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# Feedback falling on deaf ears: residents' receptivity to feedback tempered by sender credibility

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**SUMMARY** We interviewed internal medicine residents to characterize their perceptions of effective feedback. These semi-structured interviews also explored aspects of the person sending the feedback which might cause residents to discount or disbelieve the information. Well-timed, private and verbal feedback that fostered development of an action plan are examples of residents' perceptions of effective feedback. Sender credibility, and subsequent resident receptivity to feedback, was influenced by the method of feedback delivery, the content of the feedback and the residents' perceptions of sender characteristics, and their observation of sender behavior. These qualitative results may help to develop initial hypotheses and frame further investigations optimizing the reception of feedback by residents.

## Introduction

Guidelines for giving feedback (FB) have been suggested by several authors (Bing-You & Stratos, 1995; Ende, 1983; Sprafka, 1992; Wilkerson, 1994). However, FB has been described as an "intractable problem" in medical education (Irby, 1994). This difficulty may reflect inadequacies of the person communicating the FB, i.e. the sender (Ende *et al.*, 1995), or inability of residents to receive and/or respond appropriately to FB. Regarding this latter possibility, a disturbing qualitative study portrayed internal medicine residents as increasingly discounting FB as they progressed through their training (Bucher & Stelling, 1977). We attempted to characterize residents' perceptions of effective FB and aspects of the sender causing residents to discount such FB.

## Methods

Using a stratified, random sampling approach, we selected 12 residents (four Postgraduate Year [PGY] 1, six PGY-2, two PGY-3; seven men, five women) from the Maine Medical Center Internal Medicine residency to be individually interviewed. These in-depth, semi-structured interviews, lasting approximately one hour each, were conducted using the following questions:

- What is your definition of FB?
- How do you know when you are receiving FB?

- What would constitute effective FB for you?
- What would cause you to see the person giving you the FB as an unreliable source, and then discount, disparage, or not believe the FB?
- When you are given effective FB, and you believe it, what other factors would then favor your improving your performance?

The interviewer (RGB) used the preceding questions as a guide, probing each resident's response with follow-up, detailed inquiries.

The interviews were audiotaped and then transcribed. Qualitative techniques were used to analyze the transcripts (Ely, 1991). Briefly, two of the authors (RGB and JP) independently read all the transcripts, coding verbatim passages and establishing categories and subcategories. This analysis also attempted to develop major themes which linked together specific categories. The categories and themes described in this paper were agreed upon by both authors completing the data analysis.

## Results

From the interviews, three major themes were identified: (1) residents' perceptions of effective feedback; (2) areas which impacted on the credibility of the sender; and (3) factors which facilitated resident performance from feedback (see Table 1).

### *Perceptions of effective feedback*

Under this theme, residents identified three major categories that characterized their perceptions of effective FB: content of feedback given to residents; Method of delivering feedback; and Interactions with sender.

*Content of feedback given to residents.* Positive Recognition is exemplified by the following quotes:

I think probably positive feedback on what things I'm doing right is helpful in that it breeds a little

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**Table 1.** Themes identified from interviews*Perceptions of effective feedback:*

Content of feedback given to residents  
Method of delivering feedback  
Interactions with sender

*Sender credibility:*

Residents' perceptions of sender characteristics  
Residents' observation of sender behavior  
Content of the feedback  
Method of delivering feedback

*Factors facilitating resident performance from feedback:*

Commitment to change  
Time  
Physiological needs  
Resources  
Skills  
Reinforcement

bit of confidence and makes it a little better learning environment if I feel more confident about what I'm doing.

I think in general positive feedback is extremely powerful. I mean, as a parent, I use it a lot and it works extremely well.

Instances of Specific FB were mentioned: "He was very specific about finding that weakness and figuring out that that was the beginning and that we're going to do it one step at a time instead of trying to tackle it all. So I thought that was very helpful." Constructive FB is appreciated and sought after by the residents:

I like to see things spelled out. The internship is very overwhelming in a lot of respects and I'm not able to figure out where my weak points are. So it's very helpful to have someone focus and say "This is a weak point".

I think it works well, if things are pointed out. I prefer a one on one discussion about what went on. I think errors in judgement or errors of omission are important to be pointed out.

The statement "And then I thought, 'That's feedback!', that's real feedback, because he explained why he wanted ..." reflects residents' perceptions that effective FB should be accompanied by Explanations.

Comparison with One's Peers is also thought to be effective: "They'd tell you where they feel you kind of fit into the scheme of the rest of your peers so that you can kind of fit yourself into that spot." Developing an Action Plan emerged as a subcategory: "Instead of just telling me what to do with a patient, maybe asking more like 'What would you do with this patient?' and then if I can't come up with a plan, trying to trigger one." First-hand Information is also effective:

... the person who was most directly involved, rather than taking it up with a second-hand person who wasn't involved.

... she was direct about it ... that she didn't say go to the attending or program director or something and say "I have this complaint about your resident". I like to be approached directly first, rather than have it go through different channels...

*Method of delivering feedback.* Both Verbal and Non-verbal FB are effective methods for delivering FB:

... verbal discussion. I just finished a rotation with an attending who I think was very good at feedback who actually set the tone by saying 'I want to talk to you about what went on with patient X yesterday'. Because you can tell the changes in their tone, their body language, or I might say "Is there something that I should be doing? or Something I'm missing here?" and ask for some more direct feedback if I'm not picking up on something.

Timing refers to giving FB close to the observed resident behavior at any time during a rotation. As one resident stated, "The more directly related to what I've done recently, some action of mine, the easier it is to identify it as feedback". Feedback delivered in Private, as opposed to a group setting, is helpful: "I don't learn well from public negative feedback. I don't learn well where, in front of a group, negative comments about my performance are aired. Tends to make me more resentful." Both Formal and Informal FB are effective:

What I've found also very useful is the mid-rotation meetings with the attendings, saying "You're doing well with this but you need to work on that".

I've found that what I've described as informal feedback, this daily off-the-cuff kind of thing, is most useful, especially with what attendings say in rounds.

Non-judgmental FB is also an effective delivery method, as reported by one resident: "I found that most people in this program don't scream at you and are supportive of you, which I think is good."

*Interactions with sender.* Residents perceive effective FB including a Chance to Respond to FB: "a chance to react and a chance to ask questions about that kind of feedback, more detailed questions about what they were referring to or what you could do to improve". Illusion of Adequacy refers to residents concluding that they are doing well if given more responsibility for a greater number of patients: "You can get feedback in say, how much responsibility you're given and you get a feeling for how much trust your senior resident has for you. And I see that by what sort of assignments I get..."

*Sender credibility*

When asked what aspects of the sender would cause them to disbelieve or discount FB, even if it was delivered "effectively", residents identified four major categories (see

**Table 2.** Categories related to sender credibility

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*Residents' perceptions of sender characteristics:*

- Lack of trust and respect
- Low level of knowledge
- Lack of experience
- Supervisory position or status
- Resident as sender

*Residents' observation of sender behavior:*

- Lack of attention
- Lack of observation of resident
- Sender uneasiness
- Poor interpersonal skills

*Content of the feedback:*

- Focus on 'insignificant' areas
- Positive feedback inconsistent with perceived failure
- Lack of perceived mistake
- Feedback inconsistent with 'known truth'

*Method of delivering feedback*

- Judgmental of residents
- Group setting

---

Table 2): residents' perceptions of sender characteristics; residents' observation of sender behavior; content of the feedback; and method of delivering feedback.

*Residents' perception of sender characteristics.* The issue of Trust and Respect generated many comments:

... probably the biggest pull is "do you respect the person giving the advice?" I mean, if you don't necessarily agree with the person giving you the advice then you kind of take it smiling. .

I'm gonna say probably the more you like the attending, the more effective the positive feedback is, and the less you like the attending, the less important you view the negative feedback.

It may be the manner in which it's done. That may go in somewhat to an element of respect with people who don't give feedback in what I think is an appropriate way, either shouting, screaming, yelling, going over your head to someone else and then having trickle-down feedback. That kind of stuff tends to make me discredit them.

Residents would discount FB from a sender who they thought had a low level of knowledge or lacked experience as an physician:

If I don't think they have the expertise and knowledge to give that feedback. Say it's a senior resident ...

I hate to say it but I think how long they've been doing what they're doing in terms of if they've been around for a long time. I just have an innate thing of respecting them more the more they've been around.

Feedback from the program director was taken more seriously over others' FB, as reported by one resident: "He [the program director] knows more about medicine than I do, he's more experienced than I am, he's had more training, and he's also been in a position to watch a fair number of people come through a residency program". Residents also tended to value FB from fellow residents: "I think feedback happens among the residents all the time very informally, and that's not something I discount automatically because they're on the same level as me."

*Residents' observations of sender behavior.* Residents felt FB was invalid if the sender had never observed them or if the sender seemed inattentive towards the resident:

... a physician you only see in attending rounds, you've never gone to the bedside, they've never seen you do an H and P, and they're commenting on how well you interact with patients. And they just can't comment on that because they've never seen you do it!

They were in a hurry. they were busy. They just had to get this evaluation done because the criteria or curriculum says you have to do this so they just did it. They didn't pay attention, then I may not trust that.

Feedback from Senders who seemed ill at ease or who evidenced poor interpersonal skills tended to be disregarded by residents:

He was clearly defensive and didn't want to talk about it any more. So I think there are people ... there are personalities where you're really ... who are really not as open to this sort of back and forth.

And people skills ... if they have good people skills and people seem to relate well to them and then to other people, then in general I believe what they are saying.

*Content of the feedback.* Residents disbelieved FB which they thought to be focused on unimportant areas: "I discount FB sometimes because I think it is just a style issue". When they thought they had performed poorly, residents looked askance at positive FB: "where this oncologist said I was weak in my bedside manner but strong in other areas I thought I was weak in. And I kind of said ... I kind of threw out the whole evaluation out of my mind and said 'well, what does that mean?' "

Other residents would simply discount FB if they did not perceive any wrongdoing on their part or if the FB did not coincide with residents' self-perceived knowledge:

And then they say "an area to work on would be your bedside manner". I'd say, well, that's contrary to what every other evaluator has told me before and what I think are my strengths and weaknesses.

... something I didn't feel was a mistake or didn't feel needed to be improved.

... then someone else refutes that or doesn't agree

with that position that you have taken on as the Gospel, so to speak. You might not take that, whatever they tell you, as a piece of knowledge that you're gonna retain.

*Methodology of delivering feedback.* Feedback communicated in a judgmental manner was often discounted:

... there's always the possibility that if someone starts out being judgmental and negative that I may just turn off and not even listen to anything else they have to say.

... if someone's critique or feedback is more judgmental or a personal attack than an actual critique of performance, then I would discount it as irrelevant.

Residents also indicated difficulty in accepting FB in a group setting:

Suppose someone pulls you aside and says "maybe you should have done this differently". That makes you feel as if they're taking it seriously, and taking you seriously. As opposed to in front of a group of people. This would make me less inclined to value feedback, in front of a group.

#### *Factors facilitating resident performance from feedback*

When residents thought they were given effective and believable FB, factors facilitating improvement of their performance included: a Commitment to Change ("Nobody can make you do anything no matter how much good advice they give you. You have to want to do it, be willing to do it"); adequate Time ("time is a huge issue"); satisfaction of Physiological Needs ("it's hard finding time when you're not wanting to sleep or eat or just sit back and not even think about work for an hour or so. You have to come back to it"); adequate Resources ("if someone told you "well, you really aren't working in WordPerfect very well", and offer them a formal course on that rather than saying "you need to go out and learn how to do this""); appropriate Skills ("I need the tools to do better ... or more skills, giving you the opportunity to develop your skills, like doing procedures"); and Reinforcement of efforts ("It helps to have the same person then assess you again a little later. That's why it's nice to have some follow-up feedback").

#### **Discussion**

These residents' perceptions of effective FB validate some of the FB guidelines composed from other professions (Ende, 1983; Wilkerson, 1994). The perceptions are also similar to needs for feedback identified by medical students in the clerkship year (Bing-You & Stratos, 1995). In addition, the Illusion of Adequacy subcategory is a reminder of the worrisome self-validation process residents may develop if FB is ineffective (Bucher & Stelling, 1977).

Medical education literature (Bing-You & Stratos, 1995; Ende, 1983; Sprafka, 1992; Wilkerson, 1994) has focused predominantly on sender functions in giving FB,

possibly assuming that effectively sent messages are well received and utilized by residents. In other words, one should not expect necessarily that delivering specific and well-timed FB to a resident simply results in improved performances. Studies in other fields suggest that responses to FB can be tempered by the gender (Benedict & Levine, 1988; Roberts & Nolen-Hoeksema, 1989, 1994) and the effect (Swann & Read, 1981; Trope & Neter, 1994) of the receiver. There is conflicting evidence that sender credibility impacts on FB (Buchert & Stelling, 1977; Orpen & King, 1989). Our qualitative methodology has provided us with important new information on the way FB is differentially valued by residents dependent upon a host of sender-specific characteristics, and conveys a valuable message to senders to guard against having their well-intentioned FB fall on deaf ears.

Our qualitative results may help to develop initial hypotheses and frame further investigations optimizing the reception of FB by residents. For example, what factors would make a resident not trust or respect an attending, and subsequently discredit any FB? Observations of interactions, or additional descriptions by residents of such ineffectual encounters, may shed light on this question. Furthermore, even if FB is communicated well and not discounted, efforts to improve the FB process should take into account contextual factors (e.g. the institutional or programmatic environment) which may facilitate or inhibit residents' use of such important information. Lastly, could a more non-traditional, learner-centered approach (e.g. using learning contracts) be more effective in the process of trainees receiving feedback?

#### **Notes on contributors**

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