might positively influence the performance of EL. Furthermore, the MSF process might enable the ELs and HODs to lay down plans for future cooperation and support.

Conclusion: A MSF process creates an important opportunity for ELs and HODs to discuss common educational obligations and ambitions. In addition plans for future cooperation were created and agreement on managerial support from the HOD reinforced.

Take-home message: A MSF process might be a kick off for ELs and HODs to agree on common goals for educational matters, future cooperation and support. However, follow-up and anchoring is crucial and might be ensured by an ongoing process.