Feedback that engages fellows
beyond the feedback sandwich

Learning Objectives

- Provide feedback based on learner goals
- Respond to emotional reactions of learners receiving feedback
- Calibrate a learner’s self-assessment by focusing feedback on the issues that are closest to their learning edge

Building new standards for what fellows consider ‘good’

Feedback may be the single most important part of the teaching encounter. Through feedback, learners become aware of which of their behaviors facilitate or inhibit successful communication. Feedback also helps them think about how to improve their communication either by engaging in more desired behavior or decreasing ineffective ones. Feedback is most useful to the learner when the recipient does not become defensive, and when the feedback promotes open discussion, increases the testing of new skills, encourages alternative approaches and, ultimately, facilitates behavior change in the learner.

Unfortunately, feedback often results in exactly the opposite outcomes. Learners feel judged, are unwilling to experiment and end up resenting the entire communication skills training process. When they hear the word “role-play” or “standardized patient,” many physicians remember their experiences in medical school with a PTSD-like aversion. To avoid such responses, feedback must be delivered in a way that does feel critical or personal, and that is perceived to be of value to the learner.

Addressing the fellow’s learning goals

We have found that using the fellow’s learning goals makes the feedback process more straightforward. (This approach was developed by the Calgary group, who use the term “Agenda-led outcome-based analysis”). In this approach, feedback focuses on the needs of the learner and is structured to be descriptive, but non-judgmental. An important principle of the approach is that feedback should be solicited rather than imposed. As we described earlier, the learning process starts by engaging the learner in goal setting, along with an expectation that feedback will address those learning goals. After the patient encounter, the faculty need to start with those goals in talking about feedback. The analysis of the communication is outcome-based in that observations are made with regard to how the learner’s behaviors affect desired outcomes for
both the learner and the patient. This approach is useful because it minimizes judgments about persons (“you just seem to have an inability to do that”) in favor of specific behaviors (“when you said x, I observed that the patient did y”)

This process can be further augmented when the facilitator calibrates the learner’s self-assessment. Calibration refers to a process of focusing the discussion and feedback on those issues that are closest to the learning edge for each learner. Through the use of probes, such as “What is it about this case that makes you uncomfortable?” the facilitator can ask learners to think about their own internal cognitive or emotional processes affecting the interaction.

The Feedback Process – Structuring a Feedback Session

1. Start with the fellow’s previously identified goals. Remind the learner what they were. If the fellow had identified a skill, try to make an explicit connection between the skill and the communication outcome—e.g., for example, rather than only focusing on the process of “more open ended statements,” identify outcomes such as “patient feels supported after hearing bad news.”

2. Ask the fellow for self-assessment and problem solving first, prior to giving your feedback. What did the learner think went well; and what remained challenging?

3. Don’t make suggestions until the learner has identified the problems. Consider offering your observations to help the learner self-reflect.

4. Involve the fellow (and others if working with a group) in problem solving – if done well, the task then becomes one of jointly solving a problem rather than judging the learner

Nuts And Bolts Of Delivering Feedback

1. Feedback should be descriptive rather than judgmental or evaluative (I saw rather than That was good)

2. Make feedback specific rather than general (When you said X the patient did Y rather than You were empathic)

3. Provide balanced feedback and be supportive (Stress both the positive things that the learner did to achieve her goal as well as behaviors which the learner is trying to modify)

4. Focus on behaviors rather than personality

5. Share observations (I saw, I observed, I realized) more than give advice (You should, you must, you overlooked)

6. Make offers and suggestions, generate alternatives (I wonder if)

7. Check the learner’s interpretation of feedback (What do you think? We have come up with a lot of ideas. Do any seem like they would work for you?)

An example

*Faculty:* What’s your sense of what’s going on with this patient?

*Fellow:* I think she’s denying what’s going on.

*Fellow:* One of your goals was listening. How do you think you did there?
Fellow: I feel like I was talking a lot.

Faculty: What made you feel that?

Fellow: There is just so much information I was trying to get out about treatment options and our next steps. I just didn’t want her to think there was nothing more we could do.

Faculty: Do you think what you were saying accomplished that goal?

Fellow: Well, I think I never really gave her a chance to tell me how she felt about the situation.

Faculty: Let’s think about what might help you remain more quiet…

Pearls

1. **Propose and test hypotheses.** There are three types of barriers that impede communication skills. First, the learner may not know what to do. For example, the learner may not know that “wish” statements are useful to building a connection when the patient hopes for something that is unlikely to occur. Second, the learner may know what to do but not be sure how to do it. For example, I may know that I should be empathic but not be sure what how to act that way. Finally, there may be emotional or attitudinal barriers to my operationalizing the skills. For example, my sadness over the patient crying may lead me to not explore her feelings. A good question that would test this hypothesis would be “When the patient began sobbing uncontrollably, I was wondering how you were feeling at that moment.” Other examples of hypothesis generating questions are in Appendix A.

2. **Make observations in the form of suggestions** “one of the things I’d invite you to try is slowing down a bit. Because you are talking very fast, did you notice that?”

3. **Empathy for the fellow can make feedback more effective.** Most fellows are highly aware of the extent to which attending physicians and other faculty evaluate them. Empathy for the challenge of learning, as well as the awkwardness of being observed, can help create a climate in which the power differences are at least acknowledged.

4. **Phrase feedback that is unrelated to the original goal as an additional goal:** “Your goal was to try to talk less because that showed you were really trying to listen to the patient’s concern. You might also consider as a related goal that when you do talk after listening, to reflect back to the patient what they just said to make sure you heard it correctly.”

Pitfalls

1. The feedback sandwich: “These are the things you did well, this is what you did poorly, but you really did do some good things.” The positive comments are perceived as insincere, and the “meat” on the inside is felt to be judgmental. More importantly, the sandwich is not tied to the learner’s goals and thus are more difficult to internalize.

2. Evaluative and non-descriptive phrasing of feedback: “That was really good – I could tell you really cared about her” (without saying what about the behavior conveyed that). Or, “That’s really the wrong way to respond to a statement like that.”
3. Giving feedback about too many things. Like changing too many medications at once, this overwhelms the learner. In addition, when you give feedback on many things, the learner is more likely not remember the key things you wanted them to focus on.

References
