University of Massachusetts Medical School
UMASS

Feedback

Purpose of Feedback

A. Ensure that the learner improves while at the same time maintaining self-respect

1. Self respect and confidence allow the learner to take chances; to try new things. It enables them to participate in conferences and to offer their own ideas, plans, and suggestions. It enables them to question team leaders.
2. Curiosity, self respect, and confidence, produce chemicals at the synaptic level that enhance transmission of electrical impulses, therefore enhancing learning, whereas low self-esteem actually inhibits transmission.

Types of Feedback

A. Formative feedback (FFB)

1. Feedback designed to help the learner improve.
2. The earlier the feedback is given in the rotation, the greater the chance the learner has to fix the problem.
3. FFB could occur after a single interaction, e.g., an observed history, physical, oral presentation, or write-up. Because of time constraints, this kind of feedback is usually aimed at something that is fairly easy to fix, e.g., "Here is how to examine someone with suspected appendicitis."
4. FFB could occur weekly or at other defined intervals designed to review how things are going and then review *methods* for improving. It could also be used to correct a more serious or more complex issue, e.g., a learner with poor problem-solving skills or a learner who is annoying the team. This is a good time to *strategize*.

B. Summative feedback

1. Usually occurs at the end of a rotation, e.g., a final exam or the feedback given to the learner on the final clerkship evaluation. Theoretically all feedback is formative since the learner could grow from the feedback supplied at the end of one clerkship and apply it to the next clerkship, but they can no longer improve on *this* clerkship.
2. An interview with St. Peter at the Pearly Gates is probably the only true summative feedback.

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Barriers to Giving Feedback

A. The number one barrier stated by many people is **time**. Although giving feedback clearly takes some time, consider the following:
1. Feedback is teaching and teaching is our job (or one of our jobs).
2. It is OK to prioritize. We don't have to "fix" all of the learner's problems on each encounter any more than we would try to fix every issue a patient has on each of their visits.
3. In the long term, giving feedback may actually save time. A learner making the same mistake throughout the clerkship is not time effective let alone good for the patient.

B. "I don't want to be the bad guy."
1. Learners actually tell us they want feedback and they don't feel they get enough.
2. Learners rate teachers who give high quality feedback very highly.
3. By using skills and the "language of feedback" you will likely look "good" to the learner and not look like the bad guy.
4. If you *want* to be a bad guy, just tell the learner they are doing fine and then give them a poor grade at the end.

C. "I don't know how to give feedback. This was not a medical school course."
1. True! This handout and workshop should help.

Efficient and Effective Methods to Give Feedback

A. The first day sets the stage for the entire rotation:
1. Go over your expectations. The easiest thing to do is to develop a handout and give it to the learner on the first day.
2. Go over the expectations and goals of the learner. A learner who was a midwife before going to medical school may not need to attend a lot of deliveries. Although this is a somewhat extreme example, all learners have skills and have areas that they need to work on.
3. Go over expectations for feedback. "You are going to receive feedback every time we see a patient together, read a write-up, etc."
    a. Additionally, I want to sit down with you at the end of every week so I can give you feedback and you can give me feedback regarding how well we are meeting your learning objectives.
    b. "You need to understand that I LOVE mistakes. Every time you make a mistake, I know exactly what to teach you. Additionally, mistakes are expected. If you don't make any mistakes then you should be teaching this course or I am not giving you material that is challenging enough for you. If that happens you can be sure that I will rectify that."

B. Steps in feedback:
1. **CALL IT FEEDBACK** or they won't think they got feedback!

2. **Encourages self-assessment**
   a. Consider beginning with asking the learner how they think that encounter went (or the rotation is going). Sometimes this is very rich and other times it's not. It also allows the learner to say that "xyz" did not go well which means that they self-identified and it easily opens the door to feedback. Other ways to get learners to self-assess:
      i. "Were there any parts of that encounter that were particularly challenging?"
      ii. "Whenever I leave a room I always think of things I should have asked, or should have done, or wish I did not do. I wonder if you had any of these thoughts?"
      iii. "We have a few minutes to chat now. What would you like to go over?"
3. **Covers positives and negatives**
   a. Clearly we will correct or discuss the areas the learner could improve upon.
   b. Also cover some of the areas the learner did well because:
      i. This supports self-esteem
      ii. This reinforces what they did well so they will keep doing it or even recognize that it is valued and work on improving it.
4. **Refer to specific, observed behavior**
   a. When we comment on the "person", e.g., "You were not sensitive to the patient's needs", we run the risk of triggering a defensive posture in the learner, which will make the feedback session long or ineffective. If there is no reference to what the learner did to demonstrate poor sensitivity it is unlikely the learner could improve it.
   b. It is better to comment on the observed behavior. The observed behavior is just a fact. It is what happened. It is not really up for debate. For example, "I noticed that when the patient said, "It has been a really tough week", you responded by asking, "How are your headaches doing?"
      i. First, this is a factual statement.
      ii. Second, the learner may not have even been aware that it occurred. Your pointing it out is the first step in remediating this problem.
      iii. Third, it is much less likely to trigger a defensive posture.
   c. Use **the "Language of Feedback" – "I" statements**:
      i. "I noticed…."
      ii. "I wonder…"
         - "I wonder what made you decide not to address the smoking in this situation?" It may be that the learner had a good reason. It could be that they were overwhelmed or sidetracked or had some other reason, but either way, by learning the reason it occurred leads to a focused solution.
      iii. "I'm curious…" Teachers do well when they are curious, not furious. When we are generally curious we avoid making assumptions, and we take a "learner's stance" enhancing our ability to go beneath the surface and learn *why* a mistake was made, not just *that* a mistake was made. Once we know why it was made, a solution is much easier to elicit.

5. **Limited in the amount**
   a. It is hard to take in more than one or two or three things to improve upon in one sitting. The more complex or emotional the deficit, the less one can take in during a single session.
6. **Timely**
   a. The closer to the event, the more powerful the feedback.
7. **Occurs in an appropriate place**
   a. Many things can be fed back to learners in front of others. Thus, rounds are a good place to give feedback that everyone could benefit from. Examples might include:
      i. "This is how I would like the oral presentation organized."
      ii. "It is important to begin an oral presentation with a statement that contextualizes the patient, "45 yo male with Type II DM presenting with chest pain."
   b. Certain things require some privacy.
8. **Ends with an action plan**

Action Plan

A. Definition:
1. The action plan is a Method used to correct a gap found between a learner's *actual* performance and their *expected* achievement (our course Objectives).
2. It is a solution to a problem.

B. Reason for action plan:
1. To improve performance by using *explicitly stated* objectives and strategies.
2. By modeling the formation of an action plan some learners will begin to self assess and self correct.

C. Preliminary step:
1. Identify the problem (best done by direct observation):
   a. Observe learner with patient.
   b. Listen to learner's presentation of patient.
   c. Case discussions with learner.

D. Components of an action plan (GNOME):

Goal (learner's educational Goal)
Needs assessment
Objectives
Methods
reEvaluation

1. **Goal**:
   a. A "potential" problem is obtained from our observation of the learner.
   b. This *may* be what we want to fix but we will not know for sure until we do a needs assessment.
   c. If it *is* a problem, it then becomes the learner's educational goal

2. **Needs Assessment**:
   a. First decide if the "potential problem" is, in fact, a problem. If it is, then find out *why* it's a problem. Is it a knowledge, skill, or attitude problem?
   b. Before proceeding secure agreement with the learner that this is a problem worth working on.

3. **Objectives**:
   a. Objectives follow from Needs.
   b. Objectives need to be explicit and shared with the learner.

4. **Methods**:
   a. Follows from Objectives.
   b. Collaborate with the learner.
   c. Design the method with the specific objective in mind.
   d. Design the method with the learners learning style in mind.
   e. Design the method knowing what resources are available.

5. **ReEvaluate**:
   a. Summarize what has been discussed. Preferably the learner does this.
   b. Set up a specific time and method to re-Evaluate.

Example:

You have just observed a resident dealing with a family who has a child with attention deficit hyperactivity disorder. The resident did a nice job with the history and physical exam. S/he discussed the diagnosis with the family and explained the neurophysiology of the condition very well. Treatment options were also discussed including educational strategies and behavioral strategies. It was then that you noticed there was no mention of stimulant medications.

Where do we go from here? The following is a dialog between the Preceptor and the resident:

Preceptor: I would like to give you some feedback on your treatment plan for this patient. Is that OK with you?

Resident: Sure.

Preceptor: Did you accomplish everything that you wanted to accomplish?

Resident: Yes. I thought it went well.

Preceptor: I noticed you did a great job demystifying this condition to the family and presented the educational and behavioral strategies beautifully. I'm curious, however, that I did not hear any mention of stimulant medications. What are your thoughts about that?

The Goal has been identified: One needs to discuss stimulant medications with *anyone* that is newly diagnosed with ADHD.

Resident: It's true I didn't mention it. I was sort of nervous to do that because the nurse told me before I went in that the family is adamant about not "drugging" their child. I didn't want to jeopardize my relationship with the family and besides, I really don't know how to bring up stimulants in the context of a family who does not seem to want to discuss it.

Preceptor: What is your understanding of the use of stimulants including why they are used and how they are used?

Resident: I have an excellent understanding of that. I spent a week with Dr. Pietry in her ADHD clinic. But we never had a family that was so against medication.

The Need has just been identified. It is not that this resident doesn't *understand* stimulants or doesn't *think* they are evil, rather they don't know *how* to have the discussion in this context. The have a *skills* need.

Preceptor: I see. Now this makes sense to me. I agree with not jeopardizing your relationship with the family and I also know that it is our job to educate the family about what works and what doesn't. So it seems to me that the issue is, "*How* do we discuss something with the family when they have already made up their minds." Does this seem right to you?

Resident: Yes. This comes up in other circumstances as well, like with immunizations.

Preceptor: Exactly. My philosophy in this situation is as follows:

1. Be respectful.
2. It's my job to educate, not force them (or bully them) to take the medication.
3. I accomplish this by using an Ask-Tell-Ask approach. Do you know about that?

The preceptor has essentially just outlined the objectives.

Resident: No. I've never heard of it.

Preceptor: I will give you an article to read on Ask-Tell-Ask. I want you to read it but to also think about how you will apply it to this situation. How does that sound?

Resident: It sounds OK. I can read the article but whenever I read about how I'm supposed to talk to a patient it doesn't work that well. It works better when I can see it done and practice it.

Preceptor: I agree. Read the article so that you have the concepts and then I can model it for you and then we'll do some role-playing before you try it with patients. Is that comfortable?

The methods have now been identified.

Resident: Absolutely.

Preceptor: When can you have this article read, including thinking about it's application?

Resident: Is Friday OK?

A time for Re-Evaluation has been identified.

Summary of Steps in Feedback:

1. Encourages self-assessment
2. Covers positives and negatives
3. Refers to specific, observed behavior. Uses the "language of feedback"
4. Limited in the amount
5. Timely
6. Occurs in an appropriate place
7. Ends with an action plan

Summary of Action Plan:

1. Goal: Identify a problem and get agreement.
2. Need: Break down the problem to see what the learner actually needs.
3. Objective: In a set amount of time the learner will be able to....
4. Methods: Match the methods with the objectives, the learning style, and resources.
5. reEvaluate: Set a time to reevaluate.

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