Feedback in Health Professions Education

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Disclosures

I have no relevant commercial relationships/affiliations to disclose.
Objectives

At End of Today’s Session, you will be able to:

• Define feedback including the difference between feedback & assessment/evaluation
• Discuss the role of effective feedback in the education of physicians and other health professions learners
• Review effective methods of giving & receiving feedback
Dr. Brene Brown

• “Vulnerability is at the heart of the feedback process. This is true whether we give, receive or solicit feedback. And the vulnerability doesn’t go away even if we’re trained and experienced in offering and getting feedback.”

  *Daring Greatly, 2012 (p. 201)*

• This is a “guiding principle” to keep in mind!
What is Feedback?

• “Information about someone’s current performance that can be used to improve it in the future” (Whitman, 1993)

• “A two-way process in which specific information is exchanged about the comparison between students’ observed performance and a standard, given with the intention to encourage students to improve their performance” (Zayapragassarazan, 2016)
What is Feedback?

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Think About It....

• You are coaching a college tennis player & you observe that he gets a third of his first serves in. Which of the following might be effective feedback?

A. “You are being too timid”
B. “Get your act together!”
C. “Good job”
D. Roll your eyes, look at your watch & move on
E. “You need to improve your serve”
F. “You’ll win 90% of the points when you make your first serve”
G. “You are tossing the ball behind your head. I want you to practice tossing the ball straight up”
Feedback or Evaluation?

• Feedback is *formative*; evaluation is *summative*
• Feedback focuses on *current* performance (“how am I doing?”); evaluation focuses on *past* performance (“how did I do?”)
• Feedback focuses on *information*; evaluation focuses on making a judgment or *decision*
Why Important?

• Learners consistently rate “ability to give feedback” as one of the most important qualities of a good teacher
• In particular, HPE learners want more feedback on clinical skills
• Accreditation requires it (ACGME, LCME, others)
• We all want it, don’t we?
• “We all need people who will give us feedback. That’s how we improve.” (Bill Gates)
Why Important?

• Which has a stronger association with improved performance in the clinical setting: quality and frequency of supervision? Or, number of patients seen?

• Many studies have shown that lack of supervision was most strongly correlated with adverse student outcomes.
What Happens When Feedback is Not Successful?

**Learners:**
- May be beset with uncertainty
- May generate own feedback based on cues, whether accurate or not
- May be over- or under-confident in their abilities
- May eventually become resistant to any constructive criticism
- Learn by trial & error at patients’ expense
- Poor performance remains uncorrected
How do you know you’re doing a good job?

• “When you don’t call me into your office, I must be doing a good job.”
• “I must be doing okay because there haven’t been any speeches about patient safety lately.”
• “I must be doing okay because you always tell me when I make too many errors.”
• “When you don’t send my reports back, I know I’m doing a good job.”
• “When you don’t look at me and shake your head, I know I’m doing a good job.”
Highly Recommended

Thanks for the Feedback

The Science and Art of Receiving Feedback Well

Douglas Stone & Sheila Heen

New York Times Bestseller
Strangely Enough….

Curious phenomenon often observed: the “disconnect” between points of view on feedback’s existence and/or effectiveness.

- Difference between student perception of “did you get feedback?” versus faculty perception of “did you give feedback?”
Why the Disconnect?

- Feedback is:
  - Truly not asked for and/or recognized
  - Not given very well or often enough
  - Too “teacher centered”
  - Learners are not receptive (some evidence that learners who most need feedback may be least able to recognize it)
  - Learners do not engage in meta-cognition (i.e., thinking about or reflecting on one’s own performance)
How Do Learners Receive Feedback?

• People accept feedback in different ways:
  – Some dismiss it initially, but continue to think about it & eventually accept some/all of it.
  – Some seem accepting initially, but eventually dismiss some/all of it.
  – Some postpone thinking about it in favor of deciding later whether it is credible, but never quite get there.
  – Some obsess over it and never seem to get over it until a new obsession comes along.

(Stone & Heen)
Giving Effective Feedback
Use the word **FEEDBACK!!**
One Way to Think About It

• Feedback should be **FAST**
  – **Frequent**
  – **Appropriate**
  – **Specific**
  – **Timely**
What are the Requirements for Good Feedback?

- Expectations
- Timeliness
- Specificity
- Clarity
- Collegiality
Expectations

• Performance must be measured against well-established objectives
• Learners must know what is expected of them, in order for feedback to work
• While this may seem patently obvious, it’s amazing how often this rule is violated
Timeliness

• Ideally, given during a structured time when everyone knows that feedback is coming....HOWEVER

• In clinic or hospital setting, this is not always possible

• Feedback in some settings must be more “spur of the moment” in nature
  – Setting should be “safe”
  – Presentation of information should be calm
  – Stay out of “attack mode”
Specificity

• Limit your feedback to what you have observed personally
  – “Observations are the ‘currency’ of [good] feedback; without them, the process becomes ‘feedback’ in name only”
  – “Begin with the learner” rule (you may need additional info; learner may already know his mistake, which makes feedback easier)

• Focus on specific behaviors, not on generalizations (what are examples?)

• Should deal with decisions & actions, not assumed intentions or interpretations
Specificity – Which is Better?

• “The differential diagnosis did not include the possibility of tuberculosis” OR

• “Your differential diagnosis is inadequate”

• “That case presentation gave me a very detailed and useful picture of the patient’s problem” OR

• “You were great when you presented that case”
Clarity

• Should be regulated in quantity and limited to behaviors that are remediable

• Should be phrased in descriptive, non-judgmental language

• Learner should come away with a clear indication of what was lacking & what specific steps can be taken to correct it in the future
Collegiality

• Focus on behavior, not on person:
  – POSITIVE: “that case presentation gave me a very detailed and useful picture of the patient’s problem”
  – NEGATIVE: “you were terrible when you presented that case”

• Start with the learner rule: “how do you think it went today?”
It Takes Two!

• Role of Instructor
  – Provide objectives
  – Create opportunity for dialogue
  – Allow learner to self correct if possible
  – Role model the behavior

• Role of Learner
  – Know expectations
  – Ask for feedback
  – Ask clarifying questions
  – Be professional at all times

Always involves dialogue between teacher and learner!
The “Educational Alliance” as a Framework for Reconceptualizing Feedback in Medical Education

Summer Telio, MD, Rola Ajjawi, PhD, and Glenn Regehr, PhD

Abstract

Feedback has long been considered a vital component of training in the health professions. Nonetheless, it remains difficult to enact the feedback process effectively. In part, this may be because, historically, feedback has been framed in the medical education literature as a unidirectional content-delivery process with a focus on ensuring the learner’s acceptance of the content. Thus, proposed solutions have been organized around mechanistic, educator-driven, and behavior-based best practices. Recently, some authors have begun to highlight the role of context and relationship in the feedback process, but no theoretical frameworks have yet been suggested for understanding or exploring this relational construction of feedback in medical education. The psychotherapeutic concept of the “therapeutic alliance” may be valuable in this regard.

In this article, the authors propose that by reorganizing constructions of feedback around an “educational alliance” framework, medical educators may be able to develop a more meaningful understanding of the context—and, in particular, the relationship—in which feedback functions. Use of this framework may also help to reorient discussions of the feedback process from effective delivery and acceptance to negotiation in the environment of a supportive educational relationship.

To explore and elaborate these issues and ideas, the authors review the medical education literature to excavate historical and evolving constructions of feedback in the field, review the origins of the therapeutic alliance and its demonstrated utility for psychotherapy practice, and consider implications regarding learners’ perceptions of the supervisory relationship as a significant influence on feedback acceptance in medical education settings.
Four Important Aspects of the Learning Process

1. What the learner already knows
2. Complexity of the task
3. Relationship with the teacher
4. Learning Environment

For Behavioral Feedback, #3 and #4 are Critically Important
Learner Confidence

• You’re an amateur painter and you have a friend who is a professional artist. You finally get up the nerve to show your friend the self-portrait you painted. Which response is better?
  – “Hey cool. Keep working at it!”
  – “Here’s a list of twelve things you should fix.”

• Depends on your expectations & confidence!
  – If you are already self-confident, you want #2
  – If you lack self-confidence, you want #1
Maybe We Need to

• Recognize that giving & receiving feedback requires less “formula” & more “relationship.”

• Spend more time teaching/showing our learners how to ask for/receive feedback.

• Build a “Culture of Feedback”:
  – Feedback Fridays
  – Feedback Rounds
Be Willing to Make it a Dialogue!

• Invite learner to comment on “how it went” today/with this patient.
• Invite learner to self-reflect.
• **Invite learner to give YOU feedback.**
• Model the feedback behavior you want to see in your learners.
Be Willing to Make it a Dialogue!

• Why?
  – Because this is the most effective way for feedback to occur
  – Because your feedback likely won’t have as much impact w/o it
  – ESPECIALLY when giving feedback on a difficult subject, this is necessary!
Case Study #1

Your medical student has just seen Jenny, a 14-year-old softball player suffering from acute lower back pain. You observed the medical student conduct a history and physical for back pain.

When you listened to the student take the history, she did not ask when the pain started or whether the patient had tried treatment to alleviate it. The student only inspected and palpated the patient’s back and failed to check distal strength, sensation and reflexes.

What is your feedback to the medical student?
Case Study #2

Resident B.K. is considered to be an excellent senior resident in emergency medicine. He has demonstrated good diagnostic skills, has an excellent knowledge base, and initiates appropriate emergency management for most conditions. His procedural skills are outstanding, and he has scored well on the residency inservice examination each year. However, there have been numerous complaints from patients that he was “gruff” or “mean.” Additionally, numerous nurses have issued complaints that he is condescending and dictatorial. He has had several unpleasant public confrontations with colleagues. The faculty unanimously agree that while he seems to be a good doctor in many respects, his professionalism and interpersonal skills leave much to be desired. What can be done to improve these skills in a senior resident?
A resident reports to his faculty mentor that he has no interest in doing any special activities with underserved communities internationally, in the US, or even in his community. “I already do enough for poor people every day. I don’t need to do anything more on my own time. They are just lucky we are here for them,” he says. A nearby faculty member overhears the conversation and agrees with the resident.
Case Study #4

Dr. Mitchell is the senior resident on an inpatient medicine service at University Hospital. Also on the team are an attending physician, Dr. Taft (an intern), and 2 third-year medical students (Emma Jackson and Joe Green). Yesterday Dr. Mitchell was approached by Emma, who was visibly upset. Emma reported that she had learned from a classmate that Dr. Taft (the intern) posted sexually explicit comments about her on Facebook. Emma explains that although she is not a Facebook friend of Dr. Taft, her classmate is, and the classmate showed her the Facebook post in question. Emma shows Dr. Mitchell a screenshot of the Facebook page. Emma was not specifically named, but she is identifiable to peers and co-workers because Dr. Taft's Facebook posts have identified him as a resident at University Hospital, making it easy for colleagues inside the system to find out what students would be working with him at any given time.

**Emma says this is sexual harassment.** Dr. Taft has been performing well in his residency, and there have been no complaints from patients, hospital staff, or other residents regarding his behavior in the hospital. How should Dr. Mitchell respond to Emma's complaint?
Summary

1. Remember it’s a process, not an event
2. Begin with the learner
3. Create a good learning environment
4. Create a good relationship (i.e., “educational alliance”)
5. Diagnose where the learner is (educational development)
6. Allow reflection
7. Recall the difference between observation & interpretation
8. Role model/invite feedback & dialogue
Questions or Comments?

• Thank you!
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Further Reading

- Boehler ML; Rogers DA; Schwind C; et al. An Investigation of Medical Student Reactions to Feedback: A Randomised Controlled Trial. *Medical Education* 2006; 40: 746-9.
Further Reading