From feedback to action: Physicians’ teaching performance in residency training
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Chapter 7

Explaining How Faculty Members Act Upon Residents’ Feedback to Improve their Teaching Performance

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Kiki M.J.M.H. Lombarts

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Abstract

Context
Responsiveness to feedback is a complex phenomenon that requires and receives attention. However, knowledge on the responsiveness of faculty members to residents’ feedback on their teaching performance is lacking. Excellent teaching performance is essential to ensure patient safety and residents’ learning in residency training. This study aims to increase our understanding of how faculty staff react to and act upon residents’ feedback on their teaching performance.

Objectives
This multi-specialty, multi-institution interview study was conducted to gain insight into: (i) how teaching faculty proceed after they have received residents’ feedback on their teaching performance, and (ii) the factors that influence their progression.

Methods
Between August and December 2011, 24 faculty members who had received formative feedback on their teaching performance through valid and reliable feedback systems participated in this study. They reflected upon their (re)action(s) during individual semi-structured interviews. The interview protocol and analysis were guided by a comprehensive transtheoretical framework describing and explaining stages and processes of behavioural change.

Results
Faculty staff involved in residency training used residents’ feedback to different extents to adapt or improve their teaching performance. Important tipping points in the processes of change necessary for faculty staff to put feedback into practice were: experiencing negative emotions in themselves or recognizing those in residents as a failure to act upon the feedback; realising that something should be done with or without support from others, and making a strong commitment to change. In addition, having the confidence to act upon feedback and recognising the benefits of change were found to stimulate faculty members to change their teaching behaviour.

Conclusions
The responsiveness of faculty to residents’ feedback on their teaching performance varies. The adapted transtheoretical framework explains how and why faculty members do or do not proceed to action after receiving residents’ feedback. Given this, organising residents’ feedback for faculty staff in a systematic way is a first step and is necessary to effect potential improvements in teaching performance.
Introduction

Feedback is a widely applied strategy for learning and is normally used to provide direction to help learners of all levels to achieve or maintain a high level of performance. The need for credible feedback from others has been highlighted in different studies. Whether feedback is used to improve one’s performance is influenced by the recipient’s interpretation of and responsiveness to feedback, which are, in turn, influenced by that individual’s personal attributes, tensions, fear, confidence and reasoning processes. Qualitative research on specific situations and participants is probably best fit to explore the complexity of responsiveness to feedback. A specific context in which responsiveness to feedback requires exploration is residency training, which demands a high level of teaching performance from faculty staff in order to ensure residents’ learning and to maintain patient safety. Although valid, reliable and formative feedback systems through which residents provide feedback to individual faculty members are available, there is a lack of knowledge on the responsiveness of faculty staff to residents’ feedback on their teaching performance. Building on existing knowledge of change processes following interventions, we based our study on the framework of the transtheoretical model (TTM) for behavioural change developed by Prochaska et al. We chose the TTM because it is based on major theories of change and describes 4 integrated constructs: the stages and processes through which people proceed towards change, and the self-efficacy and decisional balance that stimulate or hinder people’s progression to change. This model is presented graphically in Fig. 1. Firstly, 6 stages of change represent a temporal dimension in the progression towards change. Secondly, 9 processes of change represent the covert and overt activities people use to progress through stages. Thirdly, self-efficacy describes the situation-specific confidence that people must acquire in order to cope in high-risk situations without relapsing into their former behaviour. Finally, decisional balance describes the balance between pros (benefits) and cons (disadvantages) of possible change that influence people to progress towards behavioural change.

Aided by the TTM as a framework, we sought to increase our understanding of faculty staff (re)actions to residents’ feedback on their teaching performance. We performed an interview study to answer the following research question: How do faculty members proceed through different stages of change and what determines their progression after receiving residents’ feedback on their teaching performance?

Methods

Study design and setting

We conducted a multi-institution, multi-specialty interview study allowing in-depth discussion of teachers’ personal and possibly sensitive experiences. Applying an interpretative research paradigm allowed us to investigate individual experiences and accounts of faculty members while constructing an impression of what happens when faculty staff receive feedback.
We performed this study in the Netherlands, where residency training takes place in both university medical centres and affiliated general teaching hospitals. We used the validated, specialty-specific System for Evaluation of Teaching Qualities (SETQ) to provide faculty with individual feedback on their teaching performance. During a 1-month period, residents filled out the 20–25-item web-based questionnaires with reference to faculty members with whom they had worked. Faculty members also completed an SETQ self-evaluation questionnaire. Faculty staff received quantitative feedback on 5 different teaching qualities and narrative feedback on their strengths and areas for improvement as formulated by residents. The development of the SETQ and comprehensive information on the specialty-specific instruments have been described previously. Finally, a comparison with the peer group mean, the faculty member’s self-evaluation of his or her own teaching performance, and residents’ feedback were provided in individual reports.

**Figure 1** The transtheoretical model of change, showing 4 integrated constructs: the stages and processes through which people proceed towards change, and the self-efficacy and decisional balance that stimulate or hinder progression to change.

**Participants**

From September 2008 to June 2011, 1500 faculty staff and 1100 residents from 29 hospitals, representing 28 different specialties, completed one or more SETQ forms. From this dataset, we randomly invited participants from different departments and different hospitals that met the following selection criteria: the department must employ ≥15 faculty staff; a resident response rate of ≥70% must have been achieved, and an average of 6 evaluations per report must have been obtained (a reliable feedback report must include 4-6 evaluations). The heads of departments received a missive in which we explained our study and asked for their permission to randomly select a maximum of 4 faculty members from their respective departments department.
Interviews

Between August and December 2011, one researcher (RMvdL) conducted 24 semi-structured interviews lasting approximately 1 hour each. Interviews were conducted in the faculty member’s office or home in order to encourage the interviewee to talk freely. Confidentiality was assured at the start of the interview. An interview guide was available based on our research question and informed by the TTM on behavioural change. The first 3 interviews were critically discussed within the research team in order to develop interview techniques, discover favourable phrasing of questions and adapt our interview guide if necessary. The interview guide started with an open-ended question designed to stimulate general talk about the subject: ‘What was it like to receive feedback from your residents?’ We gradually worked towards more specific questions (e.g. ‘What did you do with your feedback?’) and sought to obtain concrete examples (e.g. ‘Can you describe differences between your teaching practice as it was before and your current teaching practice?’) to elicit information on change.

Data analysis

All interviews were audio-recorded and transcribed verbatim. We analysed our data using a technique called ‘template analysis’, which allowed the incorporation of existing knowledge but supports an open analysis of the data. In this technique, a template is constructed during analysis, starting from an initial template with a priori codes that can be based on a theoretical framework, researchers’ assumptions and the coding of the first interviews. To build our initial template, we first adapted the descriptions from the original TTM to our setting of residency training, as illustrated in Table 1. Secondly, we coded the first 2 interviews using the adapted model as our initial template. We provide an example to illustrate the effect of the cross-sectional design of the study on the coding: if an interviewee shared that he or she had subscribed to a course on how to give good feedback in order to improve his or her teaching skills, this act would be coded as preparation; however, if the interviewee said that he or she had completed the course or was in the middle of it, this act would be coded as representative of action. After discussing these first 2 steps (in order to build and try out our initial template) within the research team, subsequent original transcripts were coded by the first author (RMvdL). When informative phrases could not be coded within the initial template, new codes were added to complement the initial template. The second researcher (IAS) independently coded 3 transcripts during the coding process to discuss the coding and development of the template. The template was discussed regularly within the research team to increase completeness. If two subsequent interviews did not yield any new input for our template, we discontinued the interviews. We iteratively produced matrices in order to gain overview and visualise our findings during the analysis. To produce these matrices, the template codes were used as rows and the interviews as columns. All coding was performed with qualitative data analysis software MaxQDA Version 10 (Verbi GmbH, Berlin, Germany).
### Table 1. Descriptions of all stages and processes of change, decisional balance and self-efficacy with illustrative quotes from teaching faculty staff

<table>
<thead>
<tr>
<th>Stages of change</th>
<th>Description</th>
<th>Illustrative quote (Faculty identification code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>No intention to take action after receiving a feedback report</td>
<td>'I can imagine that residents perceive me as scary sometimes, but there is not something I can do about it, that’s just how it is.' (F3)</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Intention to take action within 6 months</td>
<td>'Yes, because I am a perfectionist, I need to do everything in the best possible way. And I recognise other people who are just pleased when things are going okay, and then I think, well, it can always be done better.' (F4)</td>
</tr>
<tr>
<td>Preparation</td>
<td>Intention to undertake action soon and has taken the first steps towards action</td>
<td>'Well, it wasn’t just receiving this feedback, but it mirrored my own opinion about the situation. So, I actually was already thinking about it.' (F8)</td>
</tr>
<tr>
<td>Action</td>
<td>Overt modifications in teaching practice within the past 6 months</td>
<td>'So after the feedback I started paying attention to my teaching and evaluating situations as learning opportunities for residents. And instead of preparing everything I now let residents think about the case and the possible diagnosis and treatment options. Yes, I involve them more in the decision making process.' (F22)</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Overt modifications in teaching practice sustained for &gt; 6 six months</td>
<td>'What I always do now when I am supervising residents, is that I first let them come up with a differential diagnosis and a treatment plan for patients.' (F21)</td>
</tr>
<tr>
<td>Termination</td>
<td>No desire to return to former teaching practice</td>
<td>'If no-one had told me this, I still might have done things the way I did. So my approach has changed, partly because I enjoy this way of working more and also because I understand the residents better.' (F22)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Processes of change</th>
<th>Description</th>
<th>Illustrative quote (Faculty identification code)</th>
</tr>
</thead>
</table>
| Consciousness raising | Raising the level of consciousness on the content of the feedback          | [Not recognising feedback] 'I had quite a bit of mixed feelings too, there were a few things in the feedback in which I could not recognise myself at all.' (F11)  
[Understanding feedback] 'I must try to keep my focus and leave the less important things for what they are. I recognised this behaviour as typically me, but I didn’t realise that this also influenced the way I supervise residents.' (F13) |
| Dramatic feelings   | Experiencing negative emotions when faculty member could not use the feedback | 'And then there was “criticism isn’t given in a constructive way”, that’s something a resident experienced with me. To me that’s very disappointing.' (F8) |
| Environmental re-evaluation | Realising the possible negative impact on residents of a failure to act upon feedback | 'For the success of the treatment itself it does not really matter whether you’re interacting very formally or informally. But apparently residents perceive this as if I’m keeping a certain distance.' (F12) |
| Self re-evaluation  | Realising that something should be done with feedback and that doing it contributed to their identity as teaching faculty | 'And “a capricious and unpredictable personality”, yes, that’s something that sounds a little familiar and it was mentioned a few times, so you must do something with that feedback.' (F13) |
### Table 1 (continued)

<table>
<thead>
<tr>
<th>Helping relationships</th>
<th>Self-liberation</th>
<th>Counter conditioning</th>
<th>Reinforcement management</th>
<th>Stimulus control</th>
<th>Social-liberation</th>
<th>Decisional balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking and using social support to make use of the feedback</td>
<td>Making a strong commitment to change</td>
<td>Learning new teaching methods or substituting problematic teaching behaviour</td>
<td>Being reinforced or recognised for the changes made, or rewarded less for not doing something with feedback</td>
<td>Removing cues for former behaviour and adding prompts for doing something with feedback</td>
<td>Changing social standards to stimulate doing something with feedback</td>
<td></td>
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<tr>
<td>‘So, during annual conversation with the programme director, I will explicitly ask for his supervision of my involvement in residency training since I’m working mostly in research and therefore have only limited interaction with residents.’ (F16)</td>
<td>‘The moment I think I know it all and other people are stupid is the moment when I’m about to make a big mistake. And now that I’m aware of that and I tell myself: “Beware! You’re doing it again!”.’ (F1)</td>
<td>‘I try hiding it, because impatience is not something I try to change, but I think what you can learn is to hide it and I’ve become better at that over the course of the years.’ (F3)</td>
<td>‘Clearly, I’ve gained something from this feedback, to me that’s the focus on residents and attention to their learning needs.’ (F19)</td>
<td>‘Certain days I hand over my beeper to the secretaries when I have to deliver bad news to a patient. They receive the questions of residents and write a note and then I try to better organise supervision that way. Residents don’t need to wait and I call them back to answer their questions.’ (F18)</td>
<td>‘That’s what we had agreed upon with our colleagues, as some sort of an assignment, that we would pick out 1 or 2 items from the feedback which we would tackle and really do something with.’ (F19)</td>
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<table>
<thead>
<tr>
<th>Decisional balance</th>
<th>Description</th>
<th>Illustrative quote (Faculty identification code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pros</td>
<td>Benefits of change</td>
<td>‘Well, receiving positive feedback gets you in a good mood, I mean that it stimulates you to continue working on the things you aimed to change.’ (F1)</td>
</tr>
<tr>
<td>Cons</td>
<td>Disadvantages of change</td>
<td>‘Well, if I was going to pay extra attention [to be on time with the supervision of residents], my enthusiasm for teaching or other things could detrimentally be influenced.’ (F9)</td>
</tr>
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</table>

### Self-efficacy

<table>
<thead>
<tr>
<th>Confidence</th>
<th>Description</th>
<th>Illustrative quote (Faculty identification code)</th>
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</thead>
<tbody>
<tr>
<td>Faculty expressing the confidence to do something with the feedback</td>
<td>‘Well, in every feedback is a possible lesson and this applies to all the residents’ comments in the report, that’s good feedback and I can learn from that.’ (F7)</td>
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</table>

<table>
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<tr>
<th>Temptation</th>
<th>Description</th>
<th>Illustrative quote (Faculty identification code)</th>
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<tbody>
<tr>
<td>Faculty expressing the temptation not to do something with the feedback</td>
<td>‘You are intensely working together, but if you do not know each other well, because that’s what it often comes down to if you work in a subspecialty, you are less inclined to communicate openly or friendly. Then it just comes down to the technical stuff and the formal side of it.’ (F12)</td>
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</table>
Ethical considerations

We took precautions to guarantee and protect the anonymity and confidentiality of the study participants. Confirmation of the interview appointment was considered consent to participate in the study. Verbal consent to the use of the data for research purposes was sought before the interview commenced. Requirements for ethical approval were waived by the University of Amsterdam's institutional review board.

Results

Participants specialised in internal medicine, neurology, obstetrics and gynaecology, otorhinolaryngology, paediatrics, radiology or surgery, and represented 3 university hospitals and 3 general teaching hospitals. Twelve men and 12 women participated in the study. Response to the invitation to participate in an interview was very positive; only 5 faculty members did not respond to the invitation and appointments with a further 6 faculty staff who had agreed to participate were cancelled after saturation was reached.

Figure 2 presents an overview of the results from the analysis and shows how faculty staff proceed to change their teaching behaviour after they receive residents’ feedback. For each stage on the x-axis, we describe the dominant processes of change on the y-axis that are connected through the curved lines. The influences of self-efficacy and decisional balance are explained in the grey boxes. Illustrative quotes are provided in Table 1. To provide an overview of the responsiveness of faculty members to residents’ feedback, we describe our findings in a way that is similar to the graphic representation shown in Fig. 2. For each of the stages of change, we describe the influence of behavioural change processes, the interaction with self-efficacy and the balance between the pros and cons of change on the staff member’s progression through the stages of change. We use the stages of change to structure our Results section. We discuss the stages of change in chronological order from pre-contemplation (no intention to take action) to maintenance and termination (no intention to return to former behaviour).

Precontemplation

All faculty staff expressed certain feelings and ideas resulting from the feedback they had received. Reflection upon these feelings and ideas raised consciousness of the content of the feedback. This so called ‘consciousness raising’ was the only process of change that applied to all faculty interviewees. However, there was a wide variation in consciousness raising among faculty members. Some interviewees reported that they accepted, recognised, validated (externally or internally), appreciated, or confirmed residents’ feedback. By contrast, some faculty members said that they did not appreciate, put aside, rejected or denied residents’ feedback or questioned its credibility. Having received feedback from their residents, faculty staff described several internal and external reasons for not to developing an intention to take action. Internal reasons were: ‘I cannot change who I am’; ‘I do not recognize myself in this feedback’; ‘I still stand by my teaching methods even though
residents might like something else’, and ‘I have other priorities than becoming a better teacher’. Faculty interviewees also reported reasons external to themselves that inhibited them from taking action: ‘I have not had a long relationship with the residents’; ‘I have not read the feedback carefully’; ‘I believe the system for providing feedback is in its infancy’, and ‘I will be retiring in a few months’.

Within this first stage in which faculty did not intend to take action, self-efficacy was dominated by interviewee’s expression of their temptation not to act on feedback. The pros and cons of change were expressed equally.

**Contemplation**

Generally, when a faculty member did intend to take action within the next six months, he or she reported being driven by the motivation to perform at a high level. Faculty members intended to take action to increase their interaction with residents, to balance their time for both patient care and teaching better, to increase their enjoyment of their job, or to learn from a successful colleague. Two processes of change were found to influence faculty members in the contemplation stage of change. Firstly, interviewees reported having ‘dramatic feelings’ incurred by the receipt of negative feedback and an inability to use feedback that was not sufficiently informative. Secondly, faculty staff commented on the possible negative impact on residents if they did not act upon feedback. In the TTM, realisation of the impact of one’s behaviour on others is called ‘environmental re-evaluation’. These 2 processes elucidate why faculty staff may be in the contemplation stage of change. A decrease of potential

![Processes of change diagram](image)

**Figure 2** Overview of results showing how faculty staff proceed to change their teaching behaviour after they receive residents’ feedback. Each stage on the x-axis is linked to the dominant processes of change on the y-axis. Grey boxes show the influences of self-efficacy and decisional balance.
disadvantages of change and an increase of confidence in being able to do something with feedback demonstrate progression towards developing an intention to take action.

**Preparation**

When the feedback confirmed the faculty member’s perception of his or her teaching performance, it helped a recipient who intended to undertake action soon to take the first steps towards doing so. Interviewees noted the need to adapt to the current context of residency training, to seek possible solutions, to gather the tools required to do so and to deliberately try new tactics. Two important processes that support faculty staff in preparing for action emerged from our interview data. Firstly, reflection on and evaluation of one’s self-image as a faculty member might stimulate that person to prepare for action. For example, faculty staff might realize that they should do something with feedback and that doing so might contribute to their identity as teaching faculty. Secondly, seeking support from peers or others, categorised under ‘helping relationships’, might encourage a faculty member to prepare for change. Interviewees who expressed the intention to undertake action soon reported both benefits and disadvantages of change that might impede them from actually proceeding to action. Self-efficacy was balanced between confidence and temptation in this stage of change.

**Action**

Faculty members in the actual action stage of stage consisted of those who had made overt modifications to their teaching practices within the past 6 months. Interviewees reported on how they had adapted their teaching to residents’ learning needs, improved the balance between the time they devoted to teaching residents and the time they gave to other aspects of their job, changed their way of making contact with or approaching residents, and explicitly shared their knowledge with residents. Making a strong commitment to doing something with feedback influenced faculty staff to use their feedback to change their teaching behaviour. This endeavour requires the recipient both to believe that he or she can change and to be committed to acting on that belief; this combination of factors was denominated ‘self-liberation’. Faculty staff commitments were seen to be motivated by the responsibility to ensure the best possible outcomes in terms of both patient care and resident education. Because both the pros and cons of change, and confidence and temptation are well balanced for faculty staff in the action stage of change, they must be strongly committed to putting feedback into action.

**Maintenance and termination**

Although similar to action, adjustments to teaching performance that applied when faculty members continued their adapted teaching practice for 6 months were defined as representing ‘maintenance’. Faculty staff who reported having no desire to return to their previous teaching practice were characterised as being in the ‘termination’ stage of change. In both stages, interviewees described strategies to support and maintain the changes
in their teaching practice. These strategies or processes include: learning new teaching methods or substituting problematic teaching behaviours (counter conditioning); obtaining reinforcement or recognition of change, or rewards for having done something with the feedback received (reinforcement management); removing cues for former behaviour and adding prompts for doing something with feedback (stimulus control), and changing social standards to stimulate oneself to do something with feedback (social liberation). We found no indications for differences in impact or hierarchy of these processes between the maintenance and termination stages of change.

Discussion

Main findings
All stages and processes were evident in the data as were the other 2 constructs of self-efficacy, and pros and cons. However, not all constructs were evident in all stages. Faculty staff responsiveness to resident feedback determines their progression through different stages of change. Faculty members who experience negative emotions in relation to themselves or their environment when they do not act upon feedback, and who, in addition, make a strong commitment to change with or without help from others, will pass through the different stages of change as they progress towards acting upon residents’ feedback and changing their teaching performance.

Explanation and interpretation of results
We will discuss our main findings, namely: the emotional aspects of dealing with feedback and the need to make a strong commitment to change in order to act upon feedback and develop one’s teaching performance. We will also discuss the use of TTM to explain faculty members’ responsiveness to residents’ feedback and how they act upon this feedback.

Firstly, there are 2 instances in which interviewees expressed negative emotions in the process of change: (i) when receiving feedback, and (ii) when recognising a possible negative impact on others if they do not respond to the feedback. These negative emotional aspects of dealing with feedback can stimulate progress through stages of change. Likewise, in clinical practice evaluation, emotional tensions appear to negatively influence responsiveness to feedback. It can be difficult to deal with feedback because the recipient’s aim is to protect his or her own self-image. Mindfully receiving and reflecting upon feedback seem represent essential processes through which feedback can be assimilated or conscientiously put aside, and appeared integral to accepting feedback and using it for learning. Often facilitation of reflection is mentioned as a helpful strategy, possibly because it resonates with a faculty member’s need for help from others in preparing to take action. The importance of dealing with feedback appropriately is underscored by the fact that its emotional aspects seem to be vital to the progression of a faculty member through the stages of change.

To our knowledge, this is the first study to provide evidence on faculty staff responsiveness to resident feedback and on the action taken by faculty members after they have received
feedback on their individual teaching performance. Although preparing for change or becoming conscious of one’s own teaching performance can be considered an action, in this study we used the constructs of the TTM, in which action refers to actual behavioural change. The tipping-point that will propel a staff member to act upon feedback and change his or her teaching behaviour is that at which the individual makes a strong commitment to change. The well-known theory of goal setting supports this finding because it shows that people who are committed to their goals demonstrate the strongest goal-performance relationship.

Strengths and limitations

An important strength of this study is its random selection of participants from a large database representing multiple specialties and institutions; this assured richness of data. Faculty interviewees discussed their feedback openly and shared their difficulties. This increased our confidence in our data as authentic and comprehensive. Finally, the use of TTM offered the possibility to build on a thoroughly constructed theoretical framework. A possible limitation is the retrospective nature of this study, which may have imposed a recall bias. This may be further influenced by the fact that we gathered data on self-reported change. However, we justify our decision to conduct an interview study on the basis of our primary goal, which was to gain detailed insight into faculty progression after the receipt of feedback. Finally, our study setting was limited to residency training in the Netherlands; however, TTM is supported in research on behavioural changes conducted in several countries.

Implications for practice

Because we found that faculty staff use feedback to improve their teaching performance, organising feedback in a systematic way is essential to maintain high-quality residency training. Feedback-generating systems, such as the SETQ, facilitate the continuous process of collecting data for the purpose of individual improvement trajectories. In addition, external stimuli can contribute to the uptake of feedback. In the (medical) education literature, there is a focus on strategies to enhance reflection, such as with the help of a mentor. Overeem et al. reported that discussing feedback with facilitators is helpful in supporting reflection upon feedback. Follow-up activities in the SETQ may include reflection upon the feedback through discussion with a colleague, a group of colleagues, residents or others. In the present study, faculty staff also reported a conversation with peers to be helpful when they intended to undertake action soon. In summary, we foresee 3 meaningful implications for practice from this study building on behavioural change theory. Firstly, it is recommended that faculty staff deal with any negative emotions that may arise when they receive feedback from residents. Secondly, it is suggested that faculty members should make a strong commitment to change as this commitment was identified as representing a stimulus for faculty staff who aim to improve their teaching performance. Finally, it should be noted that the uptake of feedback can be facilitated by support from others.
Suggestions for future research

Kluger and DeNisi suggest in the final sentence of their much acclaimed review that ‘future research must focus on the processes induced by feedback interventions and not on the general question of whether feedback interventions improve performance’. The present study provides evidence on the processes of change after receiving feedback and also yields areas of interest for future research. To deepen our understanding of teaching performance, the unique position of faculty staff responsible for residency training within their department (programme directors or lead consultants) deserves further study. These leaders were included as participants, but how they handle feedback, act as role models or provide leadership may influence how other faculty staff handle feedback. In a broader sense, the context and setting in which faculty staff receive individual feedback may have significant influence on change and this impact may be an appropriate subject of future research.
Reference List


Acting on feedback


