Only When They Seek

Only When They Seek: Exploring Supervisor and Resident Perspectives and Positions on Upward Feedback

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Introduction: Verbal feedback from trainees to supervisors is rare in medical education, although valuable for improvement in teaching skills. Research has mostly examined narrative comments on resident evaluations of their supervisors. This study aimed to explore supervisors' and residents' beliefs and experiences with upward feedback, along with recommendations to initiate and facilitate effective conversations.

Methods: Using 60-minute focus group discussions, a previous study explored opinions of internal medicine residents and clinical supervisors at the Brigham and Women's Hospital regarding the impact of institutional culture on feedback conversations. For this study, we conducted a thematic analysis of the transcribed, anonymous data to identify key concepts pertaining only to verbal upward feedback, through the theoretical lens of Positioning theory.

Results: Twenty-two supervisors and 29 residents participated in three and five focus groups, respectively. Identified themes were mapped to three research questions regarding (1) existing beliefs (lack of impact, risks to giving supervisors feedback, need for preparation and reflection), (2) experiences (nonspecific language, avoidance of upward feedback, bypassing the supervisor), and (3) recommended approaches (setting clear expectations, seeking specific feedback, emphasizing interest in growth).

Discussion: Study participants appeared to assume learner–teacher positions during feedback conversations, resulting in residents' concerns of adverse consequences, beliefs that supervisors will neither accept feedback nor change their behaviors, and avoidance of constructive upward feedback. Residents suggested that emphasis on mutual professional growth and regular feedback seeking by supervisors could encourage them to take on the role of feedback providers. Their recommendations could be a valuable starting point for faculty development initiatives on upward feedback.

Keywords: feedback, upward feedback, thematic analysis, qualitative research

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Across multiple specialties, practicing physicians and surgeons describe feedback on their teaching as one of the most useful assessment data that contributes to their professional development, although behavior change does not always follow.[1,2] As medical education emphasizes learner agency to improve teaching and learning,[3,4] feedback from learners is critical for the ongoing improvement of clinical supervisors' teaching skills. While accreditation organizations require that institutions provide feedback to teachers, this mostly refers to anonymized assessment data and not verbal interactions.[1] Thus, it is not surprising that most feedback to supervisors takes the form of written comments on evaluation forms[5–9] and narratives that often lack specific behaviorally based comments.[10,11] Providing specific constructive feedback to learners and from learners remains challenging in medical education, a consequence at least in part of what has been described as a culture of "politeness and saving face,"[12] and one where learners are considered more as "consumers of education" than equal partners.[3,13] In clinical workplaces, the term upward feedback indicates verbal feedback from a trainee (eg, resident/postgraduate trainee) to their clinical

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supervisor, and we use this term to indicate feedback conversations, not evaluations.[14]

Although research indicates that specific comments with suggestions for improvement from learners are more effective than numerical ratings in improving clinical teachers' performance,[15,16] faculty perceptions of the credibility of anonymous written feedback are variable.[17,18] Some argue that open feedback conversations are more likely to enhance teachers' receptivity to upward feedback than anonymous feedback data.[7] While there is little research on residents' and supervisors' experiences of verbal upward feedback or their perceived challenges, one study by Myerholtz et al[19] reported that faculty welcomed actionable real-time feedback from trainees to stimulate ongoing professional development, but residents emphasized the need for a safe environment and shared understanding of expectations. Clinical supervisors are likely to benefit from feedback from residents on their skills as teachers[15] because residents are among the best judges of supervisors' effectiveness and uniquely positioned to provide useful feedback.[6,7,16] However, "silence in the workplace" is well documented in the business literature by experts who suggest that effective communication can lead to change, but psychological safety and inclusive leadership are critical to encourage junior professionals to speak up.[20] These findings then beg the question, how could feedback conversations between residents and supervisors promote meaningful behavioral change in clinical supervisors?

In previous research, Positioning theory has been applied as a theoretical lens to explore clinician–patient interactions and patient willingness to speak up.[21,22] There are power dynamics in clinician–patient interactions that parallel that of the supervisor–learner relationship. Therefore, we felt the theoretical stance of Positioning theory would provide a lens to explore resident–supervisor feedback interactions. Positioning theory is a social constructionist approach emerging within the field of psychology in the 1980s to examine the influence of gender on interactions between people and was later expanded to consider interactions between groups and even countries.[23] According to Positioning theory, "not everyone involved in a social episode has equal access to rights and duties to perform particular kinds of meaningful actions at that moment and with those people . . . the rights and duties determine who can use a certain discourse mode . . .. A cluster of short-term disputable rights, obligations and duties is called a position."[24] Positioning theory suggests that people use discourse to position themselves and others, claiming certain rights for themselves and assigning duties and tasks for others. Thus, human behavior is goal directed and often constrained by group norms.[23] The theory seeks to understand the roles that interactants attribute to themselves and others, how they react to those roles, and how their speech and behavior is shaped by the positions they assume.

A previous study led by two research team members (S.R. and K.D.K.) explored resident and supervisor perspectives on cultural factors that influence feedback conversations. The topic of residents providing feedback to supervisors on any aspect of their performance was not explored.[12] We wished to reexamine these data, focusing on participant experiences of upward feedback, perceptions of its value, and suggestions, mainly from residents, to enhance these exchanges in a psychologically safe manner. In light of participant comments about hierarchy, we wished to specifically look at these data through the perspective of assumed positions of supervisors and residents during feedback conversations, informed by Positioning theory.[23] While it is clear that teachers depend on feedback from learners as a primary assessment tool[1,2] and accreditation systems require that teachers receive feedback,[25,26] it is important to understand how a physician's position as a supervisor or resident influences feedback seeking and its provision and acceptance.

The purpose of the current study was to explore perspectives of clinical supervisors and internal medicine residents on upward feedback. Our specific research questions were as follows:

1. What are supervisors' and residents' beliefs about verbal upward feedback?
2. What are supervisors' and residents' experiences of engaging in verbal upward feedback?
3. What approaches might be taken to help supervisors to facilitate and enhance upward feedback conversations?

METHODS

Study Setting

This study was conducted within Brigham and Women's Hospital, a large urban academic medical center affiliated with the Harvard Medical School in the city of Boston in the United States, comprising up to 500 potential clinical supervisors (core program faculty, faculty who regularly supervise and teach residents, and those whose primary job is research or administration but supervise residents infrequently) and 160 internal medicine residents. Ward teams consist of one or two supervisors, one or two medical students, one or two postgraduate year (PGY) 2, 3, or 4 residents, and two or three PGY-1 residents who usually work together for two weeks. Supervisors also work with residents longitudinally in continuity clinics for three years. While the training program sends frequent e-mail reminders encouraging residents to provide feedback to supervisors, it does not provide practical strategies for residents on providing upward feedback or for supervisors on seeking and receiving feedback.

Study Design

We conducted secondary supplementary analysis[27,28] on previously collected qualitative data with a focus on upward feedback concepts through the lens of Positioning theory. We used the theory as an approach to understanding this aspect of feedback and not as a methodology or epistemology. Relevant to our study aims, supplementary analysis strategies enabled us to conduct a deeper exploration of upward feedback from residents to supervisors—an aspect not focused on in previously published work using the same data set.[28]

Study Sample and Recruitment

Using purposive sampling, we recruited residents who rotate on inpatient and continuity clinic settings and generalist faculty who provide most of the clinical supervision and teaching in those settings to participate in focus group discussions. All prospective participants received e-mail invitations describing the purpose of the study, emphasizing that participation was voluntary and ensuring confidentiality. Verbal consent was obtained from participants at the start of the focus groups, with the opportunity to opt out at any point.

Data Collection

Data collection occurred through focus group discussions with residents and supervisors.[29] Focus groups were facilitated by a study team member trained in qualitative methods (S.R.), along with a research assistant who monitored the discussions and debriefed with the interviewer. A semistructured interview guide consisted of open-ended questions that explored participant opinions on the institutional feedback culture, factors impacting feedback seeking by faculty, perceived faculty receptivity to feedback, and one question on seeking (supervisor groups) and provision (resident groups) of upward feedback.[12]

Five resident focus group discussions were conducted between April and June 2016; all groups consisted of PGY-1, 2, and 3 residents. Three focus groups with clinical supervisors were conducted between June and October 2016. Focus group discussions were approximately 60 minutes in duration, audiotaped, and transcribed.

Data Analysis

This supplementary secondary analyses of previously collected data[12] focused solely on identifying themes related to feedback seeking by supervisors, provision of feedback to supervisors by residents, challenges to upward feedback, and approaches used by either group to facilitate these conversations. We analyzed the eight deidentified focus group transcripts to identify themes, relationships, and patterns of meaning.[30] We used the following steps in our thematic analysis: (1) immersion in and familiarization with the tone and content of the data; (2) coding consisting of labeling segments of data that refer to a specific topic or concept; (3) generation of themes representing investigator interpretation of categories of codes and how they relate to each other; (4) discussion of themes with the entire research team; (5) finalizing and naming of themes; and (6) presentation of data.

Each transcript was independently coded by four investigators (S.R., R.C.W.L.-K., J.L., and A.R.d.O.), and two additional investigators were involved in finalizing the coding scheme (H.A. and J.T.). Only themes related to feedback from residents to faculty and applicable to the theoretical framework were identified. Identified themes were discussed with the entire research team, and ambiguities or disagreements in coding and generation of themes were resolved by consensus through videoconference meetings. Although Positioning theory guided the analysis, we did an open thematic analysis rather than a framework-based analysis to be inclusive of all themes that were related to upward feedback.

Reflexivity

Only the lead author (S.R.) was a faculty physician within the Department of Medicine at the Brigham and Women's Hospital, she is neither a program director responsible for the promotion or graduation decisions of residents nor in a position of power over fellow faculty. A research assistant monitored each focus group, took field notes and debriefed with S.R. after the discussion. Concurrent data collection and analysis, guided by field notes, ensured that questions were open ended and invited a range of perspectives. Two authors (S.R. and K.D.K.) were involved in the original study and analysis to ensure continuity. The lead author (S.R.) was also involved in the secondary analyses. The other researchers, involved in the current secondary analyses (R.C.W.L.-K., J.T., A.R.d.O., H.A., J.L.), are from outside institutions and were not involved in the original study. Therefore, they were able to analyze the data without prior knowledge and with a neutral stance. All authors are active in the field of health professions education and in the study of feedback.

Ethical Approval

The study protocol was reviewed by the Partners Institutional Review Board, the granting ethics board for the Brigham and Women's Hospital and granted exempt status. Verbal consents were recorded on audiotape, as required by the Institutional Review Board.

RESULTS

A total of 22 generalist faculty and 29 residents participated in three and five focus group discussions, respectively. For each research question on the beliefs, experiences, and suggested approaches to upward feedback, the identified themes and subthemes are described in detail below along with representative quotes. Supervisor and resident quotes are indicated as (S) and (R), respectively, with a number to indicate the focus group that the participant had attended. As residents are the providers of upward feedback and supervisors the recipients, the resident's perspectives and quotes are provided first followed by the supervisor's perspectives.

Beliefs About Upward Feedback Conversations

While most residents and supervisors acknowledged the benefits of upward feedback, they expressed underlying beliefs that could impede these conversations.

Those Who Need Feedback the Most are Not Open to It

Some residents were convinced that supervisors would not change their practice in response to feedback from residents. Often, residents classified their supervisors as "good attendings" or "challenging attendings" and noted that their receptivity to feedback varied.

> A lot of the attendings that probably need the most feedback seem to be the ones that just don't want to hear it. They're not really striving for excellence because they feel like they're already there, in my opinion. (R2)

Residents emphasized that the "good attendings" would react positively to upward feedback, in contrast to those they labelled as challenging.

> If a really good attending asks for feedback, you can give something specific. If it's a really challenging attending and there's a lot wrong with it . . . I've tried to suggest different ways of organizing the rounds or sort of not interrupt on rounds . . . they are not really recognizing how their approach is affecting the interns' lives or our lives. (R2)

Perceived Risks to Giving Supervisors Feedback

Several residents expressed a belief that providing feedback to their supervisors could result in adverse consequences for their progress during residency or when applying to fellowships.

> I think it's just—it's very hard to give feedback to someone that's evaluating you and that has power over you. I just

think that that's not a culture thing; I think it's just a reality of life. (R2)

They appeared convinced about this risk, even though they were unable to articulate what those consequences might be and they had never experienced any repercussions themselves.

It's hard to be honest … when you most want to give constructive feedback there's nothing beneficial … it can only be harmful. I have not experienced any repercussions, but there is always a sense that we're being judged and that upsetting people higher up in the hierarchy is going to be detrimental to us in some way. (R3)

Supervisors also raised the question about the potential repercussions that verbal upward feedback may have on residents and wondered if it should be anonymous or framed as an exit interview at the end of a residency training program.

… where we talk about feedback and talk about residents giving feedback to attendings … what about recrimination and what about anonymity … Sometimes they're willing to say things when they're leaving. They're going to their fellowship in July, and June is a great time to, if you have a chance, to sit down with them. (S1)

Experiences With Upward Feedback Conversations

Residents and supervisors indicated the extent of their engagement in upward feedback conversations, ranging from the use of nonspecific language to complete avoidance. For residents, many upward feedback conversations would be triggered by a problem, such as the perception that a supervisor did something wrong or ineffectively during ward rounds in, their teaching or supervisory capacity.

Nonspecific Language

Residents described their struggles in knowing what language to use in providing verbal upward feedback, especially related to constructive criticism.

… upward feedback tends to be sort of vague and usually positive. (R4)

Supervisors also expressed that when residents offered them feedback, the language was vague, and content was not helpful.

I got mostly suggestions about sign out rounds, about topics and things when I asked. I didn't get, "You didn't teach me in a good manner." I didn't get constructive criticism in that sense. (S2)

Avoidance of Upward Feedback

Some residents preferred to avoid upward feedback conversations altogether, even if the department normalized and overtly encouraged upward feedback.

I think even if you could fix it by normalizing it (upward feedback) where every attending has to ask for feedback. Even if you did that, I think it's just not going to work … I still would not do it. (R2)

Many supervisors acknowledged that they rarely sought feedback from residents, even though they felt that it would be helpful in improving their teaching and precepting skills. One supervisor specifically reflected on how she had sought more feedback from her residents as a novice faculty member and could not explain why she did not seek feedback more often.

I used to do it more when I was younger … I probably have gotten to the point where I think I'm pretty good. I don't necessarily ask. Where I would have been less confident, I might have asked more. I'm not proud of that. (S2)

Bypassing the Supervisor

A few junior residents expressed that they would report problems with their supervisors to senior residents rather than discussing their concerns with supervisors directly. They did not feel that it was their responsibility to address or correct the problem.

I don't really think it's our job to tell an awful attending about something that's going really wrong … it's probably our job to let someone else know about that, but in terms of giving direct feedback, I think it's too much of a hierarchal structure for that to be a safe thing to do. (R2)

Suggested Approaches to Enhance Upward Feedback Conversations

Residents and supervisors offered a variety of solutions to facilitate upward feedback conversations, mainly related to setting clear expectations, promoting feedback seeking by supervisors and establishing a clinical teaching environment conducive to trainees' upward feedback.

Setting Clear Expectations

Residents and supervisors emphasized that expectations for upward feedback should be established at the beginning of rotations or working relationships, and these conversations should be framed as an ongoing dialogue.

There was one attending I worked with where we would re-evaluate how rounds are going on a daily basis … I was thinking more critically about how can this be better? What sort of feedback should I have for the attending? What do I anticipate them having for me? We planned to discuss that after rounds. That seemed to make the feedback much more prescient and just relevant. (R1)

Both groups also stated that expectations for performance domains need to be clear to help guide specific feedback.

Part of why it's hard to give feedback is when expectations (of supervisors) aren't necessarily super clear. You feel like you're playing a game of Gotcha [a game where one player pursues and tries to catch another unawares]. It's like they were supposed to do something, but you had no way of knowing it. (R4)

Upward Feedback Conversations Need Preparation and Reflection

In addition to busy clinical commitments, which allow little protected time for feedback conversations, residents expressed the inability to provide specific feedback without time to prepare for the conversation and reflect on events.

I think it's really hard to come up with something constructive to say also if you're just put on the spot in that feedback

meeting and you haven't thought about it before walking into that session. (R3)

Supervisors Seeking Specific Feedback

Several residents stated that they would be willing to engage in upward feedback conversations if initiated by the supervisor seeking feedback, but few felt prepared to initiate these conversations. In addition, they recommended that supervisors be specific when seeking feedback.

> It's much easier when they ask. Then I tell them what I think could be better or that we're rounding for too long, or that the interns would like a little teaching . . . but [if] it seems like they're not interested because they're not bringing it up, then I'm not one to corner the attending and say, "Hey, listen. Can we talk?" (R1)

Supervisors who reported that they frequently sought feedback from residents focused on specific goals during these conversations.

> Really pin them down. When you just ask for the generic feedback, they are going to shy away from that. If you pick a particular thing that maybe you recognize didn't go well in getting feedback on how you could have handled it better. "What could we have done better? What could I have done better to help handle this?" (S3)

Emphasizing Interest in Growth

Supervisors who were most comfortable receiving feedback from residents emphasized that they openly acknowledged their own limitations and modeled a continuing professional development mindset.

> It's really hard for the residents to give us honest feedback because of the hierarchical structure, but I always ask for feedback very genuinely and say, "I'm being honest. I'm always striving to improve my attending skills, my teaching skills, so I'm asking you for honest feedback." (S3)

Several participants suggested that departmental leaders should emphasize the norm that feedback conversations include feedback from residents to supervisors as well as supervisors to residents. In addition, constructive feedback should be promoted as a strategy for being committed to professional growth and not interpreted as an expression of inadequacy.

> I think normalizing the fact that this is a growth process . . . No matter how wonderful you are, [you] have areas to grow and that's a really great thing. . . there's no reason that [constructive] feedback should be a negative thing. (R4)

> Setting a feedback culture where the feedback is expected and baked in [embedded], so that it isn't a big deal if you give someone feedback, whether positive or negative. It isn't dramatic and show-stopping, it's okay for the residents to say, "I need X, Y, Z that is not being addressed," without it being a big deal. (S2)

One supervisor recommended joint discussions with residents to discover their challenges and set up systems where they might feel comfortable in providing feedback.

> I mean, whatever issues come up, we might use some conference time to bring it up as a group with some residents. See what they say. Figure out ways they might be comfortable doing it and setting up systems. (S1)

DISCUSSION

Participants in our study acknowledged that upward feedback conversations rarely occurred. While many residents assumed that supervisors would not be receptive to their feedback and providing such feedback represents a personal risk, several supervisors indicated openness to receiving feedback from residents so that they could continue to improve as teachers. Most residents were willing to engage in upward feedback only when explicitly sought by supervisors but were not prepared to initiate these conversations. Finally, residents had useful recommendations for supervisors in facilitating upward feedback conversations. This study adds new insights into when and how residents might be willing to engage in providing feedback to their supervisors, the role of supervisors and the institution in this process.

Although beyond the scope of our study, we recognize that Positioning theory as a methodology could apply to future studies on upward feedback. Yet, our findings contribute to understanding of upward feedback conversations and their inherent challenges and provide insights and explanations for two of the themes, beliefs, and experiences.[24] These are individual and social elements that can be depicted as a triad comprising position, speech and other acts, and story line. Position refers to how each of the participants in a dyadic feedback conversation assume a certain position (teacher–learner, superior–subordinate, etc). Speech and other acts refer to the dynamic behavior of participants, influenced by their assumed positions. Story line can be defined as patterns created through assumed positions and resulting speech and actions. In a feedback context, the story line can be viewed as participants' interpretation and construction of institutional feedback norms and culture; for example, —"this is the way things are or will be." In Figure 1, we attempt to link study findings to the three aspects of Positioning theory.

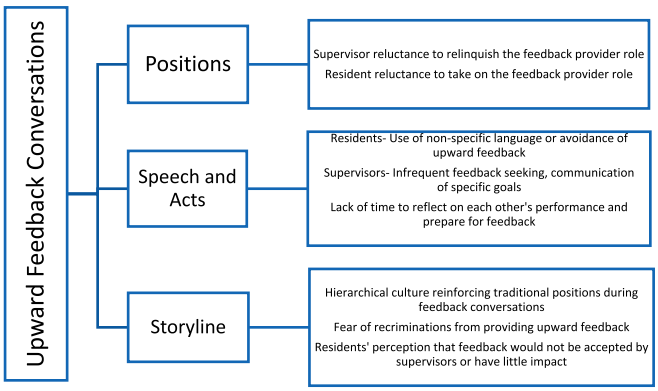

FIGURE 1. Application of Positioning theory triad to study findings. Positions refer to traditional roles assumed by supervisors and residents. Speech and acts are behaviors that result from assumed roles. Storyline refers to the underlying learning and work culture that influences assumed positions and speech and acts. Figure 1 can be viewed online in color at www.jcehp.org.

While a hierarchical culture is the norm in many health care settings,[31] patient safety literature has shown that when the goal is to deliberately break down unnecessary hierarchy, people at all levels speak up and this enhances patient outcomes.[32] In postgraduate education, despite increasing scrutiny of the clinical learning environment by accreditation bodies,[25,26] a hierarchical learning culture reinforces the traditional positions assumed by the supervisor as leader and the resident as subordinate (positions). Second, fear of recrimination or repercussions caused supervisors to avoid regular feedback seeking and residents to evade provision of constructive comments to supervisors (speech and acts). Finally, many residents assumed that their feedback was not welcomed or likely to result in changes in supervisors' behaviors (story line). Dudek et al[7] also found that residents speculated that open upward feedback might compromise their own evaluations or be hurtful to the supervisors; consequently, they "moderated the message" by clearing the feedback language of negative connotations. Supervisor and resident personal beliefs and experiences led to a story line that it is not psychologically safe for residents to verbally communicate constructive feedback to their supervisors.

This study has implications for health professions educators involved in faculty development. Based on our residents' suggestions, promoting upward feedback involves individual- (supervisor) and institutional-level initiatives. At the individual level, self-awareness, feedback seeking, welcoming diverse input, and emphasis on relationships have been described as behaviors that enhance acceptance of upward feedback.[20,33,34] Additionally, a climate of psychological safety, defined as the degree to which people view the environment as conducive to speaking up "across status lines" or asking for help is critical for feedback provision by trainees.[35,36] In health care, hierarchical communication patterns and emphasis on autonomy can be barriers to psychological safety,[37] thus active goal-oriented feedback seeking by supervisors, acknowledgement of own limitations, and conveying the desire for continuing improvement would be essential.

Viewing limitations and errors as opportunities for learning are also core components of a growth mindset, defined as the belief that success is the result of hard work, learning from failure, focus on growth, and input from others rather than innate talent.[38] Thus, attention to psychological safety, explicit modeling of a growth mindset, feedback seeking and acceptance, and overt commitments to change could be the focus of faculty development initiatives on upward feedback. Going further, one could argue that terms such as "meaningful learning conversations," coined by Tavares et al[39] to indicate a blend of feedback and debriefing, might shift the emphasis from judgement and positions toward growth.

At the institutional level, leadership initiatives that promote psychological safety at both the organizational and team levels can showcase a culture of ongoing learning at all levels.[40] Kegan and Lahey[41] have labeled a safe culture where minimal energy is expended on hiding inadequacies, playing politics, and focusing on self-image as "an everyone culture." They emphasize that such a culture is integral for deliberately developmental organizations that encourage leaders and staff to reflect on strengths and weaknesses and maximize the potential of individuals and teams through emphasis on a growth mindset. In terms of upward feedback, institutions could design interventions that specifically support supervisors who struggle with seeking and receiving constructive feedback from their trainees, the "challenging attendings" described by residents in this study.

We acknowledge the limitations of this study. The data were not specifically collected to investigate upward feedback and only one part of the interview script focused on this subject. The research was conducted in a single department at a single institution; hence, findings cannot be applied automatically to other departments, settings, institutions, or global regions without consideration of the context. Participants may have had particular interest in the topic and nonparticipants could have held contradictory opinions, which we would not have captured. During focus group discussions, we cannot be sure that all participants were able to express their opinions candidly. Finally, perceptions and expressed opinions do not always translate into actual behaviors.

The results of this study suggest that the Positioning theory can inform the dynamics of upward feedback conversations and that a deeper exploration of factors that facilitate or impede these conversations between residents and supervisors could be valuable. Future studies could explore whether faculty development initiatives with a focus on establishing psychological safety and modeling a growth mindset can contribute to effective growth-enhancing upward feedback conversations and actual behavior change. Finally, it may be useful to explore perceptions of trainees and supervisors whether these discussions perpetuate the notion of learners as consumers of education or partners in their own educational experiences.

CONCLUSION

Both residents and supervisors acknowledged the benefits of engaging in upward feedback conversations while noting that barriers within the current professional environment must be recognized and addressed. Fostering upward feedback conversations would require faculty development and leadership initiatives targeted at the individual level and institutional level, rather than simple how-to approaches. An institutional culture that emphasizes psychological safety and a growth mindset may be instrumental in navigating professional hierarchies that serve as barriers to true bidirectional feedback. Such an environment would ultimately enhance the clinical learning experience overall and allow for mutual growth of supervisors and trainees.

Lessons for Practice

- Physicians who supervise residents should engage their learners in conversations and seek specific feedback about their teaching and not depend on anonymous written data for ongoing professional development.
- Upward feedback conversations require a psychologically safe learning environment; it is imperative that supervisors establish this at the start of and throughout the duration of their working relationship with trainees at any level.
- Faculty development initiatives should address how supervisors can model continuous improvement, a growth mindset, and establish psychological safety when soliciting specific, goal-oriented feedback from residents.

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