Update in
Anaesthesia

Feedback in Medical Education is a Journey; Pack More than a Sandwich

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doi:10.1029/WFSA-D-21-00008

Abstract

The exchange of feedback between learner and teacher is a critical component of medical education. Effective feedback allows for sustained performance improvement over the continuum of training. Despite the importance of feedback in the development and growth of medical learners, the skillful provision and delivery of feedback remains a daunting task for most medical educators. Medical educators are often poorly trained to deliver effective feedback and suffer from a lack of education in feedback theory. Additionally, educators must also recognize and remove barriers to effective feedback exchange. Institutional culture and learner expectations further complicate the feedback conversation. This review seeks to provide a brief background on feedback theory in the medical education environment. Furthermore, characteristics of ideal feedback, barriers to feedback delivery, and tips and techniques for more effective feedback exchange are discussed. The role of the learning environment culture on feedback exchange is also explored. Effective feedback exchange in medical education remains a complex and difficult goal in the clinical environment. Nonetheless, the content of this review article may help improve feedback exchange in many clinical learning environments.

Key words: medical education methods; medical education/trends; teaching methods; teaching trends; learning; feedback

INTRODUCTION

Learning is a complex process that can be facilitated by the setting of goals and objectives, a period of teaching and practice, and then an assessment of performance with attention to improvement. The provision of regular feedback is one method to provide formative assessment. Feedback as a systematic approach of assessing results compared to desired outcomes, originated in engineering in the 1940s and then expanded into many other fields including medical education[1]. The role of feedback in graduate medical education was defined by Ende in his landmark article in 1983 as "information describing students' or house officers' performance in a given activity that is intended to guide their future performance in that same or in a related activity"[2]. The purpose of feedback is to help learners reflect on their actions with a goal of improving future performance. Learners often wish to get feedback that can aid in self-reflection and improve their performance[3,4]. However, many learners feel that they are provided insufficient constructive feedback[5,6]. Furthermore, educators often lack sufficient training to formulate and deliver effective feedback[7,8]. This review will seek to define feedback in medical education, identify the characteristics of effective feedback, discuss barriers to and provide tips for giving effective feedback.

Feedback vs. evaluation

Prior to an in-depth discussion of feedback, it is important to make clear the distinction between feedback and evaluation. Feedback is formative; it is information that is meant to be used to influence future performance at the completion of an observed performance. Evaluation is summative and seeks to provide an assessment of performance after a series of performances within a lengthier time span. In other words, feedback is an assessment done for the purpose of learning while evaluation is an assessment of what has been learned. Brand et al. have gone so far as to use the analogy; feedback is to evaluation as driving lesson is to driving test[9].

Characteristics of effective feedback

Feedback quality and character are important determinants of impact and acceptance. Feedback should contain discrete information regarding specific observed facets of a performance, center on actionable behaviors, and followed by an action plan to help the

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learner improve. The content should be objective and free of any reference to personal characteristics, non-observed behaviors, or past events that were not a shared experience. (see Table 1) For instance, telling a learner "You are not good at intubations. You're not a good fit for anesthesiology." is unlikely to be helpful feedback as it is non-specific, judgmental, overly broad, and likely to be taken as a personal attack. It would be better to share direct observations and suggestions on performance improvement. A more effective feedback statement might be "The intubation looked like it was difficult, did you consider raising the patient's bed to obtain a better view?" Such feedback allows the learner to share their insight into their performance and provides a catalyst for a fruitful discussion. Did the learner believe the intubation was difficult? If so, did they appreciate that the bed height may have played a role in their difficulty?

The timing of feedback delivery is another key consideration of effective feedback exchange. Ideally, the session should be a conversation between the learner and teacher; not a one-sided lecture. Feedback delivered immediately after the observed performance may be most effective. However, the teacher must balance the risks and benefits of immediate vs. delayed feedback given the learner's ability and clinical situation. Immediate feedback is often necessary when teaching clinical procedures, especially when patient care may be compromised. In that case, the learner should be redirected in order to prevent any harm from being done to the patient, but in a way that does not humiliate the learner in front of others. (see Table 2)

Barriers to effective feedback

Effective feedback exchange may prove difficult in medical education for many reasons[10]. Several common barriers to effective feedback exchange are described below.

Time limitations

The pace and acuity of modern medical care and its attendant administrative burden leave little time for the thoughtful discussion and observation required for feedback exchange. The fast-pace and time pressure of the perioperative environment limit opportunities for in-the-moment feedback exchange. A fading memory of events may make feedback exchange less effective at day's end. The use of mini feedback sessions throughout the day may result in better recall of events and a more natural dialogue with opportunities to implement practice change on the fly.

The Dilemma of negative feedback

Feedback can be perceived to be positive or negative by a recipient. Positive feedback will make the recipient feel good and reinforce behaviors of a successful performance, but it will not address areas of deficiency.

Negative feedback has the potential to identify and address performance deficiencies, but it is important to consider the barriers to the acceptance of such feedback. Negative feedback can cause significant distress on the part of the learner who, when faced with information that is damaging to their self-esteem, may dismiss the feedback as useless, critical, or controlling[11]. Studies have shown negative or corrective feedback is better accepted when learners feel the source is credible[12-15]. Credibility can be established by spending time to build rapport with the learner, having a transparent process for obtaining information used in providing feedback, and by the content and characteristics of the feedback itself[14]. The effect of negative feedback can be paralyzing and long lasting[16]. Therefore it should be given in a constructive and non-punitive manner with respect and an earnest intention to foster learning and improvement. Delivering negative feedback by lecturing, or worse, berating the learner, is only likely to cause the learner to become defensive or withdrawn and is unlikely to produce any results.

Resistant recipient

Effective feedback is not solely dependent on the skill of the deliverer. The learner's mindset is also an important determinant[17]. A "growth" mindset centering on a desire to improve and learn from mistakes is more likely to result in acceptance of feedback. A learner with a "fixed" mindset may prioritize the appearance of a good performance over anything that might be perceived as a deficiency or a mistake. The "fixed" learner may consider negative feedback as a defeat rather than a tool to improve their skills. An individual who perceives feedback to be a negative experience may not effectively process any of the information provided regardless of the content or delivery method[18].

A learner's fixed mindset is not the only reason a learner may fail to accept feedback. It is cognitively difficult to accept feedback that is discordant with our own opinion of self[11]. Therefore when challenged with negative feedback, some feedback recipients may be dismissive and or adopt a defensive or aggressive position against the feedback deliverer[16]. Conversely some learners who take feedback poorly may become upset and withdrawn rather than aggressive or defensive. Fear of appearing "weak" or "stupid" can lead a learner to avoid opportunities for feedback[18,19]. An antagonistic relationship between feedback deliverer and recipient is counterproductive to learning. A learner who displays a "fixed" mindset orientation in a feedback discussion may be encouraged to adopt a more "growth" centered perspective if successfully engaged by the teacher. This can be done by assuring the learner that feedback is provided to drive improvement; it is not intended to make them feel badly nor is it an indictment of their skills or character.

Table 1: Characteristics of ideal feedback

Specific: Use concrete and specific examples
Timely: Give close or near the event for maximal impact on performance improvement
Observed: Use firsthand observations; avoid using interpretations or inferred actions
Collaborative: Shared focus on improvement goals with exchange of ideas
Actionable: identifies discrete behaviors that the recipient can change or improve for the future.

Table 2: Tips for delivering effective feedback.

Build rapport and invest in a relationship with the learner
Time and location should be agreed upon by both parties
Seek learner's self-assessment and engagement in the conversation
Performance measured against well-defined goals that are transparent and readily available to all
Use specific examples based off first-hand data or decisions and actions
Use precise, neutral, non-judgmental language
Create an action plan by providing a scaffold for future improvement
Create a culture of feedback by making it a frequent and expected part of the learning process

The teacher may also reach out by sharing their own self-reflection of performance. The foundation for a career-long commitment to self-reflection and practice improvement can be laid during training by helping the learner understand how to constructively process negative feedback.

Occasionally, feedback recipients may refuse to accept the validity of negative feedback. They may feel that "everyone is out to get them" and dismiss the feedback as punitive and arbitrary[18]. It may be helpful for the feedback deliverer to step back in such situations and engage the learner in self-reflection. For example, take the case of the learner who is repeatedly told that they need to be more proactive in emerging patients from general anesthesia. The learner may respond by stating their belief that they are performing well in that domain, and other factors are responsible for the delay. Arguing your viewpoint with the learner is unlikely to be constructive. It may be better to ask the learner to consider the alternative to their belief. You might volunteer, "I understand how you feel, but have you considered the possibility that there may be things you could do differently to facilitate a more timely emergence?" If the learner reflects on the feedback, they may realize there are things they could improve for the future. In cases where patient harm or inappropriate care is likely to continue, it may be more prudent to pursue correction via more formal and systematic methods as available to training program directors and hospital leadership.

Learning environment/culture

Feedback in medical education has evolved from a unidirectional concept focused on the skill and training of the facilitator, to an understanding of the need for a more nuanced and bidirectional process[20,21]. The educational environment itself can facilitate or inhibit feedback. In the hierarchical world of medicine, the perceived divide between learner and teacher can also be a hindrance to effective feedback exchange[22]. Telio et al, emphasize feedback is affected by the relationship between participants. Borrowing from the concept of a "therapeutic alliance" in psychotherapy, the authors suggest that an "educational alliance" approach may provide an ideal environment for effective feedback[23].

Institutional beliefs can further complicate matters if faculty members feel that the excellence of the institution and its trainees makes constructive feedback impolite, or feedback that threatens trainee self-esteem should be avoided[24]. On the other hand, the feedback facilitator may be overly concerned that "negative" feedback may result in retaliation by the recipient, which may directly discourage faculty from giving any feedback at all[25]. Faculty development programs in feedback delivery may not be universal, and uncertainty regarding best practices for effective feedback delivery remains[7]. Faculty members may have trained in environments where feedback took the form of public shaming. Despite the counterproductive nature of antagonistic or abusive feedback, some still consider it an appropriate approach. It is unlikely that any message, even a justified one, is optimally received when there is an undertone of disrespect for the learner.

Departmental cultural norms for feedback exchange can greatly impact the success and ease of daily feedback exchange. If feedback is expected, and the norm, then its absence may become as uncomfortable as giving feedback in a setting where it is neither expected or commonplace. It is very difficult to change institutional culture. Faculty development programs can be helpful, but learner's attitudes and expectations cannot be ignored. Although wholesale cultural change would be ideal, it is more likely that effective change may be driven by individuals working to foster feedback exchange on an individual level. If such practices become widespread within a department, then the desired cultural change will follow.

Feedback Techniques

Many techniques have been described to assist the delivery of high-quality feedback. Despite exhaustive attempts at identifying a one best strategy for feedback delivery, the complex nature of feedback interactions limits the universal appeal of any one strategy.

The feedback sandwich method

The feedback sandwich technique has a long history in both medical education and the business world[26]. It is designed to assist in the delivery of feedback by lessening its perception as negative. The two "buns" of the sandwich are positive statements surrounding a middle "meat" that could be perceived as negative. This method has been subject to a great deal of criticism due to its contrived, uni-directional, nature and lack of focus on the constructive and formative facets of feedback. Positive comments may have little constructive value and come off as patronizing. Additionally, the positive bookend statements may lessen the impact of the actionable feedback in the "meat" of the sandwich[27]. Parkes suggests that although the feedback sandwich may affect the recipient's perceptions it has little effect on future performance improvement[28].

Multisource Feedback or 360 Evaluation

Recently a newer technique for providing medical trainees feedback known as the multisource feedback (MSF), or 360° evaluation, has gained popularity[29]. This method was widely used in business before transitioning into medicine. The MSF model combines feedback from both self-assessment as well as a variety of other members that function closely on a team such as peers, supervisors, nursing staff, patients, etc. This method gives learners a broader perspective, but potentially lacks the specificity required to facilitate or guide practice change.

The Ask-Tell-Ask method

The "Ask-Tell-Ask" (ATA) feedback method is constructed in three parts, with the first and last parts being learner-driven[30]. The recipient is "asked" to reflect on their performance and provide a self-assessment. The feedback deliverer then "tells" the recipient their observations of what went well and what might be improved. The final step of the ATA method requires the feedback deliverer to "ask" the recipient to clarify their understanding of the feedback and create a plan for future improvement. In contrast to the feedback sandwich, the ATA method allows the feedback recipient to impact the nature of the feedback given and incorporates planning for future improvement. As a result, feedback may be better received using the ATA method if the delivery of feedback aligns with a recipient's self-assessed area for improvement.

The Pendleton model

The Pendleton model provides a structured method for feedback between a learner and a teacher by emphasizing learner reflection on their performance with input and guidance from the feedback facilitator[31]. The learner identifies something positive regarding their performance. The feedback facilitator discusses their impression and confirms aspects of the performance that were successful. The learner then identifies areas of the performance that could have been done better. The feedback concludes with the facilitator confirming areas of the performance that could be improved. The Pendleton method shares some similarities with the plus-delta approach to debriefing popularized in medical simulation which utilizes two categories of learner-identified facets of a performance[32]. The plus category consists of things that were done well, whereas the delta category contains things that could be done differently in the future. Both techniques encourage and facilitate reflection on the part of the learner, which may be very productive in facilitating meaningful feedback. At times, it may be more appropriate for the feedback facilitator to exercise restraint and allow the leaner to provide their own feedback via self-reflection. This may be especially true if the events discussed were stressful and the learner would benefit from an opportunity to decompress. As with the feedback sandwich and the ATA method, the structure of the Pendleton method may prove artificial and impede the discussion of the more valuable areas for improvement if the learner lacks insight or does not participate fully[33].

The R2C2 method

The R2C2 feedback method builds upon a reflective model of feedback delivery. The model was created by Sargeant et al in 2015 and defined building relationships (R), exploring reactions (R),

Box 1: Box reproduced, with permission from publisher, from Lockyer J, Armson H, Könings KD, Lee-Krueger RCW, des Ordons AR, Ramani S, Trier J, Zetkulic MG, Sargeant J. In-the-Moment Feedback and Coaching: Improving R2C2 for a New Context. *J Grad Med Educ* 2020 Feb; **12(1)**: 27-35.

BOX 1: Sample Facilitative Phrases Used in Each Phase of R2C2 in the Moment

Phase 1: Build Relationships

- *First meeting*: This is the first time we have worked together. To help learners progress efficiently, I like to observe one thing learners are doing and have a feedback and coaching discussion about the experience. How does that sound and what would be useful to you?
- *For following up with continuing learners*: During our last discussion you identified that you would be working on [x]. how has that been going for you?
- *For both a first meeting and a continuing learner*: What do you want to achieve today? What skills are you working on? What can I observe?

Phase 2: Explore Reactions and Reflections

- *Gain learner perspective*: How was that experience for you? What went well? Were there challenges for you? Did anything surprise you?
- *Provide preceptor perspective*: When I watched you, I observed [x]. I wondered what made you decide to do that?
- *Enable learner to reflect on and react to preceptor's comments*: What are you thinking about hearing my observations?

Phase 3: Confirm Content

- Is there anything we discussed that isn't clear?
- Do you agree with what I have said?
- Now that we have asked about [x], what is your goal?
- To summarize, I hear you say that you want to work of [x], is that correct?

Phase 4: Coach for Change and Co-Create an Action Plan

- *Set a goal*: Now that we have established some directions for learning, what specific goal requires the most attention right now?
- *Establish plans*: How will you achieve this goal? What might get in your way? What resources will you need? Who will help you? When will you begin to implement this plan?
- *Determine a follow-up plan*: Let's talk about how we will follow up. Who will you follow up with? What will this require? What is your timeline? How long might it take for you and others to see results? How will you know when you have achieved your goal?

exploring the content (C), and coaching for change (C) as the four phases of the R2C2 abbreviation[34]. The first phase of the R2C2 method is the establishment of a relationship between feedback participants. A greater understanding of the feedback recipient's background and motivations can provide a safer and more effective feedback environment. An established relationship also helps the facilitator understand what feedback may be most helpful for the recipient prior to the observed activities. The second phase centers on the observation of the recipient's reaction to the feedback. Facilitators are encouraged to ask open nonjudgmental questions when exploring reactions to feedback. Phase three of the R2C2 method moves from the recipient's reaction to the feedback to the assessment of the recipient's understanding of the feedback provided. The facilitator must guide the recipient to explore strengths and weaknesses identified in their discussions. The facilitator should identify a few areas of importance to the recipient to address in the future. The fourth and final phase requires the facilitator to coach the recipient for change. Identification of future goals with a plan to accomplish them is the most critical characteristic of this phase. Although the R2C2 model seeks to overcome many barriers to effective feedback, it requires considerable skill and time to allow for discussion and reflection which makes it more suited for summative evaluation than brief clinical feedback. Despite this potential limitation, the R2C2 model has been adapted for use for in-the-moment feedback and coaching[35] (see Box).

CONCLUSION

Feedback in medical education is critical to driving performance improvement. Although research has provided evidence to suggest the most effective feedback content and practices, the provision of effective feedback remains challenging in most clinical environments. Historically the burden of effective feedback has been placed on the educator, but further research has led to the understanding that efforts to exchange effective feedback must consider many factors. The shift of feedback from a unilateral transfer of information to a dialogue between educator and learner is an important development in medical education; the relationship and shared goal of performance improvement between the educator and learner is key. Similarly, advances in the understanding of how feedback recipients process information and may benefit from facilitated reflection inform better feedback practices and avenues for future research. Although feedback models and best practice recommendations may elevate feedback quality in medical education, one size may not fit all. The learning environment must set feedback exchange as a valued aspect of medical education. Medical educators must leverage the collective wisdom of the available literature with their own intuition when delivering feedback to their learners.

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