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What Do Residents Want From Clinical Supervision in Primary Care Practice? Identifying Desired Behaviors for Outpatient Precepting

Allen F. Shaughnessy, PharmD, MMedEd; Omar Wahid, MD; Judy Fleishman, PhD; Randi Sokol, MD, MPH, MMedEd

AUTHOR AFFILIATION:

Department of Family Medicine, Tufts University Family Medicine Residency, Cambridge Health Alliance, Malden, MA

CORRESPONDING AUTHOR:

Allen F. Shaughnessy, Department of Family Medicine, Tufts University Family Medicine Residency, Cambridge Health Alliance, Malden, MA, allen.shaughnessy@tufts.edu

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ABSTRACT

Background and Objectives: Feedback to clinical supervisors of residents (preceptors) is critical to ensure quality teaching. Most feedback tools are based on theoretical models or expert opinion. No research has asked residents their thoughts on teaching practices. Our objective was to identify desired precepting practices by analyzing written feedback provided to preceptors by residents.

Methods: This project was conducted in a family medicine residency training program, analyzing feedback to preceptors from residents collected over 5 years. We used the nonviolent communication format, which identifies a request to a preceptor to continue an existing teaching behavior or change to a new one. The request statements were qualitatively analyzed by coders, aligning them when possible to categories of the Mayo Outpatient Precepting Evaluation Tool. Using content analysis, we coalesced all codes into categories from which we derived behaviorally based desired practices for precepting.

Results: Most (66.49%) of the requests were to continue a teaching behavior. We identified 26 desired practices in the following categories: setting the learning climate (n=5); preprecepting (n=2); preceptor presence (n=1); conveying clinical knowledge (n=4); decision-making (n=5); time management (n=4); and feedback on performance (n=5).

Conclusions: We identified precepting practices that residents desire. Some of these desired behaviors are not reflected in existing preceptor evaluation tools.

INTRODUCTION

What constitutes best practices for supervision of residents in outpatient settings (precepting) is reflected in the tools that have been developed to assess preceptors. Several current tools exist to evaluate preceptors in inpatient and outpatient teaching settings on desired teaching behaviors, often using Likert-like scales.[1–10] These instruments are derived from theoretical models or expert opinions about what constitutes good teaching. For example, the EFFECT[1] (evaluation and feedback for effective clinical teaching) model is based on the theoretical constructs of workplace learning. The WATCH[3] (Warwick assessment instrument for clinical teaching) model is built on expert consensus of what constitutes effective teaching. MOPET, the Mayo outpatient precepting evaluation tool, is a modified version of other evaluation tools used to evaluate inpatient or outpatient teaching and includes these categories: learning climate, control of session, communication of goals, understanding and retention, evaluation of decision-making, feedback, and self-directed learning.[8] While useful for summative evaluation of clinical teachers, these rubrics may not completely reflect learners' needs for teaching and support during clinical practice. Another approach to determining how precepting supports teaching is to identify residents' expectations for precepting. How a preceptor creates a learning environment, negotiates the learning agenda, determines the level of support to provide, and grants autonomy can impact residents' learning,[11] professional identity formation,[12] and patient care.[13]

These expectations are usually present in the minds of residents but may not be communicated to preceptors. For the past 6 years, we have been soliciting feedback from residents in group sessions, converting the initial feedback to a form based on nonviolent communication.[14] This format develops specific requests for preceptor practices, either requesting that a behavior be continued or requesting a different behavior. These requests provide a rich source to identify what residents

consider to be desired behaviors for outpatient precepting.

The goal of this study is to identify resident desires for precepting by analyzing written feedback residents provided in order to identify specific precepting behaviors that support residents' learning needs.

METHODS

Setting

We conducted this study in a single family medicine residency. Our 24 family medicine residents see patients in an outpatient primary care clinic supervised by approximately 40 preceptors. Each physician preceptor supervises the practice of two to four residents per half-day session. Typically, residents will see patients on their own and then report their findings to the preceptor using the SNAPPS model.[15,16] Through discussion, the resident and preceptor agree to a management plan. The preceptor then will see the patient briefly before the resident completes the visit.

Between 2018 and 2023, we collected feedback for preceptors during 1-hour in-person or virtual sessions in which six to eight residents met with one or two nonprecepting faculty to generate specific feedback for one or sometimes two preceptors. During the sessions, the group of residents were asked to identify a preceptor to whom they wished to give feedback. As a group, residents generated four to 10 instances or behaviors, which were posted on a spreadsheet. Through moderated group discussion, the rest of the session was spent converting this raw feedback into four-part statements of the nonviolent communication[14] (compassionate communication) format: "When you [a behavior], we feel [an honest feeling]. We need [a need not being met]. Please [request for a behavior]." The final nonviolent communication-formatted feedback statements were delivered to the preceptor (without the initial feedback statement). The feedback is not used for any type of assessment and is not shared with the program director.

Analysis

To analyze and identify desired practices for precepting, we separated the requests for a behavior from the rest of the feedback and analyzed them separately. Coders, working in pairs, independently coded the data using the MOPET categories, with disagreement resolved through discussion.[8] To avoid force-fitting, we created new agreed-upon codes for requests that did not fit into this framework in order to capture these additional precepting behaviors. Using thematic analysis, we coalesced all codes into categories from which we derived behaviorally based practices for precepting. We distributed these practice statements to members of the research team and to all (current) residents, who further revised them for accuracy.

Institutional Review Board

Because the goal of this study was to determine precepting practices, it was considered a quality improvement project and did not constitute human subject research. The study was exempted from institutional review board approval by the chair of the Cambridge Health Alliance Institutional Review Board.

RESULTS

Over the 5 years, 88 residents participated in the process. Not every resident participated in every feedback session due to vacations, sickness, or other reasons; but the sessions were part of their regular schedule, and they were expected to be there. Combined, these sessions generated 188 feedback statements and accompanying requests. Most (n=125, 66.5%) were requests to continue a desired behavior ("Please continue to..."). Only 64.4% of the requests fit into the MOPET categories[8] (Table 1). We created four additional categories: requests regarding attention to residents' time constraints (7.5%); requests respecting resident autonomy (11.7%); requests for preceptors to perform work with or without the resident before the clinical session (preprecepting),[17,18] (10.6%); and other requests that didn't fit into any category (5.8%).

TABLE 1. Analysis of Feedback Using Categories of the Mayo Outpatient Precepting Evaluation Tool [8]

Category	n (%)
Learning climate	51 (27.13)
Control of session	6 (3.19)
Communication of (learning) goals	3 (1.60)
(Promoting) understanding and retention	41 (21.81)
Evaluation of (resident) decision-making	4 (2.13)
Feedback (on performance)	16 (8.51)
(Guidance for) self-directed learning	0
Other Attention to time (7.45%) Respecting autonomy (11.70%) Preprecepting (10.64%) Miscellaneous (5.85%)	67 (35.64)

Categories of Requests

See Appendix for the complete document.

Setting the Learning Climate

Requests in this category reflected the need for the preceptor to create psychological safety for residents to express their decisions, thoughts, concerns, and feelings without fear of judgment or repercussions. Here is an example of a requested behavior: "Continue to be yourself, which gives us space to be ourselves." Learning climate desired behaviors include

- Be calm, speak clearly and slowly, and leave your stress outside.
- Treat us as a peer by getting to know us and letting us get to know you (but don't overstep boundaries/overshare), share your joy of medicine, and check in with us outside of precepting.
- Check in with us frequently about our state of mind and state of emotion, and about how the session is going.
- Create a safe space where it is okay for us not to know by transparently sharing your uncertainty. One way to do this is to look up something together with us.

- Show respect to us and our patients by not disparaging anyone.

Preprecepting

Residents appreciated when preceptors showed up before the session to help them prepare for the session and to anticipate their learning needs. Desired practices include

- Review the medical record of patients who are to be seen that session and make suggestions in the record before the session begins.
- Meet with us before our patient care session to answer our questions.

Preceptor Presence

Residents feel that preceptors being present and available for their needs and not distracted by other tasks or conversations is important. The desired practice is

- Be available and present for precepting and see patients with us when we ask.

Conveying Clinical Knowledge

Many requests described practices residents thought would enhance their understanding and retention of practical clinical knowledge. Residents expressed wishing to be taught clinical medicine as it pertains to the specific patient they are seeing. They requested concise, relevant summaries of just the information needed in that moment, supported by evidence or, when based on experience, noted as such. Evidence can be briefly summarized in the moment with supporting information sent later by email. Desired practices include

- Ask whether the time is right before teaching.
- Allow us to present uninterrupted and actively listen before chiming in. Don't rush us.
- Ask us before offering teaching points. When teaching, keep things concise and relevant and tailored toward our needs and interests. Notice when we are overwhelmed or time-pressured and just need an answer.
- Provide practical tips about clinical practice (eg, billing, time management) as well as medical knowledge-based content.

Decision-Making

Residents asked for supervised autonomy. Through their requests, they expressed the need to feel a sense of control and self-determination while providing care for patients. However, residents also want to know that the preceptor is there as a safety net and that they are not on their own. Desired practices include

- When seeing a patient with us, ask what our needs are [prior to coming into the room] and collaborate on a plan for care and how you will be involved.
- In the room, introduce yourself as our colleague. Respect the relationship and rapport we have with the patient by letting us lead the discussion.
- Realize that we usually have a framework for our decisions; if your plan differs from ours, acknowledge and validate our decisions.
- When offering comments about our management plan, share your thought process so we understand your rationale.
- Do not feel like you have to comment or make any changes to our plans. Sometimes "sounds like a great plan" is all we need to hear.

Time Management

Requests also focused on issues of time management and support of their clinical session. They requested that preceptors orient teaching based on resident time constraints and also know when they need a solution to their problem rather than being led to the answer. Desired practices include

- Be aware of clinic flow and help us. Even doing little things (eg, looking up questions we have in real time, coordinating care with medical assistants and nurses, finding resources) can make a big difference in our stress levels.
- Be careful when adding additional tasks to our proposed plan unless it is absolutely necessary.
- Be clear and direct with your expectations; do not beat around the bush.
- Support us while performing procedures by allowing us to perform them and being present to step in when we ask.

Feedback on Performance

Feedback on performance is also valued by residents and should identify what they performed correctly as well as what could have been done differently. Best practices include

- Validate experiences that were challenging for us.
- Role model and teach us by sending us information about a specific patient to read later.
- Provide feedback on what we're doing right, along with suggestions for change.
- Ask us when the best time is for us to receive feedback. Typically, the best time is after the session.
- Invite us to provide you with feedback, but give us permission to say we do not have any.

DISCUSSION

From this analysis of 188 feedback statements, we were able to synthesize desired behaviors for outpatient precepting from a resident's point of view. We were heartened to see that residents frequently identified behaviors they wished our preceptors would continue. That is not to say that all our preceptors consistently perform all these practices, but that residents are able to identify and agree on exemplars of precepting that meet their needs.

Several studies have determined general characteristics of precepting that residents value, including caring, promoting autonomy, role modeling, and respect.[11,19,20] Similarly, MOPET considers the important aspects of precepting to be

establishing a learning climate, controlling the session, communicating goals, promoting understanding and retention, evaluating resident decision-making, providing feedback, and supporting self-directed learning.[8] In our analysis of feedback to preceptors, though, we found that more one-third of desired practices did not fit into any of these categories.

Providing actionable feedback directly to preceptors might otherwise prove challenging for residents for several reasons. The power dynamic and potential for repercussions inherent in a preceptor-precepting relationship may prevent residents from sharing honest feedback that might be perceived as a demand or criticism. Additionally, residents may not know how to convey their feedback in a way that comments on objective, observed behaviors rather than subjective judgments. Residents also may not be skilled or recognize the importance of identifying their emotions and their subsequent unmet needs, which allows them to then identify the behavior they need from their preceptor. This study thus builds off prior feedback models and adds a new lens using nonviolent communication for identifying desired precepting practices in the outpatient settings, allowing residents to express objective precepting behaviors they need to support their clinical learning and practice.

This study is limited in that it comprised a convenience sample within a single residency. Each teaching environment has its own culture of feedback and learner-centeredness of teaching, and these guidelines for precepting may not transfer to every residency. Our residency embraces a culture of politeness that may be responsible for the preponderance of requests to keep doing existing behaviors.[21] We also have a long-standing process of faculty development for preceptors that may in part be responsible for our results. Future research should examine how the nonviolent communication format performs when providing feedback to other teachers as well as to learners.

CONCLUSIONS

Through analysis of feedback systematically collected and provided to individual preceptors, we were able to identify precepting behaviors that residents desire. Some of these desired behaviors are not reflected in existing preceptor evaluation tools.

Presentation

International Association for Communication in Healthcare Annual Meeting, September 2024, Zaragoza, Spain.

REFERENCES

1. Fluit C, Bolhuis S, Grol R. Evaluation and feedback for effective clinical teaching in postgraduate medical education: validation of an assessment instrument incorporating the CanMEDS roles. *Med Teach.* 2012;34(11):893-901.
2. Fluit C, Bolhuis S, Grol R, Laan R, Wensing M. Assessing the quality of clinical teachers: a systematic review of content and quality of questionnaires for assessing clinical teachers. *J Gen Intern Med.* 2010;25(12):337-338.
3. Haider SI, Johnson N, Thistlethwaite JE, Fagan G, Bari MF. WATCH: Warwick assessment instrument for clinical teaching: development and testing. *Med Teach.* 2015;37(3):289-295.
4. Stalmeijer RE, Dolmans D, Wolfhagen I, Muijtjens A, Scherpbier A. The Maastricht Clinical Teaching Questionnaire (MCTQ) as a valid and reliable instrument for the evaluation of clinical teachers. *Acad Med.* 2010;85(11):732-733.
5. Stalmeijer RE, Dolmans D, Wolfhagen I, Muijtjens A, Scherpbier A. The development of an instrument for evaluating clinical teachers: involving stakeholders to determine content validity. *Med Teach.* 2008;30(8):272-277.
6. Huff NG, Roy B, Estrada CA. Teaching behaviors that define highest rated attending physicians: a study of the resident perspective. *Med Teach.* 2014;36(11):991-996.
7. Castiglioni A, Shewchuk RM, Willett LL, Heudebert GR, Centor RM. A pilot study using nominal group technique to assess residents' perceptions of successful attending rounds. *J Gen Intern Med.* 2008;23(7):60-61.
8. Paulson D, Hidaka B, Nordin T. Creation and initial validation of the Mayo outpatient precepting evaluation tool. *Fam Med.* 2023;55(8):547-552.
9. Hamdy H, Williams R, Tekian A, Benjamin S, El-Shazali H, Bandaranayake R. Application of "VITALS": visual indicators of teaching and learning success in reporting student evaluations of clinical teachers. *Educ Health (Abingdon).* 2001;14(2):267-276.
10. Lombarts M, Arah OA, Busch O, Heineman MJ. Using the SETQ system to evaluate and improve teaching qualities of clinical teachers. Article in Dutch. *Ned Tijdschr Geneeskd.* 2010;154:1222.
11. Irby DM, Ramsey PG, Gillmore GM, Schaad D. Characteristics of effective clinical teachers of ambulatory care medicine. *Acad Med.* 1991;66(1):54-55.
12. Cruess RL, Cruess SR, Boudreau JD, Snell L, Steinert Y. Reframing medical education to support professional identity formation. *Acad Med.* 2014;89(11):451.
13. Edwards ST, Kim H, Shull S, Hooker ER, Niederhausen M, Tuepker A. Quality of outpatient care with internal medicine residents vs attending physicians in veterans affairs primary care clinics. *JAMA Intern Med.* 2019;179(5):711-713.
14. Rosenberg MB. *Nonviolent Communication: A Language of Life: Empathy, Collaboration, Authenticity, Freedom, 3rd edition*. PuddleDancer Press; 2015. .
15. Grünewald STF, Grünewald T, Ezequiel OS, Lucchetti A, Lucchetti G. One-minute preceptor and SNAPPS for clinical reasoning: a systematic review and meta-analysis. *Intern Med J.* 2023;53(5):680-689.
16. Wolpaw TM, Wolpaw DR, Papp KK. SNAPPS: a learner-centered model for outpatient education. *Acad Med.* 2003;78(9):893-898.
17. Lillich DW, Mace K, Goodell M, Kinnee C. Active precepting in the residency clinic: a pilot study of a new model. *Fam Med.* 2005;37(3):205-210.
18. Elgert S. Pre-precepting residents on matters of importance for today-the PROMPT study. *Med Educ Online.* 2006;11(1):4616.
19. Collings AT, Doster DL, Longtin K, Choi J, Torbeck L, Stefanidis D. Surgical resident perspectives on the preferred qualities of effective intraoperative teachers: a qualitative

analysis. *Acad Med.* 2023;98(5):629-635.
20. Kisiel JB, Bundrick JB, Beckman TJ. Resident physicians' perspectives on effective outpatient teaching: a qualitative study. *Adv Health Sci Educ Theory Pract.* 2010;15(3):357-368.
21. Ramani S, Könings KD, Mann KV, Pisarski EE, Vleuten CVD. About politeness, face, and feedback: exploring resident and faculty perceptions of how institutional feedback culture influences feedback practices. *Acad Med.* 2018;93(9):348-349.