LCC: Receiving Feedback - Facilitator Guide
A. Moffatt

CanMeds Competencies: Scholar, Medical Expert
Time: approximately 60 minutes

Objectives:
- Identify barriers to receiving feedback in the clinical setting
- Discuss strategies that can be employed to receive and use feedback effectively
- Develop an approach to delivering effective feedback

Groups will discuss barriers to receiving feedback and strategies that can be employed to give and receive feedback more effectively. Residents have been given three resource articles to read before the session:

During the session

- Groups should discuss the questions below. These questions are based on points covered in the resource articles.

- To supplement the discussion questions, groups may choose to watch a video on giving and receiving feedback (https://youtu.be/DnuOipdCWAE) or role play delivering feedback (scenarios for role playing are attached)

- Discussion questions:
  1. The resource articles identify that although feedback is essential to professional development, there are many barriers to receiving feedback successfully. Some common barriers are identified below. Discuss these barriers or barriers that you've experienced:
     - Weak self-assessment skills (significant "blind spot")
     - Lack of perceived bond or investment from the provider of feedback
     - Workplace culture or environment does not support feedback
     - Emotional response to feedback (fear of exposing weaknesses, feeling vulnerable or defensive)
     - Poor quality or content of feedback (not based on observations, vague, delayed, comments on personal qualities rather than behaviours)
2. The resource articles identify strategies learners can apply to use feedback more effectively. Some of these strategies are listed below. Discuss these strategies or personal strategies that you've used to make the most of feedback.

- Improve self-assessment skills
- Seek out feedback often
- Anticipate emotional responses to negative feedback and understand that learners are expected to make mistakes
- Ask for specific examples
- Make a plan to address weaknesses and set learning goals
- Ask about strengths and build on them

3. Residents are often asked to provide feedback to other learners. Using your knowledge of how to receive feedback effectively, discuss how you might structure your feedback to other learners. Some examples are listed below.

- Give frequent feedback
- Set aside time for feedback and choose a quiet, private location
- Try to establish a comfortable bond or relationship with learners
- Base feedback on observations and provide specific examples
- Give feedback on behaviours (not on personality traits)
- Provide feedback on strengths as well as weaknesses
- Help learners to develop goals and a learning plan
Role playing scenarios

1. Junior Resident and Staff: Dr JP Resident is at the end of a 4 week off-service rotation on Peds CTU. JP has worked with Dr. Staff for the last 2 weeks of the rotation. JP and the staff are sitting down for the final rotation evaluation.

Background information for both roles is outlined below:

- **Staff:** The CTU has been very busy during this rotation and the staff has supervised JP on rounds but has not worked with him directly (reviewing consults or observing patient encounters). Based on limited observations, JP has met the expectations for the rotation with no significant concerns. Feedback from the senior resident is positive, mostly commenting on JP's strong work ethic, thorough consults and punctuality. Dr Staff has observed that JP is well prepared for rounds, however he seems to generate a limited differential diagnosis for his patients. Dr Staff is not anticipating any difficulties with this feedback session and is caught off guard by JP's reaction to the feedback. When asked for specific examples, Dr Staff cannot remember a specific case example of where JP's differential was limited and speaks in generalizations.

- **JP:** This is JP's last off-service rotation in PGY1. He has learned a lot during his first year of residency and is confident in his skills. JP is expecting to have the final rotation evaluation with his staff and the SPR. He worked closely with the SPR during the 4 week rotation, including reviewing many ER consults. He has been reading around his patients during the rotation and has developed an approach to many common Pediatric presentations. He has worked hard to develop a thorough differential for the consults he has seen, with positive feedback from the SPR and other staff he has worked with. He is surprised to find out that the SPR will not be involved in the final evaluation since he has not worked very much with Dr Staff. He is defensive when given feedback about having limited differential diagnoses. He asks for specific examples of differentials that were too limited, and is annoyed when Dr Staff gives general advice.

Positive points in this scene include:
- the person giving feedback provided feedback in person, in a private location and in a timely fashion
- the person giving feedback provided feedback on both strengths and weaknesses
- the learner asked for specific examples for feedback when he was unclear

Issues raised in this scene include:
- the person giving feedback has not developed a rapport with the learner and is basing their assessment on limited observations
- the learner is not provided with specific examples of the behaviour to be corrected
- the learner receiving feedback reacts emotionally and is defensive
2. Clinical Clerk and SPR: The night SPR sits down with the Clinical Clerk for feedback after a night shift. This is the second night that the SP and CC have worked together.

Background information for both roles is outlined below:

- **SPR:** SP has concerns about CC's performance. CC has seen approximately 6 consults over two night shifts with SP and all have been extremely limited with major gaps in the patient histories and physical exams. After their first night shift SP reviewed with CC what a full Pediatric consult should include and specifically discussed why assessment of hydration status is important for infants admitted to hospital since they are prone to dehydration when unwell. Unfortunately, there was no improvement during their second night. CC continued to provide limited histories and did not include hydration status in her assessments. During the feedback session, it is evident that CC is not aware of her weaknesses and did not even remember the previous feedback about hydration status. Both CC and SP are tired after a busy night and wish to complete feedback quickly, so SP only discusses her concerns and does not comment on positive behaviours that should be continued. When asked by CC for strategies to improve her histories, the SPR does not have any helpful suggestions.

- **CC:** This is CC's first CTU rotation. She is struggling with night shifts as she did not expect to be working all night and does not know how to deal with the fatigue. Since this is her first rotation of clerkship, she feels that she has done well with her consults as she often formulated a diagnosis and plan. She is very uncomfortable around children, particularly infants, and tried her best to avoid examining babies. She is not aware of the gaps in her assessments and forgot about the SPR's feedback about hydration status. She accepts the SPR's feedback without argument. When told that her histories are too brief and incomplete, CC asks for advice for improvement but the SPR does not offer helpful suggestions.

**Positive points in this scene include:**
- the person giving feedback included specific examples in the feedback (ex: hydration status assessment)
- the person giving feedback provided regular feedback to the learner (after each night of call)
- the learner did not become defensive during the feedback session

**Issues raised in this scene include:**
- the learner demonstrated poor self-assessment skills
- the person giving feedback does not help the learner develop a plan to address their weaknesses
Encouraging residents to seek feedback

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Abstract

Aim: To explore resident and faculty perceptions of the feedback process, especially residents’ feedback-seeking activities.

Methods: We conducted focus groups of faculty and residents exploring experiences in giving and receiving feedback, feedback-seeking, and suggestions to support feedback-seeking. Using qualitative methods and an iterative process, all authors analyzed the transcribed audiotapes to identify and confirm themes.

Results: Emerging themes fit a framework situating resident feedback-seeking as dependent on four central factors: (1) learning/workplace culture, (2) relationships, (3) purpose/quality of feedback, (4) emotional responses to feedback. Residents and faculty agreed on many supports and barriers to feedback-seeking. Strengthening the workplace/learning culture through longitudinal experiences, use of feedback forms and explicit expectations for residents to seek feedback, coupled with providing a sense of safety and adequate time for observation and providing feedback were suggested. Tensions between faculty and resident perceptions regarding feedback-seeking related to fear of being found deficient, the emotional costs related to corrective feedback and perceptions that completing clinical work is more valued than learning.

Conclusion: Resident feedback-seeking is influenced by multiple factors requiring attention to both faculty and learner roles. Further study of specific influences and strategies to mitigate the tensions will inform how best to support residents in seeking feedback.

I do not recall residents really coming forward and saying, ‘Hey, listen, bow was I?’

Background

The majority of learning in postgraduate medical education occurs through participation in clinical experiences in the workplace. Residents and their supervisors agree that feedback is a crucial component of this process and is essential for learning (Teunissen et al. 2009; Archer 2010; Watling et al. 2012b). It enables learners to monitor their progress, provides direction for improvement and informs learners’ self-assessments (Archer 2010). Without feedback, learners may be unclear as to how well or how poorly they are performing, and the most expedient actions they should undertake for improvement (Rees & Shepherd 2005). Self-assessment alone is unreliable; and feedback from external sources is essential to confirm or disconfirm self-perceptions (Archer 2010; Sargeant et al. 2010, 2011). Residents are in the process of developing self-assessment and self-monitoring skills that will serve them throughout their professional lives and feedback enables this process.

Studies consistently show that medical students and residents feel they do not receive enough effective feedback while faculty perceive that they provide feedback that may be under-recognized by learners (Archer 2010; Jensen et al. 2012). This is an important gap. Moreover, medical education has generally viewed feedback as information created and transmitted by a teacher or supervisor to a learner, with the focus on the supervisor. Hence, research and education initiatives have addressed strategies for improving the feedback exchange process and resident feedback-seeking are influenced by multiple factors. Both faculty and learner roles require attention.

Resident feedback-seeking activities appear to be dependent on four central factors: 1. learning/workplace culture/climate, 2. relationships, 3. purpose and quality of feedback, 4. emotional responses to feedback.

Further research is needed to determine how to reduce the tensions between faculty and learner perceptions of the feedback exchange process and how to encourage residents to take an active role in seeking feedback from their clinical supervisors.

Practice points

- The feedback exchange model between clinical supervisors and learners has shifted to include the role of the learner in seeking and accepting feedback.
- The feedback exchange process and resident feedback-seeking are influenced by multiple factors. Both faculty and learner roles require attention.
- Resident feedback-seeking activities appear to be dependent on four central factors: 1. learning/workplace culture/climate, 2. relationships, 3. purpose and quality of feedback, 4. emotional responses to feedback.
- Further research is needed to determine how to reduce the tensions between faculty and learner perceptions of the feedback exchange process and how to encourage residents to take an active role in seeking feedback from their clinical supervisors.

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feedback message and the supervisor’s ability to provide feedback effectively. Less attention has been given to the learner’s role in seeking feedback.

Recent attention in postgraduate medical education has shifted to a more learner-focused model with increased attention to the role of the learner in the feedback exchange (Hattie & Timperley 2007; Boor et al. 2008; Watling et al. 2008; Watling & Lingard 2010; Bing-You & Trowbridge 2009; Goldman 2009; Teunissen et al. 2009, 2007; Krackov 2011; Milan et al. 2011). An effective feedback exchange requires learners to be active recipients and seekers of feedback (Teunissen et al. 2007). Developing a “culture of feedback” in which learner self-assessment is informed by feedback, feedback is embedded in all activities, and trainees feed back to teachers as well as teachers to students has been promoted (Cantillon & Sargeant 2008; Archer 2010).

Multiple factors influence whether learners will seek feedback as needed in clinical settings including external factors such as supervisors’ receptivity to learners, learner – supervisor relationships, the learning culture, and internal factors such as the learner’s confidence and beliefs about one’s competence (Stewart 2008; Archer 2010; Bindal et al. 2011; Sargeant et al. 2011). The acceptability and impact of feedback can be increased if it relates to personally meaningful goals set by the recipient (Goldman 2009; Archer 2010).

**Purpose**

In this qualitative study, we explored senior residents’ and faculty’s perceptions of residents’ feedback-seeking activities, with the goal of developing strategies to support meaningful feedback exchange.

**Methods**

Using an exploratory qualitative approach, we conducted focus groups with residents and faculty at Dalhousie University regarding their perceptions of residents’ feedback-seeking activities. Focus groups enable participants to describe their perceptions and experiences, hear the reactions and perceptions of others, and through discussion explore both shared and disparate views, potentially adding to understanding (Liamputtong 2009).

We invited senior residents in specialty programs and faculty in these programs by e-mail to participate in the study. Senior residents have more experience with clinical feedback to draw upon to provide suggestions for supporting feedback-seeking. To guide the data collection, we developed a semi-structured interview guide addressing residents’ experiences in seeking and receiving feedback, and faculty experiences in providing feedback and encouraging feedback-seeking, barriers or concerns perceived in the feedback exchange from their respective perspectives, and suggestions for supporting feedback-seeking. Two trained facilitators conducted the focus groups. One, KL, was consistent for all groups and the second was a clinical member of the research team from a specialty not represented by the focus group participants. This was undertaken to prevent potential bias by the interviewer.

Focus groups lasted one hour. The facilitators explained the purpose of the study, obtained consent, and informed participants that no identifying data would be included in the transcriptions. In addition to addressing the semi-structured questions, the facilitators explored related topics as they arose during the conversation. The focus groups were audiotaped and transcribed. The study was approved by the Research Ethics Board of Dalhousie University.

**Analysis**

We conducted the analysis using an iterative interpretive process (Miles & Huberman 1994). Team members initially read the transcripts to develop coding and categories and identify emerging themes, and then reread and discussed either the faculty (DD, CL, KM, SM) or resident transcripts (JH, PAB, KL, JS) in detail to confirm the codes and proposed themes. Groups met several times for this purpose. Finally, the groups compared findings across faculty and residents and developed a concept map (MindManager 2010) to clarify common themes and differences between the faculty and resident groups (Figure 1). Differences in interpretation were resolved through discussion and returning to the data.

**Results**

We conducted two focus groups each for faculty and residents. Participants included 10 senior residents (PGY3-5), eight female, two male; six in Internal Medicine, four in Pathology; and eight faculty, four female, four male; five in Internal Medicine, and one each for Surgery, Pathology, and Pediatrics.

Focus group participants confirmed many concerns regarding effective feedback reported in the literature such as the need for timely, specific feedback that is validated by observation. Importantly, new findings emerged regarding feedback-seeking. Themes included four central factors: culture or workplace/learning climate, relationships between learners and supervisors, quality of feedback and emotional responses to feedback. Subthemes were identified and illustrative quotes including similarities and differences between faculty and resident perceptions were highlighted (see Table 1).
Table 1. Quotes illustrating similarities and differences between perceptions of faculty (F) and residents (R) with respect to Influences upon residents’ feedback-seeking activities.

<table>
<thead>
<tr>
<th>Theme: Influences upon residents’ feedback-seeking</th>
<th>Subtheme</th>
<th>Agreement</th>
<th>Differences in perceptions leading to tensions</th>
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</thead>
<tbody>
<tr>
<td>1. Culture/climate</td>
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<tr>
<td>R1: “I think there just needs to be a culture shift. Right? ... we are at a teaching institution. Teaching should be built into the job. And as part of teaching, you need to let people know how they are doing.”</td>
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<td>F2: “I think that if there was a culture of okay, at the end of the day today, I want to know one thing that I can improve on.”</td>
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<tr>
<td>Safety</td>
<td>R2: “We don’t want to have our worst fears of inadequacy realized by anybody.”</td>
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<tr>
<td>F1: “or whatever, I don’t know. Don’t ask, don’t tell. Now, maybe some of them feel, ‘Geez, I don’t want to hear any bad news.’”</td>
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<tr>
<td>Time</td>
<td>F1: “I think that if there was a culture of okay, at the end of the day today, I want to know one thing that I can improve on.”</td>
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<td>Structure</td>
<td>R1: “I’ve noticed that, residents on a service in their own specialty are more likely to look for feedback than people who are just trying to get in and get out ……” So I think there is a difference between whether there’s an ownership to your own service or not.”</td>
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<tr>
<td>F1: “I find with our core program trainees, it’s easier because we have more of a longitudinal relationship with them.”</td>
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<td>2. Relationships</td>
<td>R1: “I like the feedback that I get when I feel it’s personalized and the person who I worked with really understood what I was doing, what I was trying to achieve, and how much time and effort I put into it.”</td>
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<td>Comfort</td>
<td>F1: “If you feel really comfortable with the staff then there’s no hesitancy. If it’s somebody that, I don’t know, you’re more intimidated by, there’s less of an inclination to do that.”</td>
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<td>F1: “It seems that a lot of residents all get comfortable with the same couple of staff.”</td>
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<tr>
<td>3. Quality of Feedback</td>
<td>F1: “You are working with a resident every single day. Then you have a better opportunity of seeing how they work and working with them and giving them some feedback.”</td>
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<tr>
<td>Contact</td>
<td>F1: “It’s much more difficult when you’re just dropped in somewhere for that 4 week rotation ……” something could easily get left behind.”</td>
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<td>4. Emotional Response: a barrier</td>
<td>R1: “It’s probably hard for him to tell me, and for me to take it at the time. I was completely mortified. But in retrospect, I was glad.”</td>
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*continued*
Participants in both faculty and resident groups agreed that a culture or learning climate that normalizes and encourages feedback would open residents to seeking feedback. Faculty suggested that residents must be expected to take responsibility for seeking feedback. Meanwhile residents suggested that infrequent or the lack of useful feedback discouraged feedback seeking. In addition, the tension between formative feedback and summative evaluation (such as In-training evaluation reports, ITERS) was expressed as a barrier to seeking feedback by residents although faculty did not share the resident concern that poor formative feedback may affect the final assessment. A prominent theme for faculty was perceived time pressure. Residents recognized time as a barrier to approaching busy faculty but felt that faculty did not spend enough time observing or working with them to provide meaningful feedback. Both residents and faculty suggested that “core rotation” residents, i.e. those working in their specialty program were more likely to seek feedback than residents on short placements. Structural changes such as the requirement to have evaluation forms completed prior to promotion supported residents in seeking feedback. Another structural trend that seemed to support regular feedback and feedback seeking was the “daily feedback” form that was being used in the emergency department. This strategy was being introduced in other programs. Faculty members had differing views on the burden of completing daily forms but agreed that the information helped them to complete final evaluations.

Relationships

Relationships with supervisors influenced residents' feedback-seeking activities. Residents were sensitive to whether supervisors were interested in helping them learn and dismissed supervisors whom they perceived only valued them for providing service. Strongly associated with the relationship theme was the theme of comfort. Residents were more comfortable with some faculty members than others, sometimes related to proximity in experience but also to how open and supportive versus intimidating they perceived the faculty member. In contrast, faculty were curious about whom the residents would approach and did not seem to know what behaviours might encourage feedback-seeking.

Discussions regarding the quality of feedback centered on the degree of contact. Residents were adamant that lack of observation diminished the credibility of the feedback provided, as well as its specificity and usefulness. Faculty agreed that more time spent with the resident helped them provide more specific, individualized feedback. Increased contact allowed faculty to witness residency performance improvement as a result of the feedback exchange and to identify learners in difficulty at an earlier stage. Residents reported that increased contact enhanced their comfort and willingness to seek feedback.

Emotional response

Both residents and faculty agreed that emotional responses to feedback were a barrier for residents seeking feedback and for
Adequate exposure was also important for program or with more intensive exposure with peers such as coaching of learners. Feedback reports might assist with more effective and balanced frequent yet efficient and effective feedback such as daily longitudinal relationships between learners and teachers and interfered with providing feedback. In the complex environment, not support teaching, and time pressures for patient care deficiencies. Faculty perceived that the institutional culture did not support teaching, and time pressures for patient care deficiencies. They tended to seek out faculty who they felt took an interest in their learning and gave specific constructive feedback. Faculty expressed uncertainty regarding their effectiveness in providing feedback and were frustrated in not receiving feedback from learners on whether their feedback was helpful. Learners were wary of providing feedback to faculty, for fear of repercussions. The costs or barriers to feedback seeking were strongly influenced by the emotional aspects of the feedback process. For some there was discomfort in receiving any assessment, “good or bad”. Both faculty and residents referred to the emotional costs of “negative” or disconfirming feedback. For residents fear of negative feedback was a barrier to feedback-seeking and the defensive reactions of learners on short placements and residents agreed that evaluations by faculty who had not worked closely with them were discounted.

Watling and colleagues (2012a) propose that feedback from supervisors is judged by residents for credibility much more critically than feedback gained through clinical experience or from patients. The perceived value of feedback is influenced by the belief that it is based on accurate observation. Feedback is enhanced not only by the perception of expertise but also by the continuity of the relationship (Irby 2007). The residents were unlikely to seek feedback that they felt was vague, not based on observation and did not help them to overcome their deficiencies. They tended to seek out faculty who they felt took an interest in their learning and gave specific constructive feedback. Faculty expressed uncertainty regarding their effectiveness in providing feedback and were frustrated in not receiving feedback from learners on whether their feedback was helpful. Learners were wary of providing feedback to faculty, for fear of repercussions. The costs or barriers to feedback seeking were strongly influenced by the emotional aspects of the feedback process. For some there was discomfort in receiving any assessment, “good or bad”. Both faculty and residents referred to the emotional costs of “negative” or disconfirming feedback. For residents fear of negative feedback was a barrier to feedback-seeking, and the goal of performance orientation is to demonstrate and validate the adequacy of one’s competence and thus, the learner is less inclined to seek feedback unless it confirms the self-perception of competence (VandeWalle & Cummings 1997; VandeWalle et al. 2000; Ashford et al. 2003). Learning about goal orientation may be a useful approach to assisting residents in developing an approach to seeking feedback. Goal orientations are described as either “developing” or “demonstrating” one’s ability. In a learning orientation, the learner’s goal is to develop competence by acquiring new skills and mastering new situations, thus being open to seeking feedback. Alternatively, the goal of performance orientation is to demonstrate and validate the adequacy of one’s competence and thus, the learner is less inclined to seek feedback unless it confirms the self-perception of competence (VandeWalle & Cummings 1997; VandeWalle et al. 2000; Ashford et al. 2003).

In this study we saw evidence of residents with a performance orientation (“flying under the radar”) who seemed inhibited in seeking feedback if their self-perceptions may be challenged or the final evaluation may be affected. Alternatively, there was evidence of residents with a learning orientation who appeared eager for feedback (“either positive or negative, anything!”)

Limitations

This study took place in one institution and involved senior specialty residents which may limit generalizability to other settings or other training programs. We conducted two focus
groups each for faculty and residents. We believe we reached saturation by this method as focus groups allow consensus or disagreement of topics and subsequent deeper exploration of themes. Although our study is unique in exploring perspectives from both groups in the feedback exchange process, we did not bring residents and faculty together to discuss conflicting perceptions such as the tension between formative feedback and summative evaluations. We believed residents were more likely to be open among their peers. A focus group or educational session that brings residents and faculty together may be more effective in developing shared understanding of the constraints and possible solutions to improving the feedback exchange. Finally, the interaction of the factors associated with feedback is likely more complex than we have indicated in Figure 1. The experience of the feedback exchange may influence both the relationships and the perceived quality of the feedback, just as relationships affect the culture and the culture affects the relationships.

Conclusion
We sought to understand resident and faculty perceptions of resident feedback-seeking behaviour. We have found that attention only to the skill of providing feedback is inadequate to support a culture of feedback in clinical settings. The workplace/learning culture can be strengthened by structural changes such as longitudinal experiences, use of feedback forms and expectations for residents to seek feedback, coupled with providing a sense of safety and adequate time for observation and provision of feedback. Attention to the relationships and emotional response to feedback is necessary to ensure that both residents and faculty do not avoid providing meaningful feedback. Each of these elements interacts to support or discourage residents in seeking feedback, an activity which they perceive as being fraught with risk.

Further study of the cost/benefit of feedback seeking may result in learning models to facilitate effective feedback exchange, and cultivate a more effective learning environment.

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We would like to thank Tanya Matheson for her research assistance through-out this project. Dr. Holland and Dr. Miller were the principal investigators on the proposal and all authors contributed to the conception and design of the study, acquisition of data, and analysis and interpretation of data. Dr. Delva drafted the article and all authors participated in the revisions. Each author is responsible for the entire work. Ethical approval: The study received approval from the Research Ethics Board of Dalhousie University.

Declaration of interest: This project was supported by a grant from the Royal College of Physicians and Surgeons of Canada/Associated Medical Service (AMS) Inc., CanMEDS Research Development Grant.

Glossary
Feedback: Specific information about the comparison between a trainee’s observed performance and a standard, given with the intent to improve the trainee’s performance.

References


Feedback in Clinical Medical Education: Guidelines for Learners on Receiving Feedback

Feedback skills in clinical medical education are necessary, valuable, and easily taught. Courses designed to help faculty and residents become more effective teachers often include training in effective feedback methods. The ability of residents and medical students to receive feedback as active participants in the learning process is essential for effective learning.

Feedback must be received in a way that serves to improve learning and performance. Because skills in receiving feedback have not been emphasized, we developed the following guidelines.

1. Remember that receiving feedback effectively requires a degree of maturity, self-awareness, and a commitment to the goals of learning clinical skills and improving clinical performance.
2. Formulate learning goals for yourself and share these with your supervisor. Learning goals should be mutually agreed on at the beginning of a clinical rotation or learning experience. Feedback can then be linked to your learning goals.
3. Take an active rather than passive role in receiving feedback. Seek feedback as an ongoing part of your clinical learning, both on a day-to-day basis and in formal feedback sessions.
4. When receiving feedback, ask for specific examples if your evaluator gives none. Seek clarification wherever needed. Additional information can be helpful whether the feedback is positive or negative.
5. If you are given negative feedback, make sure you understand what the issue is, why it is an issue, and what can be done about it. Ask as many questions as needed to gain clarification. Be involved in formulating solutions to improve the situation. Where appropriate, develop a concrete plan for implementing improvements. Because negative feedback can be (though rarely is) a product of interpersonal conflict between you and your evaluator, if you feel this might be the case, use a trusted adviser or friend to help sort out the issues.
6. Consider the feedback you receive as an opportunity for growth and learning. Use your adviser, mentors, and friends as sources for gaining an enlarged perspective.
7. When receiving feedback, discuss not only what you can do to improve, but also what you are doing well, your strengths, and your progress. If learners are unaware of things they are doing well, they may drop some of the positive behaviors from their repertoires.
8. Accept positive feedback as an opportunity to gain a clearer sense of your strengths and to provide an impetus for further growth.
9. Do not be too hard on yourself; you may be your harshest critic. Give yourself credit for what you do know and what you do well.
10. Timing is important. If a feedback session is offered when you are stressed or rushed, ask to reschedule.

Feedback is an important teaching method that plays an essential role in the clinical teaching process and in optimizing patient care. Skills in giving and receiving feedback can be learned and refined; developing an open and inquiring attitude toward feedback reception can facilitate learners becoming active participants in the learning process.

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**FEATURE ARTICLE**

**Ten tips for receiving feedback effectively in clinical practice**

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**Background:** Despite being recognized as a fundamental part of the educational process and emphasized for several decades in medical education, the influence of the feedback process is still suboptimal. This may not be surprising, because the focus is primarily centered on only one half of the process – the teachers. The learners are the targets of the feedback process and improvement needs to be shifted. Learners need to be empowered with the skills needed to receive and utilize feedback and compensate for less than ideal feedback delivery due to the busy clinical environment.

**Methods:** Based on the available feedback literature and clinical experience regarding feedback, the author developed 10 tips to empower learners with the necessary skills to seek, receive, and handle feedback effectively, regardless of how it is delivered. Although, most of the tips are directed at the individual clinical trainee, this model can be utilized by clinical educators involved in learner development and serve as a framework for educational workshops or curriculum.

**Results:** Ten practical tips are identified that specifically address the learner’s role in the feedback process. These tips not only help the learner to ask, receive, and handle the feedback, but will also ease the process for the teachers. Collectively, these tips help to overcome most, if not all, of the barriers to feedback and bridge the gaps in busy clinical practices.

**Conclusions:** Feedback is a crucial element in the educational process and it is shown that we are still behind in the optimal use of it; thus, learners need to be taught how to better receive and utilize feedback. The focus in medical education needs to balance the two sides of the feedback process. It is time now to invest on the learner’s development of skills that can be utilized in a busy day-to-day clinical practice.

**Keywords:** feedback; self-assessment; self-awareness; career development; medical education

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milestones enabling them to practice as competent physicians in their field (19). Effective feedback from both perspectives, delivering and receiving, helps learners to achieve those milestones. Simulation-based medical education (SBME) gained popularity and has been implemented in most medical schools and feedback is now considered to be a critical step in SBME (20).

Numerous barriers have been identified that prevent delivering effective feedback, including medical educators’ unfamiliarity with the feedback, timing and place constraints, and concerns with breaking the educational relationship between teacher and learner with negative feedback (21). In addition, the educational environment plays an important role in the process to enhance or limit the feedback process. On the other hand, there are several learners’ barriers to seek, receive, and handle feedback effectively. These include, but not limited to, inaccurate self-assessment, misconception of feedback as a negative act, and negative reaction that may prevent a productive response.

Even if we empower medical educators with the required skills and enhance the educational environment about feedback, medical practices are a busy environment that may limit the feedback process or have an impact on the way it is given. As such, feedback may be missed or delivered in a non-optimal way. Generational differences are also recognized as an important factor in the feedback process and may limit its use. All of the barriers place emphasis on the learner to seek, receive, and then handle feedback efficiently, regardless of whom, when, and how it is delivered. Empowering learners with skills to properly receive feedback will help ensure they gain the benefits from one of the most important tools in education (5, 22).

Objective
In this review, 10 key tips are provided to help clinical trainees seek, receive, and handle feedback effectively.

Table 1 summarizes the proposed 10 tips to improve receiving feedback.

**Tip #1: Self-assessment**
As the initial step in the feedback process, self-assessment is ‘a global judgment of one’s ability in a particular domain’ (17). Self-assessment is an integral component of self-regulation and is essential to self-development and educational growth (17, 23). Unfortunately, the literature indicates that you are quite poor at doing this (17, 24). Part of the problem is the way you self-assess by thinking of the big picture (globally) rather than analyzing each step separately. Typically, this type of thinking fails to discover the individual skills of interest. To better assess yourself, try to assess your performance at certain tasks by considering the task as a process and break it down into different components. For instance, when staff ask ‘How things went at a specific patient encounter?’ instead of looking at the global picture, try to dissect the task into different steps, such as building rapport with a patient, history taking, physical examination, and post-encounter discussion. By doing this, your chance to identify an area that needs work is quite high, compared to the global impression.

**Tip #2: We all benefit from feedback**
Regardless of where we are in our careers, all of us have blind spots about our abilities that prevent us from reaching the next stage of growth and development. Table 2 illustrates the blind spot issue by using the ‘Johari Window’ (25).

In an ideal situation, a small or negligible ‘blind spot’ quadrant is preferable. One way to achieve this is by receiving external feedback openly. You will learn things, either good or bad, about yourself that you were previously unaware of. By acknowledging that individuals are poor at self-assessment, and have a blind spot, you can utilize feedback to help you grow in your career. With that in mind, feedback will provide you with the opportunity to learn of your strengths and weaknesses.

**Tip #3: Connect well with your instructors**
Connecting with your instructors is the bridge that promotes the learning process and initiates dialog about your performance. Creating a positive and healthy environment is integral to the feedback process (12). Studies show that preceptors have a weak relationship with students (26, 27). Conversely, the discounting of feedback by students is related to their unfamiliarity with educators (27). Promoting this connection will ease the feedback process and eliminate a major barrier to a successful and powerful tool for self-improvement and development.

**Tip #4: Ask for feedback**
Medical practice is quite busy and feedback being overlooked or forgotten has been identified in the literature as one of the barriers to effective feedback (21). Seeking feedback is a powerful initiative towards making improvements. A proactive approach will encourage feedback and from the teacher’s perspective, set it as a priority for the student. The teacher will be stimulated to directly observe tasks performed by students, leading to opportunities for productive feedback. Feedback based on observable behavior is identified as a key element for effective and respected feedback (3, 5, 28).

**Tip #5: Be confident and take positive feedback wisely**
From clinical practice experience, trainees may have various unproductive reactions to positive feedback ranging from an embarrassing attitude, to fears that something negative will happen and this is just segue way to a negative feedback. Remember, your instructor does pay
attention during your clinical practice and observes positive skills and behaviors that need to be continued and built upon in your future career. Appear confident to your instructor by thanking them and be attentive to the details of positive feedback, because this is the basis for growth and development. Successful trainees do not stop when they are good, but instead, take it further and become even more proficient.

**Tip #6: Control your emotions**

The feedback process can be emotionally challenging, particularly when negative or unconstructive feedback is given. Whenever you are faced with that, try to think about it as an opportunity for personal growth and development rather than a failure. You are expected to make mistakes, regardless of where you are in your career and sometimes you are not aware of your mistakes. Do not take feedback personally; the focus is not about you, but about the action and what needs to be changed. Be sure to remain calm so you can deal with the feedback. If you are upset, give yourself an opportunity to calm down and first think about the feedback objectively before engaging further.

**Tip #7: Take an action plan**

Whether feedback is negative or positive, we immediately try to defend ourselves or rationalize our actions, possibly preventing understanding of the issue and considering a solution. Effective listening is a very powerful skill that allows a clear understanding of the issue and that the teacher is trying to help. It is essential to clarify any issue that appears vague and summarize the main concerns to allow active thinking about an action plan to tackle the issue. What is important about constructive feedback is developing an action plan to change and correct the identified issue (5, 29). Try to develop an action plan that is SMART (specific, measurable, achievable, relevant, and time-bound) (30).

**Tip #8: Acknowledge the generations**

The medical field is populated with different generations, and every generation is raised with different ideas and values. Knowing how different generations think and work will enhance your success with the feedback process and to understand how different generations think about feedback. Table 3 illustrates how each generation views feedback.

**Tip #9: Be specific and ask about general feedback**

Not every clinician is good at providing feedback. Indeed, there is insufficient instruction on how to give feedback (21).

### Table 1. Summary of the ten tips

<table>
<thead>
<tr>
<th>#</th>
<th>Point of emphasis</th>
<th>How to deal with it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-assessment</td>
<td><em>Break down the task into different components rather than looking at the global picture.</em></td>
</tr>
<tr>
<td>2</td>
<td>Do I really need feedback?</td>
<td><em>Everyone has a blind spot, which prevents us from reaching the next stage of growth, so go and discover it.</em></td>
</tr>
<tr>
<td>3</td>
<td>Your preceptor(s)</td>
<td><em>Connect well with your teacher and build up the bridge of success.</em></td>
</tr>
<tr>
<td>4</td>
<td>Little or no feedback</td>
<td><em>Take initiative and ask for the feedback.</em></td>
</tr>
<tr>
<td>5</td>
<td>Positive feedback</td>
<td><em>Thank your instructor and appear confident. Take that task to the proficient level.</em></td>
</tr>
<tr>
<td>6</td>
<td>Your emotion</td>
<td><em>You are expected to make mistakes. It is normal to receive constructive feedback. Feedback is an opportunity for improvement. Be a good listener.</em></td>
</tr>
<tr>
<td>7</td>
<td>Your turn! What after the feedback?</td>
<td><em>Here is what really matters, be part of the constructive action plan and follow that up.</em></td>
</tr>
<tr>
<td>8</td>
<td>General differences</td>
<td><em>Acknowledging this will help you to better understand your preceptors.</em></td>
</tr>
<tr>
<td>9</td>
<td>General, non-specific feedback</td>
<td><em>Probe and ask questions to figure out what exactly is the point.</em></td>
</tr>
<tr>
<td>10</td>
<td>Be ready for it</td>
<td><em>Situations matter, feedback can happen at any time and in any form.</em></td>
</tr>
</tbody>
</table>

Table 2. Johari window

<table>
<thead>
<tr>
<th></th>
<th>Known to self</th>
<th>Unknown to self</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known to others</td>
<td>Open</td>
<td>Blind spot</td>
</tr>
<tr>
<td>Unknown to others</td>
<td>Hidden</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Table 2. Johari window**

**Table 3. Generation and feedback**

<table>
<thead>
<tr>
<th>Generation</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditionalists (1900–1945)</td>
<td>‘No news is good news’.</td>
</tr>
<tr>
<td>Baby boomers (1946–1964)</td>
<td>‘Feedback once a year, with lots of documentation!’</td>
</tr>
<tr>
<td>Generation X (1965–1980)</td>
<td>‘Sorry to interrupt, but how am I doing?’</td>
</tr>
<tr>
<td>Generation Y (1981–1999)</td>
<td>‘Feedback whenever I want it at the push of a button’</td>
</tr>
</tbody>
</table>

**Note:** Adapted from Lancaster and Stillman (31).
A common learner complaint is that feedback is too general, such as ‘good job’ or ‘your performance wasn’t great’. Overly general feedback is not helpful (7); however, this does not mean you should dismiss it. Instead, try to probe deeper and find out the actual details of the feedback by asking specific questions as they may lead to a productive conversation about performance.

**Tip #10: Be ready! Feedback is not one type and can be given at any time**

Typically, feedback is viewed as formative assessment, occurring halfway during a clinical rotation. Feedback may come at different times and in different formats. Both short and long formats are used in clinical practice. Teachers, healthcare workers, and patients also give feedback. Situations do matter, feedback is dependent on the actual situation, and sometimes immediate feedback is necessary. Even though feedback may take different forms, it usually targets a common goal by reinforcing positive behaviors or correcting performance. The focus needs to be directed to the actual contents of the feedback and not necessarily the format. Acknowledging this will make you ready to receive, and subsequently use the feedback wisely.

**Conclusion**

Even with optimizing the delivery of the feedback, learner’s self-assessment and receptivity to feedback are essential to completing the successful feedback process and thereby change behaviors and practices. The focus in medical education needs to balance how to deliver feedback with how to receive it. Faculty development efforts need to continue and include learner development efforts. Empowering the learners with skills about how to seek, receive, and handle feedback, regardless of the way it is given, will further improve the feedback process in a busy clinical practice.

The tips provided in this article were intended to provide learners with a framework of strategies to seek, receive, and take feedback to the next level of behavioral and skill changes. The tips are also a useful framework for teaching learners how to be proactive players in the feedback process.

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**References**


