Giving Effective Feedback

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Faculty Development
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Ever come to a faculty conference like this?

It is frustrating having problem learners

More tangible to look at “Learner problems”

What is the source of the problems?

- Experiential? Is there a lack of clinical, data base or procedural skills? Lack of experience in a type of role leading to anxiety?
- Preceptor Insufficiency? Were the goals and expectations of the rotation and behavior made clear? Are the expectations reasonable?
- System issues? Time/work demands, learning supports appropriate?
- Distractors? Is there a personal/wellness situation?
- Affective – personality/professionalism/mental illness?
- Substance Abuse

Prevalence of resident problems

- 1999 survey of IM program directors found 94% of programs had at least one resident in difficulty (and under-reporting suspected).
- What were the problems?
  - Insufficient knowledge (48%)
  - Poor clinical judgment (44%)
  - Inefficiency (44%)
  - Inappropriate interactions (39%)
  - Provision of poor skills (36%)

Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. JAMA. 2000 Sep 6; 284(9):1099-1104.

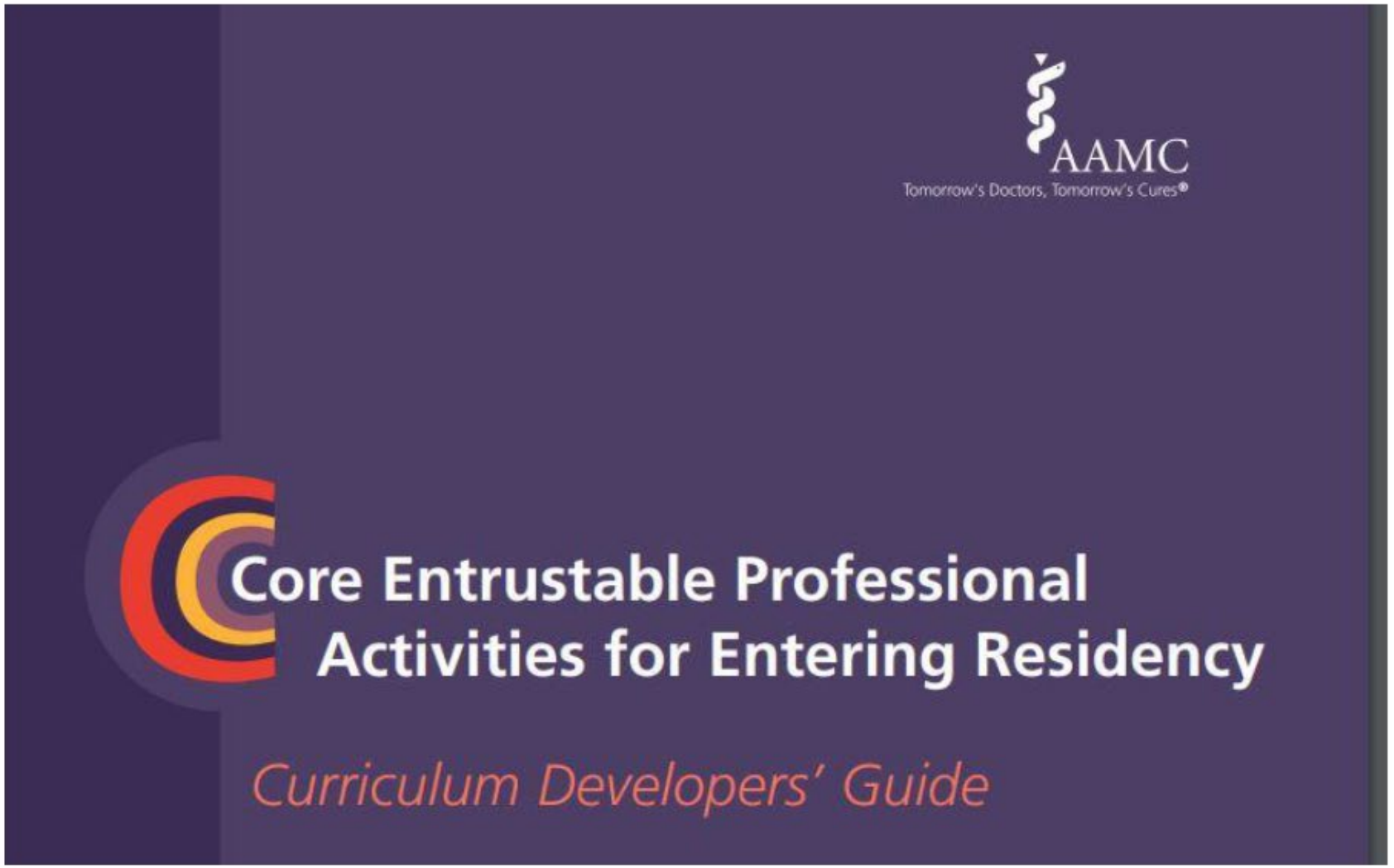
The Problem Resident: APDIM Survey 2008

- Survey of IM Program Directors
- 268 programs responded (72% of 372 programs)

- IM residents requiring remediation often have deficiencies in multiple competencies.
- Deficiencies across competencies; remediation most successful for Medical Knowledge (86%); least successful for Professionalism (41.2%).
- Application materials rarely help to identify individuals at risk.
- Performance Deficiencies rarely (5.6%) self-identified by residents.

Denis M Dupras, Randall S Edson, Andrew J Halvorsen, Robert H Hopkins, Furman S McDonalds. "Problem Residents": Prevalence, Problems and Remediation in the Era of Core Competencies. The American Journal of Medicine. Volume 125, issue 4, pages 421 - 425

Interns Have to Practice to Get a Habit: Thirteen Skills They Should be Coming in With



aamc.org/intiatives/coreepas/publicationsandpresentation

The Core Entrustable Professional Activities (EPAs) for Entering Residency

- **13 activities** that all medical students should be able to perform upon entering residency, regardless of their future career specialty.
- Based on a **performance gap between medical school and residency training.**
- EPAs chosen as the framework for the guide because they offer a **practical approach to assessing competence in real-world settings** and impact both learners and patients
- EPAs by definition require the **integration of competencies**, and competencies are best assessed in the context of performance (as can be provided by the EPA framework).

Core Entrustable Professional Activities for Entering Residency
Faculty and Learners' Guide, AAMC, May 2014

13 EPA's

- **EPA 1**: Gather a history and perform a physical examination
- **EPA 2**: Prioritize a differential diagnosis following a clinical encounter .
- **EPA 3**: Recommend and interpret common diagnostic and screening tests
- **EPA 4**: Enter and discuss orders and prescriptions
- **EPA 5**: Document a clinical encounter in the patient record
- **EPA 6**: Provide an oral presentation of a clinical encounter
- **EPA 7**: Form clinical questions and retrieve evidence to advance patient care
- **EPA 8**: Give or receive a patient handover to transition care responsibility
- **EPA 9**: Collaborate as a member of an interprofessional team .
- **EPA 10**: Recognize a patient requiring urgent or emergent care and initiate evaluation and management .
- **EPA 11**: Obtain informed consent for tests and/or procedures.
- **EPA 12**: Perform general procedures of a physician
- **EPA 13**: Identify system failures and contribute to a culture of safety and improvement

EPA's for Entering Residency – Interns still need practice for basic skills! Review of IM, IM-Prelim, EM, Peds, and other PGY-1 from one academic institutions's program directors

TABLE 2
Program Director Entrustable Professional Activity (EPA) Ratings

EPA	% Able to Perform Without Supervision	SD	% Not Observed
EPA 1: Gather a history, perform physical examination	78	0.4	0
EPA 2: Develop a differential diagnosis	72	0.5	0
EPA 3: Recommend and interpret diagnostic and screening tests	70	0.5	0
EPA 4: Enter and discuss orders/prescriptions	69	0.5	0
EPA 5: Document a clinical encounter	98	0.1	0
EPA 6: Present orally a patient encounter	94	0.2	0
EPA 7: Form clinical questions and retrieve evidence to advance patient care	61	0.5	6.1
EPA 8: Give or receive a patient handover	68	0.5	2.8
EPA 9: Collaborate as a member of an interprofessional team	88	0.3	0
EPA 10: Recognize a patient requiring urgent or emergent care	74	0.4	2.2
EPA 11: Obtain informed consent	63	0.5	9.5
EPA 12: Perform general procedures of a physician	94	0.3	14.5
EPA 13: Identify system failures and contribute to a culture of safety and improvement	38	0.5	37

Note: A total of 94% (164 of 174) of those observed are able to perform, but of the total, 14.5% were not observed.

Pearlman et al. ***J Grad Med Educ***. 2017.

Self Assessment abilities can vary widely!

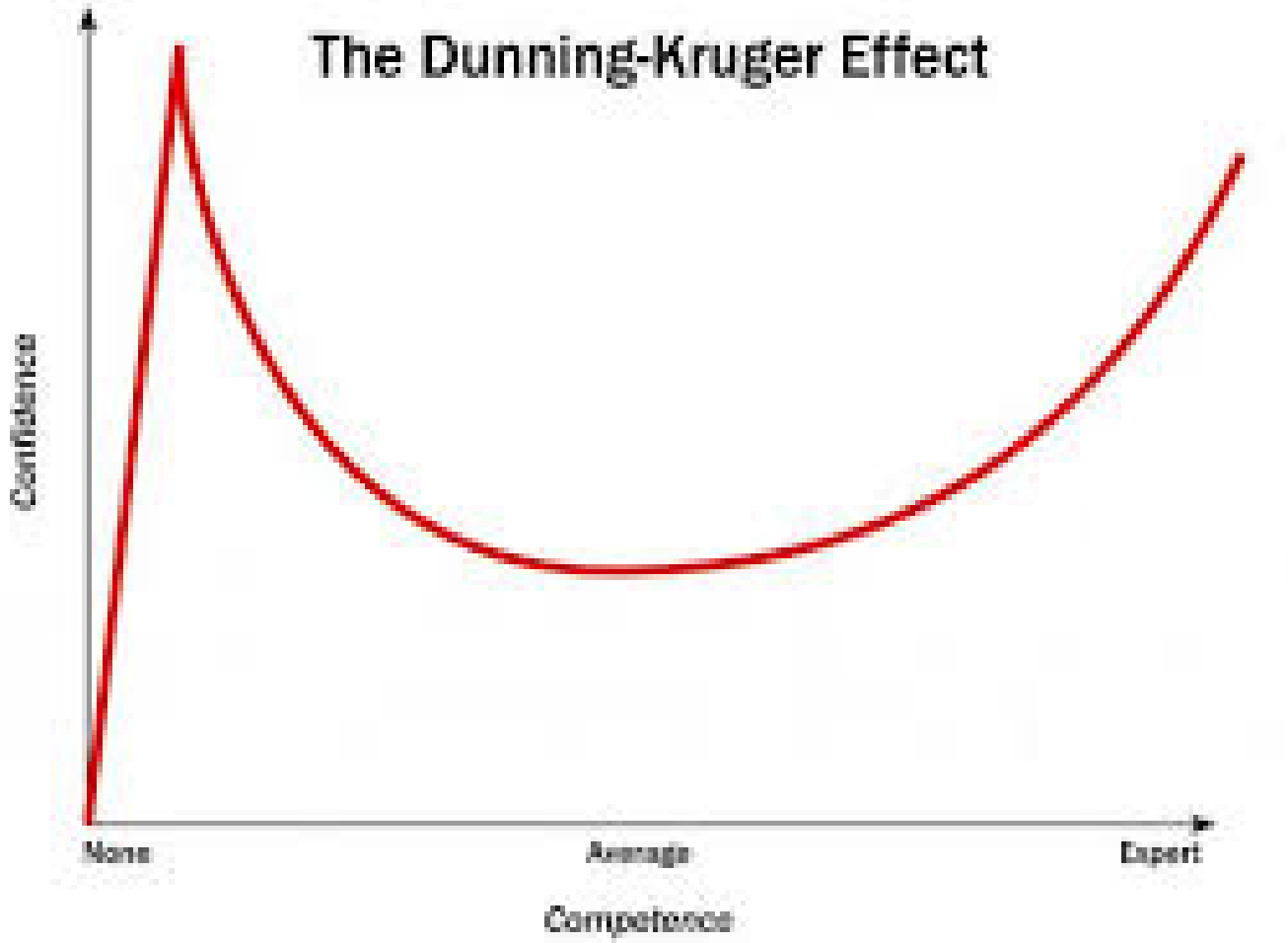
MacArthur Wheeler, 1995

David Dunning and Justin Kruger (Cornell University Psychology Dept

Inspired by MacArthur Wheeler, bumbling robber, delusional about his own abilities (thought he was invisible to cameras due to lemon juice bath), Dunning and his graduate Kruger studied 65 Cornell undergraduate psychology students with tests of

- Humor (Woody Allen, Al Franken and funny pet jokes),
- Logical reasoning (20 LSAT test prep questions),
- Grammar (20 questions from National Teacher Association Prep Guide)

to assess how well self-assessment compared to criteria-based assessment.



Davis D, Mazmanian P, Fordis M, Van Harrison R, Thorpe K, Perrier L Accuracy of Physician self-assessment compared with observed measure. JAMA (2006). 296(9):1094-110

Dunning D, Kruger J. Unskilled and Unaware of It: How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments. Journal of Personality and Social Psychology. (1999) 77 (6): 1121-34.

Everyone needs Feedback!

Dunning Kruger Effect

Least competent

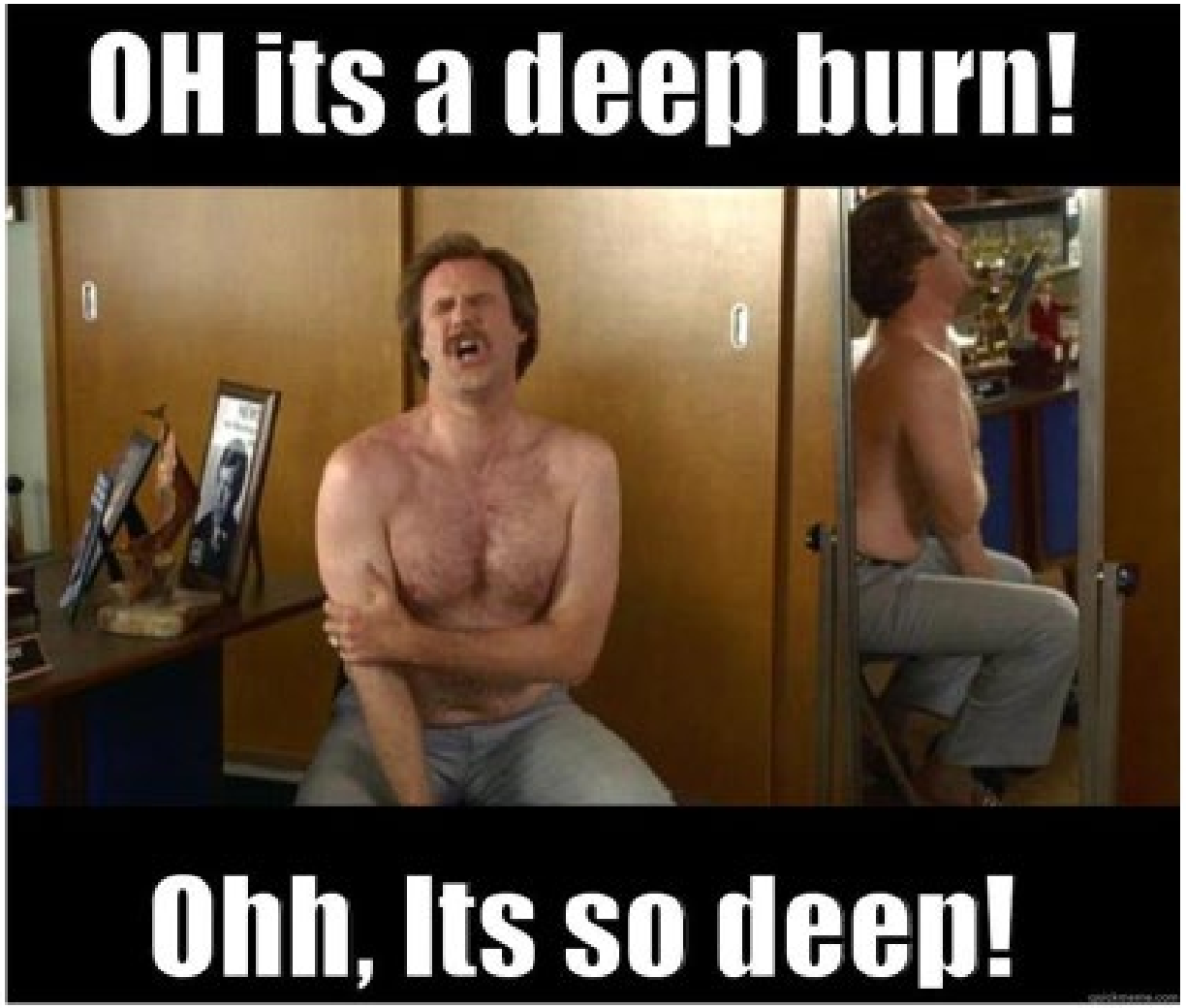
may not have the competence to recognize their deficiencies

Imposter Syndrome

As competence is gained, uncertainty about that competency arises.

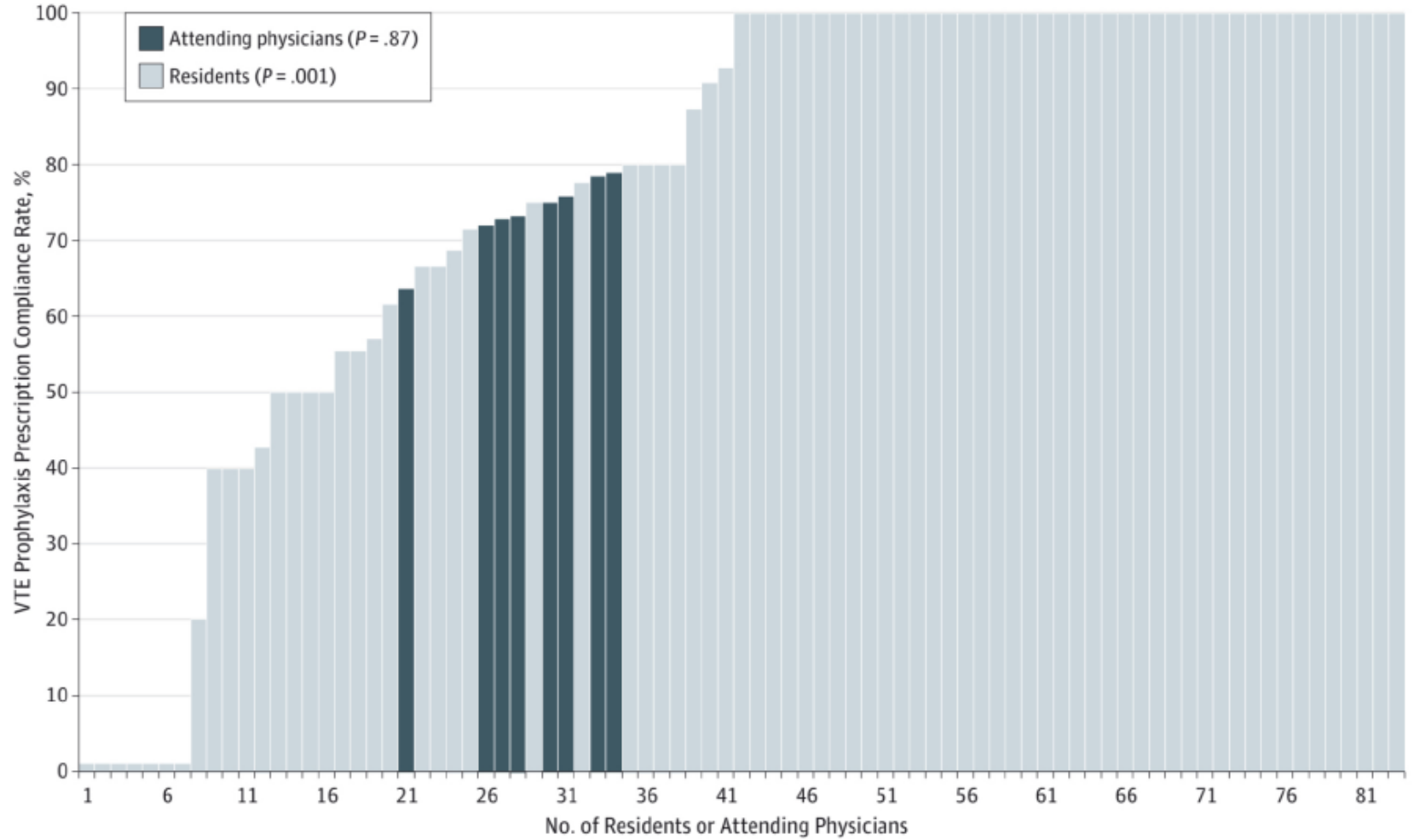
Expert

Continued practice and checking against gold standards



Will Ferrell as Ron Burgundy lifting weights in “Anchorman” (2004)

Figure. Risk-Appropriate Venous Thromboembolism (VTE) Prophylaxis Prescription Compliance Rates



Compliance rates for risk-appropriate VTE prophylaxis prescriptions attributed to residents (light blue) and attending physicians (dark blue) are compared for all adult trauma patients admitted to the Johns Hopkins Hospital during the 2012-2013 academic year. Seven residents were 0% compliant, and 42 residents were 100% compliant.

Lau et al . JAMA Surgery (2015).

Use a SOAP format

- Subjective: What do you and others say? Get feedback from other preceptors or staff
- Objective: Document specific incidences or situations with dates
- Assessment: Based on info, try to identify the problem in terms of competencies.
- Make a plan:

    Talk to resident – what is their perception.

    Discuss concerns and follow up.

    Consider a consult or referral to develop the plan. (PD)

Langios JP, Thach S. Managing the Difficult Learning Situation. Fam Med 200: 32(5); 307-309.

Frame in terms of competencies

- Professionalism/Accountability
- Systems Based Practice
- Interpersonal Communications
- Practice based Learning
- Medical Knowledge
- Patient Care

And the Specific Entrustable Activities with the rotation.

MODELS FOR FEEDBACK

What are your goals as an educator for this student?

- As a teacher, decide is this “formative” vs “summative” feedback and when does it switch? Think about informal vs formal feedback.
- Formative feedback is frequent/low stakes/self-analysis encouraged.
- Think ahead – what are your formative feedback opportunities.
- Create a feedback story…
  - Themes and specific stories
  - Final Chapter (summative: let successes and growth be a major part of the story).

What are your resident/student's goals in this educational opportunity?

- What are their concerns and goals?
- An adult learner does best if we can align the objectives of the experience and have investment in excellence.
- COACHING rather than TEACHING
- What do they want the opportunity to hone and what do they need to excel at to get there?

SET-GO mnemonic for developing comments

What I **S**aw – Describing what you saw the learner do

What **E**lse did I see – What happened next

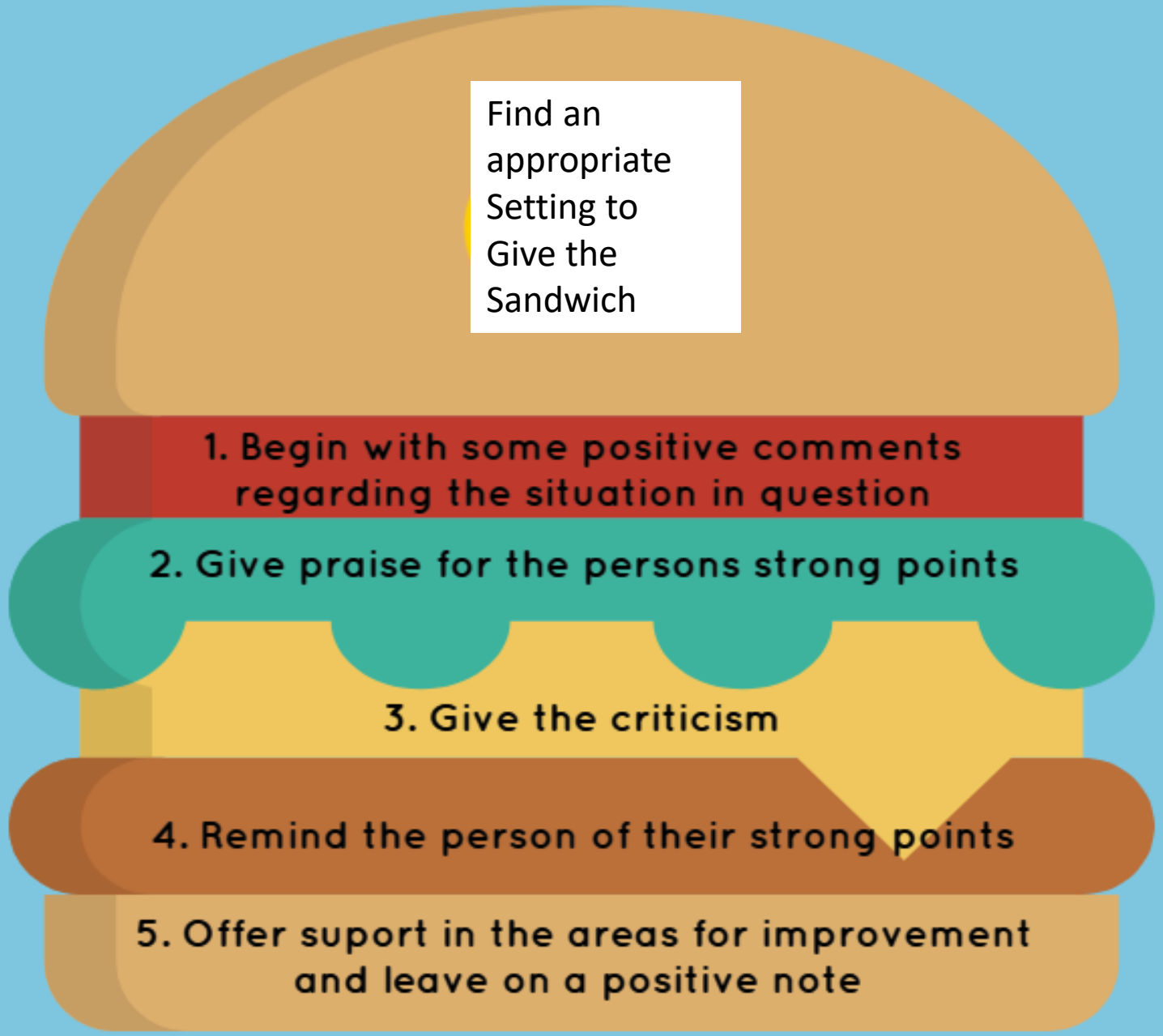
What you **T**hink? – Reflect back to the learner

What **G**oals are we trying to achieve?

Any **O**ffers on how to achieve these goals? – elicit from learner then give suggestions about skills and goals.

Silverman JD, Draper J, Kurtz SM.The CalgaryCambridge approach in communication skills teaching 2: The SET-GO Method of descriptive feedback. Educ Gen Pract 1997;8:16–23.

How To Give Constructive Criticism



https://brooksandkirk.co.uk/

Feedback Sandwich 2.0

Reinventing the Feedback Sandwich

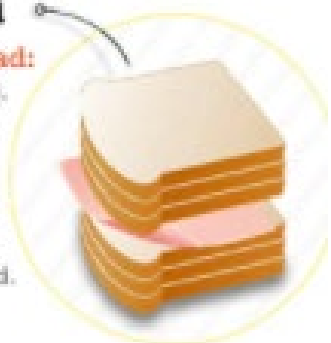
The Untraditional Wrap

Good Amount of Meat and Bread, but Intertwined:
Ask someone what they think about their performance, ask if you could share your impressions as well, and have a discussion about it. There's critique and discussion intertwined.

Weak Feedback Sandwich

Lots of Bread:
Lots of ego-stroking. Other person may not even hear your negative feedback.

Little Meat:
Feedback swamped by amount of bread.



Open-Faced Feedback Sandwich

Meat:
Significant amount critical feedback

Bread:
And ego stroking as well... but only at the end.

The Paleo Diet Sandwich

All Meat No Bread:
Just that critical message with no ego stroking at all

www.andymolinsky.com

CARE Model - Focuses on the following: appreciative, present, acknowledge feelings, project positive intent, avoid assumptions, focused.

Connecting: Communication and Careful Listening

Attention: Analysis, Action and Assertive

Respect: Responding and Responsible

Expectations: Emotional Control and Being Effective

PENDLETON'S RULES

(emphasizes learner-focused open ended questions after the learning experience)

- Learner-centered "What do you think went well?
- What was done well re-enforced by facilitator/group.
- Skills used to achieve outcome discussed. "How was this achieved?" "What could be improved?"
- Self-assessment – "What could have been done differently?" "How can this be achieved" analyzes alternative skills
- Facilitator/group suggests alternatives, if necessary.
- Learner feedback to facilitator about experience/skills/goals.

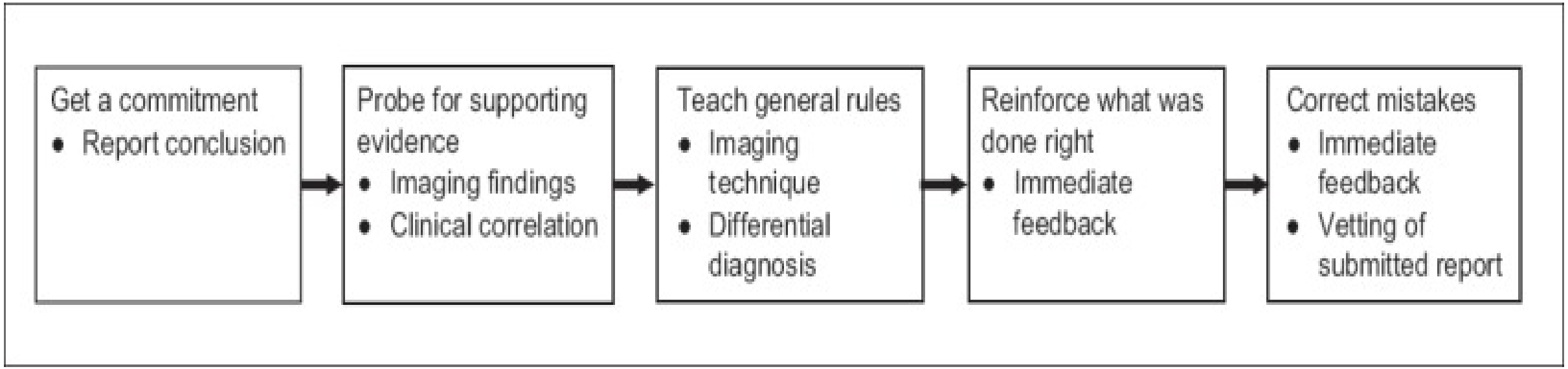
Pendleton D, Schofield T,Tate P, Havelock P. The Consultation:An Approach to Learning and Teaching. Oxford: Oxford University Press; 1984.

Agenda-Led, Outcome Based Analysis (ALOBA)

- **Learner** reflects and acknowledges areas he needs help with in advance of feedback situation.
- Tasks/goals that need to be achieved identified.
- Task assumes a learning exercise for learner and facilitator.
- Learner and facilitator identify skills to achieve outcome, with rapid feedback loop.
- Simulation or rehearsal done.
- Skills summarized.

Silverman JD, Kurtz SM, Draper J. The Calgary-Cambridge approach to communication skills teaching. Agenda-led, outcome-based analysis of the consultation. Educ Gen Pract 1996;7: 288-99.

Five step micro-skills method (Am Board Fam Med)



Tan C, Lim C. Teaching millennial radiology resident:
applying a five-step 'microskills' pedagogy. Singapore Med J. 2018; 59(2): 619-621

Neher J, Gordon K, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. J Am Board Fam Pract. July-Aug 1992; 5(4):419-24.

Best OVERALL Practices

- Meet in person with learner, review overall G+O and invite self-evaluation for personal G+O.
- At minimum, the learner should know the goals and know the evaluation form metrics.
- Do direct observation, record it (MedHub evals can be saved/added to)
- Meet with resident, call it “feedback”, set next session – this can be brief.
- Follow up changes.

Performance Dimension Training for Your Faculty

What is important to evaluate?

What is excellent, good and bad?

Develop Criteria!

ACMGE Senior VP Evaluation: Eric Holmboe MD FACP and Richard Hawkins MD FACP
Practical Guide to the Evaluation of Clinical Competence with DVD. National Board of Medical Examiners; Mosby Elsevier, 2nd Edition. 2017.

Rater Errors

Halo Effect – One factor (for example- a nice resident or a good researcher) affects evaluation of all other traits. Straight line down the evaluation form.

Leniency error (dove) – the rater's ratings are consistently overly positive. They ignore criteria and rate milestones for interns as beyond graduation based on limited encounters.

Severity or Strictness error (hawk) – everyone rated low.

Central tendency – everyone rated average.

Confirmation Bias (that's how I would do it)

NOT really observing!

The goal is to get consistency with evaluators both in clinical and non-clinical arenas

Examples of Evaluator/Learner training videos (areas to critique)

Presenting patient at bedside (good and bad examples) U Cincinnati: https://www.youtube.com/watch?v=nOewqkejNXc

Abdominal Pain: https://www.youtube.com/watch?v=l9b2oXrzMd8&app=desktop

Neck Pain: https://www.youtube.com/watch?v=MzoeBJyVlE0

Headache: https://www.youtube.com/watch?v=deCpWebRi-E

Discussing abnormal labs: https://www.youtube.com/watch?v=y1gUR82rgsk

How to Give the Feedback

- The right place/setting
- The right amount of attention
- Review of criteria
- Elicit self-assessment
- "Sandwich" but direct and specific suggestions.
- Face-to-Face
- Comments!

Rating the Raters

We want our instructors, resident teachers and student teachers to improve so feedback on giving feedback is essential. Develop criteria based on models we reviewed!

There are many models for assessing the evaluators. Videoing a feedback session is one way.

FACE model (Feedback Assessment for Clinical Education) rating system available here: https://harvardmedsim.org/feedback-assessment-for-clinical-education-face/

Learning is a fun, productive pursuit!
Don’t be a turkey – communicate and empathize!
Don’t let difficulties get your goat – keep trying!

Wild turkeys visiting our goats (1.5 miles from hospital)