Establishing Psychological Safety to Obtain Feedback for Training Programs: A Novel Cross-Specialty Focus Group Exchange

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ABSTRACT

Background Formative feedback from residents is essential to improve residency programs, and focus groups may provide rich information. However, residents may withhold information due to fear of retaliation or speak less candidly to please focus group moderators.

Objective We assessed participant perceptions and utility of feedback obtained from a confidential focus group exchange between 2 residency programs.

Methods Anesthesiology and pediatric programs at the same institution participated in 2017. Residents voluntarily provided program feedback during 1 of 2 confidential focus groups for each program. Each focus group was moderated by the program director (PD) of the other specialty. The PDs used thematic analysis to identify themes for use by the respective programs in improvement efforts. An anonymous survey was distributed after the focus groups to collect participant perceptions (quantitative and narrative) on this approach.

Results Thirteen residents of 140 (9.3%) participated (7 anesthesiology, 6 pediatrics). Thematic feedback from focus groups was largely consistent with known issues, although novel information was also obtained (eg, pediatric interns wanted earlier one-on-one meetings with their PD). Survey data suggest that residents were able to share more meaningful feedback than they would otherwise, and they did not feel that having an external moderator (a PD who may have been unfamiliar with the specialty) was a barrier to discussion. The approach required 6 hours of time for each PD and approximately $200 for dinners.

Conclusions The focus group exchange required modest resources, was perceived as safe by residents, and generated robust, actionable feedback for the programs.

Introduction

Formative feedback is intended to inform and overcome gaps between current and desired levels of performance.[1,2] It is critically important for residency programs' improvement and growth. The self-study paradigm of the Accreditation Council for Graduate Medical Education (ACGME) encourages programs to engage in process improvement informed by actionable formative feedback.[3] Though the field of medical education has embraced formative feedback for learners,[4] the literature on formative feedback for programs is less robust.

Currently, programs obtain formative feedback in various ways. Summative assessments, such as the annual ACGME Resident/Fellow Survey, are an important aspect of program evaluation and often spur improvement efforts.[5] However, they do not explore causes or ways to close performance gaps.[6] Confidential annual program surveys may be more granular, but they are subject to response bias[7] and do not allow for follow-up discussion to contextualize feedback.

Focus groups can be used to address these gaps and are a recommended program evaluation method.[8] They are often used by institutional graduate medical education (GME) offices during internal reviews of programs. However, participants may withhold feedback if the setting does not feel psychologically safe. For example, residents may succumb to social desirability pressure and fear of retaliation, or they may be concerned for their program's status within the institution.

The aim of this study was to determine if a novel focus group exchange program, in which residents from one specialty met confidentially with the program director (PD) of a different specialty, could overcome some of these feedback problems. Of particular interest was whether this type of focus group feedback session could obtain useful feedback information and be perceived as acceptable and psychologically safe by residents.

Methods

The participating anesthesiology and pediatric residency programs are core residency programs in the

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Editor's Note: The online version of this article contains the focus group interview guides and the surveys used in the study.

same institution that have minimal contact with each other. Specifically, residents from one specialty do not interact with the PD from the other program. An idea was generated from informal conversation between the PDs about the challenge of obtaining meaningful program-level feedback. One of the PDs had prior experience with focus groups. These programs were a good combination for this process because (1) there was minimal contact with individuals between programs (which could increase psychological safety), and (2) the PDs were familiar with many cultural norms and institutional policies.

The planning and execution of this pilot was performed between the summer and fall of 2017. After each program's Program Evaluation Committee (PEC) meeting, the PDs met to discuss their respective program structures, review PEC-determined improvement goals, and share remaining questions (eg, ACGME survey results without clear interpretations by the PEC).

The PDs developed focus group interview guides using common focus group elements, including opening questions, transition questions, key questions, and end questions (provided as online supplemental material).[9] Each focus group was planned for 90 minutes (60 minutes for preplanned topics and 30 minutes for resident-generated topics). TABLE 1 presents the high-level outline of the interview guides. To allow more residents to participate, 2 evening focus groups were offered for each program. If thematic saturation had not been obtained, more sessions were possible.

Each PD described to his or her residents the process and goals of the focus group, which was to confidentially collect feedback aimed at program improvement, via e-mail. Free dinner was provided as an incentive. To maximize confidentiality and psychological safety, the other PD (termed the *consulting PD*) handled all subsequent communication. Several additional measures were taken to maximize psychological safety. All residents were invited, but participation was voluntary. Focus groups were held in the consulting PD's department to minimize the chances of participating residents being inadvertently identified by program faculty. No resident names or postgraduate years were documented, and no audio recordings were made.

Focus groups were led by the consulting PD. Moderation styles followed standard practice,[10] and included facilitated discussion and encouragement of idea exchange among participants. No recordings were made, although the consulting PD took notes. A chief resident from the consulting PD's program served as an observer, primarily to take notes and help detect nonverbal cues. After the focus groups, each consulting PD used thematic analysis to synthesize feedback into written summaries for the primary PD. Each primary PD then reviewed the feedback with key stakeholders for subsequent action. The 2 PDs met together once more to discuss the overall focus group experience.

What was known and gap
Focus groups can provide an opportunity for residency programs to obtain formative feedback from residents, but participants might not feel safe discussing issues with moderators from their own program.

What is new
A confidential focus group exchange program where the moderators were program directors (PDs) from different residency programs than the resident participants.

Limitations
Low participation rate may mean feedback was not representative of all residents. This approach may not be practical to use with high frequency.

Bottom line
This cross-specialty focus group exchange program was low-cost, valued by resident and PD participants, and generated actionable and new feedback.

To assess participant perceptions, anonymous paper surveys were distributed at the conclusion of each focus group. Surveys included 6 questions, each with 5-point anchored Likert scales and space for comments (surveys provided as online supplemental material). Three of these items collected information on overall utility of the confidential focus group format as compared with other modes of providing program feedback; 2 items collected information about whether the format felt more or less confidential when compared with other modes of providing feedback; and 1 item collected information on whether having a moderator less familiar with the residents' workflow was a barrier to discussing meaningful issues. Questions were created by the authors and refined with cognitive interviews to increase item validity by asking non-study individuals to consider and respond to survey questions.

This study was deemed exempt by the Partners Human Research Committee Institutional Review Board.

Results

Two focus groups were held for each program, for a total of 4 focus groups. Seven of 74 anesthesiology and 6 of 66 pediatric residents participated in the voluntary focus groups (9.3% of eligible residents). Each focus group had between 2 and 5 residents, and each resident attended only 1 of the focus groups. All 13 residents completed the voluntary post–focus group survey.

TABLE 1
Focus Group Outline With Sample Statements From Each Section

Welcome/Overview/Confidentiality *Importantly, we will not be sharing any specific stories or names with your program.* *Instead, we will take anonymized notes that we will summarize and discuss with your program director.*	
Anesthesia Program Specific Queries	**Pediatric Program Specific Queries**
Service versus education *In what ways does your program balance, or not balance, service and education?*	Resident autonomy *Enhancing the culture of resident autonomy is one of your program's improvement goals for the year so I would like to hear more about it.*
Feedback *How could feedback be improved? In what ways do you fear retaliation for providing feedback?*	Evaluation confidentiality *What types of feedback do you think you have not given because of concerns over confidentiality?*
	New inpatient team structure *I know many of you don't know what it was like before, but what do you think of the current state?*
Resident-raised topics *What else should program leadership know about?*	

Resident Perspectives

Overall Utility: Three items addressed overall utility. Participants rated the format "very" or "extremely" helpful in allowing residents to discuss important topics (mean 4.6 of 5; range, 4–5) and substantially more useful than other formats of collecting feedback (mean 5 of 5; range, 5–5). They indicated they would recommend continuation of the exchange program "quite a bit" or "definitely" (mean 4.8 of 5; range, 4–5). TABLE 2 provides illustrative participant comments.

Some comments suggested that residents took the focus groups as an indication that the program cared about their feedback. For example, a resident reported, "I think good ideas were generated and gives a message that the program really cares about honest feedback and improvement."

Confidentiality: Two items addressed confidentiality. Participants reported that they shared "somewhat more" or "substantially more" honest feedback compared with feedback they provide by other means such as written surveys or in-person meetings (mean 4.8 of 5; range, 4–5).

Twelve of 13 (92%) residents reported that having a consulting PD was important in increasing their willingness to share information (2 responded that it was "somewhat important," 1 responded that it was

TABLE 2
Illustrative Comments From the Post–Focus Group Survey

Overall utility	▪ "We could riff off each other's ideas and comments." ▪ "Allows for further clarification on various topics." ▪ "More group discussion that allows more flexible/open discussion instead of standardized surveys." ▪ "Easier to discuss topics at length."
Confidentiality	▪ "Feels less likely to come back to me." ▪ "Equally honest, but much more in depth." ▪ "Confidential format with people who do not know you/the program allows more free/open discussion." ▪ "Blank canvas without as much contact with our program made it easier to talk." ▪ "[Moderators] do not feel defensive/are neutral to discussion topics." ▪ "Seemed more objective, helped to unpack ideas." ▪ "Makes it more comfortable." ▪ "The important feature is freedom from judgment or consequence for the resident."
Difficulty associated with having an external moderator	▪ "Had to explain some terminology or setup that's unique to anesthesia but having the other program's perspective helps compare." ▪ "Easy enough to explain things like call schedule, but there may have been points not well understood." ▪ "Facilitator is another program director—this is smart; it would be troublesome if they had no idea what patient care or residency is like."

"quite important," and 9 responded that it was "extremely important"). The remaining resident wrote that it did not affect their willingness to share information and that "the format matters more than the facilitator's origin . . . it would be fine to have [a facilitator from my program] as well."

Difficulty Associated With Having an External Moderator: One item addressed potential challenges associated with facilitation by a moderator less familiar with the residents' program. Seven of 13 (54%) residents responded that having an external moderator was "not at all" troublesome. Five residents (all anesthesia) responded that it was either "slightly" troublesome (n = 4) or "somewhat" troublesome (n = 1). One resident did not respond.

Generated Feedback

For the planned topics, the consulting PD encouraged participants to discuss their perspectives and experiences (TABLE 1). By design, residents of both programs also raised unplanned topics. For both programs, the second focus group did not yield new themes, suggesting that thematic saturation on key issues was achieved after 1 focus group.

In some cases, feedback expanded on previously identified issues. In such cases, the discussion allowed for more detailed understanding about the issues (eg, one reason anesthesiology residents were dissatisfied with feedback was that they felt it was not directly actionable). In other cases, the feedback was novel. TABLE 3 provides examples.

The feedback generated from the pilot focus group exchange program was used in various ways by the programs (TABLE 3). In some cases, new initiatives were developed. In other cases, communication efforts to address misunderstandings were enacted (eg, pediatric residents thought that anonymized evaluations of faculty were delivered immediately, but they are actually batched biannually). Other feedback did not require action (eg, pediatric residents felt that the new inpatient rotation structure was working well). Lastly, some feedback was used to justify and defend ongoing educational initiatives within the department (eg, maintenance of a novel single day elective system for anesthesiology residents).

Program Director Perspectives: Costs and Benefits

The only direct financial cost was dinner provided to participants (approximately $200). Indirect financial costs included event coordination and use of conference room space. This approach also required time commitments, including three 1-hour meetings between PDs (before, between, and after the focus groups) for planning and discussion, and an additional 3 hours for each PD and chief resident leading the focus groups.

The PDs identified several benefits, including better understanding of the gaps in their program, discussion of issues with another PD, and learning about the other program's improvement goals, struggles, and successes. Both PDs felt that the benefits greatly outweighed the modest time and resource investment.

Discussion

The use of resident focus groups led by PDs from an unrelated program to acquire formative feedback about the residency program provided new feedback and was considered safe and acceptable by residents. The PDs were able to use the novel feedback for program improvement and considered the time and cost to be modest.

Focus groups have been used in program evaluation,[8] both by GME offices (eg, internal reviews) and during site visits (eg, ACGME visits, Clinical Learning Environment Review visits). These generally require significant resources to coordinate and may not target program priorities. Additionally, because of the high-stakes nature, participants may withhold feedback out of program allegiance.

There were some secondary benefits of this process. Hosting focus groups demonstrated to residents both programs' commitment to improvement. Though not all generated feedback led to new initiatives, in some cases, PDs were able to leverage the "external" observations and recommendations to affect or maintain initiatives to a greater degree than if program leadership alone had identified a problem.

This approach has several limitations. First, few residents attended. As such, important feedback may be missing, and the feedback that was obtained may not be representative of all residents. Given the importance of confidentiality and the voluntary nature of the program, increasing attendance would be challenging had thematic saturation not been reached. A second limitation is that this approach may not be practical to use with high frequency. Ideally, formative feedback is provided on a continuous or near-continuous basis. Finally, the effectiveness of this approach may not generalize to all settings. Maintaining confidentiality was a central component of this exchange. Residents had little to no exposure to the consulting PD who facilitated their focus groups, and they reported that this degree of confidentiality increased their willingness

TABLE 3
Examples of Formative Feedback Generated From Focus Group Discussion and How Programs Used Feedback

Topics	Examples of Underlying Issues Explored[a]	Examples of How Generated Feedback Was Used
Anesthesia program		
Service versus education	▪ Some activities (eg, OR setup) feel more like service than education. ▪ Concern for inconsistent end-of-day relief for ongoing cases.	▪ Provided feedback to anesthesia technician working group for standardization of OR setup. ▪ Queried electronic health record to explore the frequency of unexpected late stay cases for residents. These were found to be rare. No further action taken.
Feedback	*Residents do not fear retaliation for giving feedback*.	Added questions to annual program survey that explore other aspects of psychological safety related to fear of retaliation but not related to giving feedback.
Unplanned topics	Some residents perceived difficulty in flexibility around scheduling job or fellowship interviews.	Devised and executed a system to allow for instantaneous approval of interview time by the chief residents that has already allowed for 17 interviews.
	Residents want a more graded experience in the SICU.	Plans to restructure the roles and deployment of each of the SICU rotations were discussed at a resident "Town Hall" meeting.
Pediatric program		
Autonomy versus supervision	Residents desire opportunities for more independent decision-making. *Residents identified several rotations as promoting independent decision-making* and some as needing the most improvement (eg, ICU).	Created working group with key stakeholder representation (faculty, RNs, fellows, residents) to address how best to balance supervision and independent decision-making in the ICU.
Evaluation confidentiality	Residents thought faculty immediately saw feedback that would make identifying source easy.	Faculty evaluations were already batched every 6 months. Program created a document outlining evaluation confidentiality and timelines for when they are shared.
Inpatient team structure	Residents identified some ambiguity in role scope of responsibilities (PGY-2 versus PGY-1).	Created written orientation for scope of each role, and orientation developed with PGY-2 residents.
Unplanned topics	*Some residents felt that required PD meetings with interns were too late in the year (near midpoint)*.	Intern PD meetings now in the summer/early fall. One associate PD now assigned to each class for midyear meeting at the time of milestones completion.

Abbreviations: OR, operating room; SICU, surgical intensive care unit; ICU, intensive care unit; RN, registered nurse; PGY, postgraduate year; PD, program director.
[a] Novel information (previously not known) is italicized.

to share feedback. Programs with more clinical or geographic overlap (eg, anesthesiology and surgery programs) or at smaller institutions may have different results.

Going forward, it may be helpful to determine the ideal frequency for this feedback approach. Also, it is critical to replicate the method with different programs to determine how many focus groups are generally required to reach saturation.

Conclusion

This novel cross-specialty focus group exchange program was low-cost, highly valued by resident and PD participants, and generated new and nuanced feedback. Though this approach cannot (and should not) replace direct feedback and connection with residents' primary programs, it required modest resources and may prove a useful adjunct to obtaining feedback.

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