THE BABY AND THE BATH WATER: RESPONDING TO LEARNERS' FEEDBACK

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LEARNING OBJECTIVES:

Interpret trends and outliers in feedback data

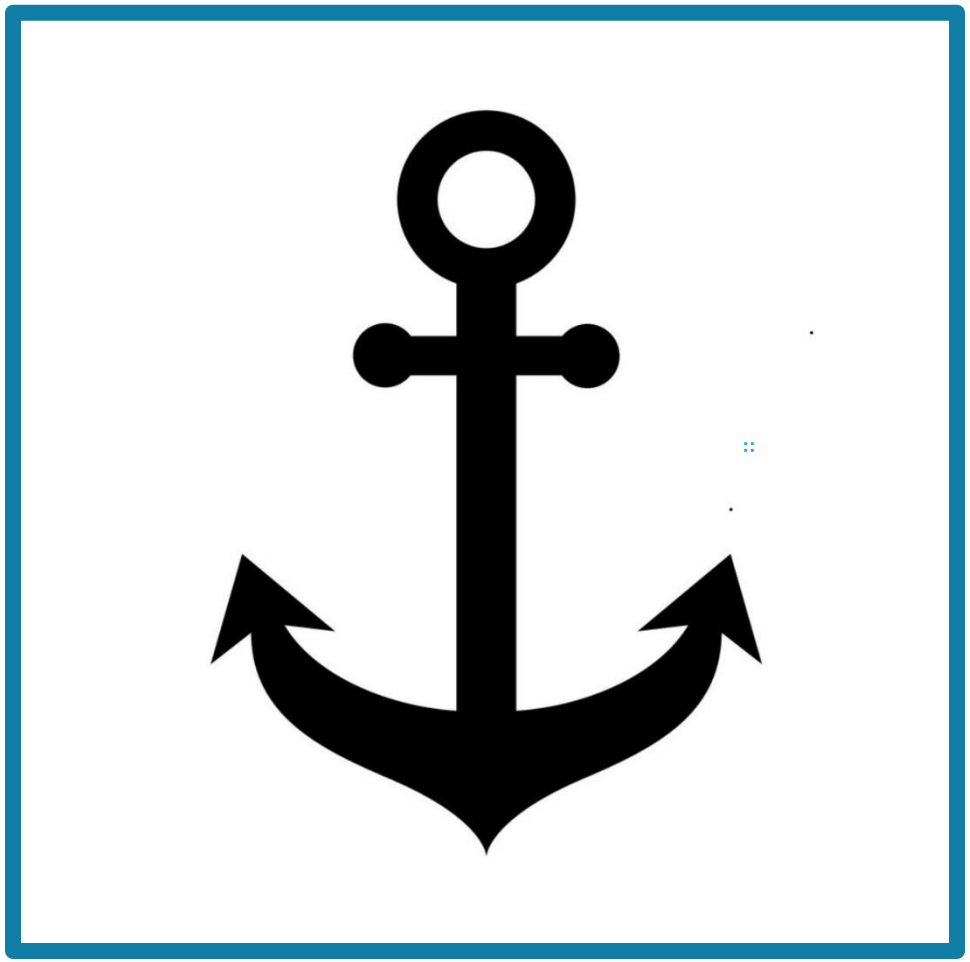
Tease out teaching style from curriculum content feedback

Recognize the value of peer teaching assessment to enhance learners' comments

Develop a focused strategy in responding to identified gaps in style or curriculum and test it

CURRENT TIMES…
CHANGING TIMES…

ARE THERE ANCHORING PRINCIPLES OF FEEDBACK?



YES!!!
ANCHORING PRINCIPLES OF FEEDBACK

Driven by data

Gathered from multiple direct sources

Collected, provided, and analyzed in a timely fashion

Provided and interpreted without emotions

Allowed respond so improvements can be made

REVIEW FROM FEEDBACK SESSION I

FEEDBACK:

Is formative/adaptable. Evaluation is summative/judgmental.

Follows clear expectations and learning objectives which are laid out in the beginning of the rotation.

Is used to appreciate the good/right things with logical explanations.

Helps to identify the bad/wrong things and provides options to change and improve.

Name it as feedback! I am now going to give you some feedback.

Be specific! Words matter. Avoid "good job". Be descriptive.

WHAT HAPPENS IF LITTLE OR NO FEEDBACK IS GIVEN?

Good performance is not reinforced and poor performance remains uncorrected.

May:

assume all is well.

have to rely on hearsay from peers to get the feedback they so desperately need.

have to guess their level of competence, based on how well they are coping.

may have to learn by trial and error at patients' or colleagues' expense. Could become a patient safety issue.

PENDLETON MODEL
REPLACES TRADITIONAL FEEDBACK SANDWICH

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Modification of the traditional feedback sandwich in which the teacher's comments are preceded by the learner's/mentee's observations. The Pendleton model usually consists of four steps. In step 1, the learner states what was good about his or her performance; In step 2, the teacher/mentor states areas of agreement and elaborates on good performance; In step 3, the learner/mentee states what was poor or could have been improved; In step 4, the teacher/mentor states what he or she thinks could be improved.

This results in more of a dialogue. Focus is on action to improve.

A FUNDAMENTAL CONCEPT IN RESPONDING TO LEARNERS' FEEDBACK

Both providing and receiving feedback should follow **expectations.**

Let's begin at the end….look at the evaluation form.

What are the expectations the learners have of us, the teachers?

In other words, on what is our teaching being evaluated?

CLERKSHIP EVALUATION CATEGORIES- *EXPECTATIONS*

1-4 UNACCEPTABLE, BELOW, MEETS, EXCEEDS

Supportive Environment

Provided Feedback

Availability

Role Model for Patient Care

CLERKSHIP EVALUATION CATEGORIES- *EXPECTATIONS*

1-4 UNACCEPTABLE, BELOW, MEETS, EXCEEDS

Student Participation

Cultural Sensitivity

Professionalism and Respect

Overall Effectiveness

KNOWING THE EXPECTATIONS, NOW WHAT?

At the beginning of your 2 week rotation as the attending, set the agenda with the team:

It is important that we create a supportive environment where everyone has an opportunity to express himself or herself. If you ever feel that is not the case, please speak up and let me know.

I will have office hours on Wednesday afternoon at 4:30 to allow for check-in and to be sure we have scheduled feedback time.

LECTURE EVALUATION CATEGORIES- *EXPECTATIONS*

1-5 STRONGLY DISAGREE-STRONGLY AGREE

Effectively organized content, flow and pace of the session

Effectively answered questions to ensure understanding of material

Took time to explain difficult concepts

Content was important for learning

LECTURE EVALUATION CATEGORIES- *EXPECTATIONS*

1-5 STRONGLY DISAGREE-STRONGLY AGREE

Styles of this faculty member's sessions were effective learning modalities.

This faculty member's sessions increased my understanding of the topics covered.

I would rate this faculty member as an effective teacher.

KNOWING THE EXPECTATIONS, NOW WHAT?

We have a lot of material to cover in this lecture and I want to be sure we go at an appropriate pace-not too slow and not too fast. I will check-in with you from time to time and ask.

Also, I will pause at certain points to see if you have questions. It is better to let me explain the concepts in details without interruptions and then ask for questions.

We will include a patient presentation which hopefully will tie in the concepts and show you how relevant and valuable our topics are for your clinical experiences.

LECTURE NARRATIVE COMMENTS

What did you find effective about this faculty member's sessions?

What could be done to improve this faculty member's sessions?

Did you experience any unprofessional behavior from this presenter?

PAUSE FOR DIALOGUE

Any comments from the chat line or by phone?

ACADEMIC MEDICINE ARTICLE- *REACTIONS TO CLINICAL FEEDBACK*

Reflections From the Rearview Mirror: Internal Medicine Physicians' Reactions to Clinical Feedback After Transitions of Responsibility

Judith Bowen, Jonathan Ilgen, Glenn Regehr, Olle ten Cate, David Irby, and Bridget O'Brien

Acad Med. 2019;94:1953-1960.

22 IM physicians at OHSU completed semi-structured interviews

Transitions of care case reported early provisional diagnosis

Evaluated response to confirmed vs disconfirmed final diagnosis compared with early diagnosis

ACADEMIC MEDICINE ARTICLE- *CONTINUED*

Study how clinical feedback is used to refine diagnostic approach

How responding to feedback could shape future clinical performance

For us: Interesting to reflect on this concept and whether it might be translatable to teaching practice and feedback in teaching.

Learning about practice through practice.

Learning about teaching through practice.

ACADEMIC MEDICINE ARTICLE- *CONTINUED*

What did they learn? What can we learn?

Confirming diagnosis-emotional response was positive 15/15

exciting, satisfying, interesting, fun, was proud, confident

Disconfirming-emotional response was neutral or negative 31/34

frustrated, feeling terrible, upset, doubt in ability, disappointed, weak

Rationalizations: nothing bad happened, others also evaluated the patient and didn't make the correct diagnosis….

ACADEMIC MEDICINE ARTICLE- *CONTINUED*

What will you do differently?

Slow down, review primary date, be cautious.

Obtain new knowledge.

Reflect on performance gaps.

Experience of physician, self-confidence and willingness to learn played roles in openness to next steps.

CASE EXAMPLES:
REFLECTION, STRATEGY AND IMPLEMENTATION

CASE EXAMPLE #1

Dr. Thomas has gathered his teaching evaluations for the past 5 years in preparation for promotion. He has 25 student comments with 21 being mostly exceeds and meets expectations. However, 4 evaluations are below expectations in availability and student participation.

He is upset and can only focus on the 4 low evaluations. He thinks what more could I have done. I bent over backwards to be there and even ran over to give extra teaching sessions on days when I planned to have a little "me time". I distinctly remember missing my daughter's softball game to show the students' physical exam findings…..

How could I be low in availability and student participation?

I bet nobody gets high in these categories. I think the other categories are more important. You know, I was thinking of focusing more on teaching the residents and fellows for next year. But wait, how is this going to look in my promotion packet?

NOW WHAT?

Dr. Thomas is clearly emotionally engaged in his response. He is using rationalization.

He could seek peer and/or observational input in his teaching style from TEACH. He could establish agenda in availability and student involvement with learning objectives and expectations at the beginning and during the clerkship.

He should implement his new strategies and measure their effect.

Ideas?

CASE EXAMPLE #2

Dr. Fredrick received her evaluations for her online sessions this semester and she is both encouraged and discouraged.

One student said: Thanks for your effort in this trying time, we know this was a first for you. The content was obviously important for us to learn. Wish we had better connection for our session.

Another student said: The material was just sooo dense. Can you make it more interactive? Please try not to talk at us.

NOW WHAT?

Dr. Frederick had been worried that all the graphs and figures were too dense but she was not sure how to better communicate the facts. Normally she brings some patients into class which add relevance to the material. She had hoped to find patient videos, but no luck.

She had wanted to use Zoom and have the students lead some of the discussion but the video connection on the day of her session was not working well. She heard from other professors, they had better connection on their days. Should she have tried to reschedule?

Ideas?

PEER FEEDBACK OPPORTUNITIES- TEACH PROGRAM

Direct observation

Applicable to multiple teaching venues

Truly formative and confidential

Follow up with repeat observation

Can be included in promotion packet, faculty member's discretion

TEACH OBSERVATION

Content: Learning objectives, knowledge

Learner Centeredness: Held learner's attention, demonstrated respect

Interpersonal and Communication Skills: Problem solved in a social context

Professionalism and Role-modeling: Well prepared, timely, inspiring

Practice-based Reflection and Improvement: Seeks faculty development opportunities to improve educational practice

Systems-based Learning: Utilizes medical education resources to advocate for learners

CONCLUSIONS
RESPONDING TO FEEDBACK. . .

Is a dynamic process.

Data driven

Follow expectations

Our response should include:

limited emotions

incorporation of peer input

strategies for goals of improvement

QUESTIONS

Thank you!!!