Embracing Multiple Stakeholder Perspectives in Defining Trainee Competence

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Abstract

Purpose

To explore how multiple stakeholder groups contribute to the understanding of trainee competence.

Method

The authors conducted a constructivist qualitative study in 2015 using focus group discussions to explore the perceptions of different stakeholder groups (patients, nurses/nurse practitioners, supervisors/senior physicians, leaders/administrators, trainees) regarding trainee competence in the emergency department. The authors used a conventional content analysis, a comparative analysis of supervisors'/senior physicians' versus other stakeholders' perspectives, and a directed analysis informed by stakeholder theory to analyze the focus group transcripts.

Results

Forty-six individuals participated in nine focus groups. Four categories of competence were identified: Core Clinical Activities, Patient Centeredness, Aligning Resources, and Code of Conduct. Stakeholders generally agreed in their overall expectations regarding trainee competence. Within individual categories, each stakeholder group identified new considerations, details, and conflicts, which were a replication, elaboration, or complication of a previously identified theme. All stakeholders stressed those aspects of trainee competence that were relevant to their work or values. Trainees were less aware of the patient perspective than that of the other stakeholder groups.

Conclusions

Considering multiple stakeholder perspectives enriched the description and conceptualization of trainee competence. It also can inform the development of curricula and assessment tools and guide learning about inter- and intradisciplinary conflicts. Further research should explore how trainees' perceptions of value are influenced by their organizational context and, in particular, how trainees adapt their learning goals in response to the divergent demands of key stakeholders.

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Competency-based medical education (CBME) has become increasingly more common over the past decade.[1] The structure of CBME has evolved almost simultaneously in several countries, including the CanMEDS roles in Canada and the Accreditation Council for Graduate Medical Education (ACGME) competencies in the United States. As of 2014, 16 countries had adopted and tailored the CanMEDS roles or the ACGME competencies.[1] One of the assumptions of CBME is that competence can be defined by a broad set of measurable competencies. However, CBME has been criticized for reducing complex workflows to a series of simple skills or tasks that correspond to the components of assessment tools rather than addressing the complete breadth and complexity of the tasks.[1–4]

Various stakeholders were included in the process of defining and validating the ACGME competencies and the CanMEDS roles[5–7]; however, recent studies suggest that senior physicians' perceptions of competence generally overshadow the perspectives of other stakeholders in the process of defining competencies for trainees.[4,8,9] For example, until now,[8] the development and description of entrustable professional activities (EPAs) and other assessment tools have focused on expert panel approaches, and the selection of stakeholders to be part of these processes has been limited to physicians with varying levels of experience.[4,10]

For this project, we wanted to engage a broader population of stakeholders, drawing on the stakeholder theory from business management developed by Freeman and Reed[11] and Mitroff.[12] Stakeholder theory assumes that the creation of value is core to any business strategy[13] and argues that all stakeholders are "customers" who decide whether the service that a company (in our case, a hospital) provides is superior to convenient alternatives. A central premise is that insight into stakeholders' perceptions of value should guide the assessment of employees' performance.[14] Stakeholders' perspectives regarding performance can help employees (in our case, trainees) determine their focus and create value for the company.[15] When conducting a stakeholder analysis, it is important to clarify which stakeholder groups are relevant, as well as their relative power.[14] The stakeholders with the most power are those who have the greatest impact at the company. Knowledge about stakeholders' power and values, including conflicting interests and different priorities, should be used by managers to inform decisions about employees' training and performance.[14–17] In this context, trainees are not only acquiring skills but also acting as

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employees in a multifaceted and complex institution.

During the last decade, the power dynamic in hospitals has changed.[18] Although physicians used to be the dominant stakeholders, other health care professionals and individuals from the public, such as economists, have increased their power. This change has given rise to conflicting priorities and, in turn, reduced clarity regarding the objective of training and performance.[18,19] Furthermore, patients' perspectives increasingly are being incorporated into treatment programs and guidelines.[20]

The term *stakeholder* is being used more often in the CBME literature.[7,9,10,21–24] However, when applying stakeholder theory to medical education, this term should not be defined as the people gaining value from the *training* of physicians (e.g., senior physicians and program coordinators). Instead, stakeholders should be those people gaining value from trainees' patient care performance.[14,18,21,25]

Previous studies have demonstrated that various stakeholders do not necessarily agree on the competencies needed to provide safe and high-quality patient care.[7,9,10] Consistent with stakeholder theory, it may be necessary to engage multiple stakeholders to accurately identify trainees' key roles and observable behaviors.[9] To date, there is little knowledge regarding the tensions between stakeholders' perspectives on this topic.[7] In this study, we aimed to explore how various stakeholder groups contributed to our understanding of trainee competence.

Method

Context

We explored stakeholders' perceptions of competence for physicians in the first year of graduate medical education training in Denmark.[26] This stage of training includes surgical, medical, and/or psychiatric rotations, during which the majority of trainees' time is allocated to working in the emergency department. Trainees' supervisors are senior physicians who typically specialize in family medicine, internal medicine, orthopedic surgery, or emergency medicine. Supporting staff are mostly nurses and nurse practitioners.

Design

We used focus groups and a constructivist qualitative methodology to explore stakeholders' perceptions of trainee competence.

To explore different stakeholders' contributions, rather than just senior physicians' perspectives,[9,27] we designed a three-step analysis. The first step was a conventional content analysis,[28] which informed our development of a list of themes, organized into broad categories, about expectations regarding trainee competence. This list served as the basis for the subsequent steps. The second step was a comparative analysis based on the previously identified themes to explore agreements, gaps, and other potential differences between stakeholders' perspectives.[7,9] Finally, we used a directed analysis based on stakeholder theory and conceptualizations of value to further examine our data.[15,19]

To learn about stakeholders' perceptions of trainees' work and performance, we conducted stakeholder-group-specific focus groups. We chose to conduct focus groups because stakeholders construct their expectations and views in a social context.[29] Because trainees also deal with stakeholders on an individual level, we chose to conduct modified focus groups, during which we obtained each individual stakeholder's perspectives at the beginning of the focus group[30] and then continued with group discussions.[29]

Sampling/participants

The Regional Ethics Committee Zealand, Denmark, deemed this research exempt from ethical review.

We identified the stakeholder groups with the most power as leaders/administrators, supervisors/senior physicians, nurses/nurse practitioners, and patients. We recruited participants from these predefined groups from August to October 2015. We included trainees in our study to triangulate the other perspectives. The principal investigator (K.S.L.) informed all participants verbally and in writing about the aims of the study and got their permission to participate.

Leaders/administrators of emergency departments were recruited before a national conference and represented seven different hospitals. Supervisors/senior physicians and nurses/nurse practitioners were recruited from three hospitals in Eastern Denmark. Patients who were over 18 (or the parents of patients who were not) and who received care for an orthopedic injury in the emergency departments of the participating hospitals were invited to participate. Direct contact in the emergency department was used to recruit these participants. Patients participated in a focus group no more than three weeks after their visit to the emergency department to diminish recall bias. Exclusion criteria were having an admission that lasted longer than 24 hours, head trauma, or a cognitive or mental health diagnosis. Trainees were recruited by e-mail and were asked to participate immediately following a mandatory, regional course in the first half-year of their graduate medical education training. They represented seven different hospitals.

Data collection

Focus group sessions had a planned duration of one to two hours. The principal investigator (K.S.L.) acted as the group facilitator and used a range of pictures[30] as well as a focus group guide (see Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/A641) to direct the discussion and provoke debate regarding trainee competence in the emergency department. The guide was developed using the existing literature on value, competence, and the Danish version of the CanMEDS roles. We continued our data collection until no new themes were generated, and we performed informant checks as part of the focus group process.

Data processing and analysis

All focus groups were recorded using a digital recorder, transcribed verbatim, and anonymized. Data analysis was carried out alongside data collection until we achieved a saturation of themes. The team responsible for the data analysis and interpretation was mixed and included medical doctors, administrators, and education scientists. The principal investigator (K.S.L.) who led the data collection and interpretation has an MD degree and a master's degree

in public governance with experience in emergency medicine and qualitative research.

Conventional content analysis. To explore how stakeholders perceived and defined trainee competence in the emergency department, we used an inductive approach where codes emerged from us first reading the transcripts as a whole, then reading them word-by-word.[28,31] Four authors (K.S.L., M.G.T., O.M., and D.Ø.) analyzed and discussed emerging codes and organized them into themes, which were subsequently organized into categories.[28,31]

Comparative analysis. Following the conventional content analysis, two authors (K.S.L. and M.M.) performed a comparative analysis,[32] during which they compared the themes and perspectives of the supervisors/senior physicians with those of the other stakeholders. The decision to use this group as the reference was based on their dominance as the primary source of data in CBME.[4,8,9] By contrasting the stakeholder groups, we were able to describe discrepancies as well as agreement, and gain important insight into the process of incorporating a stakeholder analysis into CBME. Before conducting the comparative analysis, we presented the themes from the supervisors/senior physicians to two emergency department physicians in Western Denmark to get their feedback. We asked them to comment on whether the themes were conceptually meaningful and relevant. This step did not identify any new themes or categories.

Directed analysis. As the final step, we performed a directed analysis informed by stakeholder theory and our findings from the previous two steps. We specifically coded the data for stakeholders' perspectives regarding value. We then described the emerging patterns.

Results

A total of 46 individuals participated in 9 focus groups, which ranged from 3 to 7 participants each. Table 1 includes the demographics of these participants.

Conventional content analysis: Stakeholders' expectations regarding trainee competence

Based on our conventional content analysis, we identified 18 themes about stakeholders' expectations regarding trainee competence. We sorted these 18 themes into four categories: Core Clinical Activities, Patient Centeredness, Aligning Resources, and Code of Conduct. The themes and categories are shown in List 1.

Apart from these themes and categories, stakeholders discussed how managers and supervisors should decide when and how trainees can practice independently. Stakeholders also discussed the knowledge and skills trainees need prior to working in the emergency department, as well as the frequency with which they should be assessed and the availability of sufficient supervisor support.

Comparative analysis: How additional stakeholders influence the definition of competence

From our analysis, we were able to identify the similarities and differences between the perceptions of competence of supervisors/senior physicians and those of the other stakeholder groups (see Table 2). We also were able to describe the impact of engaging in a stakeholder analysis, and as part of this process, we developed three domains to explain how stakeholders' contributions enhanced the themes we identified—replication, elaboration, and complication (see Figure 1).

Replication. We used replication to describe the situations in which we found no new perspectives or contributions from the additional stakeholders. Four themes were purely replicated as we

Table 1

Demographics of Participants in a Focus Group Study of Stakeholders' Expectations Regarding Trainee Competence in the Emergency Department, 2015

Stakeholder groups	Total no.	No. male	No. female	Hospital[a]	No. of focus groups
First-year graduate medical education trainees	13	7	6	A, B, C, D, E, F	2
Nurses/nurse practitioners	9	1	8	A, C	2
Supervisors/senior physicians	10	7	3	A, B	2
Leaders/administrators	6	3	3	A, B, C, G, H, I	1
Patients	8	4	4	A, C	2
Total	46	22	24	A, B, C, D, E, F, G, H, I	9

[a]Hospitals A, B, C, D, E, and F are located in Eastern Denmark including in the Capital Region; hospitals G, H, and I are located in Western and Southern Denmark.

List 1

Categories and Themes Generated From a Focus Group Study of Stakeholders' Expectations Regarding Trainee Competence in the Emergency Department, 2015

Core Clinical Activities

- Clinical assessment and plan
- Knowledge about the anticipated course of injury
- Recognition and management of critical diagnoses
- Considering diversity within patient populations and clinical presentations
- Comprehensive and concise documentation
- Awareness of knowledge gaps and active use of resources (to address these gaps)
- Well-structured and efficient consultation with supervisors
- Appropriate use of clinical guidelines
- Explicit communication with colleagues and patients about clinical activities
- Ensuring safe and effective care after discharge

Patient Centeredness

- Responsiveness to patients' perspectives and preferences
- Awareness of ideal patient care pathways
- Establishing rapport and providing dynamic and personalized communication
- Maintaining focus on the patient despite time constraints

Aligning Resources

- Awareness of and respect for colleagues' skills and available resources
- Managing workloads and prioritizing tasks to maximize patient flow

Code of Conduct

- Humility and respect
- Perseverance and commitment

Table 2

Categories and Themes From a Focus Group Study of Stakeholders' Expectations Regarding Trainee Competence in the Emergency Department, 2015

Category	Themes from the supervisor/senior physician focus groups	Additional perspectives from the other stakeholder focus groups[a]
Core clinical activities	Clinical assessment and plan	• Responsibility for and prioritizing of pain management (N)
	Knowledge about anticipated course of injury	• No additional perspectives
	Recognition and management of critical diagnoses	• No additional perspectives
	Considering diversity within patient populations and clinical presentations	• No additional perspectives
	Comprehensive and concise documentation	• Understanding the importance of documentation and ensuring sufficient registration (L/A)
	Awareness of knowledge gaps and active use of resources (to address these gaps)	• Identifying gaps in knowledge before problems arise (P) • Anticipating problems (P)
	Well-structured and efficient consultation with supervisors	• Dealing with disagreements and lack of knowledge in a professional way (P, N)
	Use of clinical guidelines	• Appropriate use of clinical guidelines (N)
	Explicit communication with colleagues and patients about clinical activities	• Communicating the plan to the patient (N, P) • Communicating with patients, nurses, and supervisors (L/A) • Transparency in trainees' actions (P) as well as with coworkers (where you are, what you are doing) (N)
	Knowing about safe and effective care after discharge	• Ensuring safe and effective care after discharge (N, T)
Patient centeredness	Awareness of the ideal patient care pathway	• No additional perspectives
	Establishing rapport and providing dynamic communication	• Establishing rapport and providing dynamic and personalized communication (P) • Pedagogic approach to communication/tuning in/leveling (P) • Empathic, accommodating, customized patient contact (N) • Preparing the case before seeing the patient (N) • Managing and giving space for patients' emotions (P) • Building an atmosphere of confidence/trust (P)
	Responsiveness to differences at the group level (e.g., children, elderly, multiple illnesses)	• Identifying patients that need special treatment (L/A) • Individualized examination and treatment (N) • Paying attention to the individual's needs (P) • Responsiveness to patients' perspectives and preferences (N, P)
	Keeping up speed throughout the patient encounter	• Maintaining focus on the patient despite time constraints (P)
Aligning resources	Awareness of and respect for colleagues' skills and resources	• Applying others' and one's own resources in a balanced way, appropriately and effectively (N) according to the scope of practice and context (L/A) • Collaboration with nurses (T)
	Managing workloads and prioritizing tasks to maximize patient flow	• Progressing from a focus on details to multitasking; applying overall perspective (L/A) • Keeping up speed; ensuring a "flow" in patients (N) • Knowing about workflow and how the hospital system works; navigating around the institution (P, N) • Prioritizing patients based on a professional viewpoint (e.g., age, degree of pain) (P) • Dealing with demands of efficiency and differences in assignments day/night (T)
Code of conduct	Humility and respect	• Being humble and respectful, academically and towards colleagues (N) • Balancing humility with taking responsibility (L/A) • Understanding the culture of the department and behaving accordingly (N) • Actively promoting a good work environment; being a good colleague (N) • Having situational awareness (P)
	Perseverance and commitment	• Managing insecurity (N, T) and significant responsibility and taking care of oneself (T) • Being transparent about insecurity and lack of knowledge (P)

[a]Other stakeholder groups include nurses/nurse practitioners (N), leaders/administrators (L/A), patients (P), and trainees (T).

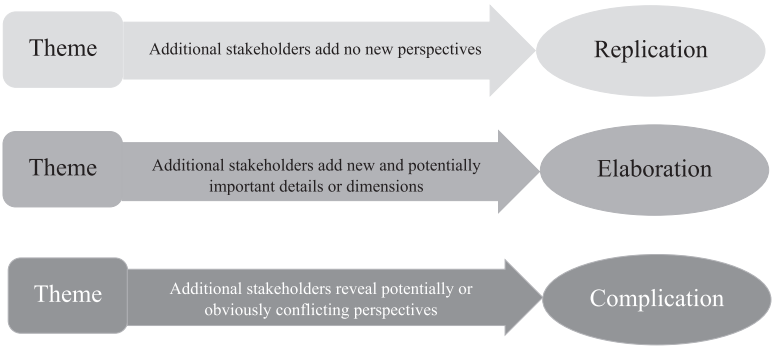

Figure 1 Domains developed based on additional stakeholders' contributions to the themes from a focus group study of stakeholders' expectations regarding trainee competence in the emergency department, 2015.

found complete concordance between the descriptions and content provided by the supervisors/senior physicians and the other stakeholders (see Table 3).

Elaboration. We used elaboration to describe the situations in which the additional stakeholders added new and potentially valuable depth, details, or dimensions to supervisors'/senior physicians' understanding of competence. We identified several notable contributions to our themes from the other stakeholders (see Table 3).

First, we found that elaboration on a theme can allow for a better and more detailed understanding of that theme's content and further explain the terms already described. One example is in the Patient Centeredness category. We found that patients' contributions were very descriptive and detailed regarding how trainees should communicate in a patient-centered way. The patients described an adaptive approach to communication, where trainees "tune in" and adjust as they engage in conversations with patients. Both the patients and the nurses explained that it is important for trainees to familiarize themselves with a patient's case before entering the room. Additionally, these groups expected trainees to be sensitive to patients' emotions and to cope with and manage these emotions.

Second, we found that elaboration on a theme could broaden the theme by adding entirely new and important considerations. Participants from all four stakeholder groups expected trainees to understand their role within a larger context as they planned their patient care work. Stakeholders also agreed that managing their workloads and knowing how to prioritize tasks were important parts of trainee competence. The nurses highlighted the importance of trainees knowing how to maximize patient flow, and the patients and nurses agreed that trainees need to know how the hospital system works to be able to navigate it. The trainees added concerns about managing demands for efficiency.

Complication. In all the examples of elaboration, stakeholders' contributions were not in conflict. For example, the patients highlighted situational awareness as a crucial aspect of competence, while the nurses added that the ability to be a good colleague is necessary to be accepted as a member of the team. Yet, these different perspectives on competence can coexist without inherent conflict. In other cases, the different perspectives were discordant. We labeled such examples as complications because stakeholders introduced potentially or obviously conflicting views on competence (see Table 3).

We found two different types of conflicts—direct and indirect. Direct conflicts were apparent when stakeholders expressed different ideas about how to approach specific issues (e.g., if trainees should ensure effective care after discharge) or about who is responsible for a specific task (e.g., whether trainees or nurses are responsible for pain management). This type of complication typically arose from a lack of clarity regarding trainees' clinical responsibilities. Another notable example of direct conflict was when supervisors/senior physicians and leaders/administrators talked about how they rely on nurses to tell them about any unsatisfactory behavior from trainees. Yet, none of the nurses felt that they had been given this responsibility, and moreover, they expressed that they were not close enough to the trainees to recognize unsatisfactory behavior.

Indirect conflicts related to the complex skills trainees needed to be competent, the related ethical considerations, and/or the impact of achieving specific aspects of competence on trainees. For example, the supervisors/senior physicians and nurses identified perseverance and commitment as essential to competence, while the trainees focused on managing insecurity and high levels of responsibility as well as taking care of themselves. Also, the patients called for transparency around trainees' need for supervision, while the trainees expressed a desire to hide their insecurities. These expectations are not innately incompatible, but they increase the risk for misunderstanding and conflict.

Supplemental Digital Appendix 2 (available at http://links.lww.com/ACADMED/A641) includes sample quotations from our comparative analysis by stakeholder group, theme, and domain.

Directed analysis: Different conceptualizations of value across stakeholder groups

All stakeholder groups were primarily concerned about the care trainees provided to patients. Not surprisingly, the patients especially focused on this aspect of competence. The other stakeholder groups, however, also had secondary concerns related to how trainees' performance could directly benefit them. For example, the supervisors/senior physicians defined value as providing appropriate patient care, but at the same time, they wanted trainees to reduce the amount of unnecessary work they made for their supervisors by not asking too many questions. In this way, they defined competence as providing high-quality patient care and minimizing the use of resources needed from senior physicians and the hospital.

The nurses also described competence as having two components—providing appropriate patient care and being able to proactively promote a positive working environment (e.g., by emptying

Table 3

Contributions of Other Stakeholders Compared With Supervisors/Senior Physicians From a Focus Group Study of Stakeholders' Expectations Regarding Trainee Competence in the Emergency Department, 2015

Category	Themes from the supervisor/senior physician focus groups	Additional perspectives from the other stakeholder focus groups[a]	Domain
Core clinical activities	Clinical assessment and plan	• Responsibility for and prioritizing of pain management (N)	Elaboration
	Knowledge about anticipated course of injury	• No additional perspectives	Replication
	Recognition and management of critical diagnoses	• No additional perspectives	Replication
	Considering diversity within patient populations and clinical presentations	• No additional perspectives	Replication
	Comprehensive and concise documentation	• Understanding the importance of documentation and ensuring sufficient registration (L/A)	Elaboration
	Awareness of knowledge gaps and active use of resources (to address these gaps)	• Identifying gaps in knowledge before problems arise (P) • Anticipating problems (P)	Elaboration
	Well-structured and efficient consultation with supervisors	• Dealing with disagreements and lack of knowledge in a professional way (P, N)	Elaboration
	Use of clinical guidelines	• Appropriate use of clinical guidelines (N)	Elaboration
	Explicit communication with colleagues and patients about clinical activities	• Communicating the plan to the patient (N, P) • Communicating with patients, nurses, and supervisors (L/A) • Transparency in trainees' actions (P) as well as with coworkers (where you are, what you are doing) (N)	Elaboration
	Knowledge about safe and effective care after discharge	• Ensuring safe and effective care after discharge (N, T)	Complication
Patient centeredness	Awareness of the ideal patient care pathway	• No additional perspectives	Replication
	Establishing rapport and providing dynamic communication	• Establishing rapport and providing dynamic and personalized communication (P) • Pedagogic approach to communication/tuning in/leveling (P) • Empathic, accommodating, customized patient contact (N) • Preparing the case before seeing the patient (N) • Managing and giving space for patients' emotions (P) • Building an atmosphere of confidence/trust (P)	Complication
	Responsiveness to differences at the group level (e.g., children, elderly, multiple illnesses)	• Identifying patients that need special treatment (L/A) • Individualized examination and treatment (N) • Paying attention to the individual's needs (P) • Responsiveness to patients' perspectives and preferences (N, P)	Elaboration
	Keeping up speed throughout the patient encounter	• Maintaining focus on the patient despite time constraints (P)	Complication
Aligning resources	Awareness of and respect for colleagues' skills and resources	• Applying others' and one's own resources in a balanced way, appropriately and effectively (N) according to the scope of practice and context (L/A) • Collaboration with nurses (T)	Complication
	Managing workloads and prioritizing tasks to maximize patient flow	• Progressing from a focus on details to multitasking; applying overall perspective (L/A) • Keeping up speed, ensuring a "flow" in patients (N) • Knowing about workflow and how the hospital system works; navigating around the institution (P, N) • Prioritizing patients based on a professional viewpoint (e.g., age, degree of pain) (P) • Dealing with demands of efficiency and differences in assignments day/night (T)	Elaboration
Code of conduct	Humility and respect	• Being humble and respectful, academically and toward colleagues (N) • Balancing humility with taking responsibility (L/A) • Understanding the culture of the department and behaving accordingly (N) • Actively promoting a good work environment; being a good colleague (N) • Having situational awareness (P)	Elaboration
	Perseverance and commitment	• Managing insecurity (N, T) and significant responsibility and taking care of oneself (T) • Being transparent about insecurity and lack of knowledge (P)	Complication

[a]Other stakeholder groups include nurses/nurse practitioners (N), leaders/administrators (L/A), patients (P), and trainees (T).

the dishwasher in the staff room). The leaders/administrators defined competence as providing proper patient care and being aware of relevant organizational and economic issues. Specifically, they emphasized the ability to provide appropriate documentation and use resources as key to competence.

We found that trainees were most concerned about threats to their value (e.g., missed learning opportunities or burnout). Even trainees' acknowledgment of competence in relation to their coworkers was about avoiding conflict (e.g., not being yelled at and getting help when needed) more than it was about creating value for patients, their coworkers, or the hospital. Trainees' comments rarely fell into the Patient Centeredness category.

Besides their differing perspectives on who gains value from trainees' competence, we also found divergent perceptions regarding what constitutes value. Stakeholders explained that trainees' value came from both their learning and service. With respect to learning as the source of trainees' value, stakeholders used terms such as skill building, training, feedback, and assessment. Trainees' duties and tasks were seen as part of a long-term goal to develop competence to become a good physician by the end of training. With respect to service as the source of trainees' value, trainees were described as working physicians who should be able to perform duties and tasks at an acceptable level of clinical proficiency. Their value in this regard included reducing costs, minimizing the use of coworkers' time and resources, and providing high-quality care without supervision.

Discussion

Our findings provide valuable insight into the perspectives of different stakeholder groups and advance our understanding of the dynamic and multifaceted nature of trainee competence. While we found overall concordance between stakeholders' expectations, we also found that each stakeholder group added detail, as well as complexity, to our understanding of trainee competence.

First, the replication of some themes by stakeholder groups emphasizes the relevance and acceptance of these themes. Similar to the findings from other recent studies that included additional stakeholders,[8,25,33] the groups in our study put a greater emphasis on trainees' patient-centered skills compared with those frameworks developed only by physicians.[8,10] And they drew more attention to the patient's perspective on competence. Such an approach may help promote better alignment between learning goals and patient-centered care.

Second, the elaboration of other themes allows us to improve our understanding of competence. Our finding that stakeholders have diverging priorities and opinions, often based on their own needs, emphasizes the need to include all key stakeholders, as suggested by stakeholder theory.[14,15] In this way, these additional stakeholder groups helped us identify other perspectives on competence that we otherwise might have missed.

Third, by way of complication, some of the stakeholders' contributions introduced new elements to our definition of competence, which were not fully consistent with the initially identified themes. This finding supports previous work that identified discordance, differences, and conflicting ideas between stakeholders' expectations regarding trainee competence.[7–10,25] However, we did not seek agreement between stakeholders or want to choose between differing viewpoints; rather, we wanted to identify the different dimensions of competence.

Within the complication domain, the nurses, leaders/administrators, and supervisors/senior physicians highlighted the fact that, in assessment and feedback, the responsibility of many becomes the responsibility of none, as no one assumes responsibility for ensuring that trainees achieve competence or for reporting unsatisfactory performance. Our finding that nurses waived this responsibility is consistent with previous findings.[34] Because of this gap, resources and training responsibilities must be assigned to specific individuals, and educators must follow up when those individuals are faced with a heavy workload in the clinical environment.[34]

Our results suggest that we risk overlooking potential areas of conflict or discordance if we seek consensus on a definition of trainee competence. Disagreements can potentially provide meaningful contributions to competency frameworks, which guide trainees and their supervisors in determining learning goals. Considering additional stakeholders' perspectives makes it possible to expand the curriculum and develop learning objectives based on other perspectives of competence than those of senior physicians.

Important findings emerged from our inclusion of trainees. Trainees were more concerned about threats to the educational value of their activities than they were about creating value for other stakeholders. Moreover, consistent with the findings from other studies exploring trainees' perspectives,[10,33] the trainees in our study were unaware of the elements of competence that related to patient centeredness. Stakeholder theory focuses on employees' ability to direct their performance toward providing value for stakeholders,[15] while self-regulated learning theory emphasizes trainees' ability to strategically plan and adapt their self-generated thoughts, feelings, and actions to attain their personal learning goals.[35] Seen through these theoretical perspectives, our results suggest that it is necessary to improve trainees' ability to identify and understand the patient perspective. Our finding of conflicting perceptions of value between stakeholder groups (i.e., trainees should be focused either on learning or service) emphasizes the need to address both elements with explicit learning objectives in the curriculum and in competency frameworks. Similarly, medical education researchers have advocated for an increased focus on the interaction between the cognitive aspects of trainees' self-regulated learning and the context of their learning.[36–40]

Our finding of conflicting values among stakeholders challenges the notion that educators should be asking various stakeholders the same questions or pooling answers in multisource feedback assessments. This approach introduces the risk of losing the significant variations in stakeholders' priorities. Previous studies support this notion; for example, one study demonstrated inconsistencies in parents' and nurses' ratings in a multisource feedback assessment of

trainees.[41] Our findings also support efforts to adapt assessment instruments with areas that are specific to a particular group of respondents (e.g., trainees' communication with patients) who may require a different approach to assessment and feedback. Some areas are potentially better assessed by those stakeholders who have the most invested in that domain of competence. For this reason, multistakeholder feedback should take into account the specific needs of each respondent group,[42,43] rather than administering general questions to all groups.

Our results have significant implications for graduate medical education. Involving additional stakeholders in CBME can help align trainees' learning goals with the demands of their work environment. Stakeholders' involvement should not be restricted to developing general frameworks, like the ACGME competencies or the CanMEDS roles, but rather should be considered at every level of CBME, including in developing assessment tools and EPAs. Specifically, involving additional stakeholders in this process may facilitate trainees' transition from medical school to clinical practice,[44–47] as this transition can be negatively affected by changes in focus, priorities related to learning and performance, and the need to adapt to different perspectives in coworkers while maintaining good relationships with supervisors.[48]

Our findings also have significant implications for medical educators. They stress the limitations of current competency frameworks, which are usually informed by expert physicians and rarely informed by other stakeholders, such as patients, nurses, leaders/administrators, and trainees. Competence is not a single entity or an end result but, rather, a dynamic process defined by those we choose to ask for their perspective. What constitutes competence will vary over time and change whenever the context or stakeholders' perceptions of value change. Defining and refining competence is an iterative, complex process that should be informed by all the stakeholders who stand to gain (or lose) value from it. Medical educators will need to focus on balancing these different perceptions of value, as the process is a negotiation between stakeholders within the context of workplace-based learning.

Our study has some limitations. First, our data were derived from focus groups, so they are confined to perspectives at the individual level and are vulnerable to social desirability bias. However, we believe that our methodology, which included a picture-guided brainstorm,[30] minimized this risk. Next, we used purposive sampling within all stakeholder groups, but because of structural changes in the Capital Region of Denmark, we were only able to include nurses, patients, and supervisors/senior physicians from three different hospitals in Region Zealand, while we were able to recruit trainees and leaders/administrators more widely. There are significant differences in the structures of the emergency departments at the three participating hospitals in Region Zealand as well as marked variation in the geographic, political, social, and economic characteristics of the patient populations, which may have improved the generalizability of our results. In addition, to avoid the omission of incongruous themes or categories, we performed our analysis inductively without applying any current frameworks, such as the CanMEDS roles. The various themes and categories expanded on previous conceptions of competence; for example, we identified a Patient Centeredness category and an awareness of ideal patient care pathways theme. These discrepancies are consistent with the findings of Lockman and colleagues,[25] who identified problems with isolating professionalism as a separate competence. Finally, we shed light on the different perspectives of competence for trainees working in the emergency department. Although some of the stakeholder perspectives we identified mimicked the results from previous studies, our results were developed within a specific context, and they cannot be extrapolated to other contexts without further study.

In summary, including additional stakeholders in the process of defining competence enriched our understanding of the topic. Their perspectives also can inform the development of curricula and assessment tools. Collectively, our results suggest that including more stakeholder groups in the definition and assessment of trainee competence can provide insight into inter- and intradisciplinary conflicts that may not be solved by consensus but, rather, should be discussed and negotiated across disciplines and professional boundaries. Further research should explore how trainees' perceptions of value are affected by their organizational context and, in particular, how trainees perceive and adapt their learning goals in response to the divergent demands of key stakeholders.

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