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Advocacy inquiry and circular questioning to maintain psychological safety in training, feedback, and conversations with residents

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Abstract

Training of emergency physicians through an emergency medicine residency program takes 5 years, that is, 3 years in junior residency and 2 years in senior residency. Throughout this period, residents will be exposed to a variety of educational methodologies and meet a spectrum of faculty, supervisors, and teachers, who will have different personalities, styles, and approaches to teaching and nurturing them. It is important to ensure the maintenance of psychological safety for these residents throughout their training journey and into the future years of practice s an emergency physician.

Communications, interactions (which involve questioning), and presentations will be an important part of this training program. This article looks at two modes of questioning: advocacy inquiry and circular questioning, which can be applied as appropriate. These two methods are examples in which faculty may consider adopting in their many interactions, follow-up, feedback, tutorials, facilitation, partnerships, and counseling sessions with residents. These two techniques offer options to maintain psychological safety, which can facilitate learners sharing and opening up. It can be included in the faculty's armamentarium of questioning techniques and applied where applicable.

Key words: Advocacy, Circular questions, Emergency medicine, Inquiry, Residents

Introduction

Psychological safety (PS) is the shared belief that it is safe to share openly and be engaged in interpersonal risk taking (this risk taking does not include unjustifiable risks pertaining to patient care which is not evidence-based) at the workplace. Simply put, it is about how comfortable staff are when talking, sharing and expressing themselves, speaking up on ideas, observations, and also concerns. Psychological safety is linked to morale and willingness to contribute and participate. With PS, when errors do happen, the practice of an open, fair, and just culture should not ridicule or embarrass the staff.[1–3] The 4 types of PS often involved in workplaces operations and workflow are as follows[1,3]:

Inclusivity: feeling a sense of belonging to the department or organization, feeling included in the group.

Learning safety: the ability to learn is linked to a staff's level of PS. The safer they feel, the more they are not afraid to ask questions, enquire, and satisfy their curiosity. which means they can learn better and deeper.

Contributory safety: when one has attained a certain level of PS at the workplace they are not held back when it comes to sharing ideas, suggestions, and views, which they feel can contribute to the program, project, or departmental development and growth.

Challenger safety: this happens when one is very comfortable and can share ideas on change and transformation and they are even comfortable questioning the status quo and developing changes.

Emergency medicine residency training

In Singapore, residency training is offered by healthcare clusters, which represent regional grouping of institutions (primary, secondary, and tertiary care institutions), accredited to provide appropriate training and certification of residents. In the emergency medicine residency training, there are 3 years of junior residency and 2 years of senior residency that each candidate has to go through and fulfill all the stipulated requirements.[4] During this period, they will be exposed to a wide spectrum of learning and various modalities of training (Table 1). They will also cross paths with many educators, faculty, and facilitators, who have different styles, philosophies, and approaches to teaching and learning. Supervision, close monitoring, and an apprenticeship-like model are applied as necessary. At each stage of the residency training candidates will be supervised accordingly. For example, for junior residency (years 1 and 2) much direct supervision may be required as compared with their years in senior residency, where indirect supervision becomes more applicable. Even with this, each resident's training and supervision are customized to their individual capability, capacity, accumulated acquisition of competencies, level of ease, and familiarity with procedures, cases, and techniques, as well as other summative and formative factors.[5–7] With all these in mind, it must always be set against the background of the emergency department, whereby the environment is extremely dynamic, fast-paced and functions on a 24/7 basis.

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

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Table 1

Activities Where Advocacy Inquiry and Circular Questioning May Be Used

Some types of educational methodologies faculty are involved in
Didactic teaching, such as lectures
Interactive teaching
Self-learning
Group learning (small and large groups)
Flipped classroom model
Bedside learning, clinical learning, immersive or embedded learning
Simulation-based learning
Interprofessional learning and education
Online learning, e-learning
Virtual learning
Technology-enhanced learning activities
Other types of activities residency faculty are involved in
Mentoring
Counseling
Nurturing
Delivery of feedback and inputs
Befriending
Mediation
Conflict resolution
Assessment and grading
Reasons for questioning in residents interaction
Question to establish context
Question to deepen understanding and perspectives
Question to explore the possibility for change/value of the change
Question to explore solutions
Question to engage residents with the (potential) solutions
Question on follow-up action, behavior
Question on moving forward and the next stage

In all these years of interaction and conversations, the resident-faculty relationship is a critical one. Every resident is allocated a personal mentor/faculty member for the whole 5 years of his training. This faculty can be a teacher, mentor, friend, counselor, advisor, debriefer, feedback provider, and many other roles, which they have to fulfill in nurturing an emergency physician (Table 1). There are other core and physician faculty members residents will be working with. Communication is a crucial part of this relationship. A big part of this involves asking the right questions, to gain the appropriate responses, to get residents to open up and share comfortably, and to maintain their psychological safety.[1,8,9] This way, the faculty can walk alongside the residents throughout their training journey.

Questioning techniques

Questioning is an important component in teaching and learning. It has a long history as an educational strategy. Questioning in the context of residency training can be useful to: [4,10–12]

a. Test prior knowledge. In adult learning, this is the principle whereby adults come in with a spectrum of life and work experiences,
b. Stimulate clinical reasoning and critical thinking in medical practice,
c. Motivate and encourage residents through proper engagement, and
d. Convey the right verbal and non-verbal vibes, just as in general communications or presentations.

All these can affect and impact all 4 types of PS. Very often, faculty are not formally given instructions on how to teach as well as other aspects of teaching and learning. It is assumed that once an emergency physician has attained a certain level of seniority, he will get involved in educational activities and this includes being a mentor to residents. The process is dependent on personal styles, comfort level, life experiences, exposure, and background training. This includes the use of questioning techniques in various contexts. Thus, faculty development courses and continuing educational activities and seminars that offer such training will help in the growth, self-awareness, capacity, and capabilities development of faculty. At the same time, the topic of PS can be thrusted and emphasized to the faculty.[13,14]

In whatever context of education and learning, questions must have an intent. This is to be helpful in deepening understanding of residents' situations, exploration of certain issues or topics, formulation of strategies, or planning change. Faculty will need to assess the right time to bring up certain questions for discussion. They must realize that their questions can trigger responses from the residents, in the invitation to speak, sharing their experiences and problems, hopes, as well as expectations.[1] Questioning may also have an underlying influencing intent or be an intended locus for initiating changes, as deemed relevant. Good questions can certainly build strong and lasting relationships between faculty and residents. It is also good practice to state right at the beginning of the interaction that the questions are being asked for faculty to understand more from the residents' perspective and viewpoint (Table 1).[9–11]

The following section will discuss two questioning methods, which can be used in the context of this article (Fig. 1):

Advocacy and inquiry

"Advocacy" is stating your views or opinions and speaking up about what you believe in by openly sharing it. "Inquiry" refers to asking questions and exploring a certain topic or event by encouraging others to share their point of view and concerns. The use of advocacy inquiry (AI) is well known among those involved in simulation debriefing as it is a questioning-facilitation technique.[15,16] The balance between advocacy and inquiry can impact learners' reflection as well as sharing. Advocacy inquiry helps facilitate conversations during debriefing and can also be applied in educational settings, learning conversations, delivery of feedback, and mentoring-counseling sessions with residents.[17,18] It is essentially a questioning technique, which is nonjudgmental, nonassuming, honest, open with no preconceived ideas, and comes across as courteous. The advocacy part states the faculty's observations, while the follow-up part of inquiry seeks to clarify (the observation) for better understanding. Advocacy inquiry comes across as respectful to learners and residents and can maintain their level of psychological safety. It can be used in individual or group sessions. Advocacy inquiry questioning is linear in nature and aims to establish facts.

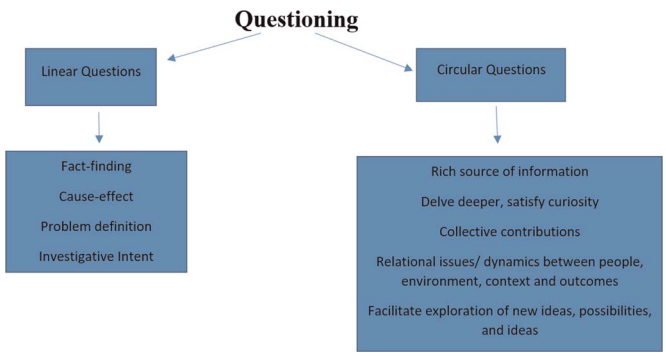

Figure 1. Comparing linear questions and circular questioning.

An example of AI used in questioning is as follows:

"I notice you... (insert resident's action)." {stating view/observation}

"I wonder what could have been the reason for... (the action)." {seeking clarifications}

This type of questioning will present a platform for the resident to explain his perspective. As can be seen, this form of questioning can be applied in a variety of contexts involving residents and will ensure faculty remain nonbias and nonjudgmental. The faculty states his observations and is open to be appraised, updated, and influenced by the residents' responses and explanation. This technique will ensure residents do not feel belittled, embarrassed, or chided before they can open up and be given a chance to speak or explain. Here, faculty will use the data they have or have observed, to get the residents' response before making a conclusion or decision. It helps gear the parties for a meaningful exchange. To advocate effectively, faculty must provide the salient data to the residents. It helps provide these systematically and one at a time so as not to overload. The art of doing this in "layers" (one at a time) takes some experience and practice. The inquiry part is open ended and should stimulate a 2-way conversation. Closed questions can still be used. These are usually the "yes" and "no" answers, which can be used to establish accuracy of certain facts that have been shared. Good inquiry questions should enable residents to reflect, such as on the need for certain actions on their part.[15,16]

Some examples would be:

"What would it take for you to perform XYZ (instead of ABC)?"

"You decided to do the procedure using technique D. What was your thinking at that time or what led you to that decision?"

"This is an important topic for us to explore. I want to understand it from your perspective, before we make any decisions together."

The choice of words is also important. The word selected may not always mean the same to each individual and their interpretation. Thus, it may become necessary for faculty to state:

"This is my understanding of EFG. What is yours?"

This comment and way of questioning can make the resident feel inclusive.

In AI, if there are high levels of utilization of both advocacy and inquiry, with good engagement, there will be mutual learning (learning PS) and understanding by all parties concerned. Such interactions involve the following:

a. Clear expression of opinion,
b. Inquiry for opinion and views of the other party, and
c. Open invitation to conversation.

Circular questions

Whereas linear questions have an investigative intent, circular questions can be categorized as those with predominantly exploratory intent (Fig. 1). Circular questions (CQ) enable faculty to discern how the behavior of one resident impacts that of another in a circular manner. This is different from and beyond the more commonly seen linear or causal relations.[19,20] This can tend to be more realistic as in life, it is often that there are multifaceted links and interactions between people. For example, if one of the residents feels upset with a situation or the approach to the situation, then how would the other residents feel when encountering that same situation.[1,2] Faculty may gather new information from this type of questioning and be able to appreciate any differences that may arise as well as the relationships involved. It may facilitate the understanding of certain dynamics with groups of residents, as well as their relations and interdependence. This approach is a more inclusive one.

Like AI, CQ is done with the element of curiosity and allows for a more collective and collaborative input. Through these CQs, there can be new connections, new ways of doing things, and new actions generated. When these CQs involve reflection, other residents and team members can be involved such that their reflective views are taken into consideration, generating a big picture view.[21–23] Thus, CQ can help and facilitate the following:

a. Making connections between faculty and residents,
b. Making connections among residents themselves,
c. Making connections with time (the temporal factor), and
d. Making connections between the inputs, ideas, and narratives shared collectively.

To provide some order and structure to the technique of questioning, especially for faculty and people who are new to its use, CQ can also be classified into the following 4 categories: [19,23,24]

a. Definition of issues/problems and points of focus (related to residents or residency issues in the context of this paper),
b. Temporal questions: this involves timeline, trends, progression, or development of the issues,
c. Triadic focus/comparison and differences: this includes differences in opinion, different ways of approaching issues, exploring alternatives through questioning, and
d. Change exploration and management: what are the changes to be implemented, how processes should be altered, and how things can be done differently.

Circular question facilitates coming up with circular assumptions. It is about the art of facilitating exploratory questions and establishing connections between people and events. The line of questioning can help bring forth patterns to recreate the whole picture of the situation to make sense to everyone. During the team questioning and facilitation session, the relationship and interactions between the residents/faculty are also crucial to maintaining PS.[24,25]

Being aware of both AI and CQ offers options for faculty to choose from. These techniques can be used individually or in blended form with other appropriate techniques, as deemed relevant. These 2 techniques are highlighted as the style can help ensure the psychological safety of residents and learners in training, as well as faculty.

Conclusion

There is little objective and randomized research to date on both the use of AI and CQ. Some literature available pertains more to their use during debriefing in simulation-based learning. The faculty may not be familiar and may feel awkward when using these questioning techniques. However, these do offer a framework that can guide questioning and conversations. There needs to be more research on this topic and models of questioning, which can maintain psychological safety. In addition, if found useful and of practical value, how can these be integrated into faculty development programs, to create awareness and empowerment of residency faculty. In the end, the topic can whet our interest and appetite to explore further and continue to refine our conversations and training of residents.

Conflict of interest statement

The author declares no conflict of interest.

Author contributions

Lateef F wrote this paper.

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Ethical approval of studies and informed consent

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