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Feedback

Introduction to PBSG-ED Series

This special series of modules is dedicated to enhancing the educational skills of busy clinical teachers. The modules provide continuing education in a case-based format that makes judicious use of the most recent and best education evidence available. Starting from real-life examples of teaching and learning situations, the modules have been designed to promote discussion with colleagues around challenging issues/dilemmas that are likely to arise when working with learners. Their purpose is to foster reflection and provide opportunities to refine skills – preparing the way for selected changes that can improve teaching and learning.

Feedback is an essential component of teaching and learning. Yet many factors may diminish or negate feedback delivery within the clinical setting. Indeed, studies show that clinical feedback is often not given, or is offered in an insufficient, inadequate or inopportune way.

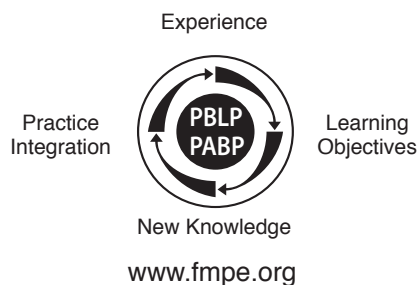
This module has been developed to facilitate an understanding of feedback, to identify barriers to its delivery, and to offer practical strategies that can promote more effective learning by your learners.

Note: While this module uses situations involving family medicine residents, the principles of feedback discussed below are applicable to learners at all stages.

Following are two specific feedback situations (“Cases”) for discussion in your group, while Appendix 3 offers additional case scenarios specifically designed for role-playing purposes. These “cases” are provided to highlight issues addressed within the module, but often the most valuable learning will occur from reflecting on your own experiences and challenges as preceptors. Please pause to complete the “Opening Lines” box for these “cases” as you read through the module, and *prior* to discussion with colleagues.

Developed in collaboration with:

The Foundation for Medical Practice Education
La Fondation pour l'éducation médicale continue



CASES

Case 1: Paul C., 1st year resident

Part 1

Paul C. is nearing the end of his four-month rotation. He has been approaching you with appropriate management questions during the clinic, with case discussions and chart reviews taking place at the end of the day. Paul usually raises one topic for in-depth discussion.

During the clinic today, Paul approaches you for advice on how to manage an asthmatic patient with a cough. He briefly reviews the history and findings: a 10-year old patient of yours, a girl who is a known asthmatic, no admissions for asthma, uses inhaled steroids only when asthma flares up and salbutamol (Ventolin®) whenever needed. Her asthma has generally been well-controlled. She comes in once a year to review her regime; there have been no changes in medications in the past three years. The complaint now is a non-productive cough for the past three weeks. It started with cold symptoms which have now resolved. The cough is worse at night and in the morning. Exertion makes no difference. Other family members shared her cold, but she is the only one coughing now. Physical examination is normal.

Paul thinks the patient has bronchitis and wants to prescribe antibiotics. However, he wants to check with you because he's unsure. Based on Paul's description, you are confident that the cough is related to the girl's asthma, and would be best treated by increasing her asthma medications.

How would you manage the situation with Paul?

What factors will influence your decision about the timing of feedback?

Opening Lines: What would you actually say to Paul at this point?
(Please write your response verbatim in box.)

How would you use the principles of feedback to guide a discussion later in the day?

Part 2

Two weeks later, during another end-of-day chart review, Paul describes a child, age eight, whose mother complained that he had been coughing non-stop for the past two weeks. He initially had a fever, but no longer, and was otherwise well. The mother wondered if antibiotics might help. Paul explained that antibiotics don't usually help, and recommended a dextromethorphan cough syrup (Robitussin® 1 teaspoon qid). You note that this child's medication list contains salbutamol (Ventolin®) and fluticasone (Flovent®) prn, even though asthma is not listed as a current problem.

You wonder why Paul, an above-average resident, would do this after your detailed review of asthma in children (including the importance of increasing inhaled bronchodilators and steroids in an acute flare-up) only two weeks prior.

Why do you think this happened?

What would be your thoughts and reactions?

Opening Lines: What would you actually say to Paul to start this discussion?
(Please write your response verbatim in box.)

Part 3

Through your discussion, you clarify that this child is asthmatic and that Paul realized that at the time of the visit. You also discover that Paul does not believe that inhaled steroids are helpful in an acute situation and may have significant adverse effects.

Opening Lines: What would you actually say to Paul to address his poor judgment in treatment of this child? (Please write your response verbatim in this box.)

With encouragement, she says she does feel less than confident about issues of practice management, particularly prioritizing and efficiency.

You both agree that she will discuss any such cases with you the same day, and that you will observe her during a couple of patient interactions. Several days later, while watching her with Mrs. B., you observe that her history-taking technique is primarily rapid-fire questions and you wonder if she has made up her mind prematurely about the etiology of the patient's problem.

Case 2: Tricia L., final year resident

What are the steps that you would take in discussing this issue with Tricia?

Part 1

Tricia L. is in her last year of training. You have worked with her for several weeks, and it appears that she is performing well in most areas. Support staff and colleagues are very positive about her – she is pleasant, efficient and keeps on schedule. You review her charts at the end of the day, and have identified no major knowledge gaps.

Opening Lines: What would you actually say to initiate this discussion with Tricia?
(Please write your response verbatim in this box.)

However, Tricia seldom comes to you for feedback or ideas about patient management. She seems to prefer to work independently and, with the busy nature of your work, this has been comfortable for you too. You are beginning to wonder if you have anything to offer her educationally.

Why might Tricia seem to prefer working so independently?

What factors would help you decide whether to have this discussion while the patient was still present, or in private at the end of the day?

How could you most comfortably address your uncertainty about contributing to her educational progress?

Part 2

At the end of the day, you comment to Tricia that you have noticed she works very independently. She tells you that she is preparing to go into practice for herself, when she won't have a teacher nearby. As well, since she is close to completing her training, she feels comfortable with most of the problems that she has been seeing.

INFORMATION SECTION

1. Although feedback is the focus of this module, it is only one of several key tools described in the literature on ambulatory teaching. Others include:^{1;2}
 - priming – brief orientation of learner to patient and task immediately prior to patient visit;
 - questioning – using open-ended questions to promote learning (e.g., “Can you explain how...?”);
 - encouraging reflection – thinking about/describing what was learned and how this links to doing; and,
 - modeling by preceptor – observation of teacher in action, complemented by discussion/explanation.
2. Feedback is the most common teaching tool discussed (and studied) in medical education literature.
3. Within the clinical setting, feedback refers to the ongoing provision of information to learners about their performance in a given clinical activity to guide and improve future efforts.³
4. It is important to distinguish between feedback and evaluation.³
 - Feedback is about presenting information, not forming a judgment. It is a fundamental *part* of the learning process and is intended to help a learner attain learning goals. It is comprised of “neutral”, non-judgmental statements.
 - Evaluation is usually provided *after* the learning process and is a judgment about a learner’s overall performance. Feedback can be included with assessment.
5. The proper provision of feedback “can accelerate and facilitate learning.”⁴
 - a. Clinical clerks in pediatrics who received feedback on videotaped interviews performed far better on their subsequent interviews and exams as compared to students who received no preceptor-guided feedback or students who made only self-guided critiques. The difference was observed for both interview and exam skills but was twice as great for interview skills.⁵ These results are consistent with another RCT which showed that clerks in a psychiatry rotation made statistically greater gains in techniques when given feedback with either videotape or audiotape review.⁶
 - b. When attending physicians are given feedback on their teaching skills, there is a high rate of change, once changes are agreed upon.⁷ If physicians do not agree with the recommendations in the feedback, change does not occur.⁸

6. Appropriate and consistent feedback can strengthen the preceptor/learner relationship and promote effective learning.^{4;9;10}
 - a. In a study of family practice residents, constructive feedback was rated second only to clinical competence as an important element of effective teaching.¹¹
 - b. Immediate feedback, during an Objective Structured Clinical Exam, had a calming effect, and made the process more enjoyable for learners and examiners.¹²
7. By providing effective feedback, preceptors can model to learners how to give feedback to patients.⁴

Current Practice

8. Feedback is commonly omitted or improperly managed within medical education.^{3;13;14}
 - a. Feedback is incomplete, overly general or given too late within the learning process to be helpful.⁴
 - b. Delays in preparing and communicating feedback are widespread, particularly if that feedback is negative.¹⁵
 - c. In a survey at two U.S. medical schools, preceptors consistently reported that their feedback was far more frequent and helpful than their students believed it to be.¹⁶ Another survey found that medical students gave preceptors the lowest score for “provides direction and feedback.”¹⁷
9. Direct observation of learners (a key component of effective feedback for development of skills) is not routine, with both students and residents rarely being observed performing basic bedside clinical skills.^{14;18;19}
10. Without appropriate feedback:^{3;4}
 - the anxiety and fear of learners newly exposed to the clinical environment may be heightened;
 - mistakes may remain uncorrected so that poor clinical skills persist;
 - positive attributes may be eliminated, as they are not reinforced;
 - learners may form incorrect assumptions that impede learning (e.g., learners may believe they are performing poorly when they’re not or, conversely, assume they are doing well when they’re not); and,
 - learners’ competence may not grow at the same rate as their confidence (experience alone has been associated with increased confidence but not with increased competence).²⁰

Barriers

11. Being aware of the barriers to giving effective feedback is the first step to overcoming them.²¹
12. Since many physician preceptors have received little, hurtful or no feedback in the past, they have few models of effective feedback for guidance.^{3;4}
13. If learners have experienced hurtful feedback in the past, they are likely to be unreceptive to feedback from a new preceptor.⁴
14. Learners are less likely to accept and act on feedback from a teacher whom they perceive to have a low level of knowledge or lack experience as a physician.²²
15. Preceptors may not provide feedback because they assume learners will instinctively know how they are faring; the reality is that many people are not good at self-assessment.^{4;23} This appears to be the case for practising physicians as well as learners.^{24;25} Higher achievers tend to underestimate their knowledge or performance, while low achievers tend to overestimate it.
16. Learners tend to disregard feedback from preceptors who have not observed their performance,²² yet obtaining data from first-hand observations of the learner in action is often neglected.^{3;26} (See Appendix 1 for tips on incorporating direct observation into clinical teaching).
 - a. Even observing the learner a limited number of times may increase their receptiveness for feedback at other times when you have not directly observed them.
 - b. Other forms of “observation” (ways to gather first-hand information) include reviewing medical records and discussing cases. This can provide invaluable information useful for feedback in other areas (e.g., therapeutics and clinical reasoning). Providing feedback based on a mix of these modalities should enrich the educational experience.
17. Time pressures in a clinical practice may reduce the frequency and quality of feedback.^{1;27}
18. The challenge of giving or receiving feedback perceived as “negative” is a significant barrier.
 - a. Clinical preceptors may fear that negative feedback will upset the learner and adversely affect their relationship.⁴ They may also be concerned that a learner will resist or reject negative feedback,

and adopt a defensive stance.²¹ As a result, “the well-intentioned teacher talks around the problem or uses such indirect statements as to obfuscate the message entirely.”³

- b. Learners, on the other hand, may avoid asking for feedback, fearing negative comments about their performance.⁴
- c. “Negative” feedback is often considered as synonymous with “corrective” feedback. However, learners often greatly appreciate corrective feedback when it is seen as helpful and linked to specific suggestions about what the learner can “do differently”.²⁸
- d. When phrased in judgmental terms, learners may find feedback unfair or hurtful. Also, when given in front of others, feedback may be discounted.^{22;28}

Giving Effective Feedback

19. According to Jack Ende’s seminal paper, feedback should be³
 - undertaken with the teacher and learner working as allies with common goals;
 - well-timed and expected;
 - based on first-hand data;
 - regulated in quantity and limited to behaviours that can be changed;
 - phrased in descriptive, non-evaluative language;
 - deal with specific performances, not generalizations;
 - offer subjective data, labeled as such; and,
 - deal with decisions and actions, rather than assumed intentions or interpretations.

Ende’s guidelines, still considered the standard in teaching,²⁸ inform the preparation and delivery of all feedback (see below), helping to ensure it is well-timed, well-executed and well-received.

20. *Situated* feedback¹³ can complement *traditional* feedback (as described by Ende).
 - a. This model may be best suited to experienced learners, for exploring relationships with patients, and for complex situations.
 - b. The steps in this model are similar to those in “Feedback at a Glance” in Appendix 2, but they *start* with questions to “probe for understanding” (patient, self, context) specific to handling this patient situation. For example, “tell me how this patient feels,” then invite the learner’s self-assessment and link feedback to learning objectives.

Preparation**Trust**

21. From the outset, it is important to establish an environment of trust. This can be achieved by demonstrating you are a credible source of feedback (a qualitative study suggests that residents feel feedback has to come from credible sources to be effective²²) and by consistently treating learners with support and respect.

Learning Goals

22. A study of 69 medical students found that learners, particularly those in the early stages of their clerkship, required an interactive process for establishing goals and then subsequent feedback tied to these goals.²⁹ These findings support Ende's recommendation that learning goals need to be jointly set and meaningful for both parties.³ Goal oriented feedback has been shown to help learners appreciate that their performance will improve with practice and effort.³⁰

Appropriate Timing and Setting

23. There are many opportunities for providing feedback within the clinical setting. However, it should never take the learner by surprise. Instead, the timing, setting and scope of feedback should be negotiated with the learner, not imposed.^{3,21,31} Finding the "right time" for feedback, the moments when a learner is becoming "hungry for help" with a difficulty, is important for optimum impact.³²

24. Feedback is most effective when it is offered on a daily basis. There is some controversy about the best timing for feedback. Experimental studies suggest that if the task is difficult, then immediate feedback is beneficial, but if the task is easy, then delayed feedback may be preferable as it can enhance the transfer of these easily learned concepts to new situations.³⁰

Generally, feedback is provided as close to the observed event as possible in order to avoid forgetting important ideas and emotional elements concerning the encounter.^{3,4}

- a. Feedback can be given in an informal way immediately following a patient encounter or during a scheduled session.^{3,33}
- b. Some feedback (e.g., physical examination skills) may be provided in the presence of patients. However, larger issues are best discussed in private to avoid possible discomfort or embarrassment for the learner.

- c. Feedback is best given when the learner is not distracted by physical needs (e.g., hunger, fatigue).^{12,22}
- d. A relaxed atmosphere is key – attention to seating arrangements can be helpful.^{3,4}

Prioritizing Issues

25. While it may be tempting to share all thoughts and observations during a feedback session, it is important to avoid overwhelming the learner.⁴ Consider using the "Feedback Grid" in Appendix 4 to help provide focused feedback to learners.
- a. An effective feedback session would focus on no more than 2-3 key points, and provide a balance between those things the learner should continue to do (positive feedback), and those things he/she should do less or differently (negative feedback).³¹
 - b. Prior to the session, consider your list of issues that need to be addressed and select those of highest priority.⁴ It may be most efficient to focus primarily on simply re-teaching the area that is not being done well, rather than spending significant amounts of time in error analysis. Simple rather than complex feedback has been shown to be more effective in enhancing learning outcomes. Providing information about learning goals and how to achieve them is likely most important.³⁰

Learner Self Assessment

26. Despite its limitations (Info Point 15), the learner's self-assessment is the most effective way to begin feedback sessions. "The more observations you can elicit from the learner without having to impose your own critique, the more helpful you are likely to be."⁵
27. You can invite the learner to assess their own performance by asking a question such as: "How do you think it went?" Encourage the learner to be as specific as possible.⁴ To move the discussion along, you might then ask: "Which parts do you think went well?" and "Which parts do you think could be improved?"³

Supervisor/Preceptor Feedback

28. The mentoring relationship between the preceptor and the learner sets the stage for effective feedback.^{32,34,35} Learners particularly value preceptors who are available and open to questions, are honest and enthusiastic in their teaching, delegate appropriate responsibility, and ensure a "safe haven" for self disclosure.³⁶

29. Using the “sandwich approach”, start *and* finish your feedback with positive, specific observations about what the learner should *continue* to do.
- By giving positive feedback first, the learner will likely be more open to subsequent suggestions about things to do less or differently.²¹ Even a comment about one positive aspect of an otherwise poor performance can be helpful.⁴
 - In a hypothetical exercise, subjects indicated they would make a greater effort in future when they received positive feedback compared to when they received more negative comments.³⁷

The Perils of Positive Feedback³

Even positive feedback has its pitfalls. A steady stream of praise can be “addicting” for the learner. Furthermore, statements such as “You were terrific with that last patient” are not specific enough to reinforce effective behaviours. It is preferable to encourage a learner’s pride in a job well done, by saying: “The way you leaned toward the patient and made good eye contact while asking questions really helped the therapeutic relationship.”

30. Discussion of what the learner might want to do differently should be as specific as possible, and focus on behaviours that can be modified.^{3,4} Providing brief written notes can improve the specificity of the feedback.³⁸
31. The feedback should deal with the actions of the learner, rather than his/her assumed intentions – observations of actions are more accurate and will facilitate the delivery of negative feedback. For example, it is preferable to say: “The antibiotic regimen you chose did not provide coverage for enterococcus.” rather than: “Your choice of antibiotic indicates a lack of appreciation for the possibility of enterococcal infection.”^{3,4}
32. Learners at the beginner level may benefit more from more directive feedback (providing corrective information), while more advanced learners do better with facilitative feedback (emphasis on guidance and cues).³⁰

Follow-up Plan

33. After providing feedback (particularly if it’s negative), a follow-up plan is vital, as meaningful change will not likely occur with only one intervention.⁴

It is important to suggest practical strategies for resolving problematic issues and help the student develop a specific plan to carry them out.^{4,21,39}

THE BOTTOM LINE

- Feedback is a critical component of effective learning in clinical situations.
- Both learner and preceptor barriers can hamper the provision of appropriate feedback.
- Feedback, like any skill, can be improved through preparation, practice and using a systematic approach.

CASE COMMENTARIES

Case 1: Paul C., 1st year resident

How would you manage the situation with Paul?

You might flag this issue as important and suggest a more detailed discussion at the end of the day. Or, you may choose to deliver the feedback on the spot (see Talking Tip below) followed by a detailed discussion later.

What factors will influence your decision about the timing of feedback?

What would help you decide whether to deliver feedback immediately? Some factors may include time limitations (e.g., you and/or the resident is too busy at that moment or patient status requires urgent action) and whether the environment is appropriate for giving feedback. Privacy may be important in this case (Info Points 23, 24).

“Opening Lines”- Teaching on the Fly

(If time is short but you opt for some immediate feedback)

“I’m glad you came to discuss this. These cases are often tough to figure out and it sounds like you’ve recognized this. You want to give antibiotics, and this suggests that you probably think an infection is the cause of her cough. But, from what you’ve told me, I think it is more likely that her recent cold has caused an exacerbation of asthma. Why don’t we increase the inhaled medications for her asthma? Then, we’ll talk about it more at the end of the day.”

How would you use the principles of feedback to guide a discussion later in the day?

You might begin by referring back to your suggestion that you agreed you would talk about the patient with asthmatic bronchitis. (At this point, you might ask if there is anything else from the day that he’d like to talk about. If so, it may be best to deal with these issues first.)

The discussion would ideally begin with Paul’s self-assessment (Info Points 26, Appendix 2). This could be initiated by asking: “Why do you think you were unsure?”, “What was going through your mind?” or “You gave me a clear, concise picture of this patient and you were seriously considering a treatment option, yet you were

holding back. What about this situation was making this choice problematic?” This line of questioning may tap into what treatment options he considered and what he knows about antibiotics vs. bronchodilators vs. steroids for persistent cough. It may also uncover his emotions about not knowing how to approach the case, and other pressures that influenced his treatment decision (e.g., parental expectations).

When providing *your* feedback, be explicit about the positives (Info Points 28, 29) – for example, that he appears to be in tune with his uncertainty, took a thorough history, and that you trust his physical assessment.

You would likely spend some time discussing the management of asthma in children, evidence for inhaled bronchodilators and steroids and against antibiotics, and cough as a presenting symptom of poorly controlled asthma. In addition, you might encourage Paul to consider a higher inhaled steroid dose in a growing child whose asthma no longer responds to previously effective treatment. Providing or suggesting a good reference can help, and will supply him with reading material that may consolidate his learning further.

Part 2

Why do you think this happened?

You might assume he has forgotten the last case or, perhaps worse in your mind, ignored your feedback altogether. It is important to remember that there may be a whole host of reasons for his actions and that these are only two possibilities – both of which may be incorrect.

What would be your thoughts and reactions?

In light of the detailed discussion you had with Paul two weeks ago, you would probably feel disappointed. You may feel anxious about delving into these issues and reluctant about possibly giving feedback he will interpret as negative (Info Points 12, 13, 18). However, having established a positive mentoring relationship during the weeks that he has worked with you should make this less worrisome (Info Point 28).

Opening Lines: What would you actually say to Paul to start this discussion?

You could deal with your disappointment and reluctance by exploring what was on Paul’s mind (Info Point 26). You might ask: “What did you think was going on?” or

“Recalling our discussion about post-infection cough and asthma two weeks ago, how else could you have handled this?” (Info Points 27,29) This would help alleviate any discomfort and allow the discussion to unfold in a positive way. Importantly, it would enable you to comment on his actions, rather than assumed intentions (Info Point 31).

The reasons behind his medication choice may have been something simple – Paul may not have done an adequate chart review or the medication list may have been buried, so he did not realize this patient had asthma. Keep in mind that it is difficult for a resident or learner to know the history of every new patient.

If Paul did know that the little girl had asthma, you might encourage him to reflect on what he was considering in terms of management strategies by asking: “You recommended a cough syrup. What other possibilities did you consider?” This would help you to understand his thinking about the place (or lack thereof) of inhaled steroids in asthma management. If Paul didn’t consider steroids, you could then ask: “Did you think about inhaled steroids?” If he disagrees with your opinion on inhaled steroids, this question could well uncover it.

Part 3

Opening Lines: What would you actually say to Paul to address his poor judgment in treatment of this child?

To put this into context, you might think about the kind of relationship you have with Paul – does he usually accept your views or have there been differences of opinion previously? The answer could well guide your plan to resolve the issue, just as the prior relationship with a patient influences the approach to potentially sensitive areas in patient care.

Some learners prefer to be led by questions (e.g., “What does the current literature say about the role of inhaled medications in asthma?”) while others would choose to be given feedback more directly. (“After our discussions about treatment of cough in asthma, I am puzzled by the fact that you recommended a cough suppressant rather than increasing the inhalers. Can you help me understand your thinking?”)

Allowing the learner an opportunity for debate and discussion may help both parties understand each other’s thinking and, perhaps, develop new perspectives and knowledge. In all cases it is important to avoid having the learner feel personally criticized as this may lead to the learner discounting the preceptor’s recommendations (Info Point 18).

However you handle it, a follow-up plan would be important in helping Paul to make a meaningful change in his use of inhaled steroids (Info Point 33). You might both decide to do a literature review together to arrive at an evidence-based answer. Alternatively, you might talk to a specialist whom you both respect. Whichever option is chosen, you would be demonstrating a commitment to expanding your knowledge as a lifelong learner.

The Real Story

In the actual case with the first patient, the physician preceptor had provided immediate implicit feedback without specific reasons by stating: “This patient needs his inhaled steroids.” The resident perceived the preceptor as being overly eager to prescribe steroids and didn’t “buy” his recommended management the first time. This resident hadn’t looked at the evidence for the benefits of steroids, but was extremely aware of the potential risks.

The preceptor concluded that he hadn’t provided appropriate feedback the first time to adequately convince the resident about steroid use. “The resident perceived me as biased and, in that interaction, I wasn’t a respected source of feedback.” As a result, the resident chose not to prescribe it for the second patient. In a subsequent feedback session, they both agreed to review the literature and, later, the resident came to appreciate the appropriate role of both inhaled steroids and bronchodilators in asthma.

Case 2: Tricia L., final year resident

Part 1

Why might Tricia seem to prefer working independently?

There are many possible explanations:

- Tricia is very competent and functioning highly.
- She has incorrectly concluded she does not need feedback, because:
 - she has overestimated her performance (Info Point 15); and/or
 - she feels confident that her skills have been well-honed through experience (Info Point 10).
- She is avoiding feedback because she is worried about receiving negative comments on problem areas (Info Point 18).
- She had an unpleasant experience with feedback in the past and is not eager to repeat it (Info Point 13).
- She might not perceive you as a trusted, respected

preceptor (Info Points 14, 16, 28). Sometimes this can be due to a conflict of personality/style.

- She might simply assume that this is what she is supposed to be doing, because there has been little or no discussion about feedback expectations and personal learning goals.

How could you most comfortably address your uncertainty about contributing to her educational progress?

Like any feedback session, you would first invite Tricia's self-assessment (Info Point 26, Appendix 2), by asking: "Do you have any areas that you would like to work on?" It may help to emphasize to her that all physicians, including yourself, have areas they feel less comfortable in.

You might then plan a mutual chart review, with both of you bringing challenging cases for discussion. The cases Tricia brings may be instructive (e.g., bringing only "bread and butter" cases may indicate that she is reluctant to share those she struggled with).

By discussing the cases you struggled with that day, you would get a sense of how she would handle them. You would also be modeling that you continue to struggle with some cases. This might open the door to a discussion about why she has not been coming to you with questions

Part 2

What are the steps that you would take in discussing this issue with Tricia?

First, it would be important to acknowledge to yourself that, as a teacher, you always have something to offer. The key is to elicit the learning needs and goals in concert with the learner. If this was not done with Tricia at the beginning of her stay in your practice, then it could be done now. It's never too late to develop an educational plan.

Opening Lines: What would you actually say to initiate this discussion with Tricia?

You could begin the discussion with Tricia's self-assessment (Info Point 26, Appendix 2). You might start with a general probe like, "Tell me about your visit with Mrs. B." A more specific question [such as: "How do you think your encounter went with Mrs. B.?" or "What surprised (puzzled) you most about the encounter with Mrs. B.?" or "What do you think went well with that patient, and what would you like help with?"] may be

appropriate to bring out Tricia's impressions. She may be unaware of her deficiencies in this area, so may not raise the issue herself. As you have now observed her "in action", you could probe her thoughts on her interview style by asking: "I noticed the patient brought up a new problem as you were wrapping up the visit. Do you have any thoughts about why this happened?" or "You were doing well with keeping on schedule; time management is important. Can you see any pitfalls with concluding early on the direction of the patient's problem?" Try to avoid covering too many issues (Info Point 25).

You could then offer some feedback about how she might do this differently. You might discuss how it is a tremendous skill to conduct an interview that has some depth, but is time efficient as well. Like other skills (playing a sport or a musical instrument), it needs to be honed through experience ("practice") with feedback or critical reflection. You could offer to share "tips" with Tricia, about how you have learned to handle such situations. You might also do a brief role-play in which she takes the part of the patient and you demonstrate how you would do the interview. Discussing a follow-up plan would be an important part of this meeting to ensure that she improves her interviewing skills (Info Point 33).

What factors would help you decide to have this discussion while the patient was still present, or in private at the end of the day?

It can be a challenge to decide when it is best to deliver feedback. If this was a minor issue (e.g., performing a clinical exam) you might do it in front of patient. However, it is likely that Tricia's history-taking performance would be best discussed in a private setting (Info Point 24).

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We encourage you to direct your questions and comments to the clinical discussion bulletin board on our Web site: www.fmpe.org

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Incorporating Direct Observation into Clinical Teaching

One-way mirrors and video equipment are not necessary to observe learners' interactions with patients. Sitting in the corner of an exam room while the learner is talking to or examining the patient can be very revealing.

Explain to both learner and patient that you are going to observe, and will not participate in the interview/exam at this time. ("Just imagine I am a fly on the wall.")

- Keep quiet – learners and patients will forget about your presence.
- Avoid eye contact with the patient, and turn first to the learner when addressed by the patient.
- Try to observe different parts of different interactions (e.g., introduction, information gathering, examination, explanation). It often is comfortable to join the learner only for these parts of the visit.
- Keep observations short – a lot can be discovered about a learner in only a few minutes.

Patients can be asked to provide feedback directly to the learner, but be careful not to undermine the learner's credibility with your comments.

Use other natural opportunities to "observe" the learner. For example, overhearing his/her conversations on the phone, in the corridor, or in the hospital room with patients and staff.

If you have video equipment, it does offer many advantages. It is often less obtrusive; learners have a chance to see and hear what they actually did; feedback can be delayed without losing the essence of the situation; etc.



Feedback at a Glance

ESSENTIAL STEPS OF A FEEDBACK SESSION

- Plan appropriate setting and timing
- Prioritize key issues for discussion
- Invite learner self-assessment (thoughts & feelings)
- Provide feedback and suggestions (continue, change)
- Develop follow-up plan

Adapted from: Runions J, Wakefield JG, Craig H. *The Essentials of a Feedback Session*. Programme for Faculty Development, Faculty of Health Sciences, McMaster University, Hamilton, 1991 (rev 1994).

Guide for Giving Feedback:

Preparation

- Establish and maintain an appropriate climate of trust and support
- Ensure location and timing of feedback is appropriate and sensitive to learner's needs
- Discuss and agree on learning goals for this situation

Action

- Directly "observe" (i.e., gather first-hand information about) the learner's performance
- Invite the learner's self-assessment
- Link feedback to learning objectives and to observations
- Use non-judgmental language
- Focus on behaviours that can be modified
- Limit discussion to 2-3 points ("right amount")
- Balance positive and negative feedback ("PNP sandwich")
- Elicit methods for improvement from learner **and** offer suggestions for improvement
- Arrange follow-up

Adapted from: Ende J. Feedback in clinical medical education. *JAMA* 1993;250:777-781 and Westberg J, Jason H. *Collaborative Clinical Education: The Foundation of Effective Health Care*. New York: Springer Publishing, 1993.



Trying It Out

Role-playing during the PBSG session

In teaching, just as in clinical work, it is important to go beyond discussion of new ideas or approaches. Integration works best by trying things out. Try applying the principles of effective feedback through some role playing activities during the session.

THE GOAL

The goal of a feedback role playing activity is to allow participants the chance to rehearse different approaches to feedback, and to learn from the experience and skill of others through observation and discussion.

SET UP

Divide up into smaller groups of three or four people. Depending on the size of the group (and the room), more than one role play can take place simultaneously. One participant takes the role of the preceptor and another the role of learner. The other participant(s) act as observers.

Participants can choose a feedback situation that they were involved in, or choose one from the examples below. It is often best if the person playing the learner imagines themselves as a student or resident with whom they have worked personally (i.e., assume that learner's characteristics and persona). For the purpose of the role play, details can be fleshed out or altered as required (e.g., depending on the needs of the group, the learner can be "programmed" to portray different characteristics or responses). The preceptors "play" themselves, but practice or experiment with new ways of giving feedback. Ideally, the preceptor and learner participants know only their own individual script until after the role play is completed.

The preceptor and the learner should determine the place and timing of the feedback session before beginning the role play. Decide how long the role play should go before stopping for discussion – usually no longer than five minutes. The observer(s) should then be prepared to comment on the manner in which the preceptor handled the situation using the principles of effective feedback, then open the discussion to all participants.

In some situations, after a time-out and discussion, different participants may assume the preceptor and/or learner role and "replay" the situation using a different approach.

SUGGESTED SCENARIOS

Scenario 1: The Misdirected Call (The telephone call that results in an ethical challenge)

The Learner:

You are a learner working in an ambulatory setting. One of your duties is to review all the laboratory results that come in that day. Last night you were running late in the office, and then had a large number of results to deal with before you could go home. Luckily, some of the patients had voice mail; and when you recognized the patient's voice on the answering machine, you left a message with the results.



The Preceptor:

One of your patients called this morning very upset; in fact, in tears. She is a 20-year-old unmarried student who lives with her mother. She came in two days ago because her period was late and she feared she was pregnant. A pregnancy test was ordered, and last night the resident who had seen her left a message on the voice mail to say that the pregnancy test was positive. Her mother picked up phone messages, and the patient is distraught.

Scenario 2: Nothing More to Do (Handling a first-trimester miscarriage)

The Learner:

You are a resident. You were on-call last night, and received a page around 1 AM from the husband of a woman who is nine weeks pregnant and bleeding. You talked for some time on the phone with the husband and then with the wife. You assessed that everything was stable and that they were prepared that she might miscarry. You discussed the danger signs and when to call back. Your care was medically appropriate — you assured the wife of this, and she seemed content to visit her regular family doctor tomorrow morning. You then spoke with the on-call supervisor, who was satisfied with your planned approach. You were relieved, as you had been up much of the night before because your two-year-old daughter was quite ill.

The Preceptor:

During your morning office, a husband and wife come to see you. The woman was nine weeks pregnant and started bleeding last night. They called and spoke with the resident doctor on-call. They had a long discussion on the phone, but after that the wife's bleeding continued and ultimately she had a miscarriage during the night. Her husband tells you that he is upset because he wonders what might have happened if the doctor had visited last night. With discussion, he realizes that no medical attention would have prevented his wife's miscarriage. However, he indicates that he wishes there had been an offer to see them — it would give them more peace of mind now.



Feedback Grid

This grid provides a framework for feedback. Use it to identify and highlight two or three useful points to guide future work — it is not necessary to write something in all four quadrants.

<p>Continue.....</p> <p><i>Comment on aspects of performance that were effective. Be specific and describe impact.</i></p>	<p>Start, or do more.....</p> <p><i>Identify behaviour the learner knows how to do, and could do, or do more often.</i></p>
<p>Consider.....</p> <p><i>Highlight a point of growth for the learner, a “doable” challenge for future interactions.</i></p>	<p>Stop, or do less</p> <p><i>Describe actions that were not helpful, or could be harmful. Be specific, and indicate potential impact.</i></p>

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Modified from the Coaching Feedback Format, Bayer Institute for Health Care Communication.



Reflections and Plans

How this session will influence what I do in the future.....

1. Key take-home message(s) for me:

2. As a result of this session, I am:

Definitely planning to change my approach to giving feedback to learners in the future.
Please note specific examples and identify any potential barriers to making the change(s):

Considering a change in my approach to giving feedback. *Please note specific examples:*

Encouraged to continue some of what I already do when giving feedback to learners in my practice environment.
I plan to continue or do more of the following:

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