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Do You Have a Minute to Talk?: Feedback, Face, and Becoming a Learning Organization

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There is a range of communication skills that can help peer feedback discussions go better. (It) is useful to approach these discussions from a perspective of curiosity (assuming you do not have all the relevant facts) rather than accusation. Pay equal attention to both information sharing and emotion-handling dimensions of these discussions. Yet, most critical may be our willingness to take the initiative to have such discussions in the first place.

The notion that treating our colleagues well is the first principle of medical professionalism harkens back to the Hippocratic Oath. The oath begins not with our duties to our patients, but rather "to hold my teacher in this art equal to my parents;… When he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art."

Many of my columns have highlighted the importance of understanding the culture of medicine. And nowhere does this culture exert a stronger influence than the way it affects our behavior toward our fellow physicians. While a strong sense of collegiality has many benefits, it also complicates our attempts to become a self-regulating profession. In my September 2017 column, I discussed the importance of adopting a framework of continuous self-improvement, one that hinged on seeking feedback on our performance. Yet a continuous self-improvement mentality calls on us not only to pursue feedback but also to provide feedback to *each other*. However, for many of us, the prospect of offering peer feedback has all the appeal of an ice-water colonic.

I became aware of how difficult physicians find it to give their colleagues feedback during my work on disclosing medical errors to patients. The most common question I heard from physicians was, "What do I do when I am aware that a colleague has made an error in the care of a patient I am responsible for? Should I tell the patient about my colleague's mistake?" As we explored this topic, it became clear that there were actually two challenging discussions[1]. One was a potential conversation with the patient about the colleague's mistake. But prior to talking to the patient, clinicians struggled with whether or not they should reach out to the involved colleague and talk with them about what happened. The prospect of confronting a colleague about an error was considerably more intimidating to physicians than the conversation with the patient. More often than not, physicians decided to just skip talking with their colleague altogether, preferring to move the patient's care forward rather than dwelling on the past.

How physicians approach feedback is a paradox. In a national survey of internists, 94% said it was important to get feedback on their clinical care, yet only 27% reported receiving such feedback[2]. Similarly, physicians express an eagerness to know about mistakes they have made, and a desire that their colleagues let them know if they were concerned about their performance. Many of us also routinely provide feedback to learners. Yet, this desire for feedback on our own performance and experience giving feedback to learners seldom translates into a willingness to speak with a colleague about a potential care problem. In the words of Jack Handey, "Before you criticize someone, be sure to walk a mile in their shoes. That way, when you criticize them, you are a mile away and have their shoes."

The reasons why we hesitate to provide feedback to our colleagues are complex. For instance, we realize we may have incomplete information about what happened, and don't want to jump to conclusions. There can be power dynamics stemming from level of training, gender, financial relationships, and hierarchy. We all make mistakes, and hope our colleagues would treat us with kindness and deference if the roles were reversed.

A professional culture that prizes collegial relationships has significant advantages. Medicine is a team sport, and a responsibility to interact respectfully with one another is essential for patient care. As the Hippocratic Oath notes, the medical profession also relies on senior physicians passing their knowledge down to younger colleagues. However, a blind commitment to collegiality has downsides. Most patient complaints cluster around a small number of physicians. In one study, 50% of all complaints against Australian physicians were attributed to just 3% of doctors, with some physicians accumulating more than 10 complaints[3]. How do individual physicians accumulate such a high number of complaints? All of us know which of our colleagues are struggling to interact effectively with patients because they are also having difficulty interacting effectively with us. But rather

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than stepping forward, we look the other way, hesitating to have a potentially uncomfortable interaction with a colleague. While some training models have been developed to make it easier to communicate against power gradients, such as TeamSTEPPS[4], speaking up in these situations is not our strong suit[5].

While speaking up when a colleague is struggling is an important litmus test of the bounds of collegiality, the more pressing need is for us to get better at providing each other with routine feedback. This may be one of the few areas where our surgical colleagues have an advantage. Morbidity and mortality conferences are a valued aspect of surgical culture. Surgical M&Ms reinforce the notion that professionalism includes having frank conversations among peers about breakdowns in quality. Accepted criteria exist for which cases will be discussed at surgical M&M conferences, with all of the cases meeting these criteria presented and reviewed (such as every surgical site infection or unplanned return to the operating room). Internists might question what can appear to be a blaming tone of the stereotypical surgical M&M conference. Nonetheless, the importance of discussing quality of care and providing each other feedback is more deeply integrated into surgical culture than it is in internal medicine.

If sociologists were to observe internal medicine physicians struggling with whether and how to provide each other with feedback, most would turn to the work of Erving Goffman, and later Penelope Brown and Steven Levinson on *politeness theory*. Goffman wrote, "Just as the member of any group is expected to have self-respect, so also he is expected to sustain a standard of considerateness; he is expected to go to certain lengths to save the feelings and the face of others present, and he is expected to do this willingly and spontaneously because of emotional identification with the others and with their feelings"[6]. *Face*, in Goffman's terms, is "the positive public image you seek to establish in social interactions." Contemporary scholars distinguish between "fellowship face" (the want to be included), "competence face" (the want to have one's abilities respected by others), and "autonomy face" (the want to not be imposed on). Much of politeness theory goes on to describe "facework"—the behaviors we exhibit during social interactions to maintain, restore, or save face.

How can we focus less on politeness and more on providing feedback to one another? SGIM's membership is fortunate to include national leaders in medical education—individuals to help us understand models of peer feedback developed for the teaching setting and apply them to a broader array of peer discussions. Mookherjee and colleagues highlighted the benefits that peer feedback can have both for the observer and for the feedback recipient, such as promoting collegiality and strengthening the learning environment[7]. Most peer feedback models start by asking the subject of the feedback to provide their perspective on the topic at hand, followed by behaviorally anchored feedback including both reinforcing and constructive comments, and a closing that includes reflecting on the feedback and developing a shared approach to moving forward.

There is a range of communication skills that can help these peer feedback discussions go better. When it comes to having difficult discussions with peers about potential breakdowns in the care, it is useful to approach these discussions from a perspective of curiosity (assuming you do not have all the relevant facts) rather than accusation. Pay equal attention to both the information sharing and emotion handling dimensions of these discussions. Yet, most critical may simply be our willingness to not look the other way and take the initiative to have such discussions in the first place.

For SGIM to become a learning organization, we also must do a better job of providing each other with feedback. At present, our mechanisms for soliciting feedback are limited to a periodic member survey, discussions via GIM Connect, and informal feedback via e-mail and hallway meetings. Committees and Task Forces receive bi-annual feedback from Council on their annual plan and progress towards meeting these

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goals (though the reverse is not true; i.e., Council does not receive formal feedback from Committees or Task Forces about its goals and progress towards meeting them).

How can we start nudging our SGIM culture a little bit away from politeness and more towards feedback and improvement? Ultimately, our obligations towards one another as colleagues, as well as our obligations as members of SGIM, require that we start taking small steps towards making providing such feedback the norm, rather than the exception. I welcome your thoughts about how we can move in this direction.

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