Exploring the Reality of Using Patient Experience Data to Provide Resident Feedback: A Qualitative Study of Attending Physician Perspectives

Steffanie Campbell, MD; Heather Honoré Goltz, PhD, LMSW, MEd; Sarah Njue, MPH; Bich Ngoc Dang, MD

ABSTRACT

Introduction: Little is known about the attitudes of faculty and residents toward the use of patient experience data as a tool for providing resident feedback. The purpose of this study was to explore the attitudes of teaching faculty surrounding patient experience data and how those attitudes may influence the feedback given to trainees.

Methods: From July 2013 to August 2013, we conducted in-depth, face-to-face, semistructured interviews with 9 attending physicians who precept residents in internal medicine at 2 continuity clinics (75% of eligible attendings). Interviews were coded using conventional content analysis.

Results: Content analysis identified six potential barriers in using patient experience survey data to provide feedback to residents: 1) perceived inability of residents to learn or to incorporate feedback, 2) punitive nature of feedback, 3) lack of training in the delivery of actionable feedback, 4) lack of timeliness in the delivery of feedback, 5) unclear benefit of patient experience survey data as a tool for providing resident feedback, and 6) lack of individualized feedback.

Conclusion: Programs may want to conduct an internal review on how patient experience data is incorporated into the resident feedback process and how, if at all, their faculty are trained to provide such feedback.

INTRODUCTION

Interpersonal and communication skills constitute one of the Accreditation Council for Graduate Medical Education's (ACGME's) 6 domains of clinical competencies for graduate medical education in internal medicine. The ACGME supports the use of patient experience data as an outcomes-based tool for providing resident feedback on interpersonal and communication skills.[1] The American Board of Internal Medicine is exploring ways to integrate this outcomes-based approach into their physician certification activities.[2] Patient experience data can serve as an effective tool for providing residents with feedback. In a study by Cope and colleagues,[3] residents in an internal medicine training program were randomized to receive a 30-minute structured feedback session in which they received mean scores on an experience survey filled out by new patients. Residents in the intervention arm had a significant increase in mean scores on a subsequent survey of new patients compared with residents who did not receive feedback. Patient experience data paired with actionable feedback (ie, feedback that can change residents' practice behavior) can be highly effective when provided by trained individuals.[4]

Although data suggest actionable feedback has a positive impact on residents' practice behaviors, many graduate medical education programs have difficulties translating this knowledge into real-world practice.[5-12] Studies evaluating feedback-based interventions typically devote immense resources on the development and training of personnel to deliver actionable feedback that is typically neither feasible nor designed for implementation in general practice.[13-20] As such, patient experience survey data are rarely used effectively outside the research context to deliver resident feedback, owing to lack of either training or time.[6,11,12,21] In addition, little is known about the attitudes of faculty and residents toward the use of patient experience data as a tool for providing resident feedback.[22] The purpose of this study was to explore how attending physicians in a real-world academic setting incorporate patient experience survey data into feedback practices, explore the attitudes and beliefs surrounding the use of patient experience data as a feedback tool, and identify potential areas for improvement. Specifically, we were interested in exploring attendings' attitudes around giving feedback and understanding the process by which attendings provide learners with actionable feedback.

METHODS

Participants

The study population was based on a nonrandomized convenience sample of attending physicians who precept residents in internal medicine at two continuity clinics in Houston, TX (clinics A and B). Eligibility criteria included 1) faculty with an appointment in the Department of Internal Medicine and 2) faculty with a role as a preceptor in the internal medicine resident continuity clinic. This study was approved by the institutional review board for our institution.

Data Collection

Participants were recruited by e-mail; attending physicians received an e-mail from the Associate Program Director of the

Steffanie Campbell, MD, is an Assistant Professor of Medicine and an Associate Director of the Internal Medicine Residency Program at Baylor College of Medicine in Houston, TX. E-mail: steffanie.campbell@bcm.edu. **Heather Honoré Goltz, PhD, LMSW, MEd,** is an Assistant Professor at the University of Houston-Downtown and Adjunct Assistant Professor in the Section of Infectious Diseases at Baylor College of Medicine in Houston, TX. E-mail: goltzh@uhd.edu. **Sarah Njue, MPH,** is a Research Coordinator in the Section of Infectious Diseases at Baylor College of Medicine in Houston, TX. E-mail: sarah.njue@bcm.edu. **Bich Ngoc Dang, MD,** is an Assistant Professor of Medicine in the Section of Infectious Diseases at Baylor College of Medicine and an Investigator at the Center for Innovations in Quality, Effectiveness and Safety at the Michael E DeBakey VA Medical Center in Houston, TX. E-mail: bndang@bcm.edu.

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Internal Medicine Residency Program (SC) inviting them to take part in the study. The e-mail informed potential participants of the study and its purpose. Twelve attending physicians met eligibility criteria and were recruited; 9 attending physicians participated. Between July and August 2013, SC conducted in-depth, face-to-face, semistructured interviews with attending physicians. She conducted 4 individual interviews at clinic B and a focus group interview involving 5 participants at clinic A. A focus group interview was conducted at clinic A per the request of the clinic director, given the time constraints of the attending staff. Staff members were willing to complete a group interview during their lunch hour, but were unable to dedicate an hour individually for interviews. Participants provided verbal but not written informed consent to protect their identities. No compensation was provided for participation. The individual interviews lasted 30 minutes to 60 minutes and the focus group lasted 60 minutes. Interviews were audiotaped using an encrypted recorder and transcribed verbatim by professional transcriptionists. The interviews were conducted using an open-ended interview guide developed by the multidisciplinary team. The interview guide consisted of open-ended questions to identify the process of feedback, the attitudes and beliefs surrounding feedback, and the training given to attending physicians to use patient experience survey data in providing resident feedback (see Sidebar: Major Topics and Key Interview Questions in Study of Resident Feedback). Interviews took place in conference rooms at the participants' respective clinic sites.

Research Team and Reflexivity

The research team's professional backgrounds and research interests informed development of the interview guide, interpretation of codes, and understanding of emergent themes within the context of medical education and patient care. Our multidisciplinary team consisted of two physicians, a social work researcher, and a research coordinator. SC, Associate Program Director of the Internal Medicine Residency Program, ensures quality education and training for residents. BND is an Assistant Professor of Medicine in the Section of Infectious Diseases. Her research examines the use of patient experience metrics as a modifiable focus for improving retention in care and adherence to medicines. HHG, Assistant Professor in Social Work, is experienced in qualitative research methods; she is interested in patients' access to and quality of care. SN is a master's-trained public health professional with a background in health promotion and behavioral science.

Data Analysis

We did not use an a priori code list. Four researchers (SC, HHG, SN, and BND) independently reviewed the transcripts and coded the data, looking for examples of facilitators and barriers to actionable feedback. The full research team then came together to compare codes and iteratively revise and refine codes until 100% consensus was reached. This occurred during several weekly team meetings. In the later stages of analysis, the team examined recurrent themes across interviews and clinic sites.

RESULTS
Characteristics of Participants

The participation rate among eligible attending physicians was 75% (9/12). Nonparticipating physicians reported demanding clinical duties and the lack of time as reasons for opting out. Baseline characteristics are outlined in Table 1. Given the small sample size, limited demographic characteristics are reported to preserve confidentiality. Five were female and 4 reported their race/ethnicity as Asian. Five participants precept residents at clinic A and 4 at clinic B.

Major Topics and Key Interview Questions in Study of Resident Feedback

Impressions of patient experience survey
- Tell me about the satisfaction surveys[a] your patients fill out on the residents.
- Tell me about how you use patient survey data in comparison to the other information you use to provide feedback to a resident.

Training in the use of patient experience survey data
- Do you feel comfortable using patient satisfaction survey data to provide feedback to the residents?
- How were you chosen to provide feedback to the residents?
- What was the time commitment required to learn how to use patient satisfaction data in order to provide feedback?
- Think about your peers who provide feedback. Why do you think they were chosen?

Process of feedback
- Context framing statement: Think about the first time you used patient satisfaction survey data to provide a resident with feedback.
- What happens during a typical feedback session?
- What parameters do you use to determine whether a feedback session was effective?
- Have you seen or been told by a colleague how they give feedback?
- Have you received feedback on the process? We are all [name of academic center] but our residents have continuity clinics at two different sites. Do you think there is anything specific to the culture of your location that impacts your feedback process?

Attitudes/beliefs surrounding feedback
- Overall, how would you describe the interaction between you and the resident when you use the patient survey data in a resident feedback session?
- Think about the best feedback session you had where you used patient satisfaction survey data. Could you describe this to me?
- Think about the worst feedback session you had where you used patient satisfaction survey data. Could you describe this to me?

Potential areas for improvement
- Is there anything the residency program can do to make the feedback sessions based on patient satisfaction survey data more effective?
- In an ideal situation, what would the process look like?

[a] The term "satisfaction survey" was used instead of patient experience in the interview guide because it was a term faculty were more familiar with.

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Table 1. Participant characteristics (N = 9)	
Characteristic	**no. (%)**[a]
Sex	
Men	4 (44)
Women	5 (55)
Age, mean (± SD)	47 (± 10.2)
Race	
Asian	4 (44)
Black or African American	3 (33)
White	2 (22)
Faculty facilitator experience, mean years	9.7
Location	
Clinic A	5 (55)
Clinic B	4 (44)

[a] Data are no. (%) except where indicated.
SD = standard deviation.

Description of Clinic, Patient Panel Assignment, and Patient Experience Survey

Each clinic has a unique structure for assignment of a primary care physician. Clinic A assigns patients to a staff physician as their primary care physician. Residents are assigned to a specific attending who then designates the resident as an associate physician for 75 to 90 of their patients. Attempts are made to schedule follow-up appointments during the time the resident is present to create continuity of care between residents and their patients. At clinic B, patients are assigned a resident physician as their primary care physician. All follow-up appointments are made on the half-day the resident physicians are available to assure continuity of care. Resident physicians then discuss care plans with the staff physician available during that half-day. A 9-item survey adapted from resident evaluation tools, including those originating from Saint Mary's Hospital and Maine Medical Center, is used to measure patients' experience with residents during a specific encounter (see Sidebar: Patient Experience Survey Questions).[23] These items reflect interpersonal and communication skills valued as important on the basis of the program's educational objectives and the extant literature. Responses are kept anonymous and filed under the resident's name.

Patient Experience Survey Questions

1. Overall, I was satisfied with this visit
2. During this visit, my doctor treated me with respect
3. My doctor answered my medical questions
4. My doctor used terms I understood
5. My doctor involved me in making decisions about my care
6. I felt my doctor listened to my concerns
7. I felt my doctor spent enough time with me
8. I would recommend this doctor to a friend
9. I was seen by the doctor in a timely fashion

For each questions, patients were asked to choose: Strongly disagree, Disagree, Neither disagree nor agree, Agree, Strongly Agree, or Unsure.

Barriers to Actionable Feedback

Specific patterns of feedback varied by clinic site; however, some core themes did emerge from the data. The research team identified six themes corresponding to potential barriers in using patient experience survey data to provide actionable feedback to residents: 1) perceived inability of residents to learn or incorporate feedback, 2) punitive nature of feedback, 3) lack of training in the use of patient-experience data to give feedback, 4) lack of timeliness in providing feedback, 5) unclear benefit of patient experience data as a tool to inform and frame actionable feedback, and 6) lack of individualized feedback.

Perceived Inability of Residents to Learn or Incorporate Feedback

On occasion, attending physicians seemed resigned to the belief that it is difficult to change residents' practice behavior. They cited difficulties in teaching adult learners and difficulties in teaching "soft skills" (eg, personal attributes). Three attending physicians specifically reported difficulty in teaching "professionalism."

"It's hard to change behavior for adults … . Just because they're trainees, we should not forget the fact that they are adults and they're supposed to be professionals, you know, so there's only so much I can do … "

"But you can't change personalities and habits of people [who are] old. You can do your best, but professionalism is a very difficult thing to teach, and it's professionalism in not just how you look or how you show up, but it's also the amount of effort you put forth in what your actual duties are, you know, and how much you can relate and communicate to the patient. So it's hard to teach soft skills. You can do your best with a resident that you might have for three years, but some personalities don't change."

—Attending physicians at clinics A and B

Punitive Nature of Feedback

Punitive feedback refers to any negative approach to providing feedback. Three of four participants at clinic B reported that they approached underperforming residents in a nonpunitive way to address patient concerns or improve their clinical competence. These attending physicians engaged the resident in coming up with task-specific and actionable solutions.

"I talked to the resident about what she thought had happened, … and then we kind of brainstormed kind of what we thought had gone wrong between that. And she asked me was there anything I thought uh could be done better in the- the situation, um and then we kind of wrote back to the patient what had happened, which I think was just a miscommunication thing."

"So I learned that we have to be sensitive but at the same time we have to get to the point because if you're too sensitive you're being too nice. And if they don't get the message then you're not getting to the feedback."

—Attending physicians at clinic B

In contrast, attendings at clinic A reported using punitive feedback in response to the residents' actions, such as removing patients from the residents' panel.

"So that is why they [the patients] don't want to write bad things, but they will come and talk to us in person; especially because many of them, if you've been seeing them for several years, they do understand that these people are in training, which is okay to some extent. And some say, 'No, I don't want to see a resident; I want to see the attending.' Then we just change the patient back to us [attendings]."

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"But some of my patients I have actually removed from his panel and either brought them back to me or put them with another person that I know is better at listening and communication."

"But it's important for the resident that he at least gets a feel that we are watching them and patients do have their opinions."

—Attending physicians at clinic A

Lack of Training in the Use of Patient Experience Data to Give Feedback

Participants were asked if they received specific training in using patient experience survey data to provide actionable feedback. Two of the five participants at clinic A reported taking a three-hour institutional workshop two years prior. Per their report, the workshop explained how to provide feedback to residents, but not specifically how to incorporate patient experience data into feedback practices.

"There's a course at [my institution] about how to evaluate residents and other groups … . The one that we specifically had taken was how to complete evaluations."

—Attending physician at clinic A

However, three of the four participants at clinic B reported no formal training in these areas.

"No, I mean, no formal training to start off with, except I mean-I mean, we had, you know, teaching as residents and a lot of teaching built into our primary care residency."

—Attending physician at clinic B

Lack of Timeliness in Providing Feedback

Lack of timeliness refers to delays in providing feedback to the residents. Branch and Paranjas[24] suggest residents should receive feedback at least every two to three months. In our analysis, two attending physicians at clinic B reported completing evaluations twice a year; they reported time constraints as a barrier to timely feedback.

"It's time consuming because I have 28 residents."

"We just do it electronically so we don't actually have that feedback like oral feedback session because they come at different times."

—Attending physicians at clinic B

"I'd rather not deal with it than deal with that because then you're sending more work for me … . Every year, every year now, I have one that is wasting my time."

—Attending physician at clinic A

Unclear Benefit of Patient Experience Data as a Tool to Inform and Frame Actionable Feedback

Benefit refers to the degree with which the attending physicians consider patient experience survey data as a beneficial tool for providing actionable feedback. Only one of five participants at clinic B reported that the surveys were a suitable tool for providing feedback to the residents. However, of the nine participants overall, eight questioned the value of patient experience survey data in providing resident feedback. These attendings reported that the surveys were not beneficial; they felt that the information obtained from the surveys was insufficient to address patient issues or give effective feedback to the residents.

"I don't see that they are a big help to the resident, nor to me, unless the patient very specifically writes something, you know, out of the ordinary that the resident did, whether it be egregious or something

positive. Short of that, I don't see that they are very helpful evaluations to me or the resident, in their current state."*

"Yeah, because I'm not getting that much useful information except uh "wonderful doctor," "the best,"… but no really constructive feedback … . We [are] doing it [patient experience surveys] just to meet this [Accreditation Council for Graduate Medical Education] requirement but yet they're not learning … . There's no feedback and they're not learning what they should do to improve themselves. There's no purpose of doing the evaluation … . So it's a little more difficult and there's no details on those and so it's a little harder to give feedback … . I don't see any comments … at all so it's hard to give the feedback."

"I don't think the residents care too much. They get evaluated so many ways and so many times a year."

—Attending physicians at clinics A and B

Most attendings did not like the survey format. They preferred open-ended questions where patients could provide specific examples and task-specific feedback.

Lack of Resident-Centered Feedback

Resident-centered feedback is feedback that engages the resident in discussion and allows for shared goal setting.[4] One participant in clinic B reported delivering feedback by having a face-to-face conversation. In contrast, the other three participants in clinic B reported providing feedback electronically; they cited lack of time and the high number of assigned residents as barriers to resident-centered feedback.

"Unfortunately we don't sit down … We don't sit down with any one of them except the ones who actually um have difficulty. Then we meet, we talk to that person personally, but other than that we just do it electronically so we don't actually have that feedback-like oral feedback session."

—Attending physician at clinic B

"I mean, ideally, yes, it would be lovely to have them come, sit, go through everything, see how you're doing, whatever, but there's so many of them."

—Attending physician at clinic B

These attendings acknowledge that use of an electronic medium alone can create a barrier to resident-centered feedback because it does not provide an opportunity for the resident to reflect, comment, or engage in the solution-making process.

DISCUSSION

This study provides insight into how attending physicians use patient-reported experience measures to provide feedback for residents in an internal medicine training program. We identified six core themes influencing the use of patient experience data in providing resident feedback: 1) perceived inability of residents to learn or to incorporate feedback, 2) punitive nature of feedback, 3) lack of training in the delivery of actionable feedback, 4) lack of timeliness in the delivery of feedback, 5) unclear benefit of patient experience survey data as a tool for providing resident feedback, and 6) lack of individualized feedback. In 2001, the Institute of Medicine codified patient-centeredness as one of six health care quality aims.[25] Patient experience is a critical facet of patient-centeredness. Moreover, studies have linked better patient experiences to favorable health behaviors and outcomes.[26-39] In alignment with this aim, the Institute of Medicine advocates

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Steps to Using Patient Experience Data to Provide Residents with Actionable Feedback

1. Generate a feedback sheet for each resident, comparing the individual scores with the scores for the entire group of residents; see example in Table 2 (individualized).

2. Provide an in-depth feedback session with the resident; use the feedback sheet to tailor feedback on the basis of areas where the resident scored low compared to his/her peers.

3. Have the resident comment on his/her scores (resident-centered).

4. Collaboratively discuss different solutions for improving areas with low scores (nonpunitive).

5. Have the resident set specific goals and solutions to improve low-scoring areas.

6. Follow-up to determine if the resident has made progress in achieving his/her goals.

the use of patient experience data as a patient-centered tool for promoting quality care. Concrete patient experience data can define key points of intervention for improving the care experience. These data argue for greater training on the use of patient experience survey data to effect practice change and ultimately to improve health behaviors and outcomes. Physicians in training are an ideal population to intervene because they are at an early stage in their career and may be more malleable.[8,40-43] Thus, actionable feedback may have a greater effect on practice behaviors.

Implementation science dictates that a tool or system must be accepted by the stakeholders for it to be successful.[44] Low acceptability of patient experience data was noted in our study and previously at other institutions.[45] Thus, methods for increasing attending buy-in on the merits of patient experience measures as tools to inform actionable feedback need to be explored. Increased buy-in could be achieved by involving attending physicians in the implementation process. For example, participants in our study suggested including open-ended questions and comment areas to elicit more detailed patient experience data. Previous studies suggest that medical education programs can benefit from more intense support and from training on how to interpret patient experience survey data and to deliver actionable feedback.[46,47] One potential method for incorporating patient experience data into actionable feedback for the resident is the use of a framework grounded in feedback-intervention theory. Feedback should be individualized, and recommendations should be solutions oriented (ie, task-specific and actionable). The highest, most effective form of feedback de-emphasizes hierarchy and embraces a supportive dialogue between the attending and resident. Beyond identifying competency gaps, it requires the attending to understand the resident as a learner (ie, understand the resident's motivations and goal orientation). The attending can then leverage this knowledge to engage and motivate the resident to reflect on his/her performance, and to set goals and develop an action plan to achieve those goals. To close the feedback loop, the attending should follow-up to determine if the resident has made progress in achieving goals.[48,49] The Sidebar: Steps to Using Patient Experience Data to Provide Residents with Actionable Feedback details the steps to using patient experience data to provide residents with actionable feedback. These steps use an individualized, resident-centered, and nonpunitive approach to providing feedback. A feedback sheet (Table 2) provides the resident's average score on each item of a patient experience survey, and compares those scores with a group of peers. Items where residents score below a certain

> **Feedback should be individualized, and recommendations should be solutions oriented … The highest, most effective form of feedback de-emphasizes hierarchy and embraces a supportive dialogue between the attending and resident. … it requires the attending to understand the resident as a learner …**

cut-off point (eg, the lowest quartile) can identify critical areas where residents can improve. A plan to improve the identified areas, in the context of specific goals, should be formulated. For example, if "listening" is identified as an area of weakness, specific goals may be 1) using more eye contact during the visit, and 2) making reflective statements to summarize what the patient has said.[50] By using this or other identified tools, one can create a robust and effective feedback process.

Table 2. Sample feedback table providing performance data on the patient experience survey in comparison to peers[1]		Individual		Total (n = X)				
Component experience	Scale[a]	Mean	SD	Mean	SD	25th[b]	50th[b]	75th[b]
Shared decision making								
1. Offer choices in your medical care	1-5							
2. Discuss the pros and cons of each choice with you	1-5							
3. Get you to state which option or choice you prefer	1-5							
4. Take your preferences into account when making treatment decisions	1-5							

[a] 1 = none of the time; 2 = a little of the time; 3 = some of the time; 4 = most of the time; 5 = all of the time.

[b] percentile.

[1] Cope DW, Linn LS, Leake BD, Barrett PA. Modification of residents' behavior by preceptor feedback of patient satisfaction. J Gen Intern Med 1986 Nov-Dec;1(6):394-8. DOI: http://dx.doi.org/10.1007/BF02596425.

SD = standard deviation. High SD indicates greater variability in patient responses (ie, responses vary a lot across patients)

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An important strength of our study is that we are one of the first to explore how patient experience data is incorporated into the resident feedback process. We identified six core themes that residency programs can use in assessing and modifying their own resident feedback process. On the basis of our findings, we believe that patient experience data can be successfully used to augment existing evaluation processes.

Limitations

The findings in our study should be interpreted with the following limitations in mind. Although our sample size is small, our participation rate of 75% is acceptable for exploratory analyses. In a qualitative study using 60 interviews, core themes were present as early as 6 interviews and data saturation was reached at 12 interviews.[51] Although we collected data at 2 very different institutions, these institutions are affiliated with the same academic center. Our findings may not be generalizable. We were forced to use mixed methods by combining data from individual interviews and focus groups. In a focus group there is the concern that 1 or 2 individuals can dominate the conversation. However, there is also the opportunity for individuals to motivate each other to express their thoughts. It has been noted that integration of these 2 study methods may provide data enrichment.[52]

CONCLUSION

Graduate Medical Education programs may want to conduct their own internal assessment of the resident feedback process. Such assessments should review how patient experience data is incorporated into the resident feedback process and how, if at all, their faculty are trained to provide such feedback. We believe there is value in adhering to the ACGME guidelines in both spirit and content so that residents emerge from training with greater competency in interpreting and using patient experience data to improve their interpersonal and communication behaviors. ❖

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ORIGINAL RESEARCH & CONTRIBUTIONS

Exploring the Reality of Using Patient Experience Data to Provide Resident Feedback: A Qualitative Study of Attending Physician Perspectives

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Compassion

The greatest single quality which the intern should develop is that of compassion for the sick, the afflicted and the suffering. … No single attribute of medical practice is more demanding, more difficult to acquire and more exacting to maintain than the bond which exists between the patient and the doctor.

— *The Internship*. Roscoe L Pullen. Springfield, IL: Charles C Thomas; 1952