

Virtual Mentor

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Vignette 7: Resident-to-Student Communication

Giving Honest Feedback

Commentary by Benjamin Blatt, MD

A resident consults with you about a third-year medical student assigned to her internal medicine team. He is always prepared, has read the patient charts, and has researched the management of the diseases and complications for which they are hospitalized. Yet his answers to specific questions—"What do these test results suggest?" or "What should be our next step?" are sometimes off the mark. In the interest of moving rounds along and making sure the others on the medical rotation have accurate information, she has not addressed this student's performance head on.

The resident tells you, "I'm afraid I am not doing right by this student. In fact, I feel like I am repeating the behavior of some of my residents when I was a student. They seemed unwilling to correct my errors on rounds. They wrote "excellent student" or "good job" on my evaluations even when I knew I had made mistakes. Not that I minded the praise. I just didn't feel I deserved it or learned much from it. So now I find myself saying "good" or "fine" to this student. What can I say to him that's more helpful without making him feel crushed?"

Commentary

This case brings up a disturbing trend: as a medical student, you received meaningless praise from your residents; now that you're a resident you find yourself repeating the pattern.

Your experience with feedback is not unique. In a survey performed in an academic medical center [1], 80 percent of the residents reported never or infrequently receiving negative, corrective feedback; 17 percent, never or infrequently receiving positive, reinforcing feedback. Fewer than 30 percent reported receiving *any* kind of feedback often. Teachers avoid giving feedback—especially when critical—and students avoid soliciting it. Neither teacher nor student wants to risk an awkward confrontation. As a result, there is no constructive feedback [2], or it morphs into half-hearted compliments. When negative feedback does occur, however, it may be dysfunctionally critical. If asked, most medical students can effortlessly offer a story or 2 of humiliating feedback encounters. Further exposing this dark side of the learning experience is a considerable literature on student abuse [3, 4].

What's wrong with giving only compliments or criticisms? Feedback is meant to be a guidance system that keeps its subject on course. It really *is* rocket science, which is where the term *feedback* originated. What's the problem with uncritical, undeserved

compliments? They don't guide—they don't reinforce specific behaviors. They provide some "feel good" motivation, but, as you yourself discovered, this is neutralized if the compliments are undeserved. Criticisms, on the other hand, may be behaviorally specific. However, if harsh and unbalanced by positive feedback, criticisms precipitate defensiveness. When attacked, students channel their energy to self-defense, not learning.

A culture in which feedback disappears or is too critical fosters an anxiety-ridden educational climate. Students don't know if they are learning and teachers don't know if their teaching is effective. Ultimately, patients bear the brunt of it; they may not get the care they need. As Ende puts it,

The goal of clinical training is expertise in the care of patients. Without feedback, mistakes go uncorrected, good performance is not reinforced, and clinical competence is achieved empirically at best, or not at all [2].

An effective feedback method is vitally important, then, for learners, teachers, and their patients—present and future. As you discovered, patterns in our academic medical culture, as in any culture, tend to get repeated. Establishing a more effective feedback method means passing on a better heritage than the one that was passed on to you.

How then can you avoid the compliment-criticism trap and give effective feedback? Let me summarize some strategies based on expert opinion, research, and personal experience [5, 6].

General Support Strategies

1. **Prepare the learner:** Make appointments for individual feedback sessions at the beginning of a rotation. Identify specific goals (eg, feedback on clinical skills).
2. **Create a supportive learning climate:** Treat the learner with respect, as a partner; approach difficulties as mutual problems (as in problem-based learning), be nonjudgmental, introduce humor, make risk-taking safe.

SOAP Paradigm for Giving Feedback

The Subjective/Objective/Assessment/Plan (SOAP) paradigm commonly used to structure clinical notes can also be used to guide you through the feedback interaction. (No great surprise: there are strong parallels between the teacher-student and doctor-patient relationship). Begin with the "subjective," eliciting the student's agenda as you would elicit a patient's agenda; proceed to the "objective"—your observations; and then go to assessment and plan as indicated below. Keep in mind, however, that the SOAP approach is a simplification; alter your course in response to teachable moments if they present themselves; be flexible when using the SOAP paradigm [5].

Let's apply the SOAP paradigm to this situation:

S Ask the learner for a subjective self-assessment: Begin the interaction by asking the learner, "How did it go? Anything you felt went especially well? Anything you were concerned about?" Make the process learner-centered: Ask the learner to help set the

agenda and goals for the session, to share past experiences, and partner with you to problem-solve. Adults learn best when they are motivated by the involvement characteristic of this sort of experiential learning [6].

O. Give objective feedback—balanced (reinforcing as well as corrective), descriptive feedback. Describe your observations and encourage the learner to reflect, thereby helping him to synthesize his own feedback (“You seemed to become a bit uncomfortable when you began the sexual history—can you tell me what was happening?”). Whenever possible, suggest choices rather than directing the learner. Keep the feedback points to a reasonable number.

A. Assess and summarize learning: Ask the learner to state 1 or 2 “take-home” points.

P Formulate an action plan: Ask the learner, “What new things will you try? What will you do differently? What research will you do?” Arrange for a follow-up to evaluate how the new strategies are working.

Finally, using the above strategies, let’s perform a hypothetical feedback session with the student who concerned you:

Strategies for Resident-Student Interchange **Prepare the Learning Climate**

Resident: This is our first of 2 feedback sessions you and I had arranged at the beginning of the rotation. My goal is to focus on clinical care and for us to work together to identify what is working well for you and what isn’t.

Does that sound OK to you? Any special goals you have?

Student: Sounds fine.

Subjective

R: So how have things been going?

S: OK, I guess.

R: Any examples?

S: Well, I have been working hard to know my patients really well, keep up with their charts, and read up on them.

R: I’ve noticed and am impressed! Anything else?

S: No, that’s about it.

Objective

R: Let me try to give you some of my observations.

Your hard work is paying off. You always know your patients cold, lab work and everything.

Tell me about your thinking process when it came to Joe Tolliver with the pleuritic chest pain.

S: Well, I guess I'm a little upset about that—I just didn't think of a pulmonary embolism. He had fever, so I was sure he had pneumonia.

R: Thinking back on the month, has that sort of thing happened before?

S: Yes, with several patients. Sometimes I get so involved that I just go with the diagnosis that first pops into my mind.

R: Agreed. This is an area you should work to improve. It's really perceptive of you to have picked up on it. Any strategies you can think of to help?

S: Slowing myself down could help—maybe just sitting down and writing out the differential, and then reflecting on what I might have missed.

R: Sounds good.

Assessment

R: So what's your take away from this feedback session?

S: Keep on top of my patients the way I have been; slow down, write and reflect when it comes to differential.

Plan

R: Let's meet again in 2 weeks and re-evaluate your plan. That OK? Also, it might help to do a few of the computerized clinical reasoning cases.

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