Perceptions of Emergency Medicine Residents of Multisource Feedback: Different, Relevant, and Useful Information

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Study objective: Multisource feedback is a process through which different members of the care team assess and provide feedback on residents' competencies, usually those that are less often addressed by traditional assessment methods (ie, communication, collaboration, and professionalism). Feasibility and reliability of multisource feedback have been addressed in previous research. The present study explores emergency residents' perceptions of multisource feedback provided by teaching physicians, nurses, and patients they have worked with during a rotation in an emergency department (ED).

Methods: A multisource feedback intervention was proposed to residents during 9 months in the ED of a tertiary care university hospital. Residents distributed feedback questionnaires to physicians, nurses, and patients that focused on competencies (collaboration, communication, and professionalism) from the CanMEDS framework. Responses were compiled and reported to participating residents. To assess residents' perceptions of multisource feedback, semistructured group and individual interviews were held 3 months after the intervention. Transcripts were analyzed qualitatively, following Miles and Huberman's method for intrasite case analysis.

Results: According to residents (n=10), each source (physicians, nurses, and patients) provided relevant comments that differed significantly in their content. Physicians focused primarily on medical expertise; nurses addressed competencies related to leadership, collaboration, and communication; and patients commented on the competencies of professionalism and communication. Residents concluded that obtaining feedback from nurses and patients was acceptable and useful. They reported modifying certain behaviors after receiving the multisource feedback.

Conclusion: Residents perceived the multisource feedback to be acceptable and useful for the assessment of medical competencies such as communication, collaboration, professionalism, and leadership. [Ann Emerg Med. 2019;74:660-669.]

Please see page 661 for the Editor's Capsule Summary of this article.

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0196-0644/$-see front matter

https://doi.org/10.1016/j.annemergmed.2019.05.019

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INTRODUCTION

Background

Assessment and feedback from teaching physicians play a core role in the development of residents' competencies,[1-3] which are defined by the CanMEDS competencies framework[4] or by the Accreditation Council for Graduate Medical Education.[5] A competent physician integrates the competencies of the 7 CanMEDS roles (Table 1). Across different levels of training and specialties, emphasis is often given to medical expertise and limited attention is paid to other competencies.[6-8] Teaching and assessing these other competencies remains a challenge and there is a need to improve this dimension in resident training.

Multisource feedback, or 360-degree assessment, "is the combined evaluation of a person by multiple individuals that have different working relationships with the person through use of questionnaires and a compiled feedback report."[9] A review of the literature on multisource feedback in the medical field[10] suggested that this approach is one of the best to provide physicians with feedback on interpersonal behaviors, communication, professionalism, and teamwork. However, although some physicians improve their practice after multisource feedback,[11,12] others either do not value or use the information received.[13] This raises questions in regard to the acceptability, perceived relevance, and receptivity toward this feedback.

Editor's Capsule Summary

What is already known on this topic

Evaluation of emergency medicine residents by nonphysicians has been studied for validity, reliability, and feasibility.

What question this study addressed

How do residents perceive the usefulness of feedback from nurses and patients compared with that from attending physicians?

What this study adds to our knowledge

This mixed-methods prospective study examined the attitudes of 10 Canadian emergency residents who received feedback in the form of 255 evaluations completed by physicians, nurses, and patients. Qualitative analysis of subsequent interviews indicated that residents generally believed that feedback from nurses and patients provided unique information, particularly about interpersonal competencies.

How this is relevant to clinical practice

Input from nurses and patients may provide useful resident evaluation assessments not offered by physicians alone.

Importance

Numerous articles have been published on the use of multisource feedback in postgraduate training, with a focus on its feasibility and the reliability of multisource feedback scales.[14-22] However, very few studies have explored residents' perceptions of multisource feedback and its usefulness,[23-25] despite its potential for providing feedback on competencies other than medical expertise.[10] The context of the emergency department (ED) is peculiar because emergency medicine rests heavily on teamwork and is characterized by brief and intense encounters with patients. Some studies have examined the use of multisource feedback in the ED,[21,22,26-28] but these consisted mainly of quantitative studies focusing on the feasibility,[21,22,26,28] reliability,[21,26,28] and validity[26,28] of multisource feedback. Three studies examined multisource feedback more specifically in emergency residents' training programs: however, 2 of these were quantitative studies,[21,22] whereas the other one had only nurses as evaluators.[27]

This study was based on the experiential learning theory of Kolb[29] and on the social cognitive theory of Bandura.[30] According to Kolb,[29] learning is a process of transforming concrete experiences into knowledge through reflective observation or active experimentation. For learners, multisource feedback is a means to obtain information on their competencies to nurture reflection on their practice and promote learning. According to Bandura,[30] learning is a social process that rests on observations and interactions with others. Multisource feedback provides learners with formal feedback from external sources with whom they are interacting in practice. It was posited that multisource feedback would provide learners with experiential and social learning opportunities that could lead to changes in their practice. In this study, residents' competencies were defined according to the CanMEDS framework.

Goals of This Investigation

The present study explored emergency medicine residents' perceptions of multisource feedback implemented in the ED and provided by their teaching

Table 1. Role descriptions from the CanMEDS 2015 Physician Competency Framework.[4]

CanMEDS Roles	Descriptions
Medical expert	Physicians integrate all of the CanMEDS roles, applying medical knowledge, clinical skills, and professional values in their provision of high-quality and safe patient-centered care.
Communicator	Physicians form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care.
Collaborator	Physicians work effectively with other health care professionals to provide safe, high-quality, patient-centered care.
Professional	Physicians are committed to the health of patients through ethical practice, high personal standards of behavior, accountability to the profession, and society.
Leader	Physicians engage with others to contribute to a vision of a high-quality health care system and take responsibility for the delivery of excellent patient care.
Health advocate	Physicians contribute their expertise and influence as they work with communities or patient populations to improve health.
Scholar	Physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others, evaluating evidence, and contributing to scholarship.

physicians, nurses with whom they worked, and patients whom they treated.

MATERIALS AND METHODS

Study Design

This was an interventional study to explore residents' perceptions of a multisource feedback intervention implemented in the ED during a 9-month period. Residents' perception of the intervention was assessed qualitatively. The study was performed as part of V.C.'s master's dissertation project[31] and approved by the hospital's institutional review board. The timeline of the study is illustrated in the Figure.

Setting and Selection of Participants

The study was conducted in the ED of Hôpital du Sacré-Coeur de Montréal, a tertiary care teaching hospital in Montreal, Canada. This hospital was the primary site where residents completed most of their rotations in emergency medicine (2 or 3 months per year). The ED is staffed by 30 full-time emergency physicians and more than 160 nurses. It has a census of greater than 65,000 visits annually, with a multicultural and multilingual population. Professional communications are conducted in French.

A convenience sample of residents was formed. All junior and senior residents from a postgraduate emergency medicine program who were completing a rotation between January and October 2015 at the ED were eligible for the study (n=13). In January, they received a letter inviting them to participate in the study and the multisource feedback intervention. Participation was voluntary and informed consent was obtained. Residents who obtained questionnaires from at least 5 individuals from each category of sources (this number was chosen to protect the anonymity of the sources) were invited by e-mail to participate in the interview phase.

Interventions

A multisource feedback intervention was developed and implemented. The intervention consisted of the distribution by emergency residents of questionnaires to physicians, nurses, and patients they had interacted with during their rotation. Responses to the questionnaires were collected and summarized to provide residents with individual feedback on their competencies.

Three questionnaires, adapted from a study by Joshi et al,[14] were designed to gather assessment of emergency residents from the following sources: teaching physicians, nurses, and patients (Appendix E1, available online at http://www.annemergmed.com). These questionnaires were chosen because they focused on competencies that are known to receive little attention in residents' assessment: communication, collaboration, and professionalism.[6-8] The research team translated the questionnaires from English to French and adapted the wording to suit the ED context and to reflect the CanMEDS framework. Each questionnaire contained 10 items scored on a 5-point scale, with changes in wording adapted to the different sources. Open-ended questions were also added to identify 2 strengths and 2 areas for improvement.[32]

On enrollment, residents received copies of each questionnaire and were asked to distribute them to teaching

TIME POINT**	*Oct.-Dec. 2014*	*Jan. 2015*	*Oct. 2015*	*Nov. 2015*	*Feb. 2016*
Recruitment	X				
Informed consent	X				
MSF INTERVENTIONS:					
Distribution of questionnaires		←	→		
Compilation of questionnaires				X	
Individual feedback meetings				X	
ASSESSMENT:					
Interviews					X

Figure. Timeline of the study. *MSF*, Multisource feedback.

physicians, nurses, and patients with whom they believed they had enough interactions during their shifts (a minimum of 2 interactions was recommended). Both French and English versions of the patients' questionnaires were available. Distribution occurred between January and October 2015 under the residents' responsibility, given that previous research has shown that responses do not differ whether questionnaires are distributed by the resident or a third party.[33] Before the intervention, physicians and nurses from the ED were invited to voluntarily attend a short 20-minute presentation explaining the multisource feedback intervention. A box was placed in the ED to collect questionnaires from all sources. A stamped envelope was also provided for patients to mail the questionnaires. All questionnaires were anonymized to protect sources' confidentiality.

After the distribution period, questionnaires were compiled by 2 members of the research team (V.C. and J.M.). They prepared individual feedback reports for each resident, which included items' scores (minimum/maximum values and means) for each source (physicians, nurses, and patients) and a summary of the qualitative responses. Residents provided a list of educators from whom they would be comfortable receiving the feedback reports. The educator listed most often was asked to conduct individual meetings with residents to present them with their feedback report. Individual meetings lasted on average 30 minutes and took place in November 2015.

Outcome Measures

The main outcome for this study was residents' perception of the multisource feedback. In February 2016, semistructured group interviews were conducted by an experienced facilitator to explore residents' perception of multisource feedback. This method of data collection was chosen to foster interactions and debate among participants.[34,35] The 3-month interval after the end of the intervention was chosen to give residents time to reflect on the feedback received and to integrate it into their practice. The interval was also chosen to examine what residents remembered from the feedback received.

The facilitator was a physician-educator working in another field of medicine who was not involved in the regular assessment of the emergency medicine residents or in the multisource feedback intervention. An interview guide designed after the study's purpose was provided to the facilitator (Appendix E2, available online at http://www.annemergmed.com). Questions focused on participants' perceptions of the influence of the multisource feedback on the development of competencies other than medical expertise. The interview guide also included a concept map representing the relationships between the study's concept and the interview questions. All interviews were audio recorded and transcribed verbatim by 2 medical transcribers. Nominal data were anonymized.

Primary Data Analysis

A total of 150 pages of transcripts were entered in QDA Miner (version 5.0; Provalis Research, Montréal, Québec. Canada) and analyzed with the Miles and Huberman[36] method for intrasite case analysis. Two independent researchers (V.C. and P.L.) read the transcripts and coded all meaningful units in the interviews. To the greatest extent possible, coding was inductive and used words from the participants' own language during the interviews. Codes were compared and amended until a satisfactory level of intercoder agreement (95%) was achieved.

Codes were subsequently classified into categories, which were derived from the interview guide and the study's purpose: relevance of multisource feedback, credibility and nature of feedback received from various sources, and perceived effect of feedback on practice. Codes were further categorized into the 7 CanMEDS competencies by the 2 researchers, who were familiar with this framework. Codes that did not fit these categories were examined and grouped into other categories. Within each category, matrix and network displays were constructed to organize and condense the codes and data. Finally, narrative descriptions of the categories were developed to note patterns and identify the categories that best captured residents' perception of the value and utility of multisource feedback.

RESULTS

Characteristics of Study Subjects

Of the 13 eligible residents, 12 agreed to experience the multisource feedback intervention. Of those individuals, 10 obtained enough questionnaires to be eligible for the interviews. On average, each resident received 7 questionnaires from nurses, 7 from physicians, and 12 from patients.

Among all returned questionnaires (n=255), 10 (4%) solely included scores on numeric scale items, whereas 245 (96%) included scores as well as qualitative comments. Numeric scale items' scores were generally high: for all residents, on the 3 different questionnaires, means values for each question ranged between 3.8 of 5 and 5 of 5. As

such, individual meetings mostly addressed the qualitative comments found on the multisource feedback questionnaires.

Six junior residents (2 men, 4 women) and 4 senior residents (2 men, 2 women) participated in the interviews. Two group interviews were conducted: one with junior residents (2.5 hours) and one with senior residents (1.5 hours). Individual interviews with one junior resident (1 hour) and one senior resident (0.5 hours) who were unable to attend the group interviews were also conducted by the same facilitator using the interview guide. Very little additional information was obtained from these individual interviews, such that saturation was deemed to have been achieved.

The codes resulting from the analysis are presented in Table 2. Residents commented that each source had provided relevant feedback. However, the feedback content differed significantly from one source to another. Physicians' feedback focused primarily on medical expertise; nurses' feedback mainly addressed the dimensions of leadership, collaboration, and communication; and patients' feedback generally assessed competencies related to professionalism and communication. Residents' perceptions of the usefulness

Table 2. Residents' perception of multisource feedback in the ED.

Categories	Description of Patterns
Relevance of multisource feedback*	MSF was relevant because it raised new perspectives, was formative, and came from colleagues. Residents appreciated the feedback from patients because patients are the main reason they practice medicine. MSF was more relevant when residents perceived congruence/complementarity between sources. MSF was less relevant when sources disagreed. MSF was irrelevant when focused on a unique moment or an event that happened a long time ago, or when comments were difficult to understand. Anonymity of MSF strips away the context of the feedback. However, residents thought that sources provided more information or said things they would not otherwise say face-to-face. Qualitative comments were more relevant than the scores on the items because they were more detailed. Numeric scale scores do not speak by themselves.
Credibility and nature of feedback received from various sources*	From physicians: focused on medical expertise, similar to usual daily assessments, some comments on communication and leadership. From nurses: different than physicians, focused on communication, leadership, teamwork, and professionalism. From patients: different than physicians, focused on communication and professionalism.
Perceived effect of feedback on practice*	MSF confirmed ways of doing things when residents received positive feedback. MSF raised awareness of residents' relationship with patients and nurses and emphasized teamwork. MSF helps to become a better physician. It promotes the refinement of practice with deliberate efforts.
MSF in the context of the ED†	Little time for MSF in the ED (short patient stays, busy staff, MSF comes with a paperwork burden).
Perception of the educator who presented the feedback†	Residents appreciated the feedback because it was constructive, neutral, comprehensive, respectful, and easy to understand. Residents preferred that the educator not partake in the MSF. Required qualities: tact, knowledge of the ED context, interest in providing feedback, senior resident.
Reaction to feedback†	Appreciated having positive feedback. It was helpful. MSF allows the assessment of strengths and weaknesses, but weaknesses had a stronger effect on residents. They want to know more about their weaknesses.
Difference feedback: self-assessment†	MSF is similar to or less severe than residents' self-assessment. MSF often confirms self-assessment.
Comments on the process†	Multiple sources of bias in the MSF. Residents chose patients who had no language barriers, a higher education, normal mental status, and low-acuity complaints. They chose staff with whom they had a positive relationship. Residents believed that there was a possibility of contamination between sources.
Ideas for improvement†	Distribution of questionnaires to every patient or random selection of patients. Distribution by someone else, not the resident. Provide questionnaires in various languages. Expand the scope of the MSF (longitudinal, involve other professionals, expand to other departments). Provide information about the MSF to patients and staff.

*Derived from the interview guide and study's purpose.
†Other categories that emerged from the interview.

of the feedback received from these 3 sources are presented separately in the following sections, using fictitious names. Residents commented that the qualitative comments were more useful than the numeric scale scores provided on individual reports. They explained that the scores did not speak in and of themselves, whereas the qualitative comments were more detailed.

According to the residents, most of the comments from teaching physicians had already been mentioned by supervisors during daily assessments.

> "No, there wasn't much that was new from our supervisors. In the [ED], we're being assessed every day…." (Flora, junior resident)

> "Honestly, from our supervisors, everything written on my [feedback] sheet was stuff I've already been told. There were no surprises for me; it was really the same." (Amelia, junior resident)

Of the competencies addressed by the physicians, although some focused on leadership and communication, medical expertise was raised most often.

> "The vision was different…. [T]he supervisor was mostly focused on clinical activity, knowledge, and ways of working…[m]ore on expertise." (Flora, junior resident)

> "More medical things came from the physician's perspective regarding diagnosis or things that were really medically oriented." (Wayne, senior resident)

However, some residents expressed frustration when they received anonymous feedback that they believed should have been told face-to-face.

> "I received a comment that…was something a supervisor should have told me in person but didn't, and it was a comment on my physical examination. This irritated me because I asked myself, 'Why write this anonymously when their role is specifically to deepen my knowledge? To help me to improve as a resident?'" (Edith, junior resident)

The residents attributed great value to nurses' feedback because they addressed competencies that teaching physicians were not in the habit of addressing or were unable to comment on. For instance, leadership and management strategies emerged as a core competency in nurses' feedback, with comments on medical records, medical orders, and leadership in the resuscitation room.

> "Putting the medical records back in place, or things like that… That's more organizational. That's not the kind of thing supervisors tell us because it makes no difference to them. Those points were really useful." (Daniel, junior resident)

> "Nurses focused on relationship, teamwork, functioning.… The orders that we write and that are done at the same time… They poke the patient; then they see your order sheet: 'Oh, there are other orders, but I don't have the tube!' They must go back and poke the patient again. These are very practical things, but they're game changing." (Charles, junior resident)

Many specific constructive comments were reported about communication, either verbal or in medical records, and order writing. Some residents said that these comments affected their work.

> "I received comments like 'In writing orders, it would be better to do this and that.' These are relevant, but most supervisors never say anything about how I write my orders." (Edith, junior resident)

> "They told me I spoke a bit too fast, that I wasn't very clear in my explanations. I wasn't aware of that.… Now I am, and I think it [has] had an impact on my work since then." (Daniel, junior resident)

Although few new elements in regard to professionalism were reported, residents thought that numerous positive comments on this competency helped reinforce the behaviors that they engaged in spontaneously. One resident commented that it was particularly helpful to discover what behaviors nurses valued in their interactions with physicians "even if it felt pretty ordinary" to her (Beatrice, junior resident).

Teamwork and collaboration were also concepts raised often by nurses. This was discussed extensively in the group interview of the senior residents, who stressed that this competency was essential to their practice to ensure safe and optimal patient care.

> "In the [ED], in terms of teamwork, things must work out well with nurses. It's a *sine qua non* condition for doing a good job. I'm an absent-minded type of guy, and I need them as a safety net. For me, [their feedback] was extremely important." (Yan, senior resident)

> "I would include other professionals. I would include respiratory therapists, the orderlies…. These are

people we're in daily contact with who are part of the team." (Zara, senior resident)

Several residents said that they engaged in conscious efforts to improve or change the points raised by nurses or that they actively sought further feedback.

"I wasn't aware of that…. Now I am, and it has had an impact on my work since then. I've sought feedback from different staff members to see if it would be helpful in any way, and they said yes, it would." (Daniel, junior resident)

All residents agreed on the importance and relevance of questioning patients.

"I could have done 5 years of residency and 15 years of practice without ever being told whether the way I behaved with patients was good or not…. We could have gone through our usual routine, everyone could hate us, and we'd never know. Even if it's just positive things like 'He's good, he's fine.' At least that tells me I'm doing something right. So that was relevant." (Daniel, junior resident)

"That's why I come to work in the morning…. [O]ur bread and butter is to reassure patients…. [P]atients leave the [ED] and they're feeling better." (Violette, senior resident)

Some patient comments were perceived as unrealistic, considering that patients were treated in an ED setting. However, residents still considered that patients' views were useful and formative.

"Without agreeing with the patient, I can understand his perspective; for example, a comment like 'It went well, but he spent less time on my second complaint.' In the [ED], my role as a physician is to take care of the chief concern. It's not surprising that the patient thinks that we should spend time on a second or a third issue. There is an obvious discrepancy between our views, but for me, it was OK to have this feedback." (Wayne, senior resident)

Patients' comments mostly addressed issues related to communication and professionalism (patient-physician relationships). Patient feedback on communication helped some residents target areas of improvement in regard to this competency.

"There are small things, like the fact that I don't speak loudly enough, that came up twice. But it's true that I don't speak very loudly. It's constructive, for sure. For me it's been relevant. I'm going to make more of an effort." (Edith, junior resident)

The residents used the questionnaire for patients in different ways. Some specifically gave questionnaires to patients with whom they had a more difficult relationship to obtain ideas for improvement or to understand their perceptions.

"Sometimes I had the impression that my interactions with patients were not very good. I thought that the patients might have the same perception, but in the end, that wasn't the case at all. That was somewhat reassuring." (Daniel, junior resident)

LIMITATIONS

The main limitation of this study was the small sample of residents from a single university program in one hospital setting. The questionnaire's structure (numeric scales and open-ended questions) could have affected sources' feedback, particularly the length of qualitative comments. It could have also influenced perception of that feedback because people could choose to ignore written commentaries when numeric scales are present; this would need to be addressed in another study. Residents' perceptions and response to the feedback gathered in the context of a research protocol may not generalize to actual settings. Moreover, because it was a research project, patients, nurses, and physicians recruited by the residents may have been overly thoughtful in completing questionnaires. Residents commented that there were challenges associated with multisource feedback in the context of the ED: short patient stays and more paperwork. The busy context of the ED might have limited the number of questionnaires that residents distributed. Choosing to conduct the interview 3 months after the feedback step to assess whether comments had been used in the residents' practice and to evaluate feedback retention and its lasting influence could have led to recall bias. This could have affected our results in a positive way because subjects could have selectively remembered details they had perceived as reinforcing. Although group interviews can promote discussion, some residents may have been inhibited about expressing their views in the presence of colleagues in the same program and at the same level. To mitigate this possibility, an experienced facilitator was involved.

DISCUSSION

This study examined emergency residents' perception of the feedback received from physicians, nurses, and patients

during a multisource feedback intervention. Although previous studies have used multisource feedback in the ED, to our knowledge, this is the first study to use qualitative outcomes to assess residents' perception of multisource feedback involving these 3 sources in the context of the ED. Considering the significant resources required and the challenges associated with the use of multisource feedback in the ED, it was important to know whether participants valued this type of feedback. In this study, emergency residents reported that multisource feedback was indeed useful and relevant to their training.

Nurses and patients commented on competencies that are generally overlooked in teaching physicians' assessments. Before the study, residents from our emergency medicine program received only formative end-of-shift evaluations from physicians and a monthly summative evaluation; they did not receive any feedback from nurses or patients. With multisource feedback, residents received information that they found helpful and reported modifying some behaviors after having obtained this feedback.

Nurses provided feedback on several competencies: leadership, communication, collaboration, and professionalism. Although these competencies are sometimes assessed by physicians, the nurses approached them from a different angle and residents saw this as an added value to their training. Communication was addressed in terms of medical records, telephone calls, and medical orders. Leadership, often perceived macroscopically by physicians having a global view of the ED, was addressed more microscopically by nurses, focusing on elements that directly concerned patient care. Nurses spontaneously commented on residents' leadership competencies, even though they had not been included in the questionnaire. These days, with increasing numbers of patients and crowded EDs, management strategies are really important.[37]

The collaborator role from the CanMEDS competencies framework emerged strongly from the nurses' feedback, and this was perceived as a core element by senior residents. Although they did not obtain as much new information as their junior colleagues, they seemed to pay more attention to it and even proposed involving other professionals. This interest was possibly due to their higher sense of responsibility as senior residents for overall patient management and good work flow in the ED. Although they appeared to have assimilated the full importance of teamwork at their level, it would be interesting to know whether receiving multisource feedback earlier in their training would have helped and better prepared them for their transition to the role of senior resident.

The information from patients was perceived as useful. Patients' comments relating to communication enabled residents to work on different aspects of this competency. The results of our study highlighted the challenges of the patient-physician relationship. Some residents still did not appear to have fully grasped this unique patient perspective because they were unable to respond to or clarify patients' hidden agendas, even to the point of invalidating some of the patients' comments. This complexity appears to have been experienced because certain residents specifically chose to distribute their questionnaires to patients with whom they thought they had a more difficult relationship. Patients, especially those with chronic conditions, have an expertise that no care provider can have: the experiential knowledge of living with illness and of the care experience.[38] At the University of Montreal, the Patients-as-Partners program is based precisely on this notion that patients have unique competencies that are useful in clinical care, research, and education.[38]

Some previous studies have found that feedback from physicians is generally the most valued by residents[25] or other physicians,[39] but the participants in this study did not share this view. Participants reported that little new information came from physicians because emergency residents are already in close contact with their supervisors and as such have frequent opportunities to receive feedback from them. Residents reported that physicians mainly provided comments on medical expertise, although questionnaires specifically highlighted other competencies. The medical expert role is central to the practice of medicine; nonetheless, developing more effective ways of specifically assessing other competencies essential to resident training is important.

Some residents expressed frustration about receiving constructive or negative feedback through the anonymous process of multisource feedback because they believed such feedback should have been given in person. This finding reflects the complexity of providing negative feedback, a well-known phenomenon in the literature.[40] Supervisors are sometimes incapable of offering constructive feedback on negative elements or are unwilling to do so. Some physicians perhaps assume residents will come to realize their errors on their own, but numerous studies have revealed health professionals' poor capacity for self-evaluation.[41] The residents' voluntary participation in this research project and their responses to the feedback attest to their sincere desire to learn and to improve themselves.

Although organizations overseeing medical training promote the development of a broader set of competencies, this study highlights that physicians tend to primarily assess medical expertise in their residents. Our results show that

other members of the care team, as well as patients, are in a good position to observe and assess other competencies in the ED. As such, multisource feedback appears promising. The residents reported that the information received from nurses and patients was relevant and useful and, more particularly, that it complemented their teaching physicians' assessments. The idea of involving other members of the care team (eg, orderlies, respiratory therapists, consultants) who have specific competencies that could be useful to residents could present a fruitful avenue for future research.

The authors want to thank the Emergency Research Group of the Hôpital du Sacré-Coeur de Montréal for their help in the distribution of questionnaires and their contribution to the study, Dr Stéphanie Raymond-Carrier for assisting with the facilitation of the focus groups and Dr Ahmed Moussa and Dr Alexis Cournoyer for their contribution to the final revision of this article.

Supervising editor: Peter C. Wyer, MD. Specific detailed information about possible conflict of interest for individual editors is available at https://www.annemergmed.com/editors.

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Author contributions: VC and RG conceived the study. JM conducted the individual resident interviews. VC and PL analyzed the data. VC drafted the article and all authors contributed substantially to its revision. VC takes responsibility for the paper as a whole.

All authors attest to meeting the four ICMJE.org authorship criteria: (1) Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND (2) Drafting the work or revising it critically for important intellectual content; AND (3) Final approval of the version to be published; AND (4) Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist.

Publication dates: Received for publication January 8, 2018. Revisions received June 4, 2018; October 8, 2018; February 27, 2019, and May 6, 2019. Accepted for publication May 9, 2019.

Presented as an abstract at the Canadian Conference in Medical Education, May 2017, Winnipeg, Canada; at the 33rd Scientific Conference of the Association des Médecins d'Urgence du Québec, October 2016, Québec, Canada; and presented as a poster at the 2017 Canadian Assocation of Emergency Physician Conference, June 2017, Whistler, Canada.

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Future Meetings of the American College of the Emergency Physicians

The following are the planned sites and dates for the future annual meetings of the American College of Emergency Physicians:

2018	San Diego, CA	October 1-4
2019	Denver, CO	October 28-31
2020	Dallas, TX	October 26-29
2021	Boston, MA	October 25-28