“How delicate should I be?”

A practical toolkit on cultivating learner-centered feedback

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Mandatory Disclosure

We do not have an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization.
Video Breakout Groups

• What was done well?
• What could have been done better?
Objectives

* Acquire skills to use coaching relationships in providing feedback and create an educational alliance
* Assess an individual’s specific learning needs
Assignment

Think about difficult cases to discuss at end of session.
What does the literature say?
Feedback Model as a Dialogue

The feedback exchange needs to focus on encouraging the learner in seeking and accepting feedback.

(Delva, D et al, 2013)
Self-Reflection: Knowing Ourselves

- What is our teaching style?
- What are our values/beliefs?
- How are we feeling about the work we do?
- What do we hope to achieve in our roles?
- How focused am I?
- What is the level of effort I am willing to put into this today?
Learner Reflection: Knowing Your Learner

Discover
- Reflect about strength
- Avoid ladder of inference and draw conclusion: ask what is going on

Dream
- Who is the clinician you want to be

Destiny
- Being and becoming
Barriers to providing effective feedback

External
- Lack of observation
- Insufficient time
- Lack of appropriate place
- Perceived importance

Internal
- No relationship with learner
- Lack of vocabulary, confidence or skill
- Purpose of feedback unclear
- Damaging preceptor-trainee relationship
- Concern about negative faculty evaluation
Barriers to accepting feedback

External

- High quality data and standards
- Credibility of source
- Supervisor engagement, effort & mentoring
- Context/culture
- Learning relationships
- Peers (data validation, interpreting, accepting)

Internal

- Confidence
- Experience
- Motivation (performance vs learning)
- Perceptions of safety of environment
- Perceptions of credibility, sincerity, engagement of others & systems
The learner’s goal
Johari Window

- **Supervisor know**
- **Supervisor doesn’t know**

**SELF**
Solicits Feedback

- Things I Know
  - ARENA
  - FACADE
- Things I Don't Know
  - BLIND SPOT
  - UNKNOWN

**Insight**

**Self-Disclosure** or **Gives Feedback**
Creating an Education Alliance

Feedback Planning
✓ Respectful set up
✓ Gather information/Observe
✓ ARTful feedback or ARCH model
✓ Next steps

Telio et al. Academic Med 2015
www.med.fsu.edu/education/FacultyDevelopment
Set Up

- Establish a respectful learning environment (Check in)
- Ensure your basic needs and the learner’s basic needs are addressed and met/competing priorities
- Privacy, Sleep, nutrition, exercise, emotional support
- How is rotation/residency going? Is today good day for feedback?
Gather Information/Observed

Negotiate goals & objectives for feedback

✶ What would they like to focus on today?
✶ What would you like them to focus on today?

Make feedback based on direct observation

✶ Watch and listen directly
✶ Try to avoid second hand reporting

Make it timely and regular

ARTful Model:

A = Ask learner to self-assess

R = Respond/Reinforce

T = Tell/Teach

ARCH Model:

A = Ask learner to self-assess

R = Reinforce correct thinking and actions

C = Correct errors

H = Help learner develop improvement plan
ARTful Approach
ASK

Anything about that visit that was particularly challenging?
What is your approach to ________________?
How familiar are you with______________?
How did that go for you?
Walk me through your reasoning.
What is your structure/approach with ________________?
Have you noticed that ________________?
**RESPOND**

**Reinforce**

- Helps learner find specific, neutral language to focus on self performance

- Recognition (verbally) increases intrinsic motivation

**Ideal ratio of reinforcing to corrective feedback?**

- **2:1** - Sandwich (Rightful demise)
- **4:1** - Cameron J. & Pierce W. 1994
- **5:1** - John Gottman’s work on relationship
Corrective Feedback/ Appreciative Coaching

- Ask about intention (cultural sensitivity)
- Increase self-reflection
- More specific, rather than generalities; focus on behaviour & skill
- Contextualize
- Therapeutic disclosure to normalize
Make A Learning Assessment

✶ What make the situation challenging for the learner and for me?
✶ What behaviours are we observing?
✶ What additional information or skills are needed?
✶ Where are we getting them?
NEXT STEPS

✱ What is the next plan?
✱ Negotiate learning plan/SMART goals
✱ Plan follow-up
  - Has the feedback been integrated?
  - Has the learner tried out what was agreed upon?

✱ How is this made into learner-centred teaching moment?
Check in
Video & Reflection

Motivational Interviewing Session
Demonstration: ARTful approach

• What was done well?
• What could have been done differently?
More Difficult Cases

✶ Examples?
✶ Discussion?
More Difficult Cases

- Focus on strengths even if inconsistent
- Consider videotaping if that is an option to review together
- Have concrete, specific examples
- Have resident watch you and give you feedback
- Explore attitudes to family medicine
- Explore if any medical knowledge gaps at play
Backpocket Examples

- Resident laid back, not auto-FIFEing, soft tone and slow pace, on time, elicits patient perspective and contextualizes medical knowledge to individual patient
- Resident believes in biomedical model
- Resident not expressive in facial cues or verbal modality which is affecting patient rapport and shared understanding
- Resident is not matching tone/pacing to where patient is at: more upbeat than patient, patient does not feel taken seriously
- Resident interrupting and asking questions before patient answers first one
- Resident avoiding eye contact, focusing on computer
- Resident following patient centred model of communication however not in sync with patient, so material is repeated and patient feels like they are not being heard.
Backpocket Examples

* Patient brings up multiple issues to address for visit the secondary issue brought up is chest pain, however the resident focuses agenda on primary reason indicated for visit. Discussion reveals lack of medical knowledge of how to address issue so resident avoided addressing it.

* Resident follows usual approach to delivering material on diabetes diagnosis to patient and appropriate information for medical plan, however misses cues early on in visit that patient is upset by diagnosis. Opportunity to discuss what is considered giving bad news, balance of not conveying that a manageable disease is scary while acknowledging the impact this has for individual depending on their circumstances.

* Resident provides good medical follow-up on medication for mood, checking both for adherence and side effects as well as efficacy. No plan identified/explored for non-medication management of mood other than assumption patient is seeing therapist.
Backpocket Examples

* Resident delivers appropriate medical interview, attempts to elicit patient perspective and at physical exam no explanation of what the physical exam questions are for, nor are results shared with patient. Patient confused about what the doctor is looking for, may be stressed and wondering what they found.

* Resident encounter with known demanding patient who has had difficulties with others and tends to control interview, resident believes rapport was established however patient provided excessive compliments to resident while asking for something others have refused, and resident shares personal information of non-therapeutic value. Time efficient encounter and resident pleased with encounter.

* Resident known to you to be an effective communicator with sound medical knowledge. In this particular encounter you see lack of engagement with patient, poor communicator behaviours. Discussion reveals bias toward patient: asking for sick note, obese patient, patient asking for abortion...

* Resident sharing lots of empathetic statements, explores patient experience, detailed assessment, detailed patient education, detailed informed decision making with accurate medical knowledge.
Conclusion

*I never teach my pupils, I only provide the conditions in which they learn.*

Albert Einstein
References


Aspergen, K. (1999). BEME Guide No.2: “Teaching and learning communication skills in medicine – a review with quality grading of articles.” Medical Teacher, 21(6), 563-570,


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