GIVING EFFECTIVE FEEDBACK

FACULTY DEVELOPMENT SERIES – EDUCATIONAL ENHANCEMENT

OCTOBER, 2020

What we will review:

- Identifying where your learners are starting from.
- Setting the expectations and goals of feedback with your learner.
- Models for feedback (ALOBA, Pendleton's Rules, Sandwich,
- Performance dimension training (validating your rating scales/training your raters)
- Giving feedback
- Making a 360 degree situation – rating your feedback givers (FACE)

Set the Expectations from the Beginning

Don’t assume all your learners understand our assumptions about residency.

Make it clear from the beginning. This is a place for 360 feedback.

That is a gift!

Self Assessment abilities can vary widely!

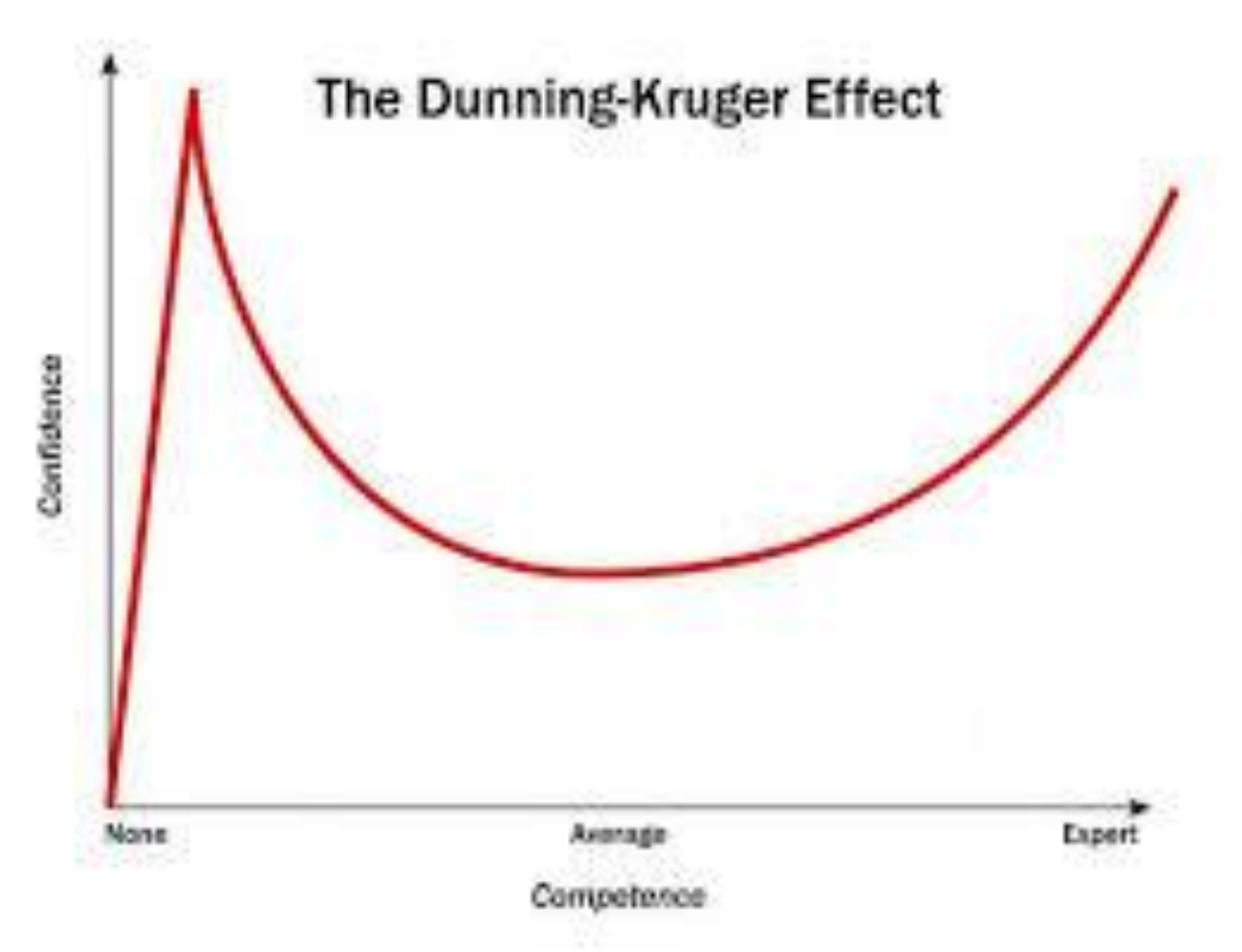
MacArthur Wheeler, 1995

DAVID DUNNING AND JUSTIN KRUGER (CORNELL PSYCHOLOGY DEPT

Inspired by MacArthur Wheeler, bumbling robber, delusional about his own abilities (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	**Imposter Syndrome**	**Expert**
Least competent may not have the competence to recognize their deficiencies	As competence is gained, uncertainty about that competency arises.	Continued practice and checking against gold standards

Short presentation methods to evaluate level of medical knowledge

You do not have to evaluate everything every student encounter!

Signpost:

Patient demographics and commit to a main issue

Student states what they have done (history/physical/provisional and differential diagnosis/plan) – may be some or all. Presumes teacher has some knowledge of patient.

Facilitator guides where discussion goes.

https://www.youtube.com/watch?v=Mew2wzpuhTs

SNAPPS:

Summarize with a few sentences (as above) - More advanced; maybe once per ½ day.

Narrow differential.

Analyze

Probe

Plan management

Select an issue to develop a question/educational prescription.

https://www.youtube.com/watch?v=zWavIV7zPFY

Wolpaw T, Wolpaw D, Papp K. SNAPPS: a learner-centered model for outpatient education. Acad Med. 2003 Sep; 78(9):893-8.

Elicit the "starting place" of your learner from them

For a brief clinical encounter:

- Have you done "x" before?
- Have you seen "x" presentation/disease before?
- Investigate understanding of health literacy and patients.
- Review what is expected.

For a clinical rotation:

- Discuss skills and situations, types of patients seen, resident/student comfort level, previous independence.
- Previous independence **may not equal** competence.

CORE ENTRUSTABLE PROFESSIONAL ACTIVITIES FOR ENTERING RESIDENCY
FACULTY AND LEARNERS' GUIDE, AAMC, MAY 2014

"The time is right to identify a short list of integrated activities to be expected of all . . . graduates making the transition from medical school to residency: the Core Entrustable Professional Activities for Entering Residency."

DEFINITIONS

- ***E**ntrustable **P**rofessional **A**ctivity* *(EPA)*: EPAs are units of professional practice, defined as tasks or responsibilities that trainees are *entrusted* to perform unsupervised once they have attained sufficient specific competence
- ***Competency:*** An observable ability of a health professional, integrating multiple components such as knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition
- ***Educational Program Objectives*** (EPOs): **Sub-competencies** that encompass the knowledge, skills, behaviors, and attitudes students are expected to exhibit as evidence of their achieving competencies necessary for graduation
- ***Milestone***: A milestone is a behavioral descriptor that marks a level of performance for a given **competency**

DEFINITIONS CONTINUED

- **Entrustable**: *Readiness* to perform the activity without direct supervision (under indirect supervision)
- **Pre-Entrustable:** Not Ready . . .
- **Direct Supervision (ACGME)**: The supervising physician is physically present with the resident and the patient
- **Indirect Supervision**:

  Direct Supervision Immediately Available: Supervising physician is physically within the hospital or other site of patient care and immediately available to provide direct supervision

  Direct Supervision Available: Supervising physician not physically present within the hospital or other site of patient care, but immediately available by means of telephonic and/or electronic modalities, and available to provide direct supervision

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

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).

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

EPAS CONTINUED. . .

Two *competencies are foundational to all of the EPAs* because they are required for any entrustment decision:

1) *trustworthiness* and

2) *self-awareness of limitations that leads to appropriate help-seeking behavior*

How much does this vary from your ACGME Milestones for your specialty?

The difference is specificity of knowledge/skills and consistency of competence in many settings.

Residents/students should have sight of where competency lies when they are embarking on their journey to it.

RIME Framework (**Reporter**, Interpreter, Manager, Educator) Appropriate Expectations for ACGME IM Subcompetencies?

I= Introduced to, R= Repeated practice, P= Proficient (basic), P^S= Proficient (complex)

	The RIME framework and the ACGME internal medicine subcompetencies (by competency number)[2*]	Progress† from undergraduate to graduate medical education: Pre-clerkship	Clerkship	Post-clerkship	Post-graduate year 1	Post-graduate years 2-4
Reporter	4.1 Communicate with patient and family	I	R	P		
	1.1 Collect data from patient or family	I/R	P			
	3.7 Use information technology		I/R	P		P^S
	4.1 Establish and maintain effective physician–patient relationships	I	R	P		
	4.2 Use effective communication skills	I	R	P	P^S	
	5.1 Demonstrate respect, compassion, and altruism	I	R	P		
	5.5 Show sensitivity to patients' culture, age, gender, disability	I	R	P		

Rodriguez R, Pangaro L. Mapping the ACGME competencies to the RIME Framework. 2012. Academic Medicine, 87 (12): 1781

RIME Framework (Reporter, **Interpreter**, Manager, Educator) Appropriate Expectations for ACGME IM Subcompetencies?

I= Introduced to, R= Repeated practice, P= Proficient (basic), P^S= Proficient (complex)

	The RIME framework and the ACGME internal medicine subcompetencies (by competency number)[3*]	Progress[a] from undergraduate to graduate medical education				
		Pre-clerkship	Clerkship	Post-clerkship	Post-graduate year 1	Post-graduate years 2-4
Interpreter	2.1 Apply both an investigatory and analytic approach	I		R	P	
	2.2 Know and apply appropriate science	I	R	P		
	2.2 Use patient-centered information (e.g., data from the electronic health record and from the literature)	I	R	P		
	6.1 Show awareness of system and provider interactions		I	R	P	

Rodriguez R, Pangaro L. Mapping the ACGME competencies to the RIME Framework. 2012. Academic Medicine, 87 (12): 1781

RIME Framework (Reporter, Interpreter, **Manager**, Educator) Appropriate Expectations for ACGME IM Subcompetencies?

I= Introduced to, R= Repeated practice, P= Proficient (basic), P^S= Proficient (complex)

	The RIME framework and the ACGME internal medicine subcompetencies (by competency number)[2*]	Progress[1] from undergraduate to graduate medical education				
		Pre-clerkship	Clerkship	Post-clerkship	Post-graduate year 1	Post-graduate years 2-4
Manager	1.3 Develop appropriate diagnostic/therapeutic plans		I	R		P
	1.4 Manage patients effectively			I	R	P
	1.7 Demonstrate technical skills		I	R	P	P^1
	1.2 Work with patients to prevent and maintain their health		I	R	P	
	4.4 Work with other health care providers		I	R	P	
	4.3 Work effectively as a team leader or member		I	R	R	P
	5.2 Provide ethically appropriate care		I	R	P	P^1
	6.3 Provide cost-effective care		I	R	P	
	6.4 Advocate for patients		I	R	P	

Rodriguez R, Pangaro L. Mapping the ACGME competencies to the RIME Framework. 2012. Academic Medicine, 87 (12): 1781

RIME Framework (Reporter, Interpreter, Manager, **Educator**) Appropriate Expectations for ACGME IM Subcompetencies?

I= Introduced to, R= Repeated practice, P= Proficient (basic), P^S= Proficient (complex)

	The RIME framework and the ACGME internal medicine subcompetencies (by competency number)[2*]	Progress† from undergraduate to graduate medical education: Pre-clerkship	Clerkship	Post-clerkship	Post-graduate year 1	Post-graduate years 2-4
Educator	3.8 Counsel and educate patients		I	R	R	P
	3.1 Apply practice-based improvement system		I	R	R	P^S
	3.6 Locate and apply scientific studies		I	R	R	P
	3.4 Obtain/use information about own patient population			I	R	P
	3.6 Appraise clinical studies			I	R	P
	3.8 Engage in teaching role			I	R	P
	6.1 Demonstrate awareness of different health care models		I	R	P	
	6.6 Actively improve system quality			I	R	P

Rodriguez R, Pangaro L. Mapping the ACGME competencies to the RIME Framework. 2012. Academic Medicine, 87 (12): 1781

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

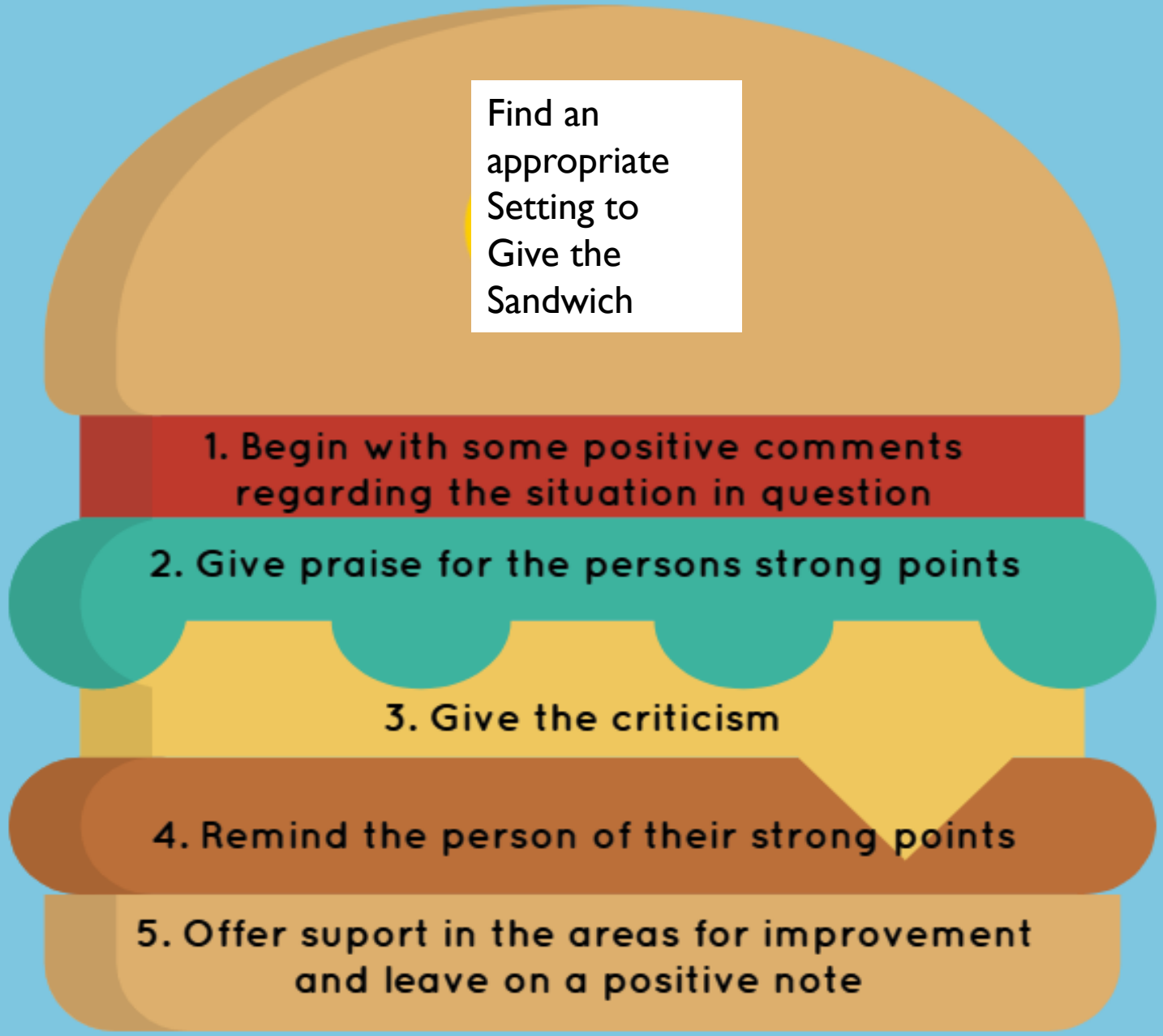
What you **T**hink? – Reflect back to the learner

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

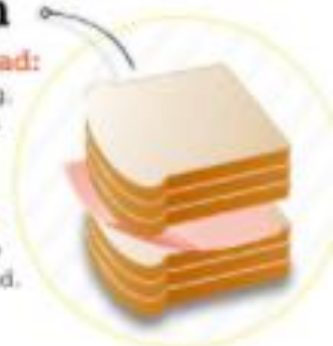
The Untraditional Wrap

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.

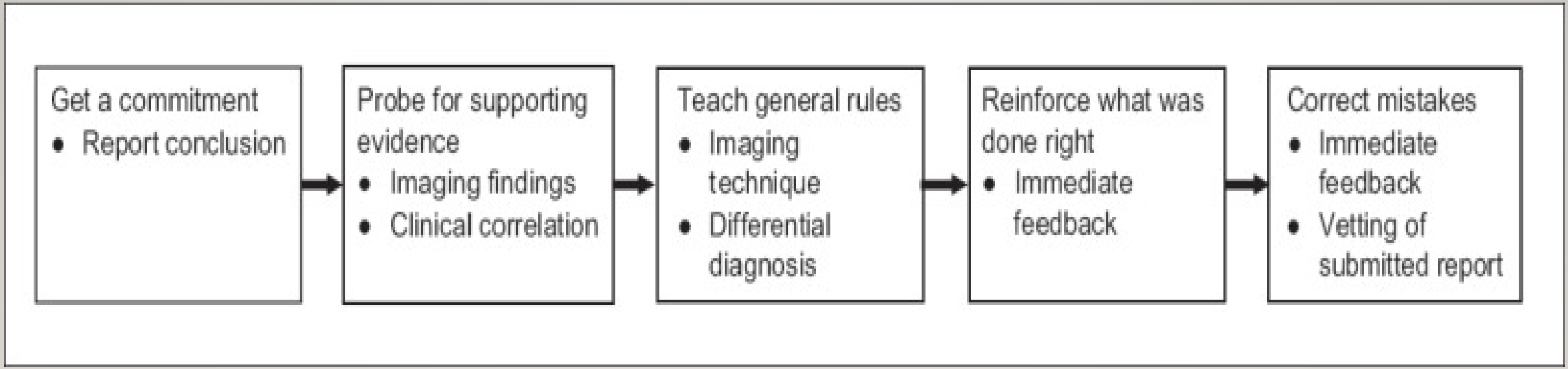
Pendleton D, Schofield T, Tate P, Havelock P. The Consultation: An Approach to Learning and Teaching. Oxford: Oxford University Press; 1984.

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.

COHEN'S KAPPA

- **Interobserver agreement.** (observed proportionate agreement - random agreement)
- Examiner A vs Examiner B.

Value of Kappa	Level of Agreement	% of Data that are Reliable
0-.20	None	0-4%
.21-.39	Minimal	4-15%
.40-.59	Weak	15-35%
.60-.79	Moderate	35-63%
.80-.90	Strong	64-81%
Above .90	Almost Perfect	82-100%

PLOS ONE (2015) TAMJEEDI ETAL. INTEROBSERVER AGREEMENT BETWEEN ON-CALL RADIOLOGY RESIDENT AND GENERAL RADIOLOGIST INTERPRETATIONS OF CT PULMONARY ANGIOGRAMS AND CT VENOGRAMS

CTPAs were reported by staff radiologists as positive for pulmonary embolism (PE) in 18% (126/694), with a **kappa of 0.81** (95% CI 0.77-0.86) with 3 outcomes (P, N, I), and a kappa of 0.89 (95% CI 0.85-0.94) with 2 outcomes (P, N). Regarding PE location, good concordance was observed for positive studies, with a **kappa of 0.86** (95% CI 0.78 – 0.95). CTVs were reported as positive by staff radiologists in 8.5% (33/388), with a kappa of 0.66 (95% CI 0.55-0.77) with 3 outcomes (P, N, I), and a **kappa of 0.89** (95% CI 0.8-1.0) with 2 outcomes (P, N). The IOA between residents and staff radiologists increased with increasing residency year level for CTPAs, but did not for CTVs.

FACULTY EDUCATION – PERFORMANCE DIMENSION TRAINING

- Get buy in from faculty and trainees..
- Develop skills checklists and behavioural anchors.
- Review as a group.
- Measure!
- Compare raters!

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=I9b2oXrzMd8&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

COUNSELING ABOUT A NEW MEDICATION

What would be the criteria for an excellent, adequate and poor counseling session?

VIDEO AND CHECKLIST - BREAKOUT

Good and bad examples of medication counselling.

https://www.youtube.com/watch?v=TBqfu-uaRpU

Gupta, S., Shaw, J. Development of medication-related counselling skills in senior medical students: a checklist-based approach. *BMC Med Educ* **19,** 335 (2019).

https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-019-1773-x

Training videos with feedback for benchmarks can help learners understand goals as well

Martin D, Regehr G, Hodges B, McNaughton N (1998) Using videotaped benchmarks to improve the self-assessment ability of family practice residents. Acad Med. Nov 73(11): 1201-6.

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/

Remind all – 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)