Ba e effec e feedbac

Hesketh and Laidlaw (2002) state that there are several barriers that prevent effective feedback from taking place. The purpose of feedback may not be clear to the teacher or learner. There may be no appropriate time or place for a feedback session. The teacher may have minimal or no formal training in giving effective feedback, may lack confidence about his/her observations, or may not know how to translate observations into specific, nonjudgemental and constructive feedback (Brukner et al. 1999; Cantillon & Sargeant 2008). Consequently, feedback may be very general and not helpful to a learner seeking to improve performance (Brukner et al. 1999). The hierarchical culture of medicine promotes a one-way flow of information from teacher to learner instead of a two-way conversation (Krackov 2011). As a result, the learner may view feedback as

improvement. Summative feedback should accompany the final evaluation so the learner can continue to grow.

The deliberate practice model (Krackov & Pohl 2011) focuses on learning outcomes, feedback, mentoring and reflection for the achievement of curricular milestones. As the model also promotes a culture of continuous learning and improvement, regular ongoing feedback is essential to promote the highest quality medical care and professional satisfaction.

Begin with the learner's self-assessment

A key goal of clinical training is to promote a reflective practitioner. Opening the feedback session by inviting the learner to self-assess can help achieve this goal. Use open-ended questions to start the meeting as a conversation and promote the learner's reflection on his/her practices. The learner may raise issues requiring a response from the teacher, which can help begin the dialogue (Branch & Paranjape 2002). The learner may well bring up the same points that the teacher had planned to address, thus providing a useful entrée.

This self-assessment can soften the perception of harshness and help make sensitive, corrective feedback feel more acceptable (Branch & Paranjape 2002). Feedback initiated solely or jointly by learners was seen as more instructive than that initiated mainly by teachers (Cantillon & Sargeant 2008; Van Hell et al. 2009).

Reinforce and correct behaviour

Begin by acknowledging and reinforcing exemplary behaviour. This approach can support good practices, motivate the learner to repeat them and prompt him/her to seek more feedback (Cantillon & Sargeant 2008; Krackov 2009). Trainees stated that positive feedback on what they were doing correctly gave them confidence in their skills and created a better learning environment (Bing-You et al. 1997).

Next, highlight necessary corrections, providing specific examples and suggestions for improvement. Learners have reported that constructive feedback was beneficial especially when it focused on specific performance accompanied by reasons why the performance was incorrect or faulty (Bing-You 1997) and when it dealt with behaviours that the learner was able to control or modify (Wood 2000).

Pendleton et al. (2003) described a similar four-step process for carrying out a feedback session. Ask the learner what he/she feels was done well; agree as appropriate and add reinforcing comments; then, ask the learner to identify areas of improvement; agree as appropriate and add more corrective feedback.

Use effective, encouraging face

Positive communication strategies are essential. The message sent by body language is important; sitting down beside the learner will minimise a position of power on the part of the teacher. Base feedback on directly observed performance, as recommended earlier in the text. When delivering reinforcing or corrective feedback, use a respectful, supportive tone and precise, descriptive and neutral wording. Focus on behaviours that can be changed, not the person or personality (Wood 2000) and provide clear examples (Cantillon & Sargeant 2008; Krackov 2009). When Internal Medicine residents were interviewed on their perceptions of useful feedback, they felt that timely, specific feedback was most effective when accompanied by suggestions for change (Bing-You 1997).

Be sure to give positive feedback too. Make the session a two-way conversation. The learner should be a partner in the feedback process who initiates and responds to questions. Be aware of the learner's response, personality and temperament. Limit the feedback given in the session to what the learner can absorb (Wood 2000; Krackov 2009). When feedback is handled well, it can enhance the teacher–learner relationship and lead to beneficial changes in the learner's behaviour (Cantillon & Sargeant 2008).

Confront emotional and defensive behaviour

A feedback session can be loaded with emotion on the part of both teacher and learner, particularly when corrective feedback is given. It is important to learn about the learner's perspectives and possible reasons for a specific behaviour (Krackov 2009). Consider the learner's background, temperament and readiness to change (Milan et al. 2006). Invite the learner to ask questions to assure that he/she has a firm understanding.

The ECO model (emotions, content and outcome) is a three-step process developed from the counselling literature to facilitate acceptance and use in multisource feedback (Sargeant et al. 2011). Step 1 focuses on acknowledging and exploring the emotional reaction to the feedback received.

as necessary. Inviting the learner to generate a plan for improvement as opposed to the teacher giving him/her a list of items to accomplish will help develop the trainee's skills of reflection, summarise the meeting by repeating the learner's

Hauer KE, Holmboe ES, Kogan JR. 2011. Twelve tips for implementing tools for direct observation of medical trainees' clinical skills during patient encounters. Med Teach 33:27–33.

Ericsson KA. 2004. Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains, 2003 Research in Medical Education invited address. Acad Med 79(10):S70–S81.

Hesketh EA, Laidlaw JM. 2002. Developing the teaching instinct: Feedback. Med Teach 24(3):245–248.

Hewson MG, Little ML. 1998. Giving feedback in medical education: Verification of recommended techniques. J Gen Intern Med 113:111–118.

Krackov SK. 2009. Giving feedback. In: Dent JA, Harden RM, editors. A practical guide for medical teachers. 3rd ed. Churchill Livingstone Elsevier.

Krackov SK. 2011. Expanding the horizon for feedback. Med Teach 33:873–874.

Krackov SK, Pohl H. 2011. Building expertise using the deliberate-practice curriculum-planning model. Med Teach 33(7):570–575.

Milan FB, Parish SJ, Reichgott MJ. 2006. A model for feedback based on communication skills strategies: Beyond "the feedback sandwich". Teach Learn Med 18:42–47.

Milan FB, Dyche L, Fletcher J. 2011. "How am I doing?" Teaching medical students to elicit feedback during their clerkships. Med Teach 33:904–910.

Pendleton D, Schofield T, Tate P, Havelock P. 2003. The consultation: An approach to learning and teaching. Oxford: Oxford University Press.

Perera J, Lee N, Win K, Perera J, Wijesuriya L. 2008. Formative feedback to students: The mismatch between faculty perceptions and student expectations. Med Teach 30(4):395–399.

Sargeant J, McNaughton E, Mercer S, Murphy D, Sullivan P, Bruce DA. 2011. Providing feedback: Exploring a model (emotion, content, outcomes) for facilitating multisource feedback. Med Teach 33(9):744–749.

Van Hell EA, Kuks JBM, Raat AN, Van Lohuizen MT, Cohen-Schotanus J. 2009. Instructiveness of feedback during clerkships: Influence of supervisor, observation and student initiative. Med Teach 31:45–50.

Wood B. 2000. Feedback: A key feature of medical training. Radiology 215:17–19.