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ORIGINAL CONTRIBUTION

"They were very very nice but just not very good": The interplay between resident–supervisor relationships and assessment in the emergency setting

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Abstract

Purpose: Clinical supervisors hesitate to report learner weaknesses, a widely documented phenomenon referred to as "failure to fail." They also struggle to discuss weaknesses with learners themselves. Their reluctance to report and discuss learner weaknesses threatens the validity of assessment-of-learning decisions and the effectiveness of assessment for learning. Personal and interpersonal factors have been found to act as barriers to reporting learners' difficulties, but the precise role of the resident–supervisor relationship remains underexplored, specifically in the emergency setting. This study aims to better understand if and how factors related to the resident–supervisor relationship are involved in assessment of and for learning in the emergency setting.

Methods: We conducted a qualitative study, using semistructured interviews of 15 clinical supervisors in emergency medicine departments affiliated with our institution. Transcripts were independently coded by three members of the team using an iterative mixed deductive–inductive thematic analysis approach. The team then synthesized the coding and discussed analysis following guidelines for thematic analysis.

Results: Participating emergency medicine supervisors valued resident–supervisor relationships built on collaboration and trust and believed that such relationships support learning. They described how these relationships influenced assessment of and for learning and how in turn assessment influenced the relationship. Almost all profiles of resident–supervisor relationships in our study could hinder the disclosing of resident weaknesses, through a variety of mechanisms. To protect residents and themselves from the discomfort of disclosing weaknesses and to avoid deteriorating the resident–supervisor relationship, many downplayed or even masked residents' difficulties. Supervisors who described themselves as able to provide negative assessment of and for learning often adopted a more distant or professional stance.

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Conclusions: This study contributes to a growing literature on failure to fail by confirming the critical impact that the resident–supervisor relationship has on the willingness and ability of emergency medicine supervisors to play their part as assessors.

INTRODUCTION

Assessment of and for learning plays a key role in health professions education (HPE).[1,2] Assessment of learning ensures graduates have developed minimal competency requirements and steers learning,[1–3] while assessment for learning provides learners with information about how close (or far) they are to reaching these requirements and how they can go about taking further steps toward them.[1,2,4] Workplace-based assessment, a critical component of assessment in HPE, typically involves clinical supervisors in providing regular feedback and documenting their interpretations of learner performance in the clinical setting using assessment forms.[5]

Despite its pivotal role in HPE, workplace-based assessment has proved challenging.[6–8] Among these challenges, failure to fail learners who perform poorly in the clinical setting has been widely documented in a variety of HPE contexts.[9–13] More broadly, supervisors avoid documenting even moderate learner weaknesses in workplace-based assessment forms, by inflating scores[14,15] and using coded language in comments.[16] Supervisors may also be reluctant to verbally discuss weaknesses with trainees, a phenomenon some refer to as "minimizing unpleasant messages" (MUM),[17,18] thus depriving learners of useful feedback.[18–21] Overall, supervisors hesitate to report or even discuss learner weaknesses, threatening the validity of assessment-of-learning decisions and the effectiveness of assessment for learning.

Several factors play a role in failure to fail,[9,10,13] and some have been addressed with the roll-out of competency-based education and the associated articulation of clear learning outcomes; development of assessment tools; and faculty development in direct observation, assessment, and feedback.[22,23] However, clinical supervisors continue to experience discomfort in providing negative assessment of and for learning.[18,24] Personal and interpersonal factors have previously been identified as barriers to reporting learners' difficulties,[9–11,20,21,25] but the specific role of the relationship between supervisors and learners in supervisors' unwillingness to disclose learners' weaknesses remains underexplored and unaddressed. In a recent study in family medicine, Laurin et al.[24] reported that supervisors were aware that their relationship with residents could influence assessment of and for learning and felt that, in turn, assessment of and for learning could influence the relationship. Supervisors emphasized the importance of the resident–supervisor relationship for learning and sought to preserve it at all costs.[24] Anticipating potential negative effects of discussing or reporting resident weaknesses on the relationship, they circumvented this threat by providing lenient assessments and minimizing negative feedback.[24] Contextual factors appeared to be at play, including the duration of resident–supervisor relationships, which typically last several months in family medicine, and the caring culture of the discipline.[24]

To our knowledge, the influence of the resident–supervisor relationship on assessment of and for learning has yet to be explored in the emergency medicine context. The emergency setting presents specific features, not only in terms of the type of clinical care provided (i.e., mainly acute and one-off) but also in terms of the supervisory context. First, physicians and residents work different shifts (day/evening/night) and residents are supervised by different physicians. Resident–supervisor relationships therefore occur in the context of a series of disconnected contacts over a given period. Second, emergency medicine hosts different categories of residents: residents who are enrolled in a 5-year emergency medicine program, family medicine residents enrolled in an additional year of emergency medicine, and residents from many other programs who must complete a rotation in emergency medicine as part of their program.

The aim of the study was to explore how, if at all, the resident–supervisor relationship influences assessment of and for learning in the emergency setting. Understanding this influence could open avenues for innovative interventions to correct or mitigate the reluctance of supervisors to discuss and report learner weaknesses.

METHODS

We conducted a descriptive qualitative study couched in a post-positivist paradigm. Between August 2021 and August 2022, we performed semistructured interviews of clinical supervisors in emergency medicine departments affiliated with Université de Montréal (Québec, Canada). At the time of the study, Université de Montréal had 20 affiliated emergency medicine departments located in urban and suburban areas.

The research team was comprised of four clinician educators involved in supervision in family medicine (SL, LCo, LCu) and emergency medicine (VC), a medical education researcher with expertise in assessment (VD), and two research assistants (MD, AJ). All researchers, except the research assistants, had experience as faculty developers on the topics of supervision, feedback, and assessment in various health professional training programs. Université de Montréal's research ethics committee approved the study (CERCES 2021-1235).

Participant recruitment

Recruitment proceeded in two steps. First, we drew a list of 36 potential participants (key informants) with the help of the emergency medicine rotation Coordinator at Université de Montréal. Potential participants were certified emergency physicians involved in supervising residents. In Canada, two residency tracks lead to certification in emergency medicine, i.e., a 5-year emergency medicine specialist residency program, and a 1-year added competence training program for family physicians, completed after a 2-year family medicine residency. As part of their educational responsibilities, supervisors are expected to provide verbal feedback and complete assessment forms (field notes[26]) at the end of each shift. These field notes are intended to be low-stakes assessments serving the dual purpose of providing feedback to learners and information to the site director who completes end-of-rotation summative assessments. The list purposefully aimed for diversity in terms of gender, geographic location, experience in supervision, and assessment.

Second, the principal investigator (SL) sent everyone on the list a personalized email with information about the study and a consent form. The interview guide (Appendix S1) was sent with the invitation email, to enable participants to reflect on our questions in advance of the interview. Fifteen physicians from our list agreed to take part. We anticipated, based on a review of the literature[27] and a previous study we had conducted on a similar topic in a different setting,[24] that we would reach data saturation with this number of interviews. This was confirmed once we analyzed the data from these participants. Therefore, we did not recruit further participants. The characteristics of our 15 participants are reported in Table 1.

Data collection

One research assistant (MD) conducted all the individual semistructured interviews and recorded them on an iPhone recorder. She had experience performing qualitative interviews and was briefed on the problem statement and the context of supervision in the emergency department. The interview guide, which remained the same throughout the study, was adapted from one used in a study of family medicine supervisors by Laurin et al.[24] Interviews lasted between 16 and 34 min (mean 30 min). She transcribed the interviews verbatim using the transcribing software Amberscript, deidentified the transcripts, and then deleted the recordings.

TABLE 1 Participants.

Gender	
Male	8
Female	7
Specialty	
Emergency medicine	8
Family medicine	7
Experience as clinical supervisor	
0–10 years	8
>10 years	7
Geographic location	
Urban	7
Suburban	8

Data coding and analysis

Transcripts were independently coded by three members of the research team to ensure researcher triangulation.[28,29] The principal investigator (SL) and one member of the research team (VC) independently coded all transcripts, with other members of the team each coding a random subset of transcripts. We coded the data using a mixed deductive–inductive thematic analysis.[30] We developed an initial coding scheme based on two publications, i.e., literature review of "failure to fail" by Yepes-Rios et al.[9] and the study by Laurin et al.[24] of the interpersonal factors involved in assessment in family medicine. We also developed additional codes inductively, when we identified new ideas in the data. No data coding software was used.

The team then iteratively synthesized the coding and discussed analysis over the course of several meetings, following published guidelines for thematic analysis.[31,32] Thematic analysis involves systematically identifying, grouping, and analyzing themes (and subthemes) within the data until saturation is reached. "Themes are actively constructed patterns (or meanings) derived from a data set that answer a research question, as opposed to mere summaries or categorizations of codes. Themes can be generated inductively or deductively."[32]

RESULTS

All participants discussed situations where the resident–supervisor relationship factors had or could have influenced assessment. Some had not experienced these situations themselves but could nevertheless describe in detail situations they had observed where they perceived that their colleagues' assessment and/or feedback had been influenced by the type of relationship these colleagues had with their residents. A few participants acknowledged the potential for the resident–supervisor relationship to influence assessment of and for learning but felt that their own assessments had never in fact been influenced.

Although it was not the focus of interviews, participants spontaneously brought up several contextual issues that contribute to the challenge of providing assessment of and for learning. Feeling tired at the end of a busy shift, especially evening or night shifts; having little protected time for feedback due to the clinical workload; and lacking a quiet space to have a private discussion with residents all chipped away at the supervisors' motivation to discuss residents' difficulties.

How the resident–supervisor relationship influences assessment of and for learning

A positive relationship usually leads to supervisors avoiding disclosing difficulties

Emergency medicine supervisors felt that the supervisory relationship was positive when the resident was motivated, friendly, and open to learning and held shared values or had a personality compatible with theirs. Supervisors avoided disclosing weaknesses with or about residents who were a good fit with them personality-wise or were interested in emergency medicine.

> I think when you "land" a resident whose personality is very, very, very similar, and who you get along with, well, um, it might be a little harder, at that point, to tell the resident "Well, you're really not good" or something like that. (P14)

> … there were very good, very amicable, relationships, "Ah, this person is quite 'chill,'" they fit in with our emergency personality, or the model of Emergency care. It's likely that that person received more positive comments. (P7)

When residents were in the 5-year emergency medicine program or the added competence program (third optional year of the family medicine program), they knew them better and felt more attached to them, which also led them to provide more lenient assessment of and for learning.

> These residents, we interact with them a lot, so we develop bonds of friendship with them, um, they are residents that we see as future colleagues, so of course, that taints our assessments. (P3)

When supervisors deemed the relationship as positive, they often sought to protect not only the resident's self-esteem and motivation, but also their self-image as a considerate teacher.

> I'm a people-pleaser, I want everyone to like me, so being the big bad wolf or being hard on my students when I give feedback or assess them, is not something I particularly want to do. (P2)

Some supervisors who chose to entertain friendly rather than hierarchical relationship with residents and, similarly, supervisors who interacted with residents outside of work, for instance because they used to be residents together, said that this relational proximity contributed to their unease in providing negative assessment of and for learning.

> This resident, you know, I saw her outside of like the routine, so she was like a friend, so that relational issue, and she's also the wife of one of my colleagues, that made it difficult to assess her. (P1)

However, some participants felt that a positive resident–supervisor relationship, that some compared to the relationship between athlete and coach, made it easier to provide negative feedback, because it was done in a climate of trust.

> … I don't always butter them up, precisely because the residents I know well, they're honest with me and I think they expect me to be honest with them too. So, if they did something that wasn't right or (…) if they have things they need to improve (…), I think they actually expect me to mention it to them … (P2)

> That's why the interpersonal relationship, I think (…) it's a bit special, (…) kind of like an athlete and their coach who develop a bond of trust, who have shared goals, and who will say it like it is, and give the right feedback to be able to improve their performance. (P10)

A negative relationship can either encourage or discourage supervisors to disclose resident weaknesses

Supervisors felt that the supervisory relationship was negative when the resident was not motivated, questioned supervisors' clinical decisions, was not open to feedback, or was overconfident, especially if the supervisor was concerned that the resident was not forthcoming in case discussions.

> … some residents who won't be completely honest in what they mention, to try and hide things they haven't done. Because I'd much rather a resident say "I didn't do that" than invent something and try and pull the wool over my eyes. (P2)

The impact of a negative resident–supervisor relationship varied: some supervisors felt that it facilitated the disclosing of weaknesses whereas other felt it hindered it, either because they worried that their assessment may be tainted by their negative feelings toward the resident or because they feared a hostile reaction from the resident.

> … there are some residents who also generate emotions, in us, that aren't always positive, there are residents we don't like as much. (…) For sure if the personal relationship with a resident isn't super good,

> then the threshold to write a negative comment can sometimes be lower. (P3)

> So that means do I limit myself a little and stop myself from telling them "Look, this aspect, I think you don't do as well on this, or you have work to do on this?" Do I limit myself, when I really have a strong countertransference and it doesn't click at all with the person? It's possible. (P2)

A weak relationship usually leads to minimal effort in assessment of and for learning

Supervisors described having not developed a meaningful relationship with residents who spent only a short amount of time in the rotation:

> If I take the example of (surgical specialty) residents who stay with us for a month, and then we never see them again … I might work with them for 2 or 3 shifts during that time. So, with them, it's super easy to be detached (…) I don't have time to get to know them, develop a relationship. (P4)

When the resident–supervisor relationship was weak, supervisors often said that they lowered their expectations, decreased their educational commitment, and provided minimal feedback.

> It's a sort of letting go, to say "Well, I give up, this student isn't interested so I'm going to give basic feedback," but maybe I won't go into the more difficult conversation. (P7)

A more distant or professional relationship can facilitate the disclosing of weaknesses

Supervisors who described themselves as able to provide negative assessment of and for learning, despite it being unpleasant, often adopted a more distant—professional—stance. They focused on their responsibility as assessors and relied on facts and the program's benchmarks to hold frank conversations with residents.

> If we do it, it's not because we enjoy it. It's super unpleasant. We understand the impacts (…) but also, being very frank, I think it helps, even with people it was hard to say to … (P13)

> You shouldn't be the student's friend, the friend who goes for a drink in the evening, and goes skiing on the weekend (…) I think that's the most useful tool, even with people who are very resistant (to feedback) or people who weren't always aware of how bad things were going. (P13)

How assessment can in turn influence the relationship: Supervisors fear that providing negative assessment of and for learning feedback may deteriorate the resident–supervisor relationship

Supervisors often struggled to provide negative assessment of and for learning, because they feared it would damage the resident–supervisor relationship and thus undermine residents' learning. They also feared residents' reaction to an unfavorable assessment and with it a deterioration of the work climate or an impact on their personal and social interactions with residents. Some felt guilty or believed they were breaking residents' trust in them.

> They might not, but they'll become less open to the content (of the feedback). That's why for me, changing the score a little … um, maybe, yeah. (P13)

Similarly, when they did decide to broach the subject with a struggling resident, supervisors often chose to provide the negative feedback verbally and not write anything explicitly negative on field notes (end-of-shift assessment forms), in the hopes of maintaining a good relationship. They would write comments that were less glowing than usual, confident that the site director would pick up that the resident was struggling.

> They were really really nice, but just not very good. I used several tricks to write their assessment, that yes, they were interested in emergency medicine, that they'd made progress … they were positive comments but I'm sure the people who read that assessment saw they weren't the same comments that I write for those who I think have aptitudes. (P11)

DISCUSSION

Our study confirms previous findings on the role of the learner–supervisor relationship in supervisors' reluctance to disclose learner weaknesses and the discomfort it generates.[9–11,20,21,25,33] Almost all profiles of supervisory relationships in our study could hinder the disclosing of resident weaknesses, through a variety of mechanisms. Weak relationships could lead to supervisors disengaging and lowering their expectations, thus decreasing the quality of their critique of resident performance in general. Negative relationships typically led to cautious restraint, except when it opened a breach in the supervisor's habitual benevolence, facilitating a blunt disclosing of weaknesses. Positive relationships,

especially friendly ones, often led to excessive benevolence and lenient feedback.

Some supervisors described feeling protective of residents, suggesting an overly caring relationship others have previously described,[10,11,20,25] where the residents' well-being was the driver of their behaviors. Negative assessment of and for learning was seen as high risk to residents and to the resident–supervisor relationship. The metaphorical talk of some participants about providing negative feedback, such as "being the big bad wolf," highlights the perceived relational risks involved in assessment and supervisors' difficulties in managing these risks.[25]

Some supervisors placed such value on the relationship that their behaviors sought to preserve the relationship at all costs. In some cases, this was because the relationship had previously been or had become of a personal nature, in others it was because supervisors saw the relationship as pivotal in resident learning. In latter cases, preserving this relationship led to a paradox: to maintain a relationship for the sake of its role in resident learning, supervisors unintentionally denied residents who needed it the honest feedback that could potentially help them progress.

Our findings point to potential strategies that could contribute to reducing the risk of "failure to fail" and "keeping MUM." Supervisors who managed to disclose resident weaknesses either held a specific view of the ideal resident–supervisor relationship that encouraged open feedback or kept some distance in the relationship. They either described their role as that of coach, pushing their athlete to peak performance, or accepted that, however unpleasant and regardless of the emotional valence of their relationship with residents, disclosing weaknesses was part of their educational responsibility. Either way, they believed that a productive resident–supervisor relationship required honesty.

The productive resident–supervisor relationship described by these supervisors essentially aligns with the concept of the educational alliance, recommended by several authors as key to effective supervision.[34–36] The educational alliance comprises three essential components: a trusting relationship between supervisor and supervisee, a shared understanding of the goals of supervision, and an agreement about how to reach these goals.[34] A strong educational alliance lays the foundation for accurate and effective assessment of and for learning. In an educational alliance, learners feel safe enough to perform realistically in front of their supervisor, disclose their difficulties, offer their perspective, and accept criticism.[35,36] Having clarity on the educational goals of supervision enables supervisors to discuss weaknesses because they focus on the benefits to residents—rather than the harms—in doing so.[36] Faculty development on how to develop and maintain an educational alliance could be a fruitful avenue in addressing failure to fail. While many of our participants were aware of the importance of the resident–supervisor relationship, they often focused on the bond of trust required, overlooking the two other components of the educational alliance, i.e. a shared understanding of the goals of supervision and the means to attain them.

Another way of managing the relational complexities of supervision discussed by a few participants in our study as well as in other studies[24,37] was to maintain a somewhat distant, "professional,"[37] relationship and avoiding "getting too close to or overly familiar with learners in the context of assessment."[37] We suggest that just as physicians are oriented about what constitutes an appropriate physician–patient relationship, e.g., through codes of conduct, and trained on how to develop and maintain appropriate physician–patient relationships, so too should supervisors be oriented to and trained on developing and maintaining an appropriate resident–supervisor relationship, balancing warmth and clear boundaries,[38,39] and focusing on residents' learning needs.

STRENGTHS AND LIMITATIONS

This qualitative study focused on an underresearched topic in the assessment of residents. It was designed and performed according to criteria for robust qualitative research in a post-positivist paradigm, i.e., purposefully diverse participants, data saturation, researcher triangulation in data coding and analysis.[40] Nevertheless, it has limitations. We recruited participants from a single specialty in a single institution in Québec, Canada. Although we cannot ascertain the transferability of our findings to different educational settings, our experience and the literature on failure to fail suggest that the resident–supervisor relationship is also at play in other specialties and other institutions. Further studies should seek to confirm this. Finally, studies should be conducted on residents' views of the resident–supervisor relationship and its potential role on assessment of and for learning. Two studies have already confirmed the importance of the educational alliance in residents' judgment of feedback credibility,[35,41] but more studies are needed.

CONCLUSION

The validity of interpretations and decisions made on the basis of workplace-based assessment hinges on the observations and judgments of clinical supervisors. This study contributes to a growing literature on failure to fail and the critical impact of the resident–supervisor relationship on the willingness and ability of supervisors to play their part as assessors. The emergency setting, with its intensity and hours, also plays a role in supervisors' discomfort in disclosing residents' difficulties.

We suggest that faculty development should focus on helping supervisors' change their conceptions of an effective resident–supervisor relationship to align with the concept of the educational alliance, on developing supervisors' skills in developing, and maintaining a strong educational alliance while maintaining appropriate boundaries, including in challenging circumstances.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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