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Improving Feedback From Residents to Preceptors: A Quality Improvement Project

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ABSTRACT

Background and Objectives: Our objective was to implement a quality improvement project to improve the content and receipt of resident feedback using the nonviolent communication (NVC) rubric.

Methods: This project was conducted between 2018 to 2025 in a single family medicine residency (24 residents each year, 38 preceptors). Nonprecepting faculty members led small groups of residents through a process of converting raw feedback into the NVC format, which names the behavior, explains the resulting feelings, describes residents' needs, and requests continuing or changing the behavior. We analyzed how the feedback changed and conducted interviews with residents and preceptors to understand the value of the project.

Results: We developed and refined the process over seven improvement cycles comprising 63 feedback sessions generating a total of 251 feedback statements. Within feedback sessions, the NVC process led to modification of behavior descriptions in 67.3% of cases, and provision of feelings descriptions increased from 23.3% prior to the process to 100% afterward. Final statements included 122 distinct needs words. Residents valued their agency and appreciated the protected group time to develop feedback. Preceptors respected the process, reported that it made them feel seen, reinforced valued behaviors, highlighted behaviors they did not realize were appreciated, and prompted them to evaluate their balance of resident teaching with patient safety.

Conclusions: We revised our method of collecting and presenting feedback from residents to their preceptors using the NVC approach. Resident and preceptor responses have been positive.

INTRODUCTION

Preceptors providing clinical supervision for residents in outpatient settings need feedback to improve their teaching. Feedback on one's performance is considered vital for improvement and development of expertise.[1] However, when feedback is delivered as a summative evaluation, it may affect preceptors' self-efficacy and self-concept, and cause anxiety, embarrassment, and other negative reactions.[2-4]

Many tools for evaluation of clinical teaching[5-9] are expressly summative, in which judgments are rendered rather than descriptions of how particular behaviors of preceptors affect learners. Feedback, instead, should identify specific preceptor behaviors that hinder or support resident learning.[10] Preceptors, then, can understand how their specific teaching behaviors are perceived in a psychologically safe environment that facilitates their objective examination of their attitudes, emotions, feelings, skills, and views about teaching.[3,11,12]

Realizing that our standard method of providing feedback from residents to preceptors was evaluative, we used a quality improvement approach to implement a new format for generating behavior-specific feedback that

communicates residents' observations as requests for change, making feedback more formative than summative. We used the Standards for QUality Improvement Reporting Excellence in Education (SQUIRE-EDU) to formulate this report.[13]

METHODS

Setting and Participants

From 2018 to 2025, with a hiatus during the pandemic, we instituted twice monthly feedback sessions in a family medicine residency training program, which included 24 residents (eight per class). Residents were precepted by core teaching faculty (N = 6) and family physicians (N = 32) in clinical practice. Most preceptors have at least 3 years of precepting experience.

Intervention

We adopted a novel approach to giving and receiving feedback using a model of communication that had not previously been used to deliver feedback in this setting. Nonviolent Communication (NVC), also called compassionate communication, is a philosophy and style of communication that seeks to bring out feelings of affection, respect, and empathy in interpersonal relationships.[14] It follows a four-step format: (1) When you (specific behavior); (2) I feel (a specific feeling); (3) I need (a need not met); (4) Please (request for specific behavior). Examples of the transformation of feedback are in Table 1.

Monthly feedback collecting sessions were incorporated into the protected didactic time of the second- and third-year residents' classes. Interns were excluded because they had only limited interaction with preceptors. Sessions were facilitated by one or two consistent nonprecepting faculty (J.F. and A.F.S.). These faculty had basic training in using the NVC approach; one (A.F.S.) learned the philosophy and practice by reading the book about it,[14] and the other, with background in psychology, learned the process as part of her training. At each feedback collecting session, the class of residents identified one or two preceptors to whom they wanted to give feedback. For each preceptor, residents then described behaviors that they valued and would like the preceptor to keep doing and behaviors that they would like the preceptor to change. The process typically identified four to 10 instances or behaviors for each preceptor. Through moderated group discussion, residents converted this raw feedback into four-part statements using the NVC format. The completed NVC feedback statements (without the raw feedback) were sent to the preceptor accompanied by an invitation (Appendix) for the recipient to work with one of the NVC facilitators to further develop their teaching and communication skills if they desired.

Residents, at the beginning of their second year, received a 1.5 hour introduction that taught the NVC format and allowed them to practice differentiating judgments (eg, "the preceptor talks too much") from behaviors (eg, "You frequently interrupt our presentations"). Residents were taught how to elucidate their feelings and how to name their needs using the NVC feelings and needs inventory.[15] To create a safe and honest space for residents to share, the feedback was collective and anonymous and was not shared with the program director or department chair, or used for punitive purposes. Residents were reminded that they had other venues (including Accreditation Council for Graduate Medical Education surveys and labor union meetings) to evaluate faculty members.

TABLE 1. Examples of Transformation of Feedback Using the Nonviolent Communication Process

Original	Nonviolent communication format
Is frantic; gets all "New York" on me	**When you** use a high-volume, energetic, and fast pace of speaking, **we feel** pressured, concerned, and anxious. **We need** not to have our anxiety and self-doubt escalated. **Please** speak quietly and more slowly when responding to our presentation.
She's not afraid to admit she doesn't know something.	**When you** communicate that you don't know something and share with us strategies you use for learning, **we feel** safe, trustful (of you), relaxed. **We need** role modeling of humility and how to be a learner. **Please** continue to tell us when you don't know something and how you will learn.

Note: Bold added to emphasize format.

Outcomes

To continuously improve the process, at the end of each session residents shared effective parts of the session and areas that could be improved. We also devoted a significant part of a single session with experienced (ie, third year) residents to gain their insights on the NVC feedback process.

To determine preceptors' reactions to NVC feedback, we conducted semistructured interviews with a purposeful sample of preceptors to hear their reactions and reflections. We analyzed notes from these interviews to identify themes in their reactions to the NVC process.

In addition, we used several ways to evaluate how the NVC structure changed the quality of the feedback. For each initial (raw) feedback statement converted to the NVC format, two investigators (A.F.S., R.S.) independently determined how the process changed the descriptions of the precepting behavior. Similarly, two investigators also independently evaluated the initial feedback statements for the presence of feelings and needs conveyed by the residents.

Ethics Approval

This project was considered a quality improvement project and thus did not constitute human subject research. It was exempted by the Chair of the Cambridge Health Alliance Institutional Review Board.

RESULTS

We conducted 63 feedback sessions with 72 residents. Many preceptors received feedback several times over the time

span of our study, though the measures to ensure anonymity prevented us from tracking exact rates of feedback.

Changes to the Feedback Sessions Over Time

Through iterative assessments, we conducted seven plan-do-study-act cycles of quality improvement,[16] which are outlined in Table 2. The original process collected feedback in person; with the requirement to move many activities online during the pandemic, we now conduct the process online. We use a shared online document (available from the authors) that each resident can add to or edit in real time, which allows rapid collection of the initial feedback statements. As residents become accustomed to the process and require less facilitation, they can be split into online "rooms" to generate feedback for more than one preceptor.

Analysis of the Effect of the NVC Format on the Feedback

The NVC process changes original, raw feedback statements in several ways. Initial feedback statements are often general judgments of the behavior rather than the action itself. For example, a typical raw feedback statement might contain a judgment, such as "It's fun to work with her!" The NVC process changed this statement to a behavior-based comment: "When you ask how things went at the end of a session . . .," which allows the preceptor to understand the behavior being commented upon. Descriptions of behavior in the raw feedback were changed in 67.3% of instances. If a specific behavior was mentioned in the raw feedback, the NVC process resulted in minor changes to the wording in 18.5%, major changes to content in 19.0%, and from a judgment to a specific behavior in 29.9% of instances.

None of the initial feedback statements expressed a need, and residents infrequently spontaneously described how they were affected (ie, their feelings) by a precepting behavior (23.3%). The NVC process encouraged residents to express a wider array of feelings; raw feedback statements that described a feeling used only one of five common feeling words; over the course of this analysis, we identified 147 distinct feeling words used because of the process.

Reactions From Resident Participants

Residents described how they valued having some agency to provide feedback on their precepting experience. They appreciated the protected time and felt that the group process improved the feedback quality, preventing an isolated experience of one resident being conveyed to a preceptor. Experienced residents noted that the communication format is transferable to other interpersonal contexts, including patient care and personal relationships. Several residents mentioned noticing a change in a preceptor's behavior after receiving feedback. Residents reported that some preceptors had discussed the NVC feedback with them in a positive way or shared with residents their efforts to change behavior or continue doing what is valued.

TABLE 2. Iterative Changes to the Feedback Collection Process

PDSA cycle	Changes made	Outcomes	Lessons learned
1	Introduction of group-obtained feedback and the NVC process	Move from infrequently collected feedback from individual residents to a regular system of providing feedback.	Assigning a time for feedback collection in groups increases its delivery.
2	Emphasize addressing the person ("When you . . .") instead of about the person ("When they . . .") in the feedback.	Reduction in judgmental comments and an increase in observations of behaviors	Using the second person (*you*) "brings the preceptor into the room" via an imagined dialogue.
3	Move from in-person to virtual meetings via Google Meet; residents have the option of having their video on or off.	Required as a response to the pandemic	Low participation online
4	Shared online document used to collect feedback, with residents entering their own feedback onto the form and then converting it to the NVC format as a group	Increased feedback generated, more involvement by all residents	Residents more willing to write feedback than sharing verbally One facilitator can conduct the meeting.
5	Given sufficient number of participants (seven or 8), the group can be divided into two virtual rooms with each group collecting feedback on a separate preceptor.	Increased number of preceptors receiving feedback	Small groups vary in their need for a facilitator and check-ins are necessary to ensure the groups don't get stuck.
6	Adapting the process to the specific needs of an experienced group	Experienced groups (eg, third-year residents in the latter half the year) use the time to give feedback about another process (eg, an inpatient service, rather than an individual preceptor).	Some groups take on more ownership of the time and environment and cocreate, with facilitators, new uses for the feedback process.
7	Invite preceptors to request specific feedback on style, content, or other aspect of precepting.	In process	Idea developed from interviews with preceptors

Abbreviations: NVC, nonviolent communication; PSDA, plan-do-study-act

Reactions From Preceptors

Thirteen preceptors were interviewed, comprising a mix of early and more experienced preceptors, and those who received feedback recently or one or more years before the interview. All interviewed preceptors were appreciative they received feedback, even if they didn't agree with all of it. Preceptors remarked that the feedback was "helpful to know what's working"; "increased my confidence"; and was "a positive experience." Although receiving feedback in this format was new to most of the preceptors, they respected the process. Some preceptors recalled specific behaviors mentioned in the feedback given to them several years ago and described how they used the feedback.

We identified several themes across the interviews. Preceptors often mentioned they felt "invisible" and that the NVC feedback acknowledged the effort they put into precepting. Some preceptors commented on the complexity of providing the appropriate teaching and supervision of residents while also ensuring patient safety. Other preceptors were surprised that their nonteaching behaviors, such as bringing snacks, sharing personal information, or simply expressing concern to the residents regarding their well-being, were valued by residents.

DISCUSSION

Over the past 7 years, we have implemented and continually refined a system of collecting feedback from residents and providing it to their preceptors via a novel approach. Using two faculty facilitators, we incorporated NVC skills training into residency didactics to provide preceptors with nonjudgmental, actionable behavior requests that were valued by both residents and preceptors.

NVC is designed to improve direct interpersonal communication. While not used previously to shape feedback, NVC has been used to improve physician-patient relationships,[17] interprofessional collaboration,[18,19] education,[20,21] and mentoring and coaching,[22] and is effective in helping health care professionals to express their observations in a nonjudgmental way.[19] Our goal for using the NVC approach is to create feedback to preceptors that is behavior-specific, actionable, timely, and personalized, yet not personal (ie, that could be interpreted as a personal criticism). Unlike many other forms of feedback, this approach explicitly conveys to the recipient the needs and feelings of the feedback givers. This approach also reflects a feed-forward stance, seeking to influence future actions rather than evaluating only past behavior.[23]

This process is different from traditional feedback approaches that typically involve evaluative statements. Rather, the NVC format conveys to preceptors how their teaching is experienced by residents and the degree to which it meets the residents' perceived needs, honoring the concept that every interpersonal interaction has a content and relationship aspect and should thus be approached with intention and respect.[24] Indeed, facilitators often must help residents find the right nuance of emotional valence[19] when describing feelings (eg, "stressed" vs "overwhelmed"). Additionally, residents often are unaccustomed to identifying and expressing their needs and must be prompted to use the provided inventory. Eliciting the needs and feelings of the residents keeps the emotional component alive, an important component to relationship-based dialogue. This approach may be more palatable to preceptors, allowing the message to be processed and acted on rather than generating a defensive response.[25]

The use of this approach is limited by the size and structure of our residency program, which is medium-sized, with regularly scheduled protected didactic time. Programs that are larger or organized differently might find it more challenging to implement. Implementation requires continual involvement of dedicated faculty to ensure consistency and integrity of the process and to create psychological safety. Additionally, preceptors who received feedback via this process were identified by residents, rather than selected in a systematic manner, limiting those who received feedback. Programs should ensure that other feedback mechanisms are in place to promote a comprehensive approach to faculty development.

While we have focused on the *process* of incorporating NVC into a residency curriculum and the resulting responses from residents and preceptors who were part of this process, future research should explore *outcomes* in more depth—whether the NVC approach results in preceptor growth and subsequent improvements in teaching behaviors. Future research also should explore how teaching the NVC format to residents and faculty results in more generalized improvements in communication skills.

CONCLUSIONS

We were able to implement a group-based method for collecting feedback from groups of residents and refine it using the NVC approach. The process was valued by residents, and the resulting feedback was valued by preceptors.

PRESENTATIONS

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